NATIONAL ABORIGINAL COMMUNITY CONTROLLED HEALTH ORGANISATION (NACCHO)

SUBMISSION

TO THE

SENATE SELECT COMMITTEE

ON THE

ADMINISTRATION OF INDIGENOUS AFFAIRS

August 2004

NACCHO is the national peak body in Aboriginal health, representing 130 Aboriginal Community Controlled Health Services throughout Australia.

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EXECUTIVE SUMMARY

The Federal Government has recommended new arrangements in Aboriginal and Torres Strait Islander Affairs. In response, the National Aboriginal Community Controlled Health Organisation (NACCHO) provides this submission expressing our concerns regarding these arrangements (See Appendix 1 for an overview of NACCHO).

While it is noted that ATSIC had its failings, there was not, as the recent ATSIC review clearly articulated, the need to dismantle the organisation. ATSIC has always been seen to be a convenient scapegoat for inaction and the failure of Governments, as best explained in the Evaluation of the National Aboriginal Health Strategy (NAHS) which was never effectively implemented.[1]

Given the range of social determinants that impact on health, spiritual, social, emotional and environmental well-being, neither ATSIC, nor the ACCHS can be held responsible for the continued disparity of health and well-being status between Aboriginal people and other Australians. It is a shared responsibility between all Australians - Government and non-government - which requires long term commitment and resources commensurate with need.

It is widely known and acknowledged that Aboriginal people are the most disadvantaged population group in Australia. The Aboriginal and Torres Strait Islander Commission Amendment Bill 2004 abolishes ATSIC and ATSIS. To dismantle the national body without due planning, consideration, consultation and negotiation with Aboriginal people leaves NACCHO totally dismayed.

What we need is a nationally elected Aboriginal self determining organisation that will fully discharge the widest range of functions efficiently and transparently for the benefit of Aboriginal people.

The right to self determining structures is clearly supported and articulated by a number of United Nations international treaties, the most recent being the *United Nations Draft Declaration on the Rights of Indigenous Peoples.*[2]

In the health sector, structures are already in place for 'whole of government' approaches to improve Aboriginal peoples health (see Appendix 2) and require strengthening, not dismantling. Aboriginal health policy development and its implementation at the coalface has been intersectoral and comprehensive for decades. Indeed the National Aboriginal Health Strategy (1989) recommended the need for a whole of government approach. Moreover, the current structures need to ensure and support effective Aboriginal community representation at all operational levels.

NACCHO reminds the Select Committee that the ACCHS sector already has extensive mainstream program and service linkages. These linkages are of critical importance and need to be expanded. Efforts to expand mainstream program responsibility to Aboriginal peoples are multiple and range from enhancing the responsiveness of national public health strategies to Aboriginal peoples to enhancing the accessibility of Aboriginal people to the Pharmaceutical Benefits Scheme, Medical Benefits Scheme and Commonwealth Hearing Services Program to name a few.

NACCHO is concerned that the proposed new arrangements may in fact create the opposite effect. Mainstream health programs may have reduced accountability for programs to target Aboriginal peoples. Mainstream programs already have a tendency to ignore Indigenous Australians and to cost-shift program outputs onto capped, *small-scale and supplementary* Indigenous-specific programs.

Failure to engage the Aboriginal and Torres Strait Islander population and organisational representatives from the beginning and right throughout the policy process risks the development of inappropriately targeted and conceived policy and at worst, it may lead to efforts which are inappropriate, unhelpful, and unsustainable for the population concerned.

SUMMARY OF RECOMMENDATIONS

NACCHO recommends:

1. That the Senate Select Committee call for the establishment of a nationally elected Aboriginal self-determining organisation, based on the principal preconditions as highlighted in Section 3 of this submission.

2. That the Select Committee consider the adverse implications that the ATSIC Amendment Bill will have to the health sector and the viability of the Aboriginal Health Framework Agreements. NACCHO objects to the proposed reform without proper negotiation and consultation with Aboriginal and Torres Strait Islander peoples.

3. That the Commonwealth Governments Aboriginal health portfolio remain the responsibility of the Australian Department of Health and Aging and the Federal Minister for Health, and the Federal Minister for Aging.

4. The Select Committee recognise that honouring existing agreements and processes by building on the capacity of existing Framework Agreement partnership arrangements is a priority, rather than creating new structures.

5. Further work to determine the most effective mechanisms for coordination of service delivery at regional levels noting that Aboriginal health partnerships are functioning very well in a number of jurisdictions.

6. The Select Committee to recommend the determination of the most effective mechanisms to ensure that elected representatives are members of the National Indigenous Advisory Council and drawn from the widest possible Aboriginal electorate and that they reflect the diversity of Aboriginal cultures and language groups.

7. The proposed National Indigenous Advisory Council draw its membership from organisations such as NACCHO, which are able to provide a representative and accountable Aboriginal voice.

8. The ATSIC representative on the NHMRC be replaced with a NACCHO representative.

9. The Senate Select Committee further investigate the proposed amendments which provide the Office of Audit and Evaluation additional powers.

1. BACKGROUND

The Government's decision to abolish the Aboriginal and Torres Strait Islander Commission appears to be based on a number of arguments or assertions and broadly they are:

(i) that ATSIC failed to properly serve the interests of Aboriginal people

(ii) that Aboriginal people were dissatisfied with the performance of ATSIC and desired substantial change or reform

(iii) that ATSIC 's deficiencies suggest that Aboriginal self determination is currently an ineffective mechanism in the administration of Aboriginal Affairs; as a corollary, government bureaucracies should be given charge of ATSIC's former portfolio interests.

(iv) that the absence of a nationally elected Aboriginal self determining multi portfolio organisation is permissible under Australian law

It is noted that there is some measure of bipartisan support for these arguments although the Australian Labor Party does not appear to have retreated from its commitment to Aboriginal self determination. The Australian Democrats and the Greens appear to be sceptical of the rationale on which the abolition of ATSIC has been based.

2. A NEW NATIONAL SELF DETERMINING ABORIGINAL ORGANISATION

In brief, we concur that many Aboriginal people were deeply concerned about ATSIC's performance and that there were compelling reasons for change. It is the form of that change that we dispute. Firstly, whatever ATSIC's failings may have been, there is no logical foundation for its abolition and replacement with non self determining structures.

As a clear matter of process governed by our rights, since ATSIC was an Aboriginal self determining structure, it should have been Aboriginal people who decided what should have been done to ensure that Aboriginal peoples' interests were to be preserved and advanced.

It is simply invalid to contend that if an organisation may have failed to discharge many of its functions, that the failure is indicative of a terminal weakness of the philosophy that underpins that organisation. For example, the HIH debacle does not necessarily argue that capitalism has failed and that insurance companies and other private enterprises should come under government control.

We are aware of an increasing tendency among some academics and those who provide advice to government to sponsor a belief to the effect that Aboriginal people do not have the capacity to manage self determining organisations. This view is almost becoming the new accepted wisdom. But it is based on fallacious reasoning, could be racist in some cases and is at best paternalistic.

Self determination is a right of all peoples not just non Aboriginal peoples. Australia is party to international agreements to that effect and those agreements have legal force in Australia.

Although, our general argument does not require supporting evidence, we make the additional point that Aboriginal Community Controlled Health Services exemplify the success of Aboriginal self determination. In the international context, the Inouet people of Greenland have been self governing for many years with very impressive results. The Harvard Project on American Indican Economic Development also identifies that self determining structures are core features of successful models of practice[3].

2.1 What is needed

What we need is a nationally elected Aboriginal self determining organisation that will fully discharge the widest range of functions efficiently and transparently for the benefit of Aboriginal people.

We recognise that interim arrangements will be necessary prior to the establishment of a new national organisation but we are confident that the new structure could be functioning within a relatively short time frame.

3. SOME CORE ISSUES IN THE DEVELOPMENT OF THE NEW SELF DETERMINING NATIONAL ABORIGINAL ORGANISATION

The principal preconditions for the establishment of the new national self determining Aboriginal organisation are:

(i) determination of the most effective mechanisms to ensure that elected representatives are drawn from the widest possible Aboriginal electorate and that they reflect the diversity of Aboriginal cultures and language groups; on this point, we note that an Aboriginal electoral roll was used in elections for the NACC and this could be a model to explore.

(ii) reconsider the provisions of the original ATSIC Bill with a view to modification of the existing ATSIC Act and make the revised legislative framework applicable to the new organisation; strengthening of or insertion of new provisions relating to corruption prevention, audit and review functions, conflict of interest

(iii) determination of the most effective mechanisms for coordination of service delivery at regional levels noting that Aboriginal health partnerships are functioning very well in a number of jurisdictions

Manifestly, there are further issues to be considered but these identified priorities are probably some of the core matters to be decided. Proper consultation in partnership with Aboriginal communities must inform the entire process of development of the new national Aboriginal elected organisation.

In practical terms, Aboriginal communities would be represented by our national self determining organisations eg NACCHO, NAILS, SNAICC. These organisations could also nominate individual Aboriginal people with requisite expertise.

We observe that much planning occurred at the time of the establishment of ATSIC and to that extent, not a great deal of new knowledge needs to be generated. There were over 90 amendments to the original draft ATSIC Bill making it the second most amended piece of legislation to have passed through the Australian parliament. At the time it was clear to many that some of those amendments would prevent the future organisation from fulfilling its aims and objectives on behalf of Aboriginal people. In other words, the ATSIC's own legislation virtually guaranteed its downfall.

We firmly believe that an effective nationally elected replacement for ATSIC is a realisable goal. While we acknowledge that there are some complexities ahead, it seems that those complexities have been somewhat overstated. Ultimately, we are not talking about rocket science!

4. POTENTIAL IMPACT OF NEW ARRANGEMENTS ON HEALTH AND WELL BEING

In this submission, NACCHO makes reference to areas where the proposed new Aboriginal and Torres Strait Islander Affairs arrangements may impact adversely on health. NACCHO reaffirms the importance of the primary health care sector to the health of Aboriginal peoples and Torres Strait Islanders. We emphasise that primary health care access is essential to reduce the health disparities between Aboriginal and non-Aboriginal Australians, as are broader reforms to address overcrowded living conditions, water supply, sanitation, drug abuse and other social problems. This is because the determinants of disease lie out side the health sector, in environmental, social, educational and economic factors. This is why ACCHSs offer a holistic approach to health care delivery, acting as the nexus for access to social services and broader health sector needs. The need for ACCHSs across Australia has long been required for the lack of action by mainstream services (see Appendix 1).[4]

Further, the demise of ATSIC and ATSIS is likely to have a significant impact on the Aboriginal Community Controlled Health Sector on consultative arrangements, concerns include for example:

- Increased demands on the sector for consultation, advice, coordination from several government departments.
- the lack of Aboriginal and Torres Strait Islander focus, experience & knowledge in the mainstream government departments.
- the operation of staff from departments who do not have an Aboriginal and Torres Strait Islander focus and will compete with a 'broader policy agenda' will find it difficult to prioritise Indigenous issues.
- The lack of coordination among departments and levels of government when responding to Aboriginal and Torres Strait Islander health Issues.
- The difficulty in developing policy expertise and experience in the area of Aboriginal and Torres Strait Islander issues when it is seen as a tertiary part of a department's activities.
- The poor historical record of government departments in addressing Aboriginal and Torres Strait Islander disadvantage.

NACCHOs submission has been drafted with the understanding that information currently available on the proposed new administrative structures is scant. Most importantly, it is not clear if and/or when it is intended by the Federal Government to draw non-ATSIC administered health and education funds into the new arrangements as indicated by Minister for Indigenous Affairs, Amanda Vanstone.[5]

We provide comments in relation to extracts from:

- The Governments summary of the new vision for the Australian Public Service *Connecting Governments*[6]
- The proposed Aboriginal and Torres Strait Islander Affairs structural arrangements through the Department of Immigration, Multicultural and Indigenous Affairs portfolio
- Our experience, knowledge and expertise in Aboriginal Health and the Aboriginal Community Controlled Health Services (ACCHS) sector.

We urge the Select Committee to consider the implications of the new Aboriginal and Torres Strait Islander Affairs arrangements to the primary health care sector as outlined in this NACCHO submission.

Aboriginal Community Controlled Health Services are the practical application of Aboriginal peoples self-determination. These services (ACCHSs) have remained the torchbearers of primary health care in Australia for over 30 years. They are unique providers of comprehensive primary health care to the Aboriginal population. The impact of ACCHSs in the Aboriginal community is more than just effective health service provision because through Aboriginal employment, engagement, empowerment and social action, they have become key strategic sites for Aboriginal community development.[7] The ACCHS model of participatory holistic primary health care integrates illness care with disease prevention, intersectoral collaboration and advocacy for social justice.

The Commonwealth Grants Commission *Inquiry into Indigenous Funding* in 2001 reported that "the most important factor that will contribute to improving access to and the effectiveness of primary health care services for Indigenous people are … the expansion of community-controlled services."[8]

Over the past 30 years, the Aboriginal community controlled health sector with over 120 ACCHSs operating across Australia in all states and territories, has built up a significant pool of knowledge and expertise about Aboriginal health issues.

The abolition of ATSIC removes an Aboriginal representative voice from the Framework Agreements forums at the state level of operations (see Appendix 2). These meetings previously brought together NACCHO Affiliates, ATSIC, ATSIS with state government representatives from the state department of health and commonwealth representatives from the Office of Aboriginal and Torres Strait Islander Health. As a consequence, the introduction of the Bill, places Aboriginal representative bodies in a minority position at the Framework Agreement table with potentially significant consequences.

The most critical outcome would be for the Bill to lead to the undermining of the state forums partnership processes and a collapse of Aboriginal health program development and accountability. This will not just affect indigenous-specific programs, but all mainstream programs as the forums represent the interface for the development and analysis of health policy more broadly. The "buck-passing" between Commonwealth and States **has always been** a major impediment to reform in Aboriginal health. The Aboriginal Health Framework Agreements are intended to address this area, and it is an area that NACCHO, its affiliates and member services have all been actively working on.

NACCHO recommends:

- Continuation of the partnership agreements in each state and territory, regardless of ATSIC's demise;
- Establishing a National Partnership Agreement to mirror the Partnership Agreements Forums established at State and Territory level. Members would be the Commonwealth, State/Territory Government representation, and NACCHO.

4.1 Existing agreements and structures should be honoured and strengthened

Prior to the transfer of responsibility for Aboriginal health from ATSIC to the Commonwealth Department of Health in 1995, Aboriginal health funding was largely jointly administered, along with other programs such as housing and infrastructure.
This approach proved unsuccessful and there is no evidence to support a return to this mechanism. This view is strongly stated by the recent Federal Government consultancy on

*† Targeted consultations were held in all States and Territories, involving people from Commonwealth and State/Territory health departments, peak national and State bodies from the Aboriginal community controlled health service (ACCHS) sector, a sample of service providers from the State/Territory and ACCHS sectors, and a few other key individuals and organisations. Approximately 60 meetings were held, involving almost 200 participants (the term used to refer to interviewees in the consultations).

National Strategies for improving Indigenous Health and Health Care (2004)[9] when it reported:

"The location of responsibility for Indigenous health within the Australian Department of Health and Ageing is virtually universally supported within the health sector, including Indigenous health organisations. The reasons for this support include the greatly enhanced ability to bring public health and medical expertise to bear, the emerging evidence of effectiveness, the leverage applied to the mainstream health system to enhance its response to Indigenous health disadvantage, and the record of achievement over the last eight years in allocating increased funding from within the health budget to Indigenous health. Responsibility for Indigenous health should remain with the mainstream health portfolio."

This is a clear and unambiguous assertion which NACCHO strongly supports. The former Chair of NACCHO, the late Dr Puggy Hunter expressed it as follows:

"Years ago, when we used to complain to the Minister for Health, we used to write letters addressed to the "Minister for Health - except Aboriginals". We used to go to him, but he would send us to the Minister for Aboriginal Affairs, who would say the responsibility is with ATSIC. The real issue was that the Government gave ATSIC the job without the money. We always argued that the Health Minister of Australia had responsibility for Aboriginal health and not ATSIC Commissioners and not the Aboriginal Affairs Minister. We classified ourselves as Australians first- Aboriginal Australians. So why couldn't the Minister for Health be responsible for us?...On top of that, the majority of money for health for all Australians was with the Commonwealth. I said it then: what's the use of kicking ATSIC? It's like kicking a dog with no teeth. They couldn't bite into the [health] problem. [The only way] was to make the Federal Minister responsible for Aboriginal health, just like everybody else." *[Sept 2000, ATSIC News]*

NACCHO recommends:
That the Commonwealth Governments Aboriginal health portfolio remain the responsibility of the Australian Department of Health and Aging and the Federal Minister for Health, and the Federal Minister for Aging.

5. OVERARCHING AUSTRALIAN GOVERNMENT GOALS

- **At the heart of the new arrangements is a whole of government approach based on building partnerships with Indigenous people at the local and regional level that customise and shape the delivery of government services.**

In his speech (20 April 2004), Dr Peter Shergold, Secretary in the Department of the Prime Minister and Cabinet[10] made reference to 'whole of government approaches' as a key platform of reform for the Howard Government.

However, intersectoral communication in health matters is already well established through a range of structures including the Aboriginal and Torres Strait Islander State and Territory Health Agreements (see Appendix 2), national public health strategies, and the efforts of the National Public Health Partnership (NPHP) being one example in health. Dr Shergold referred to traditional "interdepartmental committees (IDCs) and cross-agency task forces [providing] an effective vehicle to bring together a diverse range of central and line agencies in pursuit of a particular policy objective." But he said that "IDCs remain a necessary *but insufficient* condition of achieving a whole-of-government approach."

Dr Shergold provided only one example of what was meant by 'whole of government approaches' beyond what is currently delivered. He referred to the abolition of ATSIC and the different approach to the administration of 'indigenous-specific' programs and services.

He described this as a "bold experiment in implementing a whole-of-government approach to policy development and delivery" and one which "my reputation, and many of my colleagues, will hang."

However, this NACCHO submission highlights a range of uncertainties and concerns with the proposed reform which is being billed as best exemplifying the governments agenda for all Australians. For example, It is understood that the new arrangements will reflect the lessons emerging from the Council of Australian Government (COAG) trials. A more coordinated and planned approach redressing the disadvantage faced by Aboriginal communities is clearly necessary, welcomed and well over due. However it must be noted that COAG only involves 10 sites nationally, and is still in the early stages of development and implementation. It would also be valuable to observe and reflect on a range of programs which have been the target of many Inquiries over the years.[11] One key program, is the Primary Health Care Access Program.

The PHCAP represents the most significant source of new funding in Aboriginal health for some years. At both the state and national levels, NACCHO has called on the support of the Australian Government to speed up the process of getting needs based, PHCAP funding out to where it's needed, planned and agreed to by community.

In the health sector, structures are already in place for 'whole of government' approaches to improve Aboriginal peoples health (see Appendix 2) and require strengthening, not dismantling. Aboriginal health policy development and its implementation at the coalface has been intersectoral and comprehensive for decades. Indeed the National Aboriginal Health Strategy (1989) recommended the need for a whole of government approach. Moreover, the current structures need to ensure and support effective Aboriginal community representation at all operational levels.

It is unclear to NACCHO if the Federal Governments 'whole of government' approach with respect to health programs represents innovation (the details of which are unclear) or a relabelling of the current arrangements.

- **It is within that context that current ATSIC funding will be integrated with mainstream programmes and services.**

The Australian Government describes ATSIC funding being integrated within mainstream programs. Although ATSIC has not had a substantial health portfolio since 1995, 'indigenous-specific' health is listed as a component of the new arrangements.

NACCHO reminds the Select Committee that the ACCHS sector already has extensive mainstream program and service linkages. These linkages are of critical importance and need to be expanded. Efforts to expand mainstream program responsibility to Aboriginal peoples are multiple and range from enhancing the responsiveness of national public health strategies to Aboriginal peoples to enhancing the accessibility of Aboriginal people to the PBS, MBS and Commonwealth Hearing Services Program to name a few.

NACCHO is concerned that the proposed new arrangements may in fact create the opposite effect. Mainstream health programs may have reduced accountability for programs to target Aboriginal peoples.

Mainstream programs already have a tendency to ignore Indigenous Australians and to cost-shift program outputs onto capped, *small-scale and supplementary* Indigenous-specific programs. One example of this is the National HIV/AIDS Strategy, one of many broadbanded Commonwealth funding initiatives to the States, which a recent evaluation could not report on whether it met its responsibility to Indigenous Australians.[12] This was because sexual health program expenditure by jurisdictions for Aboriginal peoples is largely drawn from the small-

scale National Indigenous Australians Sexual Health Strategy (NIASH) - which was never meant to be the sole source of funding for sexual health.

Any new structures for health may indeed further confuse roles and responsibilities of government bodies to Aboriginal peoples. Indigenous-specific programs may be more likely than previously to be incorrectly viewed as *substitutions* for mainstream expenditure.

The responsibilities of national strategies for Aboriginal & Torres Strait Islanders policy and service delivery has recently been outlined in the recent NPHP guidelines.[13]

The Select Committee may wish to propose that effort needs to be directed towards ensuring mainstream programs fulfil their responsibilities to Aboriginal and Torres Strait Islander peoples. The proposed Aboriginal and Torres Strait Islander Affairs arrangements, if they involve the health sector, may adversely impact on these responsibilities through a number of mechanisms. These include the undermining of Framework agreements, the undermining of representative consultative structures at the national level, and increased opportunities for cost-shifting from broadbanded Commonwealth programs.

6. NATIONAL INDIGENOUS ADVISORY COUNCIL

- **The Australian Government will appoint a non-statutory National Indigenous Council as a forum for indigenous Australians to provide policy advice to the government at the national level.**

NACCHO is concerned that those involved in the new administrative arrangements are not representatives of community based organisations, rather may be individuals appointed on the basis of their public profile. For example, the proposed National Indigenous Advisory Council should draw its membership from organisations such as NACCHO, which are able to provide a representative and accountable Aboriginal voice.

Dr Shergold states that whole of government policy, prepared by public servants should, be 'frank, honest, comprehensive, accurate and timely'[14]. It is difficult to ascertain how the Australian Public Service (APS) and the Ministerial Taskforce will gain such advice through the provision of this Council if it is made up of high-profiled individuals, not democratically elected or mandated to speak on behalf of the Aboriginal population on a particular issue. A small group of hand picked individuals by Government does not replace the need for a representative process.

Failure to engage the Aboriginal and Torres Strait Islander population and organisational representatives from the beginning and right throughout the policy process risks the development of inappropriately targeted and conceived policy and at worst, it may lead to efforts which are inappropriate, unhelpful, and unsustainable for the population concerned.

The National Public Health Partnership has recently prepared guidelines on this matter following an extensive national consultation[†] on the matter of public health strategy development.[15] A key finding was that:

"Participants universally agreed that Aboriginal and Torres Strait Islander people must be effectively represented in national public health strategy development processes. This representation is seen as a vital part of ensuring that strategies prioritise Aboriginal and Torres Strait Islander health, that they are appropriate and acceptable, and that they are accessible to communities and their service providers."

In the consultation process for the guidelines, Aboriginal organisations understandably expressed frustration when individuals without a clear mandate continued to be appointed by government to represent their communities. NACCHO pointed out that the appointment to

strategy committees of individual Aboriginal or Torres Strait Islander people was problematic:

"Individual appointments bypass and undermine elected structures and protocols, and create a situation where people with no clear mandate are speaking for other Aboriginal and Torres Strait Islander people. This is seen as tokenistic and patronising ("any black face will do"). Governments are sometimes seen to be taking the easy option of appointing individuals who may be easier to work with than empowered and mandated representatives."

We encourage the Select Committee to explore this issue in more detail as outlined in sections 1-3 in this submission. Proper consultation in partnership with Aboriginal communities must inform the entire process of development of the new national Aboriginal elected organisation.

In addition, given ATSIC's demise, it is no longer appropriate for Aboriginal representation on the NHMRC to rest with an ATSIC representative. The lack of an ATSIC representative on Council without the support of "*frank, honest, comprehensive, accurate and timely advice"* from the Aboriginal community until the end of the current NHMRC triennium, leaves the Aboriginal research community without a representative voice.

NACCHO recommends:
The Select Committee to recommend the determination of the most effective mechanisms to ensure that elected representatives are members of the National Indigenous Advisory Council and drawn from the widest possible Aboriginal electorate and that they reflect the diversity of Aboriginal cultures and language groups.

The proposed National Indigenous Advisory Council draw its membership from organisations such as NACCHO, which are able to provide a representative and accountable Aboriginal voice.

The ATSIC representative on the NHMRC be replaced with a NACCHO representative.

7. MINISTERIAL TASKFORCE ON INDIGENOUS AFFAIRS

- **A Ministerial Taskforce on Indigenous Affairs chaired by the Minister for Immigration and Multicultural and Indigenous Affairs will provide high-level direction to Australian Government policy development, coordination and flexible resource allocation on indigenous affairs.**

NACCHO is unclear about the membership of this Taskforce nor the proposed Terms of Reference. Consequently, it is difficult to comment on the validity, acceptability and effectiveness of this Taskforce.

It appears that the Taskforce is to take direction from the National Indigenous Advisory Council. The Select Committee is advised to consider NACCHOs concerns regarding the proposed Council and therefore its implications on the validity of the direction given to the Ministerial Taskforce (see above).

Most importantly, unless representative organisations are members of the Council, there appears to be no forum whatsoever in the new proposed Aboriginal and Torres Strait Islander Affairs structure, for ACCHSs and their representative bodies at the national level to be involved in the policy process relating to health.

It is unclear to NACCHO if the current National Aboriginal and Torres Strait Islander Health Council (see Appendix 2) which reports to the Minister for Health and Ageing will remain or be replaced by the new arrangements. If this health forum is to be subsumed into the much broader National Indigenous Advisory Council, given its deficiencies in mandate and

representativeness, this has very serious implications for Aboriginal health policy development and resource allocation (see also below).

Further, NACCHO would welcome the opportunity to engage with Australian Government to reform the existing arrangements in health, such as the National Aboriginal and Torres Strait Islander Health Council.

- **The Task Force will use the indigenous-specific funding pool flexibly and reallocate resources to the approaches that are shown to work best in addressing indigenous disadvantage.**

NACCHO has serious concerns over the Taskforces role to allocate or reallocate *health* funding and how these decisions will be made in such a way that are superior to current funding mechanisms.

There is an urgent need for funding decisions in Aboriginal health to be based on agreed, effective needs-based planning processes. Aboriginal access to mainstream health programs (such a private GP care, hospital care, pharmaceutical care), is currently largely a function of proximity of services, rather than on community need. Compounding this, current funding for Aboriginal-specific health care services is ad hoc and historically based, rather than needs-based.

This has led to a situation where, within the context where there is vastly inadequate overall funding available for Aboriginal health, and nearly all Aboriginal communities have inadequate access to primary health care, there are also considerable inequities between Aboriginal communities in terms of their access to broader health services.

The Report of the Commonwealth Grants Commission Inquiry into Indigenous Funding in 2001[16] recognised the above and set out a number of principles for that had the potential to better align funding with needs. Two specific elements included:

- The full and effective participation of Indigenous People in decisions affecting funding distribution and service delivery, and
- Recognition of the critical importance of effective access to mainstream programs and services and clear actions to identify and address barriers to access.

Neither of the above principles are adhered to in the proposed new Indigenous Affairs arrangements. The full and effective participation of Aboriginal peoples is denied at the Federal level, and the proposed arrangements do not factor mechanisms for improving mainstream program delivery or accountability.

Over the last 10 years, there have been efforts to enhance funding allocation mechanisms and include developments in PHCAP funding.

See also NACCHOs concerns regarding what is meant by ‘Indigenous-specific” approaches in the section below.

8. SECRETARIES’ GROUP ON INDIGENOUS AFFAIRS

- **The Group has been extended to include all Secretaries with responsibility for indigenous-specific programmes and services, and is now chaired by the Secretary of the Department of the Prime Minister and Cabinet**

It is unclear to NACCHO, that in relation to health and in view of the Federal Governments ‘whole of government’ approach to health, what it means by ‘Indigenous-specific’ programs.

Health programs delivered to Aboriginal peoples and Torres Strait Islanders are made up of mainstream programs with a responsibility to specifically target Indigenous Australians because of their excess burden of disease and lower program participation rates (examples include the Commonwealth Hearing Services Program; Breast Screen; HIV AIDS Strategy) as well as *supplementary* funding allocations for health programs because of unique infrastructure needs. Examples of these programs include the National Indigenous Australians Sexual Health Strategy (NIASHS). Reviews of the NIASHS have stressed the importance of funding allocations from this program as supplementary to sexual health programs which are the responsibility of jurisdictional public health units under their Public Health Acts and the National HIV/AIDS Strategy.

Terms such as 'Indigenous-specific' without clarification in meaning, can imply programs that *substitute* for mainstream programs. This is a common and serious misconception. There are very few examples of programs developed for Aboriginal and Torres Strait Islander population that *substitute* for mainstream programs.

Others interpret the term 'Indigenous-specific' to refer to any program that targets Aboriginal peoples (whether or not it also involves the general population). For example, the recent Independent Consultancy on National Strategies for Improving Indigenous Health undertaken by La Trobe University (2003) lists a number of programs delivered by ACCHSs and State Governments as 'Indigenous-specific' programs.[17] These range from enhancing childhood immunisation rates under the National Indigenous Pneumococcal Immunisation program, to cervical screening programs, to chronic disease programs based around the Medicare Enhanced Primary Care Program.

Currently, the main problem reported by NACCHO in a number of public submissions is the lack of accountability for mainstream programs to effectively target Indigenous Australians. If the Secretaries Group brief is to examine 'Indigenous-specific' programs and these pertain only to the provision of *supplementary* programs- then the purpose of this group is redundant. A key example is the failure of accountability for the provision of hearing services to Indigenous Australians under the Commonwealth Hearing Services Program. A recent review found that only 100 Indigenous Australians were accessing the $132 million/annum Voucher scheme despite having higher rates of hearing loss than other Australians.[18] Despite this report, concerns raised through Senate Estimates[19] and a recent national Hearing Seminar, no reforms to the Voucher scheme have been announced.

The Secretaries Group, to have any value and to be consistent with the 'whole of government' scope, must examine health programs more broadly. If this is not done, the assessment of 'Indigenous-specific' programs is flawed. For example, Indigenous-specific programs by their very design, aim to supplement mainstream programs. Yet when mainstream programs fail to target Aboriginal peoples, Indigenous-specific services are forced to stretch their resources even further to meet Aboriginal peoples needs. Mr Alan Morris, Chairman of the Commonwealth Grants Commission (CGC) stressed this point at the Indigenous Governance Conference in 2002:

"The failure of mainstream programs to comprehensively address the needs of Indigenous people leads to reduced effectiveness of Indigenous specific programs. Commonwealth Indigenous specific programs are intended to provide targeted assistance to Indigenous people to supplement the delivery of services through mainstream programs. These programs are a recognition of the special needs associated with and in response to their level of disadvantage. Mainstream failure means that Indigenous specific programs are expected to do more than they were designed for, and as a consequence they focus less on the disadvantaged."[20]

- **Departmental secretaries will be accountable to their portfolio ministers and the Prime Minister for indigenous-specific programme delivery and cooperation with other parts of the Australian Government, state and territory governments and indigenous communities, as part of their performance assessments.**

NACCHO welcomes more explicit accountability regarding Departments responsibility to the health of Aboriginal peoples. Currently, there is no explicit mechanism whereby Departments can be held accountable for mainstream health program expenditure and whether these programs reach target populations such as Aboriginal peoples and Torres Strait Islanders as is required under the Australian Governments Charter of Public Services in a Culturally Diverse Society (1996).[21] [‡] [§] If enhanced Departmental accountability only pertains to a restricted set of health programs, NACCHO cannot see that this process will contribute to address the current lack of accountability.

The main public accountability mechanism in place is through the National Aboriginal and Torres Strait Islander Performance Indicators which were recently revised.[22] However, despite these there are number of examples of how accountability needs to be improved. One example pertains to child hearing assessments. Although jurisdictions are required to report annually on the: "percentage of Aboriginal and Torres Strait Islander at school entry having >25 dB hearing loss at either 1 or 4 KHz in either ear," not a single department has yet reported on this indicator. Programs to screen children for hearing at school entry have still not been established.[23] This is despite the House of Representatives Report on the Inquiry into Indigenous Health (May 2000) which recommended that the "Commonwealth provide additional resources to ensure that within 2 years all Indigenous children are able to be monitored [by all health services] for ear disease on a regular basis from birth to allow the hearing ability of all Indigenous children to be tested by the age of three years."[24]

It is also unclear to NACCHO, what form the proposed new accountability measures may take and whether it may just be a slight variation on current mechanisms.

NACCHO are concerned about the amendments to the Office of Audit and Evaluation and encourage the Senate Select Committee to further investigate the scope of these amendments to the ATSIC Act.

See also NACCHOs concerns regarding what is meant by 'Indigenous-specific" approaches in the section above.

Recommendation:
The Senate Select Committee further investigate the proposed amendments which provide the Office of Audit and Evaluation additional powers.

9. OFFICE OF INDIGENOUS POLICY COORDINATION

- **An Office of Indigenous Policy Coordination will be established in the Department of Immigration and Multicultural and Indigenous Affairs to: provide policy advice to the Minister; coordinate indigenous policy development and service delivery across the Australian Government; oversee relations with**

[‡] The *Charter of Public Service for a Culturally Diverse Society* was initially developed by the Office of Multicultural Affairs in the Department of the Prime Minister and Cabinet, and later by the Department of Immigration and Multicultural Affairs. All Government funded initiatives including services delivered via an intermediary such as another level of government or non-government organisations, need to be developed in light of the Australian Government Charter. It recognizes that the access and equity policies should ensure mainstream government services meet the needs of people from diverse cultural and linguistic backgrounds so that they can participate fully in economic, social and cultural life.

[§] In the past, when programs and services were being developed, access and equity issues had been treated as an after-thought. "The Charter places the emphasis on building cultural diversity considerations into all stages of Government service delivery from planning, right through to delivery and reporting," Mr Ruddock said. *(Minister for Immigration and Multi cultural Affairs, Media Release "Government Services Recognise Diverse Society" MPS 84/96)*

state and territory governments on indigenous issues; and monitor the performance of Australian Government programmes and services for indigenous people, including arrangements for independent scrutiny.

Coordination is clearly important in order to achieve a 'whole of government' approach in the proposed new Indigenous Affairs arrangements. However, it is unclear how all the complex and varied sector issues would be coordinated efficiently and effectively. As previously outlined, the matter of coordination rests not just with supplementary programs, but also with mainstream responsibilities.

APPENDIX 1
OVERVIEW OF NACCHO AND SUMMARY OF ACHIEVEMENTS

NACCHO – A SUMMARY
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The National Aboriginal Community Controlled Health Organisation (NACCHO) is the national peak Aboriginal health body representing Aboriginal Community Controlled Health Services throughout Australia. An Aboriginal Community Controlled Health Service (ACCHS) 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).

In keeping with the philosophy of self-determination, Aboriginal communities operate over 130 ACCHSs across Australia. They range from large multi-functional services employing several medical practitioners and providing a wide range of services, to small services without medical practitioners, which rely on Aboriginal health workers and/or nurses to provide the bulk of 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 integrated primary health care model adopted by ACCHSs is in keeping with the philosophy of Aboriginal community control and the holistic view of health that this entails.

> ***'Aboriginal health is not just the physical well being of an individual but is the social, emotional and cultural well being of the whole community in which each individual is able to achieve their full potential 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.'*** **(NAHS, 1989).**

The solution to address the ill health of Aboriginal people can only be achieved by local Aboriginal people controlling the process of health care delivery. Local Aboriginal community control in health is essential to the definition of Aboriginal holistic health and allows Aboriginal communities to determine their own affairs, protocols and procedures.

Thus, NACCHO represents local Aboriginal community control at a national level to ensure that Aboriginal people have greater access to effective health care across Australia. NACCHO provide a coordinated holistic response from the community sector, advocating for culturally respectful and needs based approaches to improving health and well being outcomes through ACCHSs.

NACCHO's work is focussed on:

- Promoting, developing and expanding the provision of health and well being services through local Aboriginal Community Controlled Health Care Services
- Liaison with organisations and Governments within both the Aboriginal and non-Aboriginal community on health and wellbeing policy and planning issues
- Representation and advocacy relating to health service delivery, health information improvement, research, public health, health financing, health programs, etc
- Fostering cooperative partnerships and working relationships with agencies that have a working respect for Aboriginal community control and holistic concepts of health and well being.

A few of NACCHO's Achievements…..

- **Leading national policy and reform of existing policy on Aboriginal health**

The 1989 National Aboriginal Health Strategy was a landmark policy document which has recently been complemented by the *National Strategic Framework for Aboriginal and Torres Strait Islander Health* (2003) after considerable direction from NACCHO. NACCHO leads the way in reforming health care service delivery to the Aboriginal population

NACCHO recently successfully advocated for Federal government introduction of a Medicare rebate for the preventive health assessment of younger Aboriginal and Torres Strait Islanders.

- **Clinical and epidemiological research**

NACCHO completed a landmark large-scale clinical research trial on chronic ear infections

NACCHO is responsible for the Service Activity Reporting data instrument that generates annual information about service delivery in the ACCHS sector

NACCHO also has a key role in epidemiological research (national health surveys and immunisation coverage), the development of mental health indicators, and guidelines for ethical research.

- **Evidence-based clinical resources**

NACCHO has been a collaborator and contributor to clinical textbooks for medical and health professionals

NACCHO has developed and collaborated on a range of national clinical guidelines

- **Curricula for the medical profession**

NACCHO in partnership with the RACGP developed Australia's first curriculum in Aboriginal health for GP Registrars (1994).

In 2000, NACCHO developed a supplementary Aboriginal Health training module for GPs

- **Improved access to pharmaceuticals in remote Australia**

NACCHO's advocacy led to Section 100 arrangements for the free supply of medicines to clients through Aboriginal Health Services in remote areas (since 1999). A review of the program reported that "Section 100 [arrangements].. have completely revolutionised medicines access…" (2003).

- **Policy framework for health workforce & social and emotional well-being**

NACCHO was a key stakeholder in the development of the *National Aboriginal and TORRES STRAIT ISLANDER Health Workforce Framework* (2002). NACCHO is actively supporting Registered Training Organisations that currently provide 75% of the training that is delivered to Aboriginal Health Workers. NACCHO was a primary contributor to the development of a *National Strategic Framework for Aboriginal and TORRES STRAIT ISLANDER Mental Health and SEWB* (2003).

- **Access to Fringe Benefits Tax (FBT) Supplementation**

NACCHO's advocacy, lobbying and FBT modelling led to the announcement by government of $42mil supplementation funding to negate the effects of Fringe Benefits Tax. Based on NACCHO's efforts, all Aboriginal non government Public Benevolent Institutions were eligible to access the funding pool.

- **Contributing to International Treaties on Indigenous peoples health**

NACCHO was the instigator of the *WONCA Kuching Statement on the Health of Indigenous Populations* in 1999. In 2003, NACCHO successfully incorporated amendments to the Statement which were forwarded to the Indigenous Peoples Forum of the United Nations.

- **Partnerships**

NACCHO has working partnerships and MoU's with a range of organisations including the Australian Divisions of General Practice and SIDs and Kids.

Why do Aboriginal people need Aboriginal specific health services?

The following is an excerpt from 'National Strategies for Improving Indigenous Health and Health Care.'[25]

> "Indigenous Australians' access to primary health care is a problem in all areas of Australia, but varies with location. Aboriginal and Torres Strait Islanders do not access mainstream services, even in cities where they are readily available, to the level that would be expected given their health status. The government's approach to improving access is based on two complementary strategies: increasing the capacity of the Indigenous-specific sector, and enhancing the accessibility of the mainstream primary health care system, through adjustments to MBS and PBS and other measures. Both of these strategies are essential, because Indigenous Australians (like all Australians) need good access to a complex network of primary health care services with good linkages. Both Indigenous-specific and mainstream services are needed by Indigenous communities.
>
> Firstly, Indigenous Australians need different services because their health needs are different. In particular, the greater prevalence of chronic diseases in the Indigenous population means that a complex ongoing set of interventions is required which can only be provided by a skilled multi-disciplinary workforce, able to sustain effective long-term treating relationships and links with other providers. General practice services funded through the MBS are not able to meet these needs fully (Keys Young 1997), while Indigenous specific agencies are designed to provide the basic health infrastructure required for effective service delivery.
>
> Secondly, for several reasons including historical and cultural ones, mainstream health services are not generally capable of meeting the needs of Indigenous Australians and this makes it hard for Indigenous people to use them. This lack of capacity is more pronounced in some areas where traditional cultures and languages are still practised. Work to change the responsiveness of mainstream services should continue, but effective primary health care is needed now. Many Indigenous Australians will go without primary health care (Keys Young 1997, p. 61) if a service that specifically welcomes them and responds appropriately to their needs is not available.
>
> Thirdly, the Indigenous population constitutes such a small proportion of the total primary health care 'market' in many areas of Australia (even if they used mainstream general practitioners (GPs) and other services proportionately) that their power in the market to stimulate mainstream health services to be responsive to their needs is severely limited. Their high levels of poverty exacerbate this problem. GPs are responsive to their markets, and a strategy that relied on GPs making independent decisions to substantially change their services to meet the needs of 2% of the market would be unlikely to produce significant results, and neither would many of them have the skills and experience to do so. However, there are some outstanding exceptions among GPs and mainstream community health agencies, and the work of these individuals and groups makes a valuable contribution, as do GPs who work part time in local Indigenous-specific clinics.
>
> Finally, the role of Indigenous-specific services is not simply one of *substitution* for mainstream services. They also provide a base for training of both Indigenous and non-Indigenous health professionals, and for research and development of new approaches to Indigenous health (either alone or in partnership with mainstream agencies and researchers). This aspect is particularly important in urban services, because of their proximity to medical schools etc. and to the headquarters of mainstream specialist providers (e.g. the leadership of child and adolescent mental health services tends to be based in capital cities). Indigenous-specific services in all areas provide the referral pathway to specialist and tertiary services, and support the providers in their responses to Indigenous patients. They are also the appropriate base for community development approaches to improving health."

APPENDIX 2: CURRENT ADMINISTRATIVE ARRANGEMENTS FOR ABORIGINAL HEALTH

A. Existing administrative arrangements at the national level

Australian Health Ministers Advisory Council
The Australian Health Ministers Advisory Council (AHMAC) is the primary national advisory body which reports to the Australian Health Ministers' Conference, and facilitates governments' participation in national programs, thereby achieving a degree of uniformity. The members are the heads of Federal, State and Territory government health authorities.

Standing Committee on Aboriginal and Torres Strait Islander Health
Standing Committee on Aboriginal and Torres Strait Islander Health (SCATSIH) is the subcommittee of AHMAC responsible for Aboriginal and Torres Strait Islander Health. AHMAC comprises the CEO's of the Commonwealth and State/Territory departments responsible for health and for reports to health ministers.

SCATSIH comprises the heads of Aboriginal and Torres Strait Islander health units at the Commonwealth/ State/Territory level and senior executives with oversight of mainstream health policy. It is chaired by AHMAC providing cross membership, whereas SCATSIH provides a forum where national activity, involving all government jurisdictions can be discussed and progressed. With advice from NATSIHC, SCATSIH is responsible for implementing the *National Strategic Framework for Aboriginal and Torres Strait Islander Health* in the health sector and for coordinating activity with non health agencies at the Commonwealth, State/Territory Government level (NATSIHC 2002).

National Aboriginal Torres Strait Islander Health Council
National Aboriginal Torres Strait Islander Health Council (NATSTIHC) provides advice to the Commonwealth Minister for Health and Ageing on matters relating to the health and substance misuse services provided to the Aboriginal and Torres Strait Islander peoples. It monitors and advises on implementation of the Framework Agreements and on ways to improve the interaction between mainstream services and ACCHSs at the national level. Membership includes representatives of Commonwealth, State and Territory Governments, ATSIC, NACCHO, the Australian Indigenous Doctors Association, the Congress of Aboriginal and Torres Strait Islander Nurses, the Chairperson of the NHMRC in an ex-officio capacity and ministerial appointees with expertise in Aboriginal and Torres Strait Islander health.

National Aboriginal Community Controlled Health Organisation
As stated above, the work of the National Aboriginal Community Controlled Health Organisation (NACCHO) in representing Aboriginal Community Controlled Health Services nationally. NACCHO is the peak body on Aboriginal health and well being, representing over 130 health and substance misuse services in Australia operated by organisations that are incorporated and controlled by Aboriginal people. NACCHO at the national level and its affiliates at the State/Territory level, provide a voice for Aboriginal Community Controlled Health Services (ACCHSs) in national negotiations, forums, consultations, policy development and planning.

B. Existing administrative arrangements at the state and territory level

Aboriginal and Torres Strait Islander Health Framework Agreements

Framework Agreements on Aboriginal and Torres Strait Islander health were signed in each State and Territory between Commonwealth and State Governments, the Aboriginal community controlled health sector, and the Aboriginal and Torres Strait Islander Commission, between July 1996 and February 1999.

The Agreements aim to improve health outcomes for Aboriginal and Torres Strait Islander peoples through improved access to health and health related programs, increased allocation of resources and transparent and regular reporting for all services and programs, and joint planning processes to inform resource allocation.

The Agreements provide for joint regional planning in each jurisdiction and in the Torres Strait, and for annual public reporting on progress to the Australian Health Ministers Advisory Council (AHMAC). The Agreements plan a key role at the policy, planning and resource allocation level the Framework Agreement partnerships, and commit the parties to a joint process of regional planning to meet Aboriginal and Torres Strait Islander health needs within that jurisdiction, and guide future resource allocation.

The statements of intent in the Framework Agreements are important guiding principles, and include:

- A shared recognition that the health of Aboriginal and Torres Strait Islander peoples is a major concern for all levels of government and the Aboriginal community, and an acknowledgement that Aboriginal and Torres Strait Islander peoples have the worst health of all Australians and are the most disadvantaged groups in the community;
- A commitment by all levels of government agree that Aboriginal and Torres Strait Islander peoples have the same rights to good health and to health care as all other Australians;
- A shared goal of achieving for Aboriginal and Torres Strait Islander peoples improved health status and equitable access to health services and resources to redress the health disparity; and
- a recognition this will require a cooperative and sustained effort from all parties.

C. Existing administrative arrangements at regional and local level

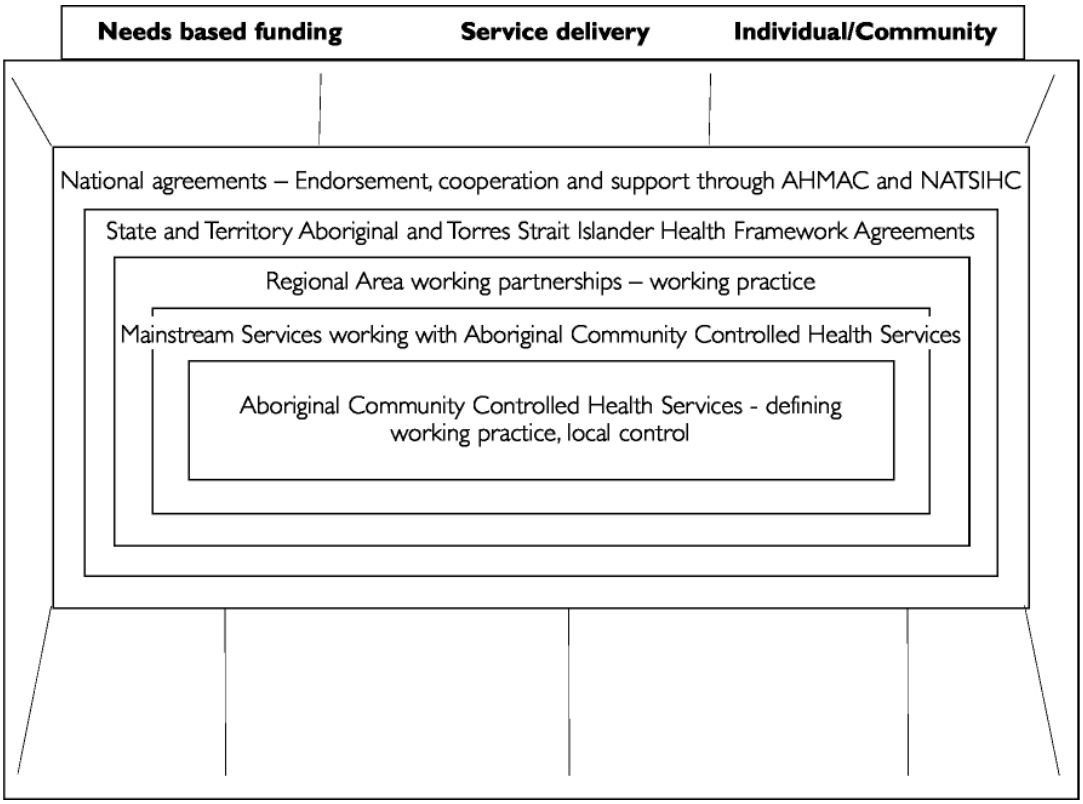
Aboriginal Community Controlled Health Services (ACCHSs)

ACCHSs are primary health care services initiated by local Aboriginal communities to deliver holistic and culturally appropriate care to people within their communities. Their board members are elected from the local Aboriginal community (NATSIHC 2002). They range from large multi-functional services employing several medical practitioners and providing a wide range of services, to small services without medical practitioners, which rely on Aboriginal health workers and/or nurse practitioners to provide the bulk of primary care services, often with a preventive, health education focus.

Regional Aboriginal Health Planning Forums

These are bodies set up under the Partnership Forums which bring together service providers at the local level to plan service delivery through regional planning processes.

Table – existing administrative arrangements



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[2] UN declaration website.
[3] www.ksg.harvard.edu/hpaied/overview.htm
[4] For example: National Aboriginal Health Strategy (1989), Report of the Royal Commission into Aboriginal Deaths in Custody (1991), HREOC Burdekin Report Inquiry on Mental Health (1993) HoR Standing Committee on Aboriginal and Torres Strait Islander (2001), HoR Health is Life Report on the Inquiry into Indigenous Health (2000) Dwyer report (2004)
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[12] HIVAIDS strategy review- most recent?
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