NACCHO Submission

Senate Select Committee on Health

October, 2014

NACCHO
National Aboriginal Community Controlled Health Organisation
Aboriginal health in Aboriginal hands
www.naccho.org.au

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October 3, 2014

National Community Controlled Health Organisation, London Circuit, Canberra
P.O. Box 5120, Braddon, ACT 2612

Contact:

Ms Lisa Briggs – NACCHO Chief Executive Officer
Email: *ceo@naccho.org.au*
Ph: 02- 6246 9307

Key Messages

- NACCHO believes the most effective and sustainable way to engage Aboriginal people is the community controlled model, underpinned by principles of self-determination and community development.
- Real savings and progress in healthy outcomes for Aboriginal and Torres Strait Islander people can only be made by shifting expenditure on hospitals to Comprehensive Primary Health Care providers, who deliver preventative treatments.
- Reject proposed additional healthcare costs, in the form of a GP co-payment and a rise in the cost of accessing PBS medicines, which would discourage Aboriginal and Torres Strait Islander patients seeking preventative health care and proactively managing chronic disease.
- Reducing the Medicare Benefit Schedule (MBS) rebates and incentives would impact the capacity of Aboriginal Community Controlled Health Services (ACCHS) to develop and maintain a sustainable service delivery model.
- Recommit to the funding of health promotion and early intervention programs, which deliver long-term benefits through improved health and wellbeing and reduce the burden on the healthcare system at the tertiary and acute end of care.
- To ensure continued inroads to *Close the Gap* in overall life expectancy and the infant mortality gap for Aboriginal and Torres Strait Islander children, funding for Aboriginal and Torres Strait Islander-specific population health initiatives and child and maternal health programs must be maintained.
- Focus needs to be placed on redirecting the expenditure gap in the mainstream services with relatively lower uptake by Aboriginal and Torres Strait Islander people to the ACCHS sector to better meet demand.
- ACCHS provide a long-term employment pathway for Aboriginal and Torres Strait Islander people, but uncertainty discourages greater uptake of positions in the sector.
- Greater funding commitments are required to facilitate pathways for Aboriginal and Torres Strait Islander people to become health professionals across a diverse range of professions, such as clinical workers, administrative officers and in management.
- Funding for ACCHS should be at a minimum indexed for population growth, demand for services and inflation.
- The shift away from National Partnership Agreements and the defunding of the COAG Reform Council challenges the transparency and independence of measuring progress in *Closing the Gap* targets. Renewed commitments are needed to ensure monitoring of outcomes and allocation of resources remains equitable and relevant.

NACCHO submit that:

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;

Government funding lacks balance, with a significant portion of total health spending directed towards hospitals.[1] In 2010-2011 Indigenous health expenditure was estimated to be at $4.55 billion, or 3.7 per cent of the total health expenditure.[2] Much of this expenditure was in hospital services. In 2010 an average of over $3,500 per person was spent on admitted Indigenous patients while less than $1000 per person was expended through the combined cost of the MBS and Pharmaceuticals Benefits Scheme (PBS).[3]

By contrast, the Comprehensive Primary Health Care model offered through ACCHS can play a significant role in preventive health and in reducing the incidence of costly hospital admissions amongst Aboriginal and Torres Strait Islander people.[4] In recent years, ACCHS have successfully implemented programs that have led to an increase in the level of clients with valid MBS health checks, General Practitioner (GP) Management Plans and Team Care Arrangements. All of these processes are critical in the prevention, early detection and management of chronic illnesses.[5]

Real savings and progress in healthy outcomes can only be made by shifting expenditure on hospitals to increased emphasis on Comprehensive Primary Health Care services and preventative treatments.

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

Proposed additional healthcare costs, in the form of a GP co-payment and a rise in the cost of accessing PBS medicines, will create additional barriers for Aboriginal and Torres Strait Islander people to accessing affordable healthcare services.

An analysis of the expected impacts of the 2014-15 Federal Budget measures, in particular the GP co-payment measure, found it will create a barrier to access, particularly for the socioeconomically disadvantaged, and can be expected to reduce use of GP services by those greatest in need.[6] A corollary to this is an expected increase in costly hospital admission rates.

Already there are concerning trends amongst the Aboriginal and Torres Strait Islander population in seeking adequate and timely medical care. Over the past 12 years the proportion of the Aboriginal population who visited either a GP, specialist or dentist has declined. On average 12 per cent of Aboriginal Australians defer GP visits for more than a year because of costs. This is more than twice the rate of the general population.[7] Aboriginal

[1] Alford, K. 2014. 'Investing in Community Controlled Health Services Makes Economic Sense – Executive Summary'.
[2] Australian Institute for Health and Welfare. 2013. 'Healthy for Life - Aboriginal Community Controlled Health Services: Report Card' Cat. no. IHW 97.
[3] Ibid. pp.7-8.
[4] See example in NACCHO Position Paper, 2014. 'Medicare Benefits Schedule: Introducing patient contributions for general practitioner, pathology and diagnostic imaging services'. p 7.
[5] Australian Institute for Health and Welfare. 2013. 'Healthy for Life - Aboriginal Community Controlled Health Services: Report Card' Cat. no. IHW 97. p.15.
[6] Eckermann, S. 2014. 'Avoiding the health system hernia and the associated outcomes and costs'. The Australian and New Zealand Journal of Public Health. pp. 303-305.
[7] Alford, K. 2014. 'Investing in Community Controlled Health Services Makes Economic Sense – Executive Summary'.

Australians also represent a disproportionately high number of 'potentially avoidable GP-type presentations' to hospital outpatient centres, particular in major cities and inner regional centres.[8] Additional costs to accessing healthcare would result in further delays to seeking care, resulting in greater health risks to patients.

Critically, given the proportionately high Aboriginal youth population, coupled with low-income households, a co-payment on GP visits would risk discouraging health checks and interactions with health services amongst expectant mothers and children.

The cost of medicines is also a significant barrier to accessing healthcare services. On average, Aboriginal and Torres Strait Islander people experience lower income levels, higher household numbers and higher incidence of chronic illness than other Australians. Despite this, PBS expenditure for Aboriginal and Torres Strait Islander people is lower than average.[9] Initiatives such as the *Section 100 Remote Aboriginal Health Services Program* and the *Closing the Gap Pharmaceutical Benefits Schedule Co- payment Measure* are critical to improving access to medicines for Aboriginal people with, or at risk of, chronic disease.[10]

The proposed GP co-payment will also affect health infrastructure designed specifically for Aboriginal and Torres Strait Island people. A policy that broadly deters bulk billing amongst primary health care providers will result in increases to ACCHS' client load, further stretching limited resources. For example, if ACCHS forgo charging the co-payment to patients with a healthcare card, they could lose approximately $11-$14 in Medicare revenue per consultation. GPs working for ACCHS provide approximately 1,215,000 episodes of care per annum (970,000 Aboriginal, 245,000 other Australians).[11] Based on this, the costs to the sector of introducing a co-payment measure could be as much as $10.9 million.

An adequately funded and indexed MBS is critical to our sector developing and maintaining a sustainably funded service model. The MBS provides our sector with an avenue of independent income, ensuring long term viability and continuous service delivery.

NACCHO advocates for an exemption from the co-payment measure for concession card holders and Aboriginal and Torres Strait Islander community health services and free provision of Indigenous child and maternal health programs.

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

Early intervention and primary healthcare reduces the burden on the healthcare system in the long term and ensures the health and wellbeing of the Aboriginal and Torres Strait Islander population.

ACCHS have been fundamental in increasing early intervention and preventative care treatment for Aboriginal communities, reducing the risk of hospitalisation where health costs greatly increase.[12]

[8] Ibid.
[9] The Pharmacy Guild of Australia. 2013. 'Position Paper: Closing the Gap Pharmaceutical Schedule Co-payment Measure'. http://iaha.com.au/wp-content/uploads/2013/06/20130429-CTG-position-paper_436824_2.pdf.
[10] NACCHO and Pharmacy Guild of Australia. 2012. 'Improving access to Pharmaceuticals Benefits Schedule medicines for Aboriginal and Torres Strait Islander people through Section 100 Remote Aboriginal Health Services Program' http://www.naccho.org.au/download/policy-positionsubmissions/20120420%20NACCHO%20Guild%20Position%20Paper%20s100_204247_1.pdf
[11] NACCHO. 2013. 'Online Services Report July 2012 - June 2013'.
[12] See example in NACCHO Position Paper, 2014. 'Medicare Benefits Schedule: Introducing patient contributions for general practitioner, pathology and diagnostic imaging services'. p 7.

And yet, Indigenous health expenditure is projected to decline, in real terms, relative to population growth and health needs. If budget projections are implemented, ACCHS face significant challenges managing their budgets as they cater to a rapidly growing population and increasing demand for their services.[13] A poorly resourced sector has significant impacts for Aboriginal and Torres Strait Islander people, including poor health, low labour force participation, unemployment, productivity losses and high rates of welfare dependence.[14]

By way of example, smoking rates amongst Aboriginal and Torres Strait Islander people have reduced over time, which demonstrates health behavioural change is possible.[15] Despite this, smoking rates amongst Aboriginal and Torres Strait Islander people remain relatively high, and as a result, life expectancy is shortened.[16] And yet, there has been a $130 million cut to Aboriginal and Torres Strait Islander-specific population health anti-smoking initiatives. The decision to cut this funding demonstrates the costs not only to Aboriginal life expectancy, but also to the health care system as a whole.

The *Closing the Gap* targets have a specific emphasis on reducing infant and child mortality rates and ensuring early childhood education. The current Australian Government's focus on mothers and babies is reflected through the *Better Start to* Life program, which will commence from July 2015, targetting areas of high need and disadvantage. However, no additional funding has been allocated in the 2014-15 Federal Budget to the *National Partnership Agreement on Indigenous Early Childhood Development,* which ended on 30th June 2014. This decision will likely result in the closure of 38 Indigenous childhood centres[17], and impact the sustainability and reach of the proposed investments.

An added complexity is that in a climate of reduced funding, a disproportionate amount of health expenditure is still channelled towards primary health care providers. Up to two-thirds of Aboriginal and Torres Strait Islander people rely on the Comprehensive Primary Health Care provided by ACCHS, yet three-quarters of all government Indigenous health expenditure goes to primary healthcare providers and nearly half goes to hospitals. Aboriginal people under-utilise primary healthcare services, preferring the services provided through ACCHS. However funding for ACCHS is not proportionate to the demand, and one of the effects of this is a greater likelihood clients will present to a hospital having delayed their care.

Deloitte Access Economics has estimated that the scale of strengthening in government budgets that would flow directly from increasing Aboriginal employment, productivity and life expectancy over a twenty year period would result in $11.9 bn net increase in government revenue from a reduction in tax payments and $4.7 bn saved in government expenditure on social security and health. It therefore makes economic sense to invest in the health and wellbeing of the Aboriginal and Torres Strait Islander population through early intervention and health promotion.

[13] Alford, K. 2014. 'Investing in Community Controlled Health Services Makes Economic Sense – Executive Summary'.
[14] Ibid.
[15] AIHW. 2011. 'Anti-tobacco programs for Aboriginal and Torres Strait Islander people.' Resource sheet no. 4
[16] Ibid.
[17] ABC. 2014. 'Budget 2014: $534 million cut to Indigenous programs'. http://www.abc.net.au/news/2014-05-13/budget-2014-534-cut-to-indigenous-programs-and-health/5451144

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

The trend in the aged care sector at the moment is increasingly market driven with a systems and consumer focus. For ACCHS, this shift could be challenging given their emphasis on comprehensive consumer focussed care rather than a "small business" model, placing greater strains on their capacity.

It is expected that a consumer driven focus could also lead to a greater portion of aged care being self-funded. This will become an issue for disadvantaged populations, such as Aboriginal and Torres Strait Islanders, who are already poorly served by the market distribution of services.

Programs that specifically deliver services for clients who are health care concession recipients are required to ensure vulnerable populations are protected. NACCHO supports continued funding for hardship provisions that are provided to clients unable to pay new aged care fees (residential, home care packages and the Commonwealth Home Support Program (CHSP)). However, there are concerns regarding the impact of the 'nationally consistent fees policy' (an increase from 5 -15 per cent) in relation to administrative time spent applying for hardship provisions.

There has been no Aboriginal and Torres Strait Islander Aged Care strategy since the 1990s, and funding to support development of a strategy is not available. There is a need to focus effort and resources into areas where Aboriginal people live based on population terms, not just in remote areas. Additionally, to ensure culturally safe aged care is delivered, more Aboriginal people need to be employed in community and aged care services.

The change from the Home and Community Care (HACC) program to the Commonwealth Home Support Program (CHSP) will affect up to 300 services which target Aboriginal and Torres Strait Islander people. Changes include assessment, loss of case management and sector development. In particular, the loss of case management will impact on the health service and aged care interface for vulnerable Aboriginal clients.

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

The model of care provided through ACCHS has a long history and a proven track record. It has achieved clinical outcomes beyond those of conventional health services through the use of multidisciplinary care including proactive approaches to chronic disease care, incorporation of health promotion and prevention into primary health care; support of an Aboriginal workforce, multi-disciplinary teams, family involvement and holistic care.

There are over 150 ACCHS around Australia which provide critical health services to nearly 300 communities, servicing over half of Australia's Aboriginal and Torres Strait Islander population. As such, demand for the services provided by ACCHS is growing at more than 6 per cent a year, a much greater increase compared with alternative primary health care providers over the last few years.[18]

Evidence supporting ACCHS as the best avenue for delivery of Aboriginal and Torres Strait Islander Health can be demonstrated by:

[18] Alford, K. 2014. 'Investing in Community Controlled Health Services Makes Economic Sense – Executive Summary'.

- The Australian Institute of Health and Welfare's *Healthy for Life Report Card,*[19] which demonstrates ACCHS are making some of the biggest gains in Closing the Gap:
    - Reducing overall Aboriginal and Torres Strait Islander mortality by 33 percent
    - Reducing child mortality by 47 percent
    - Reducing circulatory disease by 41 percent
- The Assessing Cost-Effectiveness in Prevention Project, which suggests that up to 50 per cent more health benefit can be achieved if health programs are delivered to the Aboriginal population via ACCHS, compared to if the same programs are delivered via primary healthcare providers.[20]
- A recent survey in South Australia, conducted by the University of Adelaide for the South Australian Department of Health, which found that 52.1 per cent of Aboriginal respondents preferred an Aboriginal specific health service, while only 9.6 per cent preferred a non-specific service.[21]
- The *Bettering the Evaluation and Care of Health* report, which found that ACCHS are better at treating Aboriginal health problems than mainstream general practices.[22]
- A recent review in the Medical Journal of Australia, which found that our sector is a leader in clinical governance in Australia and that input from the sector should be sought from others in Australia to inform the implementation of clinical governance across all primary health care.[23]

The primary health care sector that delivers the best results for Aboriginal Australians is the least funded. Our sector requires a strong financial commitment from the Commonwealth Government to assure front line service delivery the current environment of one year funding agreements creates uncertainty and diminishes the sector's ability to deliver services.

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;

While NACCHO supports the responsibility for the spread of Aboriginal and Torres Strait Islander health primary health care across both primary health care providers and ACCHS, there is a need to ensure that Aboriginal and Torres Strait Islander people receive effective services, not just enhanced access.

NACCHO has determined that Aboriginal and Torres Strait Islander people access many different service providers, both Aboriginal-specific and private, as well as hospitals, community health and 24 hour GP services. Effective service provision therefore requires effective collaboration and partnerships across the primary health care spectrum.

[19] Australian Institute for Health and Welfare. 2013. 'Healthy for Life - Aboriginal Community Controlled Health Services: Report Card' Cat. no. IHW 97.
[20] Vos T. et al. 2010. 'Assessing Cost -Effectiveness in Prevention (ACE–Prevention): Final Report.' http://www.sph.uq.edu.au/docs/BODCE/ACE-P/ACE-Prevention_final_report.pdf
[21] Taylor, A. et al. 2012. 'South Australian Aboriginal Health Survey.'
[22] Britt, H. et al. 2003. 'General Practice Activity in Australia 2002–2003'. AIHW Cat No. GEP 14.
[23] Phillips, C.B. et al. 2010. 'Can clinical governance deliver quality improvement in Australian general practice and primary care? A systematic review of the evidence' Medical Journal of Australia. 193:10. pp. 602 - 607.

There are some tensions between the "small business" model of private practices and ACCHS comprehensive consumer focussed care, and this will require practical strategies to address.

g. health workforce planning; and

A large scale employer of Aboriginal people and the main source of employment in many communities, ACCHS provide jobs for more than 3,200 Aboriginal people (of over 5,000 in total).

ACCHS boost education levels through onsite training and provide genuine career paths in skilled occupations. Organisational pathways require tertiary education and training and many ACCHS employ local trainees, with positions as diverse as clinical workers, administrative officers and in management. As a result, employment with ACCHS provides wages and salaries higher than the average Aboriginal Australian income.

ACCHS have experienced a growth in demand for staff for the last few years that is much greater than demand for staff in primary health care service providers.[24] To ensure that demand is met and services can continue to provide quality care requires talented, skilled and well-trained people. In spite of the growth in demand, workforce shortages have been routinely experienced, including prolonged vacancies.

Evidence shows that the majority of ACCHS routinely experience workforce shortages and often have to manage prolonged vacancies. The AIHW report *Aboriginal and Torres Strait Islander Health Organisations Online Services Report: Key Results 2012/2013* found that as at the 30th June 2013, ACCHS reported 315 vacancies, including 263 health professional roles and 52 administration roles. ACCHS were more likely to report vacancies than other agencies in all areas except outer regional areas.[25]

In remote areas in particular, the lack of pay and funding equity, relative to remuneration in the mining industry influence the uptake and retention of health positions. To retain and develop staff, capacity to support training and competitive wages are essential.[26]

An ongoing uncertainty exists around the future of ACCHS and this is having a negative impact on the existing workforce and the ability to recruit and retain appropriate medical staff to organisations and guarantee the continuity of service provision to patients.

Although there have been improvements over recent years in the overall number of trained Aboriginal and Torres Strait Islander health professionals in ACCHS, additional strategies should be developed to increase the training of health providers and ensure their recruitment and retention in services. This must be supported by appropriate investment.

NACCHO, its Affiliates and 150 members are in a unique position to provide employment to Aboriginal and Torres Strait Islander job seekers by matching them to current vacancies and workforce gaps in ACCHS across Australia. Support would be sought from a relevant Job Service agency, Vocational Training and Employment Centre or training provider to match participants with opportunities.

[24] Alford, K. 2014. 'Investing in Community Controlled Health Services Makes Economic Sense – Executive Summary'.
[25] AIHW. Aboriginal and Torres Strait Islander health Organisations Online Services Report: Key Results 2012/2013. Page 16.
[26] Remuneration, education and training formed key recommendations in the 'Growing Our Future: the Aboriginal and Torres Strait Islander Health Worker Project Final Report'.

Employment opportunities would be made available in health, administration, corporate services and other work areas; offered at a range of skill levels including: professional, para-professional, management, support, and front of house and located across Australia including in very remote, remote, outer regional, inner regional and major cities.

Although still in early stages of development, a model such as this builds an employer driven demand approach, an accessible system that is easy to navigate for both employers and job seekers, identifies and prepares job-seekers through relevant training activities and supports them into 'real' jobs at the end of their training or once they obtain a qualification

h. any related matters

NACCHO believes the most effective way to engage Aboriginal people is the community controlled model underpinned by principles of self-determination and community development.

Social and cultural determinants of health encompass the conditions and circumstances, into which people are born, grow through childhood, live, work and age, and the systems put in place to deal with illness: these are shaped by the wider forces of economics, social policies, and politics.

NACCHO considers that the social and cultural determinants of health must be seriously and comprehensively addressed when considering development of policies that affect the lives of Aboriginal and Torres Strait Islander people, not only in health, but also education and employment.

Ensuring a holistic response that considers social, political and cultural determinants of the poor health status of Aboriginal people should take advantage of the extensive and well-established knowledge networks that exist within the ACCHS movement. This should be considered in all areas of Aboriginal policy and delivery, and not considered as separate elements.

About NACCHO

NACCHO is the national authority on Aboriginal Comprehensive Primary Health Care representing over 150 ACCHS across the country on Aboriginal health and wellbeing issues.

ACCHS are a Comprehensive Primary Health Care service initiated and operated by the local Aboriginal community to delivery holistic, comprehensive and culturally appropriate health care to the community which controls it, through a locally elected Board of Management. The first ACCHS were established in Redfern in 1971 because mainstream services were not dealing adequately with the health needs of Aboriginal and Torres Strait Islander people. This problem with mainstream health services continues to the present day.

ACCHS operate in urban, regional and remote Australia. They range from large multi-functional service employing several medical practitioners and providing a wide range of services, to small services which rely on Aboriginal Health Workers and/or nurses to provide the bulk of comprehensive primary care services, often with a preventive, health education focus. The services form a network, but each is autonomous and independent both of one another and of government. The ACCHS model of service is in keeping with the philosophy of Aboriginal community control and the holistic view of health. Addressing the ill health of Aboriginal people can only be achieved by local Aboriginal people amounting to Aboriginal Health in Aboriginal Hands.

Background

The Australian Bureau of Statistics (ABS, 2011) estimated that the population of Aboriginal and Torres Strait Islander people as at the 30th June 2011 was 669,900 or 3% of the total Australian population. Life expectancy for Aboriginal and Torres Strait Islander people is estimated to be ten years less than the national Australian average, with high levels of disadvantage in areas such as education, employment and housing all contributing to disproportionately low health outcomes.

The ACCHS workforce provide 2.5 million episodes of care to an estimated 342,000 Aboriginal and Torres Strait Islander people and other Australians annually. ACCHS have successfully contributed to the Close the Gap targets that have reduced child mortality rates by 66 per cent and overall mortality rates of Aboriginal and Torres Strait Islander people by over 33 per cent over the last two decades.

Despite increased health expenditure over the last decade, up until recently health gains have been fewer than expected. The primary health care sector that has demonstrated an ability to deliver the best results for ACCHS continues to be the least funded.

Close the Gap

Aboriginal and Torres Strait Islander Australians can expect to live 10-17 years less than other Australians. Babies born to Aboriginal mothers die at more than twice the rate of other Australian babies, and Aboriginal and Torres Strait Islander people experience rates of preventable illnesses such as heart disease, kidney disease and diabetes.

The Close the Gap campaign has achieved a tremendous amount since its launch in 2007. These outcomes include:

- Commitment by government and all major political parties to take action through the formal signing of the Statement of Intent.
- Allocation of additional health funding through COAG; and,
- A stated intention to work in partnership with Aboriginal health organisations and communities.

Attachments

Attachment A:	AIHW and NACCHO Healthy for Life Report Card (2013)
Attachment B:	NACCHO Investing in Aboriginal Community Controlled Health Makes Economic Sense Executive Summary (2014)
Attachment C:	NACCHO Ten Point Plan 2013-2030
Attachment D:	NACCHO Male Health Blueprint