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

# Pre-budget Submission

## January 2021

**About NACCHO**

NACCHO is the national peak body representing 143 Aboriginal Community Controlled Health Organisations (ACCHOs). NACCHO liaises with its membership, its eight state/territory affiliates, governments, and other organisations on Aboriginal and Torres Strait Islander health and wellbeing policy and planning issues and advocacy relating to health service delivery, health information, research, public health, health financing and health programs. Our members provide about 3.1 million episodes of care per year for about 410,000 people across Australia, including about 1m episodes of care in remote regions.

ACCHOs range from large multi-functional services employing several medical practitioners and providing a wide range of services, to small services which rely on Aboriginal Health Workers/Practitioners and/or nurses to provide the bulk of primary health care services, often with a preventive, health education focus. Our 143 ACCHOs provide services from about 550 clinics.

ACCHOs contribute to improving Aboriginal and Torres Strait Islander health and wellbeing through the provision of comprehensive primary health care, and by integrating and coordinating care and services. Many provide home and site visits; 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; and help with income support.

Collectively, we employ about 7,000 staff, 54 per cent of whom are Indigenous, making us the second largest employer of Aboriginal and Torres Strait Islander people in the country.

During the early days of the recent pandemic, NACCHO led the sector's response and engagement with governments to ensure that the impact was minimised amongst Australia's First Nations, in which levels of comorbidity and socio-economic factors (e.g. overcrowding and poverty) meant that much higher death rates were expected. No deaths were recorded from COVID-19 amongst our people and our share of the caseload was 0.5 per cent when our share of the national population is 3.3 per cent. It is a remarkable story of success, when compared to the tragic outcomes experienced by First Nations people in other countries (e.g. the Navajo in the USA who have the highest death rate of all groups).[1]

This risk remains, but the existence of a national network of ACCHOs has been critical to the success thus far. If the pandemic has shown anything in our sector, it is that ACCHOs are flexible and effective frontline services. Now, more than ever, the network needs to be developed and supported.

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[1] J. Arrazola, M. M. Masiello, S. Joshi, et al., 'COVID-19 Mortality Among American Indian and Alaska Native Persons: 14 States, January-June 2020' in Centre for Disease Control and Prevention *MMW Report*, no. 69, 2020, pp. 1,853-6.

## NACCHO fully supports the new National Agreement on Closing the Gap

NACCHO played a leading role in setting up the Coalition of Peaks that grew into a group of 50 Aboriginal organisations uniting to negotiate the new National Agreement on Closing the Gap with Australian governments.

NACCHO is committed to the objectives underpinning that seminal agreement. The new approach of involving Aboriginal and Torres Strait Islander people in decision-making is reflected in this submission.

The new National Agreement was developed around four priority reform areas.

1. **Shared decision-making**: Aboriginal and Torres Strait Islander people are empowered to share decision-making authority with governments to accelerate policy and place-based progress on Closing the Gap through formal partnership arrangements.

2. **Building the community-controlled sector**: There is a strong and sustainable Aboriginal and Torres Strait Islander community-controlled sector delivering high quality services to meet the needs of Aboriginal and Torres Strait Islander people across the country.

3. **Improving mainstream institutions**: Governments, their organisations and their institutions are accountable for Closing the Gap and are culturally safe and responsive to the needs of Aboriginal and Torres Strait Islander people, including through the services they fund.

4. **Aboriginal and Torres Strait Islander-led data**: Aboriginal and Torres Strait Islander people have access to, and the capability to use, locally-relevant data and information to set and monitor the implementation of efforts to close the gap, their priorities and drive their own development.

These four priority reform areas reflect what Aboriginal and Torres Strait Islanders have been telling governments for decades. They must be embraced by all parties, if real progress is to be made. The four priorities, and the principles underlying them, form the basis of much of this submission.

## NACCHO's previous pre-budget submissions

In recent years, NACCHO has liaised with its network and other stakeholders to submit pre-budget submissions to Treasury. This submission builds on that tradition and incorporates a number of elements from earlier submissions.

NACCHO has always offered to provide further information and to work with the Australian Government to explain further its proposals and to develop any measures within the submission that might need adjustment. NACCHO makes the same offer for the thirteen policy proposals outlined in this submission for the 2021-2022 Budget process.

In 2019-2020, the sector welcomed the Commonwealth's increased funding of $33m for expanding services within the existing Indigenous Australians Health Program (IAHP) appropriation. The increase was announced in late 2019 and repeated in the 2020-2021 Budget. This will serve to keep the sector buoyant until a new needs-based funding model is resolved in the longer term and the work on the cost of core service delivery is completed as well as accounting for changes in relation to COVID-19.

While there were modest improvements in funding such as this, NACCHO's Board and membership was disappointed overall in the delayed 2020-2021 Budget. We saw it as a lost opportunity. A high-spending stimulus Budget provided a rare occasion in which the nation could have addressed long-term structural issues; in particular, the ailing infrastructure in the ACCHO sector and its 550 clinics as well as the neglected social housing stock in Aboriginal communities and across the country. If last year's proposal to redirect funding within the Infrastructure Portfolio to the ACCHO sector had been supported, it would not only have helped many of our clinics meet modern standards and respond to

increasing demand, but it would also have seen the stimulation of hundreds of local economies and generated thousands of jobs across Australia.

Although we expect that the 2021-2022 Budget will be more conservative, the need remains and our proposal for sector infrastructure investment has been resubmitted. Similarly, we repeat our calls for urgent investment in social housing, particularly in remote Aboriginal and Torres Strait Islander communities. The Commonwealth cannot walk away from its responsibilities in the respect.

## Closing the funding gap

It is also 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 per cent 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 per cent.[2]

Under the Abbott Government's inaugural 2014-15 budget, $534m was cut from Indigenous programs run by the Commonwealth.[3] More than 150 programs, grants and activities were consolidated within the Department of Prime Minister and Cabinet and the Department of Health, nominally to eliminate waste, but, in reality, $160 million of the cuts came directly out of Indigenous health programs.

A result of cuts and neglect of the sector over the years has resulted in a very substantial under-funding of Aboriginal and Torres Strait Islander primary health care relative to need, which is well in excess of $1 billion per year based on *Indigenous Expenditure Report* figures. Closing the gap in health requires closing the gap in funding.

It should also be noted that the pandemic is exacerbating an already significant difference between general CPI (now falling) and the increasing CPI experienced by the health sector.[4] The pandemic is seeing greater demands on the health sector, particularly those servicing disadvantaged communities who are most at threat from COVID-19. In addition, the travel restrictions have significantly reduced the capacity to access international staff. This will inevitably lead to increased salary costs to recruit staff from a reduced pool of professionals within Australia. A further increase in indexation would be a recognition of these differential impacts of COVID-19 and separate to the completion of the sector funding model.

Perhaps the simplest way to convey the funding gap is to consider the burden of disease for Aboriginal and Torres Strait Islander people. It is 2.3 times higher than for other Australians. In remote areas, the burden of disease is six times higher. 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'.[5]

Nevertheless, NACCHO understands that funds are limited. We appreciate the ongoing financial support of the Australian Government and the efforts of the Department of Health in supporting ACCHOs. The three-year commitment to funding for the sector announced in 2019, with indexation applied, was most welcome. NACCHO also appreciated the $1.3 million grant that the Department of Health allocated to certain ACCHOs for the bushfire recovery and in our initial response to the COVID-19 pandemic (over $15m). These funds supported the sector in keeping safe all Aboriginal and Torres Strait

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[2] *Indigenous Expenditure Report*, 2017 (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 Report*, 2017 (http://www.health.gov.au/indigenous--hpf/).

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

[4] See https://www.abs.gov.au/ausstats/abs@.nsf/mf/6401.0 .

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

Islander peoples, who have higher levels of comorbidity and face higher levels of socio-economic disadvantage.

Despite the funding gap, this submission is conservative. It has tried to present proposals, wherever possible, that are cost-neutral and/or involve the redirection of *existing* funds. However, some elements require the investment of new money or the extension of existing programs, unless savings can be found within existing portfolio budgets.

A total of $92.3m over three years is identified in the table on page 5. This consists of:

- proposal 1 ($30m over two years for the transition of government-run clinics);
- proposal 6 ($1.8m pilot over three years for health-justice partnerships);
- proposal 7 ($3m pilot for embedded pharmacists); and
- proposal 9 ($10m extension over five years of the Kimberley and NT suicide prevention programs);
- proposal 10 ($5m capital investment for GeneXpert machines, $4.5m in training and support and $20m over three years for the extension of the Enhanced Syphilis Response Program); and
- proposal 13 ($18m for the extension of funding for the National Community Connector Program beyond June 30, 2021 for a minimum of three years).

## Funding ACCHOs is cost-effective

The cost benefit of ACCHOs per dollar spent is $1.19. In remote areas our cost benefit can be fourfold. The lifetime health impact of interventions delivered by ACCHOs is 50 per cent greater than mainstream health services.[6] Our ACCHOs are not-for-profit and all revenue is re-invested into our clinics and communities.

The drought and catastrophic bushfires of 2019-2020, followed by COVID-19, have all served to emphasise the importance of ACCHOs and the frontline services they offer communities across Australia. The sector stepped up in response to the bushfires crisis in a number of communities and then, nationally, to the COVID-19 pandemic, demonstrating the strength and effectiveness of our network in these dire times. The proposals also have the advantage of having a community-development focus. Investment in communities across the country will benefit local economies suffering from drought, bushfire and, now, the prolonged and ongoing economic effects of the pandemic.

## The scope of this submission

There are three key policy initiatives that NACCHO has not included in this submission. Nevertheless, they will be closely discussed with the Commonwealth and, hopefully, our discussions will help inform decisions in the 2021-2022 Budget. The first is an aged-care proposal being developed in consultation with two of our affiliates (VACCHO and QAIHC) and which we hope is included as part of the Government's response to the Aged Care Royal Commission. The second is a submission on mental health funding, particularly related to the impact of COVOD-19, which is also being developed for consideration by agencies in February. The third is a proposal to improve funding to combat Rheumatic Heart Disease.

In this submission we have included thirteen other proposals (see Table A) which are all fundamental in helping close the gap in Aboriginal and Torres Strait Islander health. Our submission represents a minimum base for moving forward. It is a package based on 50 years of experience in the provision of comprehensive primary health care for Aboriginal and Torres Strait Islander peoples. The national footprint of ACCHOs provides a critical resource, with which all governments can partner. ACCHOs are accessed by over 370,000 Aboriginal and Torres Strait Islander people each year. The ACCHO model is proven and is well-respected, both nationally and abroad.

[6] T. Vos, et al., *Assessing Cost Effectiveness in Prevention* (Final Report 2010); K. S. Ong, et al., 'Differences in Primary Health Care Delivery to Australia's Indigenous Population: a Template for Use in Economic Evaluations', *BMC Health Services Research.* 2012: 307

**Table A: NACCHO Budget measures – summary**

| *Measure or policy proposal* | *Package* | *Funding* | *National Agreement on Closing the Gap* |
|---|---|---|---|
| **1. Transitioning 10 government-run clinics into ACCHOs by 2023**<br>Investment will strengthen community control and deliver efficiencies | Strengthening the network's capacity and stimulating local economies | Transition pool of $30m: Commonwealth funding | Priority reform areas: 1, 2 |
| **2. Sector infrastructure investment and development**<br>Investment addresses ageing infrastructure and supports economic recovery | | Cost neutral: access to existing portfolio funding | Priority reform areas: 1, 2 |
| **3. National workforce development**<br>Measure will boost employment (1,250 Aboriginal and Torres Strait Islander jobs) | | Cost neutral: existing programs | Priority reform areas: 1, 2 |
| **4. Housing for health**<br>Improve Aboriginal and Torres Strait Islander housing and environmental health | Key 'Closing the Gap' priorities | Requires significant government investment | Priority reform areas: 1, 3 |
| **5. Early childhood, youth wellbeing and reducing out-of-home care**<br>Reduction of Aboriginal and Torres Strait Islander children in care and detention | | Cost-neutral: redirection of funding | Priority reform areas: 1, 3 |
| **6. Health-justice partnerships to reduce negative legal and domestic outcomes**<br>Measure collocating a lawyer in ACCHOs to develop options for wider application | | $1.8m pilot funding with follow-up investment | Priority reform areas: 1, 2, 4 |
| **7. Embedding pharmacists in ACCHOs**<br>Measure to improve the use of medicine and access to quality pharmaceuticals | Targeted health initiatives | $3m pilot funding with follow-up investment | Priority reform areas: 1, 2 |
| **8. Returning Social and Emotional Wellbeing (SEWB) funding to ACCHOs**<br>Measure also addresses the increased impact on mental health from COVID-19 | | Cost-neutral: redirection of funding | Priority reform areas: 1, 2 |
| **9. Suicide prevention**<br>Extension of Kimberley and NT suicide prevention programs | | $10m funding over five years | Priority reform areas: 1, 2 |
| **10. Improving oral health**<br>Measures to improve oral health (including a sugary drinks tax) | | Cost-neutral: self-funded sugar tax | Priority reform areas: 1, 3 |
| **11. Indigenous identifier in pathology**<br>Inclusion of an Indigenous identifier in pathology data at point of collection | | Minimal set-up cost | Priority reform areas: 1, 4 |
| **12. Providing GeneX machines and extending Enhanced Syphilis Response Program**<br>Measure to help communities monitor and manage communicable diseases | | $20m (3yr ESRP extension); $9.5m (GeneX); MBS impact | Priority reform areas: 1, 2, 4 |
| **13. Expansion of the National Community Connector Program (NCCP)**<br>Expanding the NCCP into an ongoing, long term program providing disability services for Aboriginal people with disability in Australia. | Alignment with disability reform | $18m<br>But could be achieved through redirection | Priority reform areas: 1, 2 |

## 1. Transitioning government-run clinics into ACCHOs

Proposal

It is recommended that the Commonwealth, together with the relevant state and territory governments, increase its support in transitioning government-run clinics servicing Aboriginal and Torres Strait Islander communities into ACCHOs. A pool of $30m is proposed to fund the transition of at least ten government-run clinics by mid-2023. Meanwhile, a plan needs to be developed to ensure a timeframe and funding for the transition of the remaining government-run clinics in northern Australia.

Rationale

The community control and self-determination of Aboriginal and Torres Strait Islander organisations is imperative for achieving optimal health and wellbeing outcomes for Aboriginal and Torres Strait Islander people and communities. As demonstrated on p. 1, these principles are built into the ACCHO model. It has proved to be effective and efficient since the first ACCHO was established 50 years ago.

Many Aboriginal and Torres Strait Islander people have little trust in mainstream service providers and government-run agencies. Many of these providers do not retain Aboriginal and Torres Strait Islander clients and do not achieve optimal outcomes in Aboriginal and Torres Strait Islander communities.[7] The less control people have over their lives and environment, the more likely they are to suffer ill health, with powerlessness being a risk factor for health and social and emotional wellbeing.[8] Transitioning government-run clinics to ACCHOs will ensure better outcomes for Aboriginal and Torres Strait Islander people. Central to the exercise of self-determination are ACCHO boards, comprising Aboriginal and Torres Strait Islander people elected by Aboriginal and Torres Strait Islander people.

By signing the National Agreement on Closing the Gap in July 2020, governments have committed to the Agreement's second Priority Reform; i.e. to build the Aboriginal and Torres Strait Islander community-controlled sector. Transitioning government-run clinics to community control is an effective way towards the realisation of this commitment.

There are numerous government-run clinics in Northern Australia (Northern Territory and northern regions of Western Australia and Queensland) that would more effectively meet unmet need should they be community controlled. However, there are considerable initial costs in making the transition, including for the government-run clinic in Palm Island, where specific circumstances require additional investment. The Palm Island transition would require $3m for that government-run clinic to become an ACCHO. In Western Australia, very similar cost-estimates have been calculated in work led by the Kimberley Aboriginal Medical Service ($2.6m).

In the Northern Territory there are formal processes overseen by the NT Aboriginal Health Forum comprising Commonwealth portfolios, the Northern Territory Government, Aboriginal Medical Services Alliance Northern Territory, and the Northern Territory Primary Health Network for transitioning government-run clinics into ACCHOs. The Commonwealth and NT Government agree that community control is the preferred model for Aboriginal primary healthcare and that all of the approximately 50 government-run clinics in the NT run by the NT Government be transitioned to community control over time. The Forum has a policy that three areas will be agreed and prioritised at any one time for transition with funding provided by the Commonwealth for transition processes, with the NT Department of Health transferring infrastructure, staff and operational funding to the regional ACCHO. At present, a couple of NT Government clinics in North East Arnhem Land are under transition to Miwatj Health and a couple of NT Government clinics in West Arnhem Land are under transition to the Red Lily Health Board. In Central Australia clinics are being transitioned under a proposal from Central Australian Aboriginal Congress.

[7] Emerson, Fox and Smith, *Good Beginnings: Getting It Right in the Early Years,* The Lowitja Institute: Melbourne, 2015.

[8] Marmot, Siegrist and Theorell, 'Health and the Psychosocial Environment at Work', in Marmot and Wilkinson (edd.) *Social Determinants of Health*, Oxford University Press: Oxford, 2006.

At this pace it will take a long time to transition all government-run clinics to community control. An injection of funds will help expedite the process.

Many government-run clinics are in remote settings, which means that under the ACCHO model, which delivers a fourfold cost benefit compared to the mainstream service in remote areas, the efficiencies will be significant.

A transition plan for all jurisdictions needs to be agreed quickly to manage this process with a view to seeing all government-run clinics transition within ten years. This will bring clarity for all parties and the sector will have time to prepare. Such a plan will take time, particularly one that involves three state/territory governments, the Commonwealth and the relevant organisations from across the ACCHO sector. So that the planning process itself does not delay the transition of government-run clinics, funding should be allocated now to transition ten clinics over the next two years (i.e. by mid-2023). NACCHO is well-positioned to help broker an interim process (i.e. before a transition plan is signed-off) in which priority areas for transition are identified and discussions with the jurisdictions involved are expedited.

NACCHO is also concerned that a number of government-run Aboriginal and Torres Strait Islander aged care homes are operating, which could also be transitioned to community control. This issue could be addressed in the transition plan, as there may be opportunities to combine transition of government-run clinics in certain communities with the transition of aged care homes.

Funding

As the transition costs of government-run clinics range from $2.6 to $3.0m, a pool for the next two financial years capped at $30m to transition at least ten government-run clinics to ACCHOs is required.

## 2. Sector infrastructure development

Proposal

That the Commonwealth commits 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.

It is proposed that funding be sourced through a Ministerial agreement that involves identifying an amount within the existing funds administered by the Department of Infrastructure, Transport, Regional Development and Communications. This approach has been specifically mentioned in direct discussions with Ministers Hunt and Wyatt and Deputy Prime Minister McCormack in late 2020.

Rationale

There is a tremendous opportunity here for the Commonwealth to use this proposal to stimulate local economies and boost employment in the regions where our 143 ACCHOs are located at a time when the nation is still recovering from the impact of national disasters and the global pandemic's negative effect on GDP and employment.

A greater investment in 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
- generate their own funding.

For example, the lack of consulting rooms and derelict infrastructure severely limits our services' ability to function effectively.

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. This is critical more than ever in the light of COVID-19. 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. Many of these communities have also been vulnerable to COVID-19's impact on tourism.

Despite challenges delivering services with outdated infrastructure, 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 per cent better at attracting and retaining Aboriginal and Torres Strait Islander clients than mainstream providers.[9] However, there are limits to the extent that ACCHOs can continue to deliver quality, safe comprehensive primary health care to a fast-growing population when faced with pressing capital works and infrastructural needs.[10]

Most ACCHOs are 20- to 40-years old and require major refurbishment, capital works and updating to meet increasing population and patient numbers.

Funding

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. This need will be exacerbated as the NDIS expands its engagements with Aboriginal and Torres Strait Islander communities.

In 2019, NACCHO surveyed ACCHOs about their capital works and infrastructure needs, including Telehealth services. The 56 responses received represented a response rate of 39 per cent of NACCHO members. Survey respondents estimated the total costs of identified capital works and infrastructure upgrades, which total around $360m (see Table B below). Nationally, this equates to an investment of $900m.

**Table B: Estimated costs of capital works and infrastructure upgrades identified by ACCHOs**

| 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** |

In our consultations with affiliates and ACCHOs, NACCHO heard that Telehealth services, including infrastructure and improved connectivity, is required to support the provision of NDIS, mental health and health specialist services. A total of 22 out of the 56 survey responses identified the need for Telehealth to support service provision. This has become an even more critical issue in the wake of COVID-19 and if the survey were conducted now, the reported need would be significantly higher. To optimise outcomes achieved by Telehealth (so much more important since the pandemic) a stronger workforce is essential, including a greater presence of allied health professionals and other health workers.

[9] Ong, Carter, Kelaher and 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; Campbell, Hunt, Scrimgeour, Davey, and 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.

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

NACCHO believes the current state of service infrastructure impedes service delivery capacity (see Table C below).

**Table C: Impact of ACCHOs' infrastructure needs on service delivery**

| 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 |

Nationally, $900m is required to bring the sector back to where it should be.

Thirty-seven survey respondents indicated that they had applied for funding for infrastructure improvements from the Department of Health during 2017-2018. Of the 11 that were successful, four respondents stated that 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 hospital admissions and deaths.

## 3. National workforce development and job plan to fill 1,250 vacancies

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 those of the IAS. On current vacancy rates, this could deliver 1,250 jobs, nationally.

Rationale

NACCHO acknowledges and welcomes recent investment from the Department of Health into initiatives to build the Aboriginal and Torres Strait Islander health workforce.

Like many mainstream clinics, 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. More recently, pandemic travel restrictions have significantly reduced the capacity to access international health professionals who are particularly important for service delivery in the remote and regional areas served by a majority of NACCHO members.

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 second largest employer of Aboriginal and Torres Strait Islander staff in Australia. One in every 44 Aboriginal and Torres Strait Islander jobs in Australia is with an ACCHO. Currently, ACCHOs employ about 7,000 staff, 54 per cent of whom are Aboriginal and Torres Strait Islander people.

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 the ACCHOs'

collective workforce but on the Aboriginal employment gap, including in areas of very high and entrenched 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 service locations, but particularly in remote and very remote regions. In these times of global pandemic and plans for national vaccination, it is all the more critical to ensure that our health services are running at full capacity and vacancy rates are as low as possible.

The second issue is the low number of Aboriginal and Torres Strait Islander clinical staff. Across Australia, there are only about 300 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* reported that 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. Hence, there are significant opportunities for clinical placements and pathways 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 on existing Commonwealth programs, including the Aboriginal employment and training programs administered via the National Indigenous Australians Agency (NIAA) and mainstream services delivered by Vocational Training and Employment Centres, Jobactive members, disability employment services and RTOs.

With the devastating impact on the economy and the workforce arising from the pandemic, investment in the national health workforce is more critical now than ever. If the unfilled vacancies already existing in the ACCHO network were filled, this would deliver an immediate 1,250 job opportunities and assist about 150 existing staff in career development. The proposal will also see jobs generated in more remote communities, where the ACCHOs are already central to local economies. As a result, there will also be flow-on economic benefits.

Funding

The Commonwealth already outlays considerable funding via a range of employment and education programs and demand-driven services. These can be accessed for the funding required to develop a workforce development strategy.

## 4. Improve Aboriginal and Torres Strait Islander housing and community infrastructure

Proposals

NACCHO is calling for the urgent implementation of the formal policy partnership on housing as outlined in the National Agreement on Closing the Gap. The policy partnership will establish a multi-jurisdictional joined-up approach to reduce gaps and duplication. It is recommended the Government:

- expands the funding and timeframe of the current National Partnership for Remote Housing Northern Territory to match at least that of the former National Partnership Agreement on Remote Indigenous Housing;
- funds a program that supports healthy living environments in urban, rural, and remote Aboriginal and Torres Strait Islander communities, similar to the Fixing Houses for Better Health program, also delivered by Aboriginal and Torres Strait Islander community housing providers; and

- updates and promotes the *National Indigenous Housing Guide*, a best practice resource for the design, construction and maintenance of housing for Aboriginal and Torres Strait Islander people.

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.[11] 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 also supports the health and safety of individuals and families. Healthy housing 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.

If the sector had not been as successful as it has been in keeping COVID-19 out of discrete Aboriginal communities, the impact of the pandemic in these communities would have been catastrophic. 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.

Funding

The Commonwealth, 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 and Torres Strait Islander communities.

Governments need to expand the funding and timeframe of the current National Partnership for Remote Housing Northern Territory to match at the very least that of the former National Partnership Agreement on Remote Indigenous Housing and fund a program that supports healthy living environments in urban, rural, and remote Aboriginal and Torres Strait Islander communities, similar to the Fixing Houses for Better Health program.

## 5. Early childhood and youth wellbeing and reducing out-of-home care

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
- analyse unmet demand for Aboriginal Health Workers specialising in early childhood.

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

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.[12] 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 following 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.*[13]

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 overrepresentation in out-of-home care has either increased or remained the same in every state and territory.*[14]

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 2019, just over half of all young people in detention were Aboriginal and Torres Strait Islander, despite them making up only 5 per cent of the general population aged 10–17.
- Aboriginal and Torres Strait Islander young people aged 10—17 were 21 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 2019, 53 per cent of Aboriginal and Torres Strait Islander youth in detention were aged 10—17.[15]

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[12] 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).

[13] https://www.dss.gov.au/sites/default/files/documents/child_protection_framework.pdf.

[14] http://www.familymatters.org.au/wp-content/uploads/2018/11/Family-Matters-Report-2018.pdf.

[15] Australian Institute of Health and Welfare, *Youth Detention Population in Australia* (Bulletin 148), February 2020.

NACCHO believes that 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.[16] 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 assist ACCHOs' pivotal role in preventing and reducing Aboriginal and Torres Strait Islander children and youth from being exposed to the child protection and criminal justice systems.

Funding

This proposal is cost neutral and relies on a redirection of existing funds within education and training portfolios. Ideally, there should be Aboriginal Health Workers specialising in early childhood in every ACCHO. The sector will need to continue this discussion with governments to ensure that there is adequate funding for these positions in future years. It is expected that the issue will be closely scrutinised through the process of implementing the National Agreement on Closing the Gap.

## 6. Health-justice partnerships to reduce negative legal and domestic outcomes

Proposal

This is a pilot measure building on the successful health-justice partnership model at Wuchopperen (Cairns). Lawyers would be located in three key ACCHOs so that clients with legal issues can be assisted immediately on site and in a way that is far more likely to prevent serious negative justice outcomes (e.g. domestic violence, child protection, etc.). The pilot would develop options for wider application of the approach in a range of communities across Australia.

Health-justice partnerships provide a model of integrated service delivery that has been proven effective at reducing Aboriginal and Torres Strait Islander peoples' over-exposure to the justice system. It is an example of the community taking control to look after vulnerable people and to do that quickly, effectively and in a culturally-safe environment.

To roll out the model further, there would need to be discussions with the eight state and territory governments, who hold the bulk of justice funding. With the evidence from Wuchopperen and the three new pilot sites, it would be possible to cost a national approach and then have specific

[16] http://www.familymatters.org.au/wp-content/uploads/2018/11/Family-Matters-Report-2018.pdf; Thorburn and Marshall, 'The Yiriman Project in the West Kimberley: an Example of Justice Reinvestment?', Indigenous Justice Clearinghouse, Current Initiatives, paper 5, 2017.

discussions with the states and territories, the NIAA and other potential partners (e.g. legal support services, domestic violence and family support services).

National bodies, such as the Australian Law Reform Commission, the Law Council of Australia, and Health Justice Australia would also be invited to become involved, along with prominent legal firms with a track record in supporting Aboriginal and Torres Strait Islander communities.

Rationale

The LawRight and Wuchopperen health-justice partnership in Cairns was formally evaluated in 2019. It provides solid evidence to support this proposal.

In conversations with local elders, Wuchopperen entered into a health-justice partnership in 2016 with LawRight, an independent, not-for-profit, community-based legal organisation which coordinates the provision of pro bono legal services for individuals and community groups. The aim of the partnership was to improve health outcomes by enhancing access to legal rights and early intervention. It helped health workers to discuss with members of remote and urban communities their legal problems and connect them to legal help. A handy 'how-to guide' included conversation prompts and advice on how to capture the person's family, financial, tenancy or criminal law legal needs as well as discussing and recording their progress.

Representatives from LawRight, Wuchopperen, Queensland Indigenous Family Violence Legal Service and the Aboriginal Torres Strait Islander Legal Services came together and created a range of culturally-safe resources based on LawRight's successful Legal Health Check resources. As a result, 'Law Yarn' was officially launched at Wuchopperen Health Service, Cairns, in 2018 by the Queensland Attorney General as a Reconciliation Week event. The trial was funded to 30 June 2019 and has been comprehensively evaluated by independent academics.

With Aboriginal community control at the front and centre of service design, this partnership was able to deliver both preventive law and preventive health for Aboriginal and Torres Strait Islander peoples. The benefits flowed both ways. Health as well as justice outcomes improved, as demonstrated in the case study, below.

Case study: LawRight and Wuchopperen health -justice partnership

One of the health workers reported to the evaluation team that she saw a 17 year-old girl who was pregnant with her first child. After a while, she disclosed significant domestic violence. The girl had also been alienated from her community and was not speaking with her family. She had no proof of ID, no mobile phone, no credit card, not even a landline in her home. Her violent partner was threatening to take the child to his parents to adopt. She did not want that and asked the co-located lawyer to help her.

A safety plan was put in place. The lawyer helped her access a proof of age card, get her own payments from Centrelink for the baby and applied for housing. This was all achieved in one session.

Two days later, she needed to be evacuated because she had been assaulted again. She came back and the lawyer arranged for fast-track income support payments. The baby was coming in three weeks. The client was amazed that she had help and was very grateful. Everything was done quickly and in a way that was culturally appropriate.

If there were no partnership between the nurse and the lawyer, when she got to hospital to have the baby, at 17, with bruising on her arm, no income and no fixed address, it was almost certain that the baby would have been removed.

The evaluation included the examination of 72 client files examined in which 152 legal issues were identified and a survey of 24 clients and 44 health staff. For context:

- all clients were Aboriginal or Torres Strait Islander people;
- only one in four clients had previously had access to legal assistance;
- only 12 per cent spoke standard English; and
- almost 90 per cent were on welfare.

The main outcomes identified in the evaluation were:

- 225 health outcomes delivered;
- 281 wellbeing outcomes delivered;
- 100 per cent of clients had improved health and well-being;
- 97 per cent were connected to on-site legal clinics by health professionals; and
- 86 per cent said that they would not have resolved the legal issue without on-site lawyers.

The evaluation made the following conclusion.

> *The LawRight-Wuchopperen partnership overcame individual and cultural-specific barriers of fear, lack of legal knowledge, trauma, poverty and marginalisation by increasing accessibility through:*
>
> - *co-location and integration of the legal service within the health service;*
> - *culturally safe location and practices;*
> - *'one-stop-shop' for health and legal needs – seamless, integrated, early-prevention focused service delivery;*
> - *Indigenous lawyer; and*
> - *recognised benefit of Law Yarn, a culturally safe, legal needs diagnostic tool developed by the project.*

Legal and health services throughout Australia have since expressed interest in this holistic approach to the health and wellbeing and justice outcomes of Aboriginal and Torres Strait Islander peoples. The evaluation findings support the rollout of the model to ACCHOs across Australia.

There is considerable interest in health-justice partnerships amongst our ACCHOs. For example, Danila Dilba in Darwin has been developing a specific proposal. Orange Aboriginal Medical Service (NSW) has sourced its own funding to place a Health Justice Officer in the ACCHO. He is situated with the 'Social and Emotional Wellbeing team', which also comprises an Aboriginal Social Support Coordinator and an Aboriginal Men's Health and Wellbeing worker.

There are considerable consequential savings for the Commonwealth if it were to fund this proposal. As the case study shows, the initiative prevented a situation in which a teenage mother would most likely have lost custody of her child. If this had occurred it would have led to legal costs, out-of-home-care costs and additional health-and-wellbeing costs for the child and mother. The health impact on the individual is also significant. In the case study, the likelihood of further domestic violence was avoided and the young mother's mental health was not affected by the trauma of violence and an unnecessary separation.

Funding

The proposal would be piloted in a range of settings prior to national implementation. Beginning with Danila Dilba – which has closely supported the proposal – two other sites would be involved to test a range contexts and to solicit enough information to be able to adjust the model to different situations, noting the diversity of settings in which our 550 clinics operate.

Funding over three years of $1.88m is required for the pilot. Ongoing funding reliance would be minimised through the inclusion of pro bono support from law firms and in-kind support from other partners (e.g. legal centres and welfare groups). However, it is expected that state and territory governments would become involved as they are the key funding contributors normally for legal services.

The main costs of the pilot would be for the co-located lawyer's salary at the three sites over three years including on-costs ($1.55m), program support from NACCHO ($210,000) and research and evaluation ($120,000), culminating in a report at the end of the second financial year (i.e. mid-2023.) Ideally, the funding could be identified from within the existing program allocations administered by the NIAA.

## 7. A national program that funds ACCHOs to integrate pharmacists into their health services

Proposal

The recently commissioned project Integrating Pharmacists within Aboriginal Community Controlled Health Services to improve Chronic Disease Management – known as the 'IPAC Project' – is feasible and acceptable for ACCHOs and manifestly complementary with other Commonwealth programs and investments in medicines use for Aboriginal and Torres Strait Islander people. The model is also consistent with Priority Reform area 2 of the 2020 National Agreement on Closing the Gap and such a program would support self-determination by allowing ACCHOs to employ pharmacists of their choice to ensure a culturally-safe environment and relevant to their specific needs.

Rationale

In 2019, medicine safety was declared an Australian National Health Priority Area by the Minister for Health. In consideration of this priority and several recent national reviews and Commonwealth data that demonstrate the ongoing and gross inequity in medicines use and government spending for Aboriginal and Torres Strait Islander people compared with the other Australians, much more needs to be done, especially when considering Australia's record in delivering healthcare inequitably.[17]

While there have been some recent reforms announced to medicines use and access programs for Aboriginal and Torres Strait Islander people, these reforms alone are inadequate. There is no existing or proposed program that adequately supports ACCHOs to employ pharmacists on a sustainable basis to deliver a range of integrated and holistic medicines-related services.

The value of integrating pharmacists in Aboriginal health services is specifically acknowledged by reviewers in both the *Review of Pharmacy Remuneration and Regulation* and the *Urbis Review of Indigenous Pharmacy Programs*. The Commonwealth has also recognised the merit in this model by commissioning the IPAC Project. Global literature, including systematic reviews, now also demonstrate the positive health and economic impacts of integrating pharmacists into primary care settings.

Pharmacists' influence on medicines use in ACCHOs extends to clients, practitioners and into primary care services' medicines oversight and management. In addition to supporting community control as referenced in the National Agreement on Closing the Gap, integrating pharmacists into ACCHO may have a significant impact on several outcomes within the Agreement, specifically including outcomes 1, 2, 4 and 14. Pharmacist can have a huge impact on medicines use and health outcomes for a wide range of patients throughout their access to ACCHOs over the course of their lives.

Funding

The program may be piloted in a range of settings prior to national implementation. NACCHO has modelled the quantum of costs for a national program with full uptake of pharmacists for all ACCHOs in Australia to be around $10 million. We therefore propose that an initial pilot investment of $3 million in the first year will provide an opportunity to implement the program and conduct preliminary evaluation on an ongoing program's feasibility and effectiveness.

[17] Schneider, Dana, Sarnak, Squires, Shah and Doty, *International Comparison Reflects Flaws and Opportunities for Better U.S. Health Care*. July 14, 2017 (https://interactives.commonwealthfund.org/2017/july/mirror-mirror/ )

## 8. Returning Social and Emotional Wellbeing (SEWB) funding to ACCHOs

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 under the Health portfolio. Improving the delivery of SEWB services is all the more critical since COVID-19 and increased demand arising from the impact of the shutdowns and continuing anxiety.

Rationale

An issue that has been of concern for the ACCHO sector for several years now is the matter of the unexpected transfer of SEWB 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 the Commonwealth.

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 promise was not honoured.

Given the expertise of the sector, ACCHOs are trusted by the 370,000 Aboriginal and Torres Strait Islander people who access their services each year, it makes sense to have SEWB funding quarantined under IAHP in the Health portfolio, rather than with NIAA.

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.

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 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 works 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. 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.

Furthermore, NACCHO believes that the current artificial distinction between separating mental health, SEWB and alcohol-and-drug funding from primary health care funding must be abandoned. Primary

health care, within the holistic health model provided by ACCHOs, 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 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.[18]

The current artificial distinction, as exemplified by program funding for ACCHO activities being administered across two Commonwealth 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.

Funding

Cost neutral and likely to deliver efficiencies. This is a redirection of existing funds that will actually have the potential to deliver savings to the Commonwealth.

## 9. Suicide prevention

Proposal

That funding is provided for the Kimberley Suicide Prevention Trial and the Darwin Suicide Prevention Trial to become ongoing programs. The Kimberley and NT Trials have helped navigate and develop suitable support services for the diverse needs of the Kimberley and NT Aboriginal communities.

The Kimberley Aboriginal Suicide Prevention Trial is helping to develop a suicide prevention model suitable for the unique needs of Kimberley Aboriginal communities. In the Northern Territory, the trial aims to gather evidence of how a systems-based approach to suicide prevention might be best undertaken at the regional level to better respond to local needs and to identify new learnings in relation to suicide prevention strategies for at-risk populations. Each trial site has run for five years and have received Australian Government funding of up to $5m. The evaluation was completed in December 2020 with the aim of gathering and analysing information from the National Suicide Prevention Trial sites to determine what strategies are effective in preventing suicide at a local level and in target populations, and to consider the implications of these findings for future suicide prevention activities.

If funding ceases for the two Aboriginal specific trial sites, the focus, coordination and significant progress made to date to prevent self-harm and suicide in each site will increase the risk to Aboriginal children and young people.

Rationale

The National Agreement on Closing the Gap demonstrates the commitment from all levels of Government to making a change in the development and implementation of policies and programs that impact on the lives of Aboriginal and Torres Strait Islander people. Shared decision making between Aboriginal and Torres Strait Islander people and governments, strengthening the community-controlled sector, improving partnerships with mainstream institutions, and improving collection and access to Aboriginal and Torres Strait Islander data, are all priority reforms that underpin the National Agreement. NACCHO highlights the importance of outcome 14 in the National Agreement— that Aboriginal and Torres Strait Islander people enjoy high levels of social and emotional wellbeing which seeks to reduce the Aboriginal and Torres Strait islander suicide rate 'towards zero' .

ACCHOs are best placed to be the preferred providers of suicide prevention services and initiatives, recognising their rights as health consumers to access culturally safe and competent services, and continuity of care.

[18] The primary health care approach developed by Redfern AMS and other early ACCHOs was innovative. It mirrored international aspirations at the time for accessible, effective and comprehensive health care with a focus on prevention and social justice. It even foreshadowed the *WHO Alma-Ata Declaration on Primary Health Care* in 1978.

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.[19] 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.[20] Aboriginal people living in the Kimberley region are six times more likely to die by suicide than non-Aboriginal people.

Key findings/Outcomes

- Aboriginal Leadership in decision making
- Testing the efficacy of the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP) as an Indigenous systems-based approach
- Community level Aboriginal employment and training outcomes
- Strengthening the Aboriginal Community Controlled Organisation sector through commissioning activities
- Empowering local Aboriginal communities through the development and implementation of place-based suicide prevention programs and initiatives
- Strengthening the patient journey, cultural safety and relevance of local and regional mental health and suicide prevention services for Aboriginal people
- Developing youth led regional awareness raising campaigns and education regarding wellbeing, suicide prevention help seeking behaviours
- Mobilising community action through whole of community suicide prevention and healing events
- Strengthening Kimberley Aboriginal cultural practices as protective factors for suicide prevention
- Empowering young Aboriginal leaders to lead the conversation amongst Kimberley Aboriginal youth regarding youth suicide issues and solution

Funding

The current investment for the Kimberley Aboriginal Suicide Prevention trial is $1m for the 2020/21 FY. The current investment for the Suicide Prevention Trial in Darwin is $1m for the 2020/21 FY.

To roll over this funding for the next five financial years, $10m is required ($2m each year). Ideally, indexation should also be applied.

## 10. Improving Aboriginal and Torres Strait Islander oral health

Proposals

That the Commonwealth:

- develops a national standard for access to fluoridated water or fluoride in other forms in all Aboriginal and Torres Strait Islander communities;
- establishes a multidisciplinary national panel to provide technical advice and assistance to jurisdictions to support the implementation and maintenance of water fluoridation;

[19] AIHW, *Australia's Health 2018*, (no. 16. AUS 221), Canberra, 2018.
[20] *Ibid*.

- introduces a 20 per cent tax on sugar-sweetened beverages, with the revenue accrued redirected back into a subsidy on fresh fruit and vegetables back into communities where the impact is greatest;
- amends food and beverage labelling regulations to require a graphic warning when sugar has been added to a product; and
- increases 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 cavities than other Australians.

Our proposals 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 tax on sugar-sweetened beverages be introduced (which is supported by nearly 70 per cent of Australians), and that food and beverage labelling regulations require a graphic warning when sugar has been added to a product.

Funding

This measure would be self-funded through the tax on sweetened beverages

## 11. Indigenous identifier in pathology

Proposal

The introduction of an Indigenous identifier in pathology data at point of collection across all jurisdictions (as currently required in WA).

Rationale

The identification of Aboriginal and Torres Strait Islander people in pathology datasets is a longstanding issue that also has implications for continuity of care. It affects national cancer screening programs, including cervical cancer, and impairs our ability to respond to the syphilis outbreak in northern Australia and other sexually-transmitted infections.

Currently, there is no way of identifying the national level of testing for SARS-CoV-2 among Aboriginal and Torres Strait Islander peoples. Maintaining a high level of testing during COVID-19 is critical in identifying outbreaks early and containing them.

Regular updates on testing counts for SARS-CoV-2 amongst specific population groups is one of nine goals in the Australian National Disease Surveillance Plan for COVID-19. This plan was developed by Communicable Diseases Network Australia and endorsed by the Aboriginal and Torres Strait Islander COVID-19 Advisory Group. It cannot be achieved under the current reporting systems.

Some positive steps have been taken, for which we are most grateful. These include:

- Aboriginal and Torres Strait Islander status being a mandatory component in pathology collected within GP respiratory clinics;
- the Western Australian Chief Health Officer (CHO) issuing a COVID Testing Reporting Direction which compels the inclusion of Indigenous status in pathology reporting (the WA CHO also wrote to private pathology providers asking them to collect and report on Indigenous status); and
- state-based pathology providers in NT and WA collecting and reporting on testing by Indigenous status.

Nevertheless, we need a *national* approach and urge the Commonwealth to require the same measures across all jurisdictions. Actions that still need to be taken include:

- all CHOs to provide a similar directive to that of the WA CHO on the inclusion of Indigenous status in pathology reporting;
- immediate funding of implementation work with public and private pathology providers to ensure Indigenous status; requiring that:
    - Aboriginal and Torres Strait Islander status is provided on pathology forms printed by general practice software;
    - Aboriginal and Torres Strait Islander status is recorded by pathology electronic systems; and
    - regular reporting includes disaggregation by Indigenous status.

For this to be fully effective, of course, the means by which Aboriginal and Torres Strait Islander status is collected also needs to be culturally appropriate, so that full disclosure and accuracy of the data is achieved. Cancer Australis's report, *Using data to improve cervical cancer outcomes for Aboriginal and Torres Strait Islander women* (April 2020) is helpful in this regard.

Funding

Minimal cost, but small-scale funding could be requested from the pathology sector to support changes in data-collection processes and systems.

## 12. Closing the Gap in relation to Blood Borne Virus (BBV) and Sexually Transmitted Infection (STI) associated morbidity and mortality.

Proposal

That the Australian Government enhances capacity of all ACCHOs in urban, regional and remote areas to conduct syphilis, gonorrhoea, chlamydia, trichomoniasis and Hep C and HIV testing (as well as COVID-19 testing) by:

- committing to retaining current Enhanced Syphilis Response staffing levels ($20m over 3 years) in identified outbreak areas which is scheduled to end in June 2021;
- funding NACCHO to work with key stakeholders and research institutes to develop and deliver culturally appropriate sexual health testing, treatment and contact tracing services and training to ACCHO staff;
- expanding the TTANGO program to enable other ACCHOs to undertake STI and COVID-19 testing;
- creating an MBS Item that supports STI testing on the GeneXpert machines to further increase access to STI testing for Aboriginal and Torres Strait Islander peoples and programmatic costs and improve program sustainability in the long term; and

- ensuring the 35 GeneXpert machines provided to ACCHOs for COVID-19 testing remain in the services for STI purposes and they are supplied with testing cartridges (until the introduction of the MBS Item).

Rationale

NACCHO has recently been funded by the Commonwealth to coordinate the development and delivery of an Implementation Plan for the National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy. The plan will identify the roles and responsibilities of mainstream organisations in addressing the disproportionate prevalence of STIs and BBVs in Aboriginal and Torres Strait Islander communities (see Table D).

**Table D: Prevalence of STIs and BBVs in Aboriginal and Torres Strait Islander communities**

| STI/BBV | Prevalence in Aboriginal and Torres Strait Islander communities | Prevalence in other communities |
|---|---|---|
| Hepatitis C | 168 per 100,000 | 38 per 100,000 |
| Chlamydia | 1,194 per 100,000 | 427 per 100,000 |
| Gonorrhoea | 628 per 100,000 | 96 per 100,000 |
| Syphilis | 103 per 100,000 | 16 per 100,000 |

*HIV, viral hepatitis and sexually transmissible infections in Australia: annual surveillance report 2018, Kirby Institute, University of NSW.*

It is critical that STIs and BBVs are identified and addressed early to minimise acute and chronic health consequences (including infertility and infant fatalities) and that coordination across the ACCHO sector occurs to maximise engagement and ensure effective utilisation of limited resources. NACCHO and the ACCHO sector have demonstrated that they are able to effectively coordinate and deliver locally appropriate communicable disease services. They have:

- minimised the impact of the pandemic on the Aboriginal and Torres Strait Islander community (currently no deaths in the Aboriginal and Torres Strait Islander community, and 0.5% of those who have contracted COVID-19 are Aboriginal and Torres Strait Islander peoples);
- responded to declared syphilis outbreak regions (in North Queensland, Northern Territory, Western Australia and South Australia) by increasing rapid testing and treatment levels and supporting the development and implementation of localised community education campaigns.

Funding

Provision of GeneXpert machines and cartridges to other ACCHOs will require capital expenditure of up to $5m, along with a further funding of $1.5m per year for the implementation of a training and quality control framework.

Workforce retention of Aboriginal and Torres Strait Islander Health Practitioners and Workers employed under the Enhanced Syphilis Response Program for another three years will cost $20m.

Funding would also need to consider the cost of the MBS Item supporting sexual health testing on GeneXpert machines.

## 13. Extension of the Aboriginal and Torres Strait Islander National Community Connector Program

Proposal

That the National Disability Insurance Agency (NDIA) extend funding for the National Community Connector Program (NCCP) beyond June 30, 2021 for a minimum of three years. This will ensure the security of at least 50 jobs for Aboriginal and Torres Strait Islander people nationally and will better support Aboriginal and Torres Strait Islander people with a disability to access NDIS services. NACCHO also proposes extending the Remote Community Connectors (RCCs) program by at least three years and to combine the administration of these two programs.

This proposal aligns with the National Agreement on Closing the Gap, as the objective of the Agreement is to overcome the entrenched inequality faced by too many Aboriginal and Torres Strait Islander people so that their life outcomes are equal to all Australians.[21]

Rationale

Aboriginal and Torres Strait Islander people are twice as likely to experience a disability than other Australians, with 9 per cent having a severe condition compared to 4 per cent, respectively. As at 30 Sept 2020 only 6.6 per cent (or 27,112) of 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.[22]

NACCHO entered into a contract with the NDIA in mid-2020 to link Aboriginal and Torres Strait Islander communities with the NDIS through the NCCP. The 12-month program is underway and will eventually employ over 50 Aboriginal and Torres Strait Islander people across Australia and build capacity within ACCHOs to link their communities to the NDIS in a culturally-safe environment. However, the structural change necessary to ensure increased, culturally appropriate and more ongoing participation of Aboriginal and Torres Strait Islander people in the NDIS in the long term cannot be achieved within a 12-month period. Further funding is required for at least three years to ensure that eligible Aboriginal and Torres Strait Islander people receive the support required to become and stay participants of the NDIS.

The impacts of COVID-19 on the prompt implementation of the NCCP has been apparent. Some ACCHOs faced challenges in recruiting Community Connectors and arranging community consultations due to regional lockdowns and restrictions. An extended program would give ACCHOs a better opportunity to build the trust required in the community to connect Aboriginal and Torres Strait Islander people to the NDIS. The unique position of ACCHOs allows them to address community perceptions among Aboriginal and Torres Strait Islander people about the NDIS and assist with difficulties in understanding the NDIS and its complex eligibility criteria. Additional time and resources will also support the Commonwealth's recovery efforts from the bushfires and COVID 19 in Aboriginal and Torres Strait Islander communities with high rates of disability.

Implementing the NCCP over the last six months, NACCHO has worked very closely with key stakeholders to ensure a clear and shared understanding of the issues regarding the NDIS and the work required to address these. NACCHO allocated scarce resources appropriately to maximise the return on investment and outcomes for Aboriginal and Torres Strait Islander people with disability requiring access to NDIS services. Various ACCHOs have informed NACCHO that a 12-month contract was not sufficient time to establish the NCCP and adequately service the community including connecting

[21] Coalition of Peaks, National Agreement on Closing the Gap p 3 https://coalitionofpeaks.org.au/wp-content/uploads/2020/07/FINAL-National-Agreement-on-Closing-the-Gap-1.pdf
[22] https://www.ndis.gov.au/about-us/publications/quarterly-reports

Aboriginal and Torres Strait Islander people to the NDIS. Some ACCHOs declined the contract on this basis, and others were reluctant to partake in the program as it would take time to build trust in the community to run the NCCP effectively.

Anecdotal evidence from ACCHOs suggests that the NCCP is improving social and emotional wellbeing outcomes in some communities, and there is an increase of referrals to specialists due to the community connector's ability to manage stakeholder engagement. Some ACCHOs have indicated that their communities cannot generally be accessed by non-Indigenous organisations due to the lack of trust in some mainstream organisations and programs. Our ACCHOs are working hard towards building understanding and trust in communities about the NDIS, and this would be eroded if funding for this program were discontinued. The Aboriginal and Torres Strait Islander NCCP is a unique and vital program which demonstrates the success of the Commonwealth's Closing the Gap agenda, and its commitment to implementing the National Agreement.

The NCCP directly aligns with the principles and intention of the National Agreement. One of the 16 targets outlined in the National Agreement is that 'everyone enjoys long and healthy lives'.[23] One of the key Priority Reform Areas in the National Agreement is to build the community-controlled sector, and disability has been identified as one of the initial sectors in focus. The NCCP will help NACCHO increase community awareness within Aboriginal and Torres Strait Islander communities of the NDIS and the life-changing support it can provide as well as contribute to implementing the Closing the Gap agenda.

NACCHO also supports an extension to the RCCs which is scheduled to cease funding on June 30, 2021.

Funding

NACCHO currently has contracts with 48 of our ACCHOs to run the NCCP out of a total of 143. The current investment for the Aboriginal and Torres Strait Islander project is $4.5 million for twelve months which includes funding for the Community Connectors, contract management, ICT and travel costs. NACCHO proposes building the capacity of every ACCHO that requires the Community Connector service. Disability is a national issue and affects different communities in diverse ways. The only way to ensure cultural safety for Aboriginal and Torres Strait Islander people with disability is to support ACCHOs directly to connect their clients to the NDIS. NACCHO recommends incrementally increasing the NCCP funding so that 86 ACCHOs run the service by 2023/2024.

**Table E: Investment required**

| Year | Program | Indexation[24] | Investment |
|---|---|---|---|
| 2021/2022 | NCCP (58 ACCHOs)<br>I FTE = $77,777 | 2.5% | $382,500 (NACCHO)<br>$4,623,894 (ACCHOs) |
| 2022/2023 | NCCP (72 ACCHOs) | 2.5% | $392,062 (NACCHO)<br>$5,740,007 |
| 2023/2024 | NCCP (86 ACCHOs) | 2.5% | $401,864 (NACCHO)<br>$6,856,120 (ACCHOs) |
| **Total investment: $17,994,585** | | | |

[23] https://coalitionofpeaks.org.au/new-national-agreement-on-closing-the-gap/

[24] https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/BudgetReview201920/BudgetOverview

## CONCLUSION

These thirteen policy proposals in four interrelated packages have been devised as practical initiatives that would deliver greater service capability and improved outcomes for Aboriginal and Torres Strait Islander people.

They also provide governments at all levels and across all jurisdictions with a tangible means of delivering quickly upon the priority reforms of the new National Agreement on Closing the Gap. Although funding in response to the National Agreement was identified last year across the jurisdictions and from the Commonwealth, stronger funding commitments need to be made as a next step in the respective 2021 budget announcements of the nine Australian governments. Moreover, the Commonwealth needs to lead by example in May 2021.The best way forward is for it to address a number of the significant funding gaps identified in this submission.

The process of closing the gap in Aboriginal and Torres Strait Islander health cannot commence until these thirteen conservative measures, or a similar program, has been funded and implemented. Our submission represents a minimum base for moving forward.

Our sector's package is based on 50 years of experience in the provision of comprehensive primary health care for Aboriginal and Torres Strait Islander peoples. The national footprint of ACCHOs provides a critical resource, with which all governments can partner. ACCHOs are accessed by over 370,000 Aboriginal and Torres Strait islander people each year and about 40,000 other Australians. The ACCHO model is proven and is well-respected, both nationally and abroad. Over the past twelve months, the sector has shown itself to be a highly effective mechanism in responding to crises such as the pandemic and bushfires.

Further investment in ACCHOs will not only improve the health outcomes of Aboriginal and Torres Strait Islander peoples across the country, but it will also, at this critical juncture, provide governments with a welcome means of creating jobs and stimulating local economies in the wake of recent disasters and the decline in employment and in the rates of economic growth and GDP.

NACCHO is committed to working with the Commonwealth to develop these proposals further, including the associated costings, trials, implementation plans, and identifying further opportunities where current expenditure could be more appropriately and effectively targeted.