



# **ABORIGINAL HEALTH COUNCIL OF SOUTH AUSTRALIA INC.**

## **Submission to Senate Select Committee on Health October 2014**

## Contents

Senate Select Committee on Health Terms of Reference .....	3
Introduction.....	4
Summary of Responses .....	5
Detailed Responses to Senate Select Committee Terms of Reference .....	6
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; .....	6
The impact of additional costs on access to affordable healthcare and the sustainability of Medicare; .....	6
The impact of reduced Commonwealth funding for health promotion, prevention and early intervention; .....	7
The interaction between elements of the health system, including between aged care and health care; .....	8
Improvements in the provision of health services, including Indigenous health and rural health; .....	8
The better integration and coordination of Medicare services, including access to general practice, specialist medical practitioners, pharmaceuticals, optometry, diagnostic, dental and allied health services; .....	11
Health workforce planning.....	11
Contact Details .....	13
Attachment 1 .....	14

## Senate Select Committee on Health Terms of Reference

That a select committee, to be known as the Select Committee on Health, be established to inquire into and report on health policy, administration and expenditure, with particular reference to:

- 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;
- The impact of additional costs on access to affordable healthcare and the sustainability of Medicare;
- The impact of reduced Commonwealth funding for health promotion, prevention and early intervention;
- The interaction between elements of the health system, including between aged care and health care;
- Improvements in the provision of health services, including Indigenous health and rural health;
- The better integration and coordination of Medicare services, including access to general practice, specialist medical practitioners, pharmaceuticals, optometry, diagnostic, dental and allied health services;
- Health workforce planning; and
- Any related matters.

## Introduction

Dear Hon Senators

Thank you for the opportunity to respond to the Committee terms of reference.

The Aboriginal Health Council of South Australia (AHCSA) Inc. is the peak body for Aboriginal health in South Australia, representing Aboriginal Community Controlled Health Services (ACCHSs) and Aboriginal Health Advisory Committees (AHACs). The Aboriginal community controlled sector has been provided services to Aboriginal communities for over forty years.

AHCSA believes that ACCHSs are the most effective, efficient, safe and culturally appropriate means of continuing to make inroads into the health disparities between Aboriginal/First Nations peoples and the general population in South Australia.

AHCSA believes that ACCHSs have the infrastructure and networks which provides for a coordinated and integrated primary health care system for Aboriginal people, and are therefore better positioned to offer primary health care services than mainstream services.

The capacity and history of the ACCH sector should be recognised with maintenance and growth of investment as a cost-effective way of “closing the gap”.

By doing this AHCSA contends that further inroads into improving outcomes for Aboriginal people can be made in cost effective, safe and equitable ways.

## Summary of Responses

- The reduced health funding from the Commonwealth to the States and Territories will have an adverse impact on Aboriginal health.
  - Any reduction in hospital spending must be offset by investments in primary health care to reduce upstream costs.
  - Investment in Aboriginal community controlled primary health care is a cost effective way of “closing the gap”.
- Introducing co-payments will not close the gap in health outcomes - it will widen the gap between Aboriginal people and the rest of the community.
  - A co-payment will increase health care and administration costs for both Government and health care providers.
  - Discouraging people from visiting their GP will interfere with the early detection of illnesses and preventive action such as immunisation.
  - There will be more illness in our community and longer term health costs will be fostered on future generations through increased demand for hospital services.
- Preventative health activity is a major driver in reducing the gap in health outcomes.
  - Evidence suggests up to fifty per cent more health gain or benefit can be achieved if health programs are delivered to the Aboriginal population via ACCHSs.
- Aboriginal communities need to be involved in the design and development of programmes that affect them.
  - Significant changes to funding arrangements (from DoH to PM&C) have added to the burden of administration and costs to ACCHSs.
  - The ‘mainstreaming’ of funding has not shown to add to improvements in Aboriginal health status.
  - The Commonwealth must make a commitment to adequate and ongoing funding to well-functioning Aboriginal organisations.
  - Aboriginal organisations should be afforded the same options from incorporation as non-Aboriginal organisations under any funding guidelines.
- The integration and coordination of services could easily be made more effective and efficient if governments recognised that this integration and co-ordination works best at the health service delivery level.
  - The services provided to Aboriginal people by, for example, specialist medical practitioners are for more effective if they are well-integrated with the primary health care service.
- Improving the Aboriginal and Torres Strait Islander health workforce is fundamental to closing the gap in Aboriginal and Torres Strait Islander life expectancy.
  - AHCSA believes that Aboriginal workforce will have the best effect when focused within Aboriginal organisations.
  - The growth of the workforce for the Aboriginal and Torres Strait Island Health sector has been immediate and needs to be implemented and managed.
  - Monitoring the health workforce on an ongoing basis, identifying gaps in service provision and predicting future needs are critical components.
  - Changes to funding removed a long standing function of Affiliates that has not been fully replaced.
  - The current workload cannot be sustained.

## Detailed Responses to Senate Select Committee Terms of Reference

### 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;

The reduced health funding from the Commonwealth to the States and Territories will have an adverse impact on Aboriginal health. Aboriginal Community Controlled Health Services (ACCHSs), while primarily funded by the Commonwealth, have increasingly looked towards State health departments for funding of new and needed programs that have not been available from Commonwealth funding sources. As State governments look at ways of reducing funds, their funding to ACCHSs will be at considerable risk. This should be recognised by the Commonwealth government, and increased direct funding to ACCHSs should be considered to compensate for the losses.

AHCSA supports the National Aboriginal Community Controlled Organisation (NACCHO) submission to this committee that Government funding lacks balance, with a significant portion of total health spending directed towards hospitals<sup>1</sup>.

Our concern is that funding is generally not being invested where it is needed. The Commonwealth previously stated that Government strategy to close the gap will focus on the treatment of Indigenous Australians' illnesses "largely through the mainstream health system, because that is where 70% of Indigenous people are treated". (PM Rudd 2009)

With evidence showing that investment in primary health care showed better outcomes, the question must be asked: *Why is there not greater government investment in the most cost-effective way of improving Indigenous health and well-being – that is, Aboriginal Community Controlled Primary Health Care?*

Whilst AHCSA recognises the history of support for the ACCHO sector, we note that there has been little growth in funding to the sector at the state level with most of the expansion funding under the COAG Close the Gap (CTG) agenda going to state health services and Medicare Locals.

The capacity and history of the ACCHO sector should be recognised with maintenance and growth of investment to provide a cost-effective way of "closing the gap".

### The impact of additional costs on access to affordable healthcare and the sustainability of Medicare;

AHCSA is gravely concerned of the potential impact of the Governments proposed co-payment policy.

Imposing a \$7 Medicare co-payment on Doctor visits and medical tests (e.g. blood tests, ultrasounds, x-rays) will be bad for the health of all Australians but more so for the Aboriginal community.

<sup>1</sup> Alford, K. 2014. 'Investing in Community Controlled Health Services Makes Economic Sense – Executive Summary'.

Introducing co-payments will not close the gap in health outcomes; it will widen the gap between Aboriginal people and the rest of the community.

This would cause a significant administrative burden and financial loss for ACCHSs, and will introduce a further obstacle to accessing primary health care for Aboriginal people leading to a widening of the gap in mortality. A co-payment will increase health care and administration costs for both Government and health care providers. This will leave less money to provide the community with the care they need because more is spent on administration. This includes the ability of Aboriginal Community Controlled Health services to recruit and pay the General Practitioners who are vital to our primary health care service delivery

This will hurt the sickest and poorest people in our community as \$7 means a lot more to the most disadvantaged among us, especially those in low-income households or with chronic illness.

The AHCSA considers the proposed co-payment is poor policy. Discouraging people from visiting their GP will interfere with the early detection of illnesses and preventative action such as immunisation. There will be more illness in our community and longer term health costs will be fostered on future generations through increased demand for hospital services.

AHCSA hoped that this proposal will be dropped altogether, but if not, all Aboriginal people should be exempted from the co-payment.

### **The impact of reduced Commonwealth funding for health promotion, prevention and early intervention;**

After several years of implementation AHCSA notes there has been a \$130 million cut to Aboriginal and Torres Strait Islander-specific population health anti-smoking initiatives over five years, whilst the Department of Health undertake a review of the Tackling Smoking measure to ensure it is being implemented efficiently. With smoking rates amongst Aboriginal and Torres Strait Islander people having reduced over time<sup>2</sup>, which demonstrates health behavioural change is possible, it is difficult to understand the reasoning behind reviewing a program with no current knowledge of who will review the programs and a vague timeline. 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.

Preventative health activity is a major driver in reducing the gap in health outcomes. The ACE-Prevention project, undertaken at the University of Queensland, evaluated the cost-effectiveness of 150 preventative health interventions and also looked at the cost effectiveness and cost efficiency of mainstream vs. indigenous service providers. They concluded that up to fifty per cent more health gain or benefit can be achieved if health programs are delivered to the Aboriginal population via ACCHSs compared to the same programs being delivered via mainstream primary care services<sup>3</sup>.

An added complexity is that in a climate of reduced funding, a disproportionate amount of health expenditure is still channelled towards non-Aboriginal primary health care providers. Up to two-thirds of

<sup>2</sup> Note that ABS and AIHW analysis of the 2008 NATSISS data quoted in ATSI Health Performance Framework 2012 Report finds the smoking rate in 2008 to be 47%, down from 52% in 2002.

<sup>3</sup> Theo Vos<sup>1</sup>, Rob Carter<sup>2</sup>, Jan Barendregt<sup>1</sup>, Catherine Mihalopoulos<sup>2</sup>, Lennert eerman<sup>1</sup>, Anne Magnus<sup>2</sup>, Linda Cobiac<sup>1</sup>, Melanie Bertram<sup>1</sup>, Angela Wallace: Assessing Cost-Effectiveness in Prevention. ACE-Prevention September 2010

Aboriginal and Torres Strait Islander people rely on the Comprehensive Primary Health Care provided by ACCHSs, yet three-quarters of all government Indigenous health expenditure goes to non-Aboriginal primary healthcare providers and nearly half goes to hospitals. Aboriginal people under-utilise primary healthcare services, preferring the services provided through ACCHSs. 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.

**The interaction between elements of the health system, including between aged care and health care;**

Whilst the Aboriginal population in general is younger than the overall population<sup>4</sup>, AHCSA supports the NACCHO submission<sup>5</sup> that highlights the impacts of the changes to Aged care funding and changes from the Home and Community Care (HACC) program to the Commonwealth Community Home Support (CHSP) program.

A number of AHCSA Members have engaged in the provision of support for aged care and one of our Members currently operates an aged care facility. It is the AHCSA position that these changes will need to be evaluated over time and this should include engagement with the ACCHO sector to ensure program objectives meet the needs of the communities.

**Improvements in the provision of health services, including Indigenous health and rural health;**

Report after report has highlighted the fact that one of the major obstacles to improving Aboriginal health is the continual uncertainties of ongoing funding to ACCHSs. While in recent years attempts have been made to overcome this problem, with 3-5 year funding cycles, it appears we again have to deal every year with uncertainty. Many Aboriginal health programs managed by ACCHSs have no guarantee of funding beyond June 2015. This impedes planning and has an adverse impact on health programs and outcomes. The Commonwealth must make a commitment to adequate and ongoing funding to well-functioning Aboriginal organisations.

Much of the increased funding for Aboriginal health in recent years has not had a significant impact on improving health due to an explicit or implicit policy of successive governments of "mainstreaming". Mainstreaming has been shown not to work, and directing funds to ACCHSs has been shown to be cost-effective. If governments genuinely want to improve Aboriginal health and get good value for money, mainstreaming policies should be rejected.

Any improvements sought in the provision of indigenous health services needs to involve those best placed to deliver them. AHCSA contends that involving Aboriginal communities in the development of programmes that affect them is the only sustainable means of addressing relative disadvantages in this nation.

<sup>4</sup> <http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/B6C35289C888557DCA257A06002299FD?opendocument>

<sup>5</sup> NACCHO Submission to the Senate Select Committee on Health October 2014

Self-determination, and the right to be involved in developing and determining programs, have been enshrined at an international level, as evidenced in the United Nations Declaration on the Rights of Indigenous Peoples (2007), to which Australia is a signatory. The UN declaration - in particular Articles 3, 4 and 23 - affirms that involvement in design, planning and implementation of programs that affect indigenous populations is a right that should be afforded to all indigenous populations.

The World Health Organisation<sup>6</sup> also recognises that involving groups and communities at the local level is a necessary part of the health care equation and that Community Control addresses inequality:

*'The mobilization of groups and communities to address what they consider to be their most important health problems and health-related inequalities is a necessary complement to the more technocratic and top-down approach to assessing social inequalities and determining priorities for action'.*

International experience and research also reinforces the importance of self-determination in achieving positive outcomes. In a body of work undertaken by Harvard University in the US Cornell<sup>7</sup> determined that:

*'In a century of U.S. efforts to improve Indian economic and community conditions, Indigenous self-determination is the only policy that has had broad, positive, sustained results'.*

As outlined by NACCHO, the peak body for Aboriginal community controlled health services in Australia (NACCHO Constitution 2008):

*'Primary Health Care is all inclusive, integrated health care and refers to the quality of health services. It is a comprehensive approach to health in accordance with the Aboriginal holistic definition of health and arises out of the practical experience within the Aboriginal community itself having to provide effective and culturally appropriate health services to its communities'.*

AHCSA is concerned by the separation of many aspects of health policy and funding in the collation of programs relating to social and emotional wellbeing and alcohol and other drug funding away from the Department of Health and into the Department of Prime Minister and Cabinet. This movement effectively separates aspects of comprehensive health services and adds to the burden of planning and reporting amongst our Member services.

The recent commencement of the Department of Prime Minister and Cabinet (Indigenous Affairs) Indigenous Advancement Strategy (IAS) has not effectively reduced the red tape burden on our services. Rather it has increased it by inserting an additional grant funding application process with a different department, a new round of funding agreements to be negotiated and the need to allocate resources from service delivery support to application development. In an AIHW report Moran et al<sup>8</sup> note that *"whether in Australia or abroad, experience suggests that positive impacts can be achieved on*

<sup>6</sup> David P. Thomas, Richard F. Heller, Jennifer M. Hunt AUSTRALIAN AND NEW ZEALAND JOURNAL OF PUBLIC HEALTH 1998 VOL. 22 NO Clinical consultations in an Aboriginal community-controlled health service: a United Nations 07-58681—March 2008—4,000: comparison with general practice

<sup>7</sup> Akrabim, Ceranthor, Dthomsen8, Giraffedata, HPAIED, Johnpacklambert, Khazar2, Malcolm, OSborn, Sleepslayer, T@nn, Tim!, Toon05, Uyvsdi, Waacstats, 20 anonymous edits: Harvard Project on American Indian Economic Development Harvard Project Source

<sup>8</sup> Moran M, Porter D and Curth-Bibb J 2014. Funding Indigenous organisations: improving governance performance through innovations in public finance management in remote Australia. Issues paper no 11. Produced for the Closing the Gap Clearinghouse. Canberra: Australian Institute of Health and Welfare & Melbourne: Australian Institute of Family Studies).

*key dimensions of accountability and outcomes by (1) progressively devolving authority, by (2) amalgamating rather than fragmenting grant systems, and by (3) introducing mutually agreed measures that are directly applicable to the activities and services being funded (and within the control of the funded organisation) to incentivise performance, backed by (4) credible and enforceable rewards and sanctions".*

In addition, many service programs – such as a Fathers Support group in a regional South Australian area – were defunded in 2014 with changes in programs structure and the gap in services will only be addressed if a funding application is successful and funding is received in 2015. This leads to loss of capacity and workforce that supports service delivery.

Also, the requirements of the funding guidelines might be considered discriminatory in that organisations receiving more than \$500,000 from these programmes are directed to be incorporated under the Commonwealth Corporations (Aboriginal and Torres Strait Islander) Act (CATSI Act). This removes the choice of currently incorporated organisations from maintaining legally accepted structures, imposes a significant cost burden which is not matched by current offers of support and, offers no choice to utilise the Commonwealth Corporations Act, a choice open to non-indigenous organisations competing for the same funds.

The realignment of the funding for Indigenous health programmes across the Department of Health and the Department of PM&C has also had consequences for maintaining the ongoing effort to further improve the health status of the communities we serve by negatively impacting upon the effective relationship between the ACCHO sector and the Commonwealth Public Service. It has been a hindrance to planning that between late 2013 and 2014 Commonwealth public servants were unable to provide clear answers on their structure and roles/responsibilities as major department reshuffles were completed.

A further major impact upon the sector was the late notice of funding agreements for the 2014/15 year. Our organisation received a funding contract for financial year 2014/15 in late June 2014. Changes to funding amounts and types ensured that positions were lost at short notice and the organisation needed to focus on subsequent restructuring as an initial order of business, rather than its core roles.

Lastly, the Department of Health has decided to introduce a new funding allocation methodology for all Indigenous health grant funding which will be implemented from 2015-16 and transitioned over a number of years<sup>9</sup>. Whilst the sector was engaged in the early part of the review process undertaken by KPMG<sup>10</sup> the current position of the Review is unclear to the sector and little or no information is available on the impact of the review for the next financial year.

AHCSA would seek clarity on the review process, and commitment for engagement in the development of funding allocation methodologies to ensure that ongoing funding to the sector is transparent, equitable and recognises the long term commitment of the Sector to addressing the disparity in health outcomes that impact upon our communities.

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<http://www.health.gov.au/internet/main/publishing.nsf/Content/Aboriginal%20and%20Torres%20Strait%20Islander%20Health-1lp>

<sup>10</sup> <http://www.health.gov.au/internet/main/publishing.nsf/Content/oatsih-primary-funding-review>

**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 integration and coordination of services, including access to general practice, specialist medical practitioners, pharmaceuticals, optometry, diagnostic, dental and allied health services, for Aboriginal people could easily be made more effective and efficient if governments recognised that this integration and co-ordination works best at the health service delivery level.

The current situation consists of a plethora of funding streams, many of which are managed by mainstream organisations including Medicare Locals and Rural Doctors Workforce Agencies with little understanding of the needs of front-line services, resulting in poor co-ordination, and often poor use of specialist or allied health services.

The services provided to Aboriginal people by, for example, specialist medical practitioners are for more effective if they are well-integrated with the primary health care service providing ongoing care to the person concerned, and this is most likely to happen if this integration is managed at the primary health care level.

The most cost-effective way of ensuring integration and co-ordination of services is by amalgamating funding streams (including income currently achieved through Medicare claiming) into block-funding directly to ACCHSs and their representative bodies<sup>11</sup>.

**Health workforce planning.**

The ACCHO workforce is a vital component in addressing the inequity in Aboriginal health outcomes at several levels. AHCSA calls for continued investment for the AHCSA Registered Training Organisation (RTO), including the current commitments made through the COAG CTG agenda and for the expansion of resources to allow AHCSA to consider options for other relevant training that will benefit the sector.

Improving the Aboriginal and Torres Strait Islander health workforce is fundamental to closing the gap in Aboriginal and Torres Strait Islander life expectancy. NACCHO and its Affiliates are determined to pursue a good outcome for our people from the proposed national health reforms.

Increasing the participation of the Aboriginal and Torres Strait Islander people in the health workforce is a key element of a number of national policy drivers for improving Aboriginal and Torres Strait Islander health. Monitoring the health workforce on an ongoing basis, identifying gaps in service provision and predicting future needs are critical components of AHCSA's strategic planning activities with its Affiliate members.

The Workforce Information Project Officer's (WIPO) were the major resource in supporting the sector to address key workforce issues. WIPOs were instrumental in the consultations and contributions for the

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<sup>11</sup> Moran M, Porter D and Curth-Bibb J 2014. Funding Indigenous organisations: improving governance performance through innovations in public finance management in remote Australia. Issues paper no 11. Produced for the Closing the Gap Clearinghouse. Canberra: Australian Institute of Health and Welfare & Melbourne: Australian Institute of Family Studies).

recent industrial and legislation changes: Aboriginal Health Worker training, Aboriginal Health Worker Professional, and Award modernisation (ACCHS Award).

The WIPO Network commenced operation in June 1996, although WIPO's were not employed in all States and the NT until 1997; Tasmania in 1997 and ACT 2004 DoHA funds the National WIPO network. Following negotiations between the Aboriginal Community Controlled sector and Federal Government, it was agreed that a number of WIPO positions be established and that they be located within the NACCHO Affiliates. The WIPOs have been guided by the Aboriginal and Torres Strait Islander Health National Strategic Framework (WSF). (Urbis Keys Report)

The WIPO positions were defunded during 2013-14 and there is only one position currently funded in NACCHO and each State and Territory Affiliate. To achieve a skilled workforce, and respond to the COAG measures, which will conclusively result in an expanded delivery of comprehensive health care to Aboriginal and Torres Strait Islander People, AHCSA contends that the Government has an obligation to extend the funding to financially supported Workforce Units.

Also, the Department of Health Chronic Disease Fund – which was previously *The Indigenous Chronic Disease Package* – is one of the initiatives currently aimed at enhancing the Aboriginal workforce. There is a current role within AHCSA to assist with workforce expansion and support, including a workforce of Aboriginal and Torres Strait Islander Outreach Workers, Indigenous Project Officers and Care Coordinator Supplementary Service teams. A large cohort of these positions is currently employed through Medicare Locals. With the transition to the Primary Health Network, AHCSA recommends that these positions be placed in ACCHSs for the continuation of appropriate service delivery (i.e. they are not transitioned to PHNs)

The growth of the workforce for the Aboriginal and Torres Strait Island Health Sector has been immediate and it is imperative if these initiatives are to be implemented and managed successfully, then the capacity of NACCHO and the state Affiliates needs to be maintained. The current workload cannot be sustained.

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## **AHCSA Position Paper**

# **Value for Money: Investing in Aboriginal Community Controlled Health Services**

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The Aboriginal Health Council of South Australia (AHCSA) is the peak body for Aboriginal health in South Australia, representing Aboriginal Community Controlled Health Services (ACCHSs) and Aboriginal Health Advisory Committees (AHACs).

AHCSA believes that ACCHSs are the most effective, efficient, safe and culturally appropriate means of continuing to make inroads into the health disparities between Aboriginal/First Nations peoples and the general population in South Australia.

AHCSA believes that ACCHSs have the infrastructure and networks which provides for a coordinated and integrated primary health care system for Aboriginal people, and are therefore better positioned to offer primary health care services than mainstream services.

The capacity and history of the ACCHO sector should be recognised with maintenance and growth of investment. This paper will show why governments should invest more in Aboriginal community-controlled health services if they want a cost-effective way of “closing the gap”.

And in considering that investment AHCSA identifies four key areas that provide a broad framework for maximising returns. These areas for investment include:

1. Investing in AHCSA as the Peak Body to continue providing leadership
2. Investing in working together in partnership to improve Aboriginal health
3. Investing in ACCHO services: both existing and new ones
4. Investing in building the Workforce

By doing this AHCSA contends that further inroads into improving outcomes for Aboriginal people can be made in cost effective, safe and equitable ways.

## Contents

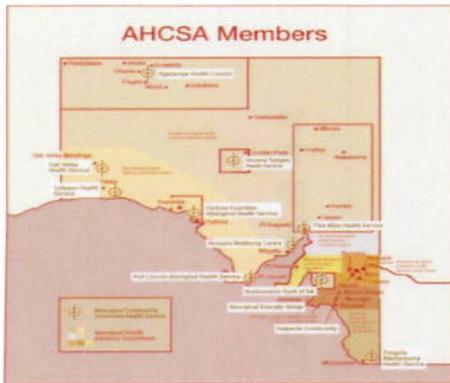
<a href="#">What is AHCSA?</a>	16
<a href="#">Why investing in ACCHSs is good value</a>	18
<a href="#">Why ACCHSs provide quality service delivery</a>	20
<a href="#">The Value Proposition</a>	30
<a href="#">The Best Areas for Investment</a>	31
<a href="#">Contact Details</a>	13
<a href="#">Reference Sources</a>	34

## Acknowledgements

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Dr David Scrimgeour  
Dr Kushani Marshall  
Mr Paul Ryan  
Ms Amanda Mitchell  
Ms Mary Buckskin  
Mr John Singer  
Ms Belinda Lock

## What is AHCSA?



AHCSA is a membership-based organisation with a Secretariat based in Adelaide. We work closely with our Members throughout South Australia. The membership consists of:

- 12 Aboriginal Community Controlled Health Services, and
- 7 Aboriginal Health Advisory Committees (that are

established under Country Health SA)

AHCSA is also a partner in a Residential Aboriginal Alcohol and Drug Rehabilitation Consortium (with Aboriginal Drug and Alcohol Council and Aboriginal Family Support Services) that is developing the service for the northern part of the state.

AHCSA brings many attributes to the table. Since the emergence of the first ACCHSs in SA around forty years ago a wealth of experience has been developed in comprehensive primary health care delivery. The AHCSA membership is the major provider of primary health care services to the Aboriginal population of SA.

The AHCSA membership strengths include:

- The organisations are comprised of dedicated, passionate staff;
- The organisations have close connections to the communities they serve;
- The organisations are accountable to those communities;
- Historically, the organisations have good, ongoing relationships with funders.

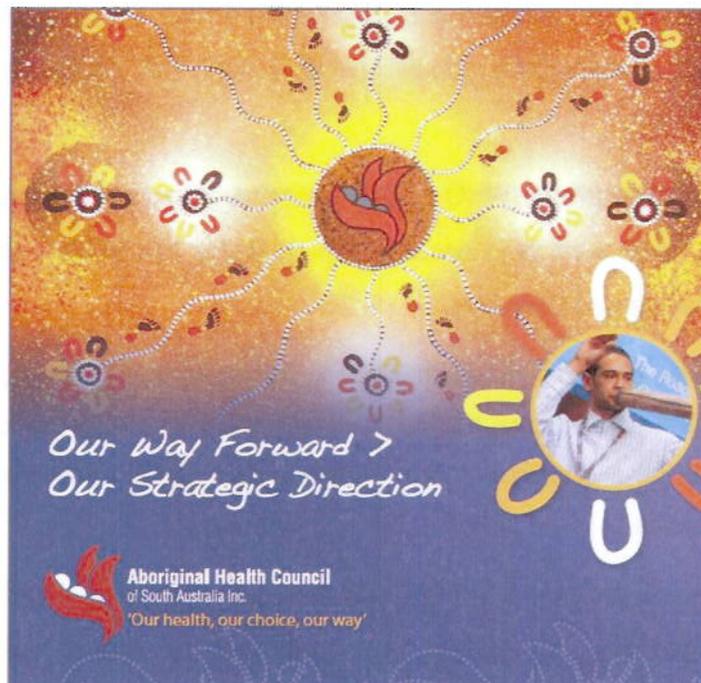
AHCSA maintains clear Objectives and Strategic Directions that drive its work. The four main Objectives state that AHCSA will:

1. Operate as the peak body for Aboriginal health in South Australia.
2. Improve the health outcomes for all Aboriginal people of South Australia, promoting and advancing the communities' commitment to physical, social and emotional wellbeing and quality of life.
3. Build the capacity of members to create a strong and enduring Aboriginal community controlled health sector and contribute to improving the capacity of mainstream health

services to respond appropriately to the health needs of the Aboriginal community within South Australia.

4. Contribute to the development of a well-qualified and trained Aboriginal health sector workforce.

The AHCSA Board provides guidance on how these Objectives are to be addressed through the Strategic Directions, a key document that expands upon the intent of the Objectives and is used to monitor the performance of the organisation.



### **Why investing in ACCHSs is good value**

AHCSA maintains a strong position that Aboriginal Community Control of health service delivery provides better results for Aboriginal people.

The ACCHO sector arose out of the awareness that mainstream health institutions were not meeting the needs of Aboriginal and Torres Strait Islander people and there needed to be community input into how services were provided. There is also an international body of literature, research and policy directions that support the statement that community involvement in health care provides better outcomes, particularly for Indigenous populations.

Self-determination, and the right to be involved in developing and determining programs, have been enshrined at an international level, as evidenced in the United Nations Declaration on the Rights of Indigenous Peoples (2007), to which Australia is a signatory. The UN declaration - in particular Articles 3, 4 and 23 - affirms that involvement in design, planning and implementation of programs that affect indigenous populations is a right that should be afforded to all indigenous populations.

The World Health Organisation (WHO 2008) also recognises that involving groups and communities at the local level is a necessary part of the health care equation and that Community Control addresses inequality:

The mobilization of groups and communities to address what they consider to be their most important health problems and health-related inequalities is a necessary complement to the more technocratic and top-down approach to assessing social inequalities and determining priorities for action.

International experience and research also reinforces the importance of self-determination in achieving positive outcomes. In a body of work undertaken by Harvard University in the US Cornell (2004) determined that:

In a century of U.S. efforts to improve Indian economic and community conditions, Indigenous self-determination is the only policy that has had broad, positive, sustained results.

In Canada, Lovie et al (2005) showed that investment in community controlled health showed that rates of avoidable hospitalisation decreased each year following a “transfer agreement” which transferred control of Indigenous health services from government control to community control, *and* that the length of stay in hospital was lower for residents of community with better control of primary health care.

We would also highlight, given the high rates of youth suicide in recent times in SA, the work by Chandler and Lalonde (1998) suggests that where there is community control of various factors (including health care) in the community there is lower rates of youth suicide.

This international work is reinforced by the Australian experience. A Healthier Future for All Australians Interim Report (2008) states that:

Aboriginal Community Controlled Health Services play an important role in the delivery of comprehensive primary health care, maximising people's potential and ameliorating illness as a barrier to Aboriginal and Torres Strait Islander people's participation in family, community and workforce. ...These Services need to be enabled to deliver services in an efficient manner.

This important role for ACCHSs is also recognised in the SA Aboriginal Health Care Plan (2010-2016) that lists amongst its key principles:

- support for the Aboriginal community controlled health care sector
- working together
- localised decision making
- developing the capacity and resources of health services and communities

### Why ACCHSs provide quality service delivery

AHCSA believes that there is evidence that demonstrates why direct investment in the sector is consistent with the development of quality health care systems.

When assessing the impact on investments in ACCHSs we would propose that there are several criteria that need to be addressed. These criteria include: Access to services, Models of services, Efficiency, Outcomes, Safety and Quality, and Capacity.

#### **Access to Services**

The ability to access services and receive appropriate levels of care is a major indicator of health outcomes. Evidence suggests that Aboriginal people's access to primary health care is improved when ACCHSs are available.

Available statistics include:

- 60% of Indigenous people across Australia use ACCHSs, despite the fact that there are many areas of Australia where Indigenous people do not have easy access to ACCHSs (Healthy for Life Aboriginal Community Controlled Health Services Report Card 2013)
- ACCHSs reported 1,812,758 episodes of care by service reporting to Commonwealth (Indigenous Health Service Delivery Division On-line Services Reporting 2012), and
- A majority of SA Aboriginal people prefer to use Aboriginal-specific health services if they are available (The SA Indigenous Health Survey 2012)

According to the A Healthier Future for All Australians Interim Report (2008), *'Aboriginal and Torres Strait Islander people are relatively higher users of 'community health services' (the classification used for community controlled health organisations) and relatively lower users of general medical services.'*

#### **Model of Service**

The way in which services are delivered is an important aspect of achieving positive outcomes in health. AHCSA would argue that the ACCHO model of primary health care (PHC) is perhaps the model that all PHC should aspire to. As outlined by NACCHO, the peak body for Aboriginal community controlled health services in Australia (NACCHO Constitution 2008):

Primary Health Care is all inclusive, integrated health care and refers to the quality of health services. It is a comprehensive approach to health in accordance with the Aboriginal holistic

definition of health and arises out of the practical experience within the Aboriginal community itself having to provide effective and culturally appropriate health services to its communities.

This model of service is better suited to the needs of Aboriginal people than the model available in fee-for-service general practice. The Bettering the Evaluation and Care of Health (BEACH) Program continuously collects information about the clinical activities in general practice in Australia. The BEACH database currently includes about 1,400,000 GP-patient encounter records (2012). Key information from the BEACH program includes:

- Only 1.4% of consults involved identified Indigenous people, although they constitute 2.2.% of the Australian population;
- The number of problems managed per encounter is the same as for non-Indigenous people although there is a significant disparity in health status; and
- There are lower rates of preventative measures at Indigenous encounters compared to non-Indigenous encounters.

This data suggest that Indigenous people with complex health issues do not receive an appropriate level of care in the mainstream primary health care system. In contrast, work from Thomas et al (1998) and Larkins et al (2005) show that there are significantly more problems managed per encounter with Indigenous patients in ACCHSs compared to Indigenous people presenting to fee-for-service general practice.

Analysis of data has shown that outcomes are better in the ACCHO sector. For example Panaretto et al (2013) found:

The limited information available suggests that the performance in the ACCHO sector on some key care activities is at a higher level than for mainstream general practice....The challenge now is to sustain this system and to continue to act on such data, which is predicated on having the appropriate time and resources in our peak bodies to support the Aboriginal and Islander health services.

Fee-for-service general practice often relies on throughput to maximise the income from the Medicare funding, which creates difficulties in addressing the health care needs of Aboriginal people, and is not suited to addressing in the manner outlined above. In one of the few studies which have investigated the barriers to providing health care to Aboriginal people in fee-for-service general practice, Craig (2000) surveyed GPs in south-west Sydney and her findings included that:

- GPs reported difficulties in establishing trust; there was a recognition that requires long consultations and the system is against it, and
- Some GPs specifically mentioned that they do not get involved in mental health or drug and alcohol issues.

It is precisely these types of issues that the ACCHO model of service seeks to address through its particular model of care.

### **Efficiency of program delivery**

There is evidence that shows that ACCHSs provide the best value for money. Preventative health activity is a major driver in reducing the gap in health outcomes. The ACE-Prevention project, undertaken at the University of Queensland, evaluated the cost-effectiveness of 150 preventative health interventions and also looked at the cost effectiveness and cost efficiency of mainstream vs. indigenous service providers. They concluded that up to fifty per cent more health gain or benefit can be achieved if health programs are delivered to the Aboriginal population via ACCHSs, compared to the same programs being delivered via mainstream primary care services.

AHCSA suggests this indicates that government should look to ACCHSs as the major provider of prevention services to Aboriginal people in SA.

### **Outcomes**

Data on health outcomes provide a mechanism for accountability - and for ACCHSs this includes being accountable to the communities they serve, as well as to the funders who invest in our services. ACCHSs have a history of developing data sources and monitoring outcomes that allow us to evaluate service delivery. This is also reinforced by the increasing number of KPI's that ACCHSs are either required or choose to report on. Voluntary and funder-required data sets include:

- OATSIH Service Reporting (OSR), a data set on service delivery and staffing numbers that is one of the longest running series of data collated on ACCHSs.
- National Key Performance Indicators (NKPI's), developed to assist with monitoring of clinical activity and outcomes to assist with evaluating the Closing the Gap, and other funding.

- HFL – Healthy for Life, a funded program with an emphasis on monitoring activity and outcomes in areas such as preventative health, antenatal care, maternal care and management of chronic diseases.
- Audit and Best Practice in Chronic Disease (ABCD), a nationwide research program which supports the implementation of continuous quality improvement in Indigenous primary health care.
- Several state based key performance indicator sets have also been developed by ACCHO peak bodies for use by their members.

At a national level there are several sources of information which support the outcomes achieved in ACCHSs.

The National Aboriginal Community Controlled Health Organisation (NACCHO) Report Card 2013 – developed in conjunction with the Australian Institute of Health and Welfare (AIHW) - highlights progress made in a number of key areas. Successes noted include:

- Increasing the proportion of adults participating in health checks
- Increasing the proportion of clients with coronary heart disease who have had a blood pressure result less than 140/90mmHg
- Raising the average birthweight of Indigenous babies and reducing the proportion of babies born with low or high birthweight
- Providing timely HbA1c tests to clients with Type 2 diabetes

The Report Card also notes areas for improvement and the ACCHO sector remains committed to continuing to improve performance.

The Aboriginal and Torres Strait Islander Health Performance Framework – 2012 report showed that:

- Two-thirds of all performance based outcomes were from the Aboriginal Community Controlled Health Sector, and
- 96% increase in episodes (1.22 mil – 2.5 mil) of care being delivered by the Aboriginal Community Controlled Health Sector between 1999/2000 and 2010/11

All of these activities have significant upstream effects on the health system, leading to decreased hospitalisation.

## **Safety and Quality in health care delivery**

Safety and Quality in health care as core concepts in service delivery have risen in prominence over time. AHCSA would contend that there is good evidence to suggest that Aboriginal community-controlled health services are amongst the leaders in Primary Health Care service delivery in terms of safety and quality.

In an overview of clinical governance in primary health care in Australia, Phillips et al (2010) noted that:

the Aboriginal community-controlled sector is in the vanguard of clinical governance in Australia ... input from the (ACCHO) sector should be sought from others in Australia to inform the implementation of clinical governance across all primary health care.

And this is also reflected in the degree to which ACCHSs expose themselves to industry standards and assessment. The major accreditation framework for accreditation in primary health care is the Royal Australian College of General Practice (RACGP) standards. The Standards are designed to be a template for safe and high quality care in the increasingly complex environment of Australian general practice. Currently 100% of eligible AHCSA Members are accredited against the RACGP Standards.

In addition, a majority of AHCSA members have achieved, or are in the process of achieving, their whole of organisation accreditation management standard frameworks. This helps our services to ensure that their structures for service delivery are of high standard and compliant with all legal and funding requirements.

AHCSA Members also have regular exposure to continuous quality improvement processes as a means of ensuring that service delivery is evidence based, evaluated and improved when appropriate.

## **Capacity to deliver services**

The ability to deliver services is enabled by the expertise and appropriateness of the workforce. The ACCHO sector across Australia is collectively one of the largest employers of Aboriginal people in the nation, and 'Health Care and Social Assistance' is the largest employment category for Aboriginal people according to the 2011 ABS Census.

In SA the AHCSA Membership employs approximately 450 staff and in many communities it is the largest employer of Aboriginal staff. The AHCSA membership is experienced in developing,

establishing and running programs and provides significant opportunities for employment, further education and personal development.

AHCSA has recently celebrated the ten-year anniversary of its accredited RTO. In the last three years alone 630 students have graduated from the courses the RTO has on scope and has been the major source of training for Aboriginal Health Workers for both AHCSA Members and Non-AHCSA (government) staff. Currently the AHCSA RTO has 269 (2012/2013) enrolments. The AHCSA RTO also provides training in partnership with various organisations. These include:

- Quit SA
- Alzheimer's Australia
- James Cook University
- Country Health SA
- Cancer Council SA
- Julian Burton Burns Trust





### **Examples of existing Service Provision and Innovation**

Our current services provide many examples of innovative and successful service delivery. Outlined below are some of the examples.

#### **Pika Wiya Aboriginal Health Service (PWHS):**

##### **The Well Women's House Initiative: Listening to Aboriginal Women in Port Augusta.**

The PWHS Well Women's initiative responded to calls from the community for the creation of a culturally and gender safe service. The aim of the service is to:

- Provide information about health and wellbeing through groups and education sessions, craft sessions and individual support
- Provide a clinical service for women's health issues including comprehensive yearly women's health checks and antenatal and postnatal care with the Anangu Bibi team (Aboriginal Family Birthing Program).
- Offer multidisciplinary care for women, connecting them to other Pika Wiya programs such as Diabetes, Social and Emotional Wellbeing and Medication Reviews

The Well Women's initiative has been operating for only a short time but data is beginning to show positive results, such as 68% of women attending for preventative health care had an adult health check undertaken – which compares to results of 14.8% - 20.1% nationally.

#### **Pangula Mannamurna Health Service:**

##### **COAG Primary Health Care Initiative: the Aboriginal Family Wellness Program (AFWP)**

AFWP was a partnership between Pangula Mannamurna Inc. (PMI) and South East Regional Community Health Service (SERCHS) to improve Aboriginal Family Wellness.

The program has resulted in strengthened partnerships between PMI and SERCHS with enhanced cultural capability of health care workers and services to improve family participation in both wellness management and chronic disease care.



**Nganampa Health Council (NHC):**  
**Child and Maternal Health delivery**

NHC has a long history of being recognised for its service delivery in many areas. For example, in the Better Health Care: Studies in the Successful Delivery of Primary Health Care Services for Aboriginal and Torres Strait Islander Australians (2001), the National Health and Hospital Reform Commission Interim Report notes that the Nganampa Health Council is one example where gains have been made in the areas of child and maternal health:

*.....women accessing antenatal care for the first time less than 20 weeks into their pregnancy had increased from 60 per cent, to around 90 per cent. Furthermore, data indicated a decrease in perinatal mortality rates and decreases in low birth weights.*

*This includes:*

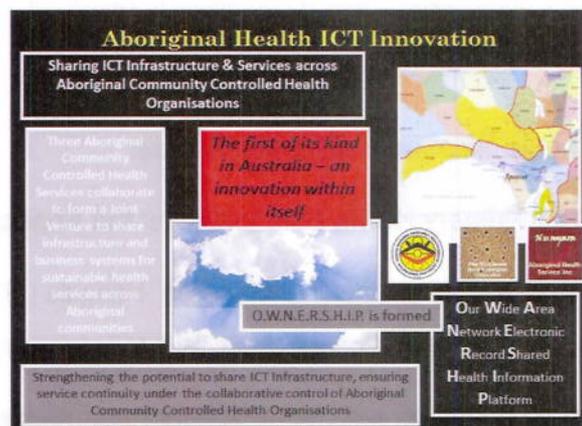
- *ensuring first presentation is made before 20 weeks;*
- *having more than five antenatal visits per pregnancy; and*
- *performance of ultrasounds in all pregnancies.*

**Ceduna Koonibba Aboriginal Health Service Aboriginal Corporation, Nunyara Aboriginal Health Service Inc. and Pika Wiya Health Service Aboriginal Corporation:**

**Our Wide Area Network Electronic Record Shared Health Information Platform (O.W.N.E.R.S.H.I.P) project**

Three Aboriginal Community Controlled Health Services collaborate to form a Joint Venture to share infrastructure and business systems for sustainable health services across Aboriginal communities. This innovation is the first of its kind in Australia.

Ceduna Koonibba, Pika Wiya and Nunyara are near completion of transitioning and migrating out of SA Health government ICT Networks and onto independently owned and managed cloud technology.



## **Port Lincoln Aboriginal Health Service (PLAHS):**

### **Choices, Chances, Changes program**

PLAHS were amongst the first cohort of AHCSA Members to complete Whole of Organisation Accreditation. They have been highly commended in the whole of organisational accreditation review and the review team noted the work of the entirely Aboriginal staffed Finance Team.

Also in a good example of collaborative preventative service delivery, the PLAHS Social Emotional Wellbeing Team ran a five week drug and alcohol program called 'Choices, Chances, Changes' with a local high school. The program focused on innovative delivery with interactive components and also utilised local resources to address health, social and legal issues facing Aboriginal youth.

## **AHCSA**

### **State-wide programs**

AHCSA facilitates a number of programs at a state-wide level that it runs to support member services. AHCSA has a good track record in the delivery of such population health focused activities. Examples of these programs include:

- Sexual Health Program - has shown a steady annual increase in the number of young Aboriginal people across SA screened for sexually transmissible infections
- BBV Program - has supported ACCHSs to have regular clinics for people with chronic hepatitis B or C
- Ear Health Program - has developed a systematic approach for the improved management of chronic otitis media in Aboriginal children in SA ACCHSs.
- Patient Information Management Systems Program - has led to better data management at the primary health care level, leading to better patient management and more accurate data collection
- eHealth Program - has led to ACCHSs in SA being fore-runners in adopting eHealth systems

### The Value Proposition

AHCSA contends that Aboriginal Community Controlled primary health care services provide the best return on investment for achieving measurable outcomes in closing the gap in health status for Aboriginal people.

Primary and preventative health care has been shown to have significant impacts on avoidable hospitalisation as seen in Lavoie's work (2005) and several overseas studies showed that improvements in early chronic disease management at the primary care level can have significant reductions in mortality and morbidity in later life.

However, our concern is that funding is generally not being invested where it is needed. The Commonwealth stated that Government strategy to close the gap will focus on the treatment of Indigenous Australians' illnesses "largely through the mainstream health system, because that is where 70% of Indigenous people are treated". (PM Rudd 2009)

With evidence showing that investment in primary health care showed better outcomes, the question must be asked:

*Why is there not greater government investment in the most cost-effective way of improving Indigenous health and well-being – that is, Aboriginal Community Controlled Primary Health Care?*

AHCSA recognises the history of support for the ACCHO sector; we note that there has been little growth in funding to the sector at the state level with most of the expansion funding under the COAG Close the Gap (CTG) agenda going to state health services and Medicare Locals.

Once again we highlight Lavoie (2005) who also found that:

*'the results of our study show that communities that entered into a transfer agreement showed better outcomes: the longer in a transfer agreement, the better the outcomes'.*

In Australia the Peak Body for Aboriginal Health – NACCHO – has set out a ten point plan to improve health outcomes that recognises the inputs needed at several levels.

This includes investing in ACCHSs:

- To deliver innovative Comprehensive PHC
- That is driven by Aboriginal Leadership, Partnership and Health system reform
- And underpinned by appropriate financing, workforce, infrastructure, research and data
- With accountability, reporting, monitoring and evaluation mechanisms

Along with NACCHO, AHCSA and our Members are looking at the way forward and have identified a set of strategic directions for investment in the community controlled sector in South Australia.

### **The Best Areas for Investment**

AHCSA proposes four key areas of investment for the greatest outcomes:

1. Investing in AHCSA as the Peak Body to continue providing leadership
2. Investing in working together in partnership to improve Aboriginal health
3. Investing in ACCHO services: both existing and new ones
4. Investing in building the Workforce

#### **1. Invest in working together in partnership to improve Aboriginal health**

AHCSA seeks further investment in meaningful engagement mechanisms. This includes continuing the regular forums with Health Minister and senior staff to foster shared priorities and address issues raised by the membership.

AHCSA also considers there to be value in investing in resourcing and commitment to formal partnership processes which includes a shared process to review and renew the Framework Agreement on Aboriginal Health in SA which is due to expire in 2015.

As part of working together AHCSA proposes that agreeing to shared principles for commitment will allow long term sustainable investments to bear fruit to the benefit of all parties.

And in working together it is important to recognise the roles that all stakeholders have, including the ongoing emerging role of the Medicare Locals in the primary health care system.

#### **2. Invest in ACCHO services**

AHCSA calls for ongoing support for existing service delivery and for the expansion of existing services to further the delivery of high quality, culturally appropriate and effective primary health care to Aboriginal people.

In addition AHCSA strongly recommends the development of new services in areas not currently covered by ACCHSs, such as the emerging services in the Murray Bridge area and the Riverland.

AHCSA also calls for the strengthening of the role of AHCSA Members as preferred providers of health services to Aboriginal people when new programs are being considered. This includes streamlining contracting arrangements so that administrative burdens on ACCHSs can be reduced to enable greater focus of resources on program delivery.

AHCSA will also seek ongoing investment in data development and support functions to further strengthen the access to information for reporting on progress and outcomes.

### **3. Invest in AHCSA as Peak Body**

AHCSA calls for governments to recognise the Leadership role that AHCSA has, and continues to play in providing leadership on key Aboriginal health issues, and to support this through meaningful investment strategies.

This means a commitment to ongoing funding for AHCSA with timelines and resource levels that support the mutual attainment of goals.

AHCSA also calls for stronger recognition and responses to the advocate voice of AHCSA on behalf of the Membership that recognise the history of AHCSA and its value to the state.

And, AHCSA plays a vital role in supporting the development of governance mechanisms for the membership in line with the principles of community control. AHCSA calls for investment to support AHCSA in further developing its governance support capacity.

### **4. Invest in Workforce**

The ACCHO workforce is a vital component in addressing the inequity in Aboriginal health outcomes at several levels. AHCSA calls for continued investment for the AHCSA RTO, including the current commitments made through the COAG CTG agenda and for the expansion of resources to allow AHCSA to consider options for other relevant training that will benefit the sector.

AHCSA also recognises that the emerging Aboriginal Health Worker registration process at a national level requires investment for concurrent development of structures to support the registered profession, including the need for ongoing AHW professional development. In addition, with the creation of a number of new positions through the CTG programs tackling smoking, obesity and chronic disease there is a need for ongoing investment in the CTG workforce.

AHCSA believes that the evidence exists that investments in the Aboriginal community controlled health sector will bring the best returns for those stakeholders wanting to address the gaps in health and social outcomes for the Aboriginal population in South Australia. By adhering to the AHCSA slogan – **Our Health, Our Choice, Our Way** – we can all walk the path towards equality in health outcomes

together. As part of this, AHCSA calls on all Members of Parliament to commit to investing in our sector within the broad framework outlined above to continue the achievements that have been made.

For further information, and opportunities to work with AHCSA, please do not hesitate to contact the AHCSA Secretariat.

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