

HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON
ABORIGINAL AND TORRES STRAIT ISLANDER AFFAIRS

INQUIRY INTO THE NEEDS OF URBAN DWELLING
ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES

Submission No. 86

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S 1071

The Hon Dr Michael Wooldridge
Minister for Health and Aged Care

Submission No:86.....

The Hon L.S. Lieberman MP
Chairman
House of Representatives Standing Committee on
Aboriginal and Torres Strait Islander Affairs
Parliament House
CANBERRA ACT 2600

Dear Lou

Thank you for your letter of 4 September 2000 in which you request information for the House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs Inquiry into the Housing Needs of Aboriginal and Torres Strait Islander people. I sincerely apologise for the delay in responding.

I welcome the Inquiry and am committed to strategically attempting to raise the health status and emotional and social wellbeing of Aboriginal and Torres Strait Islander people.

The Terms of Reference for the Inquiry defines "urban areas" to mean population centres of more than 1,000 people, and includes people living in or near country towns of this size. Since some remote traditional communities are relatively large, the definition could also include people living in traditional ways that are associated with towns located in remote areas.

The 1996 Census counted 353,000 Aboriginal and Torres Strait Islander people, representing about 2% of the Australian population. Of these:

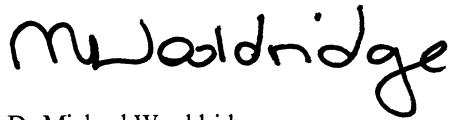
- 36% live in capital cities and other major urban areas (compared with 71% of the non-Indigenous population);
- 34% live in rural areas (26% of the non-Indigenous population); and
- 29% live in remote areas (3% of the non-Indigenous population).

Therefore, as the above definition is applicable to the majority of the Indigenous population in Australia, my Department has prepared a submission to the Inquiry which provides an overview of the Indigenous Health Program (Attachment A). The attached submission specifically address issues one, two and three as outlined in the Inquiry's Terms of Reference.

I have also attached for the Committee's information a copy of my Department's submission to the Commonwealth Grants Commission's Inquiry into Indigenous Funding (June 2000), which contains information relevant to the Committee's Inquiry. I trust this information will be useful for the Committee's examination of the needs of urban dwelling Indigenous Australians, and I look forward to receiving the Committee's final report.

With kind regards,

Yours sincerely



Dr Michael Wooldridge



- 8 NOV 2000

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Department of Health and Aged Care's Submission to the
House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs
Inquiry into the Needs of Urban Dwelling Aboriginal and Torres Strait Islander Peoples

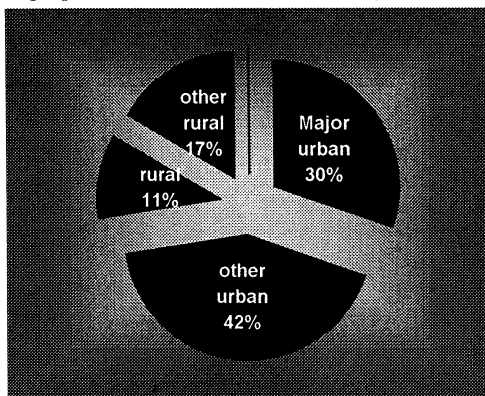
Background

The House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs Inquiry into the Needs of Urban Dwelling Aboriginal and Torres Strait Islander People Term's of Reference defines urban areas to be population centres of more than 1,000 people and includes people living in or near country areas of this size, including some towns located in remote areas.

Indigenous people are spread through all geographic areas of Australia – major urban, other-urban, rural, and other rural with the majority (nearly 72.6%) living in urban areas as defined by the Inquiry

Data extracted from the 1996 Census counted 353,000 Aboriginal and Torres Strait Islander people, representing about 2% of the Australian population. In 1996 the population distribution was:

- 30.3% of Indigenous people live in major urban areas (settlements over 100,000 persons);
- 42.3% live in other urban areas (1,000-99,999 persons);
- 10.8% in rural areas (200-999 persons);
- 16.6% in other rural (fewer than 200 persons).



As the above definition can be applied to the majority of the Aboriginal and Torres Strait Islander population, the Department has approached this submission from the position of the overall program direction as it related to Indigenous people.

The geographic spread of the population raises issues of accessibility that extend beyond geographic availability, with Indigenous populations in all geographic areas having poorer health status than the general community.

The Aboriginal and Torres Strait Islander Survey (ATSIS) conducted by the Institute of Health and Welfare in 1994, found a number of problems related to geographical accessibility to health services which, because of the high proportion of the population specifying such difficulties, obviously apply to some people living in urban and other-urban areas. Problems included :

- only one in three people had a permanent doctor within 25 kilometres;
- almost 60% had no access to a dentist within 25 kilometres of their home;
- 78% had no access to mental health services within 25 kilometres of their home;
- for more than 23% an Aboriginal medical centre was more than 100 kilometres away; and
- for over 37% a detoxification centre was more than 100 kilometres away.

These difficulties are compounded by problems with transport (many people do not own their own vehicles and public transport can be difficult to access in urban and other-urban locations), and communications ie access to telephones, faxes, Internet etc.

There are other issues (which affect all Indigenous peoples) influencing access to services including cultural and social barriers to accessing services (such as language, gender, design of health care facilities and isolation of small groups), especially mainstream services.

Department of Health and Aged Care's Submission to the
House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs
Inquiry into the Needs of Urban Dwelling Aboriginal and Torres Strait Islander Peoples

Some examples include mainstream services not employing Aboriginal health workers and under-utilisation of services by men which can be related to clinic design and the identification of clinics as places for women and children.

Geographic diversity emphasises the importance of local factors in the planning and delivery of health care services. It cannot be assumed that an initiative that is successful in one context will necessarily work in another. For example, programs designed to work in urban areas will not necessarily work in rural or remote ones and vice versa.

Primary health care services must be able to deal with the health needs of the community in terms of preventable communicable and preventable non-communicable disease and contextual issues.

Differences will exist in the delivery of an immunisation program in an urban site in Melbourne, Victoria, where the population is widely dispersed, compared to delivering it at Ngnamapa, South Australia, a remote area site but where the community is more readily accessible available infrastructure is another contextual factor that must be taken into account.

The nature of existing programs and services available to urban dwelling Indigenous Australians, including ways to more effectively deliver services considering the special needs of Aboriginal and Torres Strait Islander people

Government Approach

The Australian health system aims to provide health services for all Australians and is funded by the Commonwealth Government, the State and Territory governments and private expenditure. The health needs of Indigenous Australians are largely met through the funding and delivery of mainstream health services, with services specially targeting Aboriginal and Torres Strait Islander people complementing these mainstream services.

Broadly, the objective for the health of the Australian people is to provide equity of access to an Australian health system that promotes good health at low cost. The Portfolio's objective for the health of Aboriginal and Torres Strait Islander people is:

To raise the health status of Aboriginal and Torres Strait Islander peoples by ensuring access to effective high quality health care and population health programs.

Within the Portfolio, the Office for Aboriginal and Torres Strait Islander Health (OATSIH) has specific responsibility to meet the health needs of Aboriginal and Torres Strait Islander people, all programs have a shared responsibility for appropriate health service delivery to this health disadvantage group. This coordinated approach is based on four strategic planks. These are:

- developing the infrastructure and resources necessary to achieve comprehensive and effective health care for Indigenous Australians;

Development of the health care infrastructure requires reforms in the financing of Aboriginal health, improvements in workforce training and availability, coordinated regional planning, data systems and the accountability of services. The development of innovative service models to improve service provision, particularly in remote areas, is also required.¹

¹ Primary health care is defined at Figure 10 below.

Department of Health and Aged Care's Submission to the
House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs
Inquiry into the Needs of Urban Dwelling Aboriginal and Torres Strait Islander Peoples

- addressing some of the specific health issues and risk factors affecting the health status of Indigenous Australians;

Development of strategies to address specific health issues focusing on the major causes of excess mortality, or potential causes of excess mortality, where health care interventions can make a major impact (such as mental health, sexual health, diabetes and cardiovascular disease) as well as specific risk factors affecting poor health status in Aboriginal and Torres Strait Islander communities (such as substance misuse and poor nutrition). The Government also gives priority to diseases that contribute to the relative high level of disability within communities (such as otitis media and trachoma).

- improving the evidence base which underpins the health interventions; and

This component focuses on a more strategic approach to research, particularly research funded by the National Health and Medical Research Council (NHMRC), and to improving health data and performance measures.

- improving communication with health care services, Indigenous Australians and the general population.

The aim of this component is to inform stakeholders, the public, politicians, and the media of Indigenous health initiatives, programs and policies being progressed by the Department and by Indigenous communities. The Government will disseminate information on examples of effective, evidence based approaches to Indigenous health service delivery and health promotion activities to service providers, stakeholder groups, the academic community and Government agencies. The aim is to reduce negative media coverage, encourage positive reporting and inform attitudes to Indigenous health issues, policies, programs and initiatives.

Within the Portfolio, the OATSIH provides leadership in developing policy, and coordinating initiatives on Aboriginal and Torres Strait Islander health. It collaborates with other areas across the Portfolio to ensure that mainstream programs are responding to the particular health needs of Indigenous Australians, that there is complementarity across those initiatives, and that agencies beyond the Portfolio, including Aboriginal and Torres Strait Islander organisations and communities, are appropriately involved. So, for example, the Office works closely with the Health Access and Financing Division and the Health Insurance Commission on promoting better access to Medicare and the Pharmaceutical Benefits Scheme, and with Population Health Division on immunisation and nutrition programs.

The Office also has its major long-term strategy to improve Aboriginal and Torres Strait Islander people's access to comprehensive primary health care services. The aim is to facilitate better access to and involvement in coordinated clinical care, population health and health promotion activities to facilitate illness prevention, early intervention and effective disease management. Australian and international evidence supports this approach, showing that over time it has been demonstrated to lead to real and sustainable improvements in health status for Indigenous communities. This strategy relies on fostering close working relationships with the Aboriginal community controlled health sector, the Aboriginal and Torres Strait Islander Commission (ATSIC) and State/Territory health portfolios.

The network of Aboriginal and Torres Strait Islander primary health care services (including substance misuse services funded through the Office) complements mainstream services. Likewise, Government initiatives in relation to workforce, health financing and improving access to specialist services and care are part of the wider range of initiatives to ensure that, like

Department of Health and Aged Care's Submission to the
House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs
Inquiry into the Needs of Urban Dwelling Aboriginal and Torres Strait Islander Peoples

other Australians, Indigenous Australians have access to a comprehensive range of appropriate health services commensurate with their needs.

All programs across the Portfolio share responsibility for pursuing these strategies: Aboriginal and Torres Strait Islander people are represented within the client groups of almost all program areas.

There are a number of inter-related factors which impact on poor health among Aboriginal and Torres Strait Islander people, and its persistence. There are significant barriers for Aboriginal and Torres Strait Islander people in accessing quality health care in Australia, particularly in the primary care sector (see Figure 1). The major barriers to access are:

- *cultural and social factors* The history of dispossession and its impact on emotional and social well-being profoundly shapes the relationship between mainstream health service providers and Indigenous people. Many people, particularly from older generations, have had poor experiences with the mainstream health system, where they were made to feel unwelcome
- *locational factors* There are obvious access problems in rural and remote communities resulting from physical distance. However, this is also a factor in some urban communities – in particular those on the suburban fringes where there is poor public transport infrastructure;
- *poor linkages between health services* When primary health services do not link well with acute and/or allied health services, for example, service providers take on delivering more specialist components. This increases pressures on limited primary health care resources – these services may also be less skilled in these aspects of health care delivery;
- *the lack of a population focus* Mainstream primary health care services are structured to provide for a patient case-load that is characteristically high volume and low complexity. In contrast there is an increased proportion of Aboriginal and Torres Strait Islander people who have multiple, chronic morbidities and who require more complex management;
- *workforce issues* In general, the mainstream primary health care workforce is neither well equipped to work in a cross-cultural context, nor to deal with the complex multiple morbidities and specific illnesses, now rare in non-Indigenous Australia, that are prevalent in Indigenous communities. There are also significant problems in attracting and retaining appropriately trained and informed practitioners to work in rural and remote areas and/or to work specifically in Aboriginal and Torres Strait Islander health, regardless of location; and
- *financial barriers* Financial barriers are both income-related and structural in nature. Structural barriers encompass problems inherent in health financing systems, such as the provision of health care resources through fee-for-service systems such as the Medical Benefits Scheme.

The role played by different barriers to access varies across Australia. Nevertheless, poor access to health services is a problem for all Aboriginal and Torres Strait Islander communities, whether they are in metropolitan, other urban or rural and remote communities.

Significant improvements to access are being achieved through the Indigenous specific initiatives developed by mainstream programs including:

- *removing impediments to access to Medicare by reviewing and making changes to entitlement criteria or enrolment procedures:* eg, under section 100 of the *National Health Act*, the Minister approved arrangements whereby remote services can order pharmaceutical supplies in bulk through community pharmacies, provided that they comply with relevant state government legislation;
- *testing new ways of funding and delivering services:* eg, the Aboriginal Coordinated Care Trials are testing new ways of funding and delivering primary health care, drawing on funds

Department of Health and Aged Care's Submission to the
House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs
Inquiry into the Needs of Urban Dwelling Aboriginal and Torres Strait Islander Peoples

through both mainstream and Indigenous specific programs. The Portfolio provides a capitation payment in lieu of MBS and PBS payments, in locations where access to these sources of funding have mostly been very poor;

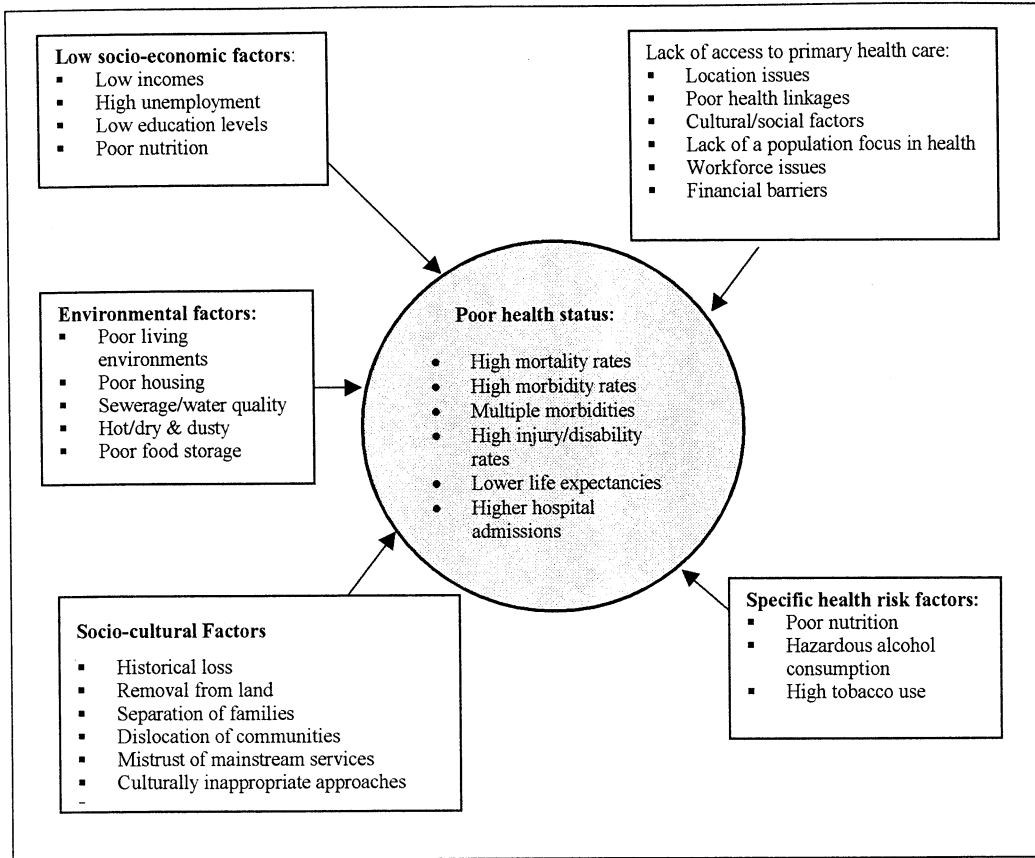
- *developing more appropriate therapeutic models*: eg, the Aboriginal and Torres Strait Islander Emotional and Social Well Being (Mental Health) Action Plan the National Mental Health Strategy, the National Illicit Drug Strategy have encouraged the development of more appropriate interventions including more appropriate therapeutic models and training in emotional and social well being;
- *targeting resources for the provision of specialist outreach services*: eg, improving access to specialist services including for surgeons, ear nose and throat specialists, eye health and renal disease;
- *developing a workforce strategy to ensure that there is a long term approach to producing and maintaining a health workforce that is highly skilled and culturally appropriate*: eg., interventions and activities to improve the availability and capacity of the Indigenous health workforce and facilitate strategies to ensure that the general health workforce is responsive to the needs of Aboriginal and Torres Strait Islander peoples;
- *maintaining community service obligation*: eg, the Australian Hearing Specialist Programs for Indigenous People;
- *improving the integration and community responsiveness of services*: eg, the Regional Health Services Program; and providing a new flexible aged care model through the Aboriginal and Torres Strait Islander Aged Care Strategy. This model provides a constant monthly income for the service to provide a mix of high, low and community services as needed by the community. These services are paid flexible funding, not paid according to the actual level of care provided, rather as a "cashed out" subsidy. The Strategy currently funds 20 operating services, with a further six services approved but not yet operating; and
- *better targeting of population health programs to ensure that the specific needs of Aboriginal and Torres Strait Islander people are taken into account by directly funding Aboriginal and Torres Strait Islander communities*: eg, in the areas of illicit drugs and chronic disease.

There are also Indigenous-specific programs, such as those managed by OATSIH, and the Aboriginal and Torres Strait Islander Aged Care Strategy, that work in conjunction with mainstream programs.

Most population health strategies also target Indigenous people with some strategies including an Indigenous specific component. There are Indigenous specific components being developed or already existing in the areas of nutrition, family planning, illicit drugs, injury prevention, immunisation and workforce development.

Department of Health and Aged Care's Submission to the
House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs
Inquiry into the Needs of Urban Dwelling Aboriginal and Torres Strait Islander Peoples

Figure 1: Factors impacting on Aboriginal and Torres Strait Islander health status



Source: Department of Health and Aged Care

The relationship between these factors is complex, and current evidence does not allow us to assess the relative importance of one factor over another. It is likely that different determinants may be major or less significant for different health problems.

Aboriginal and Torres Strait Islander people experience the lowest health status of any group within the Australian community. Life expectancies for both men and women are 15-20 years below those of other Australians whilst diseases of the circulatory system, respiratory illness, injury and cancer continue to be leading causes of death amongst Indigenous Australians.²

This general observation suggests that we need to be cautious in attributing excess morbidity or mortality among Indigenous people to any one cause. Explanatory frameworks that point to one set of factors, such as specific risk factors, to the exclusion of others, such as access to good quality health care, are unlikely to lead to effective action. To make a significant impact on

² For further details on the health status of Aboriginal and Torres Strait Islander people, see Commonwealth Department of Health and Aged Care. *Submission to the House of Representatives Standing Committee on Family and Community Affairs Inquiry into Indigenous Health*. Commonwealth Department of Health and Aged Care. Canberra, 1999.

Department of Health and Aged Care's Submission to the
House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs
Inquiry into the Needs of Urban Dwelling Aboriginal and Torres Strait Islander Peoples

health status, relevant portfolios will need to work collaboratively across all governments and with the community sector to address all factors.

There is mounting evidence that much of the illness amongst Aboriginal and Torres Strait Islander people is preventable and that better access to appropriate primary health care programs and services would assist in reducing the level of illness. For example, a recent study of hospital use for potentially preventable conditions found that age specific acute hospital separation rates for ambulatory sensitive conditions were 1.7 to 11 times higher for the Aboriginal and Torres Strait Islander populations studied.³

While the task required to improve the health status of Aboriginal and Torres Strait Islander people is considerable, progress has been made in a number of important areas. Although still unacceptably high, the infant mortality rate has improved from being 20 times higher than the non-Indigenous rate to between 3 and 5 times higher. Death rates from cardiovascular disease, lung cancer, injury and homicide amongst men have been declining since 1995. Deaths from parasitic infection and acute respiratory disease amongst children have also fallen, with improvements being reported in particular regions for specific diseases and illnesses.

Ways to extend the involvement of urban Indigenous people in decision making affecting their local communities, including partnership governance arrangements

Partnerships

Partnerships are regarded as the key to achieving improved access and improved health status: partnerships between different spheres of government, the community sector and the Aboriginal and Torres Strait Islander Commission (ATSIC).

The partnership approach and focus of effort adopted by the Portfolio recognises:

- that spheres of government are jointly responsible for responding to the needs of Aboriginal and Torres Strait Islander peoples;
- the need to work closely with the Aboriginal Community Controlled Health Services, which play a major role in providing services, providing policy and program advice and also facilitating the participation of Aboriginal Torres Strait Islander people in policy and program development and service delivery;
- that collaboration with mainstream health providers and services (both public and private) and with health professionals and educational institutions is essential;
- the importance of working with ATSIC which has responsibility for providing housing and essential infrastructure services and programs to the Indigenous community; and
- the need for collaboration between portfolios to improve health outcomes, in particular housing, education, employment and family services.

Partnership arrangements under the Aboriginal and Torres Strait Islander Health Framework Agreements were signed between the Commonwealth, State/Territory governments, ATSIC and the Aboriginal community controlled health sector between 1996 and 1999. With the exception of the Torres Strait, these Agreements expired on 30 June 2000. Following an in-principle commitment from all Australian Health ministers in August 1999 to extend the agreements for a further period, these Agreements are being re-negotiated during 2000.

³ Stamp KM, Duckett SJ, and Fisher DA 'Hospital use for potentially preventable conditions in Aboriginal and Torres Strait Islander and other Australian populations', *Australian and New Zealand Journal of Public Health*, Vol.22, No.6, 1998, pp.673-78.

Department of Health and Aged Care's Submission to the
House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs
Inquiry into the Needs of Urban Dwelling Aboriginal and Torres Strait Islander Peoples

The Portfolio believes that in order to take into account priorities and concerns of Aboriginal and Torres Strait Islander communities, health strategies require effective mechanisms for Aboriginal and Torres Strait Islander participation and need to take account of the principles of self-determination.

From a Portfolio perspective, two of the key successes of the Aboriginal and Torres Strait Islander Health Framework Agreements have been the forging of effective intersectoral links at regional and national levels and the involvement of local communities in planning and priority setting.

The partnership approach is proving successful: it has produced positive outcomes and should be further developed and built upon in the coming years. There is also a clear acknowledgment that collaboration is not easy, it requires constant effort, goodwill, flexibility and often compromise by all parties. At both the Commonwealth level and across States and Territories progress through collaboration has varied and fluctuated, as can be expected with most new approaches.

The Department is also funding a number of relevant initiatives through its Consumer Focus Strategy. It is anticipated that this Strategy will extend the involvement of urban dwelling Indigenous people in decision making affecting local Aboriginal and Torres Strait Islander communities, including partnership governance arrangements.

Literature Review on Consumer Participation, Feedback and Consumer Diversity

The Department of Health and Aged Care commissioned the National Resource Centre for Consumer Participation in Health to undertake a literature review to research information about participation in health service planning, delivery, monitoring and evaluation by previously excluded groups of consumers, and to highlight existing barriers to involvement of these groups which had been marginalised. Aboriginal and Torres Strait Island peoples were included in the study which looked at existing models of engaging indigenous people in decision making processes such as feedback about acute health services or HACC services, and advice about accessibility and appropriateness of drug and alcohol services.

The results of this project will inform the development and promotion of better methods to facilitate engagement of indigenous people in developing more appropriate mainstream services.

Consumer and Provider Partnerships in Health Project

The Consumer and Provider Partnerships in Health Project (CAPPS) was established through the Consumer Focus Strategy to fund a one-off series of small grants to local level partnerships of consumer groups and service providers to develop, demonstrate and/or document good practice in consumer participation. Three individual projects have been funded to work with Indigenous consumer groups to: develop culturally appropriate and accessible mechanisms to measure Indigenous consumers' satisfaction with services at the Alice Springs Hospital; develop an implementation plan for the training of rural and remote Aboriginal consumers to be involved in the health system of Central Australia; and an inner Melbourne Community Health Service will develop structures to maximise the access of indigenous consumers to health information and empower consumers in relation to their health. A report on the outcome of these projects is expected at the end of June 2001.

Funding

The report *Expenditures on health services for Aboriginal and Torres Strait Islander people* (the 'Deeble report') was published in May 1998. The Report sets out estimates of expenditure on health services for Aboriginal and Torres Strait Islander people, based on 1995-96 data. It

Department of Health and Aged Care's Submission to the
House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs
Inquiry into the Needs of Urban Dwelling Aboriginal and Torres Strait Islander Peoples

provided the first concrete information on amounts spent on health services for Aboriginal and Torres Strait Islander people, contradicting the widespread belief that expenditures were much higher than for the rest of the population, and quantified the inequitable low access to Medicare and the Pharmaceutical Benefits Scheme. It estimated that, in 1995-96 for all services and all sources of funds, recurrent expenditures for Aboriginal and Torres Strait Islander people, who make up about two per cent of the population, were \$853 million, or about 2.2 per cent of total health spending.

The Australian Health Ministers' Conference agreed that the report should be updated every two years. The second report will be published in December 2000.

The broad aim of the publication is to identify expenditure on Aboriginal and Torres Strait Islander health in comparison with the expenditure on the health of the rest of the Australian population for the 1998-99 year, and to comparatively analyse findings of the first and second reports. The second report will also include new sections on a regional breakdown and an expanded comparison with people of like socio economic status.

When only public funding was taken into account, expenditure on Aboriginal and Torres Strait Islander peoples was around 3 per cent. However, the higher rate of government spending did little more than compensate for a much lower rate of private spending with Aboriginal and Torres Strait Islander people on lower incomes having less capacity than the average Australian to pay for health services.

Therefore, on a per capita basis, expenditure on the health of Aboriginal and Torres Strait Islander people was almost the same as that for other Australians with the ratio of Indigenous to non-Indigenous per capita funding being about 1.08: 1 (Figure 3). This is despite Aboriginal and Torres Strait Islander people's much greater needs for health services.

While expenditure levels were about the same, there were significant differences in the source of those funds. For the population as a whole, private sources of spending accounted for about one-third of the total, whereas for the Aboriginal and Torres Strait Islander population, spending from private sources was, on average, negligible. This largely reflected relative income, with Indigenous people on lower than average incomes having less capacity to pay for health services

Aboriginal and Torres Strait Islander people therefore relied much more on government funded services than did the general population, though no more so than other Australians of like socio-economic status.

The Commonwealth and State/Territory governments contributed approximately equal amounts to the overall expenditure on Aboriginal and Torres Strait Islander health.

Commonwealth Budget measures since 1995-96 have seen spending on Indigenous specific primary health care programs increase, with funding through the Aboriginal and Torres Strait Islander Health program increasing from \$115 million in 1995-96 to \$170 million in 1999-00.

Apart from services funded through the Aboriginal and Torres Strait Islander Health program and the Aboriginal and Torres Strait Islander Aged Care Strategy, all other funding is provided through mainstream programs. Some mainstream programs include Indigenous specific initiatives aimed at improving Aboriginal and Torres Strait Islander peoples' access to mainstream services or improving the links between community controlled and mainstream services. Both mainstream and targeted programs may involve both spheres of government and may be either demand driven or provide funding in response to submissions. The Portfolio is directly involved in deciding on-the-ground distribution of only a small proportion of program funds.

Department of Health and Aged Care's Submission to the
House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs
Inquiry into the Needs of Urban Dwelling Aboriginal and Torres Strait Islander Peoples

For most programs, funding distribution largely reflects current patterns of access to benefits and services. Given the many barriers to access experienced by Aboriginal and Torres Strait Islander people, funding distribution does not necessarily represent optimal distribution across the health care system or, indeed, fully align with actual need in each of the categories.

Regional Planning

In keeping with shared responsibilities and the emphasis on working in partnerships, planning regions have been agreed through collaborative negotiations. Factors taken into consideration in deciding the regions include Aboriginal language groups, communities of interest, the geographic locations of indigenous communities, and existing mainstream health regions. In short, the regions are those that make most sense to the players involved in or affected by planning, including the Aboriginal and Torres Strait Islander people and communities affected.

Planning is intended to identify regions and communities with the greatest need for additional or improved health care services, but also to identify communities with the greatest capacity to make most effective use of additional resources. This does not mean that communities with high need, but lacking capacity, are by-passed. Rather, it will influence the nature and timing of investment in such communities. A community with limited physical infrastructure or experience in managing or delivering health care might need invest in a different mix of services and assets as compared with a community with an existing and effective health care infrastructure. Indicators of capacity, that could influence how additional resources are applied, might include:

- the availability of data to inform service development and expansion;
- expertise and experience in financial and human resource management; health service delivery; co-ordination or purchasing of services; engaging community involvement and ownership;
- clinics; staff housing; health service and financial management systems.

The factors taken into account in planning include demographics, health infrastructure, and health status. To date, the availability and usefulness of this information has varied between jurisdictions. Planning forums consider those factors for which information is available and appropriate for their local circumstances. Over time, the Portfolio envisages that regional plans will be used by both spheres of government, service providers and local communities to guide service delivery and funding decisions.

Regional plans have been completed in South Australia (November 1997), Queensland (July 1999) and Central Australia (July 1997). Regional plans continue to be developed in Western Australia, New South Wales, the top end of the Northern Territory, Victoria, Tasmania and the Australian Capital Territory, with the expectation that each jurisdiction will complete their plans during 2000.

The first comprehensive report outlining progress made in implementing the commitments made under the Framework Agreements (including regional planning) was presented to the Australian Health Minister Conference in August 1999.⁴

⁴ Commonwealth Department of Health and Aged Care, for AHMC, 1999, *Jurisdictional Reports to the Australia Health Minister Conference on Progress made Under the Aboriginal and Torres Strait Islander Framework Agreements*, August, Canberra.

Department of Health and Aged Care's Submission to the
House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs
Inquiry into the Needs of Urban Dwelling Aboriginal and Torres Strait Islander Peoples

Since 1998-99, regional planning, Service Activity Reporting data (for services funded from this program) and reviews of capital infrastructure needs, have increasingly provided data that has enabled needs-based targeting of funding.

Data

There is little data available on the health needs of Aboriginal and Torres Strait Islander peoples. A literature review of the evidence of the effectiveness of primary health care activities for Indigenous people in Australia and internationally was conducted by OATSIH as part of a study into the effectiveness of primary health care services in improving health outcomes for Aboriginal and Torres Strait Islander peoples:

- with regard to the Australian literature, it was found that all but one of the references related to studies conducted in rural/remote locations, particularly in the Northern Territory, Western Australia and South Australia; and
- this demonstrates a lack of research work into successful approaches to meet the health needs of Aboriginal and Torres Strait Islander peoples living in urban areas.

The lack of good quality data on Indigenous health and health care has been an issue for many years, and continues to constrain effective policy development, planning and program evaluation. A number of recent major reports detail the problems at length and describe the efforts to address them.⁵

Data collection issues are receiving attention from Commonwealth, State and Territory Governments, particularly through a multi-agency National Health Information Management Group sub-committee of the Australian Health Ministers Advisory Committee (AHMAC). Significant progress has been made in improving and validating births, deaths and morbidity data. The key issue of Aboriginal and Torres Strait Islander identification is being approached on a number of fronts, ranging from the addition of identification fields on records forms and data bases, training and support for data collection staff, through to audits and validation studies on hospital administrative and other data sets. A number of recent major reports detail the problems at length and describe the efforts to address them.

There are several initiatives to improve the quality or use of data.

National performance indicators and targets

The Portfolio has worked closely with state and territory governments and the community sector in developing the *National Performance Indicators and Targets for Aboriginal and Torres Strait Islander Health* that all Ministers agreed to in August 1997. Now, for the first time, there is a mechanism to annually measure progress of all governments in improving Aboriginal and Torres Strait Islander health. The 52 performance indicators cover nine areas ranging from health status measures to community involvement and social supports.

All jurisdictions have now provided two reports to AHMAC. The indicators have been refined to improve their usefulness, reliability, validity and ability to monitor data against emerging needs. Reporting will continue on an annual basis.

⁵ AIHW, *The Aboriginal and Torres Strait Islander Health Information Plan*, AIHW, 1997; Kate Ross, *Population Issues, Indigenous Australians*, ABS, 1996; ABS/AIHW, *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*, 1999; NHIMG/AIHW, *National Summary of the 1998 Jurisdictional Reports against the Aboriginal and Torres Strait Islander health performance indicators*, 2000. Aboriginal and Torres Strait Islander Health and Welfare Information Unit, *Assessing the Quality of Identification of Aboriginal and Torres Strait Islander People in Hospital Data*. AHMAC, AIHW and ABS, Canberra, 1999

Department of Health and Aged Care's Submission to the
House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs
Inquiry into the Needs of Urban Dwelling Aboriginal and Torres Strait Islander Peoples

Agreement on the set of national performance indicators has opened the way to including performance measures for Aboriginal and Torres Strait Islander peoples in mainstream health agreements. Indicators of Aboriginal and Torres Strait Islander health are included in the Australian Health Care Agreements, a subset of which is relevant to the acute care sector and will be published in an annual performance report under the Agreements. Another subset has been included in the reporting requirements of the Public Health Outcome Funding Agreements and will be published in an annual performance report.

Estimates of health expenditure

In July 1988 the Australian Health Ministers' Conference agreed that the report *Expenditures on Health Services for Aboriginal and Torres Strait Islander people* should be updated every two years. The AIHW has been contracted by the Department to produce the second report, which will be published in December 2000. The broad aim is to identify expenditure on Aboriginal and Torres Strait Islander health in comparison with the expenditure on the health of the rest of the Australian population for the 1998-99 financial year, and to compare the findings with the first report. The second report will contain more information on Indigenous private sector expenditure and improvements to the primary health care expenditure data. It will also include new sections on a regional breakdown and an expanded comparison with people of like socio-economic status.

The National Public Health Partnership, comprising all State, Territory and Commonwealth chief public health officers, has commissioned a report on expenditure on public health activity. It is intended that such a report be published regularly to assist in monitoring the level of investment in public health activities.

Service Activity Reporting

OATSIH, in partnership with the National Aboriginal Community Controlled Health Organisation, jointly conduct an annual Service Activity Reporting data collection for services funded by the Office. This combines monitoring of activity, resource needs assessment, staffing levels, and information on the Aboriginal and Torres Strait Islander population of the health service area. The National Aboriginal Community Controlled Health Organisation and the OATSIH have access to particular subsets of data arising from the collection. A specific report was also provided to each service that participated. A second collection (1998/99) is currently being returned by services for analysis.

Strategic research framework for Indigenous health

A strategic research framework for Indigenous health issues is being developed by the Research Agenda Working Group under the auspices of the National Health and Medical Research Council. This is in recognition of the historically poor links between Aboriginal and Torres Strait Islander health research funding and known health priorities. The framework is based on the need to ensure the sustainability and transferability of research in the area, and to ensure that there is an appropriate level of community participation.

Portfolio funding to improve capacity and data

The Aboriginal and Torres Strait Islander Health and Welfare Information Unit (funded jointly with AIHW and the ABS), in conjunction with the National Centre for Aboriginal and Torres Strait Islander Statistics, undertakes projects to improve identification in health system administrative data sets, for example: assessing information in hospital separation data; improving identification in vital statistics (births and deaths) collections; and developing a training package for hospital data collection staff on the importance of identification in health records.

Department of Health and Aged Care's Submission to the
House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs
Inquiry into the Needs of Urban Dwelling Aboriginal and Torres Strait Islander Peoples

To assist in improving the capacity of the community controlled sector to collect data and manage patient care, OATSIH funds the acquisition or upgrade of patient information and health planning computing applications. Around two thirds of community-controlled organisations have, or are in the process of, implementing a computerised system.

The Department of Health and Aged Care has entered into a funding partnership with the ABS to enhance the quality of the National Health Survey. Both the 2001 and 2004 surveys will be supplemented to enable the production of Aboriginal and Torres Strait Islander estimates.

Classifying remoteness and accessibility

The Department of Health and Aged Care has funded the National Key Centre for Geographical Information Systems (GISCA) to develop a measure of accessibility and remoteness for Australia. This classification, Accessibility/Remoteness Index of Australia (ARIA) has been adopted by the Department as a standard geographic classification. The index is explained in *Department of Health and Aged Care Occasional Papers: New Series No. 6*.

ARIA classifies Australia into 12 levels of remoteness, where 12 is the most remote. The 12 level index is then used to construct a 5 level classification of accessibility ranging from highly accessible (Sydney, Melbourne, etc) through to Extremely Remote (Halls Creek). ARIA will provide another useful tool when assessing relative need for resources, accessibility of services and can be useful when producing factors to allow for the additional cost structures for remote areas.

The ABS have agreed to attempt to produce estimates using the ARIA remoteness index and incorporate this measure into the Australian Standards Geographical Classification (ASGC).

Aged Care Programs

Apart from the Aboriginal and Torres Strait Islander Aged Care Strategy, all aged care funding is provided through mainstream programs. Some mainstream programs include Indigenous specific initiatives aimed at improving Aboriginal and Torres Strait Islander peoples access to mainstream services.

To ensure an equitable distribution of residential and Community Aged Care Packages, the Government has established a comprehensive planning framework which aims to provide 100 residential aged care places and Community Care Packages for every 1,000 people aged 70 years and over in each planning region. Planning statistics at the regional level take account of the age structure and health status of Aboriginal and Torres Strait Islander communities by including figures on Aboriginal and Torres Strait Islander people aged 50 – 69 years.

The Department has set itself the target of providing aged care services appropriate to the proportion of the group within the target population. Table 28 in the 1998-99 Annual Report shows that 0.72% of high care services and 0.54% of low care services went to Indigenous Australians. As Indigenous people represent 2.31% of the target group for these services this shows an under representation of Aboriginal and Torres Strait Islander people. However, 2.99% of people receiving Community Aged Care Packages were Indigenous, showing the strong preference Aboriginal and Torres Strait Islander people have for staying at home and receiving care in their community.

The Inquiry defines 'urban areas' as 'population centres of more than 1 000 people and includes people living in or near country towns of this size. Since some remote traditional communities are relatively large, the definition could also include people living in traditional ways that are associated with towns located in remote areas. The Department is not in a position to provide data on the services to Indigenous Peoples living in or near population centres of 1,000 people

Department of Health and Aged Care's Submission to the
House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs
Inquiry into the Needs of Urban Dwelling Aboriginal and Torres Strait Islander Peoples

or more. However, data on the locality of Aboriginal and Torres Strait Islander aged-care clients has been provided.

Indigenous Aged Care Places, June 2000

Locality Category	Nursing Home (High Care) Places	Hostel (Low Care) Places	Community Aged Care Packages (CACPs)	TOTAL
Capital City	200	118	78	396
Other Major Urban	30	23	40	93
Rural Areas	112	104	153	369
Remote Areas	242	172	243	657
TOTAL PLACES	584	417	514	1,515

This table includes flexibly funded places. The Aboriginal and Torres Strait Islander Flexible Aged Care Services are funded by the Commonwealth Government through the Aboriginal and Torres Strait Islander Aged Care Strategy which was launched in 1994. The flexible services introduced in the Strategy provide small services with the flexibility to respond to changing community needs. They operate mainly in regional and remote areas and currently service roughly 20 per cent of Indigenous aged care clients. The flexible services model provides the capacity for a mix of high, low and community care services. To allow the services to transfer funding between care types as needs change the funding is provided on a 'cashed-out' basis. This means that an annual level of funding is set each year and the service is able to provide any mix of care within this budget. This improves financial viability and increases annual stability.

The Aboriginal and Torres Strait Islander Aged Care Strategy (the Strategy) was developed through an interdepartmental committee to address concerns about the delivery of aged care services to Aboriginal and Torres Strait Islander People. The Strategy provided for the review of existing services and those with approvals in principle to assess whether these services could be restructured to better meet community need. It also provided for the establishment of new services in areas of high need where there was no existing service provision.

Initiatives to improve access to aged care services for Aboriginal and Torres Strait Islander people have occurred on at a State/Territory level. An example of such an initiative is the employment of a Koori Development Worker in Victoria to assist Aboriginal people to access Community Aged Care Packages. In the first 12 months of this project in metropolitan Melbourne the number of Aboriginal people accessing CACPs increase from nil to forty-three.

We currently have 31 Aboriginal and Torres Strait Islander specific mainstream nursing home / hostel facilities, which are either run by Indigenous organisations directly or which have significant management involvement from local Indigenous communities.

As a part of the planning process we have Aged Care Planning and Advisory Committees (ACPACs) in each State and Territory. These were established in 1997. The ACPACs are an essential part of the Aged Care Program's planning process and play a key role in providing advice to the Secretary of the Department of Health and Aged Care. Each ACPAC has a member who has knowledge of Aboriginal and Torres Strait Islander Aged Care.

The *Aged Care Act 1997* designates a number of groups as people with special needs. Aboriginal and Torres Strait Islander peoples are one of these groups and services specifically for this group are created each allocation round.

Department of Health and Aged Care's Submission to the
House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs
Inquiry into the Needs of Urban Dwelling Aboriginal and Torres Strait Islander Peoples

Population Health

Whilst the Population Health Division is primarily involved in developing and coordinating nationally significant programs such as immunisation, the need to target specific population groups in specific locations is increasingly being recognised. Towards this goal, a major effort is being made to increase access to relevant health information to improve local planning and evidence based decision making.

HealthWIZ is a Commonwealth funded health information and analysis tool. It contains a wide range of health and welfare data with Aboriginal and Torres Strait Islander status identification. It also provides users with metadata concerning the quality of Indigenous health statistics. Another source of Indigenous health information is the Social Health Atlas. The second edition of the Atlas provides information on regional variations in population health status and health service use of Australians by demographic characteristics including Indigenous origin for some health indicators.

Work is continuing to improve the administrative sets from which the statistics on Indigenous health are drawn for HealthWIZ and the Social Health Atlas. Available data is limited by the accuracy of identification of Indigenous people in administrative data collections, uncertainties in the estimation of the size and composition of the Aboriginal and Torres Strait Islander population, and issues around the collection of individual and household survey data.

At their February 2000 meeting the National Public Health Partnership Group (NPHPG) agreed to place Indigenous issues as a priority for the Partnership. To progress work in this area an Aboriginal and Torres Strait Islander Working Group (ATSIWG) has been established as a subcommittee of the Partnership Group. The ATSIWG, which met for the first time in Canberra on 22 September 2000, will be the national priority setting group on Aboriginal and Torres Strait Islander population health for the NPHPG and will have an interest in both the specific work program of the Partnership as well as the broader public health system.

To ensure Aboriginal and Torres Strait Islander peoples participate in decision making, the ATSIWG includes representation from the National Aboriginal Community Controlled Health Organisation (NACCHO), ATSIC and the Heads of Aboriginal Health Units (HAHU). The ATSIWG will be positioned to develop relationships with various national bodies such as the National Aboriginal and Torres Strait Islander Health Council as well as other fora, internal and external to the NPHP, which develop public health policy relevant to Aboriginal and Torres Strait Islander peoples.

Aboriginal and Torres Strait Islander peoples are a specific target group in many of the strategies and policies which guide public health priority setting and strategic directions. Increasingly, Aboriginal and Torres Strait Islander people are being involved in the development and revision of national population health strategies either through representation on national advisory committees or Indigenous specific reference groups. The National Advisory Committees to the National Cervical Screening Program and BreastScreen Australia, for example, have a member representing the needs and interests of Aboriginal and Torres Strait Islander women. This member is supported by a representative from NACCHO. Additionally, an Aboriginal and Torres Strait Islander Women's Forum has now met on two occasions to begin development of a strategic plan to address issues around barriers to Indigenous women participation in cervical screening and follow up treatment.

On 31 October and 1 November 2000, the Population Health Division will auspice a workshop to consider intersectoral approaches to improving adolescent health and wellbeing. The aim of the workshop is to examine how government departments can work in a more coordinated and

Department of Health and Aged Care's Submission to the
House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs
Inquiry into the Needs of Urban Dwelling Aboriginal and Torres Strait Islander Peoples

collaborative way in addressing the common determinants that underpin adolescent health and development; which are of interest across sectors and portfolios. Such issues include 'connectedness' to family, school and community; level of education; socioeconomic status and other social risk and protective factors. Discussions at the workshop will consider the needs of disadvantaged young people, including the needs of young Indigenous people.

The Department is attempting to move away from looking at health issues in terms of 'body parts' or single diseases and instead beginning to address risk factors, settings and/ or common themes as a way of beginning to operationalise the concept of a 'holistic' approach to health care which focuses on the maintenance of wellbeing and the early prevention of illness.

Another example of capacity enhancement for self determination in the health arena is support for the Public Health Education and Research Program (PHERP). The program is aimed at strengthening the national capacity to meet the strategic needs of public health education, training, research and policy, including supporting population health workforce development and education initiatives which focus on the needs of Indigenous Australians. The new phase of the Program will also focus on developing more opportunities for young Indigenous people to access public health education and training.