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

2022/23 Pre-budget Submission

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1. ABOUT NACCHO

NACCHO is the national peak body representing 144 Aboriginal Community Controlled Health Organisations (ACCHOs). We also assist a number of other community-controlled organisations.

The first Aboriginal medical service was established at Redfern in 1971 as a response to the urgent need to provide decent, accessible health services for the largely medically uninsured Aboriginal population of Redfern. The mainstream was not working. So it was, that over fifty years ago, Aboriginal people took control and designed and delivered their own model of health care. Similar Aboriginal medical services quickly sprung up around the country. In 1974, a national representative body was formed to represent these Aboriginal medical services at the national level. This has grown into what NACCHO is today. All this predated Medibank in 1975.

The primary health care approach developed by Redfern and other early ACCHOs was innovative and continues to be so. 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.

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.

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 practitioners and/or nurses to provide the bulk of primary health care services. Our 144 members provide services from about 550 clinics. Our sector provides over 3.1 million episodes of care per year for over 410,000 people across Australia, which includes about one million episodes of care in very remote regions.

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. Our services build ongoing relationships to give continuity of care so that chronic conditions are managed, and preventative health care is targeted. Through local engagement and a proven service delivery model, our clients 'stick'. Clearly, the cultural safety in which we provide our services is a key factor of our success.

ACCHOs are cost-effective. Our activities result in greater health benefits per dollar spent; measured at a value of $1.19:$1. The lifetime health impact of interventions delivered by our services is 50% greater than if these same interventions were delivered by mainstream services, primarily due to improved Aboriginal and Torres Strait Islander access.[1] In 2016, a cost-benefit analysis of the services provided by Danila Dilba to Aboriginal and Torres Strait Islander people in the Greater Darwin region was undertaken by Deloitte Access Economics. The findings demonstrated that each dollar invested in the health service provides $4.18 of benefits to society.

ACCHOs are also closing the employment gap. Collectively, we employ about 7,000 staff – 54 per cent of whom are Aboriginal or Torres Strait Islanders – which makes us the third largest employer of Aboriginal or Torres Strait people in the country.

[1] 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; T. Vos, et al. *Assessing Cost Effectiveness in Prevention* (Final Report 2010); M. A. Campbell,et al.: http://www.publish.csiro.au/ahr (6 March 2017).

2. INTRODUCTION

2.a Closing the funding gap

NACCHO understands that, due to the significant raft of COVID measures contained in the last two Commonwealth budgets, the national deficit is a serious concern. Therefore, our submission is conservative and presents our policies and program proposals in the light of fiscal restraint. Wherever possible, savings or offsets have been identified to fund elements of this submission and/or to secure funding sourced from other existing portfolio sources so that proposals in this submission are, effectively, cost neutral.

Nevertheless, it is important to acknowledge that there is a dangerous myth that Aboriginal and Torres Strait Islander programs receive ample funding. The truth of the matter is that funding for Aboriginal and Torres Strait Islander health has been slipping backwards and is nowhere near where it needs to be to address the burden of disease (for which, see section 2.b).

Under the Abbott Government's inaugural 2014-15 budget, $534m was cut from Aboriginal and Torres Strait Islander programs run by the Commonwealth. More than 150 programs were consolidated within the Departments of Prime Minister and Cabinet and Health, nominally to eliminate waste, but, in reality, $160 million of the cuts came directly out of Aboriginal and Torres Strait Islander health programs. The sector is still recovering from these decisions, even though it was seven years ago. Moreover, some elements (e.g. Social and Emotional Wellbeing programs) were removed from the ACCHO sector and transferred to the mainstream, where costs escalated and efficiencies declined.

NACCHO's research shows that, 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 to $3,780 per person in 2016 (based on *Report on Government Services*). Over the same period, expenditure on non-Aboriginal people rose by 10 per cent. How can the health gap be expected to close if the funding gap in health expenditure is widening?

Expenditure on Aboriginal and Torres Strait Islander health under the Commonwealth's Indigenous Australians Health Program (IAHP) funding accounts for about 13 per cent of the total expenditure on Aboriginal and Torres Strait Islander health.[2]

IAHP received an increase of 1.8 per cent for the 2021-22 financial year, but according to the Budget papers, it actually decreases by about 8 per cent in real terms across the forward estimates to 2024-25.

The historical funding shortfall has been recognised by stakeholders in the sector for some time. For example, 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.' And on 21 October 2021, the Royal Australian College of General Practitioners (RACGP) released a public statement calling 'for adequate funding for Aboriginal and Torres Strait Islander healthcare', referring to one of the findings in their report titled, *General Practice: Health of the Nation*.

It should also be noted that the pandemic is exacerbating an already significant difference between general CPI and the greater increase in costs experienced by the health sector. The pandemic is seeing higher costs and greater demands, particularly for those clinics servicing disadvantaged communities who are most at threat from COVID-19. In addition, the travel restrictions and staff furloughs (for close contacts) have significantly reduced the capacity to access Australian and international staff. This will inevitably lead to increased salary costs to recruit staff from a reduced pool of professionals. Hence, a

[2] Based on *2017 Indigenous Expenditure Report*, Productivity Commission, Canberra.

significant increase in indexation will be necessary in recognition of these differential impacts arising from COVID-19 during a period of sustained low inflation.

2.b Adjusting funding considerations to account for the burden of disease

Compounding the historical funding shortfall is the burden of disease for the Aboriginal and Torres Strait Islander population. This is 2.3 times higher than for the rest of the population, according to the latest report (*Australian Burden of Disease Study*) from the Australian Institute of Health and Welfare (AIHW). It is of no surprise that the rate is even higher in remote areas.

To address the disparity, the Commonwealth, in particular, needs to do more. It only spent $1.21 per Aboriginal and Torres Strait Island person for every $1 spent on the rest of the population. The Commonwealth has responsibility for primary health care. It must lift expenditure not just to match the states/territories' spend, but to match the burden of disease – i.e. $2.30 for every non-Aboriginal dollar at the very least. If we are to have a level of funding commensurate with the burden of disease, an additional $1.4-5 billion per year is required.

2.c New funding announced in 2021

On 5 August 2021 the Prime Minister presented his Government's *Closing the Gap Implementation Plan*.

There was welcome news. The announcement of the plan was headlined by $378.6 million over five years for a 'Territories Stolen Generations Redress Scheme'. There were also important measures related to justice partnerships and early childhood development. There was $45m for improving the health and wellbeing of Aboriginal and Torres Strait Islander mothers and babies over four years and an additional $66m for strengthening Aboriginal and Torres Strait Islander Alcohol and Other Drugs (AOD) Treatment Services. This investment will increase access to enhanced outcomes-focused AOD treatment services; enable overdue repairs of AOD infrastructure and some new services, strengthen the capacity of the AOD workforce and improve data collection and reporting.

Of greatest significance for the ACCHO sector was substantial (but overdue) funding relating to infrastructure investment. This consisted of $154.4 million of new funding and $100 million in existing IAHP funding redirected to strengthen the ACCHO sector through investment to deliver new and renovated health clinics and associated housing for health professionals. The $254.4 million in infrastructure funding responded to a serious shortfall as set out in four of NACCHO's pre-budget policy proposals requested over the previous three years. One of the elements in this year's submission addresses the remaining infrastructure shortfall estimated at $646 million.

The Government also provided NACCHO with almost $30m in funding for the sector's COVID-19 response. This was fully expended by December 2021 and in a public statement on 13 December 2021, related to $308.6m for permanent telehealth services, there was also $7.3m additional COVID funding for NACCHO announced.[3]

On 15 December 2021 the Government released the *10-year plan to improve Aboriginal and Torres Strait Islander Health*. No new funding with the plan was announced, which suggests that it could be just as ineffective as the last 10-year plan. However, the announcement does refer to the new National Agreement on Closing the Gap and implies that funding will flow through to the sector via that process. Furthermore, the announcement acknowledges 'that historic and systemic factors have

[3] Media release by Hon Greg Hunt MP (Minister for Health and Aged Care), Hon Dr David Gillespie MP (Minister for Regional Health) and Hon David Coleman MP (Assistant Minister for Mental health and Suicide Prevention), 13 December 2021.

resulted in Aboriginal and Torres Strait Islander people having a burden of disease 2.3 times that of non-Indigenous Australians'.[4]

2.d Structural reform is required

In accordance with the approach agreed in the new National Agreement on Closing the Gap (for which, see Section 5), there needs to be a process undertaken now with Commonwealth agencies and state/territory governments which leads to fundamental structural reform in the ACCHO sector, including how it is funded collectively into the future.

The second priority reform area of the agreement is as follows.

> **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.

This means that existing programs, services and funding arrangements need to be reconsidered in the light of the agreement so that the sector itself is strengthened.

One key example of the need for structural reform – as outlined in section 3.b of this submission – is hospital funding. NACCHO is aware of situations in which Aboriginal and Torres Strait Islander people are not getting their fair share of mainstream funding and the tab is being picked up by ACCHOs. Hence, the flow of funding needs to be reviewed and this could be included as part of the overall structural reform process.

Another critical early step is to ensure that all Aboriginal and Torres Strait Islander health programs and services have been co-designed. This means a *genuine* partnership process where there is equal weight given to the sector's voice at the table alongside that of governments and agencies. It is important that this is not just the sort of consultation process that has existed previously, but a meaningful partnership where the sector has equal decision-making authority.

There has been considerable work already undertaken towards this end; namely, in the *Health Sector Strengthening Plan*, developed in liaison with the Coalition of Peaks and under consideration by parties as part of the implementation of the new National Agreement. There are four strong proposals already under consideration by NIAA from its Health Sector Strengthening Virtual Funding Pool. These have been attached to the end of this submission. If they are not supported through the new funding pool, then they must be elevated to the 'tier one' proposals of this submission. As they are fully costed and 'ready to go'.

Summaries of these four proposals are attached at the end of this submission. They are:

1. Governance training and support program ($1.963 m);
2. Build the capacity of Aboriginal Community Controlled Health Registered Training Organisations to develop the Aboriginal and Torres Strait Islander health workforce ($1.17 m);
3. A co-designed National Strategic Roadmap to secure a permanent, highly skilled and nationally credentialed Aboriginal and Torres Strait Islander environmental health workforce to meet community health need ($1.228 m); and
4. Optimal utilisation of the Medicare Benefits Schedule (MBS) Project ($4.226 m).

[4] Media release by Hon Greg Hunt MP (Minister for Health and Aged Care) and Hon Ken Wyatt MP (Minister for Indigenous Australians), 15 December 2021.

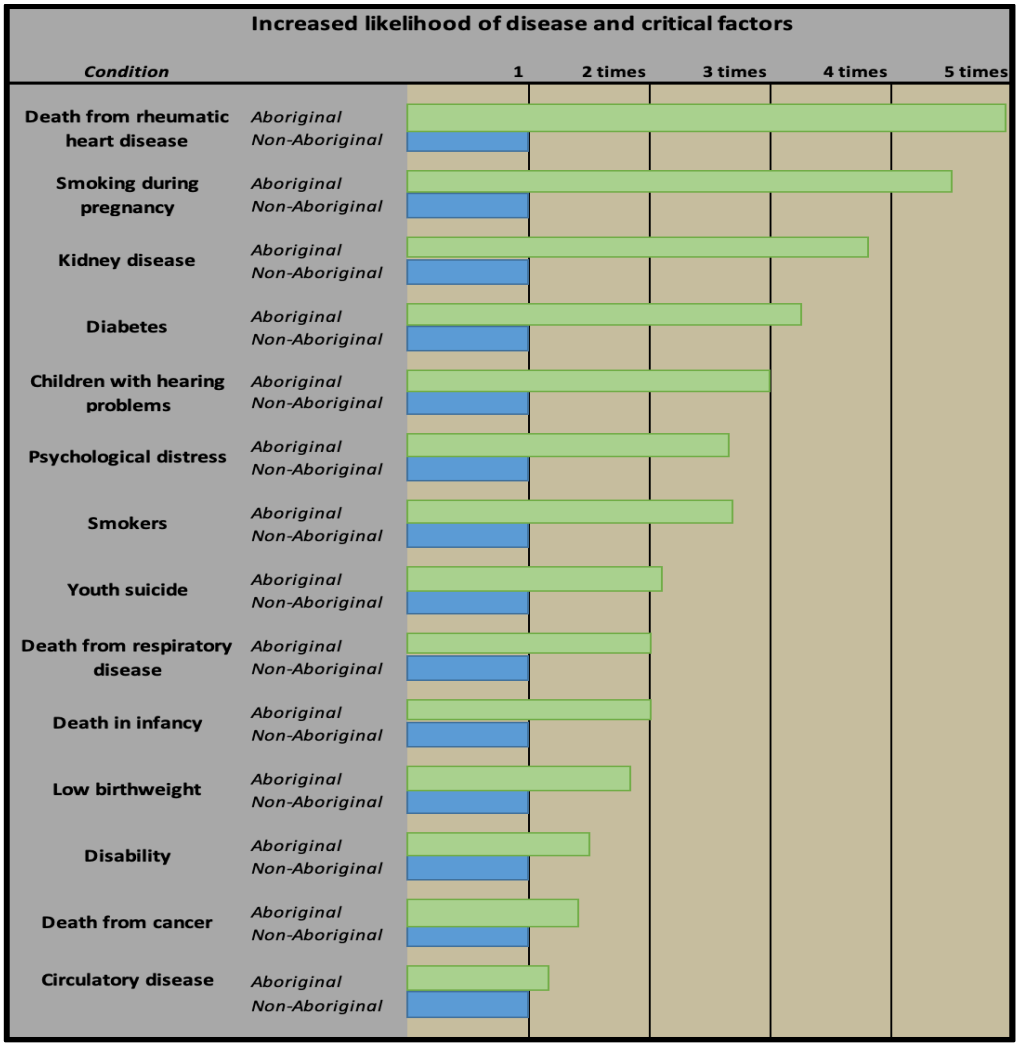
3. CLOSING THE HEALTH GAP

3.a An overview of the health gap

Key statistics show that the gap in Aboriginal and Torres Strait Islanders health is profound.[5] Aboriginal and Torres Strait Islander people are:

- 5.0 times more likely to die from rheumatic heart disease;
- 4.5 times more likely to smoke during pregnancy;
- 3.7 times more likely to have kidney disease;
- 3.2 times more likely to have diabetes;
- 2.1 times more likely to suicide as youths;
- 2.0 times more likely to die in infancy;
- 1.8 times more likely to be born with low birthweight;
- 1.4 times more likely to die from cancer;
- 1.4 times more likely to have a disability; and
- 1.2 times more likely to have circulatory disease.

Table 1: Key statistics on the health gap



[5] These statistics are sourced from a range of sources, including AIHW reports, ABS surveys, ARACY Report Card, and CAEPR papers.

3.b Relationship with mainstream services

Due to historical factors, many Aboriginal and Torres Strait Islander people have developed a mistrust of hospital systems.

This is not only borne out by the act of self-determination in 1971 to establish the first ACCHO, but by recent statistics on premature hospital exits. Almost 20,000 Aboriginal and Torres Strait Islander hospital patients left hospitals prematurely or without being discharged in 2015-17.

Also in this period, 81,100 hospitalisations of Aboriginal and Torres Strait Islander people were deemed preventable. The rate of preventable hospitalisations per 1,000 was 2.6 times higher for Aboriginal people than for other Australians. The gap is greater by remoteness.

The three top causes of preventable hospitalisations were:

- cellulitis (a bacterial skin condition): 9,500;
- chronic obstructive pulmonary (lung) disease: 8,800; and
- convulsions and epilepsy: 7,700.[6]

The fact of the matter is that, for whatever reason (systemic racism or otherwise), the mainstream hospital system is not performing at a satisfactory level for Aboriginal and Torres Strait Islander patients. Mistrust of hospitals means that Aboriginal and Torres Strait Islander people are missing out on their fair share of mainstream health services and funding.

NACCHO is seeing more cases in which patients do not engage with the mainstream health system due to cultural safety concerns. They are accessing ACCHOs for services instead.

For example, dental health that would be free if accessed via clients in the hospital system is now being accessed in a number of ACCHOs with dental chairs and services. Another key example has emerged out of the COVID-19 crisis which has seen more clients accessing 'hospital in the home' delivered via local ACCHOs. The funding for these services needs to follow the clients.

NACCHO believes that state/territory hospital funding budgets should be adjusted to recognise this, so that when the ACCHO sector in a jurisdiction picks up the tab, the funding should flow back to the ACCHOs from the hospital system. We urge the Commonwealth to address this through the funding agreements negotiated with the states. In this way, the Commonwealth should be able to deliver savings in their agreements with states and territories and reallocate this to ACCHOs via the IAHP.

Alternatively, funding to cover the cost-shifting could be negotiated within each jurisdiction. But the latter approach relies heavily on the goodwill of eight separate jurisdictions and, as the hospitals themselves are under immense financial strain and are now, with the Omicron variant, almost at capacity, such a negotiation process would be fraught. Hence, NACCHO recommends that this issue be reviewed in discussions with the Commonwealth Minister for Health in early 2022 after the Federal election.

[6] See https://www.aihw.gov.au/reports/primary-health-care/potentially-preventable-hospitalisations/contents/overview.

4. THE IMPACT OF COVID-19

4.a The success of the ACCHO model during the pandemic

The Aboriginal community-controlled health care model presents the best and most cost-effective investment model for our people. While COVID-19 overshadowed much of what we have done for the past 24 months, it has also shown the rest of Australia what the sector can do.

Before the Delta and Omicron variants arrived, not one Aboriginal or Torres Strait Islander person had died from COVID-19. But the situation has changed now. Moreover, the Omicron variant has very recently entered some of the more remote areas.

The rates of comorbidity for Aboriginal and Torres Strait Islander peoples make us far more vulnerable to the disease than other Australians. Look at what has happened to other First Nations people across the world. The Navajo and Black Feet had the highest death rates of any groups in the USA. Aboriginal and Torres Strait Islander peoples are more likely to live with cardiovascular disease, kidney disease or cancer and almost one-quarter have two or more of these chronic conditions. Hence, it is no surprise to learn that since June 2021, when the first death occurred of Aboriginal and Torres Strait Islander people (i.e. during the Wilcannia outbreak) Aboriginal and Torres Strait Islander people have been infected with COVID-19 at twice the rate of non-Aboriginal Australians.

These recent data reflect the socio-economic circumstances applicable to most Aboriginal and Torres Strait Islander people. For example, one in eight Aboriginal and Torres Strait Islander people lives in overcrowded housing, which means COVID-19 spreads rapidly through our communities. Obviously, overcrowding poses real challenges for isolating suspected cases, which is why it was so critical to see mobile homes deployed in far west NSW during the outbreak there in mid-2021.

But it is not just about infections and death rates. During the lock down we excelled at looking after our own. We kept communication going and ensured food security and mental health was maintained. Contact tracing is also a strength for us. We know our people and where they are located and if we need to contact them quickly and respond expeditiously to a crisis, we already have much of that information at hand. Where there are low vaccination rates and borders opening up, some of our communities can still take unilateral action and close themselves down, but this is not always possible and becoming all the more unrealistic as a strategy now with Omicron.

We know that COVID hits the elderly and those with underlying health conditions hardest and it is our Elders who are of critical value to our communities with the knowledge they hold and how they act to keep our communities together.

The pandemic has shown that the model of Aboriginal community control is effective and efficient. Now, more than ever, the network needs to be developed and supported.

4.b Aboriginal and Torres Strait Islander deaths during the next phase of the pandemic

Australia lost about 16,000 people during the Spanish Flu in 1918-19. The Government has estimated that without the measures put in place to combat COVID-19 during the last two years, about 30,000 Australians would have died. If their estimate is accurate this would equate with the loss of at least 2,275 Aboriginal and Torres Strait Islander people.[7] We have, so far, averted this catastrophic loss of life. Governments in Australia, therefore, should be congratulated for helping to avert such a disaster and for taking the difficult measures that they did.

As at 21 December 2021, 2,146 Australians had died from the pandemic according to the epidemiology reports of the Commonwealth Department of Health. Of these, it could be expected that 163 would be Aboriginal and Torres Strait Islander people (based on population share and burden of disease). Yet only 21 Aboriginal and Torres Strait Islander people have died as a result of COVID-19. This result speaks for itself and demonstrates the impact of ACCHOs.

But the situation is now at a critical juncture with the borders opening up and the lower vaccination rates of many Aboriginal and Torres Strait Islander communities due to hesitancy and misinformation.

Australia has a sorry history in relation to the impact of new diseases in the Aboriginal and Torres Strait Islander populations. In the two years after 1788, smallpox wiped out over half the Eora population. In the 1790s, tuberculosis and sexually transmitted diseases also decimated our populations with no immunity. In 1820, when influenza first reached Australian shores, about one third of Aboriginal and Torres Strait Islander people died along the eastern coast; most of them without even seeing a European. In the 1860s, with shorter voyages from Europe, a second wave of diseases hit (e.g. measles and whooping cough).[8] Hence, for Aboriginal and Torres Strait Islander people, a pandemic is not 'unprecedented'. It is a saddening reminder of the past.

But we know that it is our communities who are best placed to respond to them and that we now have a chance as a nation to take a very different path to what has happened before.

L-R: NACCHO CEO, Pat Turner, Minister Ken Wyatt and Prime Minister Scott Morrison at the announcement of the *Closing the Gap Implementation Plan*, 5 August 2021.

[7] 3.3 per cent share of the population with 2.3 per cent share of the burden of disease. If you factor in the doubled transmission rate for Aboriginal and Torres Strait Islanders, then the estimate grows higher still.

[8] D. Gojak, 'The 1820 Influenza Outbreak in Sydney and Its Impact on Indigenous and Settler Populations', *JRAHS*, vol. 105.2, 2018: 180-206; P. Dowling, *Fatal Contact: How Epidemics Nearly Wiped Out Australia's First Peoples*, Monash University, Clayton, 2021: passim.

4c. Cost impact of COVID-19

As mentioned earlier in this submission, the Government made additional funding available for the sector's COVID response to ensure access to vaccines and deployment of extra staff, etc. However, our services are reporting that the pandemic has meant that there are ongoing operational costs affecting most services with the continuing use of PPE, testing, isolation requirements, furloughing of staff, etc.

Therefore, consideration needs to be given to how these costs are met, at least for the duration of the current pandemic and also to have arrangements in place so that we are prepared for future serious communicable disease outbreaks.

The cost impact of COVID on our services is explained below.

Increased staffing costs

- Greatly increased salary costs for clinical staff, especially in remote areas due to greater demand and reduced supply of staff from overseas, noting that staffing costs consume a significant proportion of core funding (about 70 per cent in some remote services examples).
- Increased costs to cover furloughed staff and/or infectious disease leave.

Costs to clinical services

- Respiratory clinics to test and identify infectious people.
- Significant extra costs due to the need to triage all clients attending every clinic.
- Increased need for infection control within all service sites, including extra cleaning.
- PPE including ongoing supply of N95 masks.
- Testing capacity (includes POC PCR machines and cartridges, plus ongoing supply of RATs).

Community engagement and support

- Community engagement and advocacy to inform community members on how to keep themselves safe (e.g. mask use, social distancing, vaccination, boosters, how to manage COVID at home).
- Testing, tracing, isolation, and quarantine programs.
- Support for vulnerable families in the community (e.g. those isolating or in quarantine, and delivery of 'COVID at Home' programs).

Infrastructure

- Negative pressure isolation rooms within clinics and improved ventilation in all buildings.
- Increased need for vehicles to support outreach and patient transport.

Policy and planning

- Significantly increased need for engagement and coordination with government in developing COVID service and public health responses that meet the need of our communities.

NACCHO is ready to discuss this with governments and to work through specific costings. One idea is to introduce a time-limited COVID-19 funding levy. Depending on how the pandemic changes the way that services are delivered into the future, it may also require a re-estimation of the cost of core services, generally.

5. ALL AGENCIES NEED TO GET BEHIND THE NATIONAL AGREEMENT ON CLOSING THE GAP

NACCHO fully supports the new *National Agreement on Closing the Gap*. NACCHO's policy proposals have also been devised in the light of it and, in particular, the four priority reform areas (Table 2).

NACCHO played a leading role in setting up the Coalition of Peaks that has grown into a group of over 60 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 each policy proposal.

Table 2: National Agreement of Closing the Gap: 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.

Also note that the policies that NACCHO is continuing to develop will be informed by the very recently announced national *Health Sector Strengthening Plan* and the *10-year plan to improve Aboriginal and Torres Strait Islander Health*.

Another issue highlighted through the process of developing and implementing the National Agreement is the lack of consistency across portfolios. Some Commonwealth portfolios need to step up. The funding responsibility for Aboriginal and Torres Strait Islander health should not be left to the Department of Health and the National Indigenous Australians Agency. Other portfolios need to meet their joint and several responsibilities in closing the gap.

This is why NACCHO is looking to see the Department of Infrastructure, Transport, Regional Development and Communications, in particular, do more. Proposals no. 9 (housing for health), no. 16 (sector infrastructure renewal) and no. 8 (improved digital health capacity for ACCHOs) need to be funded through this particular portfolio's appropriations. All departments, in our view, need to do much more to ensure that Aboriginal and Torres Strait Islander communities get their fair share of mainstream funding.

6. SUMMARY OF THE THREE TIERS AND 22 PROPOSALS

The 22 NACCHO Budget proposals are set out in three tiers.

Tier 1 is a package of eleven proposals that address a number of critical health issues, servicing gaps and emerging needs. They are all fully developed proposals that are ready to go in the 2022-23 financial year.

Tier 2 is a package of two proposals that supplement critical health issues and would have significant impact if supported. They are fully developed proposals that adjust existing programs and settings rather than represent new programs.

Tier 3 is a package of nine proposals that address a number of immediate health issues which could be further developed in the 2022-23 financial year with most of the funding weighted in the out years. Many of them will also require close collaboration with other partners and Commonwealth agencies throughout the course of the 2022 calendar year.

Table 3 on the next page assembles a summary of the 22 bids. It is colour-coded to show how different types of proposals link up.

The green rows indicate five measures devised to address illness and disease.

The orange rows indicate nine measures devised to strengthen the capacity of the sector.

The yellow rows indicate two measures devised to improve the use of medicines.

The blue rows indicate three measures devised to support family, children and justice.

The grey rows indicate three important miscellaneous measures.

Most measures are cost neutral. Three actually generate significant savings for the Commonwealth that could be used to fund the bids that require new money. Proposal no. 3 (suicide prevention), for example, will generate long-term savings of $2.37 to $6.90 for every dollar spent. Proposal no. 5 (traineeships) will deliver almost $33m in savings but only costs $15m itself to deliver. Proposal no. 15 (oral health) could generate substantial revenue depending on the approach taken. Savings aside, the total cost of the package of 22 proposals is estimated at $218.64 m over four years.

Please note that the proposals are not ranked in terms of critical need. For example, the family safety partnerships proposal (no. 21) is just as important as the health justice partnerships proposal (no. 10). The difference is that the latter is fully developed, piloted and costed, whereas the family safety partnerships model requires testing in 2022.

Ideally, the full package should be supported. If funded as a whole strategy, the 22 measures would deliver substantial structural reform for Aboriginal and Torres Strait Islander health and would go a long way in closing the health gap.

One of the most important proposals in this package for Aboriginal and Torres Strait Islander health is no. 9, ‘Housing for health’. The pandemic has shown how critical good social housing is for the health and wellbeing of Aboriginal and Torres Strait Islander people. It cannot continue to be an issue batted back between the Commonwealth and state/territory governments. Responsibility must be grasped and substantial investment made by all governments as a matter of the utmost urgency. Poor housing has such far-reaching effects, especially in health. The issue cannot continue to be ignored.

Table 3: Summary of NACCHO's 22 Budget proposals

	Budget proposal	*Funding impact*	*Type of proposal*
TIER 1: URGENT PROPOSALS (ready to go)	1. Ending rheumatic heart disease (RHD)	$25.42m (new money over 4 years + once-off investment)	Disease and illness
	2. Combatting BBVs and improving sexual health	$18.5m (new money over two years)	
	3. Suicide prevention	$40.75m per year offset by savings; $206m reallocated	
	4. Integrating pharmacists into ACCHOs	$3m (new money for pilot)	Medicines
	5. Health and care sector traineeships	$15m over four years offset by $32.93m+ in reallocation	Sector strengthening
	6. FASD workforce development	$5m (new money over four years)	
	7. Transitioning 10 government AMSs into ACCHOs	$30m (new money, once-off investment over two years)	
	8. Improved digital health capacity and disaster preparation for remote and regional ACCHOs	$49.77m from Comm. Telecommunications portfolio	
	9. Housing for health	Sourced from Commonwealth infrastructure portfolio	Other
	10. Health justice partnerships	$2.56m from existing funding in NIAA	Youth, family and Justice
	11. Early childhood and youth wellbeing	Redirection of existing funds	
TIER 2: EXTRA (ready)	12. Section 100 amendment for better medicines access	Minimal funding recouped by savings	Medicines
	13 Aboriginal and Torres Strait Islander pathology identifier	Funding sourced through the private pathology sector	Other
TIER 3: PROPOSALS FOR DEVELOPMENT IN 2022 (for the out-years)	14. Addressing the disproportionate cancer burden	Further work to be undertaken	Disease and illness
	15. Improving oral health	Potential to generate substantial revenue	
	16. Sector infrastructure renewal – phase 2	$250m for out years from Infrastructure portfolio	Sector strengthening
	17. Funding security for the sector	Confirmation of existing funds and redirection of others	
	18. Cost recovery from mainstream programs	Recoups revenue for Commonwealth programs	
	19. National workforce development	Funded through the savings in proposal no. 5	
	20. Building an integrated disability and aged care capacity	$82m (new money in out years)	
	21. Family safety partnerships	$2.56m from existing funding in NIAA and A-GD	Youth, family and Justice
	22. Road accidents and fatalities package	$5m (new money in out years)	Other
	TOTAL FUNDING	**New money (2022-23): $86.02** **New in out years (2023-25): $132.62m** **Sourced from transfers: $494.05m – existing funds** **Savings generated: $142.93m** **Total new: $218.64m**	

N.b: NACCHO has four proposals currently under consideration by NIAA (through its Health Sector Strengthening Funding Pool). See pp. 48-51. If not supported, they would need to be elevated to Tier 1.

7. TIER ONE: URGENT PROPOSALS (READY TO GO)

Tier One is a package of eleven proposals addressing critical health issues. Urgent action is required in the areas they address. The proposals are all fully developed and ready to go.

PROPOSAL 1: *Ending rheumatic heart disease (RHD)*

Proposal

Funding for rheumatic heart disease (RHD) programs in an additional ten ACCHOs in high risk communities over four years ($24 m). Purchase of portable echocardiogram machines for ACCHO clinics and the development of a training program to accompany the machines to facilitate early diagnosis.

Rationale

RHD is where damage occurs to the heart valve because of one or more episodes of acute rheumatic fever (ARF). Inflammation occurs during ARF when antibodies target the heart valves and sometimes the heart lining or muscle. RHD can lead to heart failure and death. RHD is a disease of poverty, affecting predominately people living in poor quality housing. Aboriginal and Torres Strait Islander people continue to be disproportionately affected by RHD. Since the early 1990s ARF, which leads to RHD, has occurred exclusively in young Aboriginal and Torres Strait Islanders, particularly in the 5-15-year age-group. Aboriginal and Torres Strait Islanders account for 95 per cent of ARF notifications.

Recent data shared with NACCHO from Miwatj, a single region in the Northern Territory, indicates there are currently 499 clients in the region with a diagnosis of either RHD (n=438), ARF (n=115) or both (n=54). This represents a crude prevalence of approximately 6 per cent of all Miwatj clients. Several jurisdictions are predicting significant ARF outbreaks in the next six to twelve months, with some areas already experiencing unprecedented reports. For example, since July 2021, there has been a significant increase in the number of ARF cases in Galiwinku in the Northern Territory, which has been classified by the Centre for Disease Control as a possible outbreak requiring a public health response. A public health response requires a range of activities to be undertaken, including contact tracing. During a 7-week period between 29 July and 17 September 2021, there were 12 confirmed cases in this community, of which six were ARF recurrences. The 31 confirmed cases of ARF in this small community represents a 14-fold and 32-fold increase in notifications for ARF cases and ARF recurrences, respectively.

Communities at high risk of ARF outbreaks have been identified in all jurisdictions; however, current funding will not extend to providing services at these emerging outbreak and high-risk sites.

(i) Additional funding for ten high-risk areas

The $12 million funding NACCHO received from the Commonwealth in November 2021 will support up to six ACCHOs through to June 2025. This is the same number of sites and funding under the previous Commonwealth 2018-2021 Rheumatic Fever Strategy. This does not reflect increasing rates of disease. Additional funding is required to deliver essential prevention, treatment and support services.

Early cost predictions for the financial burden of ARF and RHD from 2016 to 2031 were $317 million. These predictions do not take into account increasing case numbers linked to under diagnosis of the disease as a result of the pandemic, the risks associated with limited visibility of current disease hot spots, nor the cost burden of the expected outbreaks in coming months. Actual costs can be expected to be significantly higher than early predictions.

Appropriate funding of service delivery, combined with safe and healthy housing, could contribute to the prevention of such outbreaks in future and minimise significant amounts of unplanned expenditure.

To ensure that ACCHOs at high risk can receive the necessary funding to manage and prevent outbreaks, additional funds are required to supplement the existing funding. NACCHO has identified several high-risk communities but anticipates progressively identifying more sites as the ARF and RHD program facilitates data sharing among key stakeholders.

(ii) Screening

Recent screening initiatives, linked to research projects and continuous quality improvement initiatives in the ACCHO sector have successfully used echocardiography (echo) machines to identify high rates (up to 10%) of undiagnosed RHD affecting children and young people living in high-risk communities. Community members with undiagnosed RHD or late diagnosis of RHD have significantly poorer health outcomes, requiring more interventions and experience reduced quality of life.

Effective screening programs enable earlier identification of disease and the commencement of treatment to prevent disease progression. Accurate screening is best conducted via echocardiography, and yet echo machines are not standard equipment in ACCHOs. Traditionally, echo screening has been conducted by a cardiologist, physician, or stenographer with echo expertise in specialist settings. This usually requires travel to specialist services that are often some distance from remote and rural communities which are most affected. This model of care limits the screening that can be conducted in ACCHOs. An alternative screening model, the non-expert model, has been identified. The non-expert model involves a local, briefly trained health worker (e.g. Aboriginal Health Practitioner, Aboriginal Health Worker, Nurse or General Practitioner) conducting the screening using a portable echo machine. Images are then sent to off-site cardiology services for diagnosis. Advances in smart phone technology, which all ACCHOs can access, would support this model. The non-expert model could be employed by ACCHOs in identified high-risk communities to ensure that people across all key age and life stages groups (notably children and women during the early stages of pregnancy) can be screened. This screening could occur opportunistically and/or as part of dedicated screening events.

ACCHO staff will require a single face-to-face training session to increase their capacity to conduct screening using a portable echo machine. NACCHO will work with the sector to identify training requirements and engage an external consultant to co-design an ACCHO-specific training package. This package will include a face-to-face training session delivered at each ACCHO, information materials for staff to consult post training, an online module for incoming staff and the identification of ongoing professional development mechanisms.

An evaluation and monitoring framework will identify key indicators to assist with reporting on the outcomes and impact of this project. Insights will be used by the ACCHOs to inform their future service planning and delivery. This program of work will align with the prevention and early intervention commitment under Target 1 of the new National Agreement on Closing the Gap (‘Close the Gap in life expectancy within a generation, by 2031’) and aligns with Priority Reforms 1,2 and 4.

<u>Funding</u>

The screening funding is once-off: $920,000 over 2022-23. The total number of echo machines required is 219 (at a total cost of $657,000). Training and staff costs in 2022-23 would amount to $263,000.

In ten additional high-risk area, the sector will need funds for service delivery, including staff costs, travel and programs – costed at an average $600,000 per annum per site (based on the programs at Mala’la and Miwatj) – which represents $2.4 m over four years per ACCHO ($6 m in 2022-2023). National coordination over four years adds another $0.5 m. Hence, NACCHO requests $24.5 m to fund an additional 10 ACCHOs. More high-risk communities may be identified as the ARF and RHD program continues. If the once-off screening funding is added, the total request is $25.42 m over four years.

PROPOSAL 2: *Combatting BBVs and improving sexual health*

Proposal

That the Australian government funds a dedicated workforce and associated resources for ACCHOs in urban, regional and remote areas to address the disproportionate impact of sexually transmissible infections (STIs) and blood borne viruses (BBVs) for Aboriginal and Torres Strait Islander people. This can be achieved by:

- funding 100 sexual health positions across 100 ACCHOs until 30 June 2024, as an expansion and continuation of existing programs currently funded through the Department of Health, including the Enhanced Syphilis Response;
- creating an MBS Item that supports STI testing on GeneXpert machines for Aboriginal and Torres Strait Islander people and funding programmatic costs to improve program sustainability in the long term; and
- expanding point-of-care testing for syphilis to additional ACCHOs.

Rationale

NACCHO has been funded by the Commonwealth for several programs that contribute to the *Fifth National Aboriginal and Torres Strait Islander Blood Borne Virus and Sexually Transmissible Infections Strategy*. While some individual communities and ACCHOs have had success in responding to BBVs and STIs, there is a need to translate these individual successes into a comprehensive response.

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.

Existing programs funding sexual health workforce in ACCHOs have enabled ACCHOs to employ approximately 50 dedicated sexual health staff, many of which are Aboriginal or Torres Strait Islander Health Workers. This has assisted community-led, tailored strategies for prevention, testing and treatment of BBVs and STIs that are appropriate in local contexts.

- Enhanced Syphilis Response ($19.6 million funds positions until 30 June 2024)
- BBV and STI Prevention Strategies ($10 million funds positions until 30 June 2023)

Extending the reach of these programs into an additional 50 ACCHOs and aligning programs to 30 June 2024, provides the opportunity for a more coordinated approach to close the gap between prevalence of STIs and BBVs in Aboriginal and Torres Strait Islander communities and non-Indigenous communities. This is consistent with the overarching policy context of the National Agreement on Closing the Gap. Expansion and continuation of these programs will assist in meeting targets set under the Fifth National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy 2018-2022.

Funding

Extension of current programs to fund 100 sexual health positions until 30 June 2024 will require capital expenditure of $18 million (indexation of 2.5% applied). Expansion of point-of-care testing for syphilis to an additional 20 ACCHOs will require capital expenditure of $500,000. Funding would also need to consider the cost of the MBS Item supporting sexual health testing on GeneXpert machines.

PROPOSAL 3*: Suicide prevention*

Proposal

That funding is provided to NACCHO to strengthen and expand early intervention, suicide prevention and aftercare services available for Aboriginal and Torres Strait Islander people nationally.

Existing funding provided to public health networks (PHNs) through the Indigenous Australians Health Program (IAHP) to administer the Aboriginal and Torres Strait Islander Mental Health program should also be reallocated to ACCHOs. This would honour a commitment made to the sector in 2017 by the former Minister.

Rationale

NACCHO has received funding from the Department of Health to establish up to 31 Regional and Local Suicide Prevention Networks and Aftercare Services from 2021-22 to 2024-25. These are vital in addressing the devastating impact of suicide on Aboriginal and Torres Strait Islander people and communities. Despite this funding, multiple high need regions of Australia remain un-serviced.

This proposal seeks new funding for an additional 19 Regional and Local Suicide Prevention Networks and Aftercare Services, nationally co-ordinated by NACCHO, to a total of up to 50 networks in remote, regional and urban areas. NACCHO also proposes that funding is provided to expand the scope of each network to include early intervention programs. Without the expansion of the number of networks and the additional investment in early intervention, Aboriginal and Torres Strait Islander communities, particularly children and young people, will remain at an increased risk of self-harm, suicidal ideation and suicide.

AIHW has estimated that mental health and substance use are the biggest contributors to the overall burden of disease for Aboriginal and Torres Strait Islander people. 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.[9] Aboriginal and Torres Strait Islander people aged under 24 are up to 14 times more likely to die by suicide than other Australian youth.[10]

The National Agreement on Closing the Gap demonstrates 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. NACCHO highlights the importance of Outcome 14 of 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'. Additionally, the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy proposes the roll out of Regional Suicide Prevention Networks, co-ordinated by NACCHO, and proposes the establishment of Aboriginal and Torres Strait Islander-led aftercare services. The National Suicide Prevention Adviser, in their final advice, identifies the need for targeted interventions for cohorts more vulnerable to suicidal behaviour and recommends (7.1) 'national funding of the Strategy from 2021, implementing Indigenous leadership and governance, place-based initiatives and building on workforce and community strengths', including these initiatives as proposed by NACCHO.[11]

The Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project and the Productivity Commission have both identified the need to empower Aboriginal and Torres Strait Islander

[9] AIHW, *The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples 2015*, Cat. no. IHW 147, AIHW: Canberra, 2015.
[10] J. M. Dickson, K. Cruise, C. A. McCall, and P. J. Taylor, 'A systematic review of the antecedents and prevalence of suicide, self-harm and suicide ideation in Australian Aboriginal and Torres Strait Islander Youth', *International Journal of Environmental Research and Public Health*, vol. 16.17, 2019, p. 3,154.
[11] *National Suicide Prevention Adviser – final advice*, December 2020.

communities to prevent suicide as a priority reform for Government.[12] The recent report of the House of Representatives Inquiry into Mental Health and Suicide Prevention as well as the Productivity Commission recommended that funding for Aboriginal and Torres Strait Islander suicide prevention be redirected from PHNs and mainstream organisations directly to ACCHOs.[13]

For Aboriginal and Torres Strait Islander people it is vital that aftercare for individuals following a suicide attempt or suicidal crisis, suicide prevention, and early intervention services are provided by ACCHOs to increase the likelihood that these programs are tailored to the experiences, culture and needs of the local community. Evidence indicates that suicide prevention interventions for Aboriginal and Torres Strait Islander people are most effective when the relevant community is involved and has control over the intervention.[14] This approach also aligns with key outcomes of the National Agreement on Closing the Gap, including through building capacity and capability within the ACCHO sector to deliver high-quality services that best meet the needs of Aboriginal and Torres Strait Islander people across the country.

Further, it is estimated that effective aftercare could conservatively provide a long-term return on investment of $2.37 to $6.90 for every dollar spent, depending on the extent of aftercare provided and the income earned by people whose suicide or suicide attempt was prevented.[15] For these returns to be realised, it is necessary that these services are delivered by the Community-Controlled sector.

Funding

$15m per year in funding is required to provide suicide prevention and early intervention staffing and programs in each Network (at an average cost of $300,000 per network). An additional $9.785m per year in funding is required to establish and operate an additional 19 Regional and Local Suicide Prevention and Aftercare Networks (at an average cost of $515,000 per year).

The total funding required to operate 50 Networks to provide coordination, suicide prevention, early intervention and aftercare services is $40.75m per annum ($163m for a 4-year funding commitment). Ideally indexation would be applied.

The funding in this proposal is in addition to the Aboriginal and Torres Strait Islander mental health funding given to PHNs. For the period 2016-17 to 2022-23, a total of $201.6 million has been allocated to PHNs through the Indigenous Australians Health Programme to administer the Aboriginal and Torres Strait Islander Mental Health program. This funding must be reallocated to the Community Controlled sector for the provision of culturally competent mental health programs and services, in alignment with the four Priority Reforms of the National Agreement on Closing the Gap.

[12] ATSISPEP*, Solutions That Work: What the Evidence and Our People Tell Us*, Perth, 2016.
[13] House of Representatives Select Committee on Mental Health and Suicide Prevention, October 2021.
[14] ATSISPEP, loc. cit.; J. Prince, N. Jeffrey, L. Baird, S. Kingsburra, B Tipiloura and P. Dudgeon, *Stories from Community: How Suicide Rates Fell in Two Indigenous Communities*, Healing Foundation, 2018.
[15] Productivity Commission, *Mental Health*, Report no. 95, Canberra, 2020.

PROPOSAL 4: *Integrating pharmacists into ACCHOs*

Proposal

This proposal builds on the successful Integrating Pharmacists within Aboriginal Community Controlled Health Services project (known as IPAC), which helped improve chronic Disease management 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 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.

While there have been some recent reforms announced to medicines use and access programs for Aboriginal and Torres Strait Islander people under the Seventh Community Pharmacy Agreement, 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 the range of integrated and holistic medicines-related services needed.

The IPAC Project has delivered significant benefits to ACCHO clients, their staff and to other stakeholders across the 18 ACCHOs that participated. The current Public Summary published in October 2021 states that this model of care 'enhanced service provision and significantly improved quality of care and health outcomes for adult Aboriginal and Torres Strait Islander patients with chronic disease' and calls for a nationwide program roll-out.[16] The value of integrating pharmacists in ACCHOs is also specifically acknowledged by reviewers in both the *Review of Pharmacy Remuneration and Regulation* and the *Urbis Review of Indigenous Pharmacy Programs*. Global literature, including systematic reviews, 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 $10m. We therefore propose that an initial pilot investment of $3m in the first year will provide an opportunity to implement the program and conduct preliminary evaluation on an ongoing program's feasibility and effectiveness.

[16] S. Couzos, D. Smith, M. Tremlett, et al., *Integrating Pharmacists within Aboriginal Community Controlled Health Services (ACCHSs) to improve Chronic Disease: Public Summary Document*, 2021.

PROPOSAL 5: *Health and care sector traineeships*

Proposal

That the Commonwealth provides funding to NACCHO to co-design with the ACCHO sector a traineeship program for entry-level qualifications to create local opportunities for Aboriginal and Torres Strait Islander people to join the health and care workforce.

Rationale

The *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021–2031* (*Health Workforce Plan*) aims to increase the number of Aboriginal and Torres Strait Islander health and care workers across the sector. This proposal aligns strongly with that objective and supports Priority Reform 2 of the National Agreement to build the community-controlled sector as well as Targets 7 and 8.

As identified by the 'Care Workforce Labour Market Study', growth needs for the health care and social assistance workforce overall is estimated to be in the order 14.2% to 2025, a requirement for 249,500 workers. For Aboriginal and Torres Strait Islander workers to make up a modest, proportionate component (say 3.3% in line with population share) of the forecast increase, an additional 8,233 Aboriginal and Torres Strait Islander workers are required within in the next four years.

The ACCHO sector is already facing major workforce challenges, existing services are experiencing severe staff shortages and demand will soon outstrip supply of suitably skilled and job ready Aboriginal and Torres Strait Islander employees. This shortage will impact access to culturally appropriate, effective and efficient support and assistance for our communities.

The number of apprentices and trainees has seen significant decline since 2012-13. This trend continues. The Australian Industry Group notes that training resources are too often out of date and inflexible, and that training providers make course selections that best suit their staffing profile and funding received, not the requirements of the local labour market.

The ACCHO network provides a critical and practical pathway into employment for many Aboriginal and Torres Strait Islander people. 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.

Aboriginal and Torres Strait Islander students experience multiple barriers to study and consequently, many students require intensive social and financial support to complete qualifications. Member services report that certificate qualifications are an accessible starting point for many local Aboriginal and Torres Strait Islander people many of whom have not studied before, and who may not have schooling beyond Year 10 but want to begin a career in their chosen field of interest.

Aboriginal and Torres Strait Islander community controlled registered training organisations (ACCRTOs) facilitate strong and culturally safe pathways for Aboriginal and Torres Strait Islander students. There are 11 ACCRTOs nationally which are the training arm of ACCHOs; their sole purpose to build a skilled Aboriginal and Torres Strait Islander workforce to support their communities. ACCRTOs are essential to ensuring Aboriginal and Torres Strait Islander people have a culturally appropriate training option to support both student and employer through the study journey from enrolment, work or clinical placement to graduation.

NACCHO recognises the Government's commitment of $13.6m for the Indigenous Health Workforce Trainees (IHWT) program, however notes that anecdotally, it has not been particularly successful. In part, this must be due to the impact of COVID-19. There continue to be funding gaps in such schemes

which means individual providers like ACCHOs incur additional costs, including to develop resources and supports, and undertake the additional work required to take on trainees.

This proposal mitigates these issues by funding the gap between traineeship funding and the actual cost of delivery, by supporting providers, in this case ACCHOs and ACCRTOs, to work in partnership to develop a collective delivery program and supporting resources. The resulting program and resources can be used across the sector as more ACCRTOs and ACCHOs build their capacity to deliver the traineeship program. This will enable ACCHOs to recruit staff from their local area and be assured they are receiving culturally embedded training and work experience, and will lay the groundwork for long-term careers in the health and care sector.

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 more broadly, including in areas of very high and entrenched unemployment.

This proposal will help expand the Aboriginal and Torres Strait Islander health and care workforce to meet the growing needs of community and provide genuine employment opportunities for community members who wish to work and live on country. Furthermore, it will 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.

This proposal has the potential to reshape how ACCHOs employ workers and to enhance partnerships between ACCHOs and ACCRTOs. It will support the growth of the ACCRTO sector and increase its capacity to deliver a broader range of qualifications and skill sets to Aboriginal and Torres Strait Islander students and workers and enhances the pathway model and idea of health and care work as a vocational choice from school and for those wishing to re-enter or enter the workforce as adults. It consists of the following three elements.

1. Embedding Certificate II programs in community health and individual support (disability) in the traineeship program.
2. Development of a traineeship framework and comprehensive onboarding resources to ensure ACCHOs can deliver the program in a structured and supported way in partnership with their ACCRTO and NACCHO.
3. Development of a national community of practice for all trainees to ensure ongoing support.
4. Filling the funding gap to ensure ACCHOs do not incur additional costs.

A traineeship that embeds the accredited Certificate II programs would allow for students to be employed in a local ACCHO and take advantage of the experience, support and mentoring available from existing staff whilst also gaining an accredited entry level qualification. Students would consolidate their learning quickly through the combination of culturally appropriate training and on-the-job learning. The ability to earn while studying is also a significant advantage for many students.

Two streams are required.

- **New workers:** to build entry level pathways for local people, school leavers and people returning to work, enabling students to consolidate learning with workplace experience.
- **Existing workers:** such as Aboriginal Health Workers and Aboriginal Health Practitioners, to diversify and upskill with targeted accredited skills set training in areas such as mental health, individual support for disability and aged care, VET training and assessment qualifications.

Funding

There is existing funding through both Federal and State Education Departments to support a traineeship model of delivery for the Aboriginal and Torres Strait Islander sector.

But there is an identified gap between funding available and the cost to deliver this model. Additional funding is also required to build the capacity of some ACCHOs to partner with ACCRTOs to deliver this model, and for the co-design of culturally embedded resources that can be tailored to local needs. NACCHO estimates the shortfall to be about $10-15m over four years. However, no new money would be required, if it were possible to cash out the employment assistance programs for the 8,233 trainees over four years. Current unit costs for Aboriginal and Torres Strait Islander participants in mainstream employment programs and the former CDP scheme is in the order of $4,000 per person, which equates to a cashing out of $32.93m, which well exceeds the shortfall. Moreover, this does not even account for the savings generated for the Commonwealth in income support.

Larakia children at NACCHO's *National Members' Conference*, Darwin, 2019.

PROPOSAL 6: *FASD workforce development*

Proposal

To develop and deliver a National Fetal Alcohol Spectrum Disorder (FASD) Training Program and Referral Pathways toolkit for ACCHOs to better support and refer people living with FASD in Aboriginal and Torres Strait Islander communities.

Rationale

FASD is a diagnostic term for the range of physical, cognitive, behavioural and neurodevelopmental abnormalities which can result from a woman drinking during pregnancy. While FASD impacts any community where alcohol is consumed, the National FASD Strategic Action Plan 2018–2028 has identified Aboriginal and Torres Strait Islander communities as a key vulnerable population to FASD.[17]

Pregnant Aboriginal and Torres Strait Islander women interact with a wide range of health professionals within an ACCHO during their gestational period. Aboriginal and Torres Strait Islander children living with FASD also interact with a wide range of health professionals within an ACCHO, in addition to teachers throughout their schooling. Culturally safe FASD training and resources will support FASD prevention. Clearer, more accessible referral pathways will improve FASD diagnosis, treatment and support.

There are also significant issues of misdiagnosis and missed diagnosis of Aboriginal and Torres Strait Islander children living with FASD, particularly in rural and remote settings. This has resulted in many children living with FASD, having little, or no access to clinically and culturally appropriate diagnosis, treatment and support.

The National FASD Strategic Action Plan 2018–2028 recognised that:

> *… with early and accurate diagnosis and early, individualised interventions for children and adults who have FASD along with appropriate support for parents and carers, the quality-of-life outcomes for individuals with FASD and their families can be substantially improved.*[18]

NACCHO is currently rolling out a three-year health promotion and awareness raising program for FASD targeting Aboriginal and Torres Strait Islander communities in rural and remote areas in partnership with FARE. Participatory research conducted by NACCHO has strongly identified:

> *An urgent need for targeted, culturally appropriate FASD training for all staff who work in ACCHOs, including: Clinical, non-clinical, locum staff, GPs, Social and Emotional Well Being (SEWB) workers and those who run 'mum's and bub's' programs and teachers working with children living with FASD.*[19]

The Senate Enquiry into Effective Approaches to Prevention, Diagnosis and Support for FASD, 2020-2021 has made the following recommendations:

> *Recommendation 32 - The committee recommends the Department of Health allocate specific funding aimed at supporting First Nations community-led projects to prevent and manage FASD.*
>
> *Recommendation 17 - The committee recommends that Australian universities ensure that FASD modules are included in university curriculums for relevant occupations, including those for education*

[17] *National Fetal Alcohol Spectrum Disorder (FASD) Strategic Action Plan 2018–2028*, p. 12.

[18] *National Fetal Alcohol Spectrum Disorder (FASD) Strategic Action Plan 2018–2028*, p. 6.

[19] *Materials Analysis Report, National Information Campaign for Pregnant and Breastfeeding Women* Stream 4: Information, Education and Awareness: Indigenous Health Promotion, National Aboriginal Community Controlled Health Organisation (NACCHO), Version 1 9th December 2021, p. 7.

and teaching, medicine, midwifery, psychology, social work, occupational therapy, speech and language pathology.

Recommendation 9 - The committee recommends that the Australian Government provide funding for professional development training for all health professionals involved in antenatal care, in order to embed routine FASD screening practices and tools, including AUDIT-C. [20]

The FASD Training Component - 4 Years 2022-2026 program will develop, pilot and deliver a comprehensive suite of FASD training materials targeting the following groups:

- all staff currently working in ACCHOs across Australia;
- teachers currently working with Aboriginal and Torres Strait Islander children living with FAS; and
- trainee doctors, nurse practitioners, midwives, child and maternal health workers, Aboriginal Health Workers and Health Practitioners, psychologists and SEWB workers.

It will be delivered through a sustainable, capacity building focused, train the trainer model that includes opportunities for face-to-face training and online learning led by NACCHO.

The FASD Referral Pathway Toolkit – 2 Years – 2022-2024 program will also map, develop, pilot and deliver a Referral Pathways Toolkit. This Toolkit will support health professionals to better refer and support people living with FASD in Aboriginal and Torres Strait Islander communities. It will be developed through a culturally safe, genuine co-design process with ACCHOs, with a strengths-based approach to resource development and training delivery.

This proposal aligns strongly with the aims of the *National FASD Strategic Action Plan 2018–2028*; Recommendations 9, 17 and 32 of the 2019 Senate Enquiry into Effective Approaches to Prevention, Diagnosis and Support for FASD, and supports Outcomes 2 and 11 of the National Agreement on Closing the Gap.

Funding

Total funding required is estimated at $5m over 4 years.

[20] The Senate Community Affairs References Committee, *Effective approaches to prevention, diagnosis and support for Fetal Alcohol Spectrum Disorder*, March 2021, pp. 19-23.

PROPOSAL 7: *Transitioning 10 government AMSs into ACCHOs*

Proposal

This proposal is to transition 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 the end of 2024. 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

Many mainstream providers do not retain Aboriginal and Torres Strait Islander clients and do not achieve optimal outcomes in Aboriginal and Torres Strait Islander communities.[21] 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.[22] 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, In Western Australia, cost-estimates have been calculated in work led by the Kimberley Aboriginal Medical Service to be about $2.6m per AMS.

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. In 2021, a couple of NT Government clinics in North East Arnhem Land were under transition to Miwatj Health and a couple of NT Government clinics in West Arnhem Land were under transition to the Red Lily Health Board. In Central Australia clinics are being transitioned under a proposal from Central Australian Aboriginal Congress.

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.

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

[22] 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.

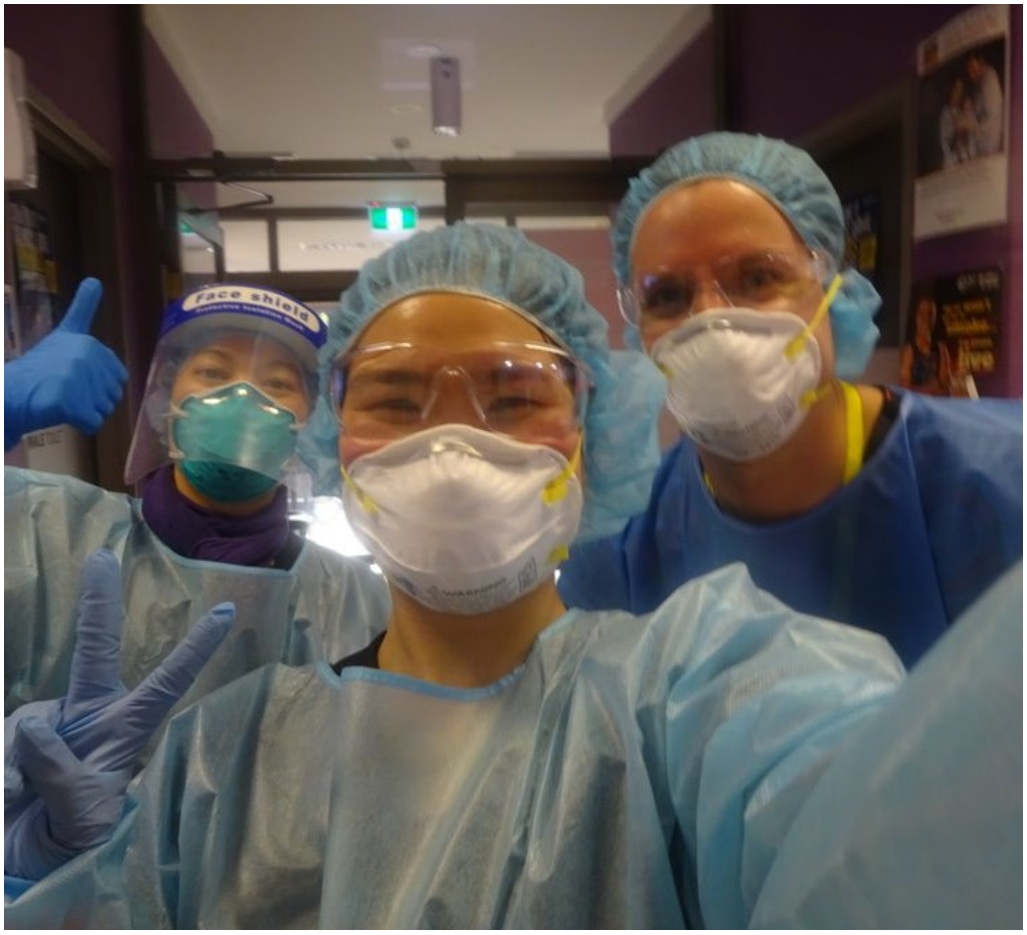
Many government-run clinics are in remote settings, which means that under the ACCHO model, which delivers a fourfold cost benefit compared to the mainstream service in remote areas, the efficiencies will be significant.

Although transitional arrangements are working well at the jurisdictional level, a national transition plan for all states/territories 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 the end of 2024). 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.



ACCHO staff in PPE during the pandemic

PROPOSAL 8: *Improved digital health capacity and disaster preparation for ACCHOs*

Proposal

Funding redirected from the Department of Infrastructure, Transport, Regional Development and Communications to improve the digital health capacity and disaster preparation for ACCHOs.

Rationale

AHCWA and nbn Co undertook a Connectivity Audit for 34 WA sites focused on troubleshooting existing digital connection problems. Information on connectivity has also been provided by nbn Co. The health industry has been on a steep digitisation trajectory that has been further accelerated throughout the course of the pandemic. Initial recommendations put forward by the Australian Broadband Advisory Council Health Expert Working Group highlighted the critical importance of virtual health in supporting improved health outcomes for Aboriginal and Torres Strait Islanders, particularly those living in regional, rural and remote areas where access to health services and health care is impacted by workforce shortages and distance to providers.

NACCHO and its affiliates have been working closing with nbn Co over the past 18 months to ensure ACCHOs across Australia are aware of, and have access to, the connectivity infrastructure required to support virtual health, current innovations within the digital health sector and supporting a digitally capable health workforce, in particular Aboriginal and Torres Strait Islander health workers. Discussions to date have focused on primary connectivity of existing buildings where current connectivity is insufficient.

For areas prone to natural disaster, or for ACCHOs delivering services in areas of high need, NACCHO and nbn Co have been exploring connectivity redundancy options which may also include primary connectivity for new sites and staff accommodation delivered as part of the Closing the Gap Implementation Plan. This partnership could extend to Australian Digital Health Agency to ensure the connectivity supports the continuity of their strategic programs including My Health Record, telehealth (in particular over video), e-prescriptions, secure messaging and system interoperability. This would also be supported by a program to lift digital literacy and confidence for clinic staff, and IT support to ensure robust business continuity plans are in place more generally.

Funding

NACCHO kindly received an independent costing exercise for this proposal from Partners in Performance International. They liaised with representatives from NACCHO, our affiliates and nbn Co to assess the digital capacity and preparedness for our ACCHOs. They have provided a detailed report which is available to explain our costings and the funding request of $49.77m to be directed to the sector from existing programs in the Department of Infrastructure, Transport, Regional Development and Communications. Basically, there are about 63 ACCHOs in need of investment (of the 144 ACCHOs across Australia) at a cost per ACCHO of $280,000 in the first year and $170,000 in each of the three out years (= $790,000 per ACCHO). But this does not include software purchases and training for telehealth, bookings etc. Of course, the funding will vary significantly from ACCHO to ACCHO depending on location, number of clinics and current capacity and the unit cost has been developed as a guide to estimate the total funding required.

PROPOSAL 9: *Housing for health*

Proposal

NACCHO is calling for the urgent implementation of the formal policy partnership on housing as outlined in the National Agreement on Closing the Gap.

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;
- supports the forthcoming Housing Sector Strengthening Plan, which is being prepared by the Coalition of Peaks; and
- invests in a permanent, highly skilled, and nationally credentialed Aboriginal and Torres Strait Islander Environmental Health workforce (as described in the *Health Sector Strengthening Plan*'s action item at Section B, A.4).

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.

COVID-19 has also shown how important this is. In Wilcannia, for example, during the tragic outbreak of the Delta variant in that community, patients could not isolate, and mobile housing needed to be urgently deployed at significant cost.

There is comprehensive, evidence-based literature which investigates the powerful links between housing and health, education and employment outcomes.[23] 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.

Funding

This is a major funding investment that requires the urgent resolution of the Commonwealth with the eight state and territory governments. Funds can be sourced via the new agreements between the jurisdictions and existing housing budgets. A funding transfer from the Department of Infrastructure, Transport, Regional Development and Communications is also an option to source a large an immediate injection of funds.

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

PROPOSAL 10: *Health-justice partnership*

Proposal

In this modest proposal NACCHO and Health Justice Australia (HJA) are partnering to support an initiative at three different locations over the next three years. It builds on strong evidence from health-justice partnership trials in Cairns (Wuchopperen evaluation) and the Barkly (report by the NT Legal Aid Commission) and on positive results from similar projects in other areas.

This is a 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, juvenile detention, etc.). It would develop options for wider application of the approach in a range of communities across Australia.

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 discussions with the states and territories, the NIAA, The Department of the Attorney General 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.

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.

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.

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.

Further to HJA, ATSILS would be potential partners. 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.

In the development of this proposal NACCHO would like to thank HJA. It is rare to find an organisation that fully understands the concept of codesign and how Aboriginal communities need to devise the solutions that are the best fit.

Funding

Funding would be over and above the existing contribution to Aboriginal legal services. Funding over three years of $1.88m is required for the pilot from existing program budgets in NIAA or additional funds via A-GD. HJA's costs would be separately calculated, by them, but it is expected to be about $0.68m. 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 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.

PROPOSAL 11: *Early childhood and youth wellbeing*

Proposal

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.

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.[24] 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.

Findings presented in the 2018 Family Matters Report reveal, however, that the aims and objectives of the *Council of Australian Governments (COAG) Protecting Children is Everyone's Business National Framework for Protecting Australia's Children 2009–2020* 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], 2018). Since the last Family Matters Report overrepresentation in out-of-home care has either increased or remained the same in every state and territory*.[25]

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

[24] 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).

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

- 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.[26]

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.[27] 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.

<u>Funding</u>

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.

[26] AIHW, *Youth Detention Population in Australia* (Bulletin 148), February 2020.
[27] Thorburn and Marshall, 'The Yiriman Project in the West Kimberley: an Example of Justice Reinvestment?', Indigenous Justice Clearinghouse, Current Initiatives, paper 5, 2017

8. TIER TWO: SUPPLEMENTARY PROPOSALS (READY TO GO)

Tier Two is a set of two proposals that supplement critical health issues and would have significant impact if supported. They are fully developed proposals and are ready to go. They adjust existing programs and settings rather than represent new programs.

PROPOSAL 12: *Section 100 amendment for better medicines access*

Proposal

The Minister, who is authorised to do so, should amend section 100 (s100) of the *National Health Act 1953* to improve access to medicines for Aboriginal and Torres Strait Islander people. This may be achieved through addressing s100's discordance in other areas including allowing:

- those clients accessing the Closing the Gap (CTG) Pharmaceutical Benefits Scheme (PBS) Co-payment to access s100 Highly Specialised Drugs at the CTG co-payment rate; and
- s100 RAAHS measure to cover Schedule 8 medicines.

Further to amending s100, NACCHO recommends including new components in this section, to further improve equity for Aboriginal and Torres Strait Islander people, such as:

- provisions for non-remote ACCHOs to stock and supply PBS-subsidised medicines from their clinics and further provisions to support pharmacy ownership (where jurisdictional legislation allows);
- a standing committee specifically for oversight of Aboriginal and Torres Strait Islander PBS medicines issues, which may include further PBS policy reform; and
- a provision to support public hospital pharmacies dispensing CTG prescriptions.

Rationale

Under section 100, the Minister for Health may make special arrangements beyond the standard PBS measures to ensure that there is an adequate supply of PBS medicines for populations who may be at risk of not accessing medicines. These include the s100 Remote Area Aboriginal Health Service (RAAHS) measure; the Highly Specialised Drugs (HSD) Measure; and others. Though NACCHO acknowledges the endeavours of the Government to address such issues through the Indigenous Pharmacy Programs Reform activities, currently, the interplay between legislation and medicines polices is still convoluted and ineffective.

In 2019, medicine safety was declared an Australian National Health Priority Area by the Minister for Health. In consideration of this priority 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.

As an illustration, the standing committee for oversight of Aboriginal and Torres Strait Islander PBS medicines issues, may consider the following options for addressing s100's incompatibility with CTG.

Option 1: Establish a program within the s100 HSD measure specifically for Aboriginal and Torres Strait Islander people.

Option 2: Establish a program within the s100 HSD measure specifically for ACCHOs.

Option 3: Change to CTG legislation to encompass s100 HSD.

Option 4: Move HSD medicines to s85 schedule.

Funding

The cost implications for these amendments would be minimal and likely to be recouped through improved health outcomes, longer-term.

ACCHO staff at Yura Yungi, Halls Creek, WA

PROPOSAL 13: *Aboriginal and Torres Strait Islander pathology identifier*

Proposal

The introduction of an identifier in pathology data for Aboriginal and Torres Strait Islander people 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. Its inclusion in pathology results would also improve the quality of information in My Health Record.

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.

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 Aboriginal and Torres Strait Islander 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.

9. TIER THREE: PROPOSALS FOR DEVELOPMENT IN 2022 (FOR OUT YEARS)

Tier three is a package of nine proposals that address a number of immediate health issues which would be further developed in the 2022-23 financial year with most of the funding weighted in the out years. Many of them will also require close collaboration with other partners and Commonwealth agencies throughout the course of the 2022 calendar year.

PROPOSAL 14: *Addressing the disproportionate cancer burden*

Proposal

NACCHO has prepared a draft *NACCHO Cancer Strategy Technical Paper*. Once this work has been finalised, further consideration of funding options for the prevention of cancer need to be considered.

In the meantime, support for the strategies that relate directly or indirectly to cancer prevention need to be rolled out as quickly as possible. These are:

- National Immunisation Program;
- *National Preventative Health Strategy* (once finalised);
- National Tobacco Strategy;
- National Drug Strategy; and
- National Alcohol Strategy.

Rationale

Cancer has overtaken cardiovascular disease as the major cause of death for Aboriginal and Torres Strait Islander peoples since 2017. While the incidence rates for other Australians is declining the rate for Aboriginal a Torres Strait Islander peoples shows an ever-increasing gap.

The cancers most likely to contribute to the cancer burden for Aboriginal and Torres Strait Islanders compared with other Australians, include: cancers of the lung, head and neck, uterus, liver, and cervix (see Figure 1 on the following page).

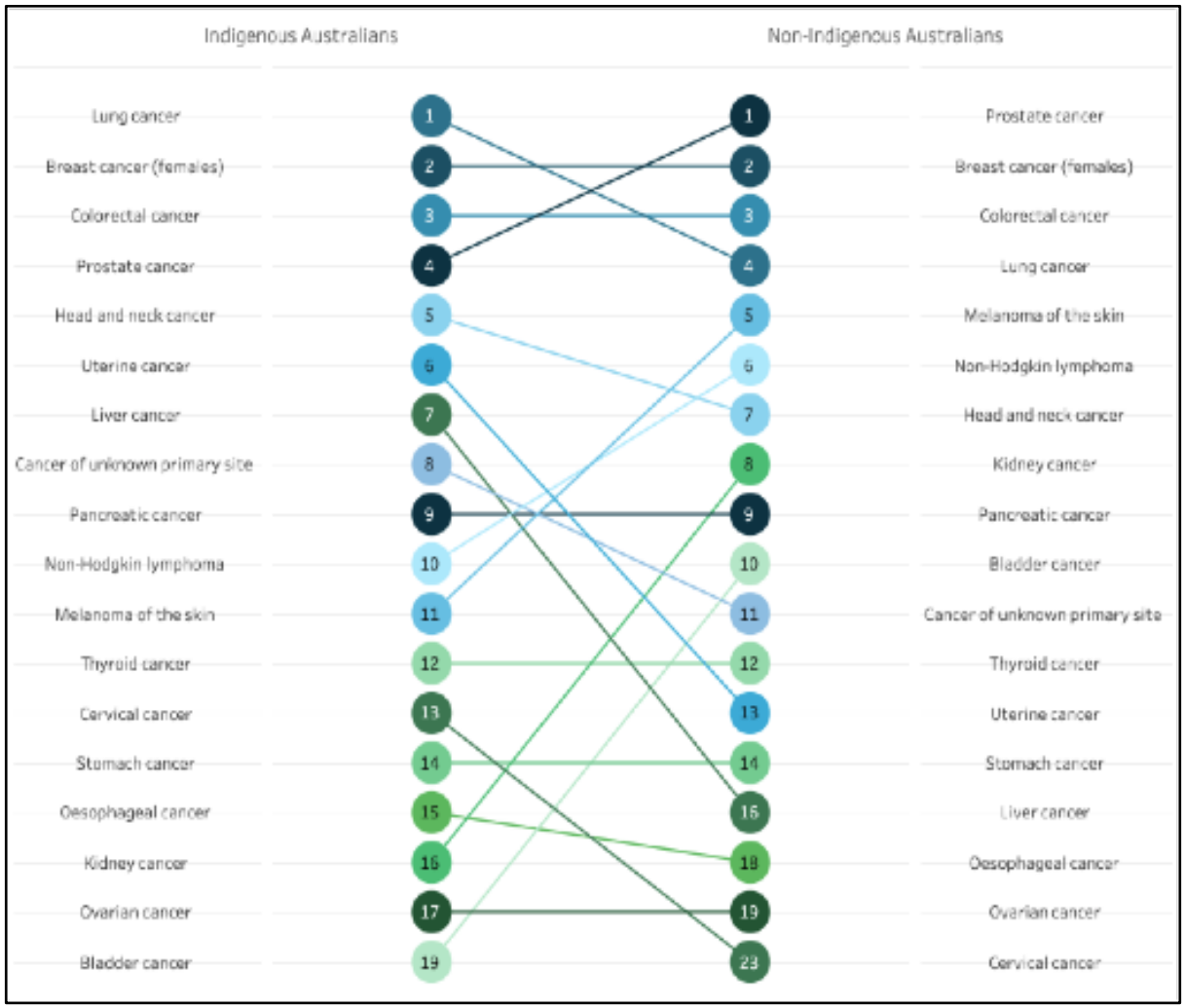
In the most recent Australia-wide burden of disease study in 2011, cancer accounted for 9.4 per cent of the total burden of disease for Aboriginal and Torres Strait Islander peoples and experienced a total burden of disease that was 2.3 times the rate of other Australians.

Funding

$187.8m has recently been announced by the Commonwealth to extend the 'Tackling Indigenous Smoking Program', which is welcome news.[28] However, a similar commitment is required for the other elements. NACCHO has identified the key areas to concentrate upon and a fast response can be arranged. Throughout 2022, NACCHO is hoping to explore further options – some of which will involve funding – and will need to work these through with stakeholders and relevant agencies.

[28] Media release by Hon Greg Hunt MP (Minister for Health and Aged Care), Hon Ken Wyatt MP (Minister for Indigenous Australians), 28 December 2021.

Figure 1: Incidence ranks of cancers by Indigenous status and cancer, 2009-13



PROPOSAL 15: *Improving oral health*

Proposal

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;
- introduces a tax on sugar-sweetened beverages, with the revenue accrued paid into communities where the impact is greatest and consideration of using the revenue to address funding gaps in Aboriginal and Torres Strait Islander health;
- amends food and beverage labelling regulations to require a graphic warning when sugar has been added to a product; and
- increases access to fruit and vegetables in Aboriginal and Torres Strait Islander communities.

Rationale

Bolstering safe fluoride water supplies for our communities is imperative. A current example is in Alice Springs with its large population and where added fluoridation could have an immediate impact on oral health. Alice Springs children are at double the risk of developing tooth decay in comparison to their Darwin counterparts.

Fluoride varnish programs are also inexpensive, simple to implement and 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 preventable, Aboriginal and Torres Strait Islander people have worse periodontal disease, decayed teeth and untreated 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.

Funding

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

The AMA estimates that Australians drink at least 2.4 billion litres of sugary drinks every year. For each one cent in tax per litre $24m would be generated. If this were approached ambitiously, the Commonwealth could generate in one measure the substantial revenue required to address other funding gaps or even close the health funding gap itself.

PROPOSAL 16: *Sector infrastructure renewal – phase 2*

Proposal

That the government allocate another $250m for the infrastructure renewal and development in the ACCHO sector for the two out years: 2023-24 and 2024-25. This builds on the $254m announced in the 2021 Closing the Gap announcement that we understand will be fully subscribed in 2022.

Rationale

In August 2021 the Government announced a new infrastructure investment of $154.4 million along with a reallocation of $100 million in existing funds from IAHP to strengthen the ACCHO sector through improved infrastructure; and to address seriously deteriorating or non-existent health infrastructure, through new and renovated health clinics and associated housing for health professionals.

As there is now a process underway to assess applications, this estimate of need can now be validated and adjusted in the light of the applications that are received. In other words, the grant process will inform us about the true quantum of the infrastructure investment required. Hence, NACCHO recommends allocating another $250m in the meantime, while this better data is derived.

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

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. Nationally, this equates to an investment of $900m. This did not include staff housing. There is also the need to develop renewal energy sources and to develop more sustainable building and infrastructure solutions, particularly in remote and regional areas.

Hence, the demand is clear and by allocating another $250m for the two out years (2023-24 and 2024-25), it is expected that at the very least, there is a shortfall remaining of $396m (exclusive of staff housing).

With so many regional economies reeling from the impact of the pandemic, this measure also represents a rare opportunity for the Commonwealth to stimulate local economies and boost employment in the regions where our 144 ACCHOs are located.

Funding

The next phase of infrastructure funding of $250m should be sourced from the existing infrastructure portfolio not IAHP, as the mainstream needs to provide its share of Aboriginal and Torres Strait Islander infrastructure funding and has a long history of not doing so (e.g. little or no representation on the 52 committees constituting Regional Development Australia). It is proposed, therefore, 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.

PROPOSAL 17: *Funding security for the sector*

Proposal

That the government invests in a timely resolution of the funding model for the sector and, in line with priority reform 2 of the National Agreement on Closing the Gap, consolidate all Aboriginal and Torres Strait Islander-specific funding in the IAHP.

Rationale

The ACCHO sector, which turned 50 in 2021, predates Medicare itself. Yet the ACCO sector is still weakened by insecure funding arrangements. For some years now, the Department of Health and its partners in the sector have struggled to finalise a robust needs-based funding model.

The recent finalisation of the highly successful Core Services Framework has put the sector in a much better position to assess the sustainability of the ACCHO model. Now is the time to expedite the process of moving to a more secure arrangement for ACCHOS, workforce peaks, NACCHO and the eight state/territory affiliates.

Currently, ACCHOS, workforce peak bodies, NACCHO and its eight affiliates are funded through a range of contracts and for varying lengths. There is little consistency or recognition of the longevity and impact of these organisations. In contrast, PHNs are funded through a rolling 4-year contract.

The same approach should be adopted for ACCHOS, workforce peak bodies, NACCHO and its eight affiliates. Four-year rolling contracts would enable stability around staffing and continuity of services. All should be subject to the requirements to provide annual audited financial statements and other outcomes reporting requirements as they do now.

Another element that would strengthen the sector and go a long way in honouring priority reform area 2 of the National Agreement on Closing the Gap would be the return of all Aboriginal and Torres Strait Islander program funding to the Department of Health (within IAHP). The key example in this is the Social and Emotional Wellbeing funding (SEWB). In many cases, the organisation with the direct funding is sub-contracting SEWB services to the local ACCHO. The return of SEWB was a commitment made by the former Minister in 2017 and despite several formal approaches to the Government, the reverse in the decision has never been explained.

Another issue that demonstrates the trust of Aboriginal and Torres Strait Islander people in ACCHOs is the uptake of MBS Aboriginal health assessments (item 715). Uptake is much higher (55 per cent) than for PHNs (34 per cent) according to the latest nKPI report by AIHW.

The current artificial distinction in which different program funding for ACCHO activities is administered across two or more Commonwealth agencies, 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.

The funding currently allocated to PHNs for all Aboriginal and Torres Strait Islander programs should be returned to the Indigenous Health Division programs to be distributed to Aboriginal and Torres Strait Islander organisations. The way funds are currently distributed to PHNs in each state and territory is not clear and therefore it would not be appropriate to continue without greater transparency and accountability. Funding should not be apportioned on the basis of population, but rather on need.

Funding

Redirection of existing funds with no fiscal impact rather than to generate more effective health outcomes.

PROPOSAL 18: *Cost recovery from mainstream programs*

Proposal

That the Government work with the Commonwealth in the course of 2022 to identify instances where ACCHOs are bearing the cost burden of services that should be delivered through state and territory programs and that the funding transfers be reviewed to ensure that the funding flows to the point of delivery.

Rationale

This proposal is closely related to proposal 17 in that it would help bring funding security to the sector.

The principle behind this proposal is that mainstream funding in all health and wellbeing programs follows patients.

NACCHO is seeing more cases in which patients, who do not engage with the mainstream health system due to cultural safety concerns and systemic racism, are accessing ACCHOs for services. For example, dental health that would be free if accessed via low-income clients in the hospital system is now being accessed in a number of ACCHOs with dental services. The funding for them needs to follow the clients.

Another key example has emerged out of the COVID-19 crisis which has seen more clients accessing 'hospital in the home' delivered via the ACCHO. In these cases, the funding should also flow to the ACCHO from the hospital system where a saving has occurred. This would also help ensure that Aboriginal and Torres Strait Islander people access their fair share of mainstream hospital funding.

It is well-documented that Aboriginal and Torres Strait Islander have 2.3 times higher burden of disease than other Australians, yet the funding is not 2.3 times higher and the recouping of costs from mainstream services in examples such as these is one way that the Commonwealth can help redress the imbalance. Recovery of funding from the mainstream is a key element in ensuring that a fair and equitable share of funding is secured for Aboriginal and Torres Strait Islander people.

It is proposed that this be done by NACCHO with the Commonwealth and the affiliates – as substantial state and territory differences will be in play – throughout the course of the 2022 calendar year to identify instances where ACCHOs are bearing the cost burden of services that should be delivered through state and territory programs. Adjustments should be made in which ACCHOs are funded directly for these services. Funding transfers could be reviewed to ensure that the funding flows to the point of delivery

Funding

Redirection of existing funds with no fiscal impact rather than to generate more effective health outcomes and long-term savings.

PROPOSAL 19: *National workforce development*

Proposal

Co-design a model of training and workplace experience for a range of qualifications and skill sets to help build and diversify the ACCHO workforce.

Note: this proposal closely relates to proposal no. 5 (Health and Care Sector Traineeships)

Rationale

There is a lack of Aboriginal and Torres Strait Islander health and care workers across the sector contributes to reduced access to health and care services for Aboriginal and Torres Strait Islander people in ACCHOs, and in mainstream primary and allied health sectors more broadly.[29]

As the Aboriginal and Torres Strait Islander population grows and the age-demographic profile alters, there will be an increasing need for Aboriginal and Torres Strait Islander workers across the health, SEWB, mental health, aged care and disability support and palliative care sectors. Targeted initiatives are required to increase the size of these workforces, particularly in ACCHOs, to ensure access to these services is not hampered by inadequate staffing.

A two-pronged approach is required to build the Aboriginal and Torres Strait Islander health and care workforce over the coming years.

1. Increase the number of new workers
2. Diversify the skills of the existing workforce

New workers

Interest in health careers is evident in Aboriginal and Torres Strait Islander student enrolment numbers, however, completion rates in both higher education and VET programs continue to lag behind that of other Australians. There is a need for strong training and career pathways and additional support for Aboriginal and Torres Strait Islander students to help improve course completion rates and transition into the workforce. These have been identified as key strategies in the *Aboriginal and Torres Strait Islander 10 year Health Workforce Plan (2021-2031).*

Proposal no 5 (Health and Care Sector Traineeships) sets out a clear and fully-funded way forward to address this in which ACCHOs and ACCRTOs would collaborate with NACCHO.

Existing workers

It is estimated there are around 30,000 care workers nationally without qualifications currently locked out of future progression in the sector, a proportion of which care for Aboriginal and Torres Strait Islander people. This proposal seeks to upskill the existing ACCHO workforce with a mix of recognition of prior learning (RPL), accredited and non-accredited training to support diversification of skills sets and career pathway development.

Current training delivery doesn't support quality outcomes as qualifications, particularly in the care sector, are often treated by employers as a form of risk mitigation, rather than assurance that workers have the necessary skills required for a role.

[29] AIHW Indigenous HPF, 3.12.

A more flexible approach is required which recognises the existing, demonstrated skills of current workers (RPL), and provides the opportunity to build on these skills with targeted accredited skills set training in areas such as mental health, social and emotional wellbeing, individual support for disability and aged care, allied health assistants, VET training and assessment qualifications.

This will help create clear pathways for new and existing workforce with a unified system of transferrable skills that enables professional mobility across and upwards.

The proposed approach has multiple benefits.

- Clear training and career pathways for current workers to build skills and expertise across an integrated health and care model.
- Clear structured and consistent national traineeship program for use across the sector.
- Mitigating many of the barriers currently experienced by students.
- Strengthening the capacity of the ACCRTO sector to meet the integrated health workforce needs of ACCHOs.
- Improving workforce retention for ACCHOs by building local workforce capacity.
- Flow on benefits for local economies.

The new *National Aboriginal and Torres Strait Islander Health Plan 2021-31* acknowledges the centrality of culture to the health and wellbeing of Aboriginal and Torres Strait Islander people and their communities. Importantly, it also acknowledges ACCHOs as a key part of the architecture of the primary health care system in Australia and prioritises them as the preferred providers of primary health care for Aboriginal and Torres Strait Islander communities. It also demands more of the health system more broadly; to eliminate racism and deliver culturally aware and trauma-informed care to the estimated 49% of Aboriginal and Torres Strait Islander people who access mainstream health services. Implementation of the Health Plan has the potential to transform health outcomes for Aboriginal and Torres Strait Islander people over the coming decade.

Funding

Funding for new workers has already been set out in proposal 5. With the cashing out of the training programs, mainstream labour market assistance and the former CDP, there will be more than enough savings generated (almost $33m) to fund the development of existing workers.

PROPOSAL 20: *Building an integrated disability and aged care capacity*

Proposal

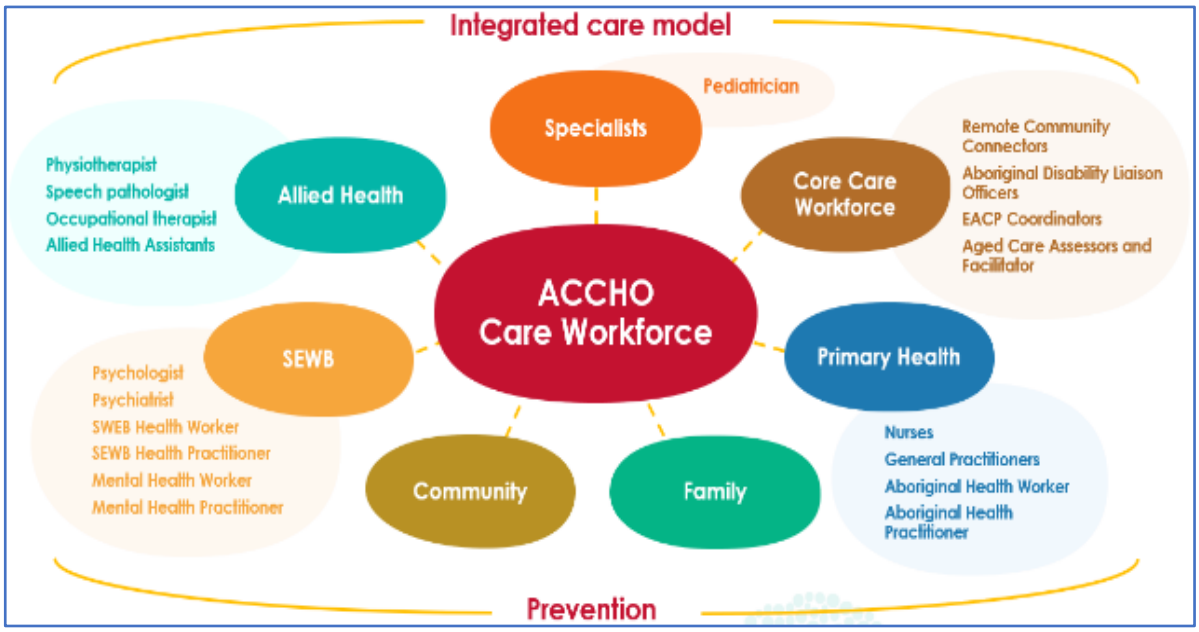
That the current NACCHO-led *NDIS Ready Program* funded by Department of Social Services (DSS) be expanded to encompass aged care and workforce support and is extended beyond June 2022, for a minimum of three years. This proposal reflects the Commonwealth's current reform agenda to align regulatory process between disability, aged care and veterans' care.

Rationale

In the next decade, the number of Aboriginal and Torres Strait Islander people aged over 50 is projected to double to 250,000. In keeping with the wider Australian population, this will require a corresponding increase in care and support services.

Currently, Aboriginal and Torres Strait Islander people do not access aged care and disability services at a rate commensurate with their level of need. Just 6.9 per cent of Australians on an NDIS Plan are Aboriginal and Torres Strait Islander peoples. This is considerably less than the percentage believed to have a significant disability. For aged care, as at mid-2020, this figure was around 2.6 per cent of places, considerably less than what is required.

Aboriginal and Torres Strait Islander people find it difficult to access mainstream care services no matter where they are. Barriers include difficulty navigating the system, a lack of service providers which may require a person to travel or even move away from family and Country to access appropriate care (thin markets), a lack of culturally appropriate and/or trauma informed provision of care, experiences of racism, and distrust of institutional care as a result of both personal and historical experiences. This is compounded in rural and remote settings. The market-based, fee-for-service approach to provision of care does not work when markets are thin or non-existent. Moreover, lack of culturally safe services exists in urban and regional settings which results in limited choices for Aboriginal and Torres Strait Islander people.



ACCHOs differ from mainstream human-services providers in that their approach is holistic. While they are first and foremost providers of primary health care, they also integrate other health services that support the social, emotional, and cultural wellbeing of Aboriginal and Torres Strait Islander people.

As trusted local providers of primary health care, ACCHOs are well placed to deliver holistic, integrated care and health services to local communities. As a network of 144 with over 550 clinics, they have a national footprint across urban, regional, rural and remote settings. The ACCHO integrated model delivering primary health and care services has the potential to overcome many of the barriers to access experienced by Aboriginal and Torres Strait Islander people, as well as address the issue of thin, and in some cases no, markets. However, the reliance on fee-for service models of delivering care services does not allow ACCHOs to deliver services sustainably. In addition, for many ACCHOs, the move to deliver care services will require a complex expansion from primary health care into a service delivery model requiring organisational capacity building, as well as workforce expansion and development.

NACCHO currently deliver the NDIS Ready program which supports ACCHOs to build their capability to deliver NDIS services. All NDIS supports for ACCHOs should be consolidated into the NDIS Ready program. The program should be expanded to include aged care capacity building and workforce support and funding extended for a minimum of three years.

Fee-for service funding and the consequent workforce casualisation are incompatible with ACCHO service delivery. ACCHOs require a combined funding approach of block funding and fee-for-service models (drawing down from NDIS and Aged Care schemes) to deliver sustainable, holistic services.

Funding

Program	***Responsible Department***	***Current allocation***	***Additional Required***
Capacity building funding allocation	Department of Health	$8m 2022-23 to20 24-25	Nil
Evidence, Access, Coordination of Planning *(increasing to 85 positions at $115,000 / FTE)*	National Disability Insurance Agency	Unknown	$26m 2022-23 to20 24-25
Aboriginal Disability Liaison Officers *(increasing to 85 positions at $115,000 / FTE)*	National Disability Insurance Agency	$4.5m 2021/22	$26m 2022-23 to 2024-25
NDIS Ready	Department of Social Services	$5.9m 2020/22 to 2021/22	$22m 2022-23 to 2024-25
Total investment: $82m			

PROPOSAL 21: *Family safety partnership*

Proposal

This proposal is to design a model of an integrated package of assistance available through ACCHOs to address family and domestic violence. The co-design phase would take place in the 2022 calendar year, with the pilot and full funding commencing which in 2023-24 and 2024-25 (i.e. the out years) in three sites.

Rationale

This proposal builds on the highly successful health-justice partnership proposal (no. 10) in that it is a co-designed model for deployment in three ACCHOs over two years. The success of trials at Wuchopperen and in the Barkly, particularly in relation to clients experiencing family and domestic violence demonstrate the need as well as the opportunity to add the additional element to the health justice partnership model.

Ideally, it would be tested in sites where a previous health-justice partnership project had taken place, or where one was currently taking place, given the clear cross-over in issues and, of course, economies of scale.

With Aboriginal community control at the front and centre of service design, this partnership would respond directly to local circumstances and be designed in a such way that it would deliver both preventive health outcomes for Aboriginal and Torres Strait Islander families, women and children as well as positive family safety outcomes

The proposal is to deploy three family safety officers in three selected ACCHOs in the out years (i.e. 2023-24 to 2024-25); however, the specific circumstances and the ability to combine these trials with the health-justice work will depend on consultations in 2022 as well as the outcome of the health justice partnership bid.

An evaluation would need to be built in and findings would support the rollout of the model to other ACCHOs across Australia.

Funding

As the substantial funding does not occur until the out years (i.e. 2023-24 to 2024-25) the impact on the 2022-23 Budget would be picked up in the budget for the health justice partnership. Hence the total funding required replicates the modelling for the health justice partnership: i.e. $1.88m for NACCHO plus $0.68m for partners (= $2.56m total).

PROPOSAL 22: *Road accidents and fatalities package*

Proposal

To develop a national framework for national framework to address road accidents and fatalities in remote communities through the Aboriginal and Torres Strait Islander health sector.

Rationale

The number of Aboriginal and Torres Strait Islander people involved in road accidents and fatalities is disproportionately high. Aboriginal and Torres Strait Islander people are 2.7 times more likely to die, and 1.4 times more likely to suffer serious injury because of road accidents compared to other Australians. This is particularly so for remote communities.

The ACCHO network is uniquely placed to develop a national framework to bring existing programs and some new elements together to best effect; particularly via SEWB services and support for patients and families upon exit from hospital, accident care equipment as well as some preventive strategies.

The communities themselves will know the best way of providing support and will be at the centre of the design process for the framework.

The framework would include:

- consideration of post-accident care arrangements,
- training for staff and family liaison officers;
- equipment to provide quality accident care when gaps are identified;
- and outcomes-based awareness campaigns.

Funding

$5m in new funding is required for the development of a national framework based on a thorough consultation process.

10. CONCLUSION

These 22 policy proposals in three tiers and five packages have been devised as practical measures 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. Further to the modest package of funding announced by the Prime Minister and Premiers in August, the major parties need to commit to the next stage of the Closing the Gap process. NACCHO's 22 fiscally responsible proposals represent a minimum base for moving forward in the health sector.

Of course, many of our ACCHOs are exhausted as a result of the pandemic and it will be difficult in some circumstances to push forward with some of the more ambitious reforms; particularly if we suffer unexpected further reverses. But we have absolute faith in our sector to respond to all the challenges they are facing, as they always have.

Our 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. In this sense, our network provides governments with an immediate mechanism for regional economic stimulation in times of crisis.

ACCHOs are accessed by 410,000 people each year (370,000 Aboriginal and Torres Strait islander people and about 40,000 other Australians). The ACCHO model is proven and is well-respected, both nationally and abroad.

While NACCHO believes that the health gap will never close until the funding gap is closed and historical inequities are addressed, these measures will go some of the way in lessening some of the primary health concerns and challenges facing our people. Of course, there needs to be substantial investment made by governments in the longer term – not just in health policies and programs to address the burden of disease – but in key related areas such as housing and workforce development.

As always, NACCHO is ready to work with governments and our key partners and stakeholders to implement these measures and to develop those which may need further adjustment.

Of course, the key to the way forward is the continued commitment of all governments to the new National Agreement on Closing the Gap. The funding announcements made in August in relation to the Agreement were most welcome, but the success of the Agreement hinges on continued commitment and genuine support for the implementation plans including the *Health Sector Strengthening Plan*.

ATTACHMENT: Health Sector Strengthening Virtual Funding Pool proposals

As key steps to implement the *Health Sector Strengthening Plan*, which is under consideration by parties as part of the implementation of the new National Agreement on Closing the Gap, there are four strong proposals already under consideration by NIAA from its Health Sector Strengthening Virtual Funding Pool.

Summaries are attached below. If they are not supported through the new funding pool, then they must be elevated to the 'tier one' proposals of this submission. As they are fully costed and 'ready to go'.

The four proposals are:

1. Governance training and support program for the ACCHO sector ($1.963 m);
2. Build the capacity of Aboriginal Community Controlled Health Registered Training Organisations to develop the Aboriginal and Torres Strait Islander health workforce ($1.17 m);
3. A co-designed National Strategic Roadmap to secure a permanent, highly skilled and nationally credentialed Aboriginal and Torres Strait Islander environmental health workforce to meet community health need ($1.228 m); and
4. Optimal utilisation of the Medicare Benefits Schedule (MBS) Project ($4.226 m).

Governance training and support program ($1.963 m)

NACCHO will deliver the Health Sector Governance Training and Support Program to develop and provide resources and training to build capacity and strengthen and support up to 196 Aboriginal and Torres Strait Islander health services (including the 144 NACCHO members). These resources will be suitable and made available for use by other organisations.

The program aims to support the role of Aboriginal and Torres Strait Islander community-controlled health service governing bodies, noting their importance in setting the strategic direction of their organisations and overseeing service performance, culture and impact.

The program will be delivered in three parts.

1. Provision of downloadable resources and tools to support smaller community-controlled boards and services and develop their pool of CEOs and leaders. This will include:
    - job descriptions for CEO positions at Aboriginal Community Controlled Health Services (ACCHOs) that can be adapted for size, scope and scale of service;
    - a framework for setting and evaluating ACCHO CEO remuneration;
    - resources and guidelines for selection panels interviewing prospective ACCHO CEOs
    - guidelines for CEO performance agreements and assessments;
    - a framework for establishment of Board committees (including in relation to Remuneration and Audit and Assurance);
    - a financial delegations framework;
    - risk register templates and WHS frameworks to support Director and CEO liabilities;
    - fraud control frameworks; and
    - other resources, as identified.

2. Board governance training for these same health services centred on a national program of 40 intensive workshops for up to 1600 board members and CEOs delivered over two years. These workshops will include topics such as:
    - general governance issues and principles;
    - managing conflict of interest;
    - delegation of powers;
    - modernising constitutions and rule books; and
    - board relationships with internal and external parties.

3. A residential Leadership Development Program for Aboriginal and Torres Strait Islander CEOs and senior managers.

Build the capacity of Aboriginal Community Controlled Health Registered Training Organisations (ACCHRTOs) to develop the Aboriginal and Torres Strait Islander health workforce ($1.17 m)

This project will build the capability and capacity of the ACCHRTO sector to grow and develop the Aboriginal and Torres Strait Islander health workforce to meet community health needs. Critical elements of this project align with the aims of the Environmental Health Worker proposal.

This project will be undertaken in two phases.

Phase 1 will be a comprehensive national project gap analysis, with three components:

- ACCHO workforce census;
- technical mapping of VET health qualifications to identify training gaps; and
- determining ACCHRTO scope of delivery.

Phase 2 will be the development of an implementation plan to build the capacity and capability of the ACCHRTO sector to deliver a broader range of nationally-accredited training to grow the Aboriginal and Torres Strait Islander health workforce, including:

- identifying key ACCHRTOs that can include the Indigenous Environmental Health training package in their scope of delivery;
- modelling costs for ongoing RTO accreditation and for full training and resource costs to ensure sustainable delivery of identified training packages; and
- determining ACCHRTO workforce gaps and delivering capacity building.

To ensure clear consultation, an expert project Advisory Group will be established, comprising representatives from the ACCHRTO sector and other relevant industry stakeholders. This group will provide sector expertise, including technical advice on qualifications and delivery requirements, as well as strategic implementation advice. They will ensure the necessary perspectives, experience and cultural expertise are integrated throughout the project's development and into the subsequent implementation phase.

A national ACCHRTO Community of Practice will also be established to inform both phases of this project. The key aim of the ACCRTO Community of Practice is to encourage knowledge sharing and ensure this project meets the needs of the sector.

A co-designed National Strategic Roadmap to secure a permanent, highly skilled and nationally credentialed Aboriginal and Torres Strait Islander environmental health workforce to meet community health need ($1.228 m)

This project will produce a comprehensive co-designed National Strategic Roadmap, validated workforce planning tools and course revision to support sustainable investment in a permanent, highly skilled, and nationally credentialed Aboriginal and Torres Strait Islander environmental health workforce as proposed by the Working Group for the Health Sector Strengthening Plan.

To undertake this two-year project, NACCHO will establish a dedicated Project Implementation Team with relevant skills and cultural competence overseen by a high-level multi-disciplinary expert Aboriginal and Torres Strait Islander Environmental Health Roadmap Steering Committee.

Through sound cultural and technical governance, this project will:

- identify practical and effective strategies including existing and previously defunded VET and tertiary-level training courses to increase the number of Aboriginal and Torres Strait Islander people who wish to become qualified and employed in community-controlled Aboriginal and Torres Strait Islander environmental health services;
- identify scope of practice and develop with key stakeholders a nationally consistent terminology for an Aboriginal and Torres Strait Islander environmental health workforce in diverse contexts: career pathways, career advancement, retention and professional development including leadership and community development skills;
- identify current and emerging strengths-based exemplars of Aboriginal and Torres Strait Islander environmental health service delivery and develop design principles for commissioning culturally safe Aboriginal and Torres Strait Islander environmental health services with high preventive health and social impact;
- develop, validate and disseminate methods and tools to enable Aboriginal and Torres Strait Islander community environmental health needs assessments in diverse contexts, consistent with data sovereignty and shared decision making;
- model costs for a national Aboriginal and Torres Strait Islander environmental health workforce based on population need, reflecting agreed design principles and supporting the socio-economic goals of the National Agreement on Closing the Gap;
- review VET sector ACCHRTO capacity and support prioritised curriculum and resource development to increase the number of Aboriginal and Torres Strait Islander people graduating with recognised environmental health qualifications;
- develop a monitoring and evaluation framework suitable for service partnerships and outcomes measurement to support Aboriginal and Torres Strait Islander environmental health workforce mobilisation and sustained investment; and
- adapt the monitoring and evaluation framework for national reporting and accountability.

To meet these aims, the Steering Committee and Project Implementation Team will use a variety of consultative and participatory methods co-ordinated in phases over 24 months as required. These will include national summits and workshops across Australia focused on key issues, policy analyses, curriculum review and VET training resource development, discussion papers and broad frameworks, consultation, fieldwork and validation testing of tools to assess needs, and effective stakeholder engagement including high-level dialogue with state/territory/local governments, non-government organisations, Aboriginal and Torres Strait Islander academic leaders active in relevant disciplines and diverse Aboriginal and Torres Strait Islander communities.

Focused consultations and resource development will enhance ACCHRTO sector capacity to train an Aboriginal and Torres Strait Islander environmental health workforce that communities will value. Governments equipped with this roadmap will have a contemporary foundation to continue sound workforce planning according to need, health data analyses and a common evaluation and monitoring framework to track workforce numbers, recruitment and retention, distribution and population health impact.

Optimal utilisation of the Medicare Benefits Schedule (MBS) Project ($4.226 m)

The Optimal Utilisation of MBS Project will strengthen and support the Aboriginal and Torres Strait Islander community-controlled sector by focusing on improving MBS claiming practices to support comprehensive multi-disciplinary health care; it will also look at building effective mechanisms for ACCHOs to utilise Practice Incentive Program (including the Indigenous Health Incentive) payments through greater awareness of the Practice Incentive Program.

This will support ACCHOs to deliver high-quality, responsive and culturally appropriate health services that achieve optimal health outcomes and meet the specific needs of Aboriginal and Torres Strait Islander people.

The project will also identify (and where necessary develop) sustainable resources and systems that must be in place to capitalise on the MBS revenue to support and expand their models of care and allow health priorities to be determined by Aboriginal and Torres Strait Islander communities and boards.

This will involve dedicated support for ACCHOs, building a Community of Practice in the Sector and the building of networks with the Australian Government Department of Health and Services Australia.