



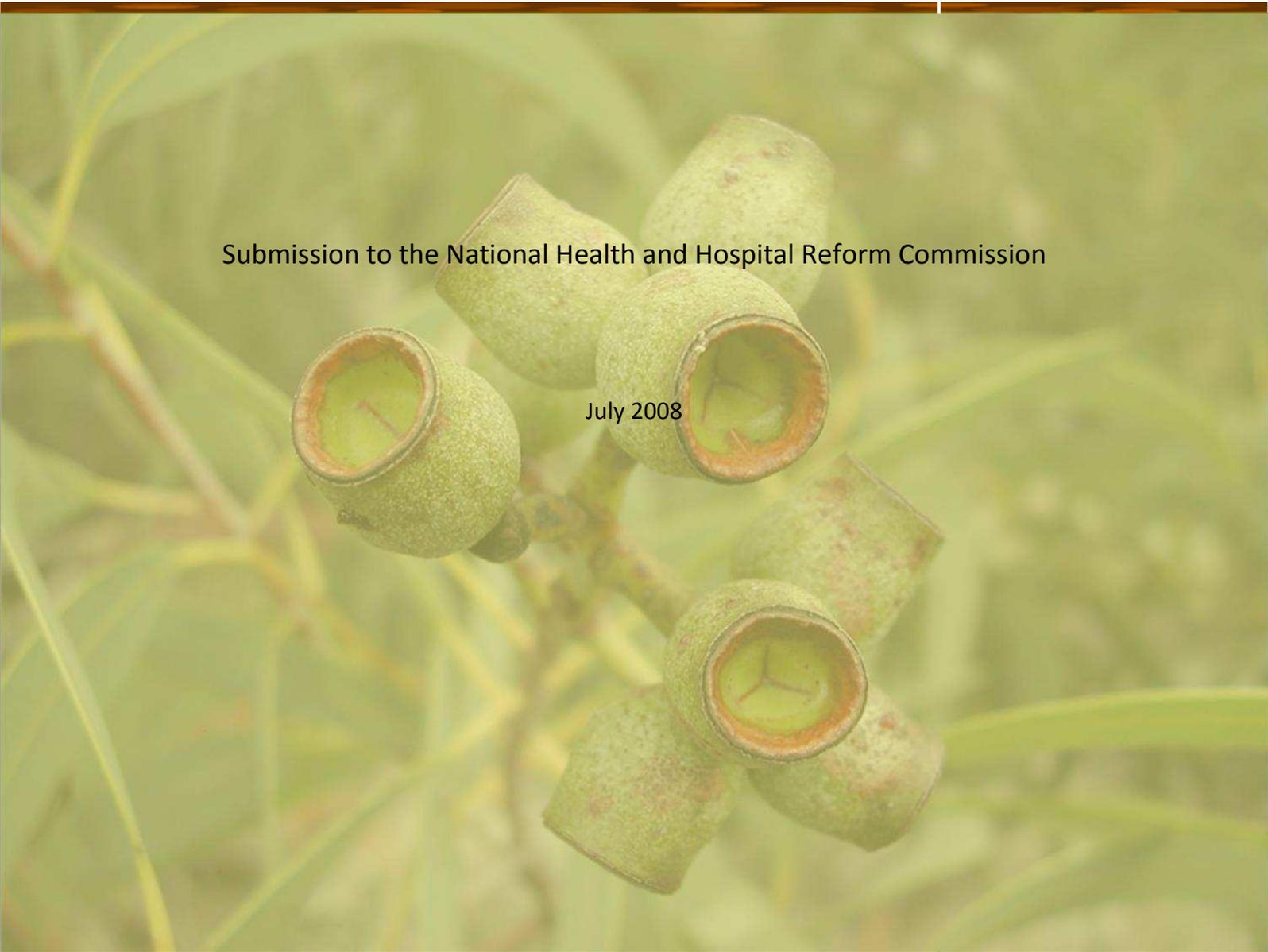
**A NEW**

**BEGINNING**

*CHARTING A BETTER WAY IN PRIMARY HEALTH CARE  
FOR ABORIGINAL AND TORRES STRAIT*

Submission to the National Health and Hospital Reform Commission

July 2008



## Introduction

The Queensland Aboriginal and Islander Health Council (QAIHC) believes the time has run out for incremental and piecemeal approaches to Aboriginal and Torres Strait Islander health. The persistently appalling health status of Indigenous Australians can only be turned around through a new model of primary health care. Experience in other countries has shown that a properly-funded and well-coordinated community-controlled primary health care sector can improve outcomes for Indigenous people. In Australia too we have seen, time and again, remarkable success in communities with community-controlled health services. This reality has been widely recognised in research and policy.

## The current arrangements

Without going into the long and involved history of Aboriginal health care in Queensland, we need to acknowledge that the strains and fragmentation affecting today's health system is the result of decades of shifts and turnarounds in policy. In particular, changes in the extent to which the Commonwealth, the States and Aboriginal communities themselves have had responsibility over or influence in Aboriginal health policy (Grant et al 2008).

Today in Queensland, there is a formal recognition of each party's role in the delivery of health care (operationalised through the *National Strategic Framework on Queensland Aboriginal and Torres Strait Islander Health*<sup>1</sup>). However, it is fair to say that tensions continue, partly because of competition for the limited Commonwealth funding on offer, and partly due to a struggle for ideological leadership on Aboriginal and Torres Strait Islander health, including the perennial debate about mainstreaming versus separatism (Grant et al 2008).

The *primary health care system* is considered to be of critical importance for Indigenous people, not least because when primary care is compromised, people present for care at a later stage and sicker. People are then often treated in an inappropriate setting, and the costs of health care provision downstream increases. The National Aboriginal Community Controlled Health Organisation (NACCHO)<sup>2</sup> describes the primary health care provided by it's sector as "essential, integrated care based upon practical, scientifically sound and socially acceptable procedures and technology made accessible to communities as close as possible to where they live through their full participation in the spirit of self-reliance and self-determination" (NACCHO website).

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<sup>1</sup> The Framework sets the policy agenda for both Indigenous specific programs and mainstream health sectors response to health needs of Indigenous peoples. See [www.health.qld.gov.au/atsihealth/partnerships/qld\\_partnership.asp](http://www.health.qld.gov.au/atsihealth/partnerships/qld_partnership.asp)

<sup>2</sup> NACCHO is the national peak Aboriginal health body representing Aboriginal Community Controlled Health Services throughout Australia. See [www.naccho.org.au](http://www.naccho.org.au)

Primary health care is delivered to Queensland's Aboriginal and Torres Strait Islanders from three sources:

1. **The Aboriginal and Islander community controlled health services (AICCHS) –**  
These are primary health care services initiated and controlled by local Aboriginal and Torres Strait Islander communities. These services are primarily funded by the Commonwealth Government via the Office of Aboriginal and Torres Strait Islander Health (OATSIH). There are 22 such organisations across Queensland. In Queensland, the first AICCHS was established in 1973.

AICCHS are a major provider of primary health care for Aboriginal people in Queensland, particularly outside the cities. In 2004-05 over 250,000 episodes of care were delivered by these organisations in Queensland (DoHA 2008). A major advantage of this service is that more than half the employees are Aboriginal or Torres Strait Islander people (DoHA 2008).

2. **Mainstream health services –** Queensland Health has twenty Health Services Districts around the State that provide services to all Queenslanders, but a number have a particular focus on servicing the Aboriginal and Torres Strait Islander communities because most of their patients are Indigenous. These services complement the primary care provided by AICCHS. Not all Aboriginal people have access to an AICCHS.

The State Government in Queensland has a stronger role in primary health care than in other states. In many of the areas where Aboriginal and Torres Strait Islander peoples live mainstream hospitals have become the default provider of primary care. In these places hospital admission is often the only practical way of delivering anything but the simplest services and hospital emergency rooms are the most accessible source of affordable medical treatment, including GP-type care. This partly accounts for the fact that Indigenous people are admitted to public hospitals at nearly two and a half times the rate of non-Indigenous Australians (SCRGSP 2007).

3. **Private services –** Indigenous people also access the system of private General Practitioners for primary health care, and the pharmaceuticals they prescribe. But Aboriginal and Torres Strait Islander peoples have proportionally lower use of purely private services than non-Indigenous people and lower usage of the Medicare and Pharmaceutical Benefits Scheme programs. The Australian Institute of Health and Welfare has estimated that Medicare benefits paid per Indigenous person is 45% of the non-Indigenous average, and PBS expenditure is 51% of the non-Indigenous average (AIHW 2008).

## **The problem with ‘business as usual’**

We all know the statistics... the gap between Aboriginal and Torres Strait Islander peoples and other Australians is as wide as ever... Indigenous Australians die nearly 20 years younger than non-Indigenous Australians... Aboriginal and Torres Strait Islander infant mortality is three times the rate of non-Indigenous Australians. This is in stark contrast to the USA, Canada and New Zealand where the life expectancy for Indigenous people is approximately seven years less than the non-Indigenous population and Indigenous infant mortality is more than 50% lower (Oxfam & NACCHO 2007).

This situation persists despite significant policy reform at both Federal and State and Territory levels, through agreements such as the *National Strategic Framework for Aboriginal and Torres Strait Islander Health (2003-2013)*; and despite implementation of targeted primary health care initiatives, such as the DoHA’s *Primary Health Care Access Program*, in operation since 1999.

In fact, in Queensland there is no evidence to show we are going forward and there is anecdotal evidence that suggests we are going backwards in terms of some health indicators. For example, median age at death for Queensland Indigenous males seems to be going down, rather than up (SCRGSP 2007).

The frustrating point of this is that the poor health of Australia’s Aboriginal and Islander population is preventable. Most of the diseases leading to premature death, hospitalization and chronic disability amongst Aboriginal and Torres Strait Islander people are preventable if diagnosed early. Indeed, most of the general health gains that have been made in recent years can largely be attributed to initiatives in the primary health care sector such as childhood vaccination programs, disease-specific screening programs and antenatal programs (Baum et al 2007). The ‘Closing the Gap’ campaign advocates a well planned allocation of human resources linked with increased investment in health infrastructure, including primary health care to help bring equality (NACCHO and Oxfam 2007).

Improving the health status of Aboriginal and Torres Strait Islander peoples is acknowledged as a long standing challenge for governments in Australia. We now have a commitment by the Federal Government to make the same primary health care available to Indigenous Australians that others receive, and to do it within 10 years, as well as a commitment to ‘close the gap’ in life expectancy by 2030. The Government has agreed to support Aboriginal and Torres Strait Islander community-controlled health services in urban, rural and remote areas in order to achieve lasting improvements.

QAIHC believes this can only be achieved with a major overhaul of the current arrangements. The following systemic issues that will need to be addressed.

- *Resources* - the younger population profile of Indigenous people means that the disease burden is set to markedly increase, requiring significant increases in programs and services
- *Administration* - poor planning and administration in the existing public system, highlighted recently by concerns for safety and security of nurses working in the Torres Strait
- *Workforce* - the challenge of recruiting and retaining a critical mass of high quality professional and technical staff
- *Responsibilities* - increasing recognition of the broader social determinants of health gives us a truer understanding of the problem, but may be used to further dilute responsibility unless accountabilities are clear
- *Uneven policy* - innovative practices are occurring in pockets of Queensland, for example, the Cape York Health Deed of Commitment, however other areas in the State are operating from old paradigms
- *Engagement* - welfare reform trials aim to help address some of the social determinants of poor health, but are perceived by some as heavy-handed and paternalistic, creating division within communities.

### **A community controlled solution**

Community control is the ability for the people who are going to use health services to determine the nature of those services and then participate in the planning, implementation and evaluation of those services. There are two parts to the argument for strengthening the community control in Queensland - the failure by the mainstream primary health care system to meet people's needs, and evidence that community control gets results.

Few Indigenous people use general practitioners as the entry point into the health care system. A 2001 study found only 0.8% of GP encounters were for Aboriginal and Torres Strait Islander persons and 70% of GPs do not see a single Aboriginal client (Britt et al 2001). Mainstream services are said to be inaccessible for a range of reasons. Remoteness is an issue, but not necessarily the most significant barrier. Access to by Indigenous people to Medicare, finance and transport; historical mistrust and difficulties in understanding the system; inadequate training in health problems faced by Aboriginal and Torres Strait Islander people; and cultural misunderstandings all play a part. (Urbis Keys Young 2006).

Numerous reports have highlighted the range of important roles played by the Aboriginal Community Controlled Health Services, including:

- providing an established mechanism for increasing Indigenous control of management of primary health care services
- representing a major source of education, training, achievement and pride and have developed a pool of knowledge and expertise about Indigenous health issues

- participating as partners with governments in policy and planning
- ensuring that a range of primary health care services are available in one place.

(Shannon and Longbottom 2004)

There are many examples in Australia where community controlled health care has led to demonstrably better health outcomes.

Looking overseas, there are some larger scale examples of success. In the USA, New Zealand and Canada in particular, treaty-based arrangements combined with 'close the gap' campaigns have seen real gains, using community controlled health care models.

Our knowledge that community control improves health status suggests that policies should aim to support self-determination, and be supported by resources that can make a difference (Baum 2008). The Australian Medical Association has come out strongly to support this position. It has called on government to provide an extra \$460M per year particularly for community controlled primary care.

### **Elements of a new system**

Whatever pathway towards greater community control is decided upon, there are some key structural changes to our current system that will need to be considered.

**Funding reform** – Research has confirmed that core funding to AICCHS is insufficient to meet the costs of comprehensive primary health care. There is now greater reliance on the MBS but even this is insufficient to meet the costs of the medical workforce (Couzos and Murray 2008). Two aspects of funding reform need to be addressed:

- *How much money is provided to the sector* – The AMA has estimated that the underspend on the sector nationally is \$460M per year (AMA 2008). QAIHC has commissioned the Centre for Health System Development at the University of Wollongong to develop a funding model based on achieving equity of outcomes using data from Cape York and Yarrabah. This work has now been completed and initial results show that the level of additional funding is significantly higher than the AMA figure.
- *How money is allocated* – The funding mechanism (e.g. one-off grants, block funding etc) and how funding is distributed amongst services affects their capacity to deliver. Under the Cape York and Yarrabah Health Deeds of Commitment government agencies have agreed to pool their funding to maximise efficiencies. This may be an approach that could be pursued more widely. Questions remain, however, about the role of the MBS and the PBS in this bigger funding pool and whether pooled funding should be based on measures of need or achievement of outcomes. Also, the mechanism needs to ensure a tight commitment to funding levels.

**Workforce reform**- There are critical shortages of all health professions across Australia and the community controlled sector has the additional problem of not

being funded sufficiently to compete for health professionals. A key priority for the sector, whatever delivery model is agreed upon, is significant new investment in recruitment, training and other workforce development issues with the aim of building up a substantial Queensland Indigenous health workforce which AICCHS can draw upon.

The solution lies in looking at new ways of delivering these services through developing new workforce groups. There are a number of models that need exploring including greater use of Aboriginal health workers, nurse practitioners, allied health aides and physicians assistants. QAIHC commissioned James Cook University to look at how Physicians Assistants could be used in the community controlled sector and is now looking at how this model could be implemented.

**Governance reform** – Governments urgently need to provide more enabling policy frameworks and program guidelines that actively promote Indigenous capacity and authority. At a minimum, governance needs to meet broader standards of corporate governance as well ensuring cultural legitimacy and that organisations are run productively and in a way that reflects local priorities. People involved in the organisation (the board, the CEO, administrators, and clinical staff) all need to understand their roles and responsibilities, and be supported to work within these boundaries. Improved communication, information transfer and input by the clients are also required.

**Support for organisations** – There is a minimum size below which health care organisations cannot be effective. Achieving critical mass and addressing capacity issues is important to ensure sustainability of programs. In their case studies of AICCHS capacity Shannon and Longbottom (2004) found that funding increases will not lead to improved outcomes unless organisations are supported to improve capacity in terms of financial planning and management, recruiting and retaining a mix of staff, implementing health information systems and leadership.

In Queensland one of the solutions may be the development of regional community controlled organisations. QAIHC has been examining various models for regionalisation, looking at both regional support service organisations and in the longer term the scope for regional health service delivery arrangements. Any new model for Aboriginal and Torres Strait Islander health would need to allow for a regional model.

**Legislation** – An important foundation for any new model is formally enshrining the role of the community controlled sector and endorsing a long term objective of maximising this role. Such recognition in legislation would provide the authority and stability needed for the sector to achieve its potential.

The legislative approach would vary, depending on the details of the chosen model.

### **Options for a new beginning**

There are different models that could be pursued to achieve widespread community control over Indigenous primary health care. Each model requires the structural

changes discussed above to maximise capacity within the sector; and each brings inherent opportunities and risks. The models presented here are not mutually exclusive. Elements of two or three of the models could be combined to form a variation on any of the proposed approaches.

### **Option 1: A National Indigenous Health Service**

This option involves the Commonwealth Government taking full responsibility for all health services for Indigenous Australians. A federally funded and operated Indigenous Health Service becomes the federal health care provider and health advocate for Indigenous people.

The National Indigenous Health Service (NIHS) would provide comprehensive, culturally appropriate personal and public health services that are available and accessible for all Indigenous people. Individuals would register with the service. Government/community agreements would be established to guide the implementation of health care. The National Indigenous Health Service would choose, on a case by case basis, to either deliver services directly or contract ACCHSs to deliver services and administer programs and facilities.

The service would have the overall role of:

- Assisting communities in developing their health programs through activities such as health management, training, technical assistance, human resource development
- Assisting communities in coordinating health planning, obtaining and using health resources and operating comprehensive health care services and health programs
- Providing comprehensive primary health care services , preventative and rehabilitative services and environmental health services in partnership with local government
- Being the principal advocate in health for Indigenous people.

### **Option 1 in practice**

In the United States the Indian Health Service is principal federal health care provider and health advocate for Indian people. This service grew out of the special government-to-government relationship between the federal government and Indian tribes. This relationship is based on the Constitution and has been given form and substance by numerous treaties, laws, Supreme Court decisions, and Executive Orders. The IHS currently provides health services to approximately 1.5 million American Indians and Alaska Natives.

IHS services are provided directly and through tribally contracted and operated health programs. Health services also include health care purchased from private providers. The management of health services by Tribes through self-determination contracts or self-governance compacts with the IHS has increased over time, corresponding with a significant increase in health status of Indian people.

### **Option 2: A tripartite agreement**

This option involves establishing a tripartite agreement between the Commonwealth Government, the State Government and Indigenous leaders. The agreement would involve a commitment to a 20-year plan which would set short and medium term goals to close the gap in health status. The roles and responsibilities of each party would be clearly identified including governance, relationships, accountability, health promotion and performance monitoring and the parties would collaborate to close the health gap.

Under the tripartite agreement there would be a National Indigenous Health Board (NIHB) with Commonwealth/State/Territory and NACCHO representatives to set the overall strategic directions. There would also be State-level Indigenous Health Boards with representatives from Commonwealth, State and state based peaks for Aboriginal community controlled health organisations, such as QAIHC. Funding from all sources would be pooled and the NIHB, and State IHBs would be responsible for resource allocation, setting broad priorities and overseeing service delivery.

The AICCHS would be the service deliverer of choice in primary health care and be funded on the same basis as mainstream services. The State Government would continue to provide hospitals and secondary and rehabilitation treatment facilities. The Commonwealth Government would continue as a joint-funder and take a key role in areas requiring a national approach such as the development of an appropriate workforce.

AICCHS would be involved in all planning and resource allocation decisions for all primary health care services for Indigenous people. This would include providing some input into future service delivery models for mainstream services to make them more accessible to Indigenous people.

### Option 2 in practice

In November 2005, the Province of British Columbia, the First Nations Leadership Council, and the Government of Canada signed a historic agreement entitled the Transformative Change Accord. The Accord recognizes the need to strengthen relationships, and affirms the Parties' commitment to close social and economic gaps in health, education, housing and infrastructure, and economic opportunities through a comprehensive 10-year implementation strategy.

A First Nations Health Plan was developed under the Accord and agreed to via a Memorandum of Understanding between the three parties. These documents identify priorities for action and are intended to guide efforts to address the critical challenges that must be overcome in order to deliver on the joint commitments to improve the health and well-being of First Nations peoples and communities.

There are four key components to the governance arrangements:

- A First Nations Health Governing Body that will ensure participation of First Nations in policy development, allocating resources and setting standards

- A First Nations Health Council comprised of representatives of the First Nations political organizations to serve as the advocacy voice of First Nations in achieving their health priorities; participate in policy and program planning processes; and provide leadership in the implementation of the First Nations Health Plan
- A Tripartite First Nations Health Advisory Committee that will review and monitor the Health Plans of regional health authorities and First Nations communities and recommend actions
- An association of health directors and other professionals to create and implement a capacity development plan for community-based services and support organisations in training, program development and knowledge transfer.

## **CONCLUSION**

It is clear that business as usual is not an option if we are to achieve the goal of equality of health status for Aboriginal and Torres Strait Islander people. There needs to be less fragmentation of services and clearer lines of responsibility between levels of government and between the various service providers that work in this area. QAIHC has identified the elements of the health system that need reform and has outlined two possible options for that systemic reform. It is acknowledged there are a number of ways the various pieces of the system could be put together to achieve the desired outcome. Central to any reform agenda is the need to develop a stronger and better resourced Aboriginal and Islander community controlled health sector as the evidence is clear that community control leads to better health outcomes.

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