

Central Australian Aboriginal Congress Aboriginal Corporation

Submission¹ to the

Senate Select Committee Inquiry into Health

13 November 2014

Executive Summary

Relative success in the Northern Territory in “Closing the Gap”

Amongst Australian jurisdictions, only the Northern Territory is on track to meet the target of ‘Closing the Gap’ in the mortality rate between Indigenous people and the general population by 2031. This relative success can be primarily attributed to:

- increased primary health care funding from the mid-1990s, directed through a network of Aboriginal community controlled health services and supported by sustained collaborative, needs-based planning structures;
- increased investment in public hospitals from the early 2000s; and
- supply reduction measures to tackle petrol sniffing and alcohol abuse.

Quality appropriate hospital care for Aboriginal and Torres Strait Islander people

Aboriginal and Torres Strait Islander people are more frequent users of hospital care and more reliant on public hospital services compared to other Australians. Reductions in hospital funding will disproportionately affect Aboriginal and Torres Strait Islander people and can be expected to slow, stall or even reverse progress in ‘closing the gap’ in health status. Instead, increased attention and resources are needed to address continuing barriers to appropriate, quality care for Aboriginal people within hospitals.

Access to primary health care for Aboriginal and Torres Strait Islander people

Primary health care is an essential, cost-effective measure for ensuring healthy populations. However, cost is a barrier to access particularly for poorer, sicker populations and Aboriginal and Torres Strait Islander people already report cost as being an important barrier to accessing health care and medicines. Any increase in point-of-care costs (for example, through the introduction of co-payments for GP services or increases in co-payments for prescription medicines) can be expected to disproportionately affect Aboriginal and Torres Strait Islander people, reducing their access to care and widening the gap in health outcomes. Reduced access to primary health care can also be expected to generate increased costs in hospital care needed to treat undiagnosed or unmanaged chronic disease.

Addressing the social determinants of health

Between one-third and one-half of the gap in health is estimated to be due to the social determinants of ill health such as poverty, poor education, poor housing, lack of nutrition, lack of meaningful employment and racism. Poverty and inequality of income are strongly correlated with poor health, and addressing them is central to improving Aboriginal and Torres Strait Islander health. Well-designed, sustained early childhood development programs have been shown to be highly cost-effective in addressing intergenerational effects on health of the social determinants. Government can also support attempts to prevent ill health through the adoption of healthy public policy measures, particularly in relation to alcohol and tobacco use and poor nutrition.

Collaborative needs-based health system planning

Collaborative, well-resourced and sustainable processes for needs-based health system planning that include the Aboriginal community controlled health sector are critical for ensuring that investment in the health system is not wasted through fragmentation, a lack of commitment to the evidence base, or lack of understanding of the needs of the Aboriginal and Torres Strait Islander community

Aboriginal Community Controlled Health Services (ACCHS) and Comprehensive primary health care

A well-resourced and robust comprehensive primary health care system is a critically important platform from which to address the health of Aboriginal and Torres Strait Islander Australians.

The evidence points to ACCHSs as a highly effective model for addressing Aboriginal and Torres Strait Islander health, particularly given the fact that Aboriginal and Torres Strait Islander people show a clear preference for the use of ACCHSs, their holistic, comprehensive approach to primary health care, focus on cultural security, and their public health and advocacy roles.

ACCHS provide an important foundation for evidence-based, culturally secure action, services and programs on issues such as alcohol, tobacco and other drugs; early childhood development and family support; aged and disability; and mental health / social & emotional health & well being.

Integration and coordination

Multi-disciplinary, comprehensive primary health care services – such as well-resourced ACCHSs operating with secure five-year block funding – are essential for better service integration and improved patient care and thus for a more efficient and effective health system.

The introduction of 'eHealth' measures in the Northern Territory has also improved service integration between different primary health care providers, and between primary health care and hospitals.

However, a sole focus on competitive tendering for the provision of services leads to fragmented services with poor integration, complex 'patient journeys' and poorly coordinated patient care.

Workforce

Coordinated effort is needed to support substantial increases in the number and proportion of Aboriginal and Torres Strait Islander people working in the health system whatever the level (primary health care, hospitals or elsewhere), or role (clinical, administration, management and policy-making etc).

In addition, the health system needs to ensure that qualified, professional and appropriate staff are available to address the specific health and wellbeing needs of Aboriginal and Torres Strait Islander people.

Recommendations

Note that these recommendations – and the points made in the Executive Summary above – are in the order in which they appear in the text of the submission, which is in turn determined by the order of the Inquiry’s Terms of Reference. They are not, therefore listed in order of significance. Central Australian Aboriginal Congress would like to especially emphasise the importance of comprehensive primary health care delivered by Aboriginal community controlled health services (recommendations 11 and 12) as the key strategy for addressing health inequity, as supported by substantial national and international evidence and by successive Australian Government policies.

1. That the Commonwealth Government commission further work to document and investigate the relative success of the Northern Territory in meeting (to date) the ‘Close the Gap’ targets relating to reducing the mortality rate of Aboriginal and Torres Strait Islander peoples, with particular attention to:
 - funding, quality and organisation of primary health care services;
 - funding and quality of hospital care;
 - actions to address substance abuse, particularly alcohol and petrol-sniffing;
 - the need to address the social ‘determinants of health’ to maintain and continue improvements made to date.
2. That, in light of Aboriginal and Torres Strait Islander people’s disproportionate reliance on public hospital services, funding to public hospitals be increased as one of the pillars to support Aboriginal and Torres Strait Islander health gain and to ‘close the gap’ in health status between Aboriginal and Torres Strait Islander and non-Indigenous Australians.
3. That specific measures be funded to encourage and support hospitals to develop culturally secure, high quality, appropriate care for Aboriginal and Torres Strait Islander people in hospital.
4. That the appropriateness and quality of hospital care for Aboriginal and Torres Strait Islander people be regularly reported on for all jurisdictions, including through such measures as:
 - identification of Aboriginal and Torres Strait Islander patients;
 - access of Aboriginal and Torres Strait Islander patients to an agreed set of ‘sentinel’ procedures to identify the existence of institutional barriers to care;
 - proportion of Aboriginal and Torres Strait Islander clients who self-discharge;
 - employment of Aboriginal and Torres Strait Islander staff;
 - documented relationship with local Aboriginal and Torres Strait Islander communities and/or ACCHS.
5. That investment in well-resourced, high quality, culturally appropriate primary health care be prioritised to reduce the pressure on hospital care by avoiding preventable hospitalisations particularly through the detection and management of chronic disease before it require hospital treatment (including dialysis).
6. That the Federal Government commits to not increasing point-of-care costs for patients. This includes but is not limited to additional co-payments for Medicare-

funded GP services or for prescription medicines in recognition that this shift in policy would:

- reduce Aboriginal and Torres Strait Islander access to health care and stall or reverse any health gains made in recent years;
 - lead to increasing costs in the future for the health system as a whole and the public hospital system in particular; and
 - potentially be in breach of Australia's international obligations.
7. As an alternative to the introduction of increased point-of-care costs for patients and cuts to the health system, government should commit to the introduction of a more highly progressive taxation system, which would see the well-off pay proportionately more of their income in tax than those on lower incomes. This would contribute to better health for Aboriginal and Torres Strait Islander people by:
- providing the revenue foundation for a well-resourced health system including additional funding specifically to address Aboriginal and Torres Strait Islander health; and
 - reducing both absolute poverty and relative inequality of income, thus addressing some of the leading drivers of ill health at a population level.
8. Access to evidence-based early childhood development programs is a key strategy for the primary prevention of ill-health, poor wellbeing and social harm. Government should commit to sustained and universal investment in such programs as a foundation for improved health and wellbeing in the Aboriginal and Torres Strait Islander community in the future. This requires the establishment of Abecedarian Educational Day Care Centres, at least as a well evaluated trial in a few locations and the continued expansion of the Australian Nurse Family Partnership Program.
9. Government should commit to adopting evidence-based healthy public policy that addresses the leading risk factors contributing to the high burden of burden of injury and disease of Aboriginal and Torres Strait Islander Australians, including at least:
- increasing the price of alcohol;
 - reducing the supply of alcohol;
 - restrictions on smoking in workplaces and public spaces; and
 - action to prevent obesity and address poor nutrition through subsidies on healthy food, restrictions on junk food advertising, taxing high-glucose foods and better food labelling.
10. That all Australian Governments continue and expand their commitment to well-resourced and sustainable processes of needs-based health planning for the Aboriginal and Torres Strait Islander community, at national, State / Territory and regional levels, as a critical investment in health system effectiveness. Such planning processes should include, at a minimum, the Aboriginal community controlled health sector and both levels of government.
11. That the Federal government commit to increasing the number, reach and effectiveness of Aboriginal community controlled health services, as a key investment to address the 'health gap'. Additional investment will be required to

extend the reach of ACCHSs to areas not currently serviced by them, either through establishing new services or resourcing current services to expand their coverage. This should take particular account of service gaps in urban and outer-metropolitan areas.

12. 'Closing the gap' requires ensuring that Aboriginal community controlled health services are resourced to deliver the full range of core services required under a comprehensive model of primary health care. This should include resourcing ACCHSs for targeted, evidence based action, services and programs on alcohol, tobacco and other drugs; early childhood development and family support; aged and disability; and mental health / social & emotional health & well being.
13. That Government at all levels commit to funding processes that promote integration of health services as a key way to promoting effective care coordination for Aboriginal and Torres Strait Islander people. This should include:
 - commitments to five year block funding for ACCHSs that include resourcing for their care coordination role;
 - recognition that contracting based solely on competitive tendering processes will reduce service effectiveness, increase costs, and undermine health gain; and
 - commitments to maintain and extend funding for collaborative eHealth measures.
14. That those organisations tasked with training Aboriginal and Torres Strait Islander workers for the health system – especially Aboriginal Health Practitioners and/or Community Workers – be adequately resourced for the task, but then held strictly to account for the quantity and quality of those to whom they provide qualifications.
15. Measures are needed to combat the poor distribution of the mainstream health workforce, to ensure equitable access to general practitioners and specialists across the country (especially in rural and remote areas)

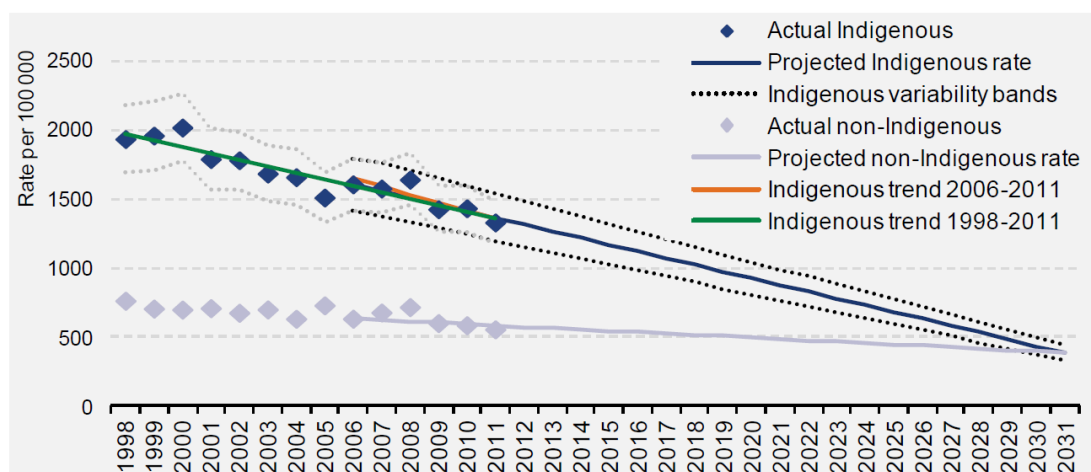
Background: relative success in the Northern Territory in “Closing the Gap”

In looking at how changes in the national health system might affect the health of Aboriginal and Torres Strait Islander people, it is important to reflect on the relative success already achieved in the Northern Territory.

In December 2007, all Australian governments agreed to work together to ‘Close the Gap’ in Indigenous disadvantage across Australia. With broad-based political and public support, this commitment was given effect through the subsequent *National Indigenous Reform Agreement* which set out a number of health, employment, and education targets to be reached by 2031.

One of the keys measures under the target of ‘Closing the life expectancy gap within a generation’ was reducing the mortality rate of Indigenous peoples to that of the general population by 2031. However, despite the efforts across the country, only the Northern Territory is on track to meet this target. The following graph illustrates this:

Figure 1: Death rates per 100 000 standard population, 1998–2031, Northern Territory².



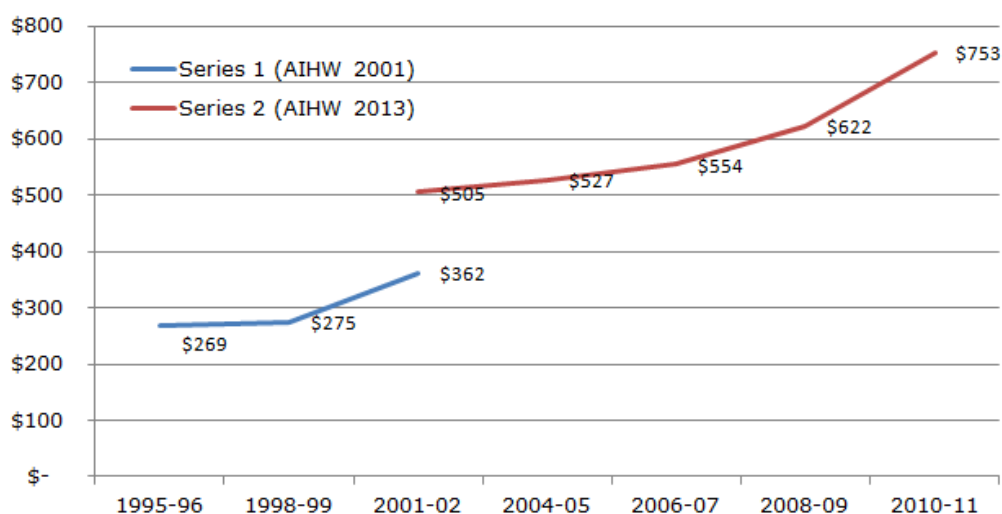
While detailed work may be required to confirm this analysis, the available data and the long experience of health services and professionals in the Northern Territory would suggest that these improvements result primarily from health systems improvements, plus health advocacy leading to action on substance abuse. In particular, there is no evidence of substantial improvements in other social determinants of ill health such as low educational attainment, unemployment, social exclusion and poverty which might contribute to the observed pattern of health gains: the COAG Reform Council report from which *Figure 1* is taken shows mixed results for such indicators over the recent period (2007 to 2011). It is also noteworthy that the improvements in mortality rates began before the investments flowing from the 2007 *National Indigenous Reform Agreement*.

We identify the following as key factors contributing to improvements in mortality rates amongst Aboriginal people in the Northern Territory.

Increased primary health care funding directed through a well-organised network of Aboriginal community controlled health services³

The 1995 transfer of 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 was a critically important reform. Beginning under the leadership of the former Federal Coalition Minister for Health, Dr Michael Wooldridge (1996-2001) and continuing thereafter, this reform enabled substantial increases in national funding for primary health care to be directed through Aboriginal community controlled health services (ACCHS) (see *Figure 2*).

Figure 2: National Commonwealth funding of ACCHS, 1995-96 to 2010-11, \$ per Indigenous person (constant prices)⁴



While these increases have been national, the Northern Territory has benefitted disproportionately because:

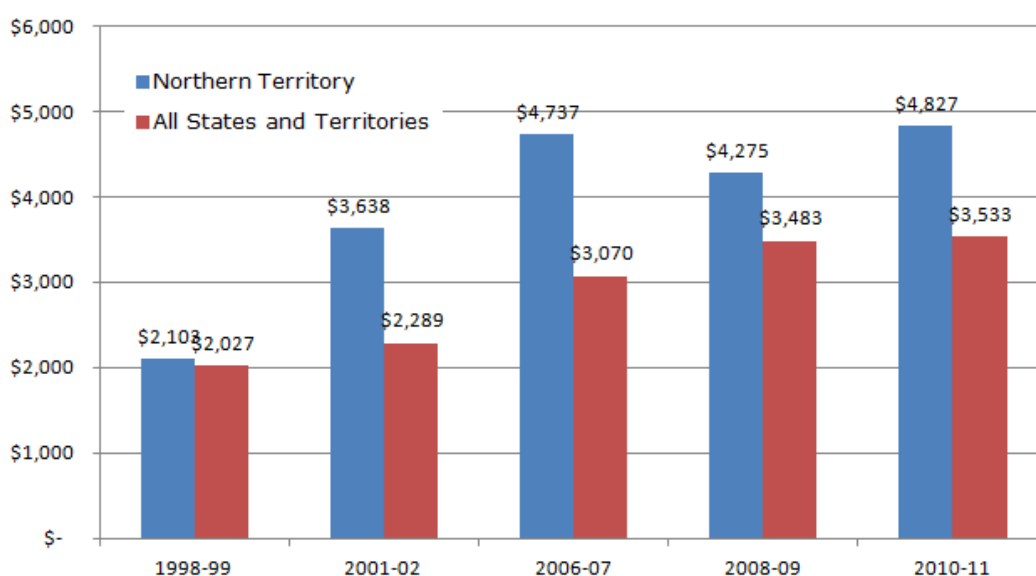
- *ACCHSs provide a significant proportion of the NT's primary health care*, with the consequence that per capita primary health care funding for Indigenous people in the Northern Territory is now estimated to be around \$3000 per person,
- *sustainable and collaborative needs-based planning processes* established in the late 1990s involving the Northern Territory and Commonwealth Health Departments, and the Aboriginal community-controlled sector, supported joint decision-making and improved health system coordination, and
- *a commitment to culturally appropriate, locally flexible health care combined with respect for evidence-based approaches* has been reflected in the development of system-wide improvements to primary health care such as agreed core services⁵ and a set of Key Performance Indicators⁶.

While no definitive evidence is available – or ever likely to be – many studies have concluded that improved primary health care services in the Northern Territory (including the development and expansion of the ACCHS sector) have been significant drivers of improvements in mortality⁷.

Increased investment in public hospitals leading to better care for Aboriginal people

Because of the greatly heavier burden of illness and injury they bear and their minimal use of private hospitals, Aboriginal people in the Northern Territory are disproportionately reliant on the public hospital system for secondary care⁸. While historically the NT public hospital system suffered from profound under-investment, limiting its capacity to treat its Aboriginal clients, the election of the first Labor Government in the jurisdiction in 2001 led to a substantial investment in public hospitals (see *Figure 3*) which has improved both the quantity and quality of hospital care available for Aboriginal clients. This investment in hospitals at the Territory level complemented the increased funds made available for primary health care by the Federal Government.

Figure 3: State and Territory Government expenditure for Indigenous people on public hospital care (constant 2010-11 \$ per person [est.]), by year⁹



Supply reduction measures to tackle substance abuse

The profound health consequences of substance abuse, particularly alcohol and petrol-sniffing, have been well-documented and the subject of concerted health advocacy campaigns by health services and public health groups. As a result, supply reduction measures to combat petrol-sniffing and alcohol abuse have also played a role in reducing the mortality rate for Aboriginal people.

In terms of alcohol abuse, while it remains a serious health issue in the Northern Territory, it appears that the levels of alcohol consumption have been falling over the last decade, with two initiatives in particular credited with having an important effect: indirect price control through the banning of wine sold and fortified wine in large containers; and the Banned Drinkers Register coupled with photo-licensing at the point of sale, in operation during 2011 and 2012 before its repeal by the current Northern Territory Government¹⁰.

With petrol sniffing, since non-sniffable fuel (OPAL unleaded) was introduced in 2007 there has only been one death in 7 years whereas prior to this there were 8 deaths per year amongst young people from petrol sniffing.

The limits of success

If the Northern Territory's relative success in meeting the 'Closing the Gap' target reflected in the downward trend in mortality rates is to be continued, the health system improvements identified above must be sustained and extended to ensure all areas of the Territory benefit. However, it appears we may be reaching the limits of what the health system can achieve: continuing to meet the COAG targets can be expected to depend not just on action within the health system but also beyond it to tackle the social determinants of health. This will mean concerted, sustained action to address educational attainment, employment, housing, poverty and social exclusion, to support the continued and expanded investment in the health system.

Recommendation

1. *That the Commonwealth Government commission further work to document and investigate the relative success of the Northern Territory in meeting (to date) the 'Close the Gap' targets relating to reducing the mortality rate of Aboriginal and Torres Strait Islander peoples, with particular attention to:*

- *funding, quality and organisation of primary health care services;*
- *funding and quality of hospital care;*
- *actions to address substance abuse, particularly alcohol and petrol-sniffing;*
- *the need to address the social 'determinants of health' to maintain and continue improvements made to date.*

Response to the Inquiry's Terms of reference

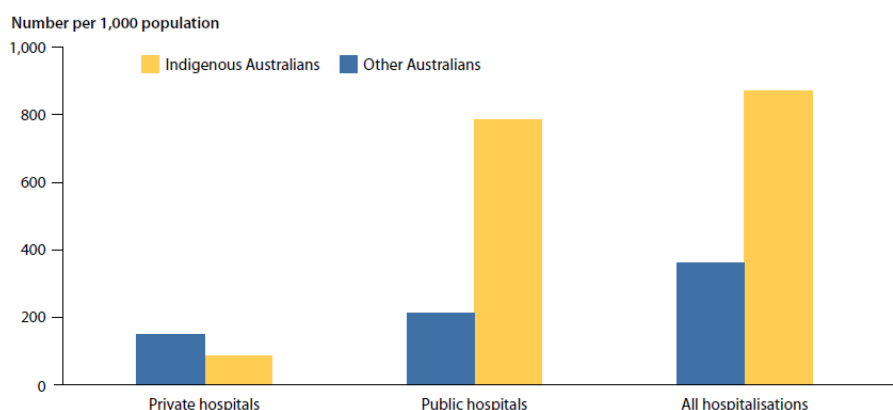
a. the impact of reduced Commonwealth funding for hospital and other health services provided by state and territory governments, in particular, the impact on elective surgery and emergency department waiting times, hospital bed numbers, other hospital related care and cost shifting

Access to hospital care for Aboriginal people

As for all Australians, access to quality hospital care is important to enable Aboriginal people to have long, healthy and well lives. However, the patterns of hospital use are quite different for Aboriginal and Torres Strait Islander people compared to mainstream Australia. Aboriginal and Torres Strait Islander people¹¹:

- *are more frequent users of hospital care*, being admitted to hospital at a rate 2.4 times that of non-Indigenous people
- *are more highly reliant on the public hospital system*, where they are admitted at nearly 4 times the rate of other Australians
- *are much more likely to be admitted to hospital for potentially preventable conditions* (4.9 times the rate for other Australians)
- *have poorer access to elective surgery*, with roughly half the admission rate for elective surgery as other Australians, and 15% longer waiting times
- *are more frequent users of emergency health care services*, making up almost 4% of presentations in 2009–10.
- *have relatively poorer access to organ transplants (including especially kidney transplants)* despite being much more likely to suffer from the health conditions that make them necessary.

Figure 4: Indigenous hospitalisations, by hospital sector, 2008–09



From these figures we can conclude that Aboriginal people, being higher users of hospital care and particularly reliant on public hospital services, are likely to be disproportionately disadvantaged by reduced hospital funding.

Systemic racism¹² and cultural competence within hospitals

Within the hospital system Aboriginal and Torres Strait Islander people face barriers to gaining appropriate health care. Despite the increased burden of disease they carry, Indigenous patients are only three-quarters (73%) as likely to undergo a procedure once admitted to hospital¹³. This difference led one key study to conclude that 'there may be systematic differences in the treatment of patients identified as Indigenous' in Australia's public hospitals¹⁴, a conclusion supported by studies showing poorer survival rates for cancer for Indigenous people, due to their being less likely to have treatment, having to wait longer for surgery, and being referred later for specialist treatment¹⁵.

Such systemic differences in care provided by hospitals contribute to Aboriginal and Torres Strait Islander people's low level of trust for hospitals as institutions – the 2008 *National Aboriginal and Torres Strait Islander Social Survey* found that little more than 60% of Aboriginal and Torres Strait Islander people said that they felt hospitals could be trusted¹⁶. This level of distrust is reflected in the fact that Aboriginal and Torres Strait Islander people are five times as likely to leave hospital against medical advice or be discharged at their own risk compared to other Australians¹⁷.

Figures such as these raise important questions about the responsiveness of hospitals to Aboriginal and Torres Strait Islander needs and about the overall quality of care they provide. Addressing these institutional barriers to appropriate care is complex but is likely to include at least:¹⁸

- developing strong partnerships with local Aboriginal communities and organisations, especially ACCHSs
- leadership by hospital boards, managers and clinical staff
- development and implementation of cultural security policies and training
- supporting Aboriginal and Torres Strait Islander workforce within hospitals.

Addressing the institutional barriers to appropriate treatment for Aboriginal and Torres Strait Islander people within the hospital system therefore requires attention, time, relationship building, and most importantly resources. Hospitals that are under pressure to cut costs in the face of rising demand are unlikely to be able to address the internal barriers to appropriate, quality care for Aboriginal and Torres Strait Islander people.

The relationship of primary care and hospital care

Access to appropriate, quality primary health care is essential to drive health gains in Aboriginal and Torres Strait Islander Australia (see *Term of Reference b.* below). However, an appropriate level of primary health care also reduces hospitalisations, in particular through the early detection and ongoing management of chronic disease. While the relationship between episodes of primary care and hospitalisations is not a simple one, it is clear that inadequate access to primary care leads to higher rates of hospitalisation – which increases cost and capacity pressures on hospitals¹⁹.

An important case in point is chronic renal disease and the need for dialysis of Aboriginal and Torres Strait Islander communities. Over two in five (44%) of Aboriginal and Torres Strait Islander hospital episodes of care involve dialysis, compared with 12% for non-Indigenous Australians)²⁰. The Alice Springs Hospital, home to the country's largest dialysis unit with 299 people currently on dialysis, almost all of whom are Aboriginal, and where service expansions in recent years are rapidly taken up by the increasing demand.

The development of End Stage Renal Disease requiring dialysis is closely associated with diabetes, high blood pressure and related conditions – adequate primary health care services are essential to identify and treat the early stages of these chronic diseases in Aboriginal communities before they become more disabling and costly to treat; consequently, reducing the pressure on hospital care requires investment in a well-resourced, culturally competent, evidence based primary health care system.

Recommendations

- 2. That, in light of Aboriginal and Torres Strait Islander people's disproportionate reliance on public hospital services, funding to public hospitals be increased as one of the pillars to support Aboriginal and Torres Strait Islander health gain and to 'close the gap' in health status between Aboriginal and Torres Strait Islander and non-Indigenous Australians.***
- 3. That specific measures be funded to encourage and support hospitals to develop culturally secure, high quality, appropriate care for Aboriginal and Torres Strait Islander people in hospital.***
- 4. That the appropriateness and quality of hospital care for Aboriginal and Torres Strait Islander people be regularly reported on for all jurisdictions, including through such measures as:***
 - identification of Aboriginal and Torres Strait Islander patients;***
 - access of Aboriginal and Torres Strait Islander patients to an agreed set of 'sentinel' procedures to identify the existence of institutional barriers to care;***
 - proportion of Aboriginal and Torres Strait Islander clients who self-discharge;***
 - employment of Aboriginal and Torres Strait Islander staff;***
 - documented relationship with local Aboriginal and Torres Strait Islander communities and/or ACCHS.***
- 5. That investment in well-resourced, high quality, culturally appropriate primary health care be prioritised to reduce the pressure on hospital care by avoiding preventable hospitalisations particularly through the detection and management of chronic disease before it require hospital treatment (including dialysis).***

b. the impact of additional costs on access to affordable healthcare and the sustainability of Medicare

The importance of access to primary health care

Access to primary health care is an essential, cost-effective measure of ensuring healthy populations. International evidence shows that increased primary health care systems are associated with²¹:

- better health outcomes (especially relating to better maternal and infant health as measured by low birth weight and infant mortality)
- lower mortality rates, and
- lower overall national health care costs.

In addition, and of particular significance in the Aboriginal and Torres Strait Islander context, primary health care is disproportionately beneficial for those people or communities suffering socioeconomic disadvantage and inequality – in other words, primary health care is a crucial factor in reducing health disparities between groups²².

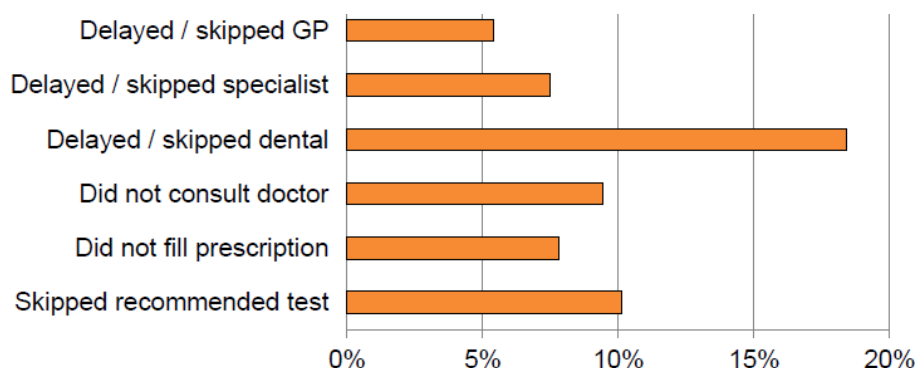
Cost as a barrier to accessing primary health care

Both from the international evidence, and from the health gains observed for Aboriginal people in the Northern Territory, it is clear that access to primary health care is a key to improving the health for Aboriginal and Torres Strait Islander people in Australia.

Access can, however, be challenged by a number of factors. Geography is one important barrier, especially important given the proportion of Aboriginal and Torres Strait Islander people who live in rural and remote regions. Poor cultural safety of services is another barrier, pointing to the need for continued and increased investment in the ACCHS sector.

However, one of the most important barriers to accessing primary health care is cost. There is substantial evidence that cost is a barrier for Australians accessing health care and/or buying prescription medicines, with 5% reporting that they delayed or skipped a visit to the GP and 8% reporting they did not fill a prescription because of cost (see *Figure 5*).

Figure 5: People avoiding health care because of cost, 2013²³

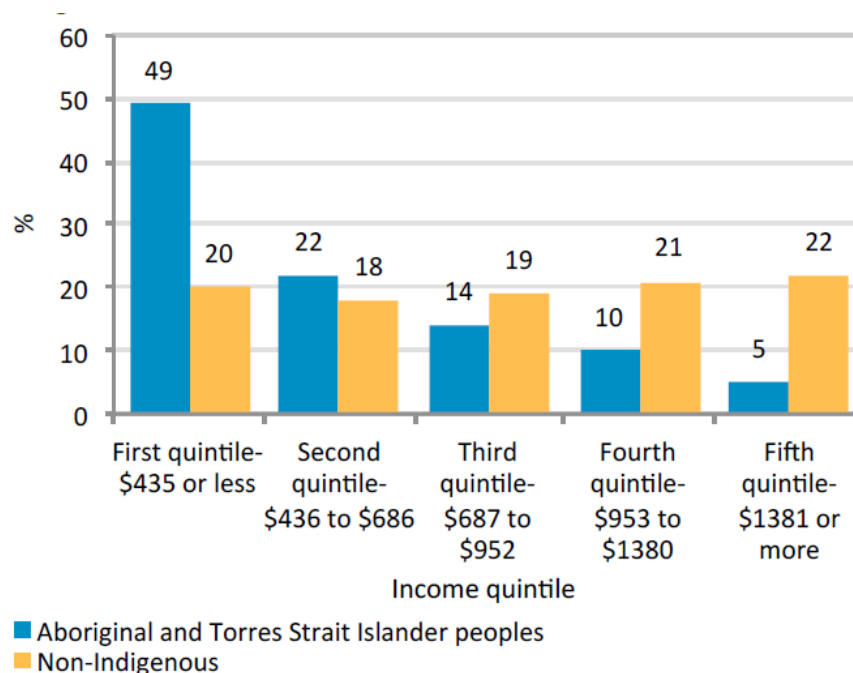


Sources: First three measures, ABS (2013), remainder, The Commonwealth Fund (2013)

Cost is a significant barrier to primary care access for those who are poorest and sickest. Of the poorest households that pay out-of-pocket costs, 10% spend more than a fifth of their disposable income on out-of-pocket health costs. In addition, people with long-term health condition face a greater cost burden for GP visits and medicines, and are consequently more likely to avoid these necessary services²⁴.

The implications for Aboriginal and Torres Strait Islander people of this pattern are disturbing. Not only do Aboriginal and Torres Strait Islander people carry a much greater burden of disease than Australians in general, they are also significantly poorer: almost half of Aboriginal and Torres Strait Islander people live in households whose income is in the lowest 20% of all households (see *Figure 6*).

Figure 6: Proportion of persons aged 18 years and over in each equivalised gross weekly household income quintile, by Indigenous status, 2008²⁵



Given this, is not surprising that Aboriginal and Torres Strait Islander people report cost as being an important barrier to accessing health care and medicines. In 2012-13²⁶:

- one in eight (12%) Aboriginal and Torres Strait Islander adults delayed or did not go to a GP due to cost,
- more than two out of five (44%) delayed or did not go to a dental professional due to cost, and
- over one-third (35%) delayed or did not fill a prescription due to cost.

Taken together, these figures paint a clear picture: Aboriginal and Torres Strait Islander find cost a significant barrier to accessing primary care and medicines. Any increase in such costs (for example, through the introduction of co-payments for GP services or increases in co-payments for prescription medicines) can be expected to lead to reduced access to health care and, by implication, to poorer health outcomes.

Health system sustainability

Raising the cost-barrier for Aboriginal and Torres Strait Islander people to access primary care and medicines also can be expected to have profound long-term implications for sustainability of the health system.

The early treatment and good management of chronic disease can prevent more acute complications, including avoidable hospitalisations. The introduction of new costs for patients at the point of care can therefore be expected, in the longer term, to lead to greater costs elsewhere in the health system particularly in public hospitals, and where dealing with the consequences of undetected or untreated chronic disease – for example, through the need for increased dialysis services.

It may be argued that the introduction of increased costs at the point of care will only discourage Aboriginal and Torres Strait Islander clients from accessing care for minor issues. However, many people do not know when seemingly minor problems may be linked to the development of serious, long term harm if there are delays in treatment. For example, acute infected skin sores in children and infected throats (streptococcus) are common in many Aboriginal and Torres Strait Islander communities, but if not treated promptly, can lead to permanent damage and to the development of chronic disease affecting the kidneys (glomerulonephritis) and heart (Rheumatic Heart Disease).

Further, although it may be proposed to exempt Medicare care planning item numbers for Aboriginal and Torres Strait Islander health from increases in point-of-care fee increases, many patients with chronic illnesses frequently present for treatment other than for care plans. For example, when a patient is commencing blood thinning medications this requires multiple standard presentations and multiple blood tests in a short space of time, all of which may attract the co-payment. A lot of preventative healthcare also occurs as part of standard consultations.

Social justice and human rights

Addressing the disparity in health and wellbeing between Aboriginal and Torres Strait Islander people and the rest of Australia has broad public and bipartisan support, as reflected in the 'Close the Gap' commitments made by all Australian Governments and endorsed across the political spectrum. The introduction of cost increases to be borne by patients at the point of care will reduce accessibility of health services for Aboriginal and Torres Strait Islander people, and undermine the commitment to address this disparity. It is also at odds with Australia's international commitments, for example as contained in the *United Nations Declaration of the Rights of Indigenous Peoples* to which Australia is a signatory and which commits nation states to acting to ensure that Indigenous peoples are able to exercise their right to access, without discrimination, all health services²⁷.

Recommendations

6. That the Federal Government commits to not increasing point-of-care costs for patients. This includes but is not limited to additional co-payments for Medicare-funded GP services or for prescription medicines in recognition that this shift in policy would:

- **reduce Aboriginal and Torres Strait Islander access to health care and stall or reverse any health gains made in recent years;**
- **lead to increasing costs in the future for the health system as a whole and the public hospital system in particular; and**
- **potentially be in breach of Australia's international obligations.**

c. the impact of reduced Commonwealth funding for health promotion, prevention and early intervention

Action on the social determinants of health

Access to high quality primary health care and to appropriate hospital care are essential if improvements on Aboriginal and Torres Strait Islander health are to be made. However, the social determinants of ill health – such as poverty, poor education, poor housing, lack of nutrition, lack of meaningful employment and racism – also have a powerful effect on the health of Aboriginal and Torres Strait Islander peoples: between one-third and one-half of the gap in health is estimated to be due to these determinants²⁸.

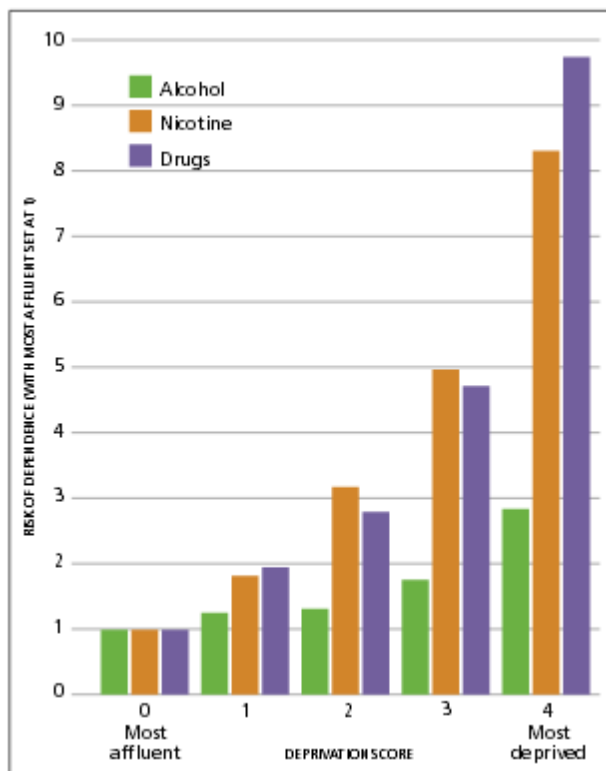
Approaches based on the promotion of health and the prevention of illness, injury and disease – rather than just the treatment of them once they have arisen – must begin with the social determinants of health. While action across the full range of social determinants is necessary, we identify two in particular that require attention: poverty / inequality and early childhood development. While addressing these social determinants of health alone can be expected to substantially increase the health of future generations of Aboriginal and Torres Strait Islander people, immediate action is also required on some of the risk factors for poor health – particularly the use of alcohol and tobacco, and poor nutrition.

Poverty and inequality of income

Explanations of illness based on an individual's exposure to risk factors (such as smoking, alcohol misuse, or being overweight) have been the basis for many improvements in the health of populations, especially when it comes to chronic disease. However, these risk factors are not evenly distributed: a person's social and economic position in society exerts a powerful influence on a person's health and their exposure to risk – the distribution of ill health in a population is strongly correlated with a social gradient, where those with lower incomes tend to be significantly sicker and die significantly earlier than those with higher incomes. For example, it has been extensively documented that addiction (to alcohol, nicotine or other drugs) is closely related to social and economic disadvantage (see *Figure 7*). The fact that these three risk factors alone are estimated to account for over 20% of the total burden of disease and injury carried by the Aboriginal and Torres Strait Islander community²⁹, combined with their strong

correlation with poverty, indicates the profound effect that low income has on health status.

Figure 7: Socioeconomic deprivation and risk of dependence on alcohol, nicotine and drugs, Great Britain, 1993³⁰



However, it is not just absolute levels of deprivation that cause ill health – there is also good evidence that relative inequality is also associated with poorer health outcomes. While this is still an emerging field of study, there is evidence that income inequality is related to higher infant and adult mortality rates, to reduced life expectancy, and to higher rates of illness³¹.

The implication of both these fields of evidence for Aboriginal and Torres Strait Islander health are clear, given that not only do Aboriginal and Torres Strait Islander people suffer high levels of absolute poverty (see *Figure 6* and discussion above) but they do so in a wealthy, highly developed country: action to reduce poverty and inequality of income should be central to attempts to address Aboriginal and Torres Strait Islander health and to 'close the gap'. Conversely, any policies which are liable to increase poverty or to increase the gap between rich and poor are likely to affect Aboriginal and Torres Strait Islander people disproportionately, and to drive poorer health outcomes.

Early childhood development

The experience of the child, including in the months before birth, is critical for a healthy life, and deficits at this time are powerfully linked to disadvantage and ill health later in life³². Early childhood is thus a key intervention point for the prevention of ill health.

The link between poor development in the early years and the subsequent development of life-long health, wellbeing and social problems has been demonstrated by many studies, including a recent major longitudinal study from Dunedin in New Zealand, which

followed a cohort of more than one thousand children from birth to age thirty-two³³. It found that poor early childhood experience was strongly linked to poorer physical health, greater substance dependence, lower income, and increased criminal offending outcomes as an adult.

Unfortunately, Aboriginal and Torres Strait Islander children are particularly at risk. The Australian Early Development Index (AEDI)³⁴ found that almost 30% of Aboriginal and Torres Strait Islander children are vulnerable on two or more developmental areas such as physical health and well-being, social competence, emotional maturity, language and cognitive skills, communication skills and general knowledge. In some regions, the figures are much worse: for example, close to half (47%) of Aboriginal children in the Northern Territory have vulnerabilities on two or more areas compared to 8% of all Australian children.

Fortunately, there is an abundance of strong evidence that well-designed early childhood development programs are a key, cost-effective intervention to address and offset the effects of poor early childhood experience. Examples of such preventative programs include the Nurse Family Partnership (NFP) Program Home Visitation and the Abecedarian model of Educational Day care. These programs work with children before developmental problems arise, supporting support children and their families to develop the stimulation, relationships and access to services needed for healthy development.

Evidence from overseas, based on decades of study, show incontrovertibly that such early childhood programs can:

- significantly lower prevalence of risk factors for cardiovascular and metabolic diseases in adults (especially men)³⁵
- reduce the use of alcohol and other substances by young adults³⁶;
- more than double school retention rates³⁷; and
- dramatically reduce the youth incarceration rates³⁸.

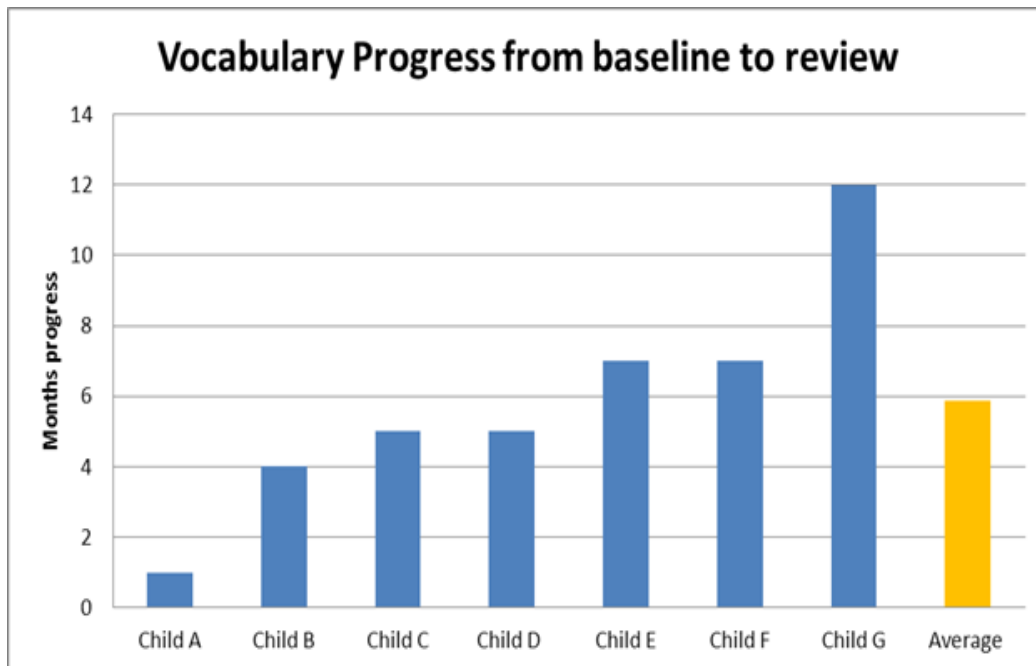
Early childhood development programs are an essential contributor to raising children who are resilient and thus better equipped to meet challenges to their health and wellbeing. Early childhood education and support are thus an essential part of the answer to reducing preventing ill-health in the Aboriginal and Torres Strait Islander and broader communities.

The Central Australian Aboriginal Congress believes that primary health care services are best placed to deliver the key services and programs from pregnancy through to Age 3. Health services regularly interact with young children and their families through a range of core services and programs and are ideally placed to expand on these into newer areas such as the Abecedarian Educational Day Care approach and programs that support children and their families through Pre-school. Congress has outlined the core services and programs that together make up an integrated and comprehensive approach to this critical area. These are both primary and secondary prevention programs and are delivered either in the home or in a dedicated centre:

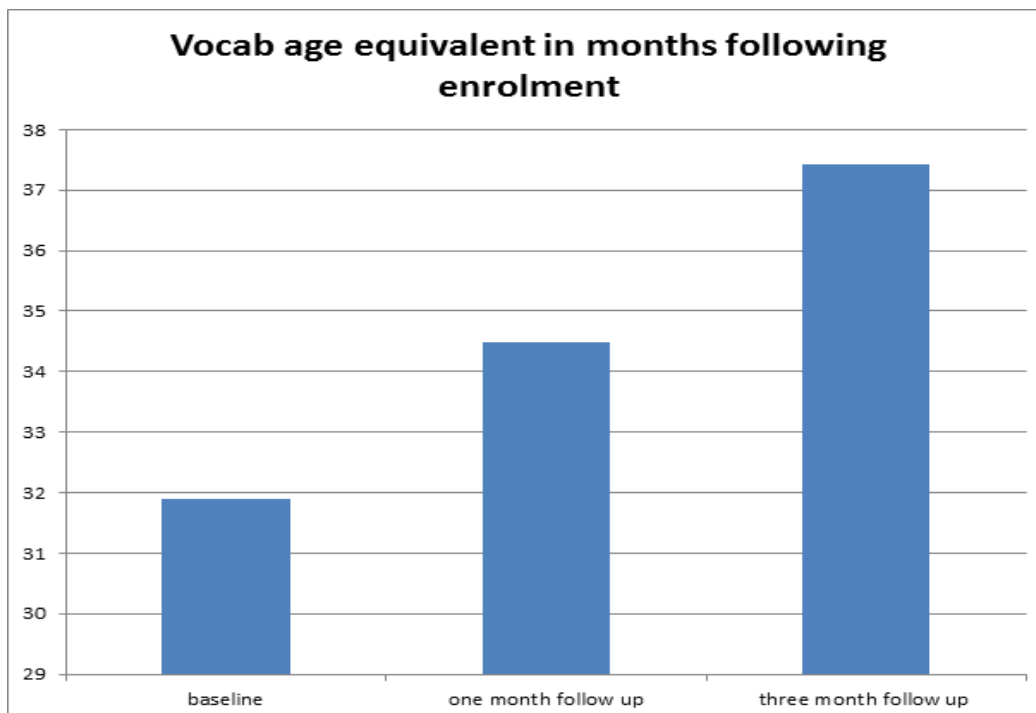
	<p>Primary Prevention Targets children with no current problems but are at risk of developing problems – identified risk usually based on low SES or maternal education level.</p>	<p>Secondary Prevention Targets children with current problems identified early in life when most likely to respond to intervention and before gets worse – determined by screening OR referral to services.</p>		
<p>Centre Based Most of work is done at a centre where child and or families come in to access service.</p>	<p>Child focussed Abecedarian Immunisations Child Health Check Developmental screening</p>	<p>Carer focus Health advice to Parents in clinic (eg nutrition, brushing teeth, toilet training)</p>	<p>Child focussed Child centred play therapy Therapeutic day care Preschool Readiness Program Antibiotics</p>	<p>Carer focus Filial Therapy Circle of security Parenting advice/programs Parent support groups</p>
<p>Home Visitation Most of work is done in the homes of families where staff outreach to children and families.</p>	<p>Child focussed Mobile Play Groups</p>	<p>Carer focus Nurse Home Visitation Families as First Teachers (home visiting Learning activities)</p>	<p>Child focussed Child Health Outreach Program Ear Mopping</p>	<p>Carer focus Targeted Family Support Intensive Family Support Case management models for children at Risk Parents Under Pressure (PUPS)</p>

Congress has been able to implement most of these programs and services to great effect but the key gap that needs to be funded, at least as a well evaluated trial, is Abecedarian Educational Day Care.

As part of the *Preschool Readiness Program*, Congress has been using the Abecedarian approach in an intensive 7 week program for children at around age 4 who have been found to have language delay following comprehensive developmental assessments as part of Child Health Checks. This program has enabled children to enter a phase of accelerated development prior to enrolment in Pre-school. The following table shows that most children who go through this program significantly improve their vocabulary as measured by the Peabody test – a good sign of improved cognitive development. The average level of improvement on baseline vocabulary levels was 6 months in a 7 week program as per the following graph:



Congress has entered into a research project with Prof Joseph Sparling to more formally evaluate the use of the Abecedarian approach in this way and to assess further the characteristics of the children that do not gain much from this approach. What is really encouraging however is that once children are enrolled in pre-school with a range of “wrap around” support services from Congress they improve very quickly on their age equivalent vocabulary.



Addressing risk factors directly: healthy public policy

At the macro-level, the risk factors for ill health are closely correlated with poverty (see *Figure 7* and discussion above) and over the long-term increased income and equity (supported by evidence-based early childhood programs) can be expected to

substantially close the gap in health and wellbeing between Aboriginal and Torres Strait Islander people and other Australians.

Simultaneously, at the more immediate local level of individuals and communities, primary health care services can assist in addressing risk factors for ill health for example through reducing substance abuse, and encouraging and supporting good nutrition, as well, of course, of treating those people who develop ill health.

Between these two levels, however, there is a need for evidence-based healthy public policy that sets the conditions for healthier lives amongst Aboriginal and Torres Strait Islander people. While there are risk factors on which good government policy can act, we identify three as being of particular importance for health gain in the Aboriginal and Torres Strait Islander community³⁹:

1. *alcohol abuse* is directly associated with 5% of the burden of disease and injury borne by Indigenous Australians, in particular through homicide, violence and suicide (though note that this does not include the indirect health effects of alcohol abuse acting through social determinants such as poverty, mental health problems and childhood neglect);
2. *tobacco smoking* is associated with 12% of the total burden of disease and injury and is the major single contributor to ill health in the Indigenous community, predominantly through Ischaemic heart disease, COPD, and lung cancer; and
3. *overweight and obesity* has been estimated as contributing to 11% of the total burden of injury and disease of Aboriginal and Torres Strait Islander Australians and is particularly associated with Type 2 diabetes and ischaemic heart disease.

Health promotion and prevention approaches to these risk factors need to be based in support for comprehensive models of primary health care (see response to term of reference (e) below). In addition, they need to be supported with evidence-based, population-level measures which are proven to be effective. These include:

- *Increasing the price of alcohol.* There is incontrovertible evidence that increasing the price of alcohol reduces consumption and alcohol related harm; it is also a highly cost effective intervention⁴⁰. This whole-of-population level intervention can be expected to have particular benefits for disadvantaged populations, as it has been shown to be most effective amongst the heaviest drinkers and young people⁴¹.
- *Reducing the supply of alcohol.* There is strong evidence that reducing the supply of alcohol reduces alcohol related harm including admissions to hospital, assaults and sexual offences⁴². Restrictions can include reductions of numbers of licenses (especially take away licenses), restrictions on hours of sale especially take away trading hours, and restrictions on quantities or types of alcohol to be sold.
- *Restrictions on smoking in workplaces and public spaces* has been a key intervention in mainstream populations⁴³. They may have had lesser reach in Indigenous communities marked by low employment, poor infrastructure and weak enforcement mechanisms, but given the strength of the evidence in the mainstream context, action to support this approach is warranted.

- *Action to prevent obesity and address poor nutrition.* A multi-faceted approach that includes subsidising healthy food in remote areas (the high cost of healthy foods that is the primary barrier to their consumption⁴⁴), restrictions on junk food advertising, introduction of a 'tax' on high-glucose foods (especially sugary drinks), and mandatory unified and easy-to-understand 'traffic light' food labelling⁴⁵.

Recommendations

7. *As an alternative to the introduction of increased point-of-care costs for patients and cuts to the health system, government should commit to the introduction of a more highly progressive taxation system, which would see the well-off pay proportionately more of their income in tax than those on lower incomes. This would contribute to better health for Aboriginal and Torres Strait Islander people by:*

- *providing the revenue foundation for a well-resourced health system including additional funding specifically to address Aboriginal and Torres Strait Islander health; and*
- *reducing both absolute poverty and relative inequality of income, thus addressing some of the leading drivers of ill health at a population level.*

8. *Access to evidence-based early childhood development programs is a key strategy for the primary prevention of ill-health, poor wellbeing and social harm. Government should commit to sustained and universal investment in such programs as a foundation for improved health and wellbeing in the Aboriginal and Torres Strait Islander community in the future. This requires the establishment of Abecedarian Educational Day Care Centres, at least as a well evaluated trial in a few locations and the continued expansion of the Australian Nurse Family Partnership Program.*

9. *Government should commit to adopting evidence-based healthy public policy that addresses the leading risk factors contributing to the high burden of burden of injury and disease of Aboriginal and Torres Strait Islander Australians, including at least:*

- *increasing the price of alcohol;*
- *reducing the supply of alcohol;*
- *restrictions on smoking in workplaces and public spaces; and*
- *action to prevent obesity and address poor nutrition through subsidies on healthy food, restrictions on junk food advertising, taxing high-glucose foods and better food labelling.*

d. the interaction between elements of the health system, including between aged care and health care⁴⁶

Collaborative needs-based health system planning

Collaborative, well-resourced and sustainable processes for needs-based health system planning are now well-recognised as critical foundations for health system

effectiveness⁴⁷. In the Northern Territory, the signing of the Framework Agreement on Aboriginal Health in 1997 established the Northern Territory Aboriginal Health Forum which brings together government and the community controlled sector to work collaboratively to⁴⁸:

- 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.

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.

A commitment to such planning processes – at a national level, jurisdictional level, and regional or local levels – requires investment of time and resources. However, this investment is critical to ensuring that investment in the health system is not wasted through fragmented services that are not based on an evidence base, or a full understanding of the particular needs of the Aboriginal and Torres Strait Islander community.

10. That all Australian Governments continue and expand their commitment to well-resourced and sustainable processes of needs-based health planning for the Aboriginal and Torres Strait Islander community, at national, State / Territory and regional levels, as a critical investment in health system effectiveness. Such planning processes should include, at a minimum, the Aboriginal community controlled health sector and both levels of government.

e. improvements in the provision of health services, including Indigenous health and rural health

The importance of comprehensive primary health care

The term 'primary health care' (PHC) gained widespread currency following the Alma-Ata Conference held by the World Health Organisation in 1978⁴⁹. The definition of PHC advanced by Alma Ata was comprehensive: as well as the provision of medical care, it also captures the ideal of 'wellness' as a goal, and prevention, health promotion, advocacy and community development as major methods to achieve it. It emphasises the need for maximum community and individual self-reliance and participation and involves collaboration with other sectors.

This comprehensive definition of primary health care is now broadly accepted in Australia especially when it comes to improving the health of disadvantaged populations such as that of Australia's Aboriginal and Torres Strait Islander peoples⁵⁰.

A well-resourced and robust comprehensive primary health care system is therefore a critically important platform from which to address the health of Aboriginal and Torres Strait Islander Australians.

The key role of Aboriginal community controlled health services (ACCHSs)

ACCHSs were first established by Aboriginal communities in the 1970s. ACCHSs promote a comprehensive model of primary health care (see above), including culturally safe practice and a multi-disciplinary team approach to service delivery in which Aboriginal Health Workers (AHWs) play a significant role alongside nurses, doctors and other health care professionals. These factors make them the best-practice service platforms for addressing complex health and wellbeing issues.

Recent evidence and literature reviews have attempted to assess the effectiveness of ACCHS in comparison to mainstream primary health care⁵¹. In doing so, they have been hampered by the fact that ACCHSs' service population has significantly more complex health needs, and frequently live in rural, remote or outer-suburban areas where private practice business models struggle and service access is a particular challenge. In addition, ACCHS provide a comprehensive model of care that goes beyond the treatment of individual clients for discrete medical conditions to include⁵²:

- 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; and
- structures for community engagement and control;
- significant employment of Aboriginal and Torres Strait Islander people.

Nevertheless, the evidence points to ACCHS as a highly effective model for addressing 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 caseload⁵³.

In particular, ACCHSs contribute 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 weight⁵⁴.

The key role of ACCHSs is supported by the fact that Aboriginal and Torres Strait Islander people show a clear preference for the use of ACCHSs, leading to greater access to care and better adherence to treatment regimes⁵⁵.

The role of ACCHSs is particularly clear in the Northern Territory, where their comprehensive model of service delivery and advocacy for public health and system

reform has been the foundation for much of the relative success of that jurisdiction in reducing mortality rates (see *Background* section above).

Therefore a key action to build a platform from which Aboriginal and Torres Strait Islander ill-health can be tackled is to increase resourcing to strengthen and extend Indigenous community-controlled comprehensive primary health care services.

Core services of comprehensive primary health care

Much work has been done within Australia in recent years to define the elements of successful comprehensive primary health care, extending and building on the concept described at Alma Ata in 1978 in the light of the Australian Aboriginal and Torres Strait Islander experience and evidence.

Successful service delivery that is able to deliver quality care to individual Aboriginal and Torres Strait Islander people, to increase their access to other areas of the health system, and to address the social determinants of health should be based around a 'core services' approach that includes at least⁵⁶:

1. *Clinical Services*: services delivered to individual clients and/or families, in both clinic and home / community settings, including treatment, prevention and early detection, rehabilitation and recovery, and clinical support systems;
2. *Health Promotion*: Non-clinical measures aimed to improve the health of the community as a whole. Health promotion includes a range of activities from building healthy public policy to providing appropriate health information and education, and encourages community development approaches that emphasise community agency and ownership;
3. *Corporate Services and Infrastructure*: Functions to support the provision of health services, including the availability and support of well-trained staff, financial management, infrastructure, information technology, administration, management and leadership, and systems for quality improvement across the organisation;
4. *Advocacy, Knowledge and Research, Policy and planning*: Includes health advocacy on behalf of individual clients, on local or regional issues, or for system-wide change; the use of research to inform health service delivery as well as participation in research projects; and participation in policy and planning processes (at the local / regional / Northern Territory and national levels); and
5. *Community engagement, control and cultural safety*: Processes to ensure cultural safety throughout the organisation, engagement of individual clients and families with their own health and care, participation of communities in priority setting, program design and delivery, and structures of community control and governance.

This core services approach is exemplified in the development of Congress over many years and is outlined in the program logic model that was created in collaboration with the Southgate Institute at Flinders University (Central Australian Aboriginal Congress 2011). This model outlines the complexity of comprehensive primary health care and the capacity of such services to improve health through a combination of pathways including clinical care, social and preventive programs and advocacy for healthy public policy.

Integrating action on specific issues within comprehensive primary health care

As the detailed work on core services of primary health care in the Northern Territory acknowledges, there are a number of issues or conditions which are often poorly integrated within the comprehensive primary health care service model. These include⁵⁷:

- alcohol, tobacco and other drugs;
- early childhood development and family support;
- aged and disability; and
- mental health / social & emotional health & well being.

Integrating action on these issues within Aboriginal comprehensive primary health care services, rather than leaving them to separate 'vertical' programs or to 'mainstream' organisations is an important investment in system effectiveness⁵⁸. Providing these targeted services within ACCHSs maximises service integration and coordination of care, promotes cultural security, and promotes accountability through clearly defined and measurable performance indicators.

Recommendations

- 11. That the Federal government commit to increasing the number, reach and effectiveness of Aboriginal community controlled health services, as a key investment to address the 'health gap'. Additional investment will be required to extend the reach of ACCHSs to areas currently not currently serviced by them, either through establishing new services or resourcing current services to expand their coverage. This should take particular account of service gaps in urban and outer-metropolitan areas.***
- 12. 'Closing the gap' requires ensuring that Aboriginal community controlled health services are resourced to deliver the full range of core services required under a comprehensive model of primary health care. This should include resourcing ACCHSs for targeted, evidence based action, services and programs on alcohol, tobacco and other drugs; early childhood development and family support; aged and disability; and mental health / social & emotional health & well being.***

f. the better integration and coordination of Medicare services, including access to general practice, specialist medical practitioners, pharmaceuticals, optometry, diagnostic, dental and allied health services

The heavy burden of disease borne by Aboriginal and Torres Strait Islander people – and in particularly the high prevalence of chronic diseases with co-morbidities – means that Aboriginal and Torres Strait Islander people often need to access multiple, different

health services to get their needs met, including not just primary medical care but also allied health care, specialist services, and hospital care. Effective care coordination is therefore a very significant enabler of effective health services⁵⁹.

There are a number of factors which support good service coordination: for example, a commitment to cultural security across the care spectrum, the involvement of local communities in care planning, investment of resources into coordination processes and support for staff across all service platforms⁶⁰. ACCHSs, with their commitment to comprehensive models of primary health care, have been shown to play a significant role in facilitating care planning for Aboriginal and Torres Strait Islander clients: for example in 2010-11 over 90% of such services reported providing care planning and 80% reported facilitated shared care arrangements for the management of people with chronic conditions⁶¹.

In the Northern Territory, the introduction of 'eHealth' measures has also improved service integration (between different primary health care providers, and between primary health care and hospitals)⁶².

However, care coordination can be undermined by poorly designed funding models. In particular, competitive tendering for short-term funding leads to complex service delivery environments with multiple providers of health services, creates a culture of competition rather than cooperation amongst those providers, promotes an emphasis on individual care rather than population health and short term outcomes rather than long term gains in health, drives increased reporting costs for agencies, and leads to a system that is difficult to navigate for Aboriginal and Torres Strait Islander clients (especially where language, literacy and cross-cultural service delivery are issues)⁶³.

13. That Government at all levels commit to funding processes that promote integration of health services as a key way to promoting effective care coordination for Aboriginal and Torres Strait Islander people. This should include:

- ***commitments to five year block funding for ACCHSs that include resourcing for their care coordination role;***
- ***recognition that contracting based solely on competitive tendering processes will reduce service effectiveness, increase costs, and undermine health gain; and***
- ***commitments to maintain and extend funding for collaborative eHealth measures.***

g. health workforce planning

A competent, qualified and professional workforce underpins the capacity of the health system to address the health and wellbeing needs of Aboriginal and Torres Strait Islander peoples. There are two key dimensions to ensuring an adequate and appropriate workforce that can deliver health outcomes:

- a workforce of Aboriginal and Torres Strait Islander people (training, recruiting and retaining Aboriginal and Torres Strait Islander people at all levels of the health system); and

- a workforce for Aboriginal and Torres Strait Islander health (ensuring the whole health system has the requisite skills and training).

A workforce of Aboriginal and Torres Strait Islander people

A high quality Aboriginal and Torres Strait Islander workforce is important to ensure the system is able to meet the health needs of Aboriginal and Torres Strait Islander communities: they are able to bring together professional training with community and cultural understanding to improve patient care and increase cultural safety across the organisation in which they work⁶⁴.

Aboriginal and Torres Strait Islander people are needed across the health system, in a range of roles (including health service management, policy and planning, as well as clinical services), service settings (including the community controlled, government, NGO and private sectors) and locations (from urban to rural and remote areas).

While Aboriginal and Torres Strait Islander people remain under represented in the health workforce, the role of the Aboriginal community controlled health sector in their training and employment has been an important part of the improvements that have been made⁶⁵.

Nevertheless, particularly in rural and remote areas, substantial barriers remain. Access to adequate primary and secondary education – and early childhood development programs (see above) – is critical for forming the foundation for future workforce gains. Once this foundation is laid, specific training in health discipline must be both culturally appropriate for the trainees, and result in skilled, competent professionals who are enabled to make a contribution to the health of their communities.

A workforce for Aboriginal and Torres Strait Islander health

A workforce 'for' Aboriginal and Torres Strait Islander peoples means qualified and professional staff (whether Aboriginal and Torres Strait Islander or not) being able to address the specific health and wellbeing needs of Aboriginal and Torres Strait Islander people.

This means equipping health professionals with the knowledge, skills, attributes and cultural understanding to competently design and deliver health services and programs and policies for Aboriginal and Torres Strait Islander communities.

In addition, the Primary health care in particular requires a workforce that is adaptable to changing service delivery environments, and is founded on multidisciplinary team approaches that recognise the complementary roles of Aboriginal and Torres Strait Islander health professions, nursing, general practice, specialists and allied health professionals.

Last, recruitment and retention of health professionals, particularly doctors and specialists, remains a challenge in rural and remote areas and addressing their maldistribution, through a combination of incentives to practice in these areas and support for ACCHSs and other primary health care agencies to employ and train registrars. Consideration may also need to be given to other ways of ensuring a more equitable distribution of medical professionals in Australia, for example, through the geographic restriction of provider numbers⁶⁶.

- 14. That those organisations tasked with training Aboriginal and Torres Strait Islander workers for the health system – especially Aboriginal Health Practitioners and/or Community Workers – be adequately resourced for the task, but then held strictly to account for the quantity and quality of those to whom they provide qualifications.***

- 15. Measures are needed to combat the poor distribution of the mainstream health workforce, to ensure equitable access to general practitioners and specialists across the country (especially in rural and remote areas).***

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