Closing the Accountability Gap:
The First Step Towards Better Indigenous Health

Sara Hudson

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Abbreviations

ABS	Australian Bureau of Statistics
ACCHS	Aboriginal Community Controlled Health Services
AH & MRC	Aboriginal Health and Medical Research Council of New South Wales
AHCSA	Aboriginal Health Council of South Australia Inc
AHCWA	Aboriginal Health Council of Western Australia
AHW	Aboriginal Health Workers
AIHW	Australian Institute of Health and Welfare
AMSANT	Aboriginal Medical Service Alliance Northern Territory
ASIC	Australian Securities and Investments Commission
COAG	Council of Australian Governments
DoHA	Department of Health and Ageing
FaHCSIA	Department of Families, Housing, Community Services and Indigenous Affairs
MBS	Medicare Benefits Schedule
NACCHO	National Aboriginal Community Controlled Health Organisation
NAIHO	National Aboriginal and Islander Health Organisation
NAHS	National Aboriginal Health Strategy
NATSIHA	National Aboriginal and Torres Strait Islander Health Authority
NHHRC	National Health and Hospitals Reform Commission
PHCAP	Primary Health Care Access Program
PBS	Pharmaceutical Benefits Scheme
TAC	Tasmanian Aboriginal Centre
QAIHC	Queensland Aboriginal and Islander Health Council
VACCHO	Victorian Aboriginal Community Controlled Health Organisation

Executive Summary

Prime Minister Kevin Rudd's pledge to 'Close the Gap' between Indigenous and non-Indigenous health outcomes was perceived as a long overdue landmark, but its achievement will require more than yet another government strategy or more funding. The Rudd government is doing what previous administrations have always done—throwing more and more money at the problem. But this is not the solution. Improvements in Indigenous health outcomes will only occur once the lack of accountability that has plagued the Aboriginal health sector ends.

Over the past 12 years, funding for Indigenous health programs has increased by 328%—from $115 million in 1995–96 to $492 million in 2007–08, with no appreciable improvements in health outcomes. The latest budget shows that the Commonwealth government is now spending 50% more on Indigenous health than it was in 2007–08.[1] Yet, recent health reports, *A Healthier Future for all Australians* and *Building a 21st Century Primary Health Care System*, continue to recommend increasing expenditure on Indigenous health, even though no one is really sure of the level of unmet need.

A battle has been played out between government and Aboriginal Community Controlled Health Services (ACCHS) for control of Indigenous health funding—with the government wanting increased control of where funding is going by channelling it into more and more Indigenous health programs, and ACCHS arguing that they deserve more funding as they provide 'culturally appropriate care.' What has been lost sight of in this fight are the people most in need of additional health funding—those Aborigines and Torres Strait Islanders living in remote communities where health services are few and far between. Most ACCHS are not in remote or very remote areas, while most Indigenous health programs are implemented without any consultation with communities or assessment of need.

Diversity in health services is not a problem—but the consequences of a lack of leadership and accountability are. The combination of different layers of government bureaucracy and the mixture of public, private and Aboriginal medical services results in duplication in some areas and service gaps in others. There are numerous programs for every foreseeable health issue, but most are provided simply because someone thinks they are a good idea or because funding can be secured from one or another of the federal or state government departments and not because of any evidence based policy.

The untargeted nature of government spending on health means it is difficult to know what services the money is buying and for whom. Without knowing this, it is not clear whether the problem is that Aboriginal health providers do not have enough straw to make bricks or whether the straw they have is being wasted.

Different departments may know where funding for individual programs is going, but information on all the funding provided by Commonwealth and state and territory governments to Indigenous health providers is difficult to find. Complex funding arrangements have resulted in separate 'buckets' of funding for different programs, with one Aboriginal health service receiving 42 different 'buckets' of money, all requiring separate applications and reporting.

Funding complexities make proper financial accountability next to impossible. Fewer than half of the Aboriginal health services file annual reports or complete their financial reporting requirements. They face few consequences for not filing reports, but the repercussions of this apathy have resulted in financial mismanagement, insolvency and even fraud.

There needs to be better management of overall funding and a strategy to coordinate how programs are delivered. One way of achieving this may be the National Health and Hospitals Reform Commission's (NHHRC) recommendation of a National Aboriginal and Torres Strait Islander Health Authority (NATSIHA) to pool disparate funding streams. But greater transparency about the cost of delivering health care to Indigenous communities cannot be achieved without accurate reporting showing how patient outcomes are related to the cost and quality of services. Current funding arrangements for Indigenous health programs and Aboriginal health services reward the provider and not the patient. Funding models designed to address patients' needs first are preferable to models that allocate a pool of funding for providers to dispense as they see fit. In this regard, it may be time to revisit the idea of coordinated care. Although there were some critiques of the coordinated care model—it was at least based on matching health services with patients needs. By separating the purchasing of health services from the delivery of health services, and tracing how funds were spent electronically, the coordinated care model also ensured that both the coordinators and (Aboriginal) medical service providers were kept accountable.

Introduction

> The poor health of Aboriginal people is a matter for concern … Comprehensive figures are not available, but it is known that in some areas Aboriginal babies die at a rate five times greater than other infants in the Australian population … low incomes, poor housing conditions and lack of appropriate knowledge continue to affect the health of Aboriginal adults and children.
>
> — *Australian Reference Service 1976:11*

For a large proportion of Aborigines and Torres Strait Islanders, particularly those living in regional and remote areas, little has changed since 1976. Although there have been some improvements in infant mortality rates and avoidable deaths, Aborigines and Torres Strait Islanders living in 'discrete' Indigenous communities still have the worst health outcomes of any population group in Australia.[2] These communities are largely in remote and rural areas, but there are pockets of disadvantaged Indigenous communities in many of Australia's main cities and towns, for example, in Mt Druitt and Redfern in Sydney. Most of the residents of these communities are unemployed and live in substandard public or community housing. Crowded living conditions contribute to high rates of infectious diseases such as rheumatic fever, nephritis and trachoma, normally found only in Third World countries.

One of the milestones in Indigenous health was the establishment of the Aboriginal Community Controlled Health Services (ACCHS) in the 1970s. Based on the principle of self-determination, these organisations promised to provide not only a more culturally appropriate service but the opportunity for Aborigines to control and manage their own affairs. The prevailing point of view (at least among government and health professionals) is that ACCHS provides an important service, yet the relative effectiveness of ACCHS overall has never been evaluated.[3]

The relative effectiveness of ACCHS overall has never been evaluated.

NACCHO (the national umbrella organisation for ACCHS) argues that it has never received the resources needed to operate effectively, and that given more funding, the ACCHS could make a greater contribution to 'closing the gap' between Indigenous and non-Indigenous Australians.[4] But Commonwealth government expenditure on ACCHS increased by 83% between 1998–99 and 2004–05 with no noticeable improvements in health outcomes.[5]

This paper analyses current funding models for Indigenous specific health programs and ACCHS, and examines why increased funding has failed to make a significant difference to health outcomes. Starting with a brief overview of the Rudd government's 'Closing the Gap' strategy, the paper looks at the problems with averaging Aboriginal health outcomes and shows the poor health of Aboriginal and Torres Strait Islanders living in discrete communities. The diversity of Indigenous Australians' experiences needs to be recognised to match funding with need.

The paper then examines current government expenditure on Indigenous health and how funding for ACCHS is lost in a maze of bureaucracy and untargeted spending, never reaching the programs and services for the people who need it most.

Next, the paper describes the problems caused by the lack of strong leadership at the national level and how this affects the delivery of Indigenous health programs and the quality of health services provided.

Finally, some recent proposals for reform are discussed and critiqued. In looking for change, we need not 'throw the baby out with the bath water.' There are lessons from the past that should be adapted and applied today, including the notion of coordinated care that is a patient centred rather than a provider focused form of health care delivery. Better and more accurate data collection is needed to match health services with need. The principle underpinning any allocation of funding should be the responsibility to document how that funding is spent. Only when there is greater accountability and efficacy will the benefits of extra Indigenous health funding be realised.

Indigenous health policy

As part of his Apology speech to the Stolen Generations in February 2008, Prime Minister Kevin Rudd set some bold targets for Aboriginal health. He promised to close the gap in life expectancy between Indigenous and non-Indigenous Australians within a generation and halve the gap in mortality rates for Indigenous children under five years of age within a decade.[6] The 'closing the gap' rhetoric was quickly adopted by the Council of Australian Governments (COAG) and used to shape its overarching reform agenda for Indigenous Australians.[7] On 30 November 2008, COAG announced $4 billion in funding to 'improve housing, health, employment and to drive fundamental reforms to Indigenous service delivery over the next ten years.' Of this funding, $1.6 billion was set aside for improving Indigenous health outcomes over the next four years. The Commonwealth government agreed to contribute $805.5 million, with the states and territories contributing the rest. This is in addition to the $204.3 million in extra funding (above baseline levels) outlined in the Commonwealth government's 2009–10 Budget.[8]

The Prime Minister has used the 'Closing the Gap' slogan to mark a new beginning in Indigenous affairs, to establish his government's commitment to addressing Indigenous disadvantage, and to speak of 'new partnerships' between Indigenous and non-Indigenous Australians.

The starting afresh approach, adopted by nearly every new government, is a way of avoiding responsibility for what is happening now by damning the past. However, often new policies simply recycle the failed policies of the past.[9]

Previous government policies show that the notion of achieving statistical equality and 'partnerships' between Indigenous and non-Indigenous Australians is not new. Since comparable statistics first became available in the 1971 Census, the extent of Aboriginal disadvantage *vis-a-vis* non-Indigenous Australians has been the subject of numerous reports. Over the years, a number of policy commitments have been made to improve Aboriginal health outcomes and 'close the gap' between non-Indigenous and Indigenous Australians. However, good intentions have never been enough to bring about change. Indigenous Australians need more than just 'frameworks' and 'strategic health partnerships.'

Noel Pearson argues that government bureaucracy interprets 'partnerships' as a continuation of existing government programs and service delivery with an emphasis on 'whole of government' and 'coordination.' Governments have failed to come to grips with the need to change the way in which services are delivered to Indigenous communities:

> … we have a situation wherever every [sic] gallah in every pet shop is calling what they do 'partnerships' without fundamentally changing the … State's relationship to Aboriginal people.[10]

Table 1: Brief History of Indigenous health policies and frameworks[11]

Year	Landmarks
1971	Aboriginal Community Controlled Health Services (ACCHS) started in Redfern in Sydney, NSW.
1973	The Central Australian Aboriginal Congress established Aboriginal Community Controlled Health Services (ACCHS) in the Northern Territory.
1976	Aboriginal community-controlled organisations providing health services formed a peak body, the National Aboriginal and Islander Health Organisation (NAIHO).
1978	The Alma Ata Declaration on Primary Health Care promoted comprehensive Primary Health Care as a means for achieving 'Health for All' by 2003.
1985	NAIHO established its own secretariat with an office in Melbourne and accepted government funds for the first time, having previously relied entirely on donated monies.
Late 1980s	NAIHO collapsed due to lack of funding.
1987	The Hawke government launched its Aboriginal Employment Development Policy to deliver statistical equality between Indigenous and other Australians by 2000.
1989	The National Aboriginal Health Strategy (NAHS) was developed to provide agreed directions for Aboriginal and Torres Strait Islander health policy in Australia.
1992	A new peak body, the National Aboriginal Community Controlled Health Organisation (NACCHO), was formed.
1994	An evaluation of the NAHS found that it had not been implemented due to underfunding by all governments.
1997	The federal government funded NACCHO to establish a Secretariat in Canberra.
1998	The Howard government committed to pursuing the goal of 'practical reconciliation' with the aim of reducing Indigenous disadvantage. The Productivity Commission was commissioned to report on progress on a biennial basis, which it has done with its series of *Overcoming Indigenous Disadvantage: Key Indicators* reports.
2003	The National Strategic Framework for Aboriginal and Torres Strait Islander Health was endorsed by all governments. The goal of the framework was to ensure that Aboriginal and Torres Strait Islander people enjoy a healthy life equal to that of the general population.
2005	Human Rights and Equal Opportunity Commission's *Social Justice Report 2005*, which focused on achieving Aboriginal and Torres Strait Islander health equality within a generation, was released.
2007	The Council of Australian Governments (COAG) agreed to a 'partnership between all levels of government to work with Indigenous communities to achieve the target of closing the gap on Indigenous disadvantage.'
Feb 2008	The commitment to closing the gap was reaffirmed by the Prime Minister in the National Apology to Australia's Indigenous Peoples on 13 February and formalised with the signing of the statement of intent in March.
Nov 2008	COAG announced $4 billion in funding to 'improve housing, health, employment and to drive fundamental reforms to Indigenous service delivery over the next ten years.'

Status of Indigenous health

One of the key measures of the health of a population is life expectancy. In Australia, the average life expectancy of Aborigines and Torres Strait Islanders is measured against the average life expectancy of non-Indigenous Australians. According to the latest statistics published by the Australian Bureau of Statistic (ABS), the difference or the 'gap' between Indigenous and non-Indigenous Australians declined from 17 years to 11.5 years for men and from 17 years to 9.7 years for women. However, the ABS attributes this decline to changes in the methods used to calculate the statistics; according to the Chairman of the Productivity Commission, Gary Banks, 'it is still not possible to say whether the gaps with non-Indigenous people have actually narrowed.'[12] The reason for this uncertainty is the lack of reliable data on which life expectancy measures are based. Only around 50% of death notices identify whether the deceased is of Aboriginal descent.[13] The availability of information also varies from state to state and territory to territory, and there is no national data available on life expectancy trends.

By averaging the outcomes of all people who identify as Aborigines and Torres Strait Islanders, the 'Closing the Gap' policy ignores those Indigenous people who have achieved success in mainstream Australia and downplays the real levels of disadvantage experienced by others. Because the statistics are an average of overall life expectancy, they fail to show how low the life expectancy is in some communities. For example, in three separate Indigenous communities—the Tiwi Islands, Wadeye, and Palm Island—the average male life expectancy is only around 46–50 years compared to 79 years for non-Indigenous Australian men.[14]

The continual highlighting of 'gaps' between Indigenous and non-Indigenous Australians perpetuates assumptions that Aboriginal ill health is related to 'ethnic' or 'racial' characteristics.[15] However, there is clear evidence that lifestyle factors such as alcohol, drug and tobacco use, physical inactivity, and poor diet account for a large percentage of the difference in health outcomes between Indigenous and non-Indigenous Australians.[16] For example, the difference between Indigenous and non-Indigenous infant birth weights largely disappears when maternal smoking is taken into account.[17]

Isolated from mainstream Australia, they live in appalling community housing and suffer from some of the highest rates of rheumatic fever and infectious diseases in the world.

In looking at the status of Indigenous health, it is important to recognise the diversity of Aborigines and Torres Strait Islanders. Of the estimated 540,000 Aborigines and Torres Strait Islanders in Australia today, some 340,000 live and work in cities and towns. They own or privately rent their homes and have similar health characteristics to the general non-Indigenous population. Approximately 130,000 Aborigines and Torres Strait Islanders are unemployed and dependent on welfare. They largely live in public housing in cities and towns and have similar health characteristics as other welfare-dependent people. Poor diet, smoking and alcohol abuse are the primary causes of ill health, and access to mainstream health services and ACCHS appears to have had little impact on the severity or prevalence of these addictions. Around 70,000 Aborigines and Torres Strait Islanders live in remote Australia. Of this group, approximately 60,000 live in 26 larger settlements, where medical services are generally available. The remaining 10,000 Aborigines and Torres Strait Islanders live in the 'homelands' on 'outstations' with limited access to medical services. The health status of these 70,000 Aborigines and Torres Strait Islanders is worse on every indicator than any other population group in Australia. Isolated from mainstream Australia, they live in appalling community housing and suffer from some of the highest rates of rheumatic fever and infectious diseases in the world.[18] Separatist education policies have resulted in low levels of literacy and numeracy, and many young people leave school with poor English language comprehension. Most residents are unable to read labels on medicine bottles or understand medical practitioners.

Box 1 paints a bleak picture of the health status of this group of Aborigines and Torres Strait Islanders. However, due to the paucity of data available on the health of Aborigines and Torres Strait Islanders,[19] caution should be exercised in interpreting these figures. With some notable exceptions,[20] only a few studies look at regional variations, so the statistics tend to show averaged outcomes and include those living in mainstream Australia. There is also evidence that not all cases of disease or illness get recorded.[21] For this reason, the following figures may not be accurate or reflect the abysmal reality. Indeed, anecdotal evidence suggests that in some communities, the health status has declined rather than improved during the last 30 years.[22]

Box 1: Health status of Aborigines and Torres Strait Islanders living in Indigenous communities[23]

- **Child mortality rates**: Babies born to Indigenous women are more likely to die in their first year than those born to non-Indigenous women. The average Indigenous child mortality rates for children aged between 0–4 years is four times higher than that of non-Indigenous child mortality rates.
- **Death rates:** Aboriginal and Torres Strait Islander people have a much higher burden of disease than other Australians.[24] Indigenous death rates for diabetes are nine times as high as non-Indigenous rates, six times as high for cervical cancer, four times as high for kidney diseases, and three times as high for digestive diseases.[25]
- **Cardiovascular disease:** The leading cause of death for Indigenous people living in Queensland, Western Australia, South Australia, and the Northern Territory is cardiovascular disease. Deaths from cardiovascular disease are around three times more common for Indigenous people than for non-Indigenous people, and Indigenous people are much more likely to die from it than other Australians at any age, but particularly in younger age groups.[26]
- **Diabetes:** Diabetes is around three and a half times more common among Indigenous people than among other Australians. End-stage renal disease treatment (a common complication of poorly treated diabetes that can be necessary if the diabetes hasn't been managed properly) is common amongst Indigenous people living in remote and very remote areas. In 2006, Indigenous people living in remote areas were 26 times more likely to register for end-stage renal disease treatment than non-Indigenous people.[27]
- **Tuberculosis**: The rate of newly diagnosed cases of tuberculosis for Indigenous people between 2002 and 2006 was more than 14 times the rate for Australian-born non-Indigenous people. Some remote Aboriginal communities also have among the world's highest recorded rates of rheumatic fever and rheumatic heart disease.[28]
- **Skin diseases**: In many remote Indigenous communities, people's skin and intestines are more diseased than those of people in Africa and other developing countries.[29] Up to half the children in some of these communities are infected with scabies. Skin diseases like scabies (caused by a mite) and streptococcal pyoderma (a bacterial infection) cause very few deaths directly, but they are linked with serious complications. In 2007–08, they accounted for about one out of every 25 hospital separations among Indigenous patients (excluding those for renal dialysis), a rate more than twice that of non-Indigenous people.[30]
- **Eye and ear**: Eye and ear problems are also much more common amongst remote Aborigines. In some remote Inland communities, more than 20% of children suffer from trachoma.[31] Otitis media (middle ear infection) is also three times more common among remote Indigenous Australians than non-Indigenous Australians. Both these diseases impair participation in education and limit employment opportunities.
- **Oral health**: Poor oral health typical of remote communities also affects educational and employment outcomes and can exacerbate other chronic diseases. Aboriginal and Torres Strait Islander children have twice the level of dental cavities compared to the general population and are less likely to have them treated.[32]

Health expenditure

Just as measuring the health status of Indigenous Australians is beset by data and methodological difficulties, so is measuring expenditure on their health. There is practically no data on what funds are spent in each region of each state, or on any group of people in any state.[33] The Australian Institute of Health and Welfare (AIHW) provides information on Indigenous expenditure as part of a series of reports, but the AIHW recommends caution in interpreting the figures because it relied on surveys to estimate some of the health services used. As a result, the reliability of expenditure estimates is affected by sampling errors.[34]

Total Australian health expenditure for 2006–07 was $80.9 billion. Of this, $54.9 billion was sourced from federal and state/territory governments. Per capita total health expenditure was about $3,800 for 21 million Australians.[35]

The AIHW estimates that the Commonwealth and state and territory governments provide more than 90% of funding for Indigenous health in contrast to around 60% of total spending on non-Indigenous health.[36] The heavy reliance on government provided health care amongst the Indigenous population is attributed to their relatively poorer socio-economic status and inability to afford private health insurance. AIHW figures also suggest that overall, Indigenous people are more likely to rely on community-based health care such as ACCHS compared to non-Indigenous Australians. After expenditure on public hospitals (which is difficult to measure reliably due to a lack of data on the Aboriginal status of patients), community health was the next largest category of government Indigenous health spending. However, only around 30% of Aborigines and Torres Strait Islanders report that their usual source of care is an ACCHS.[37] Most Aborigines and Torres Strait Islanders use Medicare and drugs subsidised by the Pharmaceutical Benefits Scheme (PBS) but are less likely to use these services compared to non-Indigenous patients owing to the shortage of doctors in many remote areas.[38]

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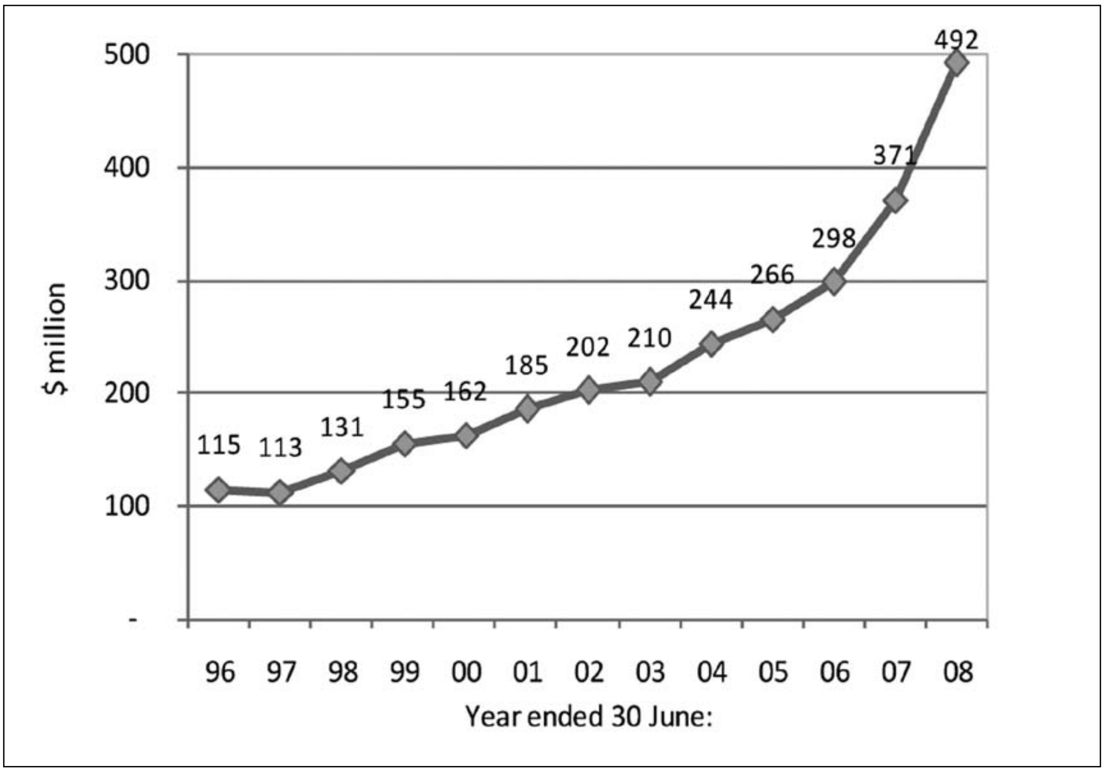
Aboriginal and Torres Strait Islander health expenditures have been rising more rapidly than overall health expenditures.[39] Between 1997–98 and 2007–08, Australia's expenditure on health in real terms (after adjustment for inflation) grew at an average of 5.2% per year, compared with average growth in real GDP of 3.5% per year.[40] Figure 1 shows that over the last 12 years, the Australian government increased its spending on Indigenous health programs by 328%—from $115 million in 1995–96 to $492 million in 2007–08. Unfortunately, total government health expenditure data on programs specifically for Aborigines and Torres Strait Islanders are not readily available.[41] But we do know that the Commonwealth government provides about 80% of specific Aboriginal and Torres Strait Islander funding while states and territories provide the other 20%.[42]

Effective lobbying by NACCHO has seen funding for ACCHS increase over the last 20 years. In 1990, the National Aboriginal Health Strategy added $47 million for community controlled health services.[43] In 1994–2005, the Commonwealth government allocated a further $162 million for Aboriginal and Torres Strait Islander health over five years to expand existing services and create new ones. Between 1997–98 and 2005–06, total Office of Aboriginal and Torres Strait Islander Health (OATSIH) funding to Aboriginal and Torres Strait Islander primary health care services (ACCHS that were required to complete a service activity report) increased from $84 million to $210 million.[44] In 2006–07, this figure increased by 15.5% to $242 million.[45] This equates to nearly half the total of Commonwealth government spending on Indigenous specific health programs.

Figure 1: Expenditure by the Australian government on Indigenous specific health programs 1995–96 to 2007–08



Source: Australian government, Department of Health and Ageing

Definitions of different types of health care

Public health focuses on the health and well-being of populations rather than individuals. Programs are usually aimed at addressing the factors that cause illness, and deal with prevention rather than the consequences of ill health.[46]

Primary health care is generally considered to mean the first point of contact that a person has with the health care system—medical services provided by GPs, ACCHS, community health nurses, Aboriginal Health Workers (AHW), pharmacists, and environmental health officers. It also includes dental care services and preventive health programs, including immunisation and diabetic screening and testing, which are often referred to as public health programs.

Secondary and tertiary care is specialist care provided either as an emergency or electively, for example, a medical specialist consulting with a patient on a complex, long-term medical condition arising from the complications of diabetes. Emergency care is available through hospitals, with the Royal Flying Doctor Service providing transport for patients in remote areas. Elective care involves planned specialist medical care or surgery, usually following a referral from a primary or community health professional such as a GP. Specialist health services are available to Aboriginal people in rural and remote areas, but are infrequent and may be difficult to access in remote settlements.[47] Visiting specialists occasionally conduct clinics at public hospitals, but these services often have long waiting lists.[48]

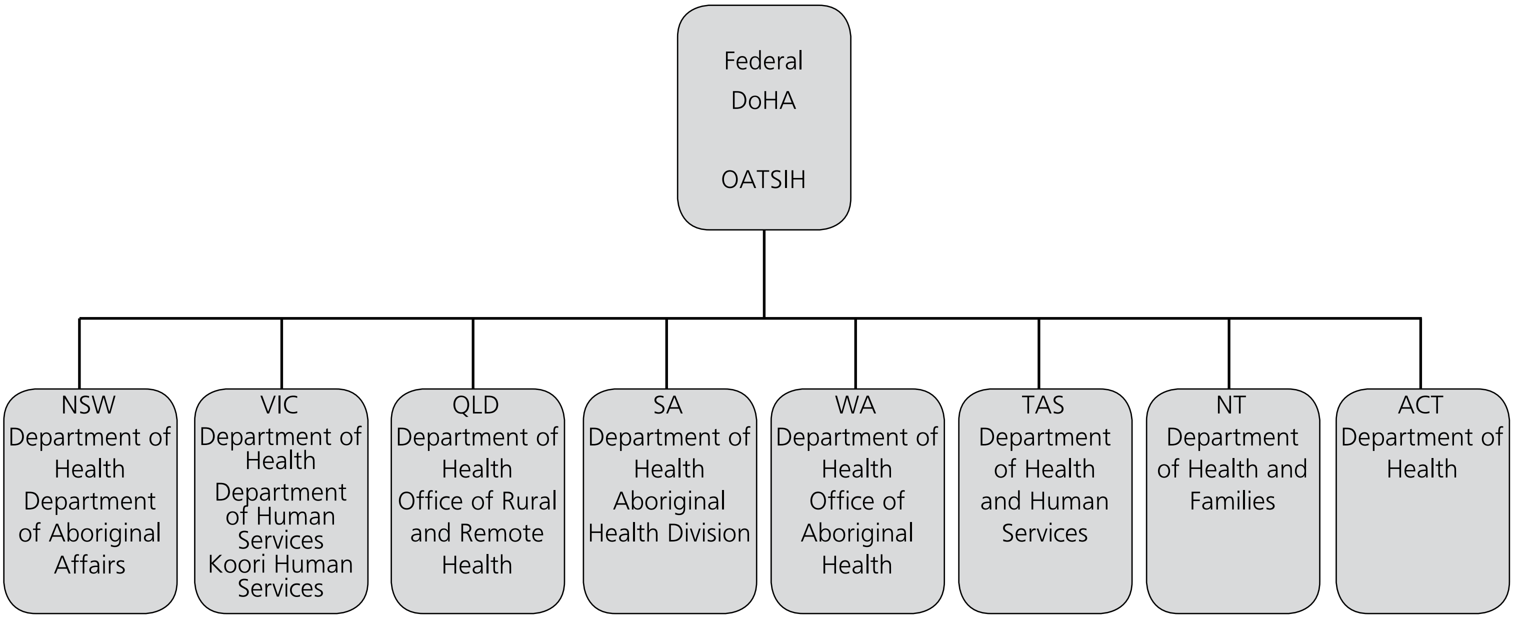
Hospitals: For many Aborigines and Torres Strait Islanders, hospitals act as a de facto primary health care provider. Aborigines and Torres Strait Islanders often do not receive medical attention until they are so sick that they require hospitalisation. For example, a toothache may be neglected to such a degree that patients require oral surgery in a hospital. Likewise, the symptoms of diabetes often go un-investigated and untreated until complications require the patient to seek medical care, which may require dialysis and surgery. Consequently, the rate of Indigenous hospitalisation (per capita) is around twice that of non-Indigenous people.[49] There is also evidence to suggest that some Aborigines and Torres Strait Islanders prefer visiting the emergency department in public hospitals than their local GP or Aboriginal Medical Service. Nhulunbuy in the Northern Territory has three Indigenous specific health care providers and a GP, but Indigenous patients still constitute more than 80% of the patients at the local hospital.[50]

The delivery of health care

The Commonwealth Department of Health and Ageing (DoHA) has overall responsibility for federal funding of Aboriginal health. Within DoHA, OATSIH is the division primarily responsible for policy development, budgeting and funding allocation, contract management, and reporting. It also manages research funds. However, other divisions of DoHA, notably Aged Care, Rural Health, Education, and Prevention, also provide funding to ACCHS. So do other Commonwealth departments, including Families, Housing, Community Services and Indigenous Affairs (FaHCSIA).

Each state and territory has its own health department, and some states and territories have separate divisions for Aboriginal policies (see Figure 2).

Figure 2: Government health bodies

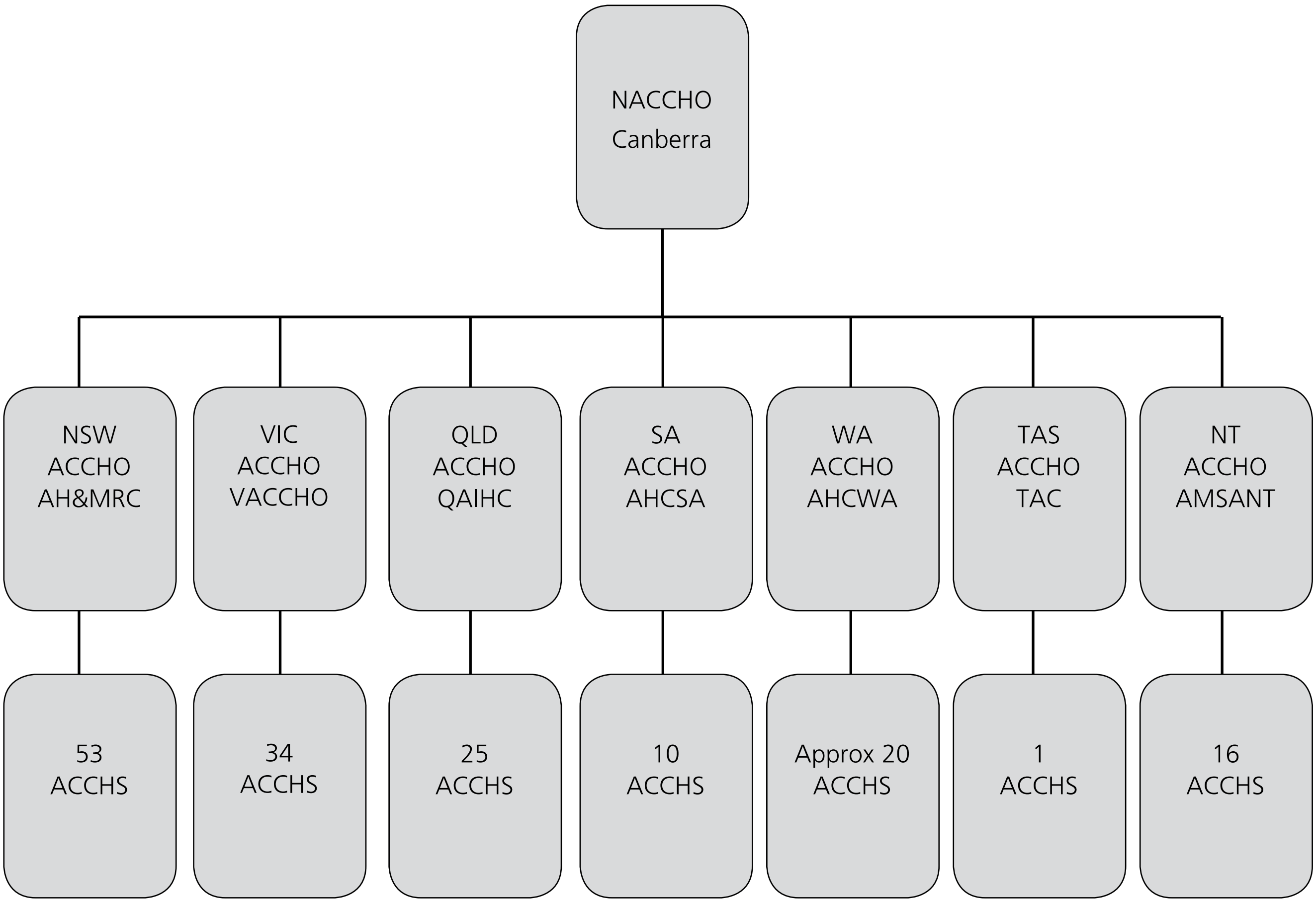


In some states and regions, the majority of health services in discrete Indigenous communities are provided by government agencies. For example, services in remote areas of Queensland are largely provided by its Department of Health through very small clinics supported by regional hospitals. The only exception is Cape York and the Torres Strait, where communities are serviced by primary health care centres as there is only one hospital on Thursday Island. In the Northern Territory, primary health care in remote areas is mostly provided by Territory Health Services through Remote Area Health Clinics. In Western Australia, the provision of primary health services differs across the state. The ACCHS in Western Australia are concentrated in the top half of the state and are mostly based in towns, although some also provide outreach services to smaller communities or are based in a remote community, such as the Marparna Cultural Health Centre in Wirrimanu Community in Balgo Hills. In other rural and remote areas of Western Australia, a network of small hospitals provide primary health care and some remote communities have nursing outposts. Larger towns have community health clinics.[51]

The ideology behind Aboriginal community controlled care is that Indigenous-owned and -operated health services are more culturally appropriate than the mainstream services provided by GPs, dentists, and the staff of public and private clinics and hospitals. Aboriginal community controlled care is supported by NACCHO in Canberra. NACCHO's main purpose is to act as an advocate for increased funding and support of ACCHS.[52] Each state and territory has an affiliate organisation known as Aboriginal Community Controlled Health Organisations or ACCHOs. Most ACCHOs have members (ACCHS) and associate members. Members must provide primary health care services and associate members must provide specialist health related services (see Figure 3). While NACCHO and its affiliates act as umbrella organisations for ACCHS, no funding is distributed through them to ACCHS. Rather, each ACCHS applies for funding from OATSIH and other relevant government departments.

As Figure 3 shows, the majority of ACCHS are located in New South Wales and Victoria. They are mostly in regional locations outside of the main cities, and only 51 are in remote locations.[53]

Figure 3: Aboriginal Community Controlled Health Services (ACCHS)[54]



The problems with ACCHS

To date, Commonwealth attempts to improve the service delivery of primary health care to remote communities have focused on strengthening and expanding the number of ACCHS. But the large increase in funding to ACCHS has had a limited effect on Aborigines and Torres Strait Islanders living in remote communities, as most ACCHS are located in cities and towns. Given the abysmal health of Aborigines and Torres Strait Islanders living in Indigenous communities, there is no disagreement as to the need for additional resources to address the problem. However, the destination of government funding for Indigenous health programs and ACCHS is opaque. Where does the $492 million in Indigenous specific funding provided by DoHA go? If it is divided amongst the total Aboriginal population of 540,000 it works out to be less than $1,000 per person, which is hardly a huge sum of money. Calculating the allocation of this funding per capita is often used as justification for increased funding for Indigenous health.[55] However, if the funding were targeted to those most in need, for example, those Aborigines and Torres Strait Islanders living in remote communities (roughly 70,000) where there are few doctors and where there is the greatest health need, then the $492 million translates to $7,028 per person.

The large increase in funding to ACCHS has had a limited effect on Aborigines and Torres Strait Islanders living in remote communities, as most ACCHS are located in cities and towns.

As the situation stands, the untargeted nature of spending means that it is difficult to know precisely what services the money is buying, for whom, and the evidence of benefit. Without detailed knowledge of these outcomes, it is not clear whether the problem is that Aboriginal health providers do not have enough straw to make bricks or whether the straw they have is being wasted.

Lacking in capabilities

There is considerable diversity amongst ACCHS, with some providing a wide range of services while others are smaller and provide fewer services. The larger ACCHS tend to have the expertise and money to meet reporting requirements for funding, but the smaller organisations struggle to fulfil the requirements for compliance with governance, and tend to lack the skills to assess whether reports have been completed satisfactorily.[56] Some services do not have up-to-date technology, or if they do, they don't have adequately trained staff to use it.

A number of Board members of ACCHS, particularly those in remote and regional areas, have barely completed Year 8 or 9. With little education and no management experience, they are expected to run multi-million dollar organisations. According to an ACCHS Finance Manager, the whole concept of community control is flawed because it is not based on Board members having the expertise to do their job but on who attends annual meetings and how well connected they are.[57]

Complex funding arrangements

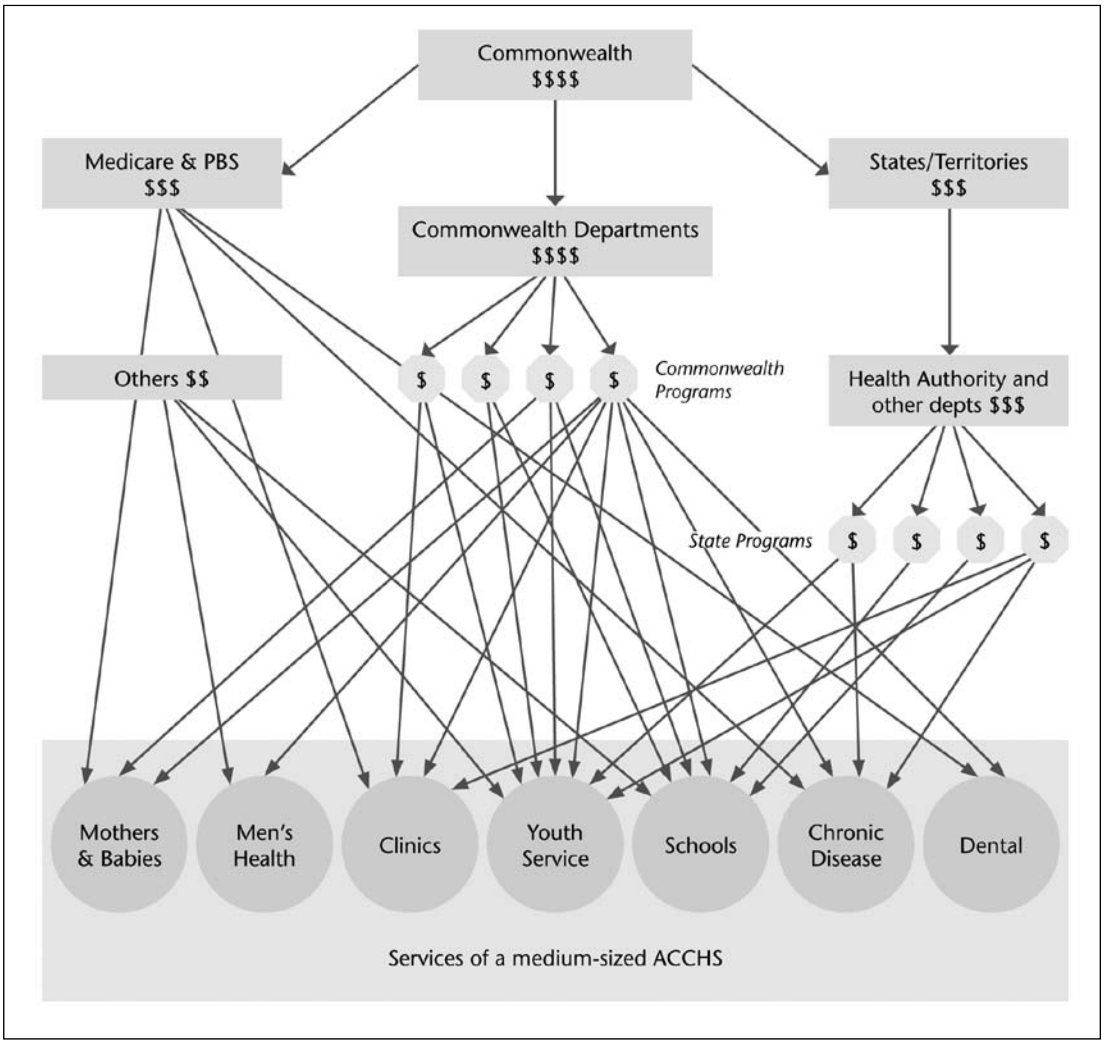
Adding to the problems caused by a lack of skill and capability is the fact that ACCHS are funded in more complex ways, and from more sources, than most other health care organisations of an equivalent size.[58] A typical ACCHS may be in receipt of funding from 25 different sources for seven separate services or programs. One Aboriginal health service operating in a remote area was funded from 42 different sources, each of which required a separate application and report, with some of the grants being for as little as $1,000.[59]

Funding is not only fragmented but frequently duplicated as well. According to an ACCHS CEO:

> There are lots of buckets of money from lots of different programs from the same funder that are addressing the same issues, but with a different name.[60]

As Figure 4 shows, the funding flows for a medium-sized ACCHS are extremely complex. These funding arrangements prevent effective health care for a number of reasons. The range of specific purpose grants with separate reporting requirements for each program brings a heavy burden of acquiring, managing and reporting to both sides of the funding relationship. These problems are compounded by the lack of consistency in reporting requirements at the federal and state/territory level.[61] Since the amount of time that goes into preparing and processing the reports is often out of proportion to the funding levels provided, some ACCHS simply give up and do not file reports. Those that do file reports often focus only on documenting minimum quantitative throughputs (head-counts of patients) rather than reporting on the health outcomes of their patients and programs.[62]

Figure 4: Funding flows for a medium-sized ACCHS



Source: The Overburden Report: Contracting for Indigenous Health Services (Melbourne, Flinders University and the Cooperative Research Centre for Aboriginal Health, 2009)

Reducing the burden on health providers by moving to long-term funding requirements, with lower and more flexible reporting requirements, is not a solution that can be applied universally. There is considerable risk in choosing this type of funding model, and it should only be used for organisations with a proven track record and with good risk management strategies in place.[63]

Lack of accountability

There is no single repository of information on the total amount of funding received by ACCHS because they receive funding from a number of different governments and government departments.[64] Adding to the difficulty in tracking ACCHS expenditure is the fact that not all ACCHS file annual reports or provide financial statements.

Health services receiving funding from OATSIH are required to supply quarterly Periodic Financial Statements and Annual Returns, and an Auditor's Report is required if the funds total more than $30,000. All services are expected to provide the same level of information and detail in their financial reporting regardless of their size or range of services provided. OATSIH project officers are responsible for administering and monitoring the funding of health services, but evidence suggests that ACCHS are not monitored or managed in any consistent way.[65]

There is a provision for organisations to apply to OATSIH to vary their financial reporting requirements, if needed. The latest DoHA annual report suggests that a number of ACCHS are struggling to meet their financial reporting requirements. These ACCHS are termed to be at 'extreme risk' and were given significant additional support to improve their governance and business management and to ensure continued service delivery.[66] But how long will government keep tolerating this failure? There must come a time when government acknowledges that some organisations lack the capabilities needed to provide a health service. Monitoring ACCHS is also made difficult by the fact that different forms of registration are used by the 200 or so ACCHS and their associates (see Table 2). In Australia, most organisations are required to register with the Australian Securities and Investments Commission (ASIC) and provide annual reports. Seven ACCHS are registered with ASIC, and presumably they filed annual reports. But Indigenous organisations have different registration requirements than other Australian businesses and can choose to register themselves with the Office of the Registrar of Indigenous Corporations (ORIC) instead of ASIC. Organisations that register with ORIC are subject to compliance with the *Corporations (Aboriginal and Torres Strait Islander) Act 2006* (*CATSI Act*), which has laxer reporting requirements than the *Corporations Act 2001* administered by ASIC. At the same time, ORIC confers extraordinary powers to the Registrar, for example, the ability to impose an Administrator in the event of mismanagement.

Half of the 103 Indigenous health corporations registered with ORIC provided annual reports and financial statements

However, ORIC does not appear to exercise its powers, as few penalties are applied to organisations that do not file their annual reports. In 2005–06, half of the 103 Indigenous health corporations registered with ORIC provided annual reports and financial statements, and a further 13% provided some of the information required.[67] Investigation of the ACCHS registered with ORIC found a number of them had not filed any annual reports since they first registered, and there were multiple exemptions from reporting notices for different ACCHS.[68] Eventually, however, organisations that repeatedly fail to provide annual reports or other financial information are threatened with prosecution and deregistration.[69] But even this does not seem to act as a deterrent, as some of these organisations then go on to register themselves as an Incorporated Association under various State and Territory Association legislation.

Table 2: Distribution of ACCHS and Associates by registration, September 2009

Registered with the Office of the Registrar of Indigenous Corporations (ORIC)	80
Registered with the Australian Securities and Investment Commission (ASIC)	7
Registered with states/ territories	45
Not listed on ORIC or ASIC website	58
Deregistered	7
In liquidation	2
Unknown	7
Total	206

Source: Author's calculations based on information from the ORIC and ASIC websites

The 45 ACCHS registered with state/territory offices are subject to less onerous reporting requirements than those reporting to ASIC or ORIC. As legislation differs in each state or territory, it is difficult to describe detailed requirements for Incorporated Associations but, as a minimum, they are required to hold regular meetings, keep minutes, and file annual reports. It is not possible to check how many Incorporated Associations filed annual reports as most states and territories do not make this information readily available. A fee for obtaining a copy of a report is required in New South Wales and the Northern Territory, and only South Australia appears to publish information online.[70]

ORIC confers no benefit on Aboriginal and Torres Strait Islander corporations by not enforcing reporting requirements.[71] On the contrary, it exposes them to inefficiency and even fraud, as illustrated by the travails of the Biripi Aboriginal Medical Service near Taree in New South Wales (see Box 2). However, Biripi Aboriginal Medical Service is not an isolated example. Investigation on the Internet found a number of ACCHS had closed down due to financial mismanagement.[72] One organisation was put in liquidation after it was found to be trading while insolvent. An examination by the Registrar of Indigenous Corporations found that it had poor record keeping, had failed to hold an annual general meeting, and that its directors were unaware of its financial position.[73] Another ACCHS was declared unsafe by the Office of Work Health after it failed to obey any of the Industrial Relations Commission's recommendations following a workers' claim that they were being bullied and harassed by management.[74]

Box 2: Biripi Aboriginal Medical Service[75]

In 2007, an administrator was called in to address a number of problems at the Biripi Aboriginal Medical Service charged with looking after the health of 3,500 Aborigines living in the Taree district in NSW.

Almost all the 75 staff, even the receptionist, had a mobile phone. According to one informant, 'there were enough cars to run a taxi fleet for the township of Taree.' Funds had been paid into a $385,000 building program with little result.

The administrator cut expenses in half and offered redundancies to staff holding unfunded positions. His administration lasted 12 months and cost taxpayers more than $150,000. In addition, close to $200,000 was paid out in redundancies.

Just 12 months after coming out of administration, the Biripi Medical Service was rocked by a spate of legally disputed dismissals, forced resignations, and the alleged misuse of taxpayer funds. Non-Aboriginal employees claimed to have been harassed and threatened.

An investigation found that Biripi had no strategy to deal with Aboriginal health issues particular to the area and had yet to produce any evidence of improved medical outcomes.

In three months from September 2009, three members of the Board, including the Chairman, were forced to resign by the DoHA as they were not qualified to serve because of criminal convictions. Biripi also faces wrongful dismissal claims from two former staff members.

Despite the administrator's tough restrictions on the use of mobile phones and petrol vouchers, spending on both items had again ballooned, with thousands of dollars a month spent on petrol vouchers by non-staff members.

The chairman was given $15,000 to buy a Pajero vehicle in April: $10,000 as a grant and $5,000 as a loan to be repaid. It is not known whether the Board approved these payments, which were authorised by the chief executive and a financial officer.

* According to the CEO of the Biripi Aboriginal Corporation Medical Centre, Biripi has overcome its difficulties and is now progressing well.

Of public concern is the fact that 58 ACCHS and associates do not appear to be registered with any statutory body. So how are they meeting their financial reporting requirements? For organisations receiving substantial public funds to deliver important and much needed health services, this situation reflects poorly on the governance and probity of ACCHS.

Problems with delivering primary health care to Indigenous communities

Numerous agreements but no leadership

Numerous government agreements purport to explain how health targets can be met and who is responsible for delivering the services that are required to meet them. Along with the National Strategic Framework for Aboriginal and Torres Strait Islander Health, there is the *Intergovernmental Agreement on Federal Fiscal Relations*, which incorporates six new National Agreements, including the *National Healthcare Agreement* and the *National Indigenous Reform Agreement*. COAG also has a number of National Partnership Agreements, including the *Remote Indigenous Service Delivery*

Partnership Agreement and the *Indigenous Health Partnership Agreement*. However, rather than providing a transparent policy framework, the sheer number of these agreements only serves to confuse. Despite the list of white papers for Indigenous policy reform, the Senate Select Committee on Regional and Remote Indigenous Communities found it frustrating that there was no '… clear and transparent policy framework governing the [overall] operation of Indigenous Affairs in Australia.'[76]

Different governments and government departments continue to squabble over who is responsible for the provision of health services to Indigenous communities. This confusion and buck-passing has had serious repercussions on Indigenous health. In 2008, NSW state departments fought over who was responsible for funding water and sewerage upgrades in Aboriginal communities. Meanwhile, health figures revealed that the number of Aboriginal children hospitalised with gastroenteritis increased by 218% (within a 10-year period) because of Third World water and sewerage systems.[77] Recently, residents in remote Western Australia and South Australia were told that they can no longer use essential blood dialysis facilities in Alice Springs (only a few hours over the border) because the NT government had decided not to provide this service to anyone living outside the territory. Instead, chronically ill patients were expected to travel more than 600 km to facilities in their own states.[78] These examples make a mockery of the 'whole-of-government' agenda.

Different governments and government departments continue to squabble over who is responsible for the provision of health services to Indigenous communities.

Ad-hoc program delivery

> So many programs are being delivered, in so many conflicting ways, that the Commonwealth and Northern Territory governments have been forced to appoint co-ordinators of remote area services: a confession of Kafkaesque gridlock.[79]

Lack of strategic planning has led to an uncoordinated maze of health programs. Funding in the 2009–10 Budget is listed by program (or desired outcome) rather than by agency or portfolio, making it virtually impossible to determine how much money is coming from, or going to, each government department. DoHA is listed five times under various programs, so working out the total amount of funding it receives requires adding up these separate amounts. Furthermore, some programs have multiple agencies charged with delivering health services, so there is no way of assessing how that money is to be dispersed among the various government departments. In total, the 2009–10 Budget allocates $204.3 million for 'closing the gap' in Indigenous health on top of base funding levels which were not reported. Most of this additional 'closing the gap' funding is for remote primary health care ($131.1 million); eye and ear health care ($58.3 million); dental care ($11.0 million); and improving pathology services for Aboriginal and Torres Strait Islander people ($3.8 million).

As well as the various programs funded by DoHA through OATSIH, each state and territory also has its own Indigenous health programs. There are programs aimed at addressing substance abuse and mental health as well as programs specifically targeting men's, women's and children's health. There are also environmental health programs that aim to ameliorate the effects of poverty, including dog health programs. Many of these different programs have evolved over time in response to a perceived need. As a result, they tend to be ad hoc and often end up duplicating already existing programs.[80]

Since there is no overall coordination nor a requirement for an evidence-base for funding, programs may be delivered simply because of the personal interest or bias of health workers, or because funding can be secured from one or another of the federal or state programs. There is often no consultation with the communities concerned or recognition of their needs. For example, in one community in the Northern Territory an attempt was made to instruct the residents on how to self-manage diabetes. While the training was delivered in the local language, the training failed to take into account the community's lack of literacy and numeracy. Most of the residents did not understand what elevated blood sugar meant and were so little acquainted with 'weight' that they could not relate to the concept of a 'healthy weight range.' Nor did the participants have enough numerical skills to understand the concept of blood sugar readings.[81]

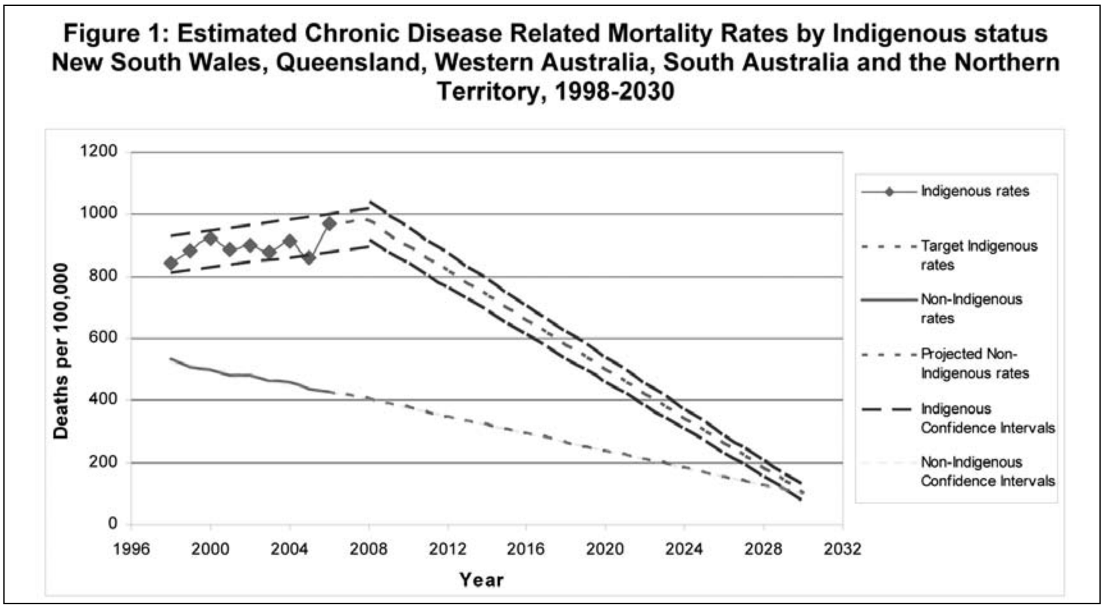
The same community was bombarded with suicide prevention training even though the community had no experience of suicide. The community was not consulted about the need for suicide training, and some of the young men had already been flown to a regional suicide prevention training session in another community at considerable cost two years previously.[82] In another community, the government decided to provide a large grant for family violence that was neither asked for nor required as the community did not have a family violence problem. The government then proceeded to apply pressure on the community to spend the money.[83]

> **In the absence of any evidence-based policy, most of the commitments agreed to by COAG appear more like wishful thinking than anything else.**

When programs are well researched and targeted, they can make a difference to health outcomes. After years of fruitless programs to reduce petrol sniffing, the substitution of OPAL fuel for petrol, though still not universal, has substantially reduced the severe illness and disability that follows petrol sniffing.[84] But, unfortunately, this example is the exception rather than the norm.

Public health programs are generally not based on evidence of beneficial outcome because there is such poor information available on previous attempts to deliver preventive health programs. Often there is no assessment undertaken of the verifiable impact on health outcomes for the money expended. Not surprisingly, this results in a lack of evidence about the best course of action and the relative cost-effectiveness of public health and preventive policies.[85] In the absence of any evidence-based policy, most of the commitments agreed to by COAG appear more like wishful thinking than anything else. A case in point is how DoHA estimates the future trajectory of chronic disease related mortality rates (Figure 5). No reasons are given for how the sharp break in trend is to occur over the next three years.

Figure 5: Commonwealth DoHA—'Closing the Gap' strategy



Source: Commonwealth of Australia, Department of Health and Ageing Budget; Portfolio Budget Statements 2009-10, p238

Gaps and under-servicing in the delivery of primary health care

> Over time, Australia's primary health care system has become increasingly complex, currently comprising a range of governance and finance mechanisms … This has led to duplication of services, wastage of effort and resources, as well as gaps and underservicing.[86]

The inefficiencies of Australia's primary health care system are the focus of current reform.[87] The problems identified in the above quotation are compounded when it comes to delivering primary health care to remote Indigenous communities. There are two reasons for this. The remote location of many Indigenous communities means that there are not the economies of scale to provide a modern primary health care service. In the larger settlements, the dual health care system of ACCHS and mainstream health providers, combined with the potential of conflict of interest from different sources of funding for specific Indigenous health programs, contributes to a lack of coordination in the provision of health services.

The range of different medical services providing health care in remote and regional Indigenous communities varies. Some communities are more than 100 km from the nearest hospital, and there is a shortage of doctors and other specialists servicing the area. In 2005, it was estimated that in major cities there were roughly 335 medical practitioners per 100,000 people. In contrast, in remote and very remote areas there are only around 148 medical practitioners per 100,000 people. The situation is worse when it comes to medical and surgical specialists; on average, remote and very remote communities only have 16 specialists for every 100,000 people.[88]

The difficulty in attracting doctors to remote locations means that many health services have to rely on overseas trained doctors. In rural and regional areas between 1995–96 and 2003–04, there was an 8.8% increase in Australian-trained GPs compared with an 80% increase in overseas-trained doctors. The proportion of overseas doctors increases with remoteness, particularly in Western Australia and Queensland.

As there are few doctors working in remote communities, it is helpful if they can be shared amongst a range of different health providers. For example, in Nhulunbuy, the District Medical Officers at the Gove Hospital also work at the General Practice and at the local ACCHS (Miwatj).[89] Unfortunately, not all doctors are able to job share in this way. Overseas trained doctors are generally granted conditional registration, which means they do not have the vocational registration needed to work in hospitals because of inadequate previous training and acquired skills, and are restricted in what they can claim under Medicare.[90]

A large number of ACCHS rely on overseas doctors and as a result miss out on receiving the full range of funding available.[91] There are also other concerns with the heavy reliance on overseas trained doctors. Since the mid-1990s, the source countries of overseas trained doctors has become increasingly diverse, extending to countries where English language and educational equivalency compared with Australian doctors is variable to low. In addition, many overseas doctors are hired on short-term contracts which prevent any continuity of care. However, there has been little evaluation of the quality of health care provided by overseas trained doctors working in remote Indigenous communities.[92]

Lack of coordination

In general, health services to remote communities and outstations are provided by Aboriginal Health Workers and a range of visiting professionals who fly or drive to communities.[93] The fly-in and fly-out service delivery makes it hard for different health professionals to coordinate with other each other, as most services do not visit the community on the same day. There may be confusion about who is responsible for delivering what, resulting in the duplication of some services and the absence of others.[94]

Administration for these separate service providers wastes large amounts of health funding, and each health provider has different computer systems so patient files are not easily shared.[95] The lack of cohesion between different providers is also influenced by the Indigenous specific funding for various programs. Different health providers often compete with each other for funding, and this leads to funding jealousies when one service gets funding for a program and another does not. As a result, some services closely guard their patient records, and even hold their patients' Medicare cards so that they cannot visit other health providers.[96]

Different health providers often compete with each other for funding, and this leads to funding jealousies when one service gets funding for a program and another does not.

Poor quality health care

In small communities known as outstations, a building in the community is designated as the health centre. These vary in quality. In recent years, the Northern Territory's building program has updated a number of health centres in different communities. Yet, this building program has been conducted in an ad hoc manner, with a new health centre being built for a community of 50 people when there is already a new health centre at a neighbouring community only 15 km away. Meanwhile, other communities continue to rely on old tin sheds.[97]

In the absence of a Remote Area Nurse, Aboriginal Health Workers from the community have the day-to day-responsibility for running the health centre, and visits from nurses and other health professionals may be as infrequent as once a month.[98] In Numbulwar, a community of about 1,200 in East Arnhem Land, there have been no regular GP visits since February 2006.[99]

In Numbulwar, a community of about 1,200 in East Arnhem Land, there have been no regular GP visits since February 2006.

The lack of literacy and numeracy amongst residents of remote communities adds to the professional stress of these health workers. They may be required to act as translators for patients who do not speak English, but nurses and doctors are often unsure about how much English Aboriginal Health Workers understand, and the accuracy of their translations can add to diagnostic difficulties.[100]

In the Northern Territory, registered Aboriginal Health Workers are entitled under section 29 of the *NT Poisons and Dangerous Drugs Act* to supply and monitor medications for patients. A Medicines Book for Aboriginal Health Workers has been produced to assist health workers unable to read other common reference manuals. Despite the prominence of pictures and diagrams to explain information, it is difficult to see how Aboriginal Health Workers with poor literacy could use this book. Simply finding the appropriate page for a particular medication requires a degree of literacy and familiarity with the alphabet.

In ACCHS and clinics in larger Aboriginal settlements, there are frequent complaints about the Aboriginal Health Worker Initial Client Assessment Policy, which requires Aboriginal Health Workers to assess patients and decide whether or not the person needs to see a nurse or a doctor.[101] Because of the poor levels of education in remote communities, these health workers have so few skills that an initial consultation has more to do with community politics than with the patient's health. Many Aboriginal people do not want to be health workers because they are torn between their obligations as an employee and their obligations to their own family, who expect preferential treatment.[102]

Recent proposals for reform

The federal government's *Expanding Health Service Delivery Initiative* plans to regionalise health care around Australia. Regionalisation plans in the Northern Territory are attempting to rationalise services in the Nhulunbuy area and replace the provision of health care to outstations provided by Outstation Resource Agencies. There has been discussion of a new health board to pool the funding provided to four different health providers.[103] Plans for a regional board are also underway in the Barkly region while the West Arnhem region, Central Australia, and the Tiwi Islands are discussing the issue. The idea of pooling disparate funding streams may improve both the efficiency and efficacy of these health services, but could prove difficult to implement. Some Outstation Resource Agencies are opposed to regionalisation as they fear an erosion of their role.

Two reports published recently contain recommendations to reform the delivery of primary health care to Indigenous Australians: National Health and Hospitals Reform Commission's (NHHRC) *A Healthier Future for all Australians* (June 2009) and *Building a 21st Century Primary Health Care System: A Draft of Australia's First National Primary Health Care Strategy* (August 2009).[104]

Six of the NHHRC's recommendations are relevant to the problems raised in this paper. These are summarised below (numbers do not reflect the NHHRC numbering of recommendations):

1. DoHA takes the lead on inter-sectoral collaboration.

2. A substantial increase on current expenditure for Aboriginal and Torres Strait Islander people's health proportionate to health need, the cost of service delivery, and the achievement of desired outcomes. This includes the recommendation for funding equivalent to national average medical benefits and primary health care service funding, appropriately adjusted for remoteness and health status, to be made available for local service provision where populations are otherwise under-served.
3. Care for people in remote and rural locations involves bringing care to the person or the person to care. A number of recommendations are made to achieve this, including the expansion of specialist outreach services.
4. Additional investment includes the funding of strategies to build and develop an Aboriginal and Torres Strait Islander health workforce across all disciplines.
5. Strengthening and expanding organisational capacity and sustainability of Community Controlled Health Services (in other words, ACCHS).
6. The establishment of a National Aboriginal and Torres Strait Islander Health Authority (NATSIHA) within DoHA to commission and broker services specifically for Aborigines and Torres Strait Islanders as a mechanism to focus on health outcomes and ensure high quality and timely access to *culturally appropriate care* (emphasis added).

While some of the NHHRC recommendations have merit and are worth considering, many others reiterate the same old top-down approach and do not address the structural impediments to reform.

The release of the Draft Strategy (as it is referred to) on primary health care is intended to follow on from the recommendations raised in the NHHRC report. The Draft Strategy identifies '**5 key building blocks**' considered essential for 'building a health care system for the 21st century':

1. Regional integration—establishment of regional organisations to drive service integration and address local health needs through flexible service delivery and financing arrangements, including fund-holding models
2. Information and technology, including eHealth—individual Electronic Health Records (computerised filing systems which are easily shared)
3. Skilled workforce
4. Infrastructure
5. Financing and system performance—improved financing arrangements that focus on cost-effective interventions and using information to drive service delivery

The Draft Strategy also identifies four priority areas for change. The first key priority area is relevant to Indigenous health as it focuses on improving access and reducing inequity through universal access to Medicare Benefits Schedule (MBS) and PBS, and targeted and well-integrated programs for rural and remote populations.[105]

Critique of the recommendations

1: DoHA to take the lead on 'inter-sectoral collaboration'

Lack of clear leadership governing the operation and delivery Indigenous health programs and policies is clearly one of the reasons for the lack of transparency and accountability in Indigenous health. Having one government department responsible for the overall management of Indigenous health could improve financial governance and clinical effectiveness, but 'inter-sectoral collaboration' has to consist of more than just 'partnership agreements.'

2: Substantially increasing expenditure on Aboriginal and Torres Strait Islander health

It is of concern that after the commitments made by COAG for a further $1.6 billion on Indigenous health (over the next four years), a substantial increase in funding is still being asked for. The recommendation to provide additional funding equivalent to the level of average Medicare rebates does not take into account the money already provided to ACCHS and through Indigenous health programs, such as the Primary Health Care Access Program (PHCAP).[106] One of the rationales for this funding is that it helps compensate for the lack of access to Medicare funding in remote communities. Yet generally, it fails in this regard because most ACCHS are not in remote communities. There is no indication that additional funding equivalent to medical benefits will be any more targeted than funding for ACCHS and Indigenous health programs. It would be better to increase the availability of Medicare funding that has already started under the Indigenous Access Program and Remote Aboriginal Health Services and Pharmaceutical Benefits Scheme.[107] It seems patently unfair that only Remote Area Health Nurses in the Northern Territory are funded under Medicare. Most ACCHS also double dip by bulk-billing patients and taking program funds.

Medicare funding, by being a fee-for-service model, reduces some of the potential for wastage that can occur when a pool of funding is provided. Although Medicare can lead to 'gaming,' with doctors scheduling more and more appointments to receive more funding, this can be contained with accurate reporting that requires explanations for why the patient had to be seen again. Simply providing organisations with a pool of funding and expecting them to deliver *x* number of services means that some organisations will over-report the number of services provided, or deliver unneeded services to fulfil their expected quota. It can also lead to some organisations denying care to people in order to stay within budgets that are often wasted on administration or mismanaged.

3: The expansion of specialist outreach services

The federal and NT governments have already indicated that they intend to rationalise the delivery of services to remote communities through their Working Future policy and the development of 26 'growth towns.' If this is to work, then investment in improved transport options for local residents is vital. In many outstation communities, residents have to rely on expensive charter flights or bush taxis to visit larger settlements or towns. During the wet season, roads are often impassable because there are no bridges or culverts. Fixing the roads may be cheaper than flying in nurses and other health professionals to remote communities.[108] Sunrise Health, an ACCHS in the East Katherine region, has purchased and commenced the operation of a Patient Travel Bus for its clients in the communities of Barunga, Manyallaluk and Wugularr.[109] This type of service should be replicated in other communities.

4: Funding an Aboriginal and Torres Strait Islander health workforce

Increasing the training and skill level of Aboriginal Health Workers is important, particularly where access to other medical services is limited. But a degree of realism is needed. Many Aboriginal Health Workers lack the fundamental English and literacy needed to undertake written course work, and these skill gaps need to be addressed before any substantive health training can be undertaken. The Northern Territory is the only jurisdiction with a registration system for Aboriginal Health Workers. Although being registered allows them to provide services on a 'for and on behalf of' basis under particular items in the MBS, it has also been found to be a barrier to increasing the number of Aboriginal Health Workers. Many potential workers lack the literacy levels needed to complete the 18-month training to become accredited and then registered.[110]

However, even with the increased training required of them, Aboriginal Health Workers should not be seen as satisfactory long-term replacement for nurses or other health professionals. They should be viewed as making a valuable contribution to the overall primary health care but not the only port of call—otherwise there is risk of exposing Aboriginal and Torres Strait Islanders to substandard levels of primary health care.

5: Strengthening and expanding organisational capacity and sustainability of ACCHS

Funding increases to ACCHS will not lead to improved outcomes while organisations are still incapable of fulfilling the legal requirements for financial planning and management. It is important to recognise that some ACCHS lack the critical mass of trained staff and capacity to provide effective primary health care delivery. Some may be able to improve with support, but others will not. Each service needs to be assessed on its own merits, not simply on the basis that having Aboriginal Community Controlled Health Care is a good idea.

By far the biggest problem when it comes to assessing the contribution that ACCHS make is the lack of data on outcomes. OATSIH recently published a consultation paper on reporting requirements for the organisations that it funds.[111] Its aim is to have simpler reporting requirements but at the same time improve the quality of the information provided. These new reporting requirements are expected to help in the evaluation of COAG agreements, specifically, closing the life expectancy gap within a generation and halving the mortality gap for children under five within a decade.

> **There must be penalties for organisations that fail to adhere to the new reporting requirements, otherwise the current situation, where half the organisations fail to report without sanction will continue.**

While these latest suggestions by OATSIH provide a strategy to improve compliance with the requirements of governance, increased and better reporting by ACCHS has been the subject of numerous reports for well over a decade. If requirements of governance are to be fulfilled, there must be penalties for organisations that fail to adhere to the new reporting requirements, otherwise the current situation, where half the organisations fail to report without sanction will continue. Inconsistencies in registration and reporting requirements could be addressed by requiring all ACCHS to register with ORIC and adjuring ORIC to exercise its powers if organisations fail to report or are mismanaged. Allowing some ACCHS to get away with not meeting their reporting requirements unfairly tarnishes the whole sector.

However, there cannot be a greater level of probity, accountability and transparency whilst there is a fractured system of funding delivery, with so many different governments and government departments involved in the process.

6: NATSIHA and 'regional integration'

The recommendation for a NATSIHA to pool disparate funding streams and hold services more accountable is worthwhile and may address some of the inherent problems in how ACCHS are managed and monitored. But the report barely explains how NATSIHA might work. Before this concept is considered the panacea to Aboriginal and Torres Strait Islander health organisational woes, it needs to be considered within the context of other strategies to integrate and coordinate service delivery.

The need for 'regional integration' and better coordination has been widely recognised for some time but has proven difficult to implement. In the early 2000s, Peter Shergold, then head of the Prime Minister's department under John Howard, introduced a 'whole-of-government approach' to policy development and service delivery as part of a number of COAG trials. The regional focus of the COAG Indigenous trial sites was expected to make them more flexible and more aligned to the needs of different communities. Joint leadership was expected to lead to greater accountability and a more streamlined and integrated approach to the provision of services to Indigenous Australians and their communities. Unfortunately, they were far from that. An evaluation of the trials found they had actually resulted in more visits and consultations by government officials, which consumed communities' time and resources and prevented them from achieving anything on the ground. Rather than reducing the administrative burden faced by these communities, the trials had actually increased the number of funding streams they had to manage. In one community, these funding streams had grown by 50% from 60 in 2004 to more than 90 in 2007. In general, the trials failed because they did not emphasise how governments would need to work differently from how they had in the past.[112]

Although governments need to address the current funding silos, it does not necessarily mean that a top-down government-centred approach is the only way. Although its popularity has waned in recent years, coordinated care provides a model that could be useful for pooling funding and delivering primary health care in Aboriginal communities. Coordinated care is not a top-down process because it relies on first assessing the needs on the ground and then delivering care to meet those needs. Over the years, there have been a number of trials and lessons learnt about what works and what does not. The government needs to start applying those lessons instead of starting from scratch and implementing new policies that often end up repeating the mistakes of the past because they lack an evidence base.

Over the years, there have been a number of trials and lessons learnt about what works and what does not. The government needs to start applying those lessons.

Coordinated care: learning from past mistakes

Coordinated care was popular during the late 1990s and early 2000s. The first round of Aboriginal coordinated care trials were in Katherine West and the Tiwi Islands in the Northern Territory; in Wilcannia in New South Wales; and in Perth and Bunbury in Western Australia. The second round took place in southwest Western Australia, Katherine East in the Northern Territory, and on the North Coast of New South Wales (see Box 3). [113]

Under the coordinated care model, health assessments are carried out to determine patients' needs. The Care Coordinators refer patients to all appropriate medical services and ensure that care is delivered and paid for.

Benefits:

1. The coordinated care model separates the purchasing of health services from the delivery of health services and because all the money can be traced electronically, it keeps both the Coordinator and (Aboriginal) medical service providers accountable. In general, the trials showed that coordinated care enhanced patients' ability to access services and improved individual and community empowerment. However, they attracted criticism because they were expensive to administer and did not reduce the number of hospital admissions. However, this could have been because the trials uncovered unmet need and, thus, can be interpreted as a good outcome that reflects the failure of the previous Aboriginal health care model. Over time, with improved access to health services, the need for patients to access public hospitals could be reduced.

2. Funding is only delivered to providers at the point at which care is provided. This reduces the problems of having a global budget and the denial of care described earlier. Unfortunately, because coordinated care trials fell out of favour, a number of them were wound up before they had time to provide evidence of benefit. It is relevant that one of the more successful ACCHS, Sunrise Health in East Katherine, originally started as part of a coordinated care trial.[114] This suggests that coordinated care could be useful as a model for mentoring and establishing best practice guidelines for ACCHS. But as it does with many programs, the government appears to have discarded coordinated care trials without adequately evaluating the effective ones. After running the Partnership for Aboriginal Care trial on the north coast of New South Wales for five years OATSIH, dismantled it on 30 June 2008.

Box 3: The Partnership for Aboriginal Care[115]

A Partnership for Aboriginal Care trial took place on the north coast of New South Wales. The trial was centred on a partnership between community Aboriginal Medcial Services, mainstream health services, non-government organisations, and private providers. The aim of the trial was to improve the health and well-being of Aborigines in the district by implementing a flexible, sustainable approach to coordinated care. The partnership did not deliver health services but purchased services from existing providers. It was therefore a true coordination model.

At the early stages of the trial, some Aboriginal patients were fearful and uncertain about using mainstream health services. But during the course of the trial, patients reported that undergoing health assessments improved their self-esteem and that the care plans addressed their ability to participate in activities and improve their own health. At the end of the trial, significant improvements had been made, including improved transport and better immunisation standards. However, the Care Coordination Manager's role was found to be overly burdensome. Communicating with participants and service providers was also found to be difficult so that reassessments and follow up care did not always follow. There were some interpersonal conflicts and confidentiality concerns between the various health providers. Overall though, most felt that the coordination of care was positive because Aboriginal people gained access to services that had previously been denied to them and became more involved in their own health.

A software program was designed to record all the information gathered on patient care and developed to the point where it was possible to tell exactly what services were used by whom and why and how much was spent overall in trying to improve a person's health.

Conclusion

It is overly simplistic to view more funding as the solution to Aboriginal and Torres Strait Islander health problems. Whilst more funding to improve access to primary health care may help alleviate some of the symptoms of ill health, it does not address the causes. Without addressing the barriers to delivering primary health care to Indigenous communities, additional funding may be lost within structural inefficiencies.

Under its current funding policy, the Rudd government has failed to differentiate between ACCHS in remote locations (where there are few mainstream services) and ACCHS in urban and regional areas with greater access to primary health care facilities and Medicare funding. As a result, Aborigines and Torres Strait Islanders living in rural and remote communities have substandard health care either in the form of untrained (or under-trained) Aboriginal Health Workers or through an ACCHS that may fail in its responsibility to be financially accountable. Structural inefficiencies and inadequate governance prevent Indigenous Australians from gaining the full benefit of state and Commonwealth health funding. The plethora of programs for Aboriginal health suggests micro-management at its worst. Paradoxically, there is also a lack of management and oversight where it is needed most. Given these problems, it is no wonder that Aboriginal health has not improved in line with the increased spending on Indigenous health programs and ACCHS.

What is needed is a reversal of the current system. Rather than the government deciding what health programs to fund, communities (or regional areas) in conjunction with health professions should be responsible for determining health needs. Mapping funding pathways would be made easier by having one national body, such as the proposed NATSIHA, which could disperse funding to regional areas. If a coordinated care model was followed, patient needs could be matched with the different health providers in their region or in other regions if services were unavailable. Linking health funding to patients should enable greater flexibility in where patients are treated and, hopefully, end the bickering between states about who is entitled to health services in their jurisdiction. An essential requirement for receiving funding for patients should be the collection of data showing the reason for patient consultation, diagnosis, referrals to specialists, and outcome of referrals. Unless this level of detail is gathered, it will be impossible to tell whether funding is going to patients or bureaucrats. If closing the gap in Indigenous health outcomes is to be achieved, the lack of accountability that has plagued the Aboriginal health sector must end.

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