NACCHO
National Aboriginal Community Controlled Health Organisation
Aboriginal health in Aboriginal hands
www.naccho.org.au

NACCHO 2020/21 Pre-budget Submission

December 2019

About NACCHO

NACCHO is the national peak body representing 144 Aboriginal Community Controlled Health Organisations (ACCHOs) across the country on Aboriginal and Torres Strait Islander health and wellbeing issues.

In 1997, the Federal Government funded NACCHO to establish a Secretariat in Canberra, greatly increasing the capacity of Aboriginal and Torres Strait Islander peoples involved in ACCHOs to participate in national health policy development.

Our members provide about three million episodes of care per year for about 350,000 people across Australia, which includes about one million episodes of care in very remote regions.

ACCHOs specialise in providing comprehensive primary care consistent with clients' needs. This includes: home and site visits; provision of medical, public health and health promotion services; allied health; nursing services; assistance with making appointments and transport; help accessing childcare or dealing with the justice system; drug and alcohol services; providing help with income support; and more.

Collectively, we employ about 6,000 staff, 56 per cent whom are Aboriginal and Torres Strait Islander people, which makes us the single largest employer of Aboriginal and Torres Strait Islander people in the country.

Any enquiries about this submission should be directed to:

National Aboriginal Community Controlled Health Organisation (NACCHO)

Level 5, 2 Constitution Avenue, Canberra City ACT 2601

Telephone: 02 6246 9300 Email: reception@naccho.org.au Website: naccho.org.au

Introduction

In the last 12 months there have been some very positive developments in the way Government is doing business with Aboriginal and Torres Strait Islander people. The Partnership Agreement on Closing the Gap, signed in March 2019 and now supported by the Australian, state and territory governments, is an historic agreement embodying the belief that Aboriginal and Torres Strait Islander peoples must share in decision-making on policies that affect their lives. We welcome the appointment of Australia's first Aboriginal Cabinet-level Minister (Hon Ken Wyatt AM, MP) with responsibility for Aboriginal and Torres Strait Islander affairs, and the Hon Greg Hunt MP retaining Indigenous Health within his portfolio.

The sector welcomes the very recent news that the Commonwealth is increasing ACCHO funding, albeit within the existing Indigenous Australians Health Program (IAHP) appropriation, which will serve to strengthen the sector until a new needs-based funding model is resolved. NACCHO and the sector appreciate the ongoing support of the Australian Government and the efforts of the Department of Health in this respect. Our sector has been disrupted for too long by unresolved funding questions, and a three-year commitment to the funding for the sector, with indexation applied, is most welcome.

Given that the Australian Government has provided clear advice that there will be no new money due to its election commitment to return the budget to surplus, NACCHO's approach is based on the redirection of existing funds and our seven proposal areas are cost neutral.

Nevertheless, it is important to note that there is a damaging myth that Aboriginal and Torres Strait Islander people receive ample health funding. In real terms, health expenditure (excluding hospital expenditure) for Aboriginal and Torres Strait Islander people fell 2 % from $3,840 per person in 2008–09 to $3,780 per person in 2015–16. Over the same period, expenditure on other Australians rose by 10 %.[1] Under the Abbott government's inaugural 2014-15 budget $534 million was cut from Indigenous programs run by the Department of the Prime Minister & Cabinet, and the Department of Health[2]. The Abbott government replaced more than 150 programs, grants and activities, nominally to eliminate waste, but $160 million of the cuts came directly out of Indigenous health programs.

This decline is a serious impediment to efforts to close the gap in health outcomes, particularly when the burden of disease for Aboriginal and Torres Strait Islander people is 2.3 times higher than for other Australians. In remote areas, the burden of disease is six times higher. Nevertheless, NACCHO understands that the Government is committed to a surplus and that additional funding in the current climate of restraint is not 'on the table'.

The following seven cost-neutral policy proposals are for practical initiatives that would deliver greater service capability and improve outcomes for Aboriginal and Torres Strait Islander people. These have been informed by NACCHO's consultations with its ACCHO members, the eight NACCHO affiliates in each state and territory and other partners in the sector.

Infrastructure

1. Secure funding for capital works and infrastructure for ACCHOs from existing funds in the infrastructure portfolio.
2. Improve Aboriginal and Torres Strait Islander housing and community infrastructure from existing funds in IAS.

[1] Steering Committee for the Review of Government Service Provision. *2017 Indigenous Expenditure Report: Pivot tables*. 2017; Available from: https://www.pc.gov.au/research/ongoing/indigenous-expenditure-report/2017#pivottables. Australian Health Ministers Advisory Council (AHMAC), *Aboriginal and Torres Strait Islander Health Performance Framework 2017 Report*. 2017, Commonwealth of Australia: Canberra. http://www.health.gov.au/indigenous--hpf/

[2] ABC News, 2014, Budget 2014 reporting, https://www.abc.net.au/news/2014-05-13/budget-2014:-$534-cut-to-indigenous-programs-and-health/5451144.

Social and emotional wellbeing

3. Return funding for social and emotional wellbeing services for Aboriginal and Torres Strait Islander peoples from the Indigenous Advancement Strategy (IAS) to the Health portfolio in IAHP, and not absorb it into other health programs but quarantine it as a separate program.

NDIS

4. In negotiation with NACCHO affiliates and ACCHOs, adopt aspects of the WA and other evidence informed models for NDIS services for Aboriginal and Torres Strait Islander people with a disability that will work in other jurisdictions across Australia, funded through the redirection of the NDIA operational budget.

Oral health

5. Invest in a range of initiatives to improve Aboriginal and Torres Strait Islander oral health.

Workforce

6. In collaboration with the Commonwealth and supported through existing employment and training programs and the IAS, develop a national workforce development strategy to boost the employment of Aboriginal and Torres Strait Islander allied health professionals and other health workers.

Child and youth wellbeing

7. Reduce the over-representation of Aboriginal and Torres Strait Islander children and young people in out-of-home care and detention through better use of program funds.

Closing the gap on Aboriginal and Torres Strait Islander health will not be achieved until these seven measures are implemented. They represent a minimum base for moving forward. Our package is also based on almost 50 years of experience in the provision of comprehensive primary health care for Aboriginal and Torres Strait Islander peoples since the first Aboriginal medical service was set up in Redfern in 1971.

NACCHO is committed to working with the Australian Government to further develop the seven proposals, including associated costings, implementation plans and identifying where current expenditure could be more appropriately targeted.

1. Secure funding for capital works and infrastructure for ACCHOs from existing funds in the infrastructure portfolio

Proposal

That the Australian Government commit to increasing funding for ACCHO infrastructure, to enhance the sustainable delivery of high quality, comprehensive primary health care services to Aboriginal and Torres Strait Islander people in discrete communities.

It is proposed that this be sourced through a Ministerial agreement that involves identifying an amount within the existing funds administered by the Department of Infrastructure, Transport, Cities and Regional Development. Access to this funding would assist economic stimulus and expand employment opportunities in the regions where our 300+ ACCHO clinics are located. The package would see funds invested in communities across all states and territories.

Rationale

A greater investment in improving the infrastructure of ACCHOs is urgently required to: strengthen their capacity to address gaps in service provision; attract and retain clinical staff; support the safety and accessibility of clinics and residential staff facilities; keep up with accreditation requirements; and to generate funding. For example, the lack of consulting rooms and derelict infrastructure severely limits our services' ability to increase MBS access.

Greater funding on ACCHO infrastructure is needed despite reports that the Commonwealth spends $1.21 on Aboriginal and Torres Strait Islander health for every $1 spent on health funding for other Australians. While the additional investment appears positive on the surface, it remains a significant shortfall as Aboriginal and Torres Strait Islander people have 2.3 times the per capita need of the rest of the population due to compounded and higher levels of illness and burden of disease. In its *2018 Report Card on Indigenous Health*, the Australian Medical Association (AMA) stated that spending less per capita on those with worse health is 'untenable national policy that must be rectified.'[3]

Infrastructure spending from existing funds represents a powerful means of stimulating regional economies in the current economic environment in which there is little further to be gained by lowering interest rates in order to stimulate the economy. It would also deliver regional jobs and training opportunities in local communities where unemployment rates have remained high and where the prolonged drought has negatively impacted on local economies.

Despite challenges delivering services with out-dated infrastructure and operating with fragmented and inadequate funding, studies have shown that ACCHOs deliver more cost-effective, equitable and efficient primary health care services to Aboriginal and Torres Strait Islander peoples. ACCHOs are 23% better at attracting and retaining Aboriginal and Torres Strait Islander clients than mainstream providers.[4] However, there are limits to the extent ACCHOs can continue to deliver quality, safe comprehensive primary health care to a fast-growing population[5] when faced with pressing capital works and infrastructural needs.

Many ACCHOs and other Aboriginal health clinics are 20 to 40 years old and require major refurbishment, capital works and updating to meet increasing population and patient numbers. This need will be increased as the NDIS expands its engagements with Aboriginal and Torres Strait Islander communities.

Funding required

The previous level of funding under the IAHP allocated for Capital Works – Infrastructure, Support and Assessment and Service Maintenance of about $15m per annum is not keeping up with demand, and the discrepancy is set to only increase.

In January 2019, NACCHO surveyed ACCHOs about their capital works and infrastructure needs, including Telehealth services. The 56 responses received represented a response rate of 38.6 % of NACCHO members. Survey respondents estimated the total costs of identified capital works and infrastructure upgrades, which total around $360,000,000 (see Table A below).

In our consultations with Affiliates and ACCHOs, NACCHO is hearing that Telehealth services, including infrastructure and improved connectivity, is required to support the provision of NDIS, mental health and health specialist services.[6] A total of 22 out of the 56 survey responses identified the need for Telehealth to support service provision. To optimise outcomes achieved by Telehealth a stronger workforce is essential, including a greater presence of allied health professionals and other health workers.

[3] https://ama.com.au/system/tdf/documents/2018per cent20AMAper cent20Reportper cent20Cardper cent20onper cent20Indigenousper cent20Health_1.pdf?file=1&type=node&id=49617, page 6.

[4] K. S. Ong, R. Carter, M. Kelaher, and I. Anderson, *Differences in Primary Health Care Delivery to Australia's Indigenous Population: A Template for Use in Economic Evaluations*, BMC Health Services Research (12), 2012, p. 307; M. A. Campbell, J. Hunt, D. J. Scrimgeour, M. Davey, and V. Jones, 'Contribution of Aboriginal Community Controlled Health Services to Improving Aboriginal Health: an Evidence Review', *Australian Health Review*, 42.2, 2017, pp. 218-226; Department of Health, *Aboriginal and Torres Strait Islander Health Performance Framework*, Canberra, 2017, p. 172.

[5] Between 2011 and 2016, the Aboriginal and Torres Strait Islander population increased by almost 23 per cent (ABS 3238.0.55).

[6] ACCHOs may apply for Telehealth funding through the IAHP, Governance and System Effectiveness: Sector Support activity.

Type	No. of respondents	% of respondents	Total estimated costs ($)
Replace existing building	43	76.7	207,559,043
New location/satellite clinic	21	37.5	53,480,000
Extension	24	42.8	18,310,000
Refurbishment	29	51.7	35,251,000
Staff accommodation	25	44.6	39,450,000
Telehealth services	22	39.2	6,018,763
Total estimated costs of capital works and infrastructure upgrades			**361,068,806**

Table A—Estimated costs of capital works and infrastructure upgrades identified by ACCHOs

Thirty-seven survey respondents indicated they had applied for funding for infrastructure improvements from the Department of Health during 2017 and/or 2018. Of the 11 that were successful, four respondents stated the allocated funds were not sufficient.

Another key priority is seed funding for the provision of more satellite and outreach ACCHOs, which would increase capacity to reach more Aboriginal and Torres Strait Islander people in remote communities; boost access to use of MBS and PBS services to more equitable levels; and reduce preventable admissions and deaths.

The current state of service infrastructure impedes service delivery capacity (see Table B below).

Infrastructure impeding service delivery	% highly affected	% somewhat affected
Safe delivery of quality health care	48.1	51.9
Increase client numbers	74.1	25.9
Expand the range of services and staff numbers	83.3	16.7
Increase Medicare billing	66.0	34.0

Table B Impact of ACCHOs' infrastructure needs on service delivery

2. Improve Aboriginal and Torres Strait Islander housing and community infrastructure from existing funds in IAS

Proposals

That the Australian Government:

- extend the current National Partnership on Remote Housing to match at least that of the former National Partnership Agreement on Remote Indigenous Housing;
- redirect resources in the relevant portfolios to fund a program that supports healthy living environments in urban, regional and remote Aboriginal and Torres Strait Islander communities, similar to the Fixing Houses for Better Health program (ensuring that rigorous data collection and program evaluation structures are developed and built into the program, to provide the Commonwealth Government with information to enable analysis of how housing improvements impact on health indicators; and
- update and promote the National Indigenous Housing Guide, a best practice resource for the design, construction and maintenance of housing for Aboriginal and Torres Strait Islander peoples.

Rationale

Safe and decent housing for Aboriginal and Torres Strait Islander people is urgently required, as housing is one of the most critical social determinants of health and cannot be overlooked when working to close the gap in life expectancy. There is comprehensive, evidence-based literature which investigates the powerful links between housing and health, education and employment outcomes.[7] Healthy living conditions are the basis from which Closing the Gap objectives may be achieved. The importance of environmental health to health outcomes is well established.

A healthy living environment with adequate housing supports not only the health and safety of individuals and families, it also enhances educational achievements, community safety and economic participation. Overcrowding is a key contributor to the poor health of Aboriginal and Torres Strait Islander peoples. In addition to overcrowding, poor and derelict health hardware (including water, sewerage, electricity) leads to the spread of preventable diseases for Aboriginal and Torres Strait Islander peoples. Healthy homes are vital to ensuring that preventable diseases already eradicated in most countries do not exist in Aboriginal and Torres Strait Islander communities and homes.

Australian Government leadership is urgently needed to appropriately invest into remote housing. Australian, State and Territory Governments have a shared responsibility to invest in Aboriginal and Torres Strait Islander housing. There is currently a disconnect between government investment into remote housing and the identified housing needs of remote communities. This is increasingly exacerbated where there are population increases in Aboriginal communities.

3. Return funding allocated to social and emotional wellbeing (SEWB) services for Aboriginal and Torres Strait Islander peoples from the Indigenous Advancement Strategy (IAS) to IAHP's health portfolio, and not absorb it into other health programs but quarantine it as a separate program.

Proposal

That funding for social and emotional wellbeing (SEWB) services for Aboriginal and Torres Strait Islander peoples be returned from the Indigenous Advancement Strategy (IAS) to IAHP's health portfolio

Rationale

An issue that has been of concern for the ACCHO sector for several years now is the matter of the unexpected transfer of 'Safety and Wellbeing' funding from IAHP to the IAS in the first Budget of the Abbott Government.

NACCHO has always argued that this program is better delivered directly by ACCHOs rather than being brokered by third parties or delivered by NGOs with little or no direct connection to Aboriginal and Torres Strait Islander communities. In many cases, NGOs are simply sub-contracting ACCHOs to provide these services, which complicates administrative and reporting arrangements and increases the costs to Government.

The former Minister for Indigenous Affairs, Senator Hon Nigel Scullion, agreed, and gave a verbal commitment in late 2017 at a Melbourne forum to transfer the program back to IAHP. However, this has not yet occurred.

Given the expertise of the sector, ACCHOs are trusted by the 350,000 Aboriginal and Torres Strait Islander people who access their services each year, it makes sense to have the 'Safety and Wellbeing' funding quarantined under IAHP in the Health portfolio, rather than IAS.

[7] ANAO performance audit report, *Indigenous Housing Initiatives: the Fixing Houses for Better Health Program*, 2010.

The Australian Institute of Health and Welfare has estimated that mental health and substance use are the biggest contributors to the overall burden of disease for Aboriginal and Torres Strait Islander peoples. Aboriginal and Torres Strait Islander adults are 2.7 times more likely to experience high or very high levels of psychological distress than other Australians.[8] They are also hospitalised for mental and behavioural disorders and suicide at almost twice the rate of the non-Indigenous population, and are missing out on much needed mental health services.

Suicide is the leading cause of death for Aboriginal people aged 5–34 years, and the second leading cause of death for Aboriginal and Torres Strait Islander men. In 2016, the rate of suicide for Aboriginal and Torres Strait Islander peoples was 24 per 100,000, which was twice the rate for non-Indigenous Australians.[9] Aboriginal people living in the Kimberley region are seven times more likely to suicide than non-Aboriginal people.

ACCHOs deliver culturally safe, trauma informed services in communities dealing with extreme social and economic disadvantage, compounded by intergenerational trauma and are supporting positive changes in the lives of their members. The below case study provided by Derby Aboriginal Health Service demonstrates how trusted local ACCHOs are best placed to be the preferred providers of mental health, SEWB, and suicide prevention activities to their communities.

Further, NACCHO believes that the current artificial distinction between separating mental health, SEWB and alcohol and drug funding from primary health care funding must be abolished. Primary health care, within the holistic health model provided by ACCHOSs, provides a sound structure to address all aspects of health care arising from social, emotional and physical factors. ACCHOs have a comprehensive primary health care approach to health in accordance with the Aboriginal holistic definition of health rising from the practical experience within the Aboriginal community itself having to provide effective and culturally appropriate health services to its communities.

The current artificial distinction, as exemplified by program funding for ACCHO activities being administered across two Australian Government departments, is inefficient and imposes additional reporting burdens on a sector that is already strained by red-tape and is delivering front-line services under challenging circumstances.

Case Study: Derby Aboriginal Health Service, WA

Derby Aboriginal Health Service's SEWB Unit have partnered with another organisation to employ an officer to work directly with families on issues that contribute to them losing their children to the Department of Child Protection (DCP). This program is designed to help prevent children from being removed by DCP by working one to one with families on issues such as budgeting, education, substance misuse, a safe and healthy home etc.

Derby's SEWB unit has a community engagement approach which involves working directly with clients and their families, counselling with a psychologist and mental health worker, the male Aboriginal Mental Health Worker taking men out on country trips as part of mental health activities for men, the youth at risk program (Shine), the Body Clinic, the prenatal program working directly with mums, dads and bubs around parenting, relationships between mums, dads and children etc. The team work directly with the community.

Derby is introducing a new SEWB designed program into the Derby prison which focuses on exploring men and women's strengths and abilities rather than looking at their deficits. Using a strengths-based program was very successfully delivered with a group of 22 Aboriginal men and 16 Aboriginal women where, for many of the participants, they were told for the first time in their lives that they matter.

[8] Australian Institute of Health and Welfare, *Australia's Health 2018*, (no. 16. AUS 221), Canberra, 2018.
[9] *Ibid*.

4. In negotiation with NACCHO affiliates and ACCHOs, adopt aspects of the WA model for NDIS services for Aboriginal and Torres Strait Islander people with a disability that will work in other jurisdictions across Australia, funded through the redirection of the NDIA operational budget

Proposal

That DSS and NDIA negotiate with ACCHOs and NACCHO affiliates in all jurisdictions an NDIS model similar to the WA model to better support Aboriginal and Torres Strait Islander people with a disability, comprising Remote Community Connectors (RCCs). Evidence and Access Coordinators (EACs) and the Early Childhood Support (ECS) Program. NDIS measures need to be culturally sensitive and evidence-based.

Rationale

Aboriginal and Torres Strait Islander peoples are twice as likely to experience a disability than other Australians, with 9% having a severe condition compared to 4% respectively. At 30 September 2019, only 6.5% of (or 18,252) NDIS participants identify as being of Aboriginal and/or Torres Strait Islander background, which is considerably less than the percentage thought to have a significant disability.

The challenges of delivering the NDIS to Aboriginal and Torres Strait Islander people are complex, multi-faceted and have been well documented. Access barriers are experienced at each access or referral point of the NDIS.

In WA, in mid-August 2019 contracts were signed between NDIA and 16 ACCHOs for services delivered by RCCs and another three are still under negotiation. The WA RCC program has seen people from remote communities employed by local ACCHOs promote understanding and awareness of the NDIS. RCCs link potential NDIS participants to planning and implementation pathways which involves testing their access to the NDIS and, if eligible, supporting them to build a plan with the NDIA. WA ACCHOs have been funded to employ RCCs, as well as to run the Evidence, Access and Coordination of Planning Program (EACP), delivered by EACs. EACs assist participants to, where required, contact the NDIS, complete necessary forms for requesting access (e.g. obtaining appropriate clinical and other assessments), utilise existing medical records and collate additional evidence.

The WA model is to include Early Childhood Support (ECS) Program to engage and support children under the age of seven, who are experiencing developmental delay or disability with timely access to early intervention supports delivered by community service providers. Multidisciplinary teams are to be located in four regions with each having a range of professionals to support the child and family, including: a child health nurse; physiologist; speech pathologist; child psychologist; and a team of family support workers.

NACCHO is also aware that other member services are negotiating to be able to utilise the ECS program funds to help resource models that build on the WA model and also include other evidence informed, culturally responsive early childhood services that will promote healthy development and prevent the onset of disability. In addition to the need for allied health professionals, there is also a place for Child Health and Development Centres where children with additional vulnerabilities can attend prior to preschool. These centres are based on play based learning, conversational reading, enriched care giving and language priority as well as the provision of a healthy, iron rich meal. Such centres can be a location in which wrap around allied health services can be provided and they provide an important employment opportunity for local Aboriginal people. They are likely to have a significant impact on the primary prevention of disability.

5. Invest in a range of initiatives to improve Aboriginal and Torres Strait Islander oral health

Proposals

That the Australian Government:

- develop a national standard for access to fluoridated water or fluoride in other forms in all Aboriginal and Torres Strait Islander communities;
- establish a multidisciplinary national panel to provide technical advice and assistance to jurisdictions to support the implementation and maintenance of water fluoridation;
- introduce a 20% tax on sugar-sweetened beverages, with part of the revenue accrued to be redirected back into a subsidy on fresh fruit and vegetables in rural and remote communities where the prices are much greater than in large population centres.. This combination of a disincentive on sugar at the same time as providing an incentive to eat more affordable, healthy food will maximise the health impact;
- amend food and beverage labelling regulations to require a graphic warning when sugar has been added to a product; and
- increase access to quality fruit and vegetables in Aboriginal and Torres Strait Islander communities.

Rationale

Bolstering safe fluoride water supplies for our communities is imperative. Fluoride varnish programs are not expensive and are also not rocket science, yet have been found to be highly effective in helping prevent dental decay — including in Aboriginal and Torres Strait Islander communities. Solutions need to be co-produced with Aboriginal and Torres Strait Islander communities.

Poor oral health also remains a significant problem for Aboriginal and Torres Strait Islander peoples, and NACCHO understands all too well that sugary drinks are a major cause of tooth decay, as well as incidence of obesity, diabetes, heart disease, and stroke. Due to accessibility and affordability, Aboriginal and Torres Strait Islander Australians living in rural and remote communities often resort to consuming sugary drinks. Despite being largely preventable, Aboriginal and Torres Strait Islander people have worse periodontal disease, more decayed teeth and untreated dental caries than non-Aboriginal Australians.

Our proposals to the Australian Government are based on the following recommendations put forward in the National Oral Health Plan, which have not yet been implemented:

- a national standard for access to fluoridated water or fluoride in other forms; and
- a multidisciplinary national panel to provide technical advice and assistance to jurisdictions to support the implementation and maintenance of water fluoridation.

Our proposals also align with the recommendations in the *AMA Report Card* that a 20% tax on sugar-sweetened beverages be introduced (which is supported by nearly 70% of Australians) with some of the revenue generated used to subsidise fresh fruit and vegetables to make them equally affordable in all rural and remote communities across Australia, and that food and beverage labelling regulations require a graphic warning when sugar has been added to a product.

6. In collaboration with the Australian Government and supported through existing employment and training programs and the IAS, develop a national workforce development strategy to boost the employment of Aboriginal and Torres Strait Islander allied health professionals and other health workers

Proposal

That a national workforce development strategy to boost the employment of Aboriginal and Torres Strait Islander allied health professionals and other health workers, including GPs, specialists, nurses, midwives and vising specialists, be co-designed with the Australian Government and supported through existing employment and training programs and the IAS.

Rationale

NACCHO acknowledges and welcomes recent investment from the Department of Health into initiatives to build the Aboriginal and Torres Strait Islander health workforce. We also acknowledge and welcome COAG's support for a National Aboriginal and Torres Strait Islander Health and Medical Workforce Plan, although we support the ACCHO sector collaborating with key Aboriginal organisations to develop a long-term plan for building ACCHOs' workforce capabilities.

Like many mainstream clinics, many ACCHOs and allied health services struggle with the recruitment and retention of suitably qualified staff. In particular, it is an ongoing challenge to attract student placements in ACCHOs; although models developed in Brisbane and the Kimberley have proved successful.

An appropriately resourced ACCHO sector is an evidence-based, cost-effective and efficient way to bring about gains for Aboriginal and Torres Strait Islander peoples' health. The ACCHO network provides a critical and practical pathway into employment for many Aboriginal and Torres Strait Islander people.

It is not widely known, but, collectively, ACCHOs are the single largest employer of Aboriginal and Torres Strait Islander staff in Australia. One in every 44 Aboriginal and Torres Strait Islander jobs in Australia is employed with an ACCHO. Currently, ACCHOs employ about 6,000 staff—56 % of whom are Aboriginal.

While this proportion of Aboriginal and Torres Strait Islander people employed by the ACCHO sector is significant, there is opportunity to increase it further. With many unfilled vacancies, particularly in remote clinics, a concerted effort could have a significant positive impact not only on ACCHOs' workforce but on the Aboriginal employment gap, including in areas of very high unemployment.

More needs to be done to develop career pathways to secure more Aboriginal and Torres Strait Islander doctors, nurses and allied health professionals. Despite the sector's success in Aboriginal employment and the strong preference of Aboriginal and Torres Strait Islander health professionals to work in our services, the challenge to recruit enough staff and keep pace with staff turnover persists. One of two key employment issues for NACCHO and the sector is the high number of vacancies across all services locations, but particularly in remote and very remote regions.

The second issue is the low numbers of Aboriginal and Torres Strait Islander clinical staff. Across Australia, there are only about 200 Aboriginal and Torres Strait Islander medical practitioners, less than 1,000 allied health professionals, and about 2,500 nurses. There were only 480 medical graduates in 2019. According to the *AHPRA 2018-19 Annual Report*, there were 690 registered Aboriginal and Torres Strait Islander health practitioners in 2018-19, which is up from 641 in 2017-18. *Healthy Futures* reports there were 1,879 clinical and 1,428 non-clinical Aboriginal and/or Torres Strait Islander staff employed by ACCHOs compared to 1,753 clinical and 892 non-clinical other Australian staff. There are opportunities for clinical placements and pathways into employment for our nurses and midwives in the ACCHO sector.

A partnership could be developed to support a national strategy which would include wage subsidies, pre- and post-placement support, vocational development opportunities, cadetships and incentives for placements in remote and very remote services. The partnership would build off existing Commonwealth programs, including IAS Aboriginal employment and training programs and mainstream services delivered by VTECs, Jobactive members, disability employment services and registered training providers.

Case Study: the IUIH student placement model

The Institute of Urban Indigenous Health (IUIH) is a metropolitan ACCHO in Brisbane and the largest NACCHO member. It has an extremely successful student placement model that could be adopted as an element within a workforce development strategy. A similar approach is also used at the Kimberley Aboriginal Medical Service in WA, just as effectively for some time, of course, with adjustments made for the remote setting.

The IUIH model has its origin in 2010 when a partnership was set up with the University of Queensland. This led to a dedicated resource from the university being embedded in IUIH to coordinate student placements. Prior to this, placements had been hit-and-miss with variable experiences for students and medical services. Students could arrive unprepared for the sometimes-confronting experiences in our clinics and our stressed services were not always able to invest the time necessary to support them.

The coordinator was able to help clinics increase their capacity to support students. This meant orientation and cultural training. Central coordination also meant the coordinator could ensure the timing and location of the placement was better planned across what are now 20 different locations. With a UQ-person as the coordinator embedded, placements became more sector-driven so whilst universities still request placement opportunities, it is most often the ACCHO staff who are identifying possible student placements and projects. IUIH was also able to understand what universities wanted and how they operated which minimised miscommunication.

IUIH research found that the student-placement model led to increased numbers and diversity of clinical placement of health students. Most respondents indicated greater awareness of First Australian culture (89%) and health concerns (87%) and believed that their clinical skills had been enhanced (79%). The IUIH model also led to positive suggestions for universities. For example, students and medical services could feed back information from placements that has since been used in curriculum development.

There have been plenty of benefits for the clinics as well. At IUIH the clinics identified a need for a structured exercise program with self-management of chronic disease, occupational therapy and exercise physiology. This was designed, implemented and evaluated by students and it is now a very successful element of what IUIH does.

Over time, the student placements have expanded to a large number of institutions and disciplines. It's not just doctors, nurses, pharmacists. For example, IUIH has placements for law students, political science students, architecture students and others.

IUIH uses a range of student placement models. These might include the traditional model of one-on-one support; collaborative models (students paired or in groups); a multiple mentoring model (shared supervision of students) and project-based placements.

7. Reduce the over-representation of Aboriginal and Torres Strait Islander children and young people in out-of-home care and detention through better use of program funds

Proposals

That the Australian Government redirects existing training funds to:

- establish an additional elective within the existing Aboriginal Health Worker curriculum that provides students with early childhood outreach, preventative health care and parenting support skills;
- waive the upfront fees of the first 100 students undertaking child safety related Aboriginal and/or Torres Strait Islander Health Worker courses;
- upskill teaching staff across the country; and
- identify an additional 144 Aboriginal Health Worker (early childhood) places across ACCHOs (one placement for each of the 144 ACCHOs).

Rationale

The over-representation of Aboriginal and Torres Strait Islander children and young people in the child protection system is one of the most pressing human rights challenges facing Australia today.[10] Young people placed in out-of-home care are 16 times more likely than the equivalent general population to be under youth justice supervision within the same year.

Despite previous investment by governments, Aboriginal and Torres Strait Islander children and young people remain overrepresented in the child protection and youth detention systems. Research reveals that almost half of the Aboriginal and Torres Strait Islander children who are placed in out-of-home care are removed by the age of four and demonstrates the strong link between children and young people in detention who have both current and/or previous experiences of out-of-home care. There is also compelling evidence of the impact of repetitive, prolonged trauma on children and young people which, if left untreated, leads to mental health and substance use disorders and increased exposure to the criminal justice system.

The Council of Australian Governments (COAG) *Protecting Children is Everyone's Business National Framework for Protecting Australia's Children 2009–2020* (the National Framework) was established to develop a unified approach for protecting children. It recognises that 'Australia needs a shared agenda for change, with national leadership and a common goal'. One of six intended outcomes of the National Framework is that Aboriginal and Torres Strait Islander children are supported and safe in their families and communities, with the overarching goal:

> *Indigenous children are supported and safe in strong, thriving families and communities to reduce the overrepresentation of Indigenous children in child protection systems. For those Indigenous children in child protection systems, culturally appropriate care and support is provided to enhance their wellbeing.*[11]

Findings presented in the 2018 *Family Matters Report* reveal, however, that the aims and objectives of the National Framework have failed to protect Aboriginal and Torres Strait Islander children:

> *Aboriginal and Torres Strait Islander children make up just over 36% of all children living in out-of-home care; the rate of Aboriginal and Torres Strait Islander children in out-of-home care is 10.1 times that of other children, and disproportionate representation continues to grow (Australian Institute of Health and Welfare [AIHW], 2018b). Since the last Family Matters Report*

[10] Australia Human Rights Commission *Social Justice and Native Title Report* 2015, cited in the Australian Law Reform Commission publication, *Pathways to Justice–Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples* (ALRC Report 133).

[11] https://www.dss.gov.au/sites/default/files/documents/child_protection_framework.pdf, p. 28.

overrepresentation in out-of-home care has either increased or remained the same in every state and territory.[12]

Furthermore, statistics on the incarceration of Aboriginal and Torres Strait Islander children and young people in detention facilities reveal alarmingly high trends of overrepresentation:

- On an average night in the June quarter 2018, nearly 3 in 5 (59 %) young people aged 10–17 in detention were Aboriginal and Torres Strait Islander, despite them making up only 5% of the general population aged 10–17.
- Aboriginal and Torres Strait Islander young people aged 10—17 were 26 times as likely as non-Indigenous young people to be in detention on an average night.
- A higher proportion of Aboriginal and Torres Strait Islander young people in detention were aged 10—17 than the rest of the nation's 10—17 year-old population. In the June quarter of 2018, 92% of Aboriginal and Torres Strait Islander youth in detention were aged 10—17.[13]

NACCHO believes an adequately funded, culturally safe, preventive response is needed to reduce the number and proportion of Aboriginal and Torres Strait Islander children in child protection and youth detention systems. It is vital that Aboriginal and Torres Strait Islander families who are struggling with chronic, complex and challenging circumstances be able to access culturally appropriate, holistic, preventive services delivered by trusted service providers with expertise in working with whole families affected by intergenerational trauma. Also, child protection as well as justice literature points to the need for Aboriginal and Torres Strait Islander self-determination, community control and cultural safety, and a holistic response.[14] For these reasons, new Aboriginal Health Workers delivering early childhood services need to be based within ACCHOs.

The cultural safety in which ACCHOs deliver services is a key factor to their success. ACCHOs have expert understanding and knowledge of the interplay between intergenerational trauma, the social determinants of health, family violence, and institutional racism, and the risks these contributing factors carry in increasing Aboriginal and Torres Strait Islander peoples' exposure to the child protection and criminal justice systems. ACCHOs have developed trauma-informed care responses that acknowledge historical and contemporary experiences of colonisation, dispossession and discrimination, and build this knowledge into their service delivery.

Further, ACCHOs are staffed by health and medical professionals who understand the importance of providing a comprehensive health service, including the vital importance of regular screening and treatment for infants and children aged 0–4 years, and providing at-risk families with early support. Within the principles, values and beliefs of the Aboriginal community controlled service model lay the groundwork for children's better health, education, and employment outcomes. The addition of Aboriginal Health Workers with early childhood skills and training will may ACCHOs pivotal role in preventing and reducing Aboriginal and Torres Strait Islander children and youth from being exposure to the child protection and criminal justice systems.

[12] http://www.familymatters.org.au/wp-content/uploads/2018/11/Family-Matters-Report-2018.pdf, p. 5.
[13] Australian Institute of Health and Welfare, *Youth Detention Population in Australia* (Bulletin 145), 2018.
[14] http://www.familymatters.org.au/wp-content/uploads/2018/11/Family-Matters-Report-2018.pdf; K. Thorburn and M. Marshall, 'The Yiriman Project in the West Kimberley: an example of justice reinvestment?' (Indigenous Justice Clearinghouse, Current Initiatives, paper 5), 2017.