Investing in Aboriginal Community Controlled Health Makes Economic Sense
Economic Value of Aboriginal Community Controlled Health Services

Dr Katrina Alford
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“There is no national strategy for community health and there is considerable variation in the services provided across jurisdictions” (ROGS 2013: 11.3)

“Every dollar that can be redirected into primary health care services, and particularly to ACCHS, from the public hospital system is money well spent” (Close the Gap Campaign Steering Committee 2013)

“An investment in Aboriginal and Torres Strait Islander health, including to the Community Controlled sector, not only works towards curbing health disparities, but is also an investment in Aboriginal and Torres Strait Islander employment” (Royal Australian College of General Practitioners 2014)
Acknowledgement to Country:

NACCHO wishes to acknowledge the traditional owners of the land of which we are meeting on the Ngunnawal people, Elders past and present.

National Aboriginal Community Controlled Health Organisation (NACCHO)

NACCHO is the national authority on Aboriginal Comprehensive Primary Health Care representing over 150 Aboriginal Community Controlled Health Services (ACCHS) across the country on Aboriginal health and wellbeing issues. It has a history stretching back to a meeting in Albury in 1974.

An Aboriginal Community Controlled Health Service is a primary health care service initiated and operated by the local Aboriginal community to deliver holistic, comprehensive and culturally appropriate health care to the community which controls it, through a locally elected Board of Management. The first Aboriginal Community Controlled Health Services was established in Redfern in 1971 because mainstream services were not dealing adequately with the health needs of Aboriginal and Torres Strait Islander people. This problem with mainstream health services continues to the present day.

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

Definition of Aboriginal Health

Aboriginal health means “not just the physical well-being of an individual but refers to the social emotional and cultural well-being of the whole Community in which each individual is able to achieve their full potential as a human being thereby bringing about the total well-being of their Community.

It is a whole of life view and includes the cyclical concept of life-death-life.

Definition of Aboriginal Community Controlled Health Services

Defined as a Community Controlled process which allows the local Aboriginal community to be involved in its affairs in accordance with whatever protocols and procedures are determined by the Community.

The term Aboriginal Community Control has its genesis in Aboriginal peoples’ right to self-determination.

An Aboriginal Community Controlled Health Service is:

• An incorporated Aboriginal Organisation;
• Initiated by a local Aboriginal Community;
• Based in a local Aboriginal Community;
• Governed by an Aboriginal body which is elected by the local Aboriginal community;
• Delivering a holistic and cultural appropriate health service to the Community which controls it.

Definition of Indigenous Primary Health Care Service

A mainstream organisation that is funded by the Australian government to provide Aboriginal health programs to Aboriginal and Torres Strait Islander people.
Close the Gap
Most Australians enjoy one of the highest life expectancies of any country in the world. This is not true for Aboriginal and Torres Strait Islander people. Indigenous Australians can expect to live 10-17 years less than other Australians. Babies born to Aboriginal mothers die at more than twice the rate of other Australian babies, and Aboriginal and Torres Strait Islander people experience higher rates of preventable illnesses such as heart disease, kidney disease and diabetes.

The Close the Gap campaign has achieved a tremendous amount since its launch by Cathy Freeman and Ian Thorpe in 2007. These outcomes include:
• Commitment by government and all major political parties to take action through the formal signing of the Statement of Intent
• Allocation of additional health funding through COAG; and
• A stated intention to work in partnership with Indigenous health organisations and communities.

But this is just the beginning. Change will take a generation. We need sustained action from Federal and State Governments.

Justin Mohamed – Chairperson of NACCHO
Justin Mohamed is a Gooreng Gooreng man from Bundaberg in Queensland. He worked with Victorian Aboriginal communities for 20 years before being elected to his current role as Chairperson of the National Aboriginal Community Controlled Health Organisation (NACCHO). As NACCHO Chair, Justin is a strong advocate for the rights and self-determination of Aboriginal people and fights for the recognition of more than 150 Aboriginal Community Controlled Health Services as key to closing the appalling gap between Aboriginal and non-Aboriginal health outcomes.

Dr Katrina Alford - Author
Dr Katrina Alford (B.A, B.Ed, PhD University of Melbourne) is a health economist with an extensive record of reports and publications in Australian and international arenas. In the past 15 years she has worked as a health economist at the University of Melbourne Schools of Rural Health and Population Health, the Australian National University and Deakin University. Dr Alford works with a range of Aboriginal organisations at a regional and national level.

The Report acknowledges contributions from Professor Ian Ring and Adjunct Associate Professor John Goss. Professor Ring is a Professional Fellow in the Australian Health Services Research Institute at the University of Woolongong, with expertise in public health and Aboriginal and Torres Strait Islander Health. Adjunct Associate Professor John Goss of the Centre for Research and Action in Public Health at the University of Canberra was previously Principal Economist in the Expenditure and Economics Unit of the Australian Institute of Health and Welfare.
Executive Summary

Background

The Australian Bureau of Statistics (ABS, 2012) estimated that as at June 2011, 669,881 people identified as Aboriginal and Torres Strait Islander, 3% of the total Australian population. Life expectancy for Aboriginal and Torres Strait Islander people is estimated to be ten years less than the national Australian average, with high levels of disadvantage in areas such as education, employment and housing all contributing to disproportionately low health outcomes.

Aboriginal Community Controlled Health Services have up to 43 years’ experience in delivery of culturally appropriate Comprehensive Primary Health Care to Aboriginal and Torres Strait Islander people. They are the largest private employer industry of Aboriginal and Torres Strait Islander people within Australia, estimated at 5829 workers, 3,215 who are Aboriginal and Torres Strait Islander.

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

Despite increased health expenditure over the last decade, up until recently health gains have been fewer than expected. The primary health care sector that has demonstrated an ability to deliver the best results for Aboriginal Australians—Aboriginal Community Controlled Health Services, continues to be the least funded. As the Commonwealth Government prepares to announce the findings of the National Commission of Audit conducted to assess the role and scope of government expenditure leading into the Federal Budget announcements in May 2014. This Report offers an alternative analysis of the gaps, barriers that are to be addressed if NACCHO, Affiliates and ACCHS are to continue to deliver positive gains in Closing the Gap on health outcomes for Aboriginal and Torres Strait Islander Australians.
Introduction

This Report was developed for the purpose of providing an evidence-base that demonstrated the economic benefit and value that Aboriginal Community Controlled Health Services nationally provide to the Australian economy and society. NACCHO engaged an independent consultant Dr Katrina Alford to develop the report on NACCHO's behalf. This report is the first health economics detailed study of Aboriginal Community Controlled Health Services (ACCHSs) and related resource and funding issues in Australia.

The Report has a dual focus:

• Assessment and evaluation of the economic (as well as health) value derived from the ACCHS sector, and any additional cross-sector benefits including in employment, economic independence and education.

• Assessment and evaluation of government policy and expenditure on ACCHS, and on Aboriginal and Torres Strait Islander health more generally.

Methodology

The Report uses a multi-methodology approach, based on:

• Literature, reports and refereed journal articles, including Online Services Reports (OSR) on Aboriginal primary health care services, reports and data on Australian (and some international) Indigenous health, expenditure, health funding reform, population, policy and government budget papers.

• Jurisdictional and geographical area evidence (ARIA).

• Longitudinal evidence if available and relevant.

• Cross-sector evidence relating to the social determinants of health, including education and employment.

• Advice and input from relevant academic experts in Aboriginal and Torres Strait Islander health, expenditure and policy, including Professor Ian Ring and Adjunct Associate Professor John Goss.

• National Aboriginal Community Controlled Health Organisation (NACCHO) sources including interviews with NACCHO senior management, submissions to government and the NACCHO 2013 Ten Point Plan 2013-2030: investing in healthy futures for generational change.

• A conservative multiplier-based analysis of the benefits of investing in ACCHS.

• Case studies of ACCHS in different geographical areas.

• Fifteen years experience working with Aboriginal community and organisation leaders.

• The Report makes recommendations relating to the evidence and findings.

Limitations

The Report is constrained by the lack of ACCHS-specific evidence in reports on Aboriginal primary health care services.

Findings

Section 1 - Overview

1.1 Health gaps

Aboriginal and Torres Strait Islander Australians do not access health services to the level expected given their health status for two main reasons — an inadequate supply of comprehensive Aboriginal primary health care services and an inequitable share of mainstream programs — lie at the heart of the problem. Government funding distributions ignore demographic trends and health needs.

1.2 Government health policy

The Commonwealth has the main responsibility for primary health care for Aboriginal and Torres Strait Islander Australians. Transition to community control is a recognised policy objective but there is no national strategy for community health. An estimated 51% to 61% of Australia’s Aboriginal population annually visit Aboriginal primary health care and Aboriginal...
Community Controlled Health services - ACCHS. The potential for a well-resourced Aboriginal primary health care sector to directly address determinants of the health gap is substantial.

1.3 **Health outcomes (Table 2)**

Mainstream primary health care services are not working well for Aboriginal people. Continuing health system issues result in unmet health and wellbeing needs, accessing mainstream primary care and preventive health services less, later and less frequently, resulting in a higher burden of disease, avoidable mortality and poorer quality of life than for non-Aboriginal Australians.

1.4 **‘Four A’ barriers to access**

More than half of all Aboriginal avoidable deaths relate to primary prevention. Availability, Affordability, (Cultural) Acceptability and Appropriateness (to health need) barriers persist in all States, Territories and geographical areas, and major cities in particular. Relatively few ACCHS services are funded for a full range of comprehensive primary health care activities.

1.5 **Preference for Aboriginal-specific primary health care (PHC) services (Tables 9, 11, 13, 14)**

A long-standing barrier that governments refuse to meaningfully address is Cultural Acceptability. Cultural competency issues pervade the mainstream health system with little evidence of improvement. Recognition of the problem has not resulted in its resolution. ACCHS are the dominant choice of Aboriginal people in all geographical areas, despite low levels of ACCHS availability in all geographical settings. In areas with more Aboriginal primary health care services on a population basis, proportionately more Aboriginal people use them. Current utilisation (and under-utilisation) patterns are the result of a chronic shortage of community-based and controlled Aboriginal Health Services.

A pervasive assumption that mainstream health services are an acceptable substitute in urban Australia is not supported by evidence. Ignoring the strong preference for ACCHS jeopardises the precarious health of Aboriginal people resulting from deferred access to health services and under-utilisation of mainstream primary health services. The strong preference for ‘own culture,’ ‘own system,’ ‘own community control’ primary health care services is indicated by 6.3% annual increase in demand for these services, notwithstanding supply and fiscal constraints on ACCHS.

1.6 **Flawed administrative and resource allocation mechanisms (Tables 4.1, 4.2, 5, 7-10, 12)**

Too much money is being spent on hospitals. High levels of avoidable admissions and avoidable deaths primarily reflect inadequacies in the provision of primary health care. Major mainstream programs fail to deliver with lower Aboriginal per capita use despite much higher levels of need. Yet government expenditure on Indigenous primary health care continues to be directed to mainstream rather than to Indigenous-specific organisations such as ACCHS. Funding for ACCHS is not based on health need, population growth, demand for services, inflation or jurisdictional equity. These indicators suggest poor health system performance against government performance framework measures of equity, effectiveness and efficiency.

1.7 **Government funding issues (Tables 3-13)**

Despite increased health expenditure until recently, health gains over the past decade have been fewer than expected, reflecting the fact that the primary health care sector that delivers the best results for Aboriginal Australians is the least funded — Aboriginal Community Controlled Health Services (ACCHS).

Government funding lacks balance. Too much money is being spent on hospitals. Government funding issues include rationing Aboriginal health expenditure, under-utilisation of mainstream services, mainstreaming Indigenous expenditure, false economies resulting in avoidable and expensive hospital usage, sustainability and reporting issues, and failure to distribute funding equitably by a coherent, transparent, formal process.

Up to two-thirds of Aboriginal people rely on Indigenous-specific primary health care services. Yet three-quarters of all government Indigenous health expenditure is on mainstream services and nearly half (48.4%) of all expenditure is on hospitals (ROGS E 2012 Table 5.2). Maldistribution of funding adversely impacts on services and clients, in New South Wales, Tasmania and Queensland severely, and Victoria considerably.

As a rough guide, Aboriginal and Torres Strait Islander people comprise 3% of the population and, on the most conservative basis, have a relative need of at least twice that of the rest of the population because of much higher levels of illness, so ought to be receiving approximately 6% of funding for mainstream programs, a level rarely, if ever achieved.

Low levels of Indigenous primary health care funding allocations are highlighted by fact that in recent years, the relative share of Australian government funding directed towards (mainstream) primary health care has increased (AIHW 2014).
Unlike sustained growth in overall mainstream health expenditure that will continue to grow and reflect population growth, Indigenous health expenditure is projected to decline, in real terms, relative to population growth and health needs. An additional $263 million should be expended between 2013-14 and 2016-17, just to retain the 2013-14 status quo in Commonwealth expenditure on Indigenous health. This is already low. Funding ACCHS to address such system failures is a pressing priority.

Mainstreaming Aboriginal health expenditure and fiscal neglect of ACCHS may be increasing. If budget projections are implemented, ACCHS face a very lean future in fiscal terms, as they struggle to cater for a rapidly growing population with increasing demand for ACCHS services.

Reforms are urgently needed to a health funding system that does not reflect population size or growth, health needs or service preferences, demand for services or equity between jurisdictions. This is jeopardising government aims to Close the Gap.

Achievement of the Closing the Gap targets requires:

- **Strengthening rather than a diminution of funding for ACCHS.**
- **Redirecting expenditure gap in relatively lower uptake of mainstream services by Aboriginal and Torres Strait Islander people to the ACCHS sector to better meet demand.**
- **As a minimum, funding for ACCHS that is indexed for population growth, demand for services (needs index) and inflation.**
- **A formal process to provide equity in the regional distribution of funding, within and between jurisdictions, taking into account population size, variable costs of service delivery, demand for services and limited substitution by mainstream services.**
- **Regional analysis of health outcomes and service capacity to identify areas where new ACCHS are required.**

1.8 Economic costs of system failures

Poor health results in low labour force participation, unemployment, productivity losses and high rates of welfare dependence. False economies—limiting current primary health care funding — result in more expensive hospital-based services and allocative inefficiencies. Inequitable health outcomes are a drain on government budgets. In the short and medium term overall, Indigenous health expenditure needs to increase. In the longer term the potential for direct cost savings as health outcomes improve is substantial, as well as additional budget savings in areas such as welfare and the justice system.

ACCHS productivity is adversely affected by increasing consumer demand facing supply constraints. Flow-on effects of spending money on ACCHS rather than on expensive hospital-based services will reduce the negatives and increase the positives in the quality of life of Aboriginal Australians.

1.9 Transforming health outcomes with ACCHS (Tables 1, 14-18)

A hub and spoke model with 150 ACCHS across Australia and up to 300 individual clinics delivers holistic primary health care services. ACCHS are overwhelmed by demand, particularly in major cities.

1.10 Economic value of ACCHS (Table 18, Section 3)

A relatively large-scale employer of Aboriginal people and the main source of employment in many communities, ACCHS provide a channel for employment and economic growth in communities. ACCHS employment in predominantly skilled occupations increases the education and skill base of the Aboriginal workforce.

An expansion of the Aboriginal health sector could do more to promote regional development than an equal expansion of other sectors. It is a particularly cost-effective investment owing to the relatively small size of the Aboriginal population and labour market.

Depending on the size and distribution of expenditure, Aboriginal employment would increase and high unemployment rates eliminated, including among former CDEP (Community Development Employment Projects) workers.

Investing in ACCHS capacity building is a cost-effective multi-sector strategy that generates multiple benefits across sectors and communities. Strategies aimed at achieving improvements in any one area will not work in isolation. Investing in ACCHS is highly effective in meeting government policy goals and targets.
Section 2 - Aboriginal Primary Health Care Services (PHC) and Aboriginal Community Controlled Health Services (ACCHS): the evidence

Section 2 indicates stark differences between the ACCHS and mainstream primary health care models.

2.1 Data limitations

ACCHS-specific data is not available in AIHW OSR and other government reports on Aboriginal primary health care services. ACCHS-specific data recently provided to NACCHO is summarised. This Report is the first ACCHS-specific health economics study in Australia. It draws on extensive health and health economics research literature. Further research would help to fully quantify the range of economic benefits of ACCHS.

2.2–2.3 Aboriginal PHCs and ACCHS (Tables 3-5, 7-10, 12-17)

ACCHS provide a broad range of preventive, population, cultural and community health and wellbeing services, in addition to individual clinical care activities and specialist referrals. ACCHS successfully address barriers to access and the overall social determinants of health. ACCHS productivity increases to date have been substantial, with large increases in episodes of care and client contacts compared with service growth. The complexity of Aboriginal health needs and range of clinical diagnostic and treatment procedures required would not be possible in many mainstream settings.

Demand for ACCHS has increased by 6.3% annually, a much greater increase compared with alternative mainstream health service growth over the last few years. Increased reliance is being placed on ACCHS to support the primary health care needs of Aboriginal people, notwithstanding a trend towards mainstreaming Indigenous health expenditure and projected declines in per capita expenditure.

Issues include supply constraints, variations in service distribution and rapid population growth. This may constrain further productivity growth and limit the supply of medical specialists and health professionals willing to work within ACCHS physical infrastructure and human resource constraints.

ACCHS staff are relatively highly educated and skilled, many with several tertiary qualifications. Organisational pathways require tertiary education and training and many ACCHS employ local trainees. ACCHS employment adds to the skill base of the Australian Aboriginal workforce.

2.4 ACCHS workforce issues

Supply constraints, under-representation and concentration in non-clinical, lesser paid sections of the health workforce, wage gaps, overall workforce shortages and policy options including partnerships and recommended workforce targets are discussed. The ACCHS workforce is highly skilled, but it is stressed by high demand and supply constraints. Funding insecurities including short-term and pilot programs are aggravating factors.

Increasing the Aboriginal health workforce is fundamental to achieving better health outcomes. The health workforce education/training sector is patchy, uncoordinated and is the subject of several sound recommendations in the (2013) Review of Australian Government Health Workforce Programs.

2.5 Evaluating ACCHS: government general performance indicators (Appendix 1)

Health services focused on body parts and clinical specialties are unlikely to be as effective as those offering a range of primary health care services in one place.

There is strong evidence that ACCHS deliver better health services to Aboriginal people, better quality services and more appropriately, efficiently and effectively than mainstream health services for Aboriginal people. ACCHS perform well in relation to the main principles of the general performance framework used in Reports on Government Services — equity (access, outcomes), quality of services, appropriateness and effectiveness, and allocative and dynamic efficiencies.

Ineffective and inappropriate measures include governments perpetuating funding insecurity, lack of engagement with communities, racism, power inequalities and lack of community-embedded and controlled services that respond the most effectively to local needs and issues. A major influence on the poor health of Indigenous Australians is their marginal position in relation to mainstream society. International health studies indicate that creating conditions that enable people to take control of their lives improves health outcomes.
Section 3 - Case studies of Australian ACCHS

Three case studies illustrate the substantial economic and social value that ACCHS provide to local and regional communities, notwithstanding severe physical capacity constraints that hamper service delivery and limit medical specialist services in particular. ACCHS face perennial funding shortages and multiple short-term funding contracts. One large ACCHS has more than 90 funding agreements and compliance requirements, only 16% of which are recurrent grants.

Clear ACCHS preference indicators include considerable distances travelled to access ACCHS, bypassing private GPs and mainstream health services on the way. ACCHS directly address cost and transport barriers, as well as the overall social determinants of health such as employment, poverty and education, either by directly providing broader health-related services, or by facilitating access to them. ACCHS are the principal source of Aboriginal employment in many communities.

Recommendations

If the Closing the Gap goals are to be achieved, NACCHO recommends that funding for ACCHS be placed on a much more rational and transparent basis as follows:

1 Funding security
A broad spectrum of medical and health organisations strongly recommend that closing the gap programs and related services are quarantined from budget cuts across all federal, state and territory jurisdictions (RACGP 2014; CtGSC 2014, 2013; Russell 2013; RACP 2012).

2 Indexation of funding for ACCHS in line with standard government procedures
As a minimum, funding for ACCHS should be indexed for inflation, population growth and service demand.

3 Inventory and identification of areas with inadequate levels of service provision
An inventory of service gaps, needs and capacity building plan is needed. An area-based analysis of output and outcome indicators and service provision is required to identify areas where additional or enhanced ACCHS services are required.

4 Capital works program
New services in areas of high demand, notably major cities, and inner regional areas to a lesser extent. For both maintenance and new infrastructure based on an inventory of current problems and future needs. The capital program should have an explicit aim of training and employing Aboriginal staff for the construction work.

5 Redress anomalies
Funding for mainstream services continues to increase in line with population growth and size, but funding for ACCHS services for the section of the population with the greatest need has been cut and will be further reduced in real terms, despite outperforming mainstream services.

Adequate funding is required to redress reduced funding in 2012-13 from the previous year.

6 Address geographic inequities in funding
A more transparent mechanism for deciding spending for ACCHS within and between jurisdictions is required - based on population size, need, remoteness and partial offsetting by mainstream services, with a phased scheme to increase funding for areas receiving less than their appropriate share.

7 Address system failure in mainstream programs
New administrative mechanisms are required to address system failure in mainstream health programs:

i) The appropriate share of funding for each program that Aboriginal and Torres Strait Islander people should receive should be determined based on population size and level of need.

ii) New mechanisms introduced to address market failure by allocating funding to raise expenditure on Aboriginal and Torres Strait Islander people to the same level as any other section of the population of equivalent size and need.

iii) Allocate funding to whichever health service provides the best return on investment - with the default assumptions being
a) Aboriginal and Torres Strait Islander people comprise 3% of the population and have a needs index of at least 2, then as a rough guide 6% of mainstream health expenditure ought to be directed towards Aboriginal and Torres Strait Islander people.

b) ACCHS outperform mainstream services and would generally be the preferred provider.

c) Subcontracting funds to Medicare Locals through National Partnership Agreements should be redirected to ACCHS to maximise returns on investments in Indigenous health.

8 Preferred provider status

ACCHS endorsement by government as the preferred provider of health services to Aboriginal and Torres Strait Islander communities (CtGSC 2014).

9 Key Performance Indicators for mainstream services

Incorporate Key Performance Indicators for culturally competent health services into accreditation processes or funding/reporting requirements (Royal Australasian College of Physicians 2012).

10 Aboriginal health workforce

(i) Develop an Aboriginal Employment Strategy for the ACCHS sector.

(ii) Consideration of explicit Aboriginal employment targets for government programs that deliver goods, environmental or personal services (Mason 2013; Hunt 2013; Gray et. al. 2012).

(iii) Consideration of recommendations of Review of Australian Government Health Workforce Programs regarding Aboriginal health workforce resources (Mason 2013).

11 Data and information ACCHS

Recommendations:

(i) A joint NACCHO/AIHW annual Report Card, containing quantitative data on population estimates by jurisdiction and geographical area, performance, service capacity in relation to need, expenditure, clients, episodes of care, client contacts, staff, workforce needs, education and training gaps and information needed to maintain good governance.

(ii) Provision of ACCHS-specific data in AIHW and ROGS Reports on Government Services.

(iii) Improvements to current ASGC-RA rural classification system (Mason 2013 recommendations 4.20, 6.7).
Section 3 - Case studies of Australian ACCHS

Case studies of three ACCHS in different geographical areas across Australia illustrate the broad range of health-related services provided that extend well beyond individual clinical health care. ACCHS deal effectively with complex health needs in a culturally safe and trusted environment, notwithstanding funding and capacity constraints and workforce shortages. The contribution of ACCHS to regional Aboriginal employment and economic independence is substantial.

Information about the ARIA (i) (Accessibility/Remoteness Index of Australia) classifications and service size (ii) of each ACCHS is included.

The case studies are

- Winnunga Nimmityjah Aboriginal Health Service
  Narrabundah CANBERRA ACT | Major cities | ARIA 1
- Rumbalara Medical Centre
  Shepparton/Mooroopna VICTORIA | Inner regional | ARIA 2
- Mulungu Aboriginal Corporation Medical Centre
  Mareeba QUEENSLAND | Outer regional | ARIA 3

(i) ARIA — Accessibility/Remoteness Index of Australia (AIHW 2004)

The ARIA classification provides a better measure of remoteness of an area than other classifications. The ARIA index score is based on road distance from the closest service centres in each class. Road distance is a surrogate for remoteness and the population size of a service centre a surrogate for availability of services. The classes are as follows:

1. **Major cities - highly accessible** — relatively unrestricted accessibility to a wide range of goods and services and opportunities for social interaction.
2. **Inner regional - accessible** — some restrictions to accessibility of some goods and services and opportunities for social interaction.
3. **Outer regional - moderately accessible** — significantly restricted accessibility of goods and services and opportunities for social interaction.
4. **Remote** — very restricted accessibility of goods, services and opportunities for social interaction.
5. **Very Remote** — very little accessibility of goods, services and opportunities for social interaction.

(ii) Service size

QAIHC (Queensland Aboriginal and Islander Health Council measures service size by the number of regular patients. Small is less than 500, medium is 500-1,500 and large is > 1,500 (QAIHC 2013:12).
Winnunga Nimmityjah Aboriginal Health Service
Narrabundah  Canberra ACT

ARIA 1
Major cities
Highly Accessible—relatively unrestricted accessibility to a wide range of goods and services and opportunities for social interaction

Catchment area, population and socio-economic profile
The 5,185 Aboriginal and Torres Strait Islanders in the ACT represent 1.5% all ACT residents (2011 census). Aboriginal population growth of 6.8% annually has been faster than in any other jurisdiction over the last five years and the rate is increasing (ABS census 2011, 2006). In general, Aboriginal people’s level of education, labour force participation and employment is higher in Canberra than in other jurisdictions but remains substantially lower than that of non-Aboriginal ACT people. 9.6% of Canberra’s Aboriginal workforce is unemployed (17.2% Australia; census 2011; ACT 2013).

Recent media reports highlight Aboriginal homelessness as a big issue in Canberra, having increased by 33% annually over the past five years. 57% of Aboriginal households rent rather than own their own home (30% for non-Aboriginal households). Along with other social determinants of health, the housing crisis may partly account for the comparatively poor health status of Aboriginal people in Canberra. 46% of Canberra’s Aboriginal population has three or more long-term health conditions, compared with 33% for Aboriginal Australians on average. 11.5% have chronic illnesses compared with 10.7% of the Australian Aboriginal population (ABS 2013;7; ACT 2013; Cox 2013).

Aboriginal and Torres Strait Islander Canberrans access health services less frequently than those in most other jurisdictions. There is high demand for Winnunga services. Aboriginal people from neighbouring New South Wales use ACT services and programs (ACT 2013).

Winnunga Nimmityjah Aboriginal Health Service

Winnunga Nimmityjah Aboriginal Health Service is located in Narrabundah, an eastern suburb of Canberra. Winnunga started 25 years ago as a single room in central Canberra, and has gradually expanded to the comprehensive primary health care service it is today.

Weekday services are provided on weekdays and afterhours services twice a week from 2013 due to “continuing requests from our clients who work fulltime and would like a culturally appropriate primary health care service to be available to them” (Annual Report 2012-13).

Winnunga offers a range of clinical services including general practitioners, practice nurses, midwives, a child health nurse, dentists, psychiatrists, drug and alcohol workers, a psychologist, pharmacist, physiotherapist, dietician, podiatrist, and a range of visiting specialists. An extensive Social Health Team provides counselling, advocacy, social and emotional wellbeing support and health education. Winnunga runs a diabetes clinic, a smoking cessation program, a parenting group, men’s and women’s groups and healthy cooking groups. There is also a needle and syringe exchange program, an opiate nurse, a youth diversion program, a home maintenance program and prison outreach. Transport is provided for Winnunga clients as required. Australian National University (ANU) medical students are placed at Winnunga for both clinical and research components of their curriculum. Hospital resident medical officers rotate on placements to Winnunga and training for GP registrars is ongoing. Winnunga is both AGPAL and QIC accredited. Winnunga is the peak Aboriginal health body in the ACT and provides advocacy at local, ACT and national levels.

Winnunga clients
In the 15 months to February 2014 82% (3,372) of 4,199 clients who visited Winnunga were Aboriginal and/or Torres Strait Islander. Winnunga provides the majority (87%) of Aboriginal and Torres Strait Islander health checks in the ACT (Figure) and provided 37,913 client contacts in 2012-2013, excluding transport (Annual Report 2012-13). There are 84 general practices in Canberra. It is clear that many Aboriginal Canberrans bypass several mainstream GP services on route to Winnunga.

Winnunga sees around 4,000 clients a year, with 22% of clients coming from outside the ACT. A large proportion of non-ACT
clients come from neighbouring Queanbeyan in New South Wales (NSW), which had an Aboriginal and Torres Strait Islander population of 1,137 in the 2011 census. Funding for Winnunga does not take the NSW population into account.

During the census year of 2011, Winnunga saw 44% of the ACT resident Aboriginal and Torres Strait Islander population (Annual Report 2012-13). Over the two-year period from July 2010 to June 2012, 56% of the ACT resident Aboriginal and Torres Strait Islander population visited Winnunga. The Winnunga client population is young, with 28% aged less than 15 years and only 2% aged 70 years or older.

**Health profile**

The types of health conditions seen by Winnunga differ from mainstream general practice, reflecting complex health care needs. They align more with national Aboriginal health statistics than those for urban non-Aboriginal Australians (Flegg et al. 2010).

**Staff (June 2013)**

62% of Winnunga 48.49 FTE staff at June 2013 were Aboriginal or Torres Strait Islander. A further 3.42 FTE staff were externally funded. Proportionately more Aboriginal staff were in non-clinical (68%) than clinical (54%) occupations.

**Winnunga FTE employment**

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<tr>
<td>Dentist/therapist</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Dental support</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Medical specialist</td>
<td>0</td>
<td>1.55</td>
<td>1.55</td>
<td>0.8</td>
</tr>
<tr>
<td>All allied health</td>
<td>0</td>
<td>0.74</td>
<td>0.74</td>
<td>0.82 (ii)</td>
</tr>
<tr>
<td>All SEWB</td>
<td>4</td>
<td>0</td>
<td>4 (iii)</td>
<td></td>
</tr>
<tr>
<td>D &amp; A, tobacco staff</td>
<td>4</td>
<td>0</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Other health worker</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Training position</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Home maintenance worker</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Total staff</td>
<td>29.93</td>
<td>18.56</td>
<td>48.49</td>
<td>3.42</td>
</tr>
</tbody>
</table>

(i) Externally funded staff.

(ii) Allied health staff include a pharmacist, physiotherapist, hearing, nutrition & diabetes staff

(iii) SEWB staff include a Link Up caseworker, counsellor and psychologist.
Economic and social value

- Employment and wages/salaries: Winnunga provides employment for thirty Aboriginal people and over 60 local jobs in total, with wages/salaries of $4.4 million annually.

- Revenue: Total income is $7,763,217. 73% is from governments, 3% non-government grants, 17% from Medicare and the balance (7%) from other sources.

Capacity constraints

Winnunga has grossly inadequate clinical space to house expanding services, resulting at times in inability to perform health checks or procedures such as pap smears without compromising patient privacy. Physical capacity is so strained that four nurses use one clinical room and Winnunga is unable to expand on-site specialist medical services due to lack of space. A priority for 2013-14 is opening a satellite service on the north side of ACT.

Winnunga summary

Winnunga is a large comprehensive primary health care service provider that caters for more than half of the region’s Aboriginal and Torres Strait Islander population and conducts nearly 90% of Aboriginal health checks in the ACT. It deals effectively with complex health needs in a culturally safe and trusted environment (Wong et. al. 2011; Flegg et. al. 2010). Severe physical capacity constraints hamper service delivery and limit medical specialist services in particular. There is a case for a satellite clinic of Winnunga in north Canberra, based on rapid Aboriginal population growth and health needs.

Rumbalara Medical Centre and Rumbalara Aboriginal Co-operative, Shepparton/Mooroopna VICTORIA

ARIA 2

Inner regional - accessible some restrictions to accessibility of some goods and services and opportunities for social interaction

Population
The Aboriginal population of 2,082 in Greater Shepparton is the largest Aboriginal community in Victoria outside metropolitan Melbourne, accounts for 3.5% of the area’s population and is growing rapidly (2011 census). Anecdotal evidence suggests the population could be as high as 6,000 people.

Socio-economic profile
Shepparton is the most socio-economically disadvantaged region in Victoria and among the most disadvantaged in Australia. Year 12 completion rates of 19% are low compared with 36% for non-Aboriginal people and 25% for the Australian Aboriginal population. Non-school qualifications are low at 17%, compared with 23% for local non-Aboriginal people. Aboriginal unemployment rates of 21% are nearly four times those of non-Aboriginal people and labour force participation rates are low (49%; census 2011). Aboriginal home ownership rates are low and waiting lists for public housing long. Homelessness is a big issue in the region, particularly for Aboriginal people. The Aboriginal housing waiting list is 2-4 years and state housing list about 15 years for priority clients.

Rumbalara services
Rumbalara is a large primary health care service open on weekdays, with both a medical and dental clinic and outreach services. Medical Clinic services include management of chronic diseases, antenatal, maternal and infant health care, a strong SEWB team including Link Up, Bringing Them Home, trauma counseling, traditional healing and outreach services, drug, alcohol and rehabilitation assessments and programs, seven different allied health services, health promotion programs and group and community health promotion activities.

Both medical and dental clinics ensure access to primary health care by addressing cost and transport barriers. Both services bulk-bill. Gym passes are given to over 100 clients wanting and needing a formal exercise program, which costs about $15,000 a year. Over 7,000 transport services were provided in 2012-13, 102 of these to specialist services in Melbourne, a 400km round trip.

The Clinics are part of the Rumbalara Aboriginal Co-operative, which provides a range of health-related service and support programs. These include a breakfast program, family services, a men's group and women's group, Elders lunches, the Rumbalara aged care facility, rental housing and home ownership programs and homelessness assistance. The Co-operative responds to individual and community issues and advocates on their behalf when needed. The Co-operative has strong links with the justice system and mentors and supports offenders and families, liaises with the Koori Court in Shepparton and operates a well-used Night Patrol that provided 700 trips in 2012-13 (84% for young people). The Cooperative also has strong links with the Academy of Sport Health and Education (ASHE), an Aboriginal TAFE academy in Shepparton that has good outcomes in education/training.

Clients (2012-2013)
The Medical Clinic has 3,446 annual regular clients and 6,338 additional non-regular clients (one visit in past two years). The Dental Clinic has 1,359 clients annually. The total number at both Clinics is 4,825 regular clients. 88% (4,236) of regular clients are Aboriginal. The Clinic serves virtually all of the local Aboriginal population as well as communities well outside the area. North-east Victoria and southern New South Wales are not well-served by ACCHS. Many clients travel up to two hours, some over 100km and a few more than five hours from southern New South Wales to access Rumbalara. There are alternative mainstream primary health care services available but the community preference is extremely strong for the Rumbalara ACCHS and negligible for mainstream services. These are not viewed as culturally acceptable.

There were 18,125 visits to the Medical Clinic with 25,097 episodes of care in 2012-12. The Dental Clinic had 3,341 visits and provided 8,331 episodes of care. The majority of clients are extremely disadvantaged and vulnerable.
Health profile

The community faces a number of health-related issues including school disengagement, increasing use of the lethal drug, ice, unemployment and racism. Trauma rates are high and many Elders have childhood recollections of walking off the Cummeragunga mission on the New South Wales side of the Murray River in protest at conditions, and having family members taken away. Rumbalara SEWB team and mental health services are vital to the community.

Staff (2012-13)

98 of 195 Rumbalara Co-operative staff work in the Medical Clinic, 28 in administration and 70 in health. 34 Clinic staff and 78% of all staff are Aboriginal, with a lower proportion in clinical areas. Cultural orientation for non-Aboriginal and Torres Strait Islander staff is provided.

FTE employment

<table>
<thead>
<tr>
<th>Occupation/function</th>
<th>ATSI</th>
<th>non-ATSI</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>CEO</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Managers, supervisors</td>
<td>19</td>
<td>6</td>
<td>25</td>
</tr>
<tr>
<td>Admin/clerical</td>
<td>28</td>
<td>9</td>
<td>37</td>
</tr>
<tr>
<td>AHW</td>
<td>6</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>GP</td>
<td>5</td>
<td>5</td>
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</tr>
<tr>
<td>Nurse</td>
<td>15</td>
<td>6</td>
<td>21</td>
</tr>
<tr>
<td>Dentist</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Dental assistant</td>
<td>4</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Aged care worker</td>
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<td>12</td>
<td>12</td>
</tr>
<tr>
<td>Personal care worker</td>
<td>17</td>
<td>3</td>
<td>20</td>
</tr>
<tr>
<td>Support worker</td>
<td>32</td>
<td>6</td>
<td>38</td>
</tr>
<tr>
<td>Other</td>
<td>19</td>
<td>19</td>
<td>19</td>
</tr>
<tr>
<td>Total</td>
<td>153</td>
<td>42</td>
<td>195</td>
</tr>
</tbody>
</table>

A further 1.55 FTE externally funded health visitors work at the Medical Clinic, including medical specialists, nurses, midwives and allied health professionals.

Partnerships

Rumbalara values partnerships with regional health and other organisations including the Goulburn Valley Primary Care Partnership and Goulburn Valley hospital.

Economic and social value

Education/training: Staff all have at least baseline tertiary Certificate 111 level qualifications. Several staff are continuing education and study, including in nursing and aged care. Rumbalara offers local work experience placements and is a site for medical, nursing and allied health student training.

Employment and wages/salaries: Rumbalara Aboriginal Co-operative provides employment for 195 people, including 98 in health. 153 employees are Aboriginal. This accounts for 31% of all Aboriginal employment in the Shepparton area. Wages/salaries in the Clinic are $4.9 million.

Revenue: The Medical Clinic budget is about $5 million annually. It receives about $4 million grants annually of which about 20% are from the State Government. Overall Co-operative annual revenue is about $9.1 million.
Capacity constraints

- Perennial funding shortages, more than 90 funding agreements and compliance requirements, only 16% of which are recurrent grants. Onerous reporting requirements are a drain on staff.
- Specific service gaps lacking funding are youth services, and alcohol, tobacco and other drugs treatment. Rehabilitation services are negligible in the area with clients waiting up to two months for a bed to become available.
- Rumbalara wants to take on more local trainees in health but is constrained by lack of staff supervision time and funding.
- Workforce issues are perennial, including lack of nurses and attracting and retaining Aboriginal staff. Overall staffing levels are strained by high service demands, with limited replacement staff for staff on sick leave and training. Retention is an issue for all staff, particularly Aboriginal staff who have strong cultural skills and relevant qualifications but lower wages than mainstream service staff.

Rumbalara summary

Rumbalara is a vital community hub. It provides a broad range of health-related services that extend well beyond individual clinical health care. Client care workloads are heavy, with additional strains on administrative staff from demanding reporting requirements to multiple funders. Rumbalara’s contribution to regional Aboriginal employment and economic independence is substantial.

Sources: Rumbalara report to NACCHO 2014; Rumbalara OSR report to Department of Health 2012-13; Rumbalara Aboriginal Co-operative Annual Report 2012-13; ABS census 2011.
Mulungu Aboriginal Corporation Medical Centre
Mareeba, QUEENSLAND

Catchment area
The Shire of Mareeba (LGA) is a rural area of 53,610.8 square kilometres located at the base of Cape York Peninsula in far north Queensland, about 60km inland from the city of Cairns.

Population and socio-economic profile
Aboriginal people in Mareeba Shire represent about 13% (1,349 in 2011) of the population of about 10,583 people (2011 census). The area is relatively disadvantaged in socio-economic terms. Three-quarters of Mulungu Centre’s clients are on a pension.

Compared with the non-Aboriginal population in the area, Aboriginal unemployment rates are high (32%, compared with 5% for the total local population) and labour force participation rates low (41%, compared with 60%). Average education levels are low. 19% have completed Year 12 (compared with 37%). 18% have non-school qualifications, compared with 34% of the local population and 25% for Aboriginal Australians on average (2011 census).

Mulungu Aboriginal Corporation Medical Centre services
Mulungu is is a large service provider, open on weekdays with home visits available. Mulungu’s primary health care approach is holistic, strongly community-focused and responsive to local needs. These include disengagement of young people from school and risk-taking behaviours.

Mulungu has an inter-disciplinary team approach, including GPs, a practice nurse, AHWs, a wellbeing team for health checks and chronic disease care, a Numoo Bubi team (Mums and bubs) for child and antenatal health, and a SEWB team including a Bringing them Home counsellor. Mulungu also provides outreach medical care with GPs and AHWs to a local correctional facility two days a week, and to a nearby residential alcohol rehabilitation facility one day a week.

Cost and transport barriers are directly addressed. Mulungu bulk-bills. It provides transport for patients to the Centre, and further afield for specialist appointments including a regular service for dialysis three days a week in Atherton. Mulungu provided 4,857 transport services in 2012-13, including 1,810 external trips.

Service gaps include “a lack of health promotion campaigns specific for the local community. “A whole of systems approach for promoting wellness and preventing illness is required” (Manager).

Mulungu clients
Nearly 90% (1,847 people) of the Centre’s annual 2,069 clients are Aboriginal, and nearly all local Aboriginal people access Mulungu, as well as communities outside Mareeba. 76% of Aboriginal clients are on a pension. Over 90% visited the Centre over the last twelve months. Many travel considerable distance to access the Centre, some up to one and a half hours by car. Several mainstream GP clinics are bypassed on the way. These measures indicate the community’s preference for ACCHS.
Health profile

Over 60% of Aboriginal clients have chronic diseases and multiple morbidities. Mental health conditions are 2.5 times higher than the national benchmark, diabetes 4.7 times and renal impairments nearly 17 times higher.

Staff

72% of 41.8 FTE staff are Aboriginal.

<table>
<thead>
<tr>
<th>Mulungu staff - FTE June 2013</th>
<th>ATSI</th>
<th>Non-ATSI</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>CEO</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Manager</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Admin/clerical</td>
<td>5</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>Driver</td>
<td>3</td>
<td></td>
<td>3</td>
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<tr>
<td>AHW</td>
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<tr>
<td>GP</td>
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<td>5.4</td>
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<tr>
<td>Nurse</td>
<td>1</td>
<td></td>
<td>1</td>
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<tr>
<td>Allied health professional (4 areas)</td>
<td>2.9</td>
<td></td>
<td>2.9</td>
</tr>
<tr>
<td>SEWB counsellor</td>
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<td></td>
<td>2</td>
</tr>
<tr>
<td>Health promote/prevention</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Program staff (PACE, CFC, MYA)</td>
<td>11</td>
<td>2.5</td>
<td>13.5</td>
</tr>
<tr>
<td>TOTAL</td>
<td>30</td>
<td>11.8</td>
<td>41.8</td>
</tr>
</tbody>
</table>

Note: medical specialists are not included.

Effective partnerships enable comprehensive primary health care

• Mulungu enables affordable dentistry, through partnership with a local dentist and copayment (with Medicare) of set fees.

• Mulungu is one of eighty agencies represented in the “Collaboration for Indigenous Outcomes in Mareeba” group that meets quarterly to ensure accountability and link initiatives in education, employment, health and justice systems to assist Aboriginal people in the local area.

• Mulungu regards education as critical to improving community health. It operates a federally government-funded PACE (Parents and Community Engagement) team and a state-funded CFC (Child and Family Centre). These link health with education and employment. Mulungu auspices a community men’s group, and recently had a Mareeba Young and Awesome (MYA) program for children who were disengaged from schools and in the justice system.

Economic and social value

• Community functioning: “Mulungu prides itself on tailoring service delivery to the needs of the community” (Mulungu management). Community engagement is strong through various means including Mulungu providing $43,000 in education or sporting vouchers to local families as incentives for keeping their family healthy.

• Employment: all Aboriginal and Torres Strait Islander employees come from the local community. Aboriginal employment at Mulungu accounts for more than 12% of all Aboriginal employment in the area.

• Wages/salaries: Combined wages, salaries and employee payments are $2.6 million (2012-13).

• Revenue: $5.62 million annually — including grants from twelve separate mainly government sources (largest is DoHA $3.4m).

• Capital: property, plant, equipment $5.5 million, land/buildings $4.2 million. Total $9.7 million.
Mulungu summary

Mulungu is a large ACCHS that caters for virtually the entire Aboriginal population in the area and contributes significantly to regional Aboriginal employment. The Centre clearly enhances community wellbeing in directly addressing local issues of school disengagement, crime and alcohol and drug use, based on the unique ACCHS model of primary health care: “Mulungu is quite different from a private GP or hospital, and looks at issues more from a community development approach” (Manager).

“Mulungu has a desire to grow local...leaders to assist with the development of the local Indigenous community and community in general. By increasing the skills and knowledge of people from local Indigenous families, those same people are able to take their skills and knowledge back to their families. This empowerment approach has far reaching consequences, beyond just those people employed at Mulungu” (Manager).