Central Australian
Aboriginal Congress
ABORIGINAL CORPORATION | ICN 7823

Response to the Draft recommendations from the Primary Health Reform Steering Group

Discussion Paper to inform the development of the Primary Health Reform Steering Group recommendations on the Australian Government's Primary Health Care 10 Year Plan

July 2021

About Congress

1. Central Australian Aboriginal Congress (Congress) is a large Aboriginal Community Controlled Health Service (ACCHS[1]) based in Alice Springs. We are one of the most experienced organisations in the country in Aboriginal[2] health, a national leader in primary health care (PHC), and a strong advocate for the health of our people.

2. Congress delivers services to more than 17,000 Aboriginal people living in Alice Springs and remote communities across Central Australia including Ltyentye Apurte (Santa Teresa), Ntaria (Hermannsburg), Wallace Rockhole, Utju (Areyonga), Mutitjulu and Amoonguna.

3. Our response to the *Draft recommendations from the Primary Health Reform Steering Group* is based on our experience of delivering comprehensive primary health care including multidisciplinary clinical care; health promotion and disease prevention programs; and action on the social, cultural, economic and political determinants of health and wellbeing.

Our response to the Draft recommendations

4. Congress would like to congratulate the Primary Health Reform Steering Group for its work on the draft recommendations to inform the Australian Government's Primary Health Care 10 Year Plan. **We strongly support the recommendations on Aboriginal and Torres Strait Islander health, and see their adoption by Government as essential for the effective implementation of the *National Agreement on Closing the Gap* for Aboriginal and Torres Strait Islander peoples.**

5. In this paper, we present:

   - **further evidence in support of the Steering Group's recommendations in Aboriginal and Torres Strait Islander PHC**, outlining the success of the ACCHS sector in addressing Aboriginal health, and the effects of previous government policies and funding levels (*Why reform is needed in Aboriginal Health*). We trust this additional information will be useful in ensuring that the draft recommendations regarding Aboriginal and Torres Strait Islander PHC are adopted;

- **some areas for further attention**, including
    a. addressing ACCHS sector infrastructure needs;
    b. establishing a national single source funding mechanism for ACCHS;
    c. addressing ACCHS Sector Workforce needs;
    d. increasing data gathering and research capacity in the ACCHS sector.

Why Reform is need in Aboriginal Health

ACCHSs: a successful model of comprehensive PHC

6. ACCHSs were first established by Aboriginal communities in the 1970s. ACCHSs promote a comprehensive model of primary health care, including culturally responsive practice and a multi-disciplinary team approach. These factors make them the best-practice service platforms for delivering comprehensive PHC.

7. A number of evidence and literature reviews have attempted to assess the effectiveness of ACCHS in comparison to mainstream primary health care [1, 2]. In doing so, they have been hampered by the fact that ACCHSs' service population has significantly more complex health needs compared to the general population, and are more likely to live in rural, remote or outer-suburban areas where private practice business models struggle and service access is a particular challenge.

8. In addition, ACCHS provide a comprehensive model of care that goes beyond the treatment of individual clients for discrete medical conditions to include:

    - a focus on cultural responsiveness;
    - assistance with access to health care (e.g. patient transport to the ACCHS and support and advocacy to access care elsewhere in the health system);
    - population health programs including health promotion and disease prevention;
    - public health advocacy and intersectoral collaboration for health gain;
    - participation in local, regional and system-wide health planning processes;
    - use of data and research to build the evidence base for what works;
    - structures for community empowerment, engagement and control; and
    - significant employment of Aboriginal and Torres Strait Islander people.

9. Despite the difficulties of comparing different models of PHC delivery, the evidence is clear that ACCHS are the most effective PHC service model for Aboriginal and Torres Strait Islander health, with:

    > *... some studies showing that ACCHS are improving outcomes for Aboriginal people, and some showing that they achieve outcomes comparable to those of mainstream services, but with a more complex caseload [2].*

10. ACCHSs have contributed significantly to reductions in communicable disease, improved detection and management of chronic disease, and better child and maternal health outcomes including reductions in preterm births and increases in birth weight [3] (see section below for further detail).

11. More recently, ACCHSs have played a leading role in the response to the COVID-19 pandemic. Rates of infection amongst Aboriginal and Torres Strait Islander people have been significantly lower than for the general population, thanks in part to swift action by the ACCHS sector which has been able to implement evidence-informed public health measures based on detailed social and cultural knowledge of local Aboriginal communities [4].

12. The key role of ACCHSs in PHC delivery was confirmed by one major study which concluded that:

> *up to fifty percent more health gain or benefit can be achieved if health programs are delivered to the Aboriginal population via ACCHSs, compared to if the same programs are delivered via mainstream primary care services [5].*

13. ACCHSs also provide a platform for reorienting the health system towards a more integrated, culturally safe response to Aboriginal health needs, through a combination of direct advocacy and the development, implementation and evaluation of evidence-based approaches to what are often seen as intractable health challenges. Congress itself has developed a strong reputation in this area, with a large range of publications in the fields of:

- multi-disciplinary health promotion in primary health care [6];
- advocacy for population-level public health approaches to preventing alcohol-related harm [7, 8];
- non-residential treatment for clients with alcohol problems, based on three streams of care (medical; psychological and socio-cultural support) [9];
- integrated models of child and family services [10];
- early childhood education for disadvantaged children [11, 12]; and
- improved funding for, and collaborative planning and implementation of primary health care services in remote and regional Australia [13-15].

1970s to 2000s: Reforms and increased funding lead to improved outcomes

14. Maximising the ability of ACCHS to deliver improved health outcomes is dependent on appropriate resourcing and funding mechanisms, and policy settings that support, rather than undermine, the Aboriginal community controlled model of PHC.

15. After the establishment of the first ACCHSs in the 1970s, over 100 such services were set up across the country in urban, regional and remote areas. However, the sector remained reliant on a range of short term, ad hoc grant funding that failed to recognise their place as a key part of Australia's health system.

16. During the 1990s there was a substantial national campaign by ACCHSs for increased funding for Aboriginal community-controlled comprehensive primary health care. In response, in 1995 the Australian Government transferred responsibility for Aboriginal and Torres Strait Islander primary health care from the Aboriginal and Torres Strait Islander Commission (ATSIC) to the Commonwealth Department of Health.

17. This was a critically important reform. Beginning under the leadership of the former Federal Coalition Minister for Health, Dr Michael Wooldridge (1996-2001) and continuing with bipartisan support thereafter, it led to increases in national funding for PHC directed through ACCHSs from around $269 per Indigenous person in 1995-96 to $753 per Indigenous person in 2010-11 (constant prices) [16, 17].

18. This increased investment in PHC delivered through ACCHSs led to significant improvements in Aboriginal and Torres Strait Islander health outcomes. For example:

    a. low birth weight rates steadily declined year on year (11.7% LBW in 1995 to 10.7% in 2010) [18];

    b. infant mortality rates declined significantly (from 10.29 per 1,000 live births in 2001 to 7.29 per 1,000 live births in 2010) [19]; and

    c. mortality rates for avoidable conditions for Aboriginal and Torres Strait Islander people fell from 497 per 100,000 in 1998 to 338 per 100,000 in 2011 [20].

19. While formal research to confirm these links is still needed, this is entirely consistent with the international evidence which shows that increased investment in PHC leads to better population health outcomes, especially relating to maternal and child health as measured by low birth weight and infant mortality [21] and lower hospitalisation rates for avoidable conditions, especially chronic conditions which account for about 80% of the health gap between Aboriginal and non-Aboriginal Australians [22].

2010s: Falling funding, poor policy and a widening health gap

20. Unfortunately, the successes of the period following 1995 were not sustained. Despite the 2008 commitment by all Australian Governments to 'closing the gap' in life expectancy between Aboriginal and Torres Strait Islander and non-Indigenous Australians by 2031, PHC expenditure for Aboriginal and Torres Strait Islander people actually fell from $3,840 per person in 2008-09 to $3,780 per person in 2015-16 [2]3.

21. Much of the fall in funding resulted from the Australian Government's implementation from 2014 of the Indigenous Advancement Strategy (IAS). The IAS cut $500M from Indigenous spending overall, and $160M from funding for Indigenous health [23].

22. A Senate review of the IAS found that its process and policy directions were significantly flawed; that it disadvantaged Aboriginal organisations and disregarded the enhanced outcomes stemming from Aboriginal led service delivery; and that it failed to distribute resources effectively to meet regional or local needs The IAS's processes led to almost half (45%) of its $4.8 billion going to non-Indigenous organisations [24].

23. During this period, while life expectancy for Aboriginal and Torres Strait Islander people gradually increased, it did so at a slower rate than that of non-Indigenous Australians. As a result, between 2006-10 and 2011-15, the national life expectancy gap widening from 10.0 to 10.6 years for females and 10.2 to 10.8 years for males [25].

2020s: Towards robust reform and long-term progress in Aboriginal health

24. The *2020 National Agreement on Closing the Gap* [26] was developed and formally agreed in a genuine collaboration between Australian governments and the Coalition of Aboriginal and Torres Strait Islander Peak Organisations (the Coalition of Peaks). The National Agreement provides the foundation for reforms that could return Australia to a path of genuine progress in Aboriginal Health.

25. The National Agreement commits all Australian Governments to:

    building formal Aboriginal and Torres Strait Islander community-controlled sectors to deliver services to support Closing the Gap [clause 42], and

> *[increasing] the proportion of services delivered by Aboriginal and Torres Strait Islander organisations, particularly community-controlled organisations* [clause 55]

recognising that

> *Aboriginal and Torres Strait Islander community-controlled services are better for Aboriginal and Torres Strait Islander people, achieve better results, employ more Aboriginal and Torres Strait Islander people and are often preferred over mainstream services* [clause 43].

Response to the Reform Group's Recommendations

26. While the *National Agreement on Closing the Gap* is a critical foundation, its commitments must be reflected across health system planning, policy and programs to support genuine, long-term, positive change. We are very pleased that the *Draft recommendations from the Primary Health Reform Steering Group* take account of the National Agreement, and strongly support the draft recommendations, noting some areas for further attention detailed below.

    4.1. Procurement and commissioning
    4.2. Integration of services within ACCHSs[1]
    4.3. Shared decision-making and co-design
    4.4. Resource ACCHSs[1] (see below for additional suggestions regarding **ACCHS infrastructure** and **funding systems**)
    4.5. ACCHS[1] geographic coverage
    4.6. Improve mainstream services
    4.7. Data (we propose renaming this **Data and research** – see below for additional suggestions
    4.8. Digital infrastructure
    4.9. Workforce (see below for additional suggestions regarding **ACCHS workforce**)
    4.10. Access to Medicines
    4.11. Medical/Health Technology
    4.12. Concurrent reform

Areas for further attention

Addressing ACCHS infrastructure needs

27. The poor state of health infrastructure (especially clinic buildings) in the ACCHS sector is a key limiting factor for the effectiveness and safety of the services our sector provides to close the gap in health for the communities we serve. In 2019, the National Aboriginal Community Controlled Health Organisation (NACCHO) surveyed its members about infrastructure needs in the ACCHS sector, and estimated an investment of $360M was required just to meet the needs of the 40% of NACCHO members who responded to the survey [27].

28. Increased investment in health infrastructure for many ACCHS clinics, especially in remote areas is urgently required to provide safe care and maintain accreditation;

ensure a safe working space for staff; recruit and retain clinical staff; and provide integrated visiting specialist and outreach services. These needs have been exacerbated by the COVID-19 pandemic where the need for safe infection control is limited by poorly maintained and overcrowded clinical spaces.

29. In many remote areas, the situation is further complicated by complex leasing / ownership arrangements resulting from the transfer of government clinics to community control in previous decades.

30. We suggest an additional recommendation addressing this issue, as follows.

> *Address the poor state of health infrastructure (especially clinic buildings) in the ACCHS sector as a key limiting factor for the effectiveness and safety of the sector, including in responding to outbreaks of infectious disease such as COVID-19. This should include:*
>
> - *surveying and identifying ACCHS health infrastructure needs in each State / Territory, focusing on clinics, staff accommodation and lease / ownership issues;*
> - *estimating the capital costs required to rectify major faults affecting service delivery and safety and/or replace buildings;*
> - *developing a* National Ten Year ACCHS Infrastructure Plan *on the basis of the State / Territory surveys; and*
> - *establishing an* ACCHS Health Infrastructure Fund *overseen by a body that includes both Government and ACCHS representation to strategically address infrastructure needs.*

Establishing a national single source funding mechanism for ACCHS

31. Currently, funding responsibility for Aboriginal and Torres Strait Islander PHC is divided between State / Territory and the Australian Governments. This lack of a single funding source and method has led to a situation where:

    - *funding levels are not transparent*: it is impossible to know on a regular basis how much Australia spends on Aboriginal PHC and where;
    - *funding is not strategic or equitable*: it is not possible to allocate new resources to areas of greatest need or to places that are underfunded on a per capita / needs basis relative to others;
    - *there is constant cost-shifting*: State / Territory Governments in particular use Australian Government funding for Aboriginal PHC to reduce their own spending, or to transfer health spending from PHC to hospital or other levels of care;
    - *there is a large administrative burden on ACCHSs* which often manage dozens of grants from different funding agencies at the Federal and State/Territory level.

32. The current collaborative work between the ACCHS sector led by NACCHO and the Australian Government on the development of a funding formula and a set of 'core PHC services' are important steps forward. However, without a single funding source the issues above will remain.

33. There are two potential ways to establish a single-source of funding: either the Australian Government takes sole responsibility for all Aboriginal and Torres Strait Islander PHC services, or existing funds are pooled into a single source administered

by a newly established National Aboriginal and Torres Strait Islander Health Authority (NATSIHA) as recommended by the National Health and Hospitals reform Commission (NHHRC) in 2009 [28].

34. The NATSIHA would be statutory authority accountable to the government of the day through the Minister for Health, governed by a board of experts with the majority being Aboriginal people. Its overall aim would be to oversee the strengthening and further development of Aboriginal and Torres Strait Islander PHC nationally by:

    - purchasing and commissioning high quality, culturally appropriate PHC, allocating regional grant funding on the basis of an agreed funding formula / set of core services, with fee-for-service (e.g. Medicare) payments available in addition to the grant funding in a "mixed model" funding model;
    - prioritise ACCHSs for funding, and set up and monitor transition arrangements to community-control where ACCHSs do not already exist;
    - providing dedicated funding for capacity building to maximise the ability of each ACCHS to deliver the highest possible quality of care through trained and supported staff;
    - reporting regularly and publicly on funding and activity on a regional basis.

35. We suggest an additional recommendation addressing this issue, as follows.

> *Ensure funding for Aboriginal and Torres Strait Islander PHC that is adequate, equitable, transparent, accountable and manageable by individual services through the establishment of single-source funding through a National Aboriginal and Torres Strait Islander Health Authority (NATSIHA). The NATSIHA would manage and allocate pooled funding from all State / Territory and Australian Government sources for Aboriginal and Torres Strait Islander PHC on a regional basis, prioritising ACCHS where they exist and ensuring processes for transition to community control are in place where they do not.*

Addressing ACCHS Sector Workforce needs

36. We welcome the strong focus of the Draft Recommendations on workforce and workforce planning (Recommendations 10 to 14, and 4.9 relating to Aboriginal and Torres Strait Islander PHC).

37. An appropriate workforce – especially clinical workforce – is critical for the continued success of the ACCHS sector to meet the health needs of the Aboriginal peoples of Australia. Today, especially in remote and very remote areas, the availability of staff to fill key roles in the primary health care multidisciplinary team is a key limiting factor in meeting those needs (i.e. just providing more funding will not substantially assist those services unless workforce is also addressed).

38. The latest data [29] shows:

    - an increase of 43% health staff vacancies between 2013-14 and 2019-20 for all Aboriginal and Torres Strait Islander specific primary health care organisations in Australia, with remote areas most severely affected where vacancies more than doubled over this period; and

- the proportion of FTE to client population for Aboriginal Health Practitioners (AHPs), General Practitioners and nurses and in the Northern Territory has fallen significantly between 2013-14 and 2019-20: AHPs down 14% (from 2.1 FTE per 1,000 clients to 1.8); GPs down 4% and nurses down 3%.

39. Congress data (which is also reflected in other unpublished data from the NT[4]) shows significant increases in the prevalence of chronic disease over the last ten years. Congress believes this is a result of both improved health care which is seeing people with chronic disease live longer, and improved PHC systems in particular leading to greater detection of chronic disease. The increased prevalence of chronic disease demands higher levels of health professional staffing to manage and treat disease.

40. In the case of General Practitioners, geographic maldistribution remains a major issue: in 2017-18 there were 103.5 GP FTEs in major cities and only 70.5 GP FTEs in very remote areas, despite the very much greater need in remote Australia [30].

41. We support the draft recommendation aimed at supporting, streamlining and bolstering the role of GPs including Rural Generalists (Recommendation 14). However, we believe that the issues of maldistribution must be tackled directly through:

    - establishing an Aboriginal Health General Practice Training Support Service;
    - ensuring transferability of entitlements between placements for registrars working in Aboriginal health to make the training program more attractive;
    - increasing the relative financial reward for becoming a GP preferably by putting a ceiling on what other specialists can earn; and
    - introducing geographic provider numbers as a non-financial incentive to work in areas of need.

42. We also note the lack of national, consistent and regular data on the primary health care workforce, by region and profession (headcount and FTE). Regular publication of this data would provide a transparent basis for the strategic allocation of resources and evaluation of policies and programs.

43. Many ACCHS have become key training providers including for GPs, nurses, AHPs, psychologists, social workers, pharmacists and other allied health professionals. The ability to train health professionals has become fundamental to the capacity to recruit and retain the culturally responsive workforce that is needed to deliver effective PHC. There needs to be dedicated resources to establish the larger regional ACCHS as training centres of excellence in Aboriginal and Torres Strait Islander health.

44. In line with these comments we suggest

    - adding under Recommendation 4.9. regarding the Aboriginal and Torres Strait Islander PHC Workforce as follows:

> *Develop a national Aboriginal and Torres Strait Islander primary health care workforce strategy to be developed in consultation with the ACCHS sector noting that this should include additional measures to encourage and support Aboriginal and Torres Strait Islander PHC staff*

- adding under Recommendation 14.2 (distribution of the medical primary care workforce) as follows:

> *Implement additional measures to ensure an adequate supply of General Practitioners to support Aboriginal and Torres Strait Islander PHC, including establishing an Aboriginal Health General Practice Training Support Service; ensuring transferability of entitlements to encourage training in Aboriginal health; increasing the relative financial reward for becoming a GP; and introducing geographic provider numbers*

- adding under Recommendation 10 (Building workforce capability and sustainability) as follows:

> *Ensure the gathering and regular publication of consistent and regular data on the primary health care workforce, by region and profession (headcount and FTE).*
>
> *Ensure there is dedicated funding to support and develop the key training role that ACCHS play in preparing health professionals to work in a culturally responsive and clinically competent way in Aboriginal primary health care*

Data and Research

45. ACCHSs play a critical role in responsible innovation, enabling the implementation and evaluation of new services and programs and building an evidence base of what works (see paragraph 13 above).

46. In partnership with research institutions, ACCHSs are also key for the successful implementation of many research projects that further develop the evidence base required to ensure that the right services, programs and public health policies are being implemented to maximise Aboriginal health improvement. Without effective engagement with ACCHSs, research cannot be implemented in a culturally responsive way and Aboriginal people and communities are unlikely to effectively participate.

47. This is an increasingly important role for ACCHS but it requires funds to ensure that they have the capacity and expertise to properly engage with research. These funds should be sourced from dedicated research funding sources such as the National Health and Medical Research Council (NH&MRC) and the Medical Research Future Fund (MRFF). This could be delivered through dedicated "research infrastructure" rounds for Aboriginal and Torres Strait Islander research to enable ACCHSs to employ research managers, evaluation officers and the data scientists to support the use of the rich data contained in our clinical information systems. Increasingly, the ACCHS sector needs the capacity to use data linkage to effectively evaluate services and programs as well as the impact of the social and cultural determinants on Aboriginal health.

48. We suggest the Recommendation 4.7 be renamed 'Data and research' and the following recommendation be added:

> *Ensure that the research funding bodies including the NH&MRC and the MRFF set aside a dedicated amount of funding to fund research infrastructure within at least the larger, regional ACCHS. This could be achieved by targeted Aboriginal health research infrastructure rounds that are only open to ACCHS.*

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[1] We note that the discussion paper refers to ACCHOs (Aboriginal community controlled health organisations). Our preferred term is ACCHSs (Aboriginal community controlled health services) as this makes clear their essential role in delivering *services* as a key part of Australia's PHC system.

[2] In this document we use the term 'Aboriginal' as the most appropriate terms in the Central Australian context to refer to Australia's First Peoples

[3] From the Productivity Commission's Indigenous Expenditure Report 2017 detailed pivot tables, Table P.5. Non-Hospital health expenditure includes:

1. **Public and community health services (excluding subsidies)**
   - Public health services
   - Community health services
     - Community mental health services
     - Patient transport
   - Other community health services
     - Other health practitioners
     - Community health
     - Dental services
2. **Health care subsidies and support services**
   - Health service subsidies
     - Medical services subsidies (including Medicare)
     - Private Health Insurance subsidies
   - Pharmaceuticals, medical aids and appliances
     - Pharmaceuticals subsidies (PBS)
     - Other medications
     - Aids and appliances
   - Research and administration
   - Health research

[4] NT Diabetes prevalence has doubled in the last fifteen years, with increased rates amongst young people and pregnant women (Dr Christine Connors, pers. comm as data not yet published)