12 December 2022

Romlie Mokak
Commissioner
Productivity Commission
GPO Box 1428
Canberra City ACT 2601

RE: Submission to the *Review of the National Agreement on Closing the Gap: Review paper 2*

Dear Romlie,

Please accept this as a submission in response to the *Review of the National Agreement on Closing the Gap: Review paper 2 (October 2022)*.

Thank you for meeting with Congress' Public Health Medical Officer, Dr John Boffa on 9 September 2022 to discuss Congress' work, and the first Review of progress under the *National Agreement on Closing the Gap*. I endorse the key points made by John in that meeting regarding:

- progress on, and threats to, improvements in Aboriginal life expectancy;
- the need to continue and extend policies and programs that we know are successful and that have led to progress over the last three decade;
- the need to continue to improve data systems to enable accurate and consistent measurement of progress; and
- an increased focus on evidence-based early childhood programs based in Aboriginal community controlled health services (ACCHSs).

In this submission, I would like to provide additional information for your review, particularly by suggesting several case studies to help understand what governments have done and the factors contributing to success and failure. The case studies we suggest are as follows.

Proposed Case Study 1: Government policy and resourcing to support a successful model of comprehensive PHC through Aboriginal community controlled health services

> *Aboriginal community controlled health services (ACCHSs) have been foundational for improvements in Aboriginal health. However, their effectiveness is dependent on Government policy that recognises their effectiveness and resources them accordingly. Since the 1970s a number of periods of government policy with regard to ACCHSs can be tracked through their effect on health gain.*

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Aboriginal health in Aboriginal hands.

Proposed Case Study 2: Collaborative needs-based planning through the Northern Territory Aboriginal Health Forum

> *The Northern Territory Aboriginal Health Forum (NTAHF) provides an excellent case study of sustained joint planning and information sharing between government and Aboriginal community controlled organisations. In association with the increased resourcing for community-controlled primary health care described above, this joint planning was the foundation for progress in Closing the Gap in the NT.*

Proposed Case Study 3: Threats to health from unilateral actions of government regarding alcohol supply

> *During the 2010s, the Northern Territory Government introduced a range of population level reforms regarding alcohol availability which were very effective in reducing levels of alcohol-related harm for Aboriginal communities. Unfortunately in July 2022, the expiry of the* Stronger Futures in the Northern Territory Act 2012 *(Alcohol Protected Areas) provisions posed a significant threat to the health gains under these reforms. Instead of a collaborative and planned approach as demanded by many leading Aboriginal organisations, the Northern Territory Government refused to act to continue those protections. Levels of alcohol related harm – including against Aboriginal women – are now rising rapidly.*

I trust that the more detailed information on the following pages is useful.

Thank you for your consideration of these important issues. I would be very happy to discuss them should you wish. In the meantime, please contact Congress' Public Health Medical Officer, Dr John Boffa on 0418 812 141 or john.boffa@caac.org.au if you would like more detail on the matters raised here.

Yours sincerely

Donna Ah Chee
Chief Executive Officer

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Proposed Case Study 1:

Government policy to support a successful model of comprehensive PHC through Aboriginal community controlled health services

Aboriginal community controlled health services (ACCHSs) have been foundational for improvements in Aboriginal health. However, their effectiveness is dependent on Government policy that recognises their effectiveness and resources them accordingly. Since the 1970s a number of periods of government policy with regard to ACCHSs can be tracked through their effect on health gain.

Evidence of effectiveness

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

2. 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 live in rural, remote or outer-suburban areas where private practice business models struggle and service access is a particular challenge.

3. 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 security;
   - 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 prevention;
   - public health advocacy and intersectoral collaboration;
   - participation in local, regional and system-wide health planning processes;
   - structures for community empowerment, engagement and control; and
   - significant employment of Aboriginal and Torres Strait Islander people.

4. 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].*

5. 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).
6. 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].
7. 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].*

8. 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];
   - SEWB services 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

9. 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.

10. After the establishment of the first ACCHSs in the 1970s, over 140 have now been 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.

11. 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.

12. 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].

13. This increased investment in PHC delivered through ACCHSs led to significant improvements in health outcomes. For example:
    - low birth weight rates steadily declined year on year (11.7% LBW in 1995 to 10.7% in 2010) [18];
    - 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
    - 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].

14. 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].

15. In Central Australia, the Congress History Project is documenting very significant health benefits over time, many of which we would argue are a result of the increased resourcing of comprehensive PHC under Aboriginal community control. The latest provisional data shows very significant falls in Years of Life Lost for Aboriginal people in Central Australia in the period 1986 to 2018, which we expect further analysis to confirm has led to significant increases in Aboriginal life expectancy in the region.

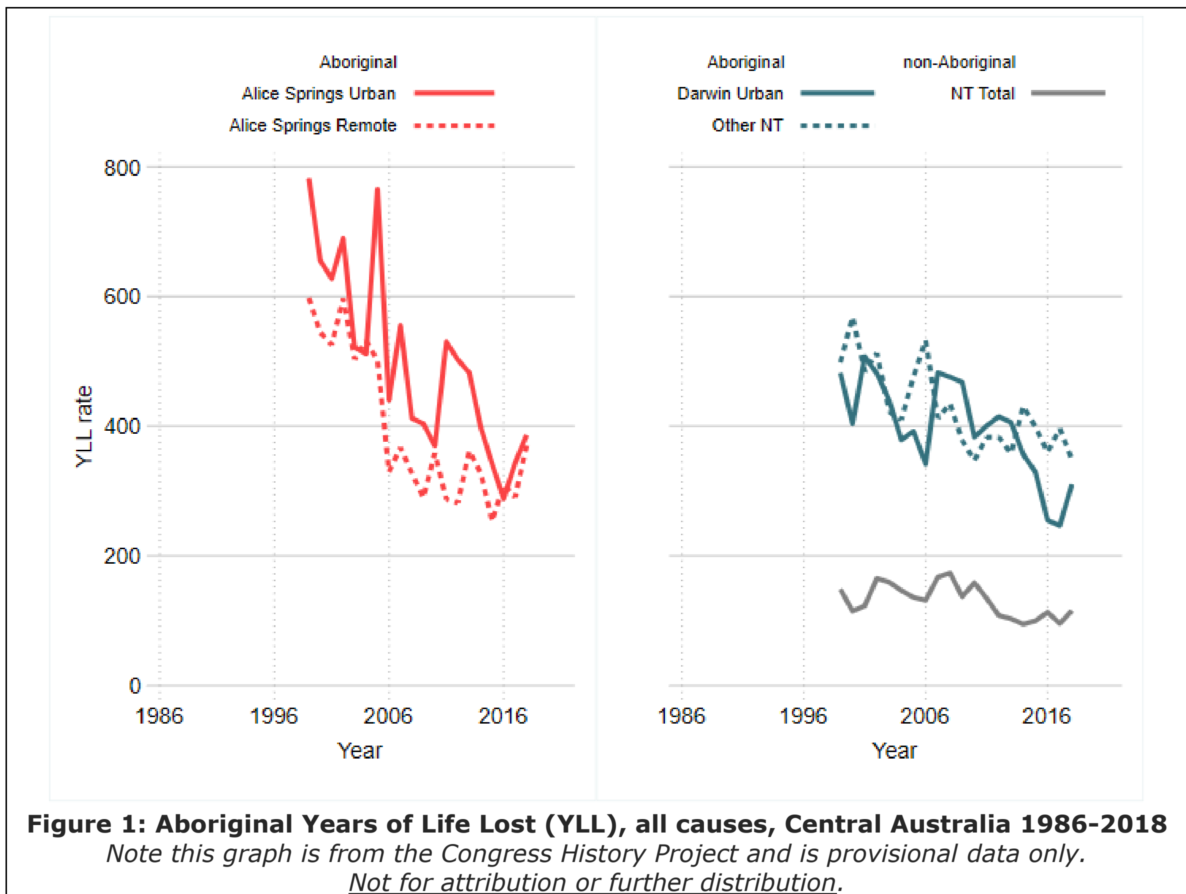

Figure 1: Aboriginal Years of Life Lost (YLL), all causes, Central Australia 1986-2018
Note this graph is from the Congress History Project and is provisional data only.
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2010s: Falling funding, poor policy and a widening health gap

16. Unfortunately, the successes of the previous period 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][1].

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[1] 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)

17. 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].

18. 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].

19. During this period, while national 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: Genuine reform and real progress in Aboriginal health?

20. 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.

21. 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].

    - Other medications
    - Aids and appliances
- Research and administration
- Health research

Proposed Case Study 2:

Collaborative needs-based planning through the Northern Territory Aboriginal Health Forum

The Northern Territory Aboriginal Health Forum (NTAHF) provides an excellent case study of sustained joint planning and information sharing between government and Aboriginal community controlled organisations. In association with the increased resourcing for community-controlled primary health care described above, this joint planning was the foundation for progress in Closing the Gap in the NT.

22. The funding and policy settings described in *Proposed Case Study 1* above would not have been effective if there was not also a means for collaboratively implementing them at a Territory and regional level. The key structure for doing so has been the Northern Territory Aboriginal Health Forum (NTAHF).

23. The signing of the *Framework Agreement* in 1998 [27] established the NTAHF, bringing together senior representation from the Australian and Northern Territory Governments with the community controlled sector (AMSANT) to work collaboratively to:

    a. ensure appropriate resource allocation;
    b. maximise Aboriginal community participation and control as a key element of sustainable, viable, effective and efficient health services;
    c. encourage better service responsiveness to / appropriateness for Aboriginal people;
    d. promote quality, evidence-based care;
    e. improve access for Aboriginal people to both mainstream and Aboriginal specific health services; and
    f. increase engagement of health services with Aboriginal communities and organizations.

24. The NTAHF has also helped to ensure that the social determinants of health are addressed through high level collaboration and advocacy outside the health system.

25. Collaborative needs-based planning through the Forum is supported by a set of agreed core primary health care functions [15]. These functions provide the basis for a rational approach to needs based funding, across five service domains:

    - Clinical Services
    - Health Promotion
    - Corporate Services and Information
    - Advocacy, Knowledge, Research, Policy and Planning
    - Community Engagement, Control and Cultural Safety

26. The agreement on core functions of primary health care has been supported by a corresponding development of Northern Territory Aboriginal Health KPIs (NTAHKPIs) that give a consistent view of need and progress over time; that enable each service to continually monitor and improve their services; and that maintain accountability through reporting to Aboriginal communities and to funding bodies.

27. The NTAHF has also overseen a process a transferring Government-run primary health care services to Aboriginal community control, based on an agreed Framework for progress [28]. The NTAHF has provided an important space in which the complexities of this transfer process have bee able to be addressed [14]. Over time this has led to a significant extension of Aboriginal community control of health services, including amongst other places in East Arnhem (Miwatj Health); West Arnhem (Mala'la Health Service, Red Lily Health Board); and Central Australia (Congress).

28. A key risk to the needs-based planning under the NTAHF is new funding is not necessarily being allocated through the Forum, and this requires continual vigilance and advocacy.

29. We suggest the operations of the NTAHF are closely aligned with elements of the *National Agreement on Closing the Gap* [26] in particular:

    - shared decision-making and building the community-controlled sector (clause 17)
    - establishing formal partnership arrangements to support Closing the Gap between Aboriginal and Torres Strait Islander people and governments in each state and territory (clause 81);
    - respecting and adding to existing partnership arrangements (clause 34).

Proposed Case Study 3:

Threats to health from unilateral actions of government regarding alcohol supply

During the 2010s, the Northern Territory Government introduced a range of population level reforms regarding alcohol availability which were very effective in reducing levels of alcohol-related harm for Aboriginal communities. Unfortunately in July 2022, the expiry of the *Stronger Futures in the Northern Territory Act 2012* (Alcohol Protected Areas) provisions posed a significant threat to the health gains under these reforms. Instead of a collaborative and planned approach as demanded by many leading Aboriginal organisations, the Northern Territory Government refused to act to continue those protections. Levels of alcohol related harm – including against Aboriginal women – are now rising rapidly.

1. During the 2010s, in collaboration with and with the support of many Aboriginal community controlled organisations, the Northern Territory Government introduced a range of alcohol reforms to deal with the jurisdiction’s long-standing issue with high levels of alcohol-related harm, including family violence. These included [29]:

    - Point of Sale Interventions (from 2018 called Police Auxiliary Liquor Inspectors or PALIs) at all bottle shops in three regional centres (2013);
    - a Banned Drinkers Register (BDR) to reduce the access to take-away alcohol by problem drinkers (2017);
    - a floor price to prevent the sale of cheap alcohol (2018);
    - a new Liquor Act that includes risk-based licencing and greater monitoring of on-licence drinking (2019); and
    - a commitment to high quality, ongoing independent evaluation.

2. These reforms were informed by the evidence from around the world on what works to reduce alcohol related harm. Over the first full year of operation of the floor price and PALIs from 1 October 2018 they demonstrated very significant reductions in wholesale sales of alcohol, which fell by 7% across the Northern Territory as a whole. Reductions in sales were greatest in those cheap types of alcohol associated with the greatest harms, with cask wine supply falling 51% and fortified wine sales down 37% following the introduction of the reforms.

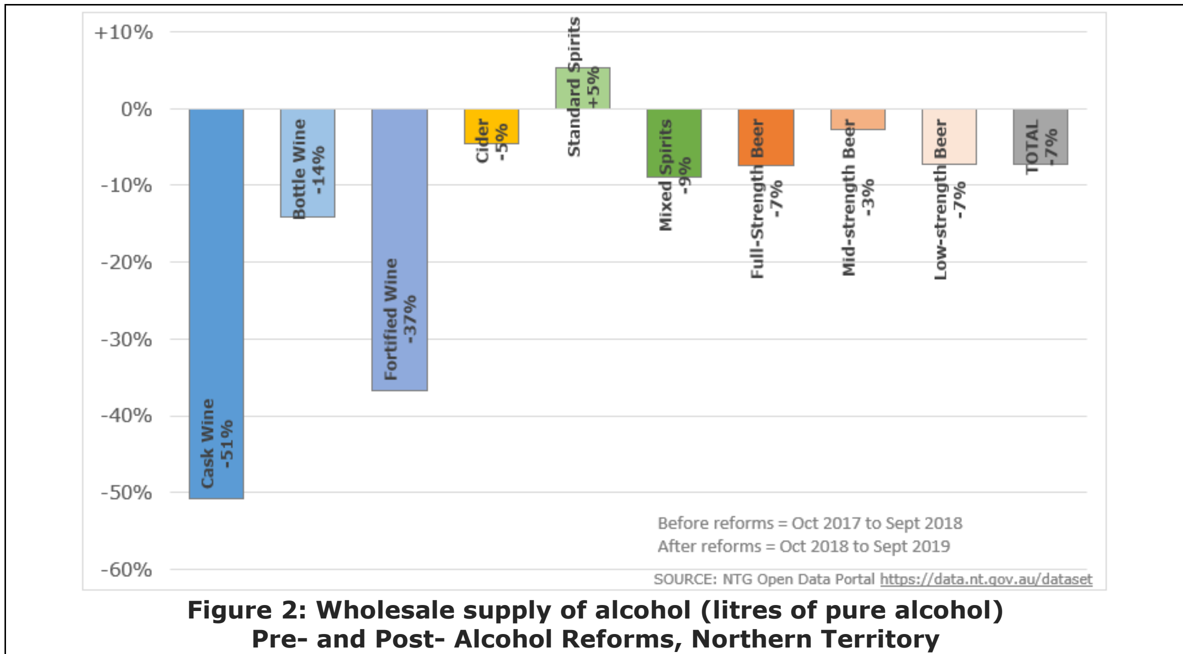

Figure 2: Wholesale supply of alcohol (litres of pure alcohol) Pre- and Post- Alcohol Reforms, Northern Territory

3. As a consequence, in the year following the introduction of the reforms there were dramatic falls in alcohol-related harm across the Northern Territory. Domestic violence assaults, as recorded by the NT Police, fell by 11% (equivalent to around 460 fewer DV assaults) in the year following the introduction of the reforms (*Figure 3*). The effect in some areas was greater – for example, Alice Springs saw over 220 fewer DV assaults after the introduction of the reforms, a fall of 22%.

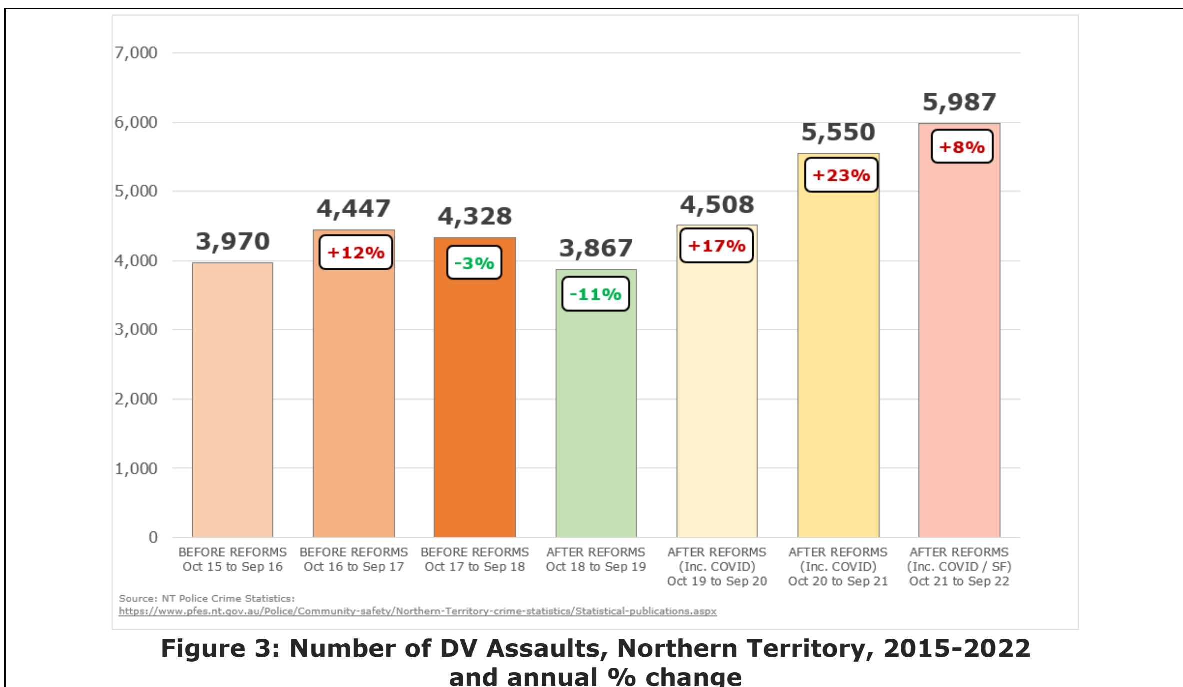

Figure 3: Number of DV Assaults, Northern Territory, 2015-2022 and annual % change

4. Unfortunately, the COVID-19 pandemic from March 2020 had a significant effect, with domestic violence assaults increasing markedly. While the reasons for this are yet to be examined in detail for the Northern Territory, it is

consistent with other Australian and international research showing that the COVID-19 pandemic was associated with both the onset and escalation of family violence [30].

5. The positive effect of the NT Government's Alcohol Reforms package has been further undermined by the expiry of the *Stronger Futures in the Northern Territory Act 2012* (Alcohol Protected Areas) provisions in mid-July 2022. Under these provisions, introduced in the wake of the Northern Territory Emergency Response, 34 town camps, six *Aboriginal Land Rights Act* communities and 74 Community Living Areas were declared 'dry'. The provisions had a sunset clause, expiring on 17 July 2022.

30. Given the lack of any substantive consultation with Aboriginal communities, Congress advocated strongly for the Northern Territory Government to pass legislation to extend the provisions for two years. During this time proper consultations could be held which ensure that all voices in the community were heard. During this consultation period communities should be able to 'opt out' of the provisions if they wish with a formal indication that this is what they want to do. Congress, along with many other community organisations predicted that unless this action was taken, there would be a wave of alcohol fuelled violence, much of it directed at Aboriginal women.

31. However, the NT Government did not act: no substantive consultations were held, and communities that wished to remain 'dry' had to 'opt in' to continue restrictions. As far as we know, no community in Central Australia has done so. The NT Government argued that the *Stronger Futures* provisions were racially discriminatory (as they only apply to Aboriginal lands and communities) and questioned the link between alcohol and family violence.

32. Congress argues stating that the Stronger Futures alcohol provisions are discriminatory misses the point. While it is true they affect Aboriginal people disproportionately, and may therefore be argued to be discriminatory, Congress along with many other Aboriginal organisations and leaders argues that unleashing severe, preventable alcohol related harms particularly upon Aboriginal women and families is also profoundly discriminatory. They have the right to live peaceful lives without the threat of violence to which alcohol so strongly contributes.

33. Further, the legislation that created these Alcohol Protected Areas in 2007 and again under the *Stronger Futures Act* in 2012, are, in our opinion, special measures under the test decided in the most recent High Court decision on this matter, *Maloney v R* in 2013[2]. Discriminatory practices can also be exempted in the Northern Territory if they are special measures, under s57 of the *Northern Territory Anti-Discrimination Act 1992*. Positive discrimination

[2] http://www7.austlii.edu.au/cgi-bin/viewdoc/au/cases/cth/HCA/2013/28.html

should not be misunderstood as racism as long as there is clear evidence of benefit and support from Aboriginal leaders and organisations.

34. The impact of the PALIs (Police Auxiliary Licensing Inspectors) depends largely on the *Stronger Futures* alcohol measures. The PALIs stationed at take away outlets require those purchasing take away alcohol to show a residential address that is not on alcohol-prohibited land. However, with the loss of the *Stronger Futures* measures people from formerly alcohol-prohibited communities who come to town and stay in a town address can now lawfully purchase alcohol along with all other people living in the former prohibited living areas.

35. The impact of PALIs was also reduced from March 2022, three months prior to the removal of the *Stronger Futures* legislation when Police were not able to recruit to these positions, leaving many alcohol outlets unattended. Historically, it has been very clear that unless all outlets are covered the PALI mechanism does not work as heavy drinkers soon learn to go to the outlet without PALI cover. This loss of PALIs explains why in the Alice Springs region there a sharp increase in family violence and other alcohol-related assaults from March onwards, an increase which continues after July 2022. The PALIs cease to be effective either because they are unfilled or because they no longer have the power to act due to the removal of the *Stronger Futures* provisions.

36. Unfortunately, predictions of increased violence against Aboriginal women due to the increased access to alcohol have been shown to be true. The number of DV assaults and the proportion that are alcohol-related has significantly increased. *Figure 4*.

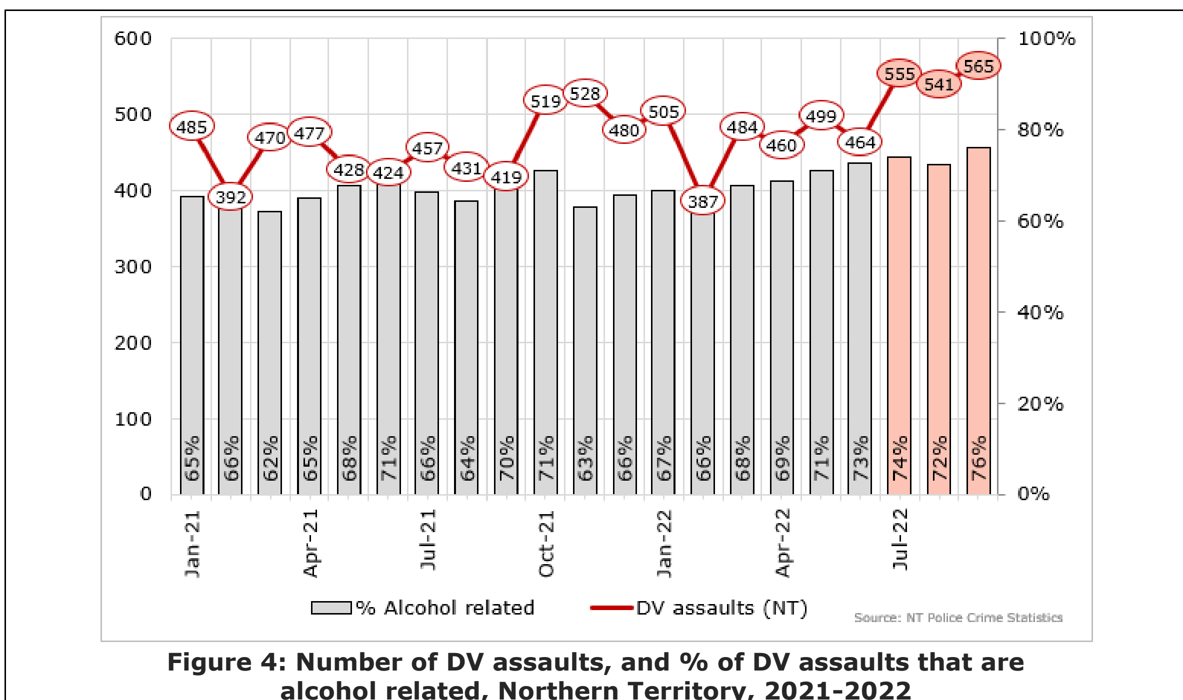

Figure 4: Number of DV assaults, and % of DV assaults that are alcohol related, Northern Territory, 2021-2022

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