



**SUBMISSION FROM THE NATIONAL ABORIGINAL COMMUNITY  
CONTROLLED HEALTH ORGANISATION**

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***TOWARDS A NATIONAL PRIMARY HEALTH CARE STRATEGY:  
FULFILLING ABORIGINAL PEOPLES ASPIRATIONS TO CLOSE  
THE GAP***

February 2009

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## Executive Summary

The National Aboriginal Community Controlled Health Organisation (NACCHO) welcomes the Rudd Government's commitment to build a better primary health care system for all Australians through the development of Australia's first National Primary Health Care Strategy.

In this submission we provide an important Introduction which sets the context and the definitions that underpin the recommendations for a national primary health care strategy that can best close the gap in life expectancy and health outcomes for Aboriginal peoples.

The National Aboriginal Community Controlled Health Organisation believes that the success of a primary health care system should be judged by how effectively, *those who are most needy* are able to access quality care. The matter is not just about *access per se*, but also about who is accessing the health system. A strategy that supports health service provision to those who are already good users of the health system will not make gains in health outcomes for Aboriginal peoples.

Access to primary health care is identified as a core obligation under the International Covenant for Economic Social and Cultural Rights (ICESCR). Within this core obligation is the understanding that Indigenous peoples have a right to design, deliver and control health services for them in order to achieve health gains. To this end, Australian Governments and non-government institutions have supported Aboriginal primary health care through Aboriginal Community Controlled Health Services (ACCHSs). The Rudd Government's definition of partnership means involving:

"Indigenous people in the design and delivery of programs locally and regionally, and share responsibility for outcomes... This strategy is firmly based on the principle of working in partnership with the Aboriginal and Torres Strait Islander community-controlled health sector."

The primary health care delivered by Aboriginal *community-controlled* health services is *culturally appropriate* because they are:

'An incorporated Aboriginal organisation, initiated by a local Aboriginal community, based in a local Aboriginal community, governed by an Aboriginal body which is elected by the local Aboriginal community, delivering a holistic and culturally appropriate health service to the community which controls it

Services that are not Aboriginal community-controlled, by definition, cannot deliver culturally appropriate primary health care. However, services that are not Aboriginal community-controlled can be encouraged to deliver healthcare that is *culturally secure*. A definition and program prepared by the ACCHS sector for the delivery of Aboriginal *cultural safety training* for mainstream health services should be supported.

NACCHO wishes to impart the message that the Strategy affirm the critical role and impact that accessible and *culturally appropriate* primary health care can make to close the gap in Aboriginal health standards by 2018 (Rudd Government's Statement of Intent), and for the Strategy to support the required actions needed to realise that objective. In this regard, NACCHO provides numerous recommendations under each of the 10 elements of the Discussion Paper: *Towards a National Primary Health Care Strategy*.

Principal of these recommendations is that ACCHSs are the preferred service model in the delivery of comprehensive primary health care to Aboriginal peoples across Australia. Unless ACCHSs are supported as the key providers in a strategy to close the gap, through an appropriately resourced Capacity Building Plan, the disparities in Aboriginal people's health status will not be alleviated. A systematic framework for working towards a primary health care system for Aboriginal peoples that maximises local community control (such as through a national plan aligned with the Northern

Territory Aboriginal Health Forum ‘Pathways to Community Control’<sup>1</sup>) should underwrite a 5 year Capacity Building Plan for ACCHSs. Resourcing pathways to community control for primary health care services will require pooling of all Aboriginal–specific primary health care funds currently being directed to State Governments, Divisions of General Practice and other private health care providers. This will maximize the potential of primary health care to close the gap in life expectancy for Aboriginal peoples. Such fund pooling should be governed by an appropriate mechanism, requiring the involvement of, and endorsement by, the NACCHO Aboriginal leadership.

Capacity building will require capital and recurrent funding and workforce strategies to train, recruit and retain staff including measures to address the vast salary disparities which currently prevent staff recruitment within ACCHSs. It will require resourcing based on the model of the Primary Health Care Access Program (PHCAP). A systematic approach towards defining the core deliverables for Aboriginal primary health care services (ie what funding would buy with an acceptable per capita benchmark funding allocation) is needed. ACCHSs funding should be based on a weighted population basis, according to need. A resource allocation formula that reflects the actual cost of ACCHSs providing the agreed core services at particular locations must be agreed to by NACCHO and Affiliates.

Progressing such a Plan will require a formalised partnership between the Department of Health and Ageing and the NACCHO leadership, particularly in the form of a new National Framework Agreement.

The expert advisory group is encouraged to read the full evidence-based NACCHO submission, but in summary, we draw attention to the following core requirements in order to expand ACCHSs:

1. A long-term plan of action for the expansion of ACCHSs developed in partnership between the Department of Health and Ageing and NACCHO and Affiliates (see Element 1), which meets specified targets and is measured by the indicators identified at the National Indigenous Health Equality Summit (2008) (Element 5).
2. Joint governance of an expansion program based on a National Framework Agreement (see Element 3).
3. The plan to support the adoption of core functions for ACCHSs across Australia (see Elements 2 & 10).
4. A workforce support program (see Elements 2, 8 & 9).
5. An evidence-based, ethical and acceptable quality assurance and performance management program developed by ACCHSs and for ACCHSs (see Elements 5 & 6)
6. A funding base for ACCHSs that utilises:
  - funding on a weighted population basis according to need
  - pooling of all *Aboriginal-specific* primary health care funds (including those to State Governments, Divisions of General Practice and other private providers). See Element 10.

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<sup>1</sup> Northern Territory Aboriginal Health Forum. Pathways to Community Control. A Framework to further promote Aboriginal community control in the provision of comprehensive primary health care services. April 2008.

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## Introduction

The National Aboriginal Community Controlled Health Organisation (NACCHO) welcomes the Rudd Government's commitment to build a better primary health care system for all Australians through the development of Australia's first National Primary Health Care Strategy.

This introduction is a vital part of the submission from NACCHO. It provides a context and the definitions that underpin the recommendations for a national primary health care strategy. Such a strategy has a responsibility to Aboriginal peoples and Torres Strait Islanders<sup>2</sup> in closing the gap in life expectancy.

The National Aboriginal Community Controlled Health Organisation believes that the success of a primary health care system should be judged by how effectively, *those who are most needy* are able to access quality care. The matter is not just about *access per se*, but also about who is accessing the health system. This submission proposes recommendations that should address the disparity in primary health care access for Aboriginal peoples and Torres Strait Islanders.

Aboriginal people's access to primary health care is considerably less than that for non-Indigenous Australians. We know this through disparities in:

- expenditure for primary health care (at only 1.2 times that for Aboriginal peoples, yet burden of disease is 3 times higher);<sup>3</sup>
- higher rates of potentially preventable acute and chronic conditions;<sup>4</sup>
- less than half the rate of medicines utilisation and less access to Australia's universal primary health scheme than other Australians;<sup>5</sup>
- indicators of health system performance (eg lower rates of immunisation, and antenatal care access by Aboriginal peoples, higher STI rates, and lower rates of early detection/early treatment);<sup>6</sup> and through
- referral-sensitive conditions (where rates of hospital procedures dependant on primary care referrals are considerably lower for Aboriginal peoples).<sup>7</sup>

In this submission, we refer to the Discussion Paper from the Australian Government: 'Towards a *National Primary Health Care Strategy*', as the Discussion paper.

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<sup>2</sup> This submission respects the preferred terminology when referring to Aboriginal peoples. The term 'Aboriginal peoples' reflects the diversity of the original people of Australia, and is referred throughout in preference to 'Indigenous'. Torres Strait Islanders have similar health problems to Aboriginal peoples, and have their own representative bodies. NACCHO respects Torres Strait Islanders right to self-determination. *Source: NSW Health. Communicating positively: A guide to appropriate Aboriginal terminology. NSW Department of Health 2004.*

<sup>3</sup> Australian Institute of Health and Welfare 2008. Expenditures on health for Aboriginal and Torres Strait Islander peoples 2004–05. Health and welfare expenditure series no. 32. Cat. no. HWE 40. Canberra: AIHW.

<sup>4</sup> Report on Government Services, 2007.

<sup>5</sup> Australian Institute of Health and Welfare 2008. Op. cit

<sup>6</sup> National Aboriginal and Torres Strait Islander Health Performance Framework, 2007.

<sup>7</sup> AIHW National Hospital Morbidity Database. Data for 2002-04.

## **History and Definitions**

- I. The National Aboriginal Community Controlled Health Organisation (NACCHO) is Australia's national peak body in Aboriginal health representing the health interests of Aboriginal peoples. It was established in Albury in 1974 and represents over 140 Aboriginal community-controlled health services (ACCHSs) around Australia.
- II. NACCHO is governed by a Board of community elected Aboriginal leaders from every State and Territory across Australia and has offices in Canberra. As such the NACCHO Board is the legitimate representative of all the Aboriginal communities serviced by ACCHSs across Australia.
- III. NACCHO's major activities include promoting, developing, and expanding the provision of culturally appropriate health care through local ACCHSs. To do that, NACCHO works with its State and Territory Affiliates (NACCHO Affiliates) and liaises with governments, departments, and organisations within both the Aboriginal and non-Aboriginal communities on matters relating to the well-being of Aboriginal communities.
- IV. The Aboriginal community controlled health movement established the first Aboriginal community controlled health services (ACCHS), in 1971, in the suburb of Redfern, in Sydney, NSW. From that time onwards, these services have delivered community controlled primary health care, identifying 'upstream' social determinants, addressing ways to reduce inequalities, and providing a political voice for Indigenous Australians health.<sup>8</sup>
- V. Through employment, engagement, empowerment and social action, ACCHSs have become strategic sites for Aboriginal community development, by empowering Aboriginal people to 'disarm the rhetoric of victimhood'. They are a proven mechanism for Aboriginal people to take responsibility over their health matters.
- VI. The development of ACCHSs was an organised response by Aboriginal peoples to deliver 'culturally appropriate, comprehensive primary health care' in their populations and foreshadowed the World Health Organisations Alma Ata Declaration on Primary Health Care (1978).
- VII. The ACCHSs sector uses the following definition of 'health' for Aboriginal peoples:

'Aboriginal health is not just the physical well-being of an individual but the social, emotional and cultural well-being of the whole Community in which each individual is able to achieve their full potential as a human being.'
- VIII. The ACCHSs sector uses the following definition of primary health care:

'Primary health care is a holistic approach which incorporates body, mind, spirit, land, environment, custom and socio-economic status. Primary health care is an Aboriginal cultural construct that includes essential, integrated care based upon practical, scientifically sound and socially acceptable procedures and technology made accessible to Communities as close as possible to where they live through their full participation in the spirit of self-reliance and self-determination. The provision of this calibre of health care requires an intimate knowledge of the community and its health problems, with the community itself providing the most effective and appropriate way to address its main

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<sup>8</sup> ACCHSs are a response to a health system that was (and remains for many) alien, racist and unresponsive to Aboriginal peoples needs.

health problems, including promotive, preventative, curative and rehabilitative services. (Adapted from the W.H.O. Alma-Ata Declaration 1978).<sup>9</sup>

IX. The primary health care developed by these services is *comprehensive* because it is encompasses:

“.. the provision of medical care, with its clinical services treating diseases and its management of chronic illness, it includes such services as environmental health, pharmaceuticals, counselling, preventive medicine, health education and promotion, rehabilitative services, antenatal and postnatal care, maternal and child care, programs and necessary ...aspects of health care arising from social, emotional and physical factors.” [ibid]

X. The broad scope of service provision from ACCHSs is evident in Service Activity Reports.<sup>10</sup> Moreover, clinical services provided to Aboriginal clients in ACCHSs is more complex than conditions managed within private general practice.<sup>11 12</sup>

XI. This definition of primary health care is important as it differentiates ACCHSs from *primary medical care* providers, other providers of health care to Aboriginal peoples and from selective PHC which is : “*often imposed by experts, proposing scientific or technical solutions; that are short term; vertical rather than horizontal; central rather than local/ decentralised; program owned rather than community owned; universal rather than locally specific and contextual; and, they foster dependency rather than empowerment.*”<sup>13</sup>

XII. The ACCHSs sector uses the following definition of *community control*:

"Community control is the local community having control of issues that directly affect their community". Implicit in this definition is the clear statement that Aboriginal people must determine and control the pace, shape, and manner of change and decision making at [all] levels (NAHS 1989a: xiv).

XIII. The primary health care delivered by Aboriginal *community-controlled* health services is *culturally appropriate* because they are:

‘An incorporated Aboriginal organisation, initiated by a local Aboriginal community, based in a local Aboriginal community, governed by an Aboriginal body which is elected by the local Aboriginal community, delivering a holistic and culturally appropriate health service to the community which controls it’.<sup>14</sup>

XIV. Services that are not Aboriginal community-controlled, by definition, cannot deliver culturally appropriate primary health care.

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<sup>9</sup> [www.naccho.org.au](http://www.naccho.org.au)

<sup>10</sup> Office of Aboriginal and Torres Strait Islander Health, National Aboriginal Community Controlled Health Organisation. Service Activity Reporting: 2003–04 Key Results. Commonwealth of Australia, 2006.

<sup>11</sup> Thomas D,R. Heller, et al. Clinical consultations in an Aboriginal community controlled health service: how are they different to consultations with Australian general practice. *Australian and New Zealand Journal of Public Health* 1998 22: 86-91.

<sup>12</sup> Larkins S, L. Geia, et al. Consultations in general practice and at an Aboriginal community controlled health service: do they differ. *Rural and Remote Health* 20066(560 (online)): 1-12.

<sup>13</sup> Newell, K. (1988). "Selective primary health care: the counter revolution." *Social Science and Medicine* 26(9): 903-906

<sup>14</sup> [www.naccho.org.au](http://www.naccho.org.au)

- XV. However, services that are not Aboriginal community-controlled can be encouraged to deliver healthcare that is *culturally secure*. A definition and program prepared by the ACCHS sector for the delivery of Aboriginal *cultural safety training* for mainstream health services can be accessed.<sup>15</sup>
- XVI. The Discussion paper uses the term ‘culturally appropriate’, but does not define it. The use of this term in a Primary Health Care strategy must be consistent with the definition developed by Aboriginal peoples (as provided in this submission).
- XVII. The ACCHSs sector uses the following definition of Aboriginality:<sup>16</sup>
- As used by the Federal Government as their ‘working definition, in state legislation and by the High Court, this definition is a three-part definition requiring all 3 parts to be established for Aboriginality to be recognized:
- *descent* (the individual can prove that a parent is of Aboriginal or Torres Strait Islander descent);
  - *self-identification* (the individual identifies as an Aboriginal or Torres Strait Islander); and
  - *community recognition* (the individual is accepted as such by the Aboriginal or Torres Strait Islander community in which he/she lives).
- XVIII. The development of a Primary Health Care strategy must ensure that Aboriginality is defined according to that provided in this submission. As financial incentives are increasingly being provided to mainstream health services in order to enhance their care of Aboriginal peoples, it is vital that the community is able to identify Aboriginal peoples.
- XIX. Through NACCHO, NACCHO Affiliates at the State/Territory level and through ACCHSs at the regional and local level, Aboriginal peoples have a leading role in identifying and responding to the nature and challenges facing their populations.

## Community participation in the Right to Health

- XX. Access to primary health care is identified as a core obligation under the International Covenant for Economic Social and Cultural Rights (ICESCR). This entered into force in Australia in 1976. In 2000, the United Nations Committee on Economic, Social and Cultural Rights (CESCR), in order to assist parties with implementation and reporting obligations, clarified that Article 12 referred to the provision of community-level preventive and curative care, screening programs, and essential drugs; and the participation of the population in these health services.<sup>17</sup> The CESCR also stated that:

“Indigenous peoples have the right to specific measures to improve their access to health services and care...States should provide resources for Indigenous peoples to design, deliver and control such services so that they may enjoy the highest attainable standard of physical and mental health”.<sup>18</sup>

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<sup>15</sup> Cultural Safety Training. <http://www.culturalsafetytraining.com.au/>

<sup>16</sup> [www.naccho.org.au](http://www.naccho.org.au)

<sup>17</sup> 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

<sup>18</sup> Office of the United Nations High Commissioner for Human Rights. Committee on Economic, Social, and Cultural Rights. General comments. No. 14. The right to the highest attainable standard of health (Article 12 of the International Covenant on Economic, Social, and Cultural Rights). E/C.12/2000/4. 11 Aug 2000. <http://www.ohchr.org/english/bodies/cescr/comments.htm> (accessed Feb 2007).

- XXI. The Royal Australian College of General Practitioners, the Australian College of Rural and Remote Medicine, the Australian General Practice Network and the Australian Medical Association, through Memoranda of Understanding with NACCHO and through their position statements on Aboriginal people's health, support ACCHSs and their representative bodies (NACCHO and Affiliates). The AMA believes that the medical profession has a responsibility to partner and support the efforts of Aboriginal peoples and work in partnership with ACCH organisations.<sup>19</sup>
- XXII. On the 13 March, 2008, the Federal Minister for Health and Ageing, Ms Nicola Roxon, confirmed to NACCHO delegates gathered in Parliament House that lessons had been learned from the ACCHS sector and that *'Superclinics bring people together in ways that ACCHSs have been doing for some time'*.
- XXIII. In 2005, the Australian Medical Association (AMA) affirmed:
- 'That Aboriginal community control must be supported and appropriately resourced in recognition of its demonstrated effectiveness in providing appropriate and accessible health services to a range of Aboriginal communities and its role as a major provider within the comprehensive primary health care context...[and] that all health services provided specifically for Aboriginal peoples and Torres Strait Islanders should be designed, developed and controlled by the communities they serve in collaboration with mainstream processes.'<sup>20</sup>
- XXIV. The 2007 AMA Report Card affirmed that:
- '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.'<sup>21</sup>

### **Do primary health care services matter in 'closing the gap'?**

- XXV. On 21 June 2006, then Federal Minister for Health and Ageing Mr Tony Abbott in a speech at the launch of 'Australia's Health' 2006, remarked: *'There is much evidence that the extremes of Indigenous ill health result from social conditions that no amount of improvement in health services can ever really deal with'*.<sup>22</sup>
- XXVI. On April 2nd 2007, the Hon Mr Tony Abbott remarked upon the release of the Oxfam/NACCHO 'Close the Gap: Solutions to the Indigenous health crisis' report stating that *".. these days, the problem is rarely inadequate health services"*.<sup>23</sup>
- XXVII. These were reaffirmations of the Howard Governments position that because health services alone were insufficient to close the gap in health status, that investments towards Aboriginal people's health should focus on social interventions.

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<sup>19</sup> AMA Position Statement 2005

<sup>20</sup> AMA Position Statement 2005

<sup>21</sup> Australian Medical Association. 2007 Report card: Institutionalised Inequity. Not Just a matter of money. <http://www.ama.com.au/node/3229>

<sup>22</sup> Abbott T. [Former Minister for Health and Ageing, Leader of the House of Representatives.] Speech notes for the launch at the AIHW Conference, Hyatt Hotel, Canberra, 21 June 2006.

<sup>23</sup> Abbott T. [Former Minister for Health and Ageing, Leader of the House of Representatives.] Transcript. Door stop interview, Mt Carmel Secondary College, Rosewater, Adelaide, 2<sup>nd</sup> April 2007.

- XXVIII. An independent review examining how primary health care can contribute to closing the gap in life expectancy between Aboriginal and non-Aboriginal peoples of Australia concluded however that ‘the evidence does not support such a position’.<sup>24</sup>
- XXIX. There is international evidence that while health services alone cannot fully address differential health status, primary health care is ‘equity producing’, contributing to lower mortality and partially mitigating the association between socioeconomic factors (like income inequality) and mortality. Internationally, access to comprehensive primary health care is a significant determinant of lower mortality. Primary health care improvements can lead to improved health outcomes despite the existence of social inequalities.<sup>25</sup>
- XXX. Consequently, funding comprehensive primary health care to a level that delivers a critical mass of workforce and service capacity is an equity-producing strategy that can help offset the impact of social inequality on the health of Aboriginal peoples and Torres Strait Islanders. Health service expansion should proceed in parallel with broader social welfare and economic reforms.
- XXXI. However, Aboriginal health services expansion has been inadequate. There is ample evidence of inadequate public investment in culturally appropriate primary health care that is accessible to Aboriginal peoples and substantial new funding is still required to ensure equity.<sup>26</sup>

### **Partnerships with Aboriginal peoples and their representative bodies- what it means**

- XXXII. On 13 May 2008, the Federal Minister for Indigenous Affairs Ms Jenny Macklin outlined the Rudd Governments definition of partnership with Aboriginal peoples:

[This means] “... working with Aboriginal and Torres Strait Islander people rather than imposing solutions on them. Above all we are building partnerships with Aboriginal and Torres Strait Islander people based on mutual respect and mutual responsibility... The Australian Government's relationship with Aboriginal and Torres Strait Islander people is being recast through meaningful engagement, not just consultation for its own sake.... Indigenous Australians must be involved in developing and driving solutions....Our 'closing the gap' commitments require effective engagement with Aboriginal and Torres Strait Islander people at all levels. Government needs to involve Indigenous people in the design and delivery of programs locally and regionally, and share responsibility for outcomes... This strategy is firmly based on the principle of working in partnership with the Aboriginal and Torres Strait Islander community-controlled health sector.”  
*Macklin, 13 May 2008 Federal Budget 2008-09.*

- XXXIII. The National Strategic Framework for Aboriginal and Torres Strait Islander Health (NSFATSIH, 2003-2013) endorsed by all Australian Health Ministers commits to the community control of primary health care services.

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<sup>24</sup> Griew R, Tilton E, Cox D, Thomas D. The link between primary health care and health outcomes for Aboriginal and Torres Strait Islander Australians. A Report for the Office of Aboriginal and Torres Strait Islander Health, Australian Government Department of Health and Ageing, June 2008.

<sup>25</sup> Couzos S, Murray RB. Health, Human Rights, and the Policy Process. In: Aboriginal Primary Health Care: An evidence-based Approach. 3<sup>rd</sup> ed. Oxford University Press, 2008.

<sup>26</sup> 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? Op. Cit

“Supporting community decision-making, participation and control [is] a fundamental component of the health system that ensures health services for Aboriginal and Torres Strait Islander peoples are provided in a holistic and culturally sensitive way”.

XXXIV. In the development of a new Primary Health Care strategy and any accompanying implementation plan, NACCHO recommends that development should proceed in partnership with Aboriginal community representative bodies. NACCHO recommends the Department of Health and Ageing utilise the following guidelines: “Making the Connections” endorsed in 2006 by AHMAC. These provide guidance to those within the Department to achieve more effective approaches to strategies involving Aboriginal people’s health. A checklist is also provided.<sup>27</sup>

### **Proposals for a new Primary Health Care Strategy**

- XXXV. Investments towards culturally appropriate primary health care for Aboriginal peoples and Torres Strait Islanders will reduce hospital admissions, prevent chronic health problems, and enhance community capacity.<sup>28</sup>
- XXXVI. NACCHO recommendations towards a new Strategy are listed in the following sections addressing each of the ten elements identified in the Discussion Paper.
- XXXVII. The key message NACCHO wishes to impart is that the Strategy affirm the critical role and impact that accessible and *culturally appropriate* primary health care can make to close the gap in Aboriginal health standards by 2018 (Rudd Governments Statement of Intent), and for the Strategy to support the required actions needed to realise that objective.
- XXXVIII. The Discussion paper proposes 10 elements that could underpin an Australian Primary health care system. NACCHO has responded to each of these elements. These elements capture important aspects needed in a primary health care system:
1. Accessible, clinically and culturally appropriate, timely and affordable;
  2. Patient-centred and supportive of health literacy, self-management and individual preference;
  3. More focussed on preventive care, including support of healthy lifestyles;
  4. Well-integrated, coordinated, and providing continuity of care, particularly for those with multiple, ongoing, and complex conditions;
  5. Safe, high quality care which is continually improving through relevant research and innovation;
  6. Better management of health information, underpinned by efficient and effective use of eHealth;
  7. Flexibility to best respond to local community needs and circumstances through sustainable and efficient operational models;
  8. Working environments and conditions which attract, support and retain workforce;
  9. High quality education and training arrangements for both new and existing workforce;
  10. Fiscally sustainable, efficient and cost effective.

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<sup>27</sup> National Public Health Partnership (2006). Making the Connections. Guidelines for effective approaches to Aboriginal and Torres Strait Islander Public Health. Melbourne: NPHP.  
[http://www.nphp.gov.au/publications/making\\_connections.pdf](http://www.nphp.gov.au/publications/making_connections.pdf)

<sup>28</sup> (National Strategic Framework for Aboriginal and Torres Strait Islander Health, NSFATSIH, 2003-2013).

- XXXIX. However, not captured in this structure is an explicit reference to *equitable delivery of services*. A primary health care system must be responsive to the needs of those who are marginalised and ‘hard to reach’, such as minority groups and disadvantaged populations. In particular, we refer to the Aboriginal and Torres Strait Islander population, as needing specific attention because of the substantially greater degree of excess morbidity and mortality than other Australians. The responsiveness of a primary health care system to Aboriginal peoples is a vital marker of equity.
- XL. The Discussion paper refers to a health system needing ‘flexibility to best respond to local community needs’ but does not cite reference to ACCHSs (on pages 39-40) even though they best exemplify mechanisms for transparent community accountability, governance and management, more than any other primary care service provider. This is a major oversight.
- XLI. The Discussion paper elements do not adequately capture the necessity for *community governance* of primary health care services, as defined by Aboriginal peoples. As described earlier, Aboriginal community governance underpins the success of ACCHSs in closing the health disparity gap.
- XLII. Moreover, the matter of ‘flexibility to respond to local needs’ is not just about developing models of care with enhanced community accountability (such as whether Divisions of General Practice have consumers on their Boards) but also about the degree with which the services/programs can respond to Aboriginal and high-risk patients and those who are ‘hard to reach’.
- XLIII. There are a plethora of reports that confirm the failure of mainstream general practices and government programs to target those who need services the most. Known as the ‘inverse care law’, this is particularly evident with respect to failures in Medicare,<sup>29</sup> PBS access<sup>30</sup> and the Practice Incentive Program (PIP).<sup>31</sup>
- XLIV. We do not believe that the elements capture issues relating to the need for transparent and evidence-based levels of service funding, sufficient to meet the level of health need in a community. We discuss these and the above matters in more detail.
- XLV. Finally, we reiterate that the success of a primary health care system should be judged by how effectively, *those who are most needy* are able to access quality care. The matter is not about *access per se*, but also about who is accessing the health system.

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<sup>29</sup> Furler JS, Harris E, et al. The inverse care law revisited: impact of disadvantaged location on accessing longer GP consultation times. *MJA* 2002 177 (2): 80-83

<sup>30</sup> Couzos S. PBS medications. Improving access for Aboriginal and Torres Strait Islander peoples. *Aust Fam Physician*. 2005 Oct; 34 (10):841-4.

<sup>31</sup> Urbis Keys Young. Aboriginal and Torres Strait Islander Access to Major Health Programs. Prepared for Medicare Australia and the Department of Health and Aging. November 2006.

## 1 Accessible, clinically and culturally appropriate, timely and affordable services

### Recommendations:

For a new primary health care strategy, NACCHO recommends that:

- 1.1 Aboriginal Community Controlled Health Services are the preferred service model in the delivery of comprehensive primary health care to Aboriginal peoples across Australia.
- 1.2 Aboriginal Community Controlled Health Services are the only providers of *culturally appropriate* comprehensive primary health care to Aboriginal peoples in Australia (see Introduction).
- 1.3 A capacity-building plan is in place to allow for the expansion of ACCHSs into communities where there is an identified need; existing services are augmented through capital works and recurrent support to provide comprehensive primary health care to an accredited standard, and to meet the level of need. (See also element 10)
- 1.4 The NT Aboriginal Health Forum 'Pathways to Community Control'<sup>32</sup> strategy be supported nationally as a positive and systematic framework for working towards a primary health care system for Aboriginal peoples that maximises local community control. (See Element 10).
- 1.5 Progressing a *national* primary health care plan of action to close the gap and to promote pathways to community control will require a formalised partnership between the Department of Health and Ageing and the NACCHO leadership, particularly in the form of a new National Framework Agreement. (See Element 10)
- 1.6 Making private general practices and other mainstream health care providers *culturally secure* for Aboriginal and Torres Strait Islander peoples is possible by supporting the adoption of cultural safety training programs which have been endorsed by the Aboriginal community-controlled health sector.<sup>33</sup> Cultural Safety Training modules have been developed and national roll-out of this program should be supported. (See also Element 9).
- 1.7 The gap in Aboriginal health status cannot be closed unless access to primary health care is enabled for those who are not accessing services. Therefore, the expansion of ACCHSs is a priority in efforts to close the gap in life expectancy for Aboriginal peoples.

### Responses to questions:

*How can we ensure appropriate services for all geographical areas and population groups?*

Aboriginal Community Controlled Health Services were established to meet the needs of Aboriginal peoples across all geographical areas and since the 1989 National Aboriginal Health Strategy, the Royal Commission into Aboriginal Deaths in Custody, the 2003 NSFATSIH, and

<sup>32</sup> Northern Territory Aboriginal Health Forum. Pathways to Community Control. A Framework to further promote Aboriginal community control in the provision of comprehensive primary health care services. April 2008.

<sup>33</sup> <http://www.culturalsafetytraining.com.au/>

numerous independent reviews, are affirmed to be the most appropriate providers of primary health care to Aboriginal peoples. (See Introductory briefing).

Services that are not Aboriginal community-controlled, by definition, cannot deliver culturally appropriate health care (see XIII Introduction). However, they can be encouraged to deliver healthcare that is *culturally secure*. A definition and program prepared by the ACCHS sector for the delivery of Aboriginal *cultural safety training* for mainstream health services can be accessed.<sup>34</sup>

The Northern Territory Aboriginal Health Forum (comprising representatives of AMSANT, Department of Health and Community Services, and the Department of Health and Ageing) has developed a framework to support Aboriginal communities in the planning, development and management of primary health care and community care services, in a progressive movement towards greater participation in health care, and ultimately to Aboriginal community control.

The framework, known as 'Pathways to Community Control', is based on the principle that Aboriginal communities have the right to participate in decision-making that affects their health and wellbeing. To this end, Forum partners agree that community controlled governance of health services is the optimal expression of the right of Aboriginal peoples to participate in their health care provision. This level of participation provides for a more responsive health and family services system, improved quality of care, cultural security, improved family and community functioning, all of which improve levels of Aboriginal health and wellbeing.<sup>35</sup>

The framework also accepts that not all Aboriginal communities will have the same aspiration or capability to manage the planning, development and delivery of primary health and community services at the same point in time. The framework therefore supports a capacity building approach in the transition of primary health care services towards Aboriginal community control.

The NT Aboriginal Health Forum is also committed to the regionalisation of services to ensure more efficient and sustainable delivery of core health services. In accordance with 'Pathways to Community Control', each region would ideally be under community control. However, movement towards community control of the regionalised health services will depend on community aspirations and capacity. (See also element 10).

In November 2008, the NACCHO membership of ACCHSs endorsed the approach in the NT<sup>36</sup> and recommended that 'Pathways to Community Control' be adapted as a national framework. This will require a partnership with the Department of Health and Ageing, particularly in the form of a new national Framework Agreement with NACCHO.

*How could primary health care services/workforce be expanded to improve access to necessary services?*

Aboriginal Community Controlled Health Services provide services to Aboriginal peoples with more complex health problems<sup>37 38</sup> and are more effective at reaching those who are needy than

<sup>34</sup> <http://www.culturalsafetytraining.com.au/>

<sup>35</sup> NT Aboriginal Health Forum. Pathways to Community Control. An Agenda to further promote Aboriginal community control in the provision of Primary Care Services. April 2008. [www.nt.gov.au/health](http://www.nt.gov.au/health)

<sup>36</sup> NACCHO Annual General Meeting Resolutions, Broome, November 2008.

<sup>37</sup> Thomas, D., R. Heller, et al. (1998) "Clinical consultations in an Aboriginal community controlled health service: how are they different to consultations with Australian general practice." *Australian and New Zealand Journal of Public Health* 22: 86-91.

mainstream general practices. In this respect they are more effective at ensuring those who are 'hard to reach' access primary health care. (See Element 4 for further discussion). The gap in health status cannot be closed unless access to primary health care is enabled for those who are not accessing services. For this reason, the expansion of ACCHSs is a priority in efforts to close the gap in life expectancy for Aboriginal peoples.

However, the expansion of ACCHSs has been a prime policy objective since the 1989 National Aboriginal Health Strategy. Lacking in the ensuing twenty years has been a sufficient resourcing commitment by governments to expand ACCHSs provision. Whilst expansion has occurred, independent analyses have confirmed this has not been to the level necessary to close the gap in service access.<sup>39</sup> Moreover, with the current proportionate federal health expenditure through the OATSIH being just short of 0.8% of the total, of this only 75% reaches ACCHSs. This proportion is gradually reducing as Aboriginal –specific primary care funding is increasingly diverted towards Divisions of GP and mainstream private practices (see below in Element1).

In order to expand ACCHSs, the following is needed:

7. A long-term plan of action for the expansion of ACCHSs developed in partnership between the Department of Health and Ageing and NACCHO and Affiliates.
8. Joint governance of an expansion program based on a National Framework Agreement (see Element 3).
9. The plan to support the adoption of core functions for ACCHSs across Australia (see element 10).
10. A workforce support program (see Elements 8 & 9).
11. A funding base for ACCHSs that utilises:
  - funding on a weighted population basis according to need
  - pooling of all *Aboriginal-specific* primary health care funds (including those to State Governments, Divisions of General Practice and other private providers). See Element 10.

*What more needs to be done for disadvantaged groups to support more equitable access?*

The key message NACCHO wishes to impart is that the Strategy affirm the critical role and impact that accessible and *culturally appropriate* primary health care can make to close the gap in Aboriginal health standards by 2018 (Statement of Intent), and for the Strategy to support the required actions needed to realise that objective.

The Rudd Governments commitment to 'close the gap' in Aboriginal peoples health status, was outlined in the signing of the Statement of Intent, on 20 March 2008. The Statement committed the Australian Government 'to developing a comprehensive, long-term plan of action, that is targeted to need, evidence-based and capable of addressing the existing inequities in health services...by 2030.'

<sup>38</sup> Larkins, S., L. Geia, et al. (2006) 'Consultations in general practice and at an Aboriginal community controlled health service: do they differ.' *Rural and Remote Health* 6(560 (online)): 1-12.

<sup>39</sup> 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? Op. Cit

Moreover, ‘*crucial to ensuring equal access to health services is ensuring that Aboriginal and Torres Strait Islander peoples are actively involved in the design, delivery, and control of these services.*’ The commitment is ‘*to supporting and developing Aboriginal and Torres Strait Islander community-controlled health services in urban, rural and remote areas in order to achieve lasting improvements in Aboriginal and Torres Strait Islander health and wellbeing.*’

The current ‘long term plan of action’ for governments to improve the health of the Aboriginal and Torres Strait Islander population is called the National Strategic Framework for Aboriginal and Torres Strait Islander Health (NSFATSIH) which was endorsed by the Australian Health Ministers Advisory Council (AHMAC) in 2003.<sup>40</sup> This framework supports ACCHSs, and at the population level, Indigenous-specific public health strategies.

The NSFATSIH was meant to be a 10 year plan of action from 2003 to 2013, with its accompanying Implementation Plans developed both at a federal level and at each State and Territory. The federal ‘Implementation Plan’ (2007-2013) was developed by the Office of Aboriginal and Torres Strait Islander Health (OATSIH) to guide its work.<sup>41 42</sup>

However, this 2007-2013 Implementation Plan was developed with little input from Aboriginal representative bodies. Moreover, this Plan was hastily developed by OATSIH and released a few weeks prior to the Federal Election in November 2008, even before the previous Plan had expired.

The NSFATSIH commits to supporting ‘adequately resourced’ ACCHSs through a methodology to determine the level of resourcing needs and ‘real costs of providing services’. Such negotiations are meant to progress at the State/Territory level through forums established through tripartite Framework Agreements (NACCHO Affiliate, State and Territory Department of Health, and the Commonwealth Department of Health and Ageing). The Framework Agreements commit signatories to an increased level of resources allocated to reflect the level of need; joint planning; access to both mainstream and Aboriginal and Torres Strait Islander specific health and health related services which reflect their higher level of need; and improved data collection and evaluation. However, government funding priorities away from ACCHSs (mainstreaming- see Element 4), and an increasing tendency at a Department level to resource ACCHSs through competitive program grants and a plethora of vertical programs in an adhoc manner has hampered services capacity (see below).

Moreover, at a national level, there is no Framework Agreement tied to a plan of action, and no formal engagement between the Department of Health and Ageing and the NACCHO leadership in order to develop appropriate policy and its implementation.

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<sup>40</sup> National Aboriginal and Torres Strait Islander Health Council for the Australian Health Ministers Conference. National Strategic Framework for Aboriginal and Torres Strait Islander Health (2003–2013). Framework for Action by Governments. Canberra: Department of Health and Aged Care, 2004.

<sup>41</sup> National Aboriginal and Torres Strait Islander Health Council for the Australian Health Ministers Conference. National Strategic Framework for Aboriginal and Torres Strait Islander Health: Australian Government Implementation Plan 2007–2013. Canberra: Australian Government, Department of Health and Ageing, 2007.

<sup>42</sup> Senate Community Affairs Committee Answers To Estimates Questions On Notice Health And Ageing Portfolio Budget Estimates 2008-2009, 4 & 5 June 2008 Question: E08-027.

Consequently, NACCHO does not believe the current NSFATSIH Implementation Plan represents a long-term plan of action to close the gap in health inequalities between Aboriginal and non-Aboriginal Australians.

Whilst the development of a new Aboriginal Health Plan requires Aboriginal governance and the Department of Health and Ageing to restructure the way it does business with NACCHO, a new Primary Health Care strategy must acknowledge that closing the gap depends on appropriately resourced and supported ACCHSs. Funding allocated towards ACCHSs is considerably less than that needed to provide the level of services to meet health needs. This situation is further discussed under Element 10.

*With limited public health dollars, how could priorities for accessing primary health care services be determined and targeting of public resources improved?*

Through the Statement of Intent, Aboriginal primary health care through ACCHSs has been identified as a priority by the Rudd Government (see above). The issue is thus a matter of enabling these services and targeting public resources (for primary health care) in that direction.

Currently, opportunities for ACCHS to increase their base funding over and above consumer price index increases is limited to piecemeal, short-term grant funding for isolated and vertical program delivery.

This is more recently illustrated by the COAG commitments of previously unprecedented levels of funding (\$806 million through the Commonwealth over 4 years), but with distribution to ACCHSs continuing to be through vertical programs (with separate acquittals) and tenders, thus introducing competition between ACCHSs with mainstream service providers.

Competitive tendering not only amongst ACCHSs, but between ACCHSs and other government and non-government agencies, including area health services and Divisions of General Practice promotes fragmented and piecemeal program development reducing coordinated care rather than increasing it. The burden of reporting this creates is unprecedented and has led the OATSIH to consult on ways in which this burden might be reduced.<sup>43</sup>

Mainstream health services have a responsibility to provide health care to all Australians, and should target their service provision according to their own populations needs. Every Aboriginal Australian has a choice to access mainstream services or ACCHSs and many Aboriginal peoples already access mainstream primary health care services. This does not mean that mainstream services should compete for funding with ACCHSs. Rather, the provision of culturally secure services, as outlined by the RACGP standards for general practice as well as Quality Improvement Council (QIC) core standards, is a part of standard service provision. It neither warrants nor justifies sourcing of additional monies for provision of services to Aboriginal peoples.

ACCHSs on the other hand, specifically provide a primary health care environment which mediates social change- services by Aboriginal people for Aboriginal people- with expanded and comprehensive interventions, especially for those who are 'hard to reach'. Such services cannot be provided through Medicare generated funds alone, and cannot (by definition) be provided by mainstream agencies. It is for this reason that the mainstreaming primary health care agenda of the

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<sup>43</sup> OATSIH. Issues Paper: Review of Reporting Requirements for OATSIH funded organizations., September 2008.

former Howard Government is unlikely to lead to better health outcomes.<sup>44</sup> (See also Elements 3 & 4).

OATSIH recently called for submissions to establish Indigenous-specific brokerage services in selected urban or regional areas. While it was claimed that this program will “increase the range of health services that urban Aboriginal and Torres Strait Islander people access, and the number of times they access these services”, it will in fact restrict the range of services available, because the funding can only be used to access mainstream services. The guidelines for the program explicitly state that funds cannot be used to expand the services of ACCHSs. This is another example of how limited Aboriginal funds can distort service provision and block progress towards closing the gap.<sup>45</sup>

The priorities towards the allocation of limited Aboriginal health dollars should be determined by Aboriginal representative bodies in partnership with the Department of Health and Ageing and Government Ministers. This occurs to some extent at the State/Territory level through the State/Territory Framework Agreements. However, at the national level, in the absence of a Framework Agreement with NACCHO, and with opposition to the creation of such an Agreement expressed by the OATSIH,<sup>46</sup> there is no mechanism for joint priority setting with the national elected Aboriginal leadership representing community controlled health service providers.

Whilst the establishment of the National Indigenous Health Equality Council has permitted a forum for ‘national leadership in responding to Government’s commitment to closing the gap on Indigenous disadvantage by *providing advice* to Government’, it acts purely as an advisory body and is made up of only two representatives from the ACCHSs sector.

NACCHO recommends that progressing a national primary health care plan of action to close the gap and to promote pathways to community control will require a partnership between the Department of Health and Ageing and the NACCHO leadership, particularly in the form of a new national Framework Agreement. Such a process will ensure priority setting involves the elected Aboriginal health leadership.

## 2 Patient-centred and supportive of health literacy, self-management and individual preference

### Recommendations:

A new Primary Health Care strategy should support:

- 2.1 ACCHSs as prime examples of services which support the health literacy of the Aboriginal population (see Element 1 for action needed).

<sup>44</sup> Scrimgeour M, Scrimgeour D. 2007, Health Care Access for Aboriginal and Torres Strait Islander People Living in Urban Areas, and Related Research Issues: A Review of the Literature, Cooperative Research Centre for Aboriginal Health, Darwin.

<sup>45</sup> Altman J. 2004 ‘Practical reconciliation and the new mainstreaming: Will it make a difference to Indigenous Australians’ *Academy of Social Sciences: Dialogue* 23(2):35-46

<sup>46</sup> Senate Community Affairs Committee Answers To Estimates Questions On Notice Health And Ageing Portfolio Budget Estimates 2008-2009, 4 & 5 June 2008 Question: E08-027.

- 2.2 Several ACCHSs sites as 'Teaching Health Centres of Excellence in Aboriginal Health' (according to the model of existing exemplar sites) in order to increase the potential of the health workforce towards holistic health care delivery. (See also Element 9).

**Responses to questions:**

*What is needed to improve the patient and family-centred focus of primary health care in Australia for:*

*a) individual patient encounters;*

ACCHSs provide patient-centred care whilst also recognising that for many Aboriginal peoples, their health choices are influenced by their family circumstances, the population, social and economic influences. Hence, health care comprises interactions with Aboriginal health workers and allied health staff as well as doctors, including programs and systems of engagement which support health promotion (and literacy) in the community. Health care provision is 'holistic' being patient, family, and community centred in keeping with the definition of Aboriginal health (see Introduction).

An Aboriginal workforce, Aboriginal governance and close community interaction, are vital influences towards patients greater adherence to treatment options, health seeking behaviour and involvement in decision making. Such structures provide community role models, local employment and foster community harmony.

*b) health professionals;*

Health professional staff within ACCHSs learn from and adopt the systems of health care established by ACCHSs. In this respect, they are excellent training grounds for health professionals to be skilled in the provision of individual health care whilst fostering community engagement and growth. The recent COAG Indigenous Health National Partnership Payment has incorporated some training for health professionals within ACCHSs for this reason.

Several large regional ACCHSs currently serve to coordinate training across all health professionals from AHWs, to medical students and nurses, to GP registrars (such as the Kimberley Aboriginal Medical Services Council, in remote WA<sup>47</sup>) and are exemplar sites. They function as a 3-way collaboration between ACCHSs, hospitals and the education sector that provides best practice care and teaching. Apart from teaching output, they showcase innovation in primary health care.

These systems could be expanded to increase training opportunities. NACCHO recommends further funding and development of ACCHSs sites as 'Teaching Health Centres of Excellence in Aboriginal Health' according to the model of existing exemplar sites.

Upgrading a number of existing ACCHSs to become Teaching Health Centres is a crucial initial element in improving the standard of health service delivery for Aboriginal and Torres Strait Islander people. The centres would provide model health services, teaching a range of health practitioners, doctors, nurses, allied health workers and AHWs, how to deliver the highest quality of health services.

Practical teaching would encompass students from medicine, nursing, allied health, and most importantly, Aboriginal Health Workers (AHW) at Diploma, Advanced Diploma, graduate and

<sup>47</sup> <http://www.kamsc.org.au/capter.html>

postgraduate levels. Support would be required to backfill for service delivery staff providing teaching.

The Teaching Health Centres would showcase the methods by which the Aboriginal life expectancy gap could be halved in the next 10 years, achieving the gains already experienced by the Indigenous populations of NZ, Canada and the US. This initiative would build on experience within ACCHSs in Australia and around the world in the training and development of health services and health professionals.

*c) health service organisations;*

See Element 1.

*d) the broader primary health care system?*

See Element 1.

*Are there specific strategies that are needed to better support consumer engagement and input?*

ACCHSs are specifically governed by the community (through elections), are exemplar sites for community engagement, and the preferred model for providing culturally appropriate comprehensive primary health care to Aboriginal populations (see Element 1). The Rudd Governments Super clinics were modelled on the ACCHS sector (see Introduction). Improved primary care resourcing to ACCHSs will ensure these services continue to reach Aboriginal patients most effectively (see Element 10).

Specific strategies to improve Aboriginal people's engagement with primary health care (pathways to Aboriginal community control) were outlined in Element 1. Community- control of health care provision represents the highest level of consumer participation in health care, and is the gold standard.

### **3 More focussed on preventive care, including support of healthy lifestyles**

#### **Recommendations:**

A primary health care strategy should:

- 3.1 Confirm preventive health care as a core function of primary health care and define those services which constitute core primary health care activity.
- 3.2 Support ACCHSs as primary deliverers of preventive health care to Aboriginal peoples across Australia.
- 3.3 Support the Aboriginal State/Territory tripartite forums involving NACCHO Affiliates as mechanisms for the determination of preventive health care priorities in each jurisdiction and support the development of a National Framework Agreement with NACCHO at the national level (see also Element 1).
- 3.4 Recommend the adoption of principles that prevent Departmental funds allocation for preventive health care through tenders and separate grants where it is deemed to comprise core primary health care activity.

3.5 Maximise preventive health care by supporting a range of activities, such as:

- Updating and distributing the 'National Guide to a Preventive Health Assessment in Aboriginal peoples and Torres Strait Islanders' to every GP;
- Supporting the ACCHS sector to deliver cultural security training to GPs and other health care providers (see also Element 1);
- Using the expertise of Aboriginal community controlled health services through coordinator positions established within NACCHO Affiliates;
- Enhancing and supporting the role of Aboriginal health workers (through training and MBS rebates for preventive activities. See Elements 8 &9);
- Developing a communication strategy for the broader Aboriginal and Torres Strait Islander population to increase the demand for health checks;
- Introducing clinical audit points on Aboriginal health checks for professional development;
- Bulk-billing for these assessments given the significant socioeconomic disparity between Aboriginal and Torres Strait Islander people and the broader Australian population.

#### Responses to questions:

*How could primary health care be enhanced to better support prevention activities?*

According to ACCHSs, preventive health is a core function of primary health care.<sup>48 49</sup> (See also the Introduction which outlines the CESCRs definition of primary health care). The most vital strategy to enhance preventive activities is to implement a capacity building plan to fund and support ACCHSs nationally to a weighted population needs basis. (See Element 1 & 10). If ACCHSs were appropriately resourced, the delivery of preventive health care could be better coordinated, optimised, with efficient use of resources, given that the model of service delivery is already geared towards prevention.

An example of inefficient and inappropriate vertical approaches to preventive health care is the recent COAG Indigenous Partnership Payment which allocated \$161 million over four years to tackle risk factors for chronic diseases. From this, the Department of Health and Ageing have proposed to *put to tender* the placement of 57 Regional Coordinators for smoking cessation programs targeting Aboriginal peoples. The placement of 100 health promotion officers will proceed through a *separate grants process* inviting ACCHSs in competition with Divisions of GP and State health services. This diverts service delivery and encourages an expanding bureaucracy.

These two examples illustrate the Departments wasteful approach to delivering the outcome intended- a reduction in smoking cessation. The bureaucratic manipulation of public monies such that vast sums are expended in devising vertical programs that divert services from health care provision should not be permitted. However, given the absence of the peoples governance over

<sup>48</sup> AMSANT. Indigenous Access to core primary health care services in the NT, 2007.

<sup>49</sup> Aboriginal Health and Medical Research Council. Core functions of primary health care in ACCHSs. AHRMC Monograph Series, Vol1 No 1, 1999.

Departmental choices and preferences, there are no mechanisms in place that prevent public servants from distributing funds in this manner (see Element 1).

A primary health care strategy would do well to recommend the adoption of principles that prevent Departmental funds allocation through tenders and separate grants where it is deemed to comprise core primary health care activity.

Other sources of funds for preventive health care include Medicare. For ACCHSs, Medicare alone cannot provide sufficient funds to support comprehensive primary health care (see Element 10). However, Medicare can *supplement* funding towards preventive health care.

For example, in 2004, NACCHO successfully negotiated the introduction of Medicare Rebate for the adult Aboriginal health check (item 710).<sup>50</sup> The underlying premise was that Aboriginal peoples needed earlier preventive health assessments, given the occurrence of preventable chronic disease at younger ages and higher rates than in other Australians, and incentives to health providers could increase the provision of these checks (see Box 1).

There are numerous examples of Aboriginal peoples missing out on early preventive health care. The consequences are increasing costs to the health system. For example, during 1997–2002, Aboriginal and Torres Strait Islander Australians (compared with non-Indigenous Australians) were *twice as likely* to be referred late for dialysis treatment. (Late referral is defined as first attending a renal unit or being seen by a nephrologist less than 3 months before the initiation of dialysis). Given that kidney disease can be prevented and existing kidney disease progression can be delayed, the lack of access to primary health care can increase the costs of tertiary sector dialysis and surgery. The cost of renal replacement therapy for all new cases of end stage kidney disease in Indigenous Australian patients (diagnosed between 2004-2010) and projecting treatment forward ten years, will exceed \$200 million by the end of 2010 and will rise to \$365 million by 2019.<sup>51</sup>

*Box 1. The need for prevention targeting Aboriginal peoples*<sup>52</sup>

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<sup>50</sup> Mayers N, Couzos S. Towards health equity through an adult health check for Aboriginal and Torres Strait Islander people. *Med J Aust.* 2004; 181 (10): 531-532

[http://www.mja.com.au/public/issues/181\\_10\\_151104/may10471\\_fm.html](http://www.mja.com.au/public/issues/181_10_151104/may10471_fm.html)

<sup>51</sup> Cass A, Chadban S, Craig J, Howard K, McDonald S, Salkeld G, White S. The economic impact of end-stage kidney disease in Australia. Part I of the 'Study of the economic impact of the burden of kidney and urinary tract disease in Australia'. The George Institute for International Health; Sydney 2006.

<sup>52</sup> Mayers N, Couzos S. Op. Cit

#### Justification for a Medicare Benefits Schedule rebate for adult health checks for the Aboriginal and Torres Strait Islander population

##### Aboriginal people and Torres Strait Islanders:

- have lower participation rates in preventive health programs (eg, cervical screening and breast cancer detection).<sup>7</sup>
- have high rates of undetected risk factors and chronic disease.<sup>6</sup>
- are referred late for end-stage disease, making treatment options more expensive (eg, if renal failure develops).<sup>6</sup>
- are less likely to ask for preventive health assessments (significantly lower rates of requests for check-ups).<sup>6</sup>
- have unequal access to Medicare (rate of use of the Medicare Benefits Schedule by Aboriginal people and Torres Strait Islanders is less than half that of other Australians, yet their overall health needs are about three times greater).<sup>9</sup>

##### General practitioners:

- miss opportunities for prevention (eg, significantly lower rates of vaccination by GPs in encounters with Aboriginal and Torres Strait Islander people<sup>10</sup>), leading to higher rates of hospital admissions for preventable diseases.<sup>11</sup>
- find the preventive assessment process complex (comorbidity, sociocultural considerations).<sup>6</sup>
- experience difficulties in delivering preventive healthcare to the Aboriginal and Torres Strait Islander population (inadequate remuneration for the time required, lack of knowledge of relevant health issues and inability to identify Indigenous Australians).<sup>6</sup>

The guidelines underpinning the delivery of preventive health checks were developed by NACCHO with the support of eight non-government organisations (chronic disease alliance), and were published together with the RACGP. The ensuing '*National Guide to a Preventive Health Assessment in Aboriginal peoples and Torres Strait Islanders*<sup>53</sup>' complements the RACGP 'red and green books' and a revision is now being planned.

Changing practice to maximise the uptake of adult health checks for this population will require a range of supportive activities, such as:

- Updating and distributing the '*National Guide to a Preventive Health Assessment in Aboriginal peoples and Torres Strait Islanders* to every GP;
- Supporting the ACCHS sector to deliver cultural security training to GPs and other health care providers;
- Using the expertise of Aboriginal community controlled health services through coordinator positions established within NACCHO Affiliates;
- Enhancing and supporting the role of Aboriginal health workers (through training and MBS rebates);
- Developing a communication strategy for the broader Aboriginal and Torres Strait Islander population to increase the demand for health checks;
- Introducing clinical audit points on Aboriginal health checks for professional development;

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<sup>53</sup> National Aboriginal Community Controlled Health Organisation, the Chronic Disease Alliance of Non-Government Organisations (Aboriginal and Torres Strait Islander Health), RACGP. *National Guide to a Preventive Health Assessment in Aboriginal and Torres Strait Islander Peoples*. RACGP, Melbourne, August 2005.  
<http://www.racgp.org.au/guidelines/nationalguide>

- Bulk-billing for these assessments given the significant socioeconomic disparity between Aboriginal and Torres Strait Islander people and the broader Australian population.

Whilst Medicare Benefits Schedule (MBS) rebates for Aboriginal Health Workers (AHWs) have been established, access to those rebates has been restricted to only the NT. This anomaly has been highlighted by NACCHO for several years. There is a need to remove the jurisdictional inconsistencies pertaining to AHWs claiming certain rebates (eg wound care MBS item 10996 which can only be claimed by NT AHWs). The arguments maintaining the jurisdictional barriers preventing other AHWs from claiming these rebates promote inequity and are based on the premise that only NT AHWs are registered, however, that registration process is not linked to standards. Any AHW certified to level III or IV from a registered training provider (RTP), providing GP delegated care, should have access to the MBS rebates.

The Department has used the RTP approach for permitting PIP rebates for work undertaken by AHWs across Australia (and not just NT). In addition, the Allied Health MBS Rebates permit AHWs from all States and Territories to claim them. (Item number 10950). This MBS item requires AHW training to Cert III level from a RTP. The RTPs that fulfil the criteria are listed in the Schedule. Basically, there is one set of rules for some rebates and another set of rules for others- with inconsistent logic underpinning them.

*How could health professionals be better supported to provide lifestyle modification advice and support consumers in behavioural change?*

From the development of resources as outlined above and an implementation plan to promote uptake, the provision of appropriate training, such as through teaching centres of excellence within ACCHS (see Element 2). This support would be inherent through appropriately resourced ACCHSs (see Element 10).

*How can consumers be linked with local primary health care services to support a stronger focus on population-based preventive health care with national reporting?*

Aboriginal consumers, by definition, have a transparent and essential role in devising local priorities through appropriately resourced ACCHSs (See Introduction and Element 1). Regarding national reporting, please see Element 5.

*What measures have been, or could be, effective in addressing prevention for specific population groups (eg. Indigenous, rural and remote, low socio-economic status, CALD)?*

In brief, prevention is a core part of primary health care service delivery through ACCHSs, and when appropriately resourced, ACCHSs are most effective at delivering preventive health care to Aboriginal peoples. More detail on the breadth of preventive activity within ACCHSs,<sup>54</sup> the range

<sup>54</sup> Department of Health and Ageing. Service Activity Reporting 2003-04 Key Results: A National Profile of Commonwealth Funded Aboriginal Primary Health Care Services. Commonwealth of Australia, 2006 Canberra.

and effectiveness of interventions to Aboriginal populations (by disease),<sup>55 56</sup> and success stories<sup>57 58</sup> and can be sourced from a range of publications.<sup>59</sup>

*With limited public health dollars, how could preventive care priorities be determined and public resources subsequently targeted?*

The determination of preventive health care priorities requires an evidence-based approach with flexibility to accommodate the specific needs of communities. For example, preventive health strategies towards acute rheumatic heart disease will be a priority in remote areas, but not necessarily in non-remote. Substance misuse strategies will need modification depending on the drug taking behaviour and preferences in differing communities. ACCHSs are best placed to gauge their community's needs in this respect and should have governance authority over how preventive strategies will be developed and implemented.

At the State and Territory level, the utilisation of the State Forums through the Framework Agreements (see Introduction and Element 1) is vital in determining funding allocations and priorities.

At the National level, the establishment of a National Framework Agreement between NACCHO and the Department of Health and Aging is vital to introduce more effective Aboriginal governance over the health programs needed by Aboriginal peoples. (See Introduction and Element 1).

#### **4 Well-integrated, coordinated, and providing continuity of care, particularly for those with multiple, ongoing and complex conditions**

##### **Recommendations:**

- 4.1 Aboriginal peoples have higher rates of co-morbidity and social disadvantage, and need more support in negotiating the health system than other Australians. ACCHSs are best placed to coordinate local and regional service provision to Aboriginal peoples.
- 4.2 A new national primary health care strategy should structure the coordination of care for Aboriginal peoples through ACCHSs, and that as a priority, all public monies allocated to

<sup>55</sup> Couzos S, Murray R [Eds] for the Kimberley Aboriginal Medical Services Council (KAMSC). *Aboriginal Primary Health Care: an Evidence-based Approach*. Third Edition. Oxford University Press, Melbourne, 2008

<sup>56</sup> National Aboriginal Community Controlled Health Organisation, the Chronic Disease Alliance of Non-Government Organisations (Aboriginal and Torres Strait Islander Health), RACGP. *National Guide to a Preventive Health Assessment in Aboriginal and Torres Strait Islander Peoples*. RACGP, Melbourne, August 2005.  
<http://www.racgp.org.au/guidelines/nationalguide>

<sup>57</sup> Griew R, Tilton E, Cox D, Thomas D. The link between primary health care and health outcomes for Aboriginal and Torres Strait Islander Australians. A Report for the Office of Aboriginal and Torres Strait Islander Health, Australian Government Department of Health and Ageing, June 2008.

<sup>58</sup> Fletcher S. *Communities Working for Health and Wellbeing: Success stories from the Aboriginal Community controlled health sector in Victoria*, 2007. Published together with Victorian Aboriginal Community Controlled Health Organisation.

<sup>59</sup> See also OATSIH Best Practice Case studies and the AMA Report Card series.

- close the gap in health status be allocated in a manner that will target needy Aboriginal peoples through these services. (See Elements 1 & 10)
- 4.3 In line with the Memorandum of Understanding between NACCHO and the Australian General Practice Network, a primary health care system that allocates funding for Indigenous-specific primary health care should require mainstream services that apply for such funding (such as Divisions of GP) to show evidence of engagement and written agreement from the local ACCHS for that funding.
- 4.4 ACCHSs should not be required to compete for Indigenous-specific funding with mainstream health services (see also Elements 1 & 3).
- 4.5 A new Primary Health Care Strategy, in providing a systematic framework for working towards a primary health care system for Aboriginal peoples that maximises local community control should note that the AGPN has committed to *'support work towards achieving the goal of each Aboriginal community having its own community based, locally-owned, culturally appropriate and adequately resourced primary health care service in which GPs have a role'*. [NACCHO-AGPN Memorandum of Understanding, 2007]. (See Element 1).

#### Responses to questions:

*What target groups would most benefit from active clinical care and/or service coordination?*

Aboriginal peoples have higher rates of co-morbidity and social disadvantage, and need more support in negotiating the health system than other Australians. As a response, ACCHSs were established to deliver comprehensive primary health care. (See Introduction which explains how ACCHSs define primary health care, which exemplifies coordinated care).

*Who is best placed to coordinate the clinical and/or service aspects of care?*

ACCHSs are staffed by multidisciplinary health teams, in a model of service provision that is accountable to the Aboriginal community. In many ACCHSs, Senior Aboriginal Health Workers have the responsibility for coordinating outstation programs and preventive care. In larger services that employ several GPs, a senior medical officer may have the task of coordinating clinical care in conjunction with Aboriginal health workers. In outstation clinics where there is no medical officer, nurses and AHWs jointly play a role in coordinating clinical care. The key element to the coordination of care of patients is that it is a team responsibility, and that often the first point of contact for Aboriginal patients is an Aboriginal Health Worker.

In the provision of specialist and allied health care from visiting services, most ACCHSs prefer on-site clinics and have made special arrangements with State health departments and local hospitals for these provisions. Specialists services are thus provided in an 'Aboriginal space' and can be integrated with other elements of care. These provisions should be supported. Limitations to this approach are a lack of consulting rooms and a need for capital works to accommodate service provision (see Element 10).

Similarly, the provision of dental services is a core element of comprehensive primary health care and several ACCHSs have established dental facilities. Most ACCHSs have insufficient funds for

dental facilities. The coordination of dental care for Aboriginal peoples is deemed a core function of ACCHSs.

The House of Representatives Report on the Inquiry into Indigenous Health in 2000 remarked:

'Many of the [ACCHSs] visited by the Committee were stretching their existing resources to the limit. In one instance the Committee was impressed by the dental facilities at a medical service, only to find that the organisation was unable to use these facilities because of the lack of sufficient funding to employ a dentist.' (3.14). The Committee was informed about other communities where there was no ambulance and the general service vehicles often had to be used to transport seriously injured patients over long distances (3.15). These problems are symptomatic of the confused nature of the funding process... (3.16)<sup>60</sup>

In the provision of primary health care to Aboriginal peoples, ACCHSs are best placed to coordinate local and regional service provision. (See Element 10 for regional models of support in the pathway to Aboriginal community control).

*How could information and accountability for patient handover between settings (eg. hospital and general practice) be improved?*

State and Territory Affiliates of NACCHO are best placed to answer this question. NACCHO Affiliates have specific recommendations pertaining to State Government coordination programs such as Patient Assistance Transport Schemes, the provision of accommodation during transfers to/from remote areas, and ways in which electronic systems can be used to enhance handover and transfer of information. Several NACCHO Affiliates have provided separate submissions in response to the Discussion paper towards a new Primary Health Care Strategy.

*What changes are needed to improve integration between different primary health care organisations?*

An example of inefficient and inappropriate 'vertical' approaches to integration is the recent COAG Indigenous Partnership Payment which allocated \$470 million federal funds over four years for improved coordination of chronic diseases affecting Aboriginal peoples.<sup>61</sup> With this objective in mind, the Department has deemed that it will establish a new Indigenous Practice Incentive Payment (PIP) for general practices to claim.

Contrary to several independent evaluations which have shown that financial incentives to GPs through PIP have not improved the delivery of care to Aboriginal peoples,<sup>62 63</sup> it is inappropriate for the Department to justify this approach as evidence-based. Moreover, financial incentives through PIP automatically 'lock out' ACCHSs because over one-third of these services are not RACGP accredited (which is an eligibility criterion).

There are a number of other concerns with this initiative. In the past, although PIPs were established for 'hard to reach' populations such as underscreened women in need of Pap smears, there was little in the way of performance measures of success. Aboriginal women, although known

<sup>60</sup> Health is Life Report (2000). Page 38.

<sup>61</sup> COAG Communique, November 29, 2008.

<sup>62</sup> Urbis Keys Young, Op. cit.

<sup>63</sup> Beilby J, Zwar N, Burgess T, Hasan I, Davies GP, Couzos S, Davis S. ABS17: Linking evidence to policy - lessons from the national evaluation of the Asthma 3+ Visit Plan in Australia. Prim Care Respir J. 2006 June 15 (3): 190.

to be significantly underscreened, were not specifically targeted. Mainstream GPs also had difficulty identifying women who were Aboriginal. In the absence of transparent performance assessment, and failure to publically release evaluation findings, Senate Estimates confirmed in 2006 that few Aboriginal women must have benefited from the program, which cost tax payers over \$200 million from 2001 to 2010.<sup>64</sup>

This is an example of the inability of mainstream practices to identify Indigenous Australians and to identify those Aboriginal clients who are needy. Aboriginality is not the sole criterion for disadvantage. Tax payers expect health allocations to close the gap in Aboriginal health status and doing that requires identification of those Aboriginal peoples who have difficulty accessing the health system and who need specific supports for health literacy and social disadvantage.

An Indigenous PIP is likely to fund GPs to coordinate the care of Aboriginal peoples who are already good users of health services, and make no difference to those whom the COAG Payments were meant to assist.

Similarly, other elements of the COAG chronic disease coordination package will be provided through the Divisions of GP. The Department envisages that funds will be given to Divisions to employ 80 Indigenous Outreach Workers. A funds pool will also be established for transport support to support follow up care. It is unclear if it is proposed that Divisions act as fund holders.

These initiatives lack the evidence-base to underpin such a substantial investment. In the absence of trials to show that Aboriginal peoples will benefit from such structures, and in the presence of evaluations which have confirmed that Aboriginal peoples have not benefited from systems thus far, NACCHO is unable to support these investments.

It is vital that a primary health care strategy structure the coordination of care for Aboriginal peoples through ACCHSs, and that all public monies allocated to close the gap in health status be allocated in a manner that will target needy Aboriginal peoples through these services first.

Divisions of GP have a role in providing care to all Australians and NACCHO has committed to assisting the Australian General Practice Network (AGPN) to support Divisional efforts to encourage practices to record self-identified Aboriginal and Torres Strait Islander patients in order to target appropriate and relevant health care provision.<sup>65</sup> In turn, AGPN has committed to *'support work towards achieving the goal of each Aboriginal community having its own community based, locally-owned, culturally appropriate and adequately resourced primary health care service in which GPs have a role'*.

The former CEO of AGPN reported to the NACCHO Board of Directors in June 2007, that:

“it is our view that Divisions should not compete with ACCHSs for funding” and that “we will only ever auspice if we are asked to”.

Divisions of GP that apply for Aboriginal health funding, should be required to show evidence of engagement and agreement from the local ACCHS for that funding. The delivery of services of this nature should not be competitive.

Negotiations of this nature are difficult to sustain if government Departments undermine these relationships by favoring mainstream health service providers over ACCHSs. Rather, the

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<sup>64</sup> Couzos S, Murray RB. Health, Human Rights and the Policy Process. In: Aboriginal Primary Health Care: An evidence-based approach. 3<sup>rd</sup> Edn. Oxford University Press, 2008

<sup>65</sup> NACCHO MOU with AGPN, November 2007.

coordination of care at the regional and local level is the responsibility of ACCHSs, and at the State/Territory level through NACCHO Affiliates, where they are best placed to provide advice on optimal systems of coordinated care for Aboriginal peoples. Where smaller ACCHSs do not yet have the capacity for optimal coordination of care, larger regional ACCHSs should auspice these services. Such an approach is operational across many parts of Australia, such as in the Kimberley region of WA. (See Element 1 for pathways to community control).

*Would there be advantages in patients having the opportunity to 'enrol' with a key provider?*

It has been proposed by the National Health and Hospitals Reform Commission (NHHRC) that improvements in the care of people with chronic disease can occur if services “work with a defined population identified through voluntary enrolment” and that “Aboriginal and Torres Strait Islander people should also be able to enrol with a primary health care service including ACCHSs”.<sup>66</sup> The purpose of the enrolment is so that Aboriginal people can receive services funded specifically to deliver care to this population. Services receiving these funds would also include mainstream providers and would be accredited services.

The NHHRC suggestion (as drafted) is not supported by NACCHO. Aboriginal peoples face difficulties accessing health services, are highly dispersed and mobile populations, and currently have the freedom to choose their service provider. The creation of another bureaucratic layer to health services delivery, with the primary intention of rationing and accounting for health services expenditure, may in fact worsen Aboriginal people’s access to health care.

Such a system sanctions a market approach to the provision of health care, which is the antithesis of optimal methods in delivering care to the underserved. It further promotes competition between ACCHSs and mainstream health services. Moreover, no evidence is provided that such an approach would be effective for Aboriginal peoples. The premise assumes that all Aboriginal peoples are disadvantaged and that permitting mainstream services to access capitation-based funding systems (on the basis of patient enrolments) will close the gap in health inequity. As described in earlier sections (see above and Elements 1,3), most of the gap in health status is contributed to by populations who are not accessing health services. Those populations are mostly being reached by ACCHSs. Delivering services to those who are ‘hard to reach’ has already been proven through ACCHSs, and requires a systematic, capacity building plan concentrating on culturally appropriate primary health care delivery. Mainstream health services employing a new class of health worker called- ‘Indigenous outreach workers’- has not been proven to be effective and should be considered for trialling rather than widespread program support as is currently planned through the COAG Partnership Payments.

ACCHSs are able to identify their baseline and regular Aboriginal patient populations as well as provide estimates of visiting clients they also provide services to. This applies to ACCHSs across Australia. Indigeneity is also able to be confirmed and ACCHSs play a vital role in brokering this function where needed. Mainstream practices in contrast, have not shown that they are able to control leakage of Indigenous-specific program resources to non-Aboriginal patients. Enrolment processes will need to be able to identify Indigeneity and ACCHSs are best placed to do that.

<sup>66</sup> NHHRC report Better Health for all Australians, 2009.

Whilst, the ACCHS sector is currently exploring ways in which the development of a new funding authority for Aboriginal primary health care might improve resourcing for ACCHSs, such planning must be led and sanctioned by Aboriginal elected leaders from NACCHO.

## **5 Safe, high-quality care which is continually improving through relevant research and innovation**

### **Recommendations:**

- 5.1 NACCHO recommends that a primary health care strategy incorporate the 'National Indigenous Health Equality Targets' presented as the outcome from the National Indigenous Health Equality Summit in March 2008 (Australian Human Rights Commission), as performance benchmarks by which the activities of government departments towards Aboriginal primary health care can be assessed.
- 5.2 Suggested mechanisms of monitoring of Departmental activity (and public accountability) could include:
  - Incorporating the Indigenous Health Equality Summit performance indicators into the existing National Aboriginal and Islander Performance Framework;
  - A requirement for the Department to formally report back to Aboriginal representative bodies, such as NACCHO and State/Territory Affiliates through established Framework Agreements;
  - A requirement for the Department to officially accept a response from NACCHO and State/Territory Affiliates as to the success of progress;
  - A national bipartisan authority established to monitor government's effort to close the gap, to assess NACCHO's response to the Department and make recommendations for action;
  - Reporting as part of the Australian Government's reporting obligation to the United Nations CESCR.
- 5.3 It is recommended that a national primary health care strategy support NACCHO and Affiliates to develop and endorse a national set of quality assurance indicators for ACCHSs in partnership with the Department of Health and Ageing.
- 5.4 A single reporting framework for ACCHSs has advantages in streamlining reporting to funding bodies, but requires funding streams to be consolidated into core grants capable of funding the delivery of comprehensive primary health care to an acceptable standard.
- 5.5 It is recommended that a primary health care strategy should require the Department of Health and Ageing to amend the Aboriginal health performance indicators of Divisions of GP to ensure they capture Divisional activity alone and are endorsed by NACCHO and Affiliates.
- 5.6 A performance framework for a primary health care strategy should ensure that Divisions of General Practice in receipt of additional Indigenous-specific monies are accountable through new performance indicators developed in a partnership between AGPN with NACCHO and State Affiliates, and auspiced by the Department.
- 5.7 It is recommended that the Department of Health and Ageing (eg OATSIH) commence negotiations with NACCHO in the:

- development of a new Information Agreement with NACCHO with regard to a performance management system for ACCHSs (as outlined in box 3);
- establishment of an Aboriginal information and data advisory group made up of NACCHO Affiliates and NACCHO which will act as the principal source of advice to the Department on a performance management system which rationalizes the collection and use of data from ACCHSs;
- provision of support to NACCHO and Affiliates to develop and endorse a national set of quality assurance indicators for ACCHSs.

5.8 It is recommended that the primary health care strategy support the establishment of ‘a national unit for collaborating in research and quality assurance’ as an expansion of the activities of NACCHO.

### Responses to questions:

*What aspects of performance of the primary health care sector could be monitored and reported against (eg. for each Element in this Discussion Paper, what are key areas of performance that could be monitored and how)?*

NACCHO advocates that efforts to close the gap in Aboriginal health status need performance monitoring. Given that a primary health care strategy is a vital mechanism to ‘close the gap’ (see Introduction), it is essential that progress towards the provision of primary health care to Aboriginal peoples is monitored. This also means monitoring the efforts and processes of the Australian Government Department of Health and Ageing.

### National Aboriginal and Torres Strait Islander Health Performance Framework

The National Aboriginal and Torres Strait Islander Health Performance Framework (HPF) that has been agreed to by the Australian Health Ministers’ Advisory Council (AHMAC) is an important adjunct to measuring progress with the NSFATSIH, but it is difficult to see how it may be used to promote equitable health service delivery from the mainstream health sector. For example, while the burden of Aboriginal children’s hearing loss is a measure in the HPF, Federal Government expenditure towards hearing services provision as a response to this problem is not.<sup>67</sup>

There are no targets whatsoever in the HPF for the responsiveness of health systems. Per capita expenditure on primary health care disaggregated by Indigenous status is identified in the HPF, but targets for the optimal level of expenditure are not.

The Council of Australian Governments (COAG) initiative, Indicators for Overcoming Indigenous Disadvantage, aims to inform Australian governments about whether policy programs and interventions are achieving positive outcomes for Indigenous Australians, but again does not examine governments’ targeted funding outlays.<sup>68</sup> Efforts are underway to update these indicators in light of the subsequent COAG commitments, but these efforts have not engaged with Aboriginal representative bodies like NACCHO.

<sup>67</sup> Oxfam/NACCHO Close the Gap report

<sup>68</sup> SCRGSP (Steering Committee for the Review of Government Service Provision). Overcoming Indigenous disadvantage: key indicators 2005. Canberra: Productivity Commission, Commonwealth of Australia, 2005. [www.pc.gov.au/gsp/reports/indigenous/keyindicators2005/index.html](http://www.pc.gov.au/gsp/reports/indigenous/keyindicators2005/index.html).

## A Performance Framework to Close the Gap in Primary Health Care Access

The lack of Government targets to close the gap in health services access for Aboriginal peoples underlies the need for the 'National Indigenous Health Equality Targets' presented as the outcome from the National Indigenous Health Equality Summit in March 2008 (Australian Human Rights Commission).<sup>69</sup> These provide performance benchmarks by which the activities of government departments towards primary health care can be assessed. The Primary Health Care Strategy Reference Group is referred to the National Indigenous Health Equality targets which can be accessed at: [http://www.hreoc.gov.au/social\\_justice/health/targets/index.html](http://www.hreoc.gov.au/social_justice/health/targets/index.html)

A summary is included in box 2.

Indicators for the adequacy of the primary health care system must reflect the core responsibilities of those services. It is necessary to avoid indicators of health status (for example), that are also a function of influences outside primary health care.

Box 2. Primary health care indicators (to close the gap in health status for Aboriginal peoples by 2013)

**Goal: To increase access to culturally appropriate primary health care to bridge the gap in health standards**

**Indicators:**

**Obligations to Aboriginal Community Controlled Health Services**

- [Evidence of utilization of] a *national framework agreement* to secure the appropriate engagement of Aboriginal people and their representative bodies in the design and delivery of accessible, culturally appropriate and quality primary health care services.<sup>70</sup>
- 60% of communities and representative bodies are active partners in regional planning of primary health care at the State/Territory level.<sup>71</sup>
- Services [ACCHSs] are funded by a single core of pooled funds for a minimum of 3 years at a time, and at least three times the per capita MBS utilisation by non-Indigenous Australians (with a rural and remote loading of up to an additional three times).
- Uptake of PBS and MBS by Aboriginal peoples and Torres Strait Islanders is increased to at least 1.2 times the per capita utilisation for the non-Indigenous Australian population.
- 100% of ACCHSs have access to pharmaceuticals through Section 100 or its equivalent.<sup>72</sup>
- [100% of ACCHSs have access to] an established quality use of medicines scheme for Aboriginal primary health care services in non-remote areas that also increases access to medicines.
- 80% of ACCHS provide home visiting services and have facilities for provision of visiting allied health and specialist services.
- Aboriginal and Torres Strait Islander primary health care services are supported to deliver child and maternal health services as core activity. These services act as hubs for parenting support referrals.
- 80% of ACCHSs are accredited in the new accreditation framework.
- Resources are in place for NACCHO Affiliates and Torres Strait Islanders CCHSs to support every Aboriginal and Torres Strait Islander community that wishes to develop their Aboriginal & Torres Strait Islander primary health services into legally incorporated community-controlled services.
- Capital works programs to assist Aboriginal communities wishing to develop a new ACCHS are established.

<sup>69</sup> Human Rights and Equal Opportunity Commission. Close the Gap. National Indigenous Health Equality Targets. Outcomes from the National Indigenous Health Equality Summit, Canberra, March 18-20, 2008.

<sup>70</sup> The establishment of a national framework agreement is listed as a 'target'. Here, it has been expressed as an indicator.

<sup>71</sup> An indicator could also require 'Evidence of utilization of quarterly formal consultative forums such as the State/Territory Framework Agreements'.

<sup>72</sup> An equivalent example is the QUMAX Program.

- Cultural safety training programs are delivered in partnership with and recognized by ACCHSs and their representative bodies.

**Obligations of Australian Government Department of Health and Ageing**

- The Federal Government coordinates a National Indigenous Australians' Oral Health Care Program which allocates resources and responsibilities for the provision of clinical care by State/Territory public dental providers and NACCHO on a regional basis.
- Commonwealth and State/Territory health programs agree to health impact assessments of policies relevant to Aboriginal and Torres Strait Islanders in order to ensure their accessibility.
- Australian Health Care Agreements commit to monitor and report on access to health programs by Aboriginal peoples and Torres Strait Islanders.
- Performance indicators are agreed for which funding is contingent, that pertains to meeting targets that improve Aboriginal peoples and Torres Strait Islanders access to hospital and other services.
- Targets are developed and agreed to under the Health Care Agreements including for kidney dialysis; population health programs (such as sexual health, cervical screening, Breastscreen); rehabilitation services (eg cardiac rehabilitation, Commonwealth Hearing Services Program); residential aged care services, and immunisation.

**Obligations of General Practices**

- The Multi- Program Funding Agreement between the Department of Health and Ageing with Divisions of General Practice in Australia have a set of performance expectations pertaining to delivery of services to Aboriginal peoples and Torres Strait Islanders.
- All Australian Governments commit to make it part of the accreditation process that all government funded and private general practices provide culturally sensitive services to Aboriginal and Torres Strait Islander people.
- All health care providers to commit to 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.

**Obligations of Allied health providers**

- Performance indicators for hearing service providers under the Commonwealth Hearing Services Program are developed to improve hearing services provision and rehabilitation services.

Suggested mechanisms of monitoring of Departmental activity (and public accountability) could include:

- Incorporating the Indigenous Health Equality Summit performance indicators into the existing National Aboriginal and Islander Performance Framework;
- A requirement for the Department to formally report back to Aboriginal representative bodies, such as NACCHO and State/Territory Affiliates through established Framework Agreements;
- A requirement for the Department to officially accept a response from NACCHO and State/Territory Affiliates as to the success of progress;
- A national bipartisan authority established to monitor government's effort to close the gap, to assess NACCHO's response to the Department and make recommendations for action;
- Reporting as part of the Australian Governments reporting obligation to the United Nations CESC.

*Who should be responsible for developing and maintaining a performance framework?*

There are two aspects to this issue. The first is a performance framework to assess the success and progress of a primary health care strategy, and the other is a performance framework at the primary health care services level. The first approach has already been discussed in the above section.

Any performance framework at the service level should be developed and maintained by the relevant industry body. If services are funded to provide health care to Aboriginal peoples (such as in the case of Divisions of GP), such a performance framework should be developed in partnership with the ACCHS sector. In this section we refer to performance frameworks for ACCHSs and for Divisions of General Practice.

### **An ACCHS Performance Framework**

In the case of ACCHSs, NACCHO in conjunction with State/Territory Affiliates should be supported to develop and maintain a national performance framework.

In order for such a framework to succeed, ACCHSs must be receiving sufficient core funding to deliver comprehensive primary health care to meet the level of community need. If this is not the case, services will continue to have imposed on them, separate reporting for grants and programs in order to supplement their funding.

The success of a single reporting framework thus depends on funding streams being consolidated into core grants capable of funding the delivery of comprehensive primary health care to an acceptable standard.

There are two principles to a performance framework for ACCHSs:

- A performance framework should be '*a single format- ideally one that collected both the information necessary for government to measure service activity, quality and outcomes, as well as the information needed by organisations to improve planning and to gauge how well they are meeting the needs of their local client population*'.<sup>73</sup>
- Such a framework should be underpinned by a national *Information Agreement* with the sector.

It is 10 years since the Information Agreement between the OATSIH and NACCHO was first negotiated. In November 2008, Ms Helen Evans and the late Dr Puggy Hunter signed the Agreement for Service Activity Reporting (SAR) Data from ACCHSs. The goal of the Agreement was to provide a framework for mutual respect and cooperation in the collection, storage and analysis of information from these services in order to contribute data and information to the health policy and program development processes of both parties. There was an understanding that government accountability requirements needed to be satisfied with regard to the quality and activity of Australian Government funded Aboriginal primary health care services. In return, the information collected would also inform resource gaps in the sector to assist the Government to meet funding responsibilities, and program and policies towards these services.

Underpinning these objectives were specific principles which were agreed to by both parties which aimed to protect and reassure the sector as to the use of the data collected. Paragraph 2.1.4 stated:

*"It is not the intention of the Department that Aboriginal communities will suffer the withdrawal of health care resources as a direct or indirect result of the provision of Service Activity Reporting information."*

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<sup>73</sup> Section 5.8. OATSIH Issues Paper: Review of Reporting Requirements for OATSIH Funded Organisations. September 2008.

Agreed activities were noted such as the creation of a joint committee to oversee the reporting process, the devising of data collection instruments, training, data processing and analysis and the production of reports. It was also pre-empted that NACCHO Affiliates may also play a role in supporting their members at a jurisdictional level in the information process.

Importantly, it was agreed that both OATSIH and NACCHO would have access to the de-identified dataset and that both parties would jointly be conducting analysis of the information with the assistance of experts in Aboriginal health. The aim of joint access is for accountability of government funding outlays, and for NACCHO to use in accordance with its role and responsibilities in supporting its members.

In the last 5 years, the Department's commitment to the Agreement has dwindled to such a degree that neither NACCHO nor Affiliates can access aggregated, de-identified data from ACCHSs in order to fulfil their support responsibilities to their members.<sup>74</sup> The reciprocal respect and cooperation agreed to between the Department and the ACCHS sector operating for the last 10 years no longer applies.

Moreover, despite the Department of Health and Ageing supporting the Australian General Practice Network and State-based Organisations (within the mainstream health sector) for the development of performance management systems,<sup>75</sup> such an approach with NACCHO has been defensively opposed by the OATSIH.<sup>76</sup>

A new Information Agreement with ACCHSs will strongly benefit a performance management system that relies on data collection from ACCHSs. As the performance management systems are meant to support quality assurance, maximum utility requires a sense of ownership by ACCHSs and this can only be achieved by maximizing contribution from the ACCHS sector.

OATSIH have invested in NACCHO and Affiliates to support services in quality assurance, and doing that at a national level requires coordination, a systematic approach to performance management, and partnership with NACCHO. Such partnerships need to be underpinned by mutual understanding and respect, which an Agreement would provide. The suggested role of an Information Agreement is shown in box 3.

**Box 3. Role of an Information Agreement for a ACCHSs performance management system**

- An *Information Agreement* between NACCHO and the Department of Health and Ageing would:
- articulate clear objectives to the collection of data from ACCHSs as part of a performance management system to ensure that information is used solely for the purpose for which it was collected;
  - rationalize reporting by balancing the needs for accountability with those that foster quality improvement;
  - support central coordination and strategic planning of information management to avoid any future 'blowout' of reporting;
  - clarify information sharing responsibilities;
  - foster shared understandings and the capacity of ACCHSs;
  - avoid mismanagement of reporting processes and ensure approaches are ethical;
  - commit partners to the development of supports such as guidelines;

<sup>74</sup> As in the Healthy for Life Program.

<sup>75</sup> Gardner K, Sibthorpe B, Longstaff D. National quality and performance system for Divisions of General Practice: early reflections on a system under development. ANZ Health Policy. 2008 5:8.

<sup>76</sup> Senate Estimates by the Community Affairs Committee (4-5 June 2008). At that hearing, OATSIH reported that they *would not enter* into an Information Agreement. Page 54.

- support an Aboriginal governance structure for information management ensuring accountability back to the community;
- is a form of quality assurance for peak bodies and the Department as both NACCHO and OATSIH could be accountable to each other in supporting performance improvement;
- sustain cogent systematic approaches which might be undermined by frequent staff turnover both within the Department and NACCHO.

An Information Agreement would ensure guidance on a range of related matters including obligations pertaining to publication of aggregated data, the use of that data beyond services use for benchmarking and quality improvement, use of that data for a public report card, timely release of information for service planning, and so on.

Without such guidance, data management decisions risk being made in an adhoc manner and without mandate. The risk that performance management may be driven by data agencies rather than by primary health care services themselves has already been realised.<sup>77</sup> Other risks exist when research or health surveillance activity poses as quality assurance to circumvent the need for ethics committee assessment. This has the potential to distort clinical practice and, in fact, divert services away from clinical care.<sup>78</sup>

The matter of ethical management of Aboriginal health related performance systems deserves attention in the development of a primary health care strategy. Quality improvement activities are believed to not require ethics committee oversight because they are systematic, data-guided activities designed to bring about immediate improvements in health care delivery as by-products of usual clinical activity. Moreover, the knowledge gained is relevant internally such as when a clinic checks vaccination coverage and implements improvements accordingly. Research on the other hand is a systematic investigation designed to enhance generalisable knowledge from activity that is not usual for the clinic. Human research requires ethics committee clearance.

Thus, if some quality improvement activities are in fact research, the failure to assess the ethical implications of the activity may pose a risk for consumers and health services if they don't comply with recognised ethical standards and values of the community. It has been said that because a "quality improvement activity might be commendable, [this] does not imply that any given project is acceptable."<sup>79</sup> Consequently, it has been argued that certain quality improvement activity should be subject to ethical oversight.

NHMRC Guidelines (2003) on this subject recommend ethics committee review if the proposed quality assurance activity potentially infringes the rights, privacy or professional reputation of carers, health care providers or institutions.<sup>80</sup> We ask, how are such risks assessed in Australia and by whom? Should it be left to government agencies? Or should consumers and their representative bodies be the arbiters?

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<sup>77</sup> See NACCHO submission to Urbis Pty Ltd regarding the Evaluation of the Healthy for Life Program.

<sup>78</sup> Sheldon TA. The healthcare quality measurement industry: time to slow the juggernaut? *Qual Saf Health Care* 2005;14:3-4

<sup>79</sup> Perneger TV. Why we need ethical oversight of quality improvement projects. *International Journal for Quality Health Care* 2004 16:5: 343-344.

<sup>80</sup> NHMRC. When does quality assurance in health care require independent ethical review? Advice to Institutions, human research ethics committees and health care professionals. Commonwealth of Australia, 2003.

These issues have long been a matter of concern by Aboriginal groups and is why NACCHO developed national data protocols several years ago,<sup>81</sup> and is now recommending a new national *Information Agreement* to underpin a performance management program.

With regards to performance indicators for ACCHSs, the plethora of performance measures expected of services have lead the OATSIH to streamline reporting requirements.<sup>82</sup> In the OATSIH Issues Paper (2008), it is clear that ACCHSs have borne a heavy reporting burden, in excess of any other primary health care provider and that this “*is likely to be a cause for inefficiency, not to mention potential frustration for organisations*”.

Steps have already been taken by NACCHO Affiliates to develop a quality assurance reporting mechanism for ACCHSs at the State/Territory level. Two sets of performance indicators have been developed by the Queensland Aboriginal and Islander Health Council (QAIHC)<sup>83</sup> and the Aboriginal Medical Services Alliance in the Northern Territory (AMSANT).<sup>84</sup> These indicator sets are similar, and provide a framework for a national set from which other jurisdictions could consider using. Having a national set creates efficiencies and ensures that some form of national benchmarking is possible. The NACCHO membership in November 2008, subsequently endorsed that NACCHO should develop a national set of performance indicators based on those already developed by Affiliates.

The Department of Health and Ageing must engage with and be led by the representative bodies of the ACCHS sector in order to support the development of appropriate indicators to meet the separate and distinct purposes of quality assurance (internal) and accountability (external).

This is currently being resisted by the Department. For example, the OATSIH has tendered the development of ACCHSs performance indicators to research bodies,<sup>85</sup> to cover the delivery of maternal and child health and chronic disease services (core primary health care). Moreover, this has been done through mechanisms that are not endorsed by ACCHSs representative bodies like NACCHO and NACCHO Affiliates. This approach is counterproductive. The RACGP for example, are the arbiters and the developers of standards for general practice and quality assurance of those services. It would be inappropriate for standards and quality assurance to be imposed by government and research agencies,<sup>86</sup> as has occurred in this example.

The World Health Organisation (WHO) has identified principles for health service indicators. Indicators should be ‘use- and action-orientated’ rather than ‘data or information led’; development of data recording and reporting should be made only to ‘improve the provision of

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<sup>81</sup> NACCHO website: [www.naccho.org.au](http://www.naccho.org.au)

<sup>82</sup> OATSIH Issues Paper: Review of Reporting Requirements for OATSIH Funded Organisations. September 2008.

<sup>83</sup> QAIHC Health Information Project. Queensland Community Controlled Health Sector- Performance Indicators. November 2007.

<sup>84</sup> NT Aboriginal Health Forum. Key Performance Indicator Information System. The list of 19 KPIs, October 2007.

<sup>85</sup> Such as the Healthy for Life program being tendered to Menzies School of Health Research and the Australian Institute of Health and Welfare.

<sup>86</sup> Sapirie S, Orzeszyna S. Selecting and defining national health indicators. Geneva: Strengthening Country Health Information Unit Division of Epidemiological Surveillance and Health Situation and Trend Assessment, World Health Organization, September 1995

health care'; and the priority should be for data to be 'generated and used at a local level' to support enhancement of services.<sup>87</sup> Moreover, the WHO stated:

*"The principle of an indicator being formulated to improve practice is fundamental as one could impose upon general practices and health services a suite of data collection requirements for disease surveillance that is more rightly the responsibility of public health units or researchers.... The level of effort going into the development of these performance indicators has not been matched by critical evaluation of the impact of externally imposed indicators on primary health care service quality."*

For this reason, NACCHO recommends that the Department of Health and Aging provide support to NACCHO and Affiliates to develop and endorse a national set of quality assurance indicators for ACCHSs.

### **Divisions of General Practice Performance Framework**

In the development of a primary health care strategy, the Discussion paper states that: *"There is relatively little information on the performance of primary health care services in respect to safety and quality, consumer outcomes or consumer experiences."* NACCHO agrees with this statement, with particular reference to mainstream general practices and Divisions of General Practice that are poorly accountable for the receipt of public monies towards Aboriginal peoples and in outcomes to the community in general.

Divisional performance indicators over the period 2005-08 with regard to Aboriginal peoples were an attempt to disaggregate data capture by encouraging Divisions to support practices to record Aboriginality in patients with chronic disease; disaggregate for lipid testing and glycated haemoglobin; show one significant achievement (over three years) that demonstrated chronic disease care and one example that demonstrated collaboration and community input for health programs.<sup>88</sup> It is unclear how well these indicators have been reported against, as no data is required to be referred back to NACCHO or Affiliates.

The 2008-09 National Performance Indicators for Divisions have since been changed to simplify data capture. Divisions are now required to report on the number of MBS health checks to Aboriginal peoples (item 710) provided *'by GPs within the Division'*. Whilst this is the intent, the technical specification for this indicator does not differentiate health checks undertaken by GPs *that are not members of the Division, nor by ACCHSs*. Data is to be sourced from Medicare Australia for items 710 and 708, which includes non-Divisional GPs and ACCHSs. The same issues apply for other indicators such as those examining the uptake of MBS rebates 10993-99.

It is completely inappropriate for Divisional performance measurement to capture the efforts of ACCHSs and claim these efforts as Divisional achievements. This is especially in view of additional Aboriginal monies that Divisions will tender for under the COAG National Indigenous Partnership Payment. Moreover, as part of core block grant funding to Divisions, the Department of Health and Ageing provides Divisions with a loading of \$2.55 per capita of Aboriginal persons within the Divisional area.<sup>89</sup> There is no accountability for this bonus.

NACCHO recommends that a primary health care strategy require the Department of Health and Ageing to request Divisions of GP amend their Aboriginal health performance indicators, and those

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<sup>87</sup> Sapirie S, Orzeszyna S. OP.cit.

<sup>88</sup> National Performance indicators for Divisions of General Practice, 2007.

<sup>89</sup> This figure may have increased.

Divisions in receipt of additional monies for Aboriginal health care support, should be accountable through the development of *additional* performance indicators to be developed in a partnership between AGPN with NACCHO and State Affiliates, and auspiced by the Department.

*Would there be advantages in linking patient health outcomes and quality of care provided to incentives for health care professionals?*

Financial incentives are a useful mechanism to influence health professionals behaviour provided they are developed effectively. A good example, is the development of MBS rebates for Aboriginal health checks. When financial incentives (such as PIP) are linked with poor accountability, poor targeting, and poor design and development of Aboriginal indicators as in our example of the Divisions of General Practice (see Elements 3 & 4), financial incentives are wasteful and ineffective.

A primary health care strategy that appropriately resources ACCHSs to deliver culturally appropriate primary health care to Aboriginal peoples, and maintains a quality assurance program, many not need financial incentives to health professionals.

Aboriginal health related financial incentives should only be developed in partnership with Aboriginal representative bodies as they are best placed to inform on their validity, and problems with application and accountability.

*How can we improve the current research culture and evidence-base in primary health care?*

The *Royal Commission into Aboriginal Deaths in Custody (RCIADIC)* said:

268: That the NHMRC actively stimulate research into health concerns identified as priorities by appropriate *Aboriginal health advisory bodies*...particularly research that involves Aboriginal peoples at both the development and implementation stages.

270: That:

- Aboriginal people be involved in each stage of the development of Aboriginal health statistics: and
- Appropriate *Aboriginal health advisory bodies*...consider developing an expanded role in this area, perhaps in an advisory capacity to the Australian Institute of Health and that the aim of this involvement should be to ensure that priority is given to the collection, analysis, dissemination and use of those Aboriginal health statistics most relevant to Aboriginal health development.

Key Result Area 7 of the NSFATSIH (2003-2013), commits to:

*"Build research and evaluation capacity in the primary health care sector, particularly ACCHSs and increase Aboriginal and Torres Strait Islander participation in and control of research and research funding processes including in NHMRC funding decisions and as members of research teams"*

While the intent for participatory research with Aboriginal and Torres Strait Islander people and their representative bodies is strongly expressed, the reality is that research is still driven by non-Indigenous interests and there is no clarity on the level of participation that is intended. Most research involving the Aboriginal population is not community driven, and this problem has still not been rectified.

In line with the RCIADIC and the NSFATSIH, NACCHO has attempted to resolve this matter by proposing an expansion to the NACCHO Secretariat to enhance its current role in nationally

coordinating quality improvement activity and enhance the capacity of ACCHSs to engage in national-level research (in line with its Articles of Association<sup>90</sup>).

In 2003, the NACCHO Board of Directors released the NACCHO 2003-2006 *Business Plan*.<sup>91</sup> A core element of the plan was the establishment of a research unit to be resourced from governments and private means.

The development of an Aboriginal 'national unit for collaborating in research and quality assurance', under the governance of the NACCHO Board of Directors, and as a branch of NACCHO is proposed. However, NACCHO is currently under-resourced to optimize its coordination role in research and quality improvement and needs additional support.

NACCHO's national role in research and quality assurance complements the activity of NACCHO Affiliates at the State/Territory level. NACCHO Affiliates such as QAIHC, and the Aboriginal Health Council of SA, have developed centres of research excellence within their organizations. A summary of current research collaborations across jurisdictions is shown in Table 1.

*Table 1. NACCHO Affiliates, collaborating research bodies, and the status of Aboriginal Ethics Committees, by jurisdiction.*

Affiliate	Collaboration	Aboriginal Human Research Ethics Committee
NACCHO	National Centre for Immunisation Research and Surveillance (NCIRS) James Cook University National Centre for HIV Epidemiology and Clinical Research Burnet Institute	NACCHO Board and State-based HRECs
AHCWA (WA)	Kulunga Research Network	WAAHEIC
AHMRC (NSW)	Coalition for Research to Improve Aboriginal Health (CRIAHA) Sax Institute	AHMRC Ethics Committee
AHCSA (SA)	CCRE (with Flinders University)	SAAHEC (AHCSA)
AMSANT (NT)	Centre for Remote Health (Flinders University) (No formal collaboration with CRCAH)	Nil
QAIHC (QLD)	University of Queensland (Centre for Indigenous Health) Monash University (School of Public Health) James Cook University Mater Mothers Hospital (Perinatal Research Unit) Sax Institute	QAIHC Board
TAHS (Tas)	Nil	Nil
VACCHO (Vic)	Melbourne University (Onemda & GP Training Unit) Project agreements: Deaking & Monash & Latrobe University & NGOs	VACCHO
Winnunga (ACT)	National Centre for Epidemiology and Population Health AIATSIS Australian National University	Nil

<sup>90</sup> National Aboriginal Community Controlled Health Organisation (2001). Articles of Association of the National Aboriginal Community Controlled Health Organisation (as amended up to 6<sup>th</sup> November 2001). Canberra, ACT.

<sup>91</sup> NACCHO 2003-2006 *Business Plan*. <http://www.naccho.org.au>

The proposed NACCHO Unit would support the development of:

- National research priorities (through consultation with our Affiliates and members)
- Principles that underlie collaborative relationships and promotion of partnerships<sup>92</sup> in research projects and research consortia led by, or including, NACCHO;
- Data Governance protocols for the management and external release of nationally aggregated Aboriginal health data from ACCHSs;
- Establishment of:
  - core national performance indicators for ACCHSs (for internal quality assurance activities); and
  - baseline surveillance data that could be collected from ACCHSs;
- Guidelines for the ethical conduct of quality assurance activities;
- Guidelines for ethical research (to complement the 1991 NHMRC research guidelines)
- Principles that underlie research funding acceptance from industry sponsors and the finalisation of criteria for acceptance of research funding;
- Principles/protocols for the release of documents with the NACCHO imprimatur; issues around Intellectual Property that relate to NACCHO discussion papers, NACCHO research or any other products from the NACCHO Secretariat;
- Principles for the critical appraisal of Aboriginal health related research;
- Structures needed to support a coalition of Aboriginal human research ethics committees;
- A National Communication Network for members and Affiliates in quality improvement and research.

It is recommended that the primary health care strategy support the establishment of ‘a national unit for collaborating in research and quality assurance’ as an expansion of the activities of NACCHO.

*How can we translate evidence or innovation into practice more systematically?*

There is a quite a high level of experience in this matter within the ACCHS sector. Guidelines are an effective way of putting research into practice. Often, the review of literature to develop clinical practice guidelines can identify research gaps, and these can lead to research with concomitant policy reforms. In the translation of research evidence into policy/practice, a

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<sup>92</sup> Refers to partnerships with other research agencies. Partnerships are forged because of interdependence, where partners cannot achieve alone what they can achieve together. A true partnership cannot proceed unless partners agree to share information, and demonstrate integrity and commitment. The power relationship within a partnership is critical. Recognition, acceptance and understanding of Aboriginal community-control is critical to the effectiveness of partnerships between agencies.

number of systematic approaches are possible, and discussion of each method is beyond the scope of this submission. We refer you to the NHMRC guidelines on this matter.<sup>93</sup>

NACCHO is well placed to advocate for Aboriginal health policy reforms. For example, guidelines in Aboriginal primary health care have been led by NACCHO and member services for over 10 years, such as the National Guide to a Preventive Health Assessment (which underpinned the MBS rebates for health checks); the management of otitis media (which led to further primary research and PBS listing of a new antibiotic for chronic suppurative otitis media), and asthma management review (which led to the Asthma Spacers Ordering Scheme for ACCHSs). These are just brief simple examples, but further large-scale examples are accessible by visiting the NACCHO website.<sup>94</sup>

See also our earlier for recommendations pertaining to a NACCHO unit for collaboration in research and quality assurance.

*What options could be used to support health care professionals' involvement in research and innovation?*

See earlier for recommendations pertaining to a NACCHO unit for collaboration in research and quality assurance.

## **6 Better management of health information, underpinned by efficient and effective use of eHealth**

### **Recommendations:**

- 6.1 Planning for improved management of Aboriginal health related information in a new primary health care strategy requires a joint planning between NACCHO, Affiliates and OATSIH as to the future of SAMSIS and OSCAR, so that ACCHSs can feel secure that data is governed by Aboriginal representative bodies.
- 6.2 The Strategy needs to support NACCHO and Affiliates to access aggregated data from ACCHSs, under an agreed data governance structure, whether the national dataset be contained in OSCAR or SAMSIS or other systems.
- 6.3 NACCHO does not support the provision of Aboriginal client-level (unit health record) data to the OSCAR or other external web-based reporting system. Individual ACCHSs may agree to provide this identified data (after informed consent) and should be considered as sentinel sites.
- 6.4 The following are recommended Primary Health Strategy priorities to improve the management of health information management within ACCHSs:
  - Continued investment towards ACCHSs for Patient Information Recall Systems (PIRS) training, PIRS administrators, PIRS auditing and data cleansing and networks so that the database from which the reports will be created are accurate.
  - Shared procurement of computing hardware and shared strategies for replacement. Eg economies of scale buying in bulk.

<sup>93</sup> Refer to the NHMRC guidelines evidence into practice.

<sup>94</sup> NACCHO. Aboriginal peoples making the health system equitable. 2007. [www.naccho.org.au](http://www.naccho.org.au)

- A national quality assurance coordination role and communication network (for PIRS officers within ACCHSs) supported through NACCHO (such as through a national unit for quality assurance, see Element 5).
- NACCHO and Affiliates to define and rationalise their members data needs (domains of information) and chosen systems of support for quality improvement: (eg national PIs, preferred CQI systems and tools)
- An acceptable and supported nationalised Data Management System in order to standardise data collection: (eg an information base such as OSCAR, or SAMSIS Plus)
- A formalised Agreement to Aboriginal data governance such as through a revised Information Agreement between NACCHO and OATSIH (which may involve other agencies such as the AIHW) (See Element 5.7).

### Responses to questions:

*What is the role for eHealth in supporting the provision of quality primary health care?*

ACCHSs have been using electronic Patient Information Recall Systems (PIRS) for over 20 years.<sup>95</sup> PIRS plays a vital role in supporting quality improvement within services as well quality assurance to the community and to funding bodies. When clinicians are able to receive feedback on health service delivery and outcomes, they become more responsive to using PIRSs, whilst this information is important for management, communities and funders to ensure that health delivery is targeted to the areas required.

NACCHO and Affiliates use service activity reporting information from services to help the sector with planning and future policy development. In turn, ACCHSs are supported by Affiliates to enhance their own internal quality assurance activity such as through improvements to PIRS and efforts to build staff capacity.

The development of QAIHC and AMSANT key performance indicators, based on PIRS data submitted by services and compiled within jurisdictions, has seen an important step towards establishing systems of benchmarking, in order to facilitate quality improvement.

Over the last 5 years, NACCHO and Affiliates have been working with the OATSIH in order to improve PIRS systems within ACCHSs, through the Departmental provision of capital as well as workforce support at a service, regional and jurisdictional level to enhance the use of PIRS by ACCHSs.

The potential for PIRS to improve the quality of care at a local level is already evident. In terms of State/Territory or national level collation, the benefits to services is dependant on the ease with which services can interface with centralised systems of reporting, alleviation of concerns over data ownership and storage, accessibility to Affiliates and NACCHO, and a myriad of other issues, including how government departments intend to use the data. (See Element 5 with respect to the need for an information agreement with NACCHO).

NACCHO and OATSIH have supported the formation of SAMSIS (Secure Aboriginal Medical Services Information System) as a site for aggregated ACCHS data which is owned by the

<sup>95</sup> Murray RB. Organising Prevention. In: Aboriginal primary health care: An evidence-based approach. OUP, 2008.

ACCHS sector. At present SAMSIS is only able to collect service activity reporting, workforce and training data. SAMSIS is owned and governed by the ACCHS sector.

However OATSIH has recently invested in the development of a competing data management system, the OSCAR<sup>96</sup> web-based reporting system, and the current intent is for aggregated data collected from ACCHSs to feed into this system. This action however, has not been endorsed by NACCHO nor Affiliates.

Joint planning between NACCHO, Affiliates and OATSIH is necessary on the future of SAMSIS and OSCAR so that ACCHSs can feel secure that data is governed by Aboriginal representative bodies.

NACCHO recommends that OATSIH develop mechanisms for NACCHO and Affiliates to access aggregated data from ACCHSs, under a data governance structure with these Aboriginal representative bodies, whether the national dataset be contained in OSCAR or SAMSIS or other systems.

NACCHO does not support the provision of Aboriginal client-level (unit health record) data to the OSCAR or other external web-based reporting system. Individual ACCHSs may agree to provide this identified data (after informed consent) and should be considered as sentinel sites.

*Where should the Government prioritise its actions in relation to implementing eHealth reform?*

NACCHO believes that there are six priorities requiring government action and support for improving use of PIRSs within ACCHSs:

- Continued investment towards ACCHSs for PIRS training, PIRS administrators, PIRS auditing and data cleansing and networks so that the database from which the reports will be created are accurate.
- Shared procurement of computing hardware and shared strategies for replacement. Eg economies of scale buying in bulk.
- A national quality assurance coordination role and communication network (for PIRS officers within ACCHSs) supported through NACCHO (see earlier).
- NACCHO and Affiliates need to be supported define and rationalise their members data needs (domains of information) and chosen systems of support for quality improvement: (eg national PIs, preferred CQI systems and tools)
- An acceptable and supported nationalised Data Management System in order to standardise data collection: (eg an information base such as OSCAR, or SAMSIS Plus)
- An agreement to Aboriginal data Governance: eg Information Agreement between NACCHO and OATSIH and AIHW (see earlier).

*How can the various information systems be integrated (e.g. state health services and general practice)?*

<sup>96</sup> OATSIH Service. Collection, Analysis and Reporting system

AMSANT has had experience in the remote NT in trialling the use of systems which provide PIRS over a wide area network. With a secure server in Sydney storing PIRS, clinicians across remote communities in the NT can access the system via internet. Called the AMSNet IT project, it commenced in October 2007 and has been deemed to be successful.

PIRS in the NT ACCHSs is almost completely paperless now and include linkage with pathology.

Shared electronic health records are also used. The NT Secure Electronic Messaging Service (SEMSs), allows documents to be securely sent from health service to health service, such as referrals. This now operates in two-thirds of ACCHSs in the NT. Hospitals are willing participants, but other sectors are reluctant and still use paper based systems. All private sector GPs use SEMS.

Whilst other jurisdictions are not using these systems, the issue of third party sharing of information is contentious and needs approval from individual services. Issues of concern are the degree of patient consent for uploading to shared electronic health records, whether only clinicians can access that information, and whilst currently it is entirely voluntary, the future may see uploading of information as a mandatory action. The potential for the violation of human rights exists, if the future deems that certain conditions require mandatory reporting by clinicians. Examples include mandatory reporting of child abuse to shared electronic records; HIV/AIDS status; and Aboriginality. These issues require ethical debate and consultation with bodies like NACCHO.

## **7 Flexibility to best respond to local community needs and circumstances through sustainable and efficient operational models**

### **Recommendations:**

Please refer to other Elements for recommendations relevant to this topic.

### **Responses to questions:**

*How could planning for primary health care services at the local level be improved?*

See responses to Elements 1, and 10.

*What advantages/disadvantages would there be in having a regional organisational structure with responsibilities (ranging from local planning through to service delivery) for primary health care services?*

See responses to Elements 1, and 10.

*Who could undertake this role? – What changes would be need to existing organisations (eg. Divisions of General Practice, Area Health Services) to undertake this?*

A discussion on the role of mainstream primary care providers in the provision of care to Aboriginal peoples has been described in earlier sections (see Elements 1, 3, 4).

*What advantages/disadvantages would there be if regional organisations were responsible for purchasing some primary health care services for their communities - that is, should they 'hold funding' for health services?*

See Elements 5 & 10.

*What mechanisms could be used to improve the accountability of primary health care services being delivered in a locality (in respect to quality of care, reach and equity)?*

See detailed discussion under Element 6.

*How can greater community engagement be supported in primary health care?*

See Introduction, Element 1 and Element 5 and 6.

## **8 Working environments and conditions which attract, support and retain workforce**

### **Recommendations:**

8.1 The primary health care strategy needs to adopt the objective of addressing the workforce shortfall within ACCHSs (an extra 250 doctors, 450 AHWs, nurses and allied health workers) in order to ensure access by Aboriginal peoples to primary health care.

8.2 Mechanisms to address this shortfall include:

- GP workforce salaries [within ACCHSs] to be on a par with mainstream primary health care services.<sup>97</sup> This can be achieved by resource allocation formula for ACCHSs based upon core functions of Aboriginal primary health care. (See Element 10)
- Incentive schemes for health staff to work within ACCHSs and to retain and expand the workforce pool to meet specified service requirements.
- Incentives should be both financial (to GPs working within ACCHSs in recognition of the greater skills needed and attendance to more complex consultations) and non-financial (such as regulating and restricting GP provider numbers to areas of need).
- Training and support should be provided to GPs in ACCHSs (in partnership with NACCHO and Affiliates) in claiming MBS and incentive payments.
- Forward planning, funding and recruitment strategies to achieve the goal of the ideal doctor: patient ratios within ACCHSs of 1:800.

8.3 A national approach to the scope of Aboriginal Health Worker (AHW) practice, such as medication dispensing and administration rights, would assist in ensuring national consistency in the work performed by AHWs.

8.4 Whilst ACCHSs have standard drugs protocols and adhere to all legislative requirements, a uniform Positions Act across the jurisdictions would greatly assist in alleviating uncertainties

<sup>97</sup> HREOC targets: [http://www.hreoc.gov.au/social\\_Justice/health/targets/index.html](http://www.hreoc.gov.au/social_Justice/health/targets/index.html)

regarding dispensing and administration of drugs by medical and allied health personnel, particularly AHWs.

8.5 NACCHO recommends that priority be given to further considering AHWs inclusion in a National Registration Scheme.

### Responses to questions:

*What changes in working arrangements and conditions will better support primary health care professionals?*

According to Access Economics in 2004, the ACCHSs sector needs an extra 250 doctors, 450 Aboriginal Health Workers, nurses and allied health workers.<sup>98</sup>

Across Australia, there are workforce shortages throughout the health sector and across professions, with extreme shortages experienced in many areas of rural and remote Australia in particular. The shortage of doctors within ACCHSs (regardless of location) however, is most dire, due principally to salary disparities when compared with mainstream health services.

In the case of the medical workforce, insufficient local graduates coupled with increasing restrictions on International Medical Graduates has resulted in supply being unable to meet demand, with market forces driving salary increases. In WA, the AMA has successfully negotiated a significant boost to the state health sector GP award structure, resulting in salary gaps of between \$150,000 and \$200,000 between ACCHS and state health sector GPs in the north west of WA.

This threat was anticipated in WA by the NACCHO Affiliate, working with the AMA to introduce a new award for ACCHS GPs, and in parallel, sought additional funding from OATSIH to offset the budget gap which would result from the introduction of such an award. However, the ACCHS efforts failed in the face of a rejection from the Commonwealth of a comprehensive, global approach to the issue, reiterating its adherence to a process of selective, case-by-case consideration.

The Aboriginal Health Council of WA's submission to the Commonwealth for funds to support a comprehensive approach to workforce capacity broadly across the ACCHSs was also declined. ACCHSs are now faced with a situation where they are effectively being forced out of the competition for GPs, with examples of GPs leaving the sector to work in mainstream services, and of ACCHS left with severe shortages of GP services.

These experiences are not unique to WA, and have been confirmed across the nation by NACCHO. Access economics analysis indicate parity would be achieved with a base salary of \$170,000 for Vocationally Registered and Fellowship qualified GPs working full time in ACCHSs.<sup>99</sup> How is salary disparity to be addressed?

An argument which has been repeatedly put to NACCHO when issues of global funding are raised is that of Medicare will offset the shortfalls. There are a number of key points to make in relation to this argument:

<sup>98</sup> AMA Discussion Paper 2004 –Update.

<sup>99</sup> AMA Indigenous Health Taskforce, 2007

a) Aboriginal peoples suffer a burden of ill-health and premature mortality around three times that of non-Indigenous Australians. Despite this, average overall per capita health expenditure on Indigenous Australians is only 17% higher than that for non-Indigenous people.<sup>100</sup> The introduction of the 19(2) exemption (of the Health Insurance Act 1973)<sup>101</sup> for ACCHSs has increased MBS claims by Aboriginal peoples, so that per capita expenditure through Medicare is now less than half that of their non-Indigenous counterparts (instead of a third). The truth is that MBS claiming will not provide sufficient global funding for the delivery of comprehensive primary health care. A review commissioned by OATSIH reported that, in order to address the additional burden of Aboriginal peoples ill-health, overall expenditure would need to be at least 2.2 times that for non-Indigenous people, not taking onto account additional factors such as remoteness in this equation.<sup>102</sup> (See Element 10)

b) ACCHS with the least resources relative to needs and who have the most difficulty recruiting GPs will also have the least capacity to draw in Medicare funding to offset any core grant shortfalls. The Kutjungka region of WA is a prime example of this, where services are provided in an extremely remote location and where core funding clearly falls short of existing service need, let alone the need to broader, more comprehensive primary health care service provision, yet potential to generate Medicare income is severely restricted.

c) The Medicare model is not one which suits the nature of service provision in most ACCHSs, and efforts to maximize Medicare income by resource-poor services potentially introduces a need to compromise their approach. Reliance on Medicare funding encourages a fee-for-service approach, where MBS services are defined as *primary medical care* and discrete rather than multi-disciplinary, comprehensive, community-responsive, culturally appropriate services. The MBS does not equitably factor service activity to a population with much greater and complex health problems than populations seen within mainstream general practices.<sup>103,104</sup>

Mechanisms to address this workforce shortfall include:

- A financial and non-financial incentive scheme (such as regulating and restricting GP provider numbers to areas of need) for health staff to work within ACCHSs and to retain and expand the workforce pool to meet specified service requirements.

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<sup>100</sup> The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples (2008) – ABS / AIHW. <http://www.aihw.gov.au/publications/ihw/hwaatsip08/hwaatsip08.pdf>

<sup>101</sup> Exemptions to the provisions of Section 19(2) of the Health Insurance Act 1973 were introduced allowing doctors employed by Aboriginal and Torres Strait Islander primary health care services to access Medicare. Medicare also became payable under the Section 19(2) exemption for GP services provided by salaried medical officers employed by the state government at specified and agreed locations in non-urban areas of Queensland (This provision was extended to locations in the Northern Territory from 1 January 2003).

<sup>102</sup> Econotech Pty Ltd, *Costing Models for Aboriginal and Torres Strait Islander Health Services*, OATSIH/Commonwealth of Australia, Canberra, 2004.

<sup>103</sup> Thomas, D., R. Heller, et al. (1998) "Clinical consultations in an Aboriginal community controlled health service: how are they different to consultations with Australian general practice." *Australian and New Zealand Journal of Public Health* 22: 86-91.

<sup>104</sup> Larkins, S., L. Geia, et al. (2006) 'Consultations in general practice and at an Aboriginal community controlled health service: do they differ.' *Rural and Remote Health* 6(560 (online)): 1-12.

- GP workforce salaries [within ACCHSs] to be on a par with mainstream primary health care services.<sup>105</sup> This can be achieved by resource allocation formula for ACCHSs based upon core functions of Aboriginal primary health care. (See Element 10)

*How is teamwork facilitated in primary health care services and between them?*

See Introduction and earlier sections.

*How can newer models of care or newer workforce roles (such as nurse practitioners and physician assistants) better support health professionals to meet demands created by a changing primary health care environment?*

Recognition and expanded roles, for health professionals, such as the Aboriginal and/or Torres Strait Islander Health Workers, can only be achieved and supported through providing realistic funding to the relevant Aboriginal Registered Training Organisations, collectively known as the Aboriginal and Torres Strait Islander Registered Training Organisation National Network (ATSIHRTONN).

The newly developed Aboriginal and/or Torres Strait Islander Health Workers qualifications need to be funded appropriately for the comprehensive roll out and delivery of training. Aboriginal Community Controlled Registered Training Organisations that are members of ATSIHRTONN are the most appropriate bodies to deliver training as they are positioned to provide primary health care education and training to both the new and existing Aboriginal health workforce. Further, their role in providing ongoing professional development and specialisation to undertake roles as Aboriginal and/or Torres Strait Islander Health Workers in areas such as Child and Maternal Health is essential.

In addition, improvements to maximizing Aboriginal and Torres Strait Islander participation in the health workforce, by promoting and improving pathways between school, the VET sector and higher education such as the AHW Certificate II national rolled out into schools through the ATSIHRTONN are required; together with supporting retaining and building the capacity of the existing Aboriginal and Torres Strait Islander health workforce through addressing ongoing support and career development needs.

At present the roll-out of Social Emotional Well Being workers (SEWB), Bringing Them Home Councillors, and Aboriginal Home and Community Care Workers are also under review. NACCHO asserts that these health workforce positions are required by ACCHSs to fulfil the comprehensive primary health care model offered by services to Aboriginal clients to provide continuity of care through all stages of their lives. If ATSIHRTO's are not funded adequately to fulfil their training roles or to encourage and support enrolment and completion of training then adequate workforce numbers cannot be maintained and ACCHSs will continue to experience significant workforce shortages.

*Are there specific changes needed in those regions or populations where there is difficulty attracting and retaining staff?*

<sup>105</sup> HREOC [http://www.hreoc.gov.au/social\\_justice/health/targets/index.html](http://www.hreoc.gov.au/social_justice/health/targets/index.html)

Achieving parity for GP salaries within ACCHSs is a vital component of attracting doctors to remote regions and for work within ACCHS regardless of location. (See earlier for recommendations to address this, as well as recommendations for optimal resource allocation).

Forward planning, funding and recruitment strategies to achieve the goal of the ideal doctor: patient ratios within ACCHSs is also needed. In 2005, a coalition of NT Aboriginal and General Practice bodies suggested that “effective PHC requires one Full Time Workload Equivalent (FTWE) GP working in Aboriginal primary health care, for every 800 Aboriginal people across the NT.”<sup>106</sup>

In October 1993, the Rural Doctors Association of Australia recommended that “in communities where the practitioner is providing in-patient, emergency and after-hours services a full time practitioner per 750 patients would be appropriate”.

Whilst this ratio appears to be an acceptable industry benchmark, it is far from reality. For the federal electorate of Lingiari (the most remote seat in the NT), the doctor: patient ratio was 1:2861. In the more populous seat of Solomon, the doctor: patient ratio was 1:2155. For the 40,000 Aboriginal people resident in remote zones of the NT, a doctor: patient ratios of 1:800 would be equivalent to having a remote primary health workforce that included 50 full-time doctors working in the remote NT.<sup>107</sup>

*What funding arrangement could best support team-based care?*

See Introduction Element 10.

*How is it determined who is best placed to lead in multi-disciplinary team arrangements?*

See Introduction and earlier sections.

*Are other changes needed to current roles and responsibilities (eg. for prescribing and referral rights to be extended to non-GPs and specialists)?*

Within the scope of current legislation, effective delegated care regimes currently exist within the ACCHSs, whereby AHWs are the first point of contact for patients and undertake a range of clinical responsibilities that are often reserved for doctors and nurses within a mainstream setting. This is particularly relevant in isolated areas of practice.

Similarly in the area of health education, Aboriginal and/or Torres Strait Islander Health Workers and other health professionals work together as a multi disciplinary team to deliver client/family/community education responsibilities, with the Aboriginal and/or Torres Strait Islander Health Workers undertaking delegation with regard to cultural obligations/competence. However, what is required nationally to provide a consistent approach to the above described delegation arrangements is the following:

- A national approach to the scope of AHW practice, such as dispensing and administration rights, would assist in ensuring national consistency in the work performed by AHWs;

<sup>106</sup> Darwin Statement published in April 2005 by GPPHCNT in conjunction with NT Department of Health and Community Services, AMSANT, the Department of Health and Ageing; Top End Division of General Practice; the Central Australian Division of PHC and NT General Practice Education Ltd Refer: <http://www.gpphcnt.org.au/www/index.cfm?itemID=136andprint>

<sup>107</sup> AMSANT. Indigenous Access to Core PHC Services in the NT. 2007.

- AHWs are currently only registered in the Northern Territory. In March 2007, Australian Health Ministers agreed that priority be given to further considering AHW inclusion in the National Registration Scheme. NACCHO continues to advocate for AHW inclusion in the Scheme and believes that a comprehensive scoping of AHW practice can influence and inform further consideration of their inclusion in the National Registration Scheme;
- Given the different legislative requirements in the States and Territories and that many AHW move between jurisdictions it is essential that a National uniform approach to drug dispensing and administration be implemented as a matter of urgency. Whilst the Sector has standard drugs protocols and adheres to all legislative requirements a uniform Positions Act across the jurisdictions would greatly assist in alleviating uncertainties regarding dispensing and administration of drugs. Further, this would allow for consideration of an expanded role for AHW in prescribing, similar to Nurse Practitioners in remote areas, supported by Medical Practitioners.

The key underpinnings to such approaches would be defined by: flexibility which recognises that some jurisdictions are already well advanced in developing scopes of practice and have already identified gaps, needs and timelines, and the use of existing structures. A national approach would build on these existing models.

In developing a national approach to Scopes of Practice for AHWs, it is important to recognise the range of interconnected activities already underway that relate to this discussion. This includes the National Indigenous Health Workforce Training Plan and Aboriginal Health Worker Assessor Training. Each jurisdiction will need to recognise existing legislation that may impact on the duties performed and care provided by AHWs and other related professions. National uniformity regarding poisons acts would alleviate the confusion of dispensing rights, transportability of roles across jurisdictions, and understanding of roles and delegation responsibilities.

## **9 High quality education and training arrangements for both new and existing workforce**

### **Recommendations:**

Complementing the recommendations outlined in Element 8, mechanisms for a national Primary Health Care Strategy to address Aboriginal health workforce shortfalls through training include:

- 9.1 The establishment of Centres for Training Excellence within the ACCHS sector for the clinical placement of those graduate health professionals wishing to gain experience in the delivery of culturally appropriate comprehensive primary health care to Aboriginal populations (see also Element 2).
- 9.2 The national roll-out of Cultural Safety Training modules which have been developed and endorsed by NACCHO and Affiliates. (See also Introduction and Element 1).
- 9.3 Aboriginal and/or Torres Strait Islander Health Workers to be included in the National accreditation and registration scheme, and that the industry be supported to establish appropriate mechanisms to accredit courses and Registered Training Organizations wishing to deliver Aboriginal and/or Torres Strait Islander Health Workers training.

- 9.4 The development of a national award for the pay and conditions for Aboriginal Health Workers to enable workers to make suitable employment choices appropriate to their skills and experience. Pay and terms and conditions of service should not vary across state and territory boundaries as they do currently.
- 9.5 The Introduction of a national program to fully implement the national Aboriginal Health Worker Qualifications within the Aboriginal Community Controlled health services sector including career structure, pay equity and professional development.
- 9.6 Recognition that Aboriginal Community Controlled Registered Training Organisations that are members of ATSIHRTONN are most appropriate and in the best position to provide primary health care education and training to new and existing Aboriginal health workforce. Streamlined ongoing core funding should be provided for ATSIHRTONN member RTOs from the Department of Education, Employment and Workplace Relations (DEEWR) and the Department of Health and Ageing.
- 9.7 Enhancements to the delivery of training for Aboriginal Health Workers such as through systems for the:
- training and/or up-skilling of new and existing Aboriginal primary health care workforce nationally in the qualifications of the new Training Package (HLT07);
  - training of AHW-assessors and AHW-trainers and assessors nationally;
  - promotion of the role of assessor/trainer as a career path for AHWs with appropriate remuneration;
  - ACCHSs to involve supervisory and managerial staff in monitoring on-the-job training;
  - development of an Aboriginal assessor network to build the capacity of AHW assessors nationally through training.

### Responses to questions:

*What improvements are needed to primary health care education and training?*

#### **Training of Health Professionals within the ACCHS**

The COAG Communique (28 November 2008), announced that the Commonwealth and the States had committed to a reform package of \$1.6 billion for training and education of the Health workforce to meet the future challenges confronting the Australian health system. The aim of the reform package is directed at workforce reform by providing \$500 million in additional Commonwealth funding for undergraduate clinical training, including increasing the clinical training subsidy to 30 per cent for all health undergraduate places.

NACCHO recognizes the need for high quality education and training for the primary health care workforce, and is involved in assisting with the development of cultural awareness training for health professionals. There is a great need for trainees, such as GP registrars, to be exposed to working in Aboriginal health, and ACCHSs provide the ideal setting for this to occur. Working within an ACCHS is one important method of attracting and retaining medical practitioners and hence build the future workforce required by ACCHSs (see also Element 1 & 8).

However, current difficulties in recruiting staff means that many ACCHSs currently lack the staffing levels necessary to provide the supervision and support that is required for training purposes. Achieving salary parity to enable ACCHSs to offer appropriate GP salaries is a vital part of addressing the issue of primary health care education and training (discussed under Element 8). Also necessary is a National Centre for Training Excellence to appoint an Aboriginal Health Medical Educator in each jurisdiction to provide training, education, supervision and support to GP Registrars and other primary health care professional trainees working in ACCHSs. Such an approach fits with more recent COAG announcements regarding Indigenous clinical placement. (see Element 8).

Recently COAG announced Indigenous clinical placement of nurses and doctors. If funded adequately, such a Centre for Training Excellence could work jointly with universities to offer nurses clinical placements and Graduate Nurse Programs, similarly to GPET and doctors. The Centre for Training Excellence could also undertake Cultural Safety Training, for potential and existing Health Professionals. Sound cultural safety training has already been developed, endorsed and adopted by the Aboriginal Community-Controlled Health Sector with 108 Cultural Safety Training Modules developed. For full implementation and national roll-out of this program adequate resources should be supported (see also Element 1).

### **National Registration and Accreditation Scheme**

The Australian Federal Government has announced plans to introduce a system of national registration and accreditation of health professions by July 2010. The establishment of a National Registration Database of health professionals has in the past received broad industry support, and has the potential to increase workforce mobility and improve patient safety. The NACCHO has recommended to the Health Workforce Principals Committee that the Aboriginal and/or Torres Strait Islander Health Worker (AHW) workforce be included in this scheme. This initiative reflects the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework Strategies endorsed by AHMAC in 2002.

Although national training standards for the content and desired outcomes of the AHW workforce has been endorsed, the delivery of the training has yet to undergo Industry set standards, such as those processes undertaken by Registered Training Organisations wishing to deliver Medicine and Nursing courses.

In response NACCHO has developed a set of draft standards with the industry. These standards also reflect the World Indigenous Nations Higher Education Consortium (WINHEC) Accreditation Scheme. WINHEC has developed an Indigenous education accreditation system, which was adopted by its board in 2003. This is an exciting accreditation option – one that could provide international recognition and validation for educational initiatives grounded in Indigenous world views, knowledge systems, and ‘ways of knowing’. It is also an accreditation scheme that not only can be applicable to the VET sector but can span into the University sector and could be placed under the auspice of the proposed Centre for Training Excellence. This would further ensure quality training outcomes, improved patient safety, Aboriginal and/or Torres Strait Islander Health Worker professional recognition, recruitment and retention of AHWs and would fall in line with national accreditation and registration which AHWs are currently striving to be included. This can only occur if supported and resourced by the Australian Federal Government, as has been the

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<sup>108</sup> <http://www.culturalsafetytraining.com.au/>

historical process for the success of other health professions in the embryonic stages of establishing accreditation boards.

### **National Award for Aboriginal and/or Torres Strait Islander Health Workers**

It is clear that if ACCHSs are to achieve their full potential, which will be necessary if the government's commitment to Close the Gap is to be fulfilled, ACCHS must be able to provide adequate remuneration and other incentives to attract and retain appropriate high quality trained staff. The under-resourcing of ACCHSs has however meant that salaries offered by ACCHS are often considerably less than the salaries offered in mainstream health services. Remuneration for Aboriginal and/or Torres Strait Islander Health Workers roles varies nationally and from jurisdiction to jurisdiction. At present there is a great variation in the pay, terms and conditions under which Aboriginal Health Workers are employed. In particular there is a systemic difference between remuneration within and outside the Community Controlled sector. (See Element 8 for detailed discussion).

Further, it is unfortunate that many AHW trained, educated and supported by the ACCHSs whose preference is to continue working within these services, are unable to do so for financial reasons. Staff are often lost to the private sector due to under-resourcing of ACCHSs, which is further exacerbated by the lack of resources placed into their training.

Therefore, it is essential for the AHW profession that a uniform structure to calculate pay and conditions is established to enable workers to make suitable employment choices appropriate to their skills and experience and based less on financial considerations. This would enable real employment choice and in particular prevent the drift of workers trained by ACCHSs into the mainstream who rely and benefit upon this training provided without having to expend funds themselves.

Pay and terms and conditions of service should not vary across state and territory boundaries. They should depend on the following:

- Level of responsibility including availability of supervision;
- Level of education and training;
- Experience;
- Evidence of ongoing skills development (life long learning);
- Cost of living – food/housing related to location of employment;
- Distance from nearest town with a hospital;
- Available support structures;
- Availability and cost of transport.

NACCHO proposes the establishment of standard rates of pay primarily based on the level of responsibility and education/training with 5 increments representing years of experience at a particular level of practice. It is proposed that the other factors should also be considered as factors in determining minimum rates of pay in a transparent and clearly stated fashion.

### **Funding for Health Workforce Training**

Funding for RTOs has long been the domain of DEEWR. However in order to best meet the education and training needs of the new and existing Aboriginal health workforce, the Department

of Health and Ageing must also make a commitment to the ongoing viability of ATSIHRTONN member RTOs in the form of recurrent core funding. This will ensure that the capacity of these RTOs to meet the Aboriginal health training needs within their communities remains high and not so reliant on the numbers of students enrolled. Education of the new and existing Aboriginal health workforce should reflect industry need rather than the capacity of the RTO to deliver the training.

### **Aboriginal and/or Torres Strait Islander Health Worker Training**

Current Aboriginal and/or Torres Strait Islander Health Worker qualifications are nationally recognised, competency based qualifications aimed at producing Aboriginal Health Workers who operate holistically to meet the needs of their communities. In 2008, ATSIHRTONN member RTOs started the delivery of the new Aboriginal and/or Torres Strait Islander Primary Health Care Training Package (HLT07).

The delivery of this training differs from the old Aboriginal Primary Health Care curriculum delivered from 2004 – 2008, with the key difference being that the new qualifications are competency based rather than a curriculum based. Essentially, students are assessed according to what they can do rather than just what they know. This focus on competency based education is essential in preparing students to participate in the workforce.

Delivery of the old curriculum often involved regular block sessions in the classroom necessitating extensive absences from work for students which created backfilling issues for health services.

Delivery of the new Training Package may involve:

1. Pre-assessment interviews on site with individual students;
2. Development of an individualized 'learning plan' for each student;
3. Negotiations with managers and supervisors on site for:
  - on-the-job training conducted by supervisors
  - observations of student's duties by assessors on-the-job
  - third party (validations) of a student's skills by supervisors
4. block release / workshops off-the-job

The new system of training and assessment will require:

1. a close relationship between ATSIHRTONN RTOs and the local Aboriginal Community Controlled Health sector in coordinating the on-the-job training, and the follow-up of evidence from supervisors to validate skills and knowledge of individual students;
2. active involvement of clinic and community program staff in the training and support of students on-the-job;
3. the involvement of AHW-assessors to assess competency on-the-job, and through the recognition process
4. the involvement of AHW-trainers to conduct mini lessons at the workplace or off-the-job
5. the potential to organise follow-up training for sessions conducted off-the-job
6. the necessity for AHCSA's trainers to keep Health service management apprised of individual student's progress and procedural issues that may arise

7. the potential for management to restructure the organisation to promote training and assessment – to become in effect a teaching organisation

Further requirements to ensure the consistency and quality of Aboriginal primary health care training across Australia include:

1. Intensive training and/or up-skilling of new and existing Aboriginal primary health care workforce nationally in the qualifications of the new Training Package (HLT07)
2. Intensive training of AHW-assessors and AHW-trainers and assessors nationally
3. Promotion of the role of assessor/trainer as a career path for AHWs with appropriate remuneration
4. Support for the restructuring at a systems level for Aboriginal Community Controlled Health services to involve supervisory and managerial staff in monitoring on-the-job training
5. Development of an Aboriginal assessor network to build the capacity of AHW assessors nationally through training.

## 10 Fiscally sustainable, efficient and cost-effective

### Recommendations:

- 10.1 A primary health care strategy should support a 5-year Capacity Building Plan for ACCHSs that provides an additional \$500 million per annum within 5 years.<sup>109</sup> The investment is for increased core funding of ACCHSs, made up of capital investment and recurrent funding to provide comprehensive primary health care to an accredited standard, and to provide core deliverables in meeting the level of need.
- 10.2 There should be a triennial funding commitment, utilizing funds pooling specifically for ACCHSs, to meet health service gaps identified by the Service Activity Reporting (SAR) and regional plans to expand the service delivery capacity of ACCHSs.
- 10.3 It is recommended that the Primary Health Care Strategy adopt the model of resourcing for ACCHSs based on the Primary Health Care Access Program (PHCAP). ACCHSs funding should be based on a weighted population basis, according to need.
- 10.4 ACCHSs funding should be sourced from pooling of all Aboriginal-specific primary health care funds currently being directed to State Governments, Divisions of General Practice and other private health care providers. This will maximize the potential of primary health care to close the gap in life expectancy for Aboriginal peoples. Such fund pooling should be governed by an appropriate mechanism, requiring the involvement of, and endorsement by, the NACCHO Aboriginal leadership.
- 10.5 A resource allocation formula (agreed to by NACCHO and Affiliates) that reflects the actual cost of ACCHSs providing the agreed core services at particular locations, is needed to guide the Department of Health and Ageing and its obligations under the NSFATSIH (or

<sup>109</sup> This is based on the calculated shortfall in primary health care spending calculated by *Access Economics* for the AMA for the 2006/07 budget (updated 2008). The actual shortfall may now be greater than this.

- other national health action plan) according to the Rudd Governments Statement of Intent to close the gap.
- 10.6 A systematic approach towards defining the core deliverables for Aboriginal primary health care services (ie what funding would buy with an acceptable per capita benchmark funding allocation) is needed. This should be supported at the national level through NACCHO, taking into account efforts underway in some jurisdictions through NACCHO Affiliates.
- 10.7 A systematic framework for working towards a primary health care system for Aboriginal peoples that maximises local community control (such as through a national plan aligned with the NT Aboriginal Health Forum 'Pathways to Community Control'<sup>110</sup>) should underwrite the 5 year Capacity Building Plan for ACCHSs.
- 10.8 Pathways to community control should assess whether regionalisation is an appropriate mechanism in the expansion of ACCHSs in each jurisdiction.
- 10.9 Medicare alone is incapable of providing core funding for the delivery of comprehensive, culturally appropriate primary health care to Aboriginal peoples, and neither will the introduction of more blended payment systems such as Indigenous financial incentives under the Practice Incentive Program. Labeling these incentives 'Indigenous' serves to distort Aboriginal expenditures meant to 'close the gap',<sup>111</sup> and particularly in the absence of a robust accountability system to ensure there is no leakage to the non-Aboriginal population.
- 10.10 The delivery of the agreed set of services depends on building additional capacity in ACCHSs. This cannot be achieved instantly. Over time, such capacity building will see greater uptake and utilisation of medicines and Medicare, and a reduced reliance on hospital care. Investing in Aboriginal community controlled health services to close the gap in health status is a long-term process and requires a vision for the future.

### Responses to questions:

*Are there other funding models for primary health care that need to be considered?*

In the absence of a systematic, comprehensive, evidence-based approach to the resourcing of ACCHSs in Australia and investment in processes which engage and support Aboriginal community control, long-standing short-falls in funding have arisen. This submission refers to funding models needed to address those shortfalls for ACCHSs as well as estimated costs.

Service Activity Reporting (SAR)<sup>112</sup> from ACCHSs indicates funding gaps across the entire range of services provided by ACCHSs. Services have identified funding shortfalls in capital infrastructure (service buildings and facilities, staffing accommodation and vehicles), staffing (with both vacant funded positions and insufficient funding for adequate staffing across administrative, management, medical, Aboriginal Health Workers, nursing, and allied health), and program and service delivery

<sup>110</sup> Northern Territory Aboriginal Health Forum. Pathways to Community Control. A Framework to further promote Aboriginal community control in the provision of comprehensive primary health care services. April 2008.

<sup>111</sup> See earlier for a discussion as to the need to target 'hard to reach' Aboriginal peoples and those who are most disadvantaged.

<sup>112</sup> SAR ref

(social and emotional well-being counselling, child and maternal health, substance misuse, preventive and population health programs).

A 2003 report on the Indigenous Australian burden of disease estimates that the burden is 2.4 times higher than for the total Australian population.<sup>113</sup> Yet, overall primary health care expenditure (federal and state) for Aboriginal peoples and Torres Strait Islanders is only 0.27 times higher (2004-05). Federal per capita expenditure for primary health care is even less for Aboriginal peoples than for non-Aboriginal Australians at 93 cents for every dollar respectively.<sup>114</sup>

Expenditure for ACCHSs on a per capita basis varies around the country and follows no explicit method of resourcing allocation. Analysts commissioned by the Australian Government in 2004 reported that funding for Indigenous-specific primary health care services should be around \$1244 per capita.<sup>115</sup> In reality, only \$426 per capita was expended through such services by the Office for Aboriginal and Torres Strait Islander Health (OATSIH) in 2004–05. Spending is higher in remote areas and less in urban areas so that only \$252 per capita was expended on Aboriginal peoples in urban ACCHSs in 2004-06, with just \$683 per capita in remote ACCHSs.<sup>116</sup>

The best available estimates suggest that ensuring Aboriginal peoples access to the full range of core primary health care services requires at least \$3,600 per Aboriginal person per year. In remote zones, this figure needs to rise to \$5100 per capita per annum.<sup>117</sup> Econotech, commissioned by OATSIH in 2004,<sup>118</sup> proposed that, on a relative needs basis, “per capita spending on health services would need to be about 2.2 times higher for Indigenous Australians than for non-Indigenous Australians”. The study took the view that, “by inference, the 2.2 factor would also apply to primary health care.”<sup>119</sup>

The Econotech study also explored the additional costs involved in providing an Indigenous-specific primary health care service across geographical locations. In per capita terms it costs around 3.5 times more to deliver a universal Indigenous-specific primary health care service in a very remote location compared to the cost of the same service in an urban location.

The present funding formula for ACCHSs within OATSIH is based on historical spending and a very general aim to increase funding to the equivalent of three times the average Australian MBS per capita spend.

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<sup>113</sup> Vos T, Barker B, Stanley L, Lopez AD 2007. The burden of disease and injury in Aboriginal and Torres Strait Islander peoples 2003. Brisbane: School of Population Health, The University of Queensland.

<sup>114</sup> Australian Institute of Health and Welfare 2008. Expenditures on health for Aboriginal and Torres Strait Islander peoples 2004–05. Health and welfare expenditure series no. 32. Cat. no. HWE 40. Canberra: AIHW.

<sup>115</sup> Econotech Pty Ltd. Costings models for Aboriginal and TSI health services. Canberra: Commonwealth of Australia, 2004.

<sup>116</sup> Australian Institute of Health and Welfare 2008. Expenditures on health for Aboriginal and Torres Strait Islander peoples 2004–05. Health and welfare expenditure series no. 32. Cat. no. HWE 40. Canberra: AIHW.

<sup>117</sup> AMSANT. Indigenous Access to Core PHC Services in the NT. 2007.

<sup>118</sup> Econotech Pty Ltd, Costing Models for Aboriginal and Torres Strait Islander Health Services, OATSIH/Commonwealth of Australia, Canberra, 2004.

<sup>119</sup> Ibid, page ix

This formula needs to be developed to reflect the actual cost of providing the agreed core services at particular locations. The actual utilisation of the core funds should be up to each ACCHS but they would be required to provide the agreed set of services.

For example, a resource allocation formula and distribution of funds would take into account population distribution, age/sex, geography, degree of socio-economic disadvantage, burden of disease, cost of providing the service above the agreed standard (eg measure of difficulty in staff recruitment, transport and outreach factors) and finally the scope of the primary health care service provided.

This was the approach taken through the Commonwealth Primary Health Care Access Program (PHCAP). The initiative arose from work undertaken by a joint NACCHO and Commonwealth Health Department Aboriginal health financing working group in 1996–97. PHCAP was to progressively replace inadequate historical grant funding with a mechanism to pool state/territory and Commonwealth primary health care resources at a regional level, topped up to an agreed per-capita funding benchmark and based on regional-level planning and partnerships.<sup>120</sup>

While the PHCAP initiative was funded for \$78.8 million for four years from 1999, it required ongoing appropriation of funding through the Cabinet or COAG budget processes for continued roll-out. A handful of regional funds-pooling models were established by mid 2003 but only around \$20 million had been allocated for service delivery—largely because of wrangling between governments over funds-pooling. The Howard years saw the PHCAP largely abandoned before it could be rolled out across Australia.

Key elements of PHCAP included: (1) a funding formula which provided a per capita estimate of primary health care funding requirements, calculated at 4 times the average national per capita MBS expenditure, giving a total of around \$2000 per capita; (2) regional planning and decision-making capacity in the expenditure of the funds; (3) cooperative arrangements between State and Commonwealth with a process of transparency across providers; and (4) investment of funds and human resources to progress community participation and engagement in planning and delivery of health services.

There is evidence in the NT- the Katherine West model- recognised as an example of the impact of community-control in conjunction with a level of health resourcing which approximates that required for delivery of basic, comprehensive primary health care. Katherine West has a per capita funding level of around \$2,550 per Aboriginal person per year, the highest per capita funding level of all NT zones, and has been able to demonstrate high levels and quality of care with positive short to intermediate health outcomes for people with chronic diseases, as well as reductions in hospital admission rates in comparison to other, less resourced zones in neighbouring areas.<sup>121</sup>

In the NT, around \$100 million in primary health care investment is being rolled out over the next two years, with Katherine West as the benchmark. The intent is to raise other NT health zones to a level of resourcing equivalent to this in the first instance, and for all sites to reach a level of resourcing beyond this, commensurate with access to optimal comprehensive primary health care services.<sup>122</sup> Elements of the roll-out of this primary health care investment are common to the

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<sup>120</sup> Couzos S, Murray RB. Health, Human Rights and the Policy Process. Op. cit.

<sup>121</sup> AMSANT. Indigenous Access to Core PHC Services in the NT. 2007.

<sup>122</sup> Indigenous Access to Core Primary Health Care Services in the NT – Technical Working Group of the Northern Territory Health Forum, 2007.

previous PHCAP funding model, and include: (1) A commitment which includes financial resourcing for regionalisation of service provision<sup>123</sup> and pathways to progressively increase community engagement and eventual control of health planning and service delivery; and (2) application of a rational resourcing model which aims to comprehensively address core Aboriginal primary health service funding.

Unfortunately Darwin (as an urban area) has not been included in this funding initiative despite the inadequate per capita funding levels for Aboriginal peoples in Darwin. This reflects the misconception that urban Aboriginal people don't have pressing health needs and are able to access mainstream services. The evidence however does not support this argument and indeed living in urban areas can in some instances adversely affect health outcomes.<sup>124</sup> The health gap won't be closed without investment in the health of people in urban and regional areas.

The ambitious reform process in the NT is funded for only two years with no guaranteed funding past June 2010. It is unlikely that regionalization can be accomplished across the NT in this time frame given the complexities of consulting with communities and of transferring health infrastructure and staff from the government to the community-controlled health services.

The reforms under way in the NT need to be implemented across Australia including in urban areas if the government is serious about closing the gap in Aboriginal people's health inequity. The reforms need local adaptation but the principles of a commitment to community control, equitable funding and comprehensive primary health care could be applied across the board.

### **Core Aboriginal primary health care services**

A systematic approach towards defining the core deliverables for Aboriginal primary health care services (ie what funding would buy with an acceptable per capita benchmark funding allocation) is needed. In the NT, core PHC service delivery in all remote areas should ultimately aim to achieve:

- Aboriginal community control of the health service. While not all locations within remote areas of the NT are yet at a point where implementation of a community controlled model is possible, it is expected that the proposals contained in the "Pathways to Community Control" report developed on behalf of the NT Aboriginal Health Forum will form the 'blueprint' for future service development;
- Comprehensive PHC service delivery. Evidence shows that this will achieve maximum health gain and reduction in disease burden;
- Multidisciplinary service provision (typically involving teams comprising medical officer, Aboriginal Health Workers, Remote Area Nurse together with Allied Health professionals and administration support); with agreed benchmark ratios of practitioners-to-population for each discipline within each zone;
- Access to extended clinical roles including acute care services, population health services, accident and emergency responses and secondary and tertiary care providers including a system of visiting specialists;

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<sup>123</sup> The view of the NT Aboriginal Health Forum was that service populations of less than 3000-4000 Aboriginal persons were unlikely to ensure the economies of scale needed to sustain service development. If this rationale were to be applied across the existing 19 remote NT Aboriginal health planning zones agreed by the NT Aboriginal Health Forum, some zone amalgamations would be necessary to achieve the desired service population base.

<sup>124</sup> Scrimgeour D: 2007: Town or Country . Which is best for Australia's Indigenous people .MJA: 186(10). 532-533

- Access to health teams able to:
  - safely respond to the complex health needs of a small, highly mobile and dispersed Aboriginal population with poor health status;
  - maintain their relevance and competence in a cross-cultural context in which many of the service population have minimal skills in either speaking or writing the English language;
  - operate in locations subject to extreme isolation, extreme climatic conditions and with few or non-existent public transport services;
  - maintain operational effectiveness in conditions of geographic, professional and social isolation; and
  - maintain operational effectiveness in situations where team members may be subject to rapid turnover with the potential to disrupt program continuity.

Recurrent funding for ACCHSs would support competitive salary packages for all staff (medical – doctors, nurses, Aboriginal health workers; dental; allied health; administrative and support staff); Medical consumables including non-PBS medicines and consumables; utilities; on going training of staff; and basic transport costs– for staff to visit patients/subsidiary clinics etc, to pick up patients, etc.

Per capita benchmarks however, do not cover non-clinical costs needed, such as those needed for the community to participate in matters of health decision making at the local, regional or jurisdictional level; start-up costs in establishing an ACCHS; capital works and costs associated with the current Patient Assisted Travel Scheme.<sup>125</sup>

The capital expenditure component of an expanded core primary health care budget would support:

- Existing clinic buildings to accommodate projected health service and training requirements;
- Staff accommodation;
- Equipment ranging from medical equipment such as examination couches, dental chairs and sterilisation units through to computers, desks, chairs and kitchen equipment;
- Transport: vehicles and ambulances to allow workers to visit patients in their homes when necessary, bring patients to the clinic for appointments and transport sick people either to the nearest hospital or airstrip for evacuation;
- New clinic development based on regional plans.

Regional Planning processes will inform on the relative distribution of both capital and recurrent funding to ACCHSs across Australia. These funds should be combined in a global budget to each ACCHS.

The delivery of the agreed set of services depends on building additional capacity in ACCHSs. This cannot be achieved instantly. Over time, such capacity building will see greater uptake and

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<sup>125</sup> AMSANT. Indigenous Access to Core PHC Services in the NT. 2007.

utilisation of medicines and Medicare. Enhanced primary health care (accessible to Aboriginal peoples) will see a reduced reliance on hospital care.

*How can we ensure that primary health care expenditure is sustainable?*

As outlined earlier, funding for ACCHSs has neither been commensurate with independently determined benchmarks, nor guaranteed. This impedes the delivery of comprehensive care and undermines the building of effective structures for Aboriginal peoples. For this reason the Rudd Governments and State/Territory Governments commitment to close the gap in life expectancy for Aboriginal peoples were welcomed. It is now clear, however that \$806 million federal allocation (over 4 years) will not address the needs of Aboriginal primary health care to close that gap in health status.

The main reason is that COAG funding allocations cannot be used to create long-term capacity building of ACCHSs. The vast bulk of the funding will not supplement core deliverables for these services. Rather, funding is to be provided for vertical programs which will require separate grant acquittals, the creation of new workforce roles with no security of tenure; and more mainstream funding such as through incentives to private GPs and Divisions of General Practice.

For Aboriginal leaders, the issues are thus not so much about how can primary health care expenditure be sustainable- but how can primary health care expenditure be made equitable for Aboriginal peoples? If the COAG commitment to close the gap, has led to poorly conceived programs, firstly who is responsible for these decisions? Is it too late to correct these mistakes? Neither NACCHO, nor its Affiliates were party to the decisions made to allocate these COAG funds.

NACCHO and Affiliates are currently developing recommendations that can help guide government investment in ways that may effectively close the gap and provide for sustainable approaches in the delivery of culturally appropriate primary health care for Aboriginal peoples.

It could be for example that a legislative basis for government allocations towards closing the gap in Aboriginal life expectancy needs to be developed. Such a legislative approach would prevent government Departments of Health and Aging arbitrarily spending public monies in ways that were unacceptable to the peoples the funds were meant to assist. If it is widely accepted that culturally appropriate primary health care is a priority for closing the gap, can the law be used to ensure funding is used in that way? Under such an approach, funding should be assured, regardless of the government of the day, until the gap in life expectancy between Aboriginal and non-Aboriginal peoples has been closed.

As we have seen, it is unlikely that direct use of the MBS will ever approach a level commensurate with the need of the Aboriginal population, hence the need for the direct investment in ACCHSs. In this context, Medicare cannot be seen to be a sustainable source of funds for Aboriginal primary health care. Augmenting the capacity of ACCHSs, through expansions in capital and recurrent funding (see earlier), will however, significantly increase both PBS and MBS utilization.

At the same time (and partly in response to limitations in MBS arrangements), the development of a range of blended and targeted payments such as the Practice Incentives Program (PIP), will not provide for, nor sustain the delivery of core primary health care as defined by ACCHSs (as has been described earlier). Labeling these incentives 'Indigenous' serves to distort Aboriginal expenditures

meant to 'close the gap',<sup>126</sup> and particularly in the absence of a robust accountability system to ensure there is no leakage to the non-Aboriginal population.

*Should a new mechanism(s) be implemented to consider whether proposed new primary health care interventions should be subsidised?*

Proposed new primary health care interventions for Aboriginal peoples should be agreed to by Aboriginal peoples through their representative bodies. Interventions should be evidence-based, and if acceptable, should be adapted to meet the needs of Aboriginal peoples, accessible, affordable and of good quality. These decisions necessarily require assessment by Aboriginal peoples and their representative bodies.

*What should be an appropriate mix of public and private funding for primary health care?*

Until, the relative deprivation and socioeconomic disadvantage experienced by Aboriginal peoples is minimised, bulkbilling will remain a priority for ACCHSs. All ACCHSs provide bulkbilling services across Australia.

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<sup>126</sup> See earlier for a discussion as to the need to target 'hard to reach' Aboriginal peoples and those who are most disadvantaged.