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

Pre-budget Submission

August 2020

(delayed Commonwealth Budget)

About NACCHO

NACCHO is the national peak body representing 143 Aboriginal Community Controlled Health Organisations (ACCHOs) across Australia.

Our primary health care network represents a national footprint of more than 550 sites. ACCHOs provide 3.1 million episodes of care per year for almost 410,000 people across Australia, which includes about one million episodes of care in remote regions.

ACCHOs are not-for-profit organisations controlled by local Aboriginal and Torres Strait Islander communities. They specialise in providing comprehensive primary care consistent with clients' needs, including home 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; providing help with income support; and more.

The ACCHO model is proven and value for money. The model was developed almost 50 years ago when the very first Aboriginal medical service was established at Redfern in 1971. ACCHOs are 23% better at attracting and retaining Aboriginal clients than mainstream providers. Our cost benefit per dollar spent is $1.19. In remote areas cost benefit can be fourfold. The lifetime health impact of interventions delivered by ACCHOs is 50% greater than with mainstream health services. ACCHOs are community organisations with all revenue re-invested into our clinics.

Collectively, ACCHOs employ 7,000 staff, 54 per cent of whom are Aboriginal and Torres Strait Islander people, which makes us one of the two largest employers of Aboriginal and Torres Strait Islander people in Australia.

During the early days of the recent pandemic, NACCHO led the sector's response and engagement with governments to ensure that the impact was minimised amongst Australia's First Nations, in which levels of comorbidity and socio-economic factors (e.g. overcrowding and poverty) meant that much higher death rates were expected. This risk remains, but the existence of a national network of community-controlled health services has been critical to the success thus far. If the pandemic has shown anything in our sector, it is that ACCHOs are flexible and effective frontline services. Now, more than ever, the network needs to be developed and supported.

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NACCHO’s earlier pre-budget submission (December 2019)

NACCHO lodged a pre-budget submission in December 2019 for public consideration as part of the 2020-21 Budget process. Due to the pandemic measures, the Budget was deferred to October. In late July 2020, the Assistant Treasurer called for further submissions from individuals, businesses and community groups on their views regarding priorities for the 2020-21 Budget.

Although the 400 individuals and groups (such as NACCHO) who had already provided submissions were not required to re-submit, NACCHO has taken the opportunity to redraft its submission, particularly in the light of the profound impact of the COVID-19 pandemic as well as the need to realign our priorities with the recent National Agreement on Closing the Gap (signed on 27 July 2020).

The four packages of twelve proposals in this submission have been informed by NACCHO’s consultations with its members for the preparation of the December 2019 submission. That submission also benefited from feedback from the eight state/territory affiliates and other key partners in the sector and was signed-off by the NACCHO Board. Since the December submission, further targeted consultation has taken place, particularly in relation to the additional measures (nos.: 1, 6, 9-10, 12). This redrafted submission has also been endorsed by the NACCHO Board.

NACCHO fully supports the new National Agreement on Closing the Gap

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

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

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

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

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

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

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

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

Funding context

This submission is conservative. It has tried to present proposals, wherever possible, that are cost-neutral and/or involve the redirection of *existing* funds. However, some elements require the investment of new money or the extension of existing programs. A total of $59.5m over three years is identified in the table on page 4 re: proposal 1 ($30m over two years for the transition of government-run clinics), proposal 6 ($3m pilot for embedded pharmacists), and proposal 10 ($5m capital investment for GeneXpert machines, $1.5m in training and support and $20m over three years for the extension of the Enhanced Syphilis Response Program).

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

NACCHO appreciates the ongoing financial support of the Australian Government and the efforts of the Department of Health in this respect. A three-year commitment to the funding for the sector announced in 2019, with indexation applied, is most welcome. Our sector has been disrupted for too long by unresolved funding questions and neglected infrastructure. NACCHO has also appreciated the additional funding allocated to certain ACCHOs for the bushfire recovery and in our initial response to the pandemic and keeping safe all Aboriginal and Torres Strait Islander peoples, who have such high levels of comorbidity and face higher levels of socio-economic disadvantage.

Given the enormous impact of the COVID-19 measures on GDP, Government revenues and national debt, NACCHO's approach is primarily based on the redirection of existing funds. Hence, nine of our twelve proposals are, effectively, cost neutral. They also have the advantage of having a community-development focus. Investment in communities across the country will benefit local economies suffering from drought, bushfire and, now, the economic effects of the pandemic.

The only measure requiring significantly increased funding is the housing initiative. Addressing chronic overcrowding and improving environmental health is a key priority of the new National Agreement on Closing the Gap and governments need to find significant additional money if this target is to be met. There is no way of doing this without the allocation of new money.

It is also important to note that there is a damaging myth that Aboriginal and Torres Strait Islander people receive ample health funding. In real terms, health expenditure (excluding hospital expenditure) for Aboriginal and Torres Strait Islander people fell 2 % from $3,840 per person in 2008–09 to $3,780 per person in 2015–16. Over the same period, expenditure on other Australians rose by 10 %.[1]

Under the Abbott Government's inaugural 2014-15 budget $534 million was cut from Indigenous programs run by the Department of the Prime Minister & Cabinet, and the Department of Health.[2] More than 150 programs, grants and activities were consolidated, nominally to eliminate waste, but, in reality, $160 million of the cuts came directly out of Indigenous health programs.

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

While the three-year indexation to sector funding announced in 2019 is welcome, the pandemic is exacerbating an already significant difference between general CPI (now falling) and the increasing CPI experienced by the health sector.[3] The pandemic will see greater demands on the health sector, particularly those servicing disadvantaged communities who are most at threat from COVID-19. In

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[1] *Indigenous Expenditure Report*, 2017 (https://www.pc.gov.au/research/ongoing/indigenous-expenditure-report/2017#pivottables). Australian Health Ministers Advisory Council (AHMAC), *Aboriginal and Torres Strait Islander Health Performance Framework Report*, 2017 (http://www.health.gov.au/indigenous--hpf/).

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

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

addition, the travel restrictions have significantly reduced the capacity to access international staff. This will inevitably lead to increased salary costs to recruit staff from a reduced pool of professionals within Australia. An increase in indexation would be a recognition of these differential impacts of COVID-19 and separate to the completion of the sector funding model.

This funding decline is a most critical issue, particularly when the burden of disease for Aboriginal and Torres Strait Islander people is 2.3 times higher than for other Australians. In remote areas, the burden of disease is six times higher.

The drought and catastrophic bushfires of 2019-2020, followed by COVID-19, have all served to emphasise the importance of ACCHOs and the frontline services they offer communities across Australia. The sector stepped up in response to the bushfires crisis in a number of communities and then, nationally, to the COVID-19 pandemic, demonstrating the strength and effectiveness of our network in these dire times.

NACCHO Budget measures – summary

Measure or policy proposal	*Package*	*Funding*	*National Agreement on Closing the Gap*
1. Transitioning 10 government-run clinics into ACCHOs by 2020 Investment will strengthen community control and deliver efficiencies	Strengthening the network's capacity and stimulating local economies	Transition pool of $30m: Commonwealth funding	Priority reform areas: 1, 2
2. Infrastructure development Investment addresses ageing infrastructure and supports economic recovery		Cost neutral: access to existing portfolio funding	Priority reform areas: 1, 2
3. National workforce development Measure will boost employment (1,250 Aboriginal and Torres Strait Islander jobs)		Cost neutral: existing programs	Priority reform areas: 1, 2
4. Housing for health Improve Aboriginal and Torres Strait Islander housing and environmental health	Key 'Closing the Gap' priorities	Requires significant government investment	Priority reform areas: 1, 3
5. Early childhood, youth wellbeing and reducing out-of-home care Reduction of Aboriginal and Torres Strait Islander children in care and detention		Cost-neutral: redirection of funding	Priority reform areas: 1, 3
6. Embedding pharmacists in ACCHOs Measure to improve the use of medicine and access to quality pharmaceuticals	Targeted health initiatives	$3m pilot funding with follow-up investment	Priority reform areas: 1, 2
7. Returning Social and Emotional Wellbeing (SEWB) funding to ACCHOs Measure also addresses the increased impact on mental health from COVID-19		Cost-neutral: redirection of funding	Priority reform areas: 1, 2
8. Improving oral health Measures to improve oral health (including a sugary drinks tax)		Cost-neutral: self-funded sugar tax	Priority reform areas: 1, 3
9. Indigenous identifier in pathology Inclusion of an Indigenous identifier in pathology data at point of collection		Minimal set-up cost	Priority reform areas: 1, 4
10. Providing GeneX machines and extending Enhanced Syphilis Response Program Measure to help communities monitor and manage communicable diseases		$20m (3yr ESRP extension); $6.5m (GeneX); MBS impact	Priority reform areas: 1, 2, 4
11. Application of the WA NDIS model Improving NDIS services for Aboriginal people with disability in other jurisdictions.	Alignment with disability and aged care reform	Cost-neutral: redirection of funding	Priority reform areas: 1, 2
12. Consideration of measures for improved aged care Commitment from Government to work with NACCHO and the sector		No cost involved: commitment to co-design	Priority reform area: 1

1. Transitioning government-run clinics into ACCHOs

Proposal

It is recommended that the Commonwealth, together with the relevant state and territory governments, increase its support in transitioning government-run clinics servicing Aboriginal and Torres Strait Islander communities into ACCHOs. A pool of $30m is proposed to fund the transition of at least ten government-run clinics in northern Australia by 2022. Meanwhile, a plan needs to be developed to ensure a timeframe and funding for the transition of the remaining government-run clinics in northern Australia.

Rationale

The community control and self-determination of Aboriginal and Torres Strait Islander organisations is imperative for achieving optimal health and wellbeing outcomes for Aboriginal and Torres Strait Islander people and communities. As demonstrated on p. 1, these principles are built into the ACCHO model. It has proved to be effective and efficient since the first ACCHO was established 49 years ago.

Many Aboriginal and Torres Strait Islander people have little trust in mainstream service providers and government-run agencies. Many of these providers do not retain Aboriginal and Torres Strait Islander clients and do not achieve optimal outcomes in Aboriginal and Torres Strait Islander communities.[4] 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 ill-health and poor social and emotional wellbeing.[5] Transitioning government-run clinics to ACCHOs will ensure better health and wellbeing 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 recently signing the National Agreement on Closing the Gap, 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 a realisation of this commitment.

There are numerous government-run clinics in Northern Australia (Northern Territory and northern regions of Western Australia and Queensland) that would more effectively meet unmet need should they be community controlled. However, there are considerable initial costs in making the transition, including for the government-run clinic in Palm Island, where specific circumstances require additional investment. The Palm Island transition would require $3 million for that government-run clinic to become an ACCHO.

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 Northern Territory Department of Health transferring infrastructure, staff and operational funding to the regional ACCHO. At present, a couple of NT Government clinics in North East Arnhem Land are under transition to Miwatj Health and a couple of NT Government clinics in West Arnhem Land are under transition to the Red Lily Health Board. In Central Australia clinics are being transitioned under a proposal from Central Australian Aboriginal Congress. At this pace it will take a long time to transition all government-run clinics to community control.

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

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

A transition plan for all jurisdictions needs to be agreed quickly to manage this process with a view to seeing all government-run clinics transition within ten years. This will bring clarity for all parties and the sector will have time to prepare. Such a plan will take time, particularly one that involves three state/territory governments, the Commonwealth and the relevant organisations from across the ACCHO sector. So that the planning process itself does not delay the transition of government-run clinics, funding should be allocated now to transition ten clinics over the next two years (i.e. by the end of 2022). 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 of the Palm Island government-run clinic ($3m) represents the higher end of transition costs, a pool for the next two years capped at $30m to transition at least ten government-run clinics to ACCHOs is required.

2. Sector infrastructure development

Proposal

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

It is proposed that funding be sourced through a Ministerial agreement that involves identifying an amount within the existing funds administered by the Department of Infrastructure, Transport, Cities and Regional Development.

Rationale

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

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

Greater funding on ACCHO infrastructure is needed despite reports that the Commonwealth spends $1.21 on Aboriginal and Torres Strait Islander health for every $1 spent on health funding for other Australians. While the additional investment appears positive on the surface, it remains a significant shortfall as Aboriginal and Torres Strait Islander people have 2.3 times the per capita need of the rest of the population due to compounded and higher levels of illness and burden of disease. In its *2018 Report Card on Indigenous Health*, the Australian Medical Association (AMA) stated that spending less per capita on those with worse health is 'untenable national policy that must be rectified'.[6]

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

Infrastructure spending from existing funds represents a powerful means of stimulating regional economies in the current economic environment in which there is little further to be gained by lowering interest rates in order to stimulate the economy. This is critical more than ever in the light of COVID-19. It would also deliver regional jobs and training opportunities in local communities where unemployment rates have remained high and where the prolonged drought has negatively impacted on local economies.

Despite challenges delivering services with outdated infrastructure and operating with fragmented and inadequate funding, studies have shown that ACCHOs deliver more cost-effective, equitable and efficient primary health care services to Aboriginal and Torres Strait Islander peoples. ACCHOs are 23% better at attracting and retaining Aboriginal and Torres Strait Islander clients than mainstream providers.[7] However, there are limits to the extent that ACCHOs can continue to deliver quality, safe comprehensive primary health care to a fast-growing population when faced with pressing capital works and infrastructural needs.[8]

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

Funding

The previous level of funding under the IAHP allocated for Capital Works (Infrastructure, Support and Assessment and Service Maintenance) of about $15m per annum is not keeping up with demand, and the discrepancy is set to only increase. This need will be exacerbated as the NDIS expands its engagements with Aboriginal and Torres Strait Islander communities.

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

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

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

In our consultations with affiliates and ACCHOs, NACCHO heard that Telehealth services, including infrastructure and improved connectivity, is required to support the provision of NDIS, mental health and health specialist services. A total of 22 out of the 56 survey responses identified the need for Telehealth to support service provision. This has become an even more critical issue in the wake of COVID-19 and if the survey were conducted now, the reported need would be significantly higher. To

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

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

optimise outcomes achieved by Telehealth a stronger workforce is essential, including a greater presence of allied health professionals and other health workers.

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

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

ACCHOs believe the current state of service infrastructure impedes service delivery capacity (see Table B below).

Table B: Impact of ACCHOs' infrastructure needs on service delivery

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

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

Proposal

That a national workforce development strategy to boost the employment of Aboriginal and Torres Strait Islander allied health professionals and other health workers, including GPs, specialists, nurses, midwives and vising specialists, be co-designed with the Australian Government and supported through existing employment and training programs and the IAS. On current vacancy rates, this could deliver 1,250 jobs, nationally.

Rationale

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

Like many mainstream clinics, ACCHOs and allied health services struggle with the recruitment and retention of suitably qualified staff. In particular, it is an ongoing challenge to attract student placements in ACCHOs; although models developed in Brisbane and the Kimberley have proved successful. More recently, pandemic travel restrictions have significantly reduced the capacity to access international health professionals who are particularly important for service delivery in the remote and regional areas served by a majority of NACCHO members.

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

It is not widely known, but, collectively, ACCHOs are the second largest employer of Aboriginal and Torres Strait Islander staff in Australia. One in every 44 Aboriginal and Torres Strait Islander jobs in Australia is employed with an ACCHO. Currently, ACCHOs employ about 7,000 staff, 54 per cent of whom are Aboriginal and Torres Strait Islander people.

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

More needs to be done to develop career pathways to secure more Aboriginal and Torres Strait Islander doctors, nurses and allied health professionals. Despite the sector's success in Aboriginal employment and the strong preference of Aboriginal and Torres Strait Islander health professionals to work in our services, the challenge to recruit enough staff and keep pace with staff turnover persists. One of two key employment issues for NACCHO and the sector is the high number of vacancies across all service locations, but particularly in remote and very remote regions. In these times of global pandemic, it is all the more critical to ensure that our health services are running at full capacity and vacancy rates are as low as possible.

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

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

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

Funding

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

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

Proposals

NACCHO is calling for the urgent implementation of the formal policy partnership on housing as envisaged in the National Agreement on Closing the Gap. The policy partnership will establish a multi-jurisdictional joined-up approach to reduce gaps and duplications in housing policies and programs.

It is recommended that the Australian Government:

- expand 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;
- fund a program that supports healthy living environments in urban, rural, and remote Aboriginal and Torres Strait Islander communities, similar to the Fixing Houses for Better Health program, also delivered by Aboriginal and Torres Strait Islander community housing providers; and
- update and promote the *National Indigenous Housing Guide*, a best practice resource for the design, construction and maintenance of housing for Aboriginal and Torres Strait Islander people.

Rationale

Safe and decent housing for Aboriginal and Torres Strait Islander people is urgently required, as housing is one of the most critical social determinants of health and cannot be overlooked when working to close the gap in life expectancy. There is comprehensive, evidence-based literature which investigates the powerful links between housing and health, education and employment outcomes.[9] Healthy living conditions are the basis from which Closing the Gap objectives may be achieved. The importance of environmental health to health outcomes is well established.

A healthy living environment with adequate housing also supports the health and safety of individuals and families. Healthy housing enhances educational achievements, community safety and economic participation. Overcrowding is a key contributor to the poor health of Aboriginal and Torres Strait Islander peoples. In addition to overcrowding, poor and derelict health hardware (including water, sewerage, electricity) leads to the spread of preventable diseases for Aboriginal and Torres Strait Islander peoples.

If the sector had not been as successful as it has been in keeping COVID-19 out of discrete Aboriginal communities, the impact of the pandemic in these communities would have been catastrophic. Healthy homes are vital to ensuring that preventable diseases already eradicated in most countries do not exist in Aboriginal and Torres Strait Islander communities and homes.

Funding

The Commonwealth, state and territory governments have a shared responsibility to invest in Aboriginal and Torres Strait Islander housing. There is currently a disconnect between government investment into remote housing and the identified housing needs of remote communities. This is increasingly exacerbated where there are population increases in Aboriginal communities.

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

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

Proposals

That the Australian Government redirects existing training funds to:

- establish an additional elective within the existing Aboriginal Health Worker curriculum that provides students with early childhood outreach, preventative health care and parenting support skills;
- waive the upfront fees of the first 100 students undertaking child safety related Aboriginal and/or Torres Strait Islander Health Worker courses;
- upskill teaching staff across the country; and
- analyse unmet demand for Aboriginal Health Workers specialising in early childhood across the ACCHOs.

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

Rationale

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

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

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

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

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

> *Aboriginal and Torres Strait Islander children make up just over 36% of all children living in out-of-home care; the rate of Aboriginal and Torres Strait Islander children in out-of-home care is 10.1 times that of other children, and disproportionate representation continues to grow (Australian Institute of Health and Welfare [AIHW], 2018b). Since the last Family Matters Report overrepresentation in out-of-home care has either increased or remained the same in every state and territory.*[12]

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

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

NACCHO believes an adequately funded, culturally safe, preventive response is needed to reduce the number and proportion of Aboriginal and Torres Strait Islander children in child protection and youth detention systems. It is vital that Aboriginal and Torres Strait Islander families who are struggling with chronic, complex and challenging circumstances be able to access culturally appropriate, holistic,

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

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

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

[13] Australian Institute of Health and Welfare, *Youth Detention Population in Australia* (Bulletin 145), 2018.

preventive services delivered by trusted service providers with expertise in working with whole families affected by intergenerational trauma. Also, child protection as well as justice literature points to the need for Aboriginal and Torres Strait Islander self-determination, community control and cultural safety, and a holistic response.[14] For these reasons, new Aboriginal Health Workers delivering early childhood services need to be based within ACCHOs.

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

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

Funding

This proposal is cost neutral and relies on a redirection of existing funds within education and training portfolios. Ideally, there should be Aboriginal Health Workers specialising in early childhood in every ACCHO. The sector will need to continue this discussion with governments to ensure that there is adequate funding for these positions in future years.

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

Proposal

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

Rationale

In 2019, medicine safety was declared an Australian National Health Priority Area by the Minister for Health. In consideration of this priority and several recent national reviews and Commonwealth data that demonstrate the ongoing and gross inequity in medicines use and government spending for Aboriginal and Torres Strait Islander people compared with the other Australians, much more needs to be done, especially when considering Australia's record in delivering healthcare inequitably.[15]

While there have been some recent reforms announced to medicines use and access programs for Aboriginal and Torres Strait Islander people, these reforms alone are inadequate. There is no existing or

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

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

proposed program that adequately supports ACCHOs to employ pharmacists on a sustainable basis to deliver a range of integrated and holistic medicines-related services.

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

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

Funding

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

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

Proposal

That funding for social and emotional wellbeing (SEWB) services for Aboriginal and Torres Strait Islander peoples be returned from the Indigenous Advancement Strategy (IAS) to IAHP under the Health portfolio. Improving the delivery of SEWB services is all the more critical since COVID-19 and increased demand arising from the impact of the shutdowns and continuing anxiety.

Rationale

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

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

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

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

The Australian Institute of Health and Welfare has estimated that mental health and substance use are the biggest contributors to the overall burden of disease for Aboriginal and Torres Strait Islander peoples. Aboriginal and Torres Strait Islander adults are 2.7 times more likely to experience high or very high levels of psychological distress than other Australians.[16] They are also hospitalised for mental and

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

behavioural disorders and suicide at almost twice the rate of the non-Indigenous population, and are missing out on much needed mental health services.

Suicide is the leading cause of death for Aboriginal people aged 5–34 years, and the second leading cause of death for Aboriginal and Torres Strait Islander men. In 2016, the rate of suicide for Aboriginal and Torres Strait Islander peoples was 24 per 100,000, which was twice the rate for non-Indigenous Australians.[17] Aboriginal people living in the Kimberley region are seven times more likely to suicide than non-Aboriginal people.

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

Case Study: Derby Aboriginal Health Service, WA

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

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

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

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

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

<u>Funding</u>

Cost neutral and likely to deliver efficiencies. This is a redirection of existing funds.

[17] *Ibid*.

8. Improving Aboriginal and Torres Strait Islander oral health

Proposals

That the Commonwealth:

- develops a national standard for access to fluoridated water or fluoride in other forms in all Aboriginal and Torres Strait Islander communities;
- establishes a multidisciplinary national panel to provide technical advice and assistance to jurisdictions to support the implementation and maintenance of water fluoridation;
- introduces a 20% tax on sugar-sweetened beverages, with the revenue accrued redirected back into a subsidy on fresh fruit and vegetables back into communities where the impact is greatest;
- amends food and beverage labelling regulations to require a graphic warning when sugar has been added to a product; and
- increases access to quality fruit and vegetables in Aboriginal and Torres Strait Islander communities.

Rationale

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

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

Funding

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

9. Indigenous identifier in pathology

Proposal

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

Rationale

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

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

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

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

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

We need a national approach and urge the Commonwealth to require the same measures nationally. Actions that still need to be taken include:

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

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

Funding

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

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

Proposal

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

- ensuring 35 GenXpert machines provided to ACCHOs for COVID-19 testing remain in the services for STI and BBV purposes and that they are supplied with testing cartridges;
- funding NACCHO to:
  - o provide GenXpert machines and cartridges to other ACCHOs (up to $5m) that commit to undertaking BBV, STI and COVID-19 testing;
  - o engage service providers to develop and deliver culturally appropriate testing, treatment and contact-tracing training to ACCHO staff ($1m per year) and provide machine quality management services ($500,000 per year);
  - o retain current staffing levels ($20m over 3 years) in the Enhanced Syphilis Response Program, which is scheduled to end in June 2021; and
- creating an MBS Item to support ongoing BBV and STI testing of Aboriginal and Torres Strait Islander peoples as a longer term measure (proposal being developed by Kirby Institute, Flinders University and NACCHO).

Rationale

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

Table C: Prevalence of STIs and BBVs in Aboriginal and Torres Strait Islander communities.

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

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

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

The sector has:

- minimised the impact of COVID-19 on the Aboriginal and Torres Strait Islander community (currently no deaths in the Aboriginal and Torres Strait community, and less than 1% of those who have contracted COVID-19 are Aboriginal and Torres Strait Islander peoples); and
- responded to declared syphilis outbreak regions (in North Queensland, Northern Territory, Western Australia and South Australia) by increasing rapid testing and treatment levels.

Funding

Provision of GenXpert machines and cartridges to other ACCHOS will require capital expenditure of up to $5m, along with further funding of $1.5m per year for training. Workforce retention of Aboriginal Health Workers employed under the Enhanced Syphilis Response Program for another three years will cost $20m. MBS costs will need to be determined.

11. Application of the WA model for NDIS services for Aboriginal and Torres Strait Islander people with a disability in other jurisdictions

Proposal

That the DSS and the NDIA negotiate with ACCHOs, NACCHO and affiliates in all jurisdictions an NDIS model similar to the WA model to better support Aboriginal and Torres Strait Islander people with a disability. NDIS measures need to be culturally sensitive and evidence-based, including training and resources.

Rationale

Aboriginal and Torres Strait Islander peoples are twice as likely to experience a disability than other Australians, with 9% having a severe condition compared to 4%, respectively. At , March 2020, only 6.2% of (or 22,749) NDIS participants identify as being of Aboriginal and/or Torres Strait Islander background, which is considerably less than the percentage thought to have a significant disability.

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

In WA, as of July 2020, there were nine contracts between ACCHOs and the NDIA for services delivered by Remote Community Connectors (RCC). The WA RCC program has seen people from remote communities employed by local ACCHOs promote understanding and awareness of the NDIS. RCCs link potential NDIS participants to planning and implementation pathways which involves testing their access to the NDIS and, if eligible, supporting them to build a plan with the NDIA. WA ACCHOs have been funded to employ RCCs, as well as to engage Evidence, Access and Coordination of Planning (EACP) positions. EACPs assist participants to, where required, contact the NDIS, complete necessary forms for requesting access (e.g. obtaining appropriate clinical and other assessments), utilise existing medical records and collate additional evidence.

The Remote Community Connector Program has now been expanded to become the National Community Connector Program (NCCP), which funds Community Connectors in urban, regional and rural communities. NACCHO entered into a contract with the NDIA in mid-2020 to link Aboriginal and Torres Strait Islander communities with the NDIS through the NCCP. The 12-month program will employ over 50 Aboriginal and Torres Strait Islander people across Australia and build capacity within ACCHOs to link their communities to the NDIS in a culturally safe environment. However, the structural change necessary to ensure increased, culturally appropriate and more ongoing participation of Aboriginal and Torres Strait Islander people in the NDIS in the long term cannot be achieved within a 12-month period. Further funding is required past the current 12-month contract to ensure that Aboriginal and Torres Strait Islander people receive the support required to enter the NDIS.

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

NACCHO is also aware that other member services are negotiating with NDIA (with mixed success) in order to utilise ECEI program funds to help resource models that build on the WA model and also include other evidence informed, culturally responsive early childhood services that will promote

healthy development and prevent the onset of disability. In addition there is also a need for Child Health and Development Centres where children with additional vulnerabilities can attend prior to preschool. These centres focus on play based learning, conversational reading, enriched care giving and language priority as well as the provision of a healthy, iron-rich meal. These centres can provide wrap-around allied health services and are an important employment opportunity for local Aboriginal and Torres Strait Islander people.

In summary, what is required, is national acceptance of the WA NDIS funding model. In effect, the individual NDIS packages would be 'cashed out' at a population level to fund disability services for Aboriginal and Torres Strait Islander children. How those funds are then applied is then a matter for negotiation between the ACCHOs of each region or jurisdiction with the NDIA. For example, in Central Australia the sector is advocating for the creation of child health and development hubs to provide the central focus for early childhood development activities.

Funding

Redirection of existing NDIS funds and extended support for existing arrangements.

12. Consultation in measures for improved arrangements in aged care

Proposal

This proposal, simply, is a commitment from the Commonwealth to work with NACCHO to ensure that Aboriginal and Torres Strait Islander elders' interests are identified in coming aged-care reforms.

Rationale

The recent pandemic with devasting consequences in NSW and Victorian nursing homes has highlighted the need for reform in the aged care sector. With the Royal Commission underway, we are also expecting the Commonwealth to consider substantial reforms to the sector and it is critical that ACCHOs be involved, not just as providers of health services to older Aboriginal and Torres Strait Islander people, but as an increasing number of ACCHOs are becoming directly engaged in the aged care sector itself.

In the spirit of the National Agreement on Closing the Gap and its focus on co-design, what we are asking is that the Commonwealth involve our sector closely before committing to any reforms affecting our communities. The needs of Aboriginal and Torres Strait Islander peoples in the aged care sector have been neglected over time and the current circumstances provide an opportunity for this to be rectified.

One particular issue that is already apparent is the number of government-run aged care homes in discrete Aboriginal and Torres Strait Islander communities. These need to be transitioned to community control models, similar to the process outlined in measure 1 (i.e. the transitioning of government-run clinics to ACCHOs).

Funding

No cost is involved. This is a request for agreement for a commitment to co-design.

CONCLUSION

These twelve policy proposals in four interrelated packages have been devised as practical initiatives that would deliver greater service capability and improved outcomes for Aboriginal and Torres Strait Islander people. They also provide governments at all levels and across all jurisdictions with a tangible means of delivering quickly upon the priority reforms of the new National Agreement on Closing the Gap.

The process of closing the gap in Aboriginal and Torres Strait Islander health cannot commence until these twelve measures are implemented. They represent a minimum base for moving forward. Our sector's package is based on almost 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, which all governments can partner with. ACCHOs are accessed by 370,000 Aboriginal and Torres Strait islander people each year. The ACCHO model is proven and is well-respected, both nationally and abroad.

Over the past twelve months, the sector has shown itself to be an effective mechanism in responding to crises such as the pandemic and bushfires. Further investment in it will not only improve the health outcomes of Aboriginal and Torres Strait Islander peoples across the country, but it will also, at this critical juncture, provide governments with a welcome means of creating jobs and stimulating local economies in the wake of recent disasters.

NACCHO is committed to working with the Commonwealth to develop these proposals further, including the associated costings, trials, implementation plans, and identifying further opportunities where current expenditure could be more appropriately targeted. The ‘new money’ element of $59.5m is modest and most proposals are built on the redirection of existing funding or are cost-neutral.