98-99

Performance Audit

The Aboriginal and Torres Strait Islander Health Program

Department of Health and Aged Care

The Auditor-General Audit Report No.13

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Performance Audit

The Aboriginal and Torres Strait Islander Health Program

Department of Health and Aged Care

Australian National Audit Office

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Australian National
Audit Office

Canberra ACT
12 November 1998

The Australian National Audit Office has undertaken a performance audit of the Department Health and Aged Care in accordance with the authority contained in the *Auditor-General Act 1997.* I present this report of this audit, and the accompanying brochure, to the Parliament. The report is titled *Aboriginal and Torres Strait Islander Health Program.*

Following its tabling in Parliament, the report will be placed on the Australian National Audit Office's Homepage —

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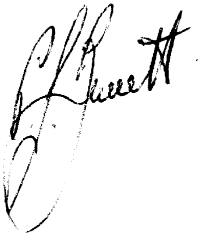
Yours sincerely



P. J. Barrett
Auditor-General

The Honourable the President of the Senate
The Honourable the Speaker of the House of Representatives
Parliament House
Canberra ACT

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Abbreviations/Glossary

ABS	Australian Bureau of Statistics
AHMAC	Australian Health Ministers' Advisory Council
AHMC	Australian Health Ministers' Conference
AHSs	Aboriginal Health Services
AIHW	Australian Institute of Health and Welfare
AMA	Australian Medical Association
ANAO	Australian National Audit Office
ATSIC	Aboriginal and Torres Strait Islander Commission
CHIP	Community Housing Infrastructure Program
DAA	Department of Aboriginal Affairs
DHAC	Department of Health and Aged Care
DHFS	Department of Health and Family Services
DHSH	Department of Human Services and Health
DEETYA	Department of Employment, Education, Training and Youth Affairs
FINEST	A financial management information system
GMS	Grant Management System
HAHU	Heads of Aboriginal Health Units
Health Council	Aboriginal & Torres Strait Islander Health Council
HIC	Health Insurance Commission
HIPP	Housing Infrastructure Priority Projects
HRSCAA	House of Representatives Standing Committee on Aboriginal Affairs
JHPC	Joint Health Planning Committee
MOU	Memorandum of Understanding
MBS	Medicare Benefits Scheme
NACCHO	National Aboriginal Community Controlled Health Organisation
NAHS	National Aboriginal Health Strategy
NPIs	National Performance Indicators
OATSIHS	Office for Aboriginal and Torres Strait Islander Health Services
ORAC	A financial management information system
PBS	Pharmaceutical Benefits Scheme
QAIHF	Queensland Aboriginal and Islander Health Forum

Summary and Recommendations

Summary

Background

1. In 1995, the Commonwealth Government transferred responsibility for the delivery of the Aboriginal and Torres Strait Islander health program from the Aboriginal and Torres Strait Islander Commission, ATSIC, to the Department of Human Services and Health. The primary purpose of the transfer was to ensure that primary health care for Indigenous Australians had a priority position within the mainstream health system, against the background of continuing high rates of Aboriginal and Torres Strait Islander morbidity and mortality. Government changes in 1996 resulted in the Department of Health and Family Services (DHFS) becoming responsible for Aboriginal and Torres Strait Islander health. Administrative arrangements effective 21 October 1998 place the program in the Department of Health and Aged Care (DHAC). Where this report refers to DHAC, it should be read as including reference to the Department prior to the recent restructure.

2. The Government decided that it was necessary to develop a national and strategic approach to the planning and delivery of primary health services for Aboriginal and Torres Strait Islander peoples, to clarify roles and responsibilities within the Commonwealth — and between the Commonwealth and the States — for the delivery and funding of services, and as part of new measures to achieve change. The advantages for Aboriginal and Torres Strait Islander communities were envisaged as being an approach which reduced administrative complexity, fostered community control and accountability, and encouraged longer term planning by communities to address local health needs.

3. At the 1996 Census, 386,000 individuals self-identified as Indigenous Australians. This was a 33 per cent increase in the Indigenous population since the 1991 Census. Australian Bureau of Statistics (ABS) research indicates that:

- Aboriginal and Torres Strait Islander people have a life expectancy at birth 15-20 years less than other Australians. Their life expectancy is lower than that for residents of most countries of the world with few exceptions;
- for all causes of death combined, there are 3.5-4 times more deaths than expected among Indigenous people;
- Indigenous people are 2-3 times more likely to be hospitalised; and

- in the last 10 years, there has been little improvement in the mortality of Indigenous Australians.

4. The Commonwealth's funding of the Aboriginal and Torres Strait Islander health program has increased significantly - from $85.4 million in 1994-95, the last year of ATSIC's responsibility, to $165.6 million in 1998-99 (including transfers of $9.5 million from other programs). DHAC's research found that, for all services and all sources of funds, recurrent expenditures for and by Indigenous people were estimated at $853 million in 1995-96, some 2.2 per cent of total Australian health expenditure. Per person, total spending for and by Aboriginal and Torres Strait Islander people was $2 320, about 8 per cent higher than that for or by other Australians. The Departmental sponsored research concluded that public expenditures on the health of Indigenous Australians appear to have been very similar to those for other Australians in the same income category. However, their health status was almost certainly much worse.

5. The Department pointed to the considerable difficulties experienced in transferring Indigenous health programs from ATSIC and the establishment of the Office for Aboriginal and Torres Strait Islander Health Services (OATSIHS). Recruitment action was taking place at the same time that basic administrative systems and processes were being developed. Required staffing levels were not attained in either central or state offices until early 1996, with little continuity in program administration possible due to the small number of staff transfers from ATSIC and lack of transferability of existing management systems.

Audit objective

6. The objective of this performance audit was to form an opinion on the administrative effectiveness, efficiency and accountability of the Department of Health and Aged Care's (DHAC's) delivery of health services to the Aboriginal and Torres Strait Islander population.

Audit scope

7. The focus of the audit was the Department's implementation of its responsibility for administration of the Aboriginal and Torres Strait Islander health program. Most of this report addresses the work of OATSIHS. The Government established OATSIHS within DHAC as a focus for the Department's work in Indigenous health. Where appropriate, the report refers to other parts and programs of the Health Portfolio.

Audit methodology and criteria

8. The Australian National Audit Office (ANAO) established an Advisory Group to enable the audit team to gain a sound understanding of the complex area of Indigenous health, and to receive comments on audit findings and proposed recommendations. Audit criteria were designed to assist in the development of the audit opinion. They concerned the adequacy of DHAC's processes to implement Government policy, including the efficiency and effectiveness of its management information systems, DHAC's success in meeting performance standards and in establishing working relationships with stakeholders, and whether DHAC was accountable for the administration of the Aboriginal and Torres Strait Islander health program.

Audit conclusions

9. The ANAO found that DHAC had taken a national role in the Aboriginal and Torres Strait Islander health program; was in the process of bedding down in OATSIHS its program administration; and met the Government's and the Parliament's external accountability requirements. However, management processes could be enhanced by greater attention to allocation of program resources on the basis of need; improved data collections; clearer identification of Indigenous Australians as a special needs group in the Department's mainstream programs; clearer specification of the health outputs and outcomes or performance standards the Department expects from its programs; information systems which measure the level of its achievement of raising the health status of Aboriginal and Torres Strait Islander people; greater cooperation with ATSIC in environmental health; and provision of more information to stakeholders about the Department's role and focus.

Key findings

10. DHAC has taken both a national role and a program administration role. Both roles are discussed below.

DHAC's national role

11. DHAC has played a key role in the signing of Agreements on Aboriginal and Torres Strait Islander health (Framework Agreements) by the Commonwealth Minister for Health, Ministers for Health in the States and Territories, ATSIC and representatives of the Aboriginal community controlled primary health care sector. These Agreements are milestones in inter-agency cooperation and are a foundation for a concerted national effort to address the poor health status of Aboriginal and Torres Strait Islander people.

12. DHAC took a leading role through the Australian Health Ministers' Advisory Council (AHMAC) which led to the first ever inter-governmental agreement on national performance indicators for Aboriginal and Torres Strait Islander health.

13. Further, DHAC sponsored research into Commonwealth, total public sector and private sector expenditure on Aboriginal and Torres Strait Islander health. Such research had not been undertaken previously and is an important step in more transparent reporting by Commonwealth, State and Territory governments on their efforts in Indigenous health.

14. DHAC is participating in efforts to address the lack of an inadequate national data collection on Aboriginal and Torres Strait Islander health. Problems which are not yet solved include poor and uncertain levels of identification of Indigenous people in existing data collections, inconsistent data classification standards and data collection protocols, a general lack of guidelines or protocols concerning the ownership, usage and confidentiality of data for the exchange of information between Indigenous communities and health agencies, and little attention to the information needs of Indigenous communities

DHAC has established effective working arrangements with stakeholders. However, DHAC's and ATSIC's coordination of their programs is still at an early stage and needs to have ongoing emphasis

15. Working arrangements with stakeholders include a Joint Committee with ATSIC to co-ordinate the efforts of the DHAC Aboriginal and Torres Strait Islander health program with ATSIC's work in environmental health; an Aboriginal and Torres Strait Islander Health Council (Health Council) with representatives of stakeholders at the national level; and State Forums with stakeholder representation at the state/territory level.

16. State Forums are identifying the health needs of Aboriginal and Torres Strait Islander communities through regional planning under Framework Agreements. This is a first step towards achieving the cooperative funding of Aboriginal Health Services (AHSs) and Substance Misuse Services by Commonwealth and State/Territory governments on the basis of identified health needs.

17. DHAC's programs to improve access to health and medical services could be better integrated with ATSIC's programs to provide adequate housing, water and sewerage systems in Indigenous communities.

Co-operation between Commonwealth and State/Territory programs in Indigenous health can improve

18. There is limited reporting by Commonwealth and State/Territory programs under the Framework Agreements of:

- services provided by and funding for community controlled health services;
- the effectiveness of and improved outcomes for mainstream services; and
- linkages between community controlled and mainstream services including innovation in co-ordinated care.

19. It is too early to conclude whether the Framework Agreements, which define the roles of DHAC and other stakeholders, will be effective in addressing the ill-health of Indigenous Australians, or whether DHAC may need to adopt other approaches.

Indigenous health is more visible as a priority in mainstream health programs

20. DHAC has identified Aboriginal and Torres Strait Islander health as a priority in Public Health Outcome Agreements which have been signed with all state and territory governments except Western Australia, where negotiations are at an advanced stage. All Agreements would then have to be implemented. Indigenous health status is becoming more prominent in the performance indicators of DHAC' mainstream programs. Indigenous Australians have a comparatively low level of usage of Medicare and the Pharmaceutical Benefits Scheme (PBS). There are no performance indicators for Indigenous health usage of these mainstream programs.

For the first time, DHAC has set national targets for improvements in Indigenous health status

21. 1998-99 was the first time that DHAC had specified targets for its Indigenous health program. One indicator addresses life expectancy at birth (mortality), and has a target consistent with a 20 per cent reduction in age standardised all-causes mortality rate ratios over ten years. The ABS has advised that this approximates to a 3.7 year gain in Indigenous life expectancy by 2008-2009. The second indicator is the age standardised all-causes hospital separation rate ratio by sex (morbidity), with a target of a 20 per cent reduction over ten years.

22. Partly because of the relatively large number and recency of national performance indicators for Commonwealth and State/Territory Indigenous health programs, effective reporting by all levels of government against those indicators remains a goal to be achieved.

23. Measurement of the achievement of DHAC's cross-program goal of national leadership to raise the health status and well being of Aboriginal and Torres Strait Islander peoples remains a challenge for the Department. It will be difficult for the Department to distinguish the program's effects from the effects of other factors, such as any improvements in environmental health, and easier access to education and employment.

Program funds not distributed on a needs basis

24. DHAC does not allocate its funding to AHSs and Substance Misuse Services on the basis of the health needs of local Aboriginal and Torres Strait Islander communities. One reason is that DHAC does not have comprehensive data to identify which Indigenous communities have the greatest health needs.

25. DHAC has taken steps to measure the achievement of improvements in health status by ensuring access to effective high quality health care and population health programs. These steps include initiatives to collect data from AHSs and Substance Misuse Services on the quality and level of activity of their service delivery.

Program administration can improve

26. Following the transfer of program responsibility to DHAC, the Department maintained the continuity of funding to AHSs and Substance Misuse Services. This allowed Aboriginal and Torres Strait Islander community controlled primary health care services to operate without service reductions to clients. Subsequently, DHAC has provided AHSs and Substance Misuse Services with a predictable funding base.

27. DHAC has yet to identify the skill profiles required by AHSs to deliver primary health care services; to assess skill levels available in AHSs; to identify any skill gaps; and to develop a strategy to address those skill gaps. Administration of the Recruitment Services project was poor and required a rationale for funding, adequate support for State Offices, and the need for grant acquittals and periodic reporting.

28. Finally, DHAC is assisting the Aboriginal and Torres Strait Islander community controlled health sector to develop its capacity to manage service delivery to Indigenous communities.

Departmental response

29. The Department believed that the report provided a fair and accurate assessment of the Program. It agreed with all the recommendations except one, where it agreed with qualification.

Recommendations

The following recommendations are grouped under those relevant to the Department's national role and those relevant to improvements in program administration

A. National Role

Recommendation No.1 para. 2.21	The ANAO recommends that DHAC identify better practice in terms of program objectives, delivery mechanisms and efficient resource usage in Indigenous health programs in comparable countries and adopt, where justified, to improve overall program performance. **DHAC:** Agreed
Recommendation No.3 para. 4.22	The ANAO recommends that DHAC establish a suitable timeframe for the implementation of funding AHSs and Substance Misuse Services on the basis of the health needs of the Aboriginal and Torres Strait Islander communities to whom they deliver services. **DHAC:** Agreed
Recommendation No.4 para. 4.52	The ANAO recommends that, as part of the health needs-based planning process, DHAC identify, in conjunction with stakeholders: • a means by which a total funding picture of AHSs can be obtained and revised on a regular basis for the information of decision-makers; and • the most effective methods of funding Aboriginal Health and Substance Misuse Services. **DHAC:** Agreed
Recommendation No.6 para. 4.85	The ANAO recommends that DHAC collect and analyse information from funded organisations, which would enable it to report effectively against relevant national and departmental performance indicators. **DHAC:** Agreed
Recommendation No.8 para. 5.37	The ANAO recommends that DHAC and ATSIC more effectively coordinate their primary and environmental health programs by sharing data on the level, nature and geographical location of their expenditures. **DHAC:** Agreed **ATSIC:** Agreed

Recommendation No.9 para. 5.65

The ANAO recommends that DHAC:

- emphasise in State Forums the importance of a focus on health status outcomes as a key component of regional planning;
- take action, through its State Forum representatives, to establish a timeframe for the implementation of needs-based funding;
- examine the feasibility of providing suitable incentives to stakeholders to complete regional planning; and
- where the progress of regional planning is likely to unduly delay the health needs of the Aboriginal and Torres Strait Islanders being identified, address other suitable options and take action to identify those health needs as a matter of priority.

DHAC: Agreed with qualification

Recommendation No.10 Para. 5.71

The ANAO recommends that DHAC, in its national role, work with other stakeholders through State Forums to identify models of best practice in primary health care which could be applied to relevant programs.

DHAC: Agreed

Recommendation No.11 para. 5.76

The ANAO recommends that, as part of its national role, DHAC meet its reporting obligations under the Framework Agreements and work with state/territory health agencies to assist them to fulfil their reporting obligations.

DHAC: Agreed

B. Program Administration

Recommendation No.2 para. 3.25

The ANAO recommends that DHAC measure the achievement of its Aboriginal and Torres Strait Islander Health Program objective of raising health status by ensuring access to effective high quality health care and population health programs.

DHAC: Agreed

Recommendation No.5 para. 4.65

The ANAO recommends that DHAC:

- follow-up late financial returns and review them in a timely fashion in accordance with departmental procedures; and
- assess this review activity across State Offices for greater program effectiveness.

DHAC: Agreed

Recommendation No.7 para. 4.116

The ANAO recommends that DHAC:

- use its Workforce Modelling project to identify the skill profiles required by AHSs to deliver primary health care to Aboriginal and Torres Strait Islander communities;
- assess the level of skills available in AHSs and any skill gaps; and
- identify an appropriate strategy to address any skill gaps.

DHAC: Agreed

Recommendation No.12 para. 6. 27

The ANAO recommends that DHAC coordinate the efforts of OATSIHS and mainstream programs in order to deliver the most effective and efficient funding to AHSs, including in relation to streamlining their accountability arrangements to make them more effective.

DHAC: Agreed

Audit Findings and Conclusions

1. Introduction

This Chapter outlines the subject of the audit, audit objectives, how the audit was conducted, and the audit opinion.

Background to the audit

1.1 This audit report addresses the implementation by the Commonwealth Department of Health and Aged Care (DHAC) of its responsibility for the Aboriginal and Torres Strait Islander health program. In 1995, the Government transferred responsibility for the Aboriginal and Torres Strait Islander health program from the Aboriginal and Torres Strait Islander Commission (ATSIC) to the then Department of Human Services and Health for the five year period from 1995-2000. The current Commonwealth Government (elected in 1996), maintained Health Portfolio responsibility for the program through the renamed Department of Health and Family Services (DHFS). In 2000, there is expected to be a review of program responsibility. Administrative arrangements effective 21 October 1998 place the Aboriginal and Torres Strait Islander health program in DHAC. Where this report refers to DHAC, it should be read as including reference to the Department prior to the recent restructure.

1.2 At the 1996 Census, 386 000 individuals self-identified as Indigenous Australians. This was a 33 per cent increase in the Indigenous population since the 1991 Census. Australian Bureau of Statistics (ABS) research indicates that:

- Aboriginal and Torres Strait Islander people have a life expectancy at birth 15-20 years less than other Australians. Their life expectancy is lower than for most countries of the world with few exceptions;
- for all causes of death combined, there are 3.5-4 times more deaths than expected among Indigenous people;
- Indigenous people are 2-3 times more likely to be hospitalised; and
- in the last 10 years, there has been little improvement in the mortality of Indigenous Australians.

1.3 The Commonwealth's funding of the Aboriginal and Torres Strait Islander health program has increased significantly — from $85.4 million in 1994-95, the last year of ATSIC's responsibility, to $165.6 million in 1998-99 (including transfers of $11.5 million from other programs). DHAC's research found that, for all services and all sources of funds, total health expenditures for and by Indigenous people were estimated at $853 million in 1995-96, some 2.2 per cent of total Australian health expenditure. Per person, total spending for and by Aboriginal and Torres Strait Islander people was $2 320, about 8 per cent higher than that for or by other Australians. The Departmental sponsored research concluded that public expenditures on the health of Indigenous Australians appear to have been very similar to those for other Australians in the same income category. However, their health status was almost certainly much worse.[1]

1.4 The Government's transfer of responsibility for Indigenous health programs required a transfer of resources for health programs and administration from ATSIC to DHAC. DHAC built its administrative capacity for delivery of those programs from a small base. The Government established OATSIHS within DHAC as a focus for the Department's work in Indigenous health.

1.5 Clearly, DHAC had much experience in the design and delivery of health programs for the national population. It was required to focus that experience on the delivery of programs to a small population with the most severe morbidity and mortality rates of all races comprising the Australian population.

Aboriginal and Torres Strait Islander health

1.6 The health status of Aboriginal and Torres Strait Islander people is widely reported as being well below that of other Australians.[2] Appendix 1 provides some detailed information from recent research undertaken on the size of the Indigenous population and notable indicators of their health status. In summary, the research showed that in comparison to other Australians:

- Aboriginal and Torres Strait Islander people have a life expectancy[3] at birth 15-20 years lower;

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1 Department of Health and Family Services, Australian Institute of Health (AIHW) and National Centre for Epidemiology and Population Health (NCEPH), ANU, Expenditures on Health Services for Aboriginal and Torres Strait Islander People. AIHW Catalogue No HWE 6, May 1998, Canberra.

2 ABS, 1997b, *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples,* Cat. No. 4704.0, ABS, Canberra.

3 Life expectancy at birth represents the average number of years a newborn baby could be expected to live if the mortality rates of today were to continue throughout that baby's life.

- for all causes of death combined there were 3.5-4 times more deaths than expected among Indigenous people; and
- Indigenous people are 2-3 times more likely to be hospitalised.

1.7 The research also identified that in the last 10 years there has been little improvement in the mortality of Indigenous Australians and life expectancy for Indigenous people was lower than for most countries of the world with a few exceptions. There was some evidence that Indigenous infant mortality rates were declining in some jurisdictions, however, those rates remain higher than for non-indigenous infants.

What is meant by Aboriginal and Torres Strait Islander health?

1.8 The National Aboriginal Community Controlled Health Organisation (NACCHO) provided a short description of Aboriginal health in a recent submission to a Parliamentary Inquiry into Indigenous health[4]. It stated that:

> *Improving Aboriginal health is not just about improving the physical well being of an individual. It is about working towards the social, emotional, and cultural well being of the whole community in which each individual is able to achieve their full potential as a human being.*

1.9 Other descriptions highlight the interaction of a number of factors in explaining the complex issue of Aboriginal health. For example, DHAC in its submission to the same Inquiry commented that:

> *there are a number of inter-related factors which impact on poor health among Indigenous people, and its persistence. These include: socio-economic factors, social and cultural factors resulting from the history of dispossession, environmental factors, problems with accessing good quality health care and specific risk factors. The relationship between these factors is complex, and current evidence does not allow us to address the relative importance of one factor over another. It is likely that different determinants may be more or less significant for different health problems*[5].

1.10 In its submission, the Department went on to suggest that caution was needed in attributing excess morbidity or mortality amongst Indigenous people to any one cause, and that to focus on one set of factors to the exclusion of others would be unlikely to lead to effective action. Further, the Department suggested that determinants of poor Indigenous health need to be seen as complex and multi-factorial and that to make a significant impact on health status, there was a need to address all of them.

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4 NACCHO Submission to the House of Representatives Standing Committee on Family and Community Affairs Inquiry Into Indigenous Health, Volume 1 of Submissions, December 1997.

5 DH&FS Submission, Volume 1, December 1997.

The Commonwealth's past role in Indigenous health

1.11 The Commonwealth's role in Indigenous health has taken different forms and the responsible Commonwealth agency has changed on a number of occasions. Appendix 2 provides some detail on the Commonwealth's role. In summary:

- prior to the 1967 referendum, the Commonwealth was impeded by the Constitution from greater involvement in Aboriginal health;
- State government health departments began (in the early 1970s) to establish Aboriginal health units to receive and make use of Commonwealth funds;
- Aboriginal community controlled organisations also began to emerge in the early 1970s (the Aboriginal Medical Service in Redfern in 1971 and the Victorian Aboriginal Health Service in Fitzroy soon after), and made strong claims for financial and other government support;
- in 1984 responsibility for Aboriginal health was transferred from the Department of Health to the Department of Aboriginal Affairs (DAA); and
- in 1990 Commonwealth and State Ministers endorsed a National Aboriginal Health Strategy.

Transfer of responsibility from ATSIC to the Department

1.12 Prior to the 1995 Budget initiatives the poor health status of the Aboriginal and Torres Strait Islander population had been addressed through the implementation of the National Aboriginal Health Strategy (NAHS) in 1990[6]. An evaluation of the NAHS was conducted in 1994[7]. That evaluation reported that there was little evidence of where the NAHS funding had been spent and it identified minimal gains in Aboriginal health.

[6] National Aboriginal Health Strategy Working Party 1989, A National Aboriginal Health Strategy, NAHWP, Canberra.

[7] Aboriginal and Torres Strait Islander Commission 1994, The National Aboriginal Health Strategy : An Evaluation, ATSIC, Canberra.

1.13 The NAHS Evaluation Report was the most recent in a long line of reports on Aboriginal and Torres Strait Islander health[8]. These included the second annual report (1994) of the Aboriginal and Torres Strait Islander Social Justice Commissioner, recommendations of the Royal Commission into Aboriginal Deaths in Custody (1991) and a 'The Last Report' by the New South Wales Task Force on Aboriginal health (1990). Following the NAHS Evaluation, the then Federal Government announced some major initiatives for Aboriginal and Torres Strait Islander health in its 1995 Budget.

1.14 The package of initiatives was based on one very significant change in government policy, that of the transfer of responsibility for primary health care for Aboriginal and Torres Strait Islander people from ATSIC to the then Department of Human Services and Health. In conjunction with that change was a major focus on bilateral arrangements with stakeholders, an assessment of health needs, attention to recruitment and training of Aboriginal Health Service (AHS) health personnel and measures to address specific health problems. ATSIC maintained responsibility for the Commonwealth's funding of environmental health, comprising infrastructure (including water, waste disposal and power generation) and housing.

1.15 The Government's approach to the initiatives was two pronged in that as well as addressing health service delivery through adequate funding of AHSs, a major focus was expected to be equitable access to mainstream health services for Aboriginal and Torres Strait Islander people. In announcing the 'New Commitment to Aboriginal Health'[9], the then Federal Minister for Human Services and Health referred to the package of initiatives as setting the direction for long term change and that:

- Aboriginal health should not be a sideline issue;
- the Department of Human Services and Health should be equally accountable for the health and well being of Aboriginal and Torres Strait Islander Australians; and
- to achieve real improvements to the health and well being of Aboriginal and Torres Strait Islander people there was a need to ensure equitable access to health services.

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8 These and other notable reports are referenced in Innovation without change? : Commonwealth involvement in Aboriginal health policy, Gardiner-Garden J. 1994, Current issues brief no. 12, department of the Parliamentary Library, Canberra

9 Media Release - Budget 1995-96, Dr Carmen Lawrence, Minister for Human Services and Health, 9 May 1995, CL 139/95.

1.16 The current Commonwealth Government has continued to support the transfer of responsibilities from ATSIC to the Department. In addition, the 1998-99 Budget announced the continuation of funding of primary health care services beyond 2001. However, the Government has maintained the requirement for a review of the effectiveness of program delivery through the Health Portfolio in 1999-2000.

Expenditure for Aboriginal and Torres Strait Islander health

1.17 Table 1.1 sets out the Commonwealth's resources for the Aboriginal Health Program from 1994-95, the last year of ATSIC management, to 1998-99 under the responsibility of the Department.

1.18 The figures in the Table represent the total funding for the program as published in the documents referred to in Note 1 to the Table. This includes funding paid directly to Aboriginal Health and Substance Misuse Services as well as capital works funding for projects managed by third parties on behalf of the services.

Table 1.1
Aboriginal and Torres Strait Islander Health Program[1]

	ATSIC 1994-95	OATSIHS 1995-96	OATSIHS 1996-97	OATSIHS 1997-98	OATSIHS 1998-99 $m (est)
Appropriation Bill No 1					
Health Services Program	69.2	97.1	95.5	109.6	131.3
Substance abuse services	15.5	17.7	17.1	17.3	17.5
Total Program Costs	**84.7**	**114.8**	**112.6**	**126.9**	**148.8**
Total Running Costs	**0.7**	**5.8**	**9.2**	**8.9**	**9.6**
Total Appropriation Bill No 1	**85.4**	**120.7**	**121.8**	**135.8**	**158.4**
Appropriation Bill No 2					
Health infrastructure for Indigenous communities	0	0	0	0	1.2
Combatting infectious diseases of Indigenous people	0	0	0	0	6.0
Total Appropriation Bill No 2	**0**	**0**	**0**	**0**	**7.2**
Total Appropriations	**85.4**	**120.7**	**121.8**	**135.8**	**165.6**
Transfers from other programs		-.8[2]	-2.0[2]	-7.8[3]	-7.8[3] -1.7[4]
Total Appropriations (net of transfers)	**85.4**	**119.9**	**119.8**	**128.0**	**156.1**
Staff[5]	7	71	102	105.7	110.6

Notes:
1. This Table has been prepared by the ANAO from several sources namely, the ATSIC 1994-95 Annual Report, the DHFS 1996-97 Annual Report and the DHFS 1998-99 Portfolio Budget Statements.
2. Transfer from Commonwealth Dental Program.
3. Transfer from Public Health Program for National Sexual Health Strategy.
4. Transfer from National Rural Health Support Services Program for National Eye Health Strategy.
5. OATSIHS staff number fluctuations relate to the development of the program, particularly the specific health issues programs, and recruitment of administrative staff to the State offices.

1.19 Direct Commonwealth funding for the Aboriginal Health Program has increased from $85.4 million in 1994-95 under ATSIC to an estimated $165.6 million in 1998-99 under the Department. Of the 1998-99 appropriation, $9.5 million were funds transferred from other programs, notably the National Sexual Health Strategy and the National Eye Health Strategy. The increase of $70.7 million in program funding in four years or the increase of $80.2 million if funds transferred from all other programs are included can be attributed to several notable components, namely:

- a $30 million increase concurrent with the move from ATSIC to DHAC. This included $15.5 million additional funding for new policy for Aboriginal and Torres Strait Islander primary health programs, and a once off $6.5 million roll-over from ATSIC;
- a $4.3 million increase in funding for Aboriginal health, including $3 million in 1998-99 to reflect population growth identified in the 1996 ABS Census;
- a $35.5 million increase for new policy; including $7.2 million for improving access of Aboriginal people to primary care in remote areas, $10.1 million for preventive health, $8.7 million for the Government's response to the National Inquiry into the separation of Aboriginal and Torres Strait Islander children from their families "Bringing them Home", and the remainder includes the transfer of sexual health, and eye health programs from within the Health Portfolio to the OATSIHS;
- an overall $8.9m increase in running costs. ATSIC's running costs for the program only related to central office and did not include a proportion of regional office running costs. OATSIHS has a much larger program than ATSIC, including more staff in the States and Territories specifically assigned to Aboriginal and Torres Strait Islander health and specialist health issue programs. OATSIHS advised that the running costs increase from 1995-96 to 1996-97 represents appropriations made specifically for the ATSIC transfer and related new policy, and that additional resources were internally provided to build OATSIHS in areas of mainstream links and policy development plus transfers of functions to OATSIHS.

1.20 OATSIHS' central office roles and responsibilities include to:

- advise the Minister on planning, priorities and performance of OATSIHS and to oversight the provision of accurate information and advice;
- develop policy in consultation with State/Territory and community organisations to ensure efficient and effective policy implementation;
- develop procedures and guidelines for project administration;

- monitor and report on programs;
- develop and monitor a range of standards, agreements and protocols with other agencies; and
- maintain funding records systems and prepare reports as required.

1.21 OATSIHS' State/Territory based staff are primarily responsible for monitoring and supporting the Aboriginal and Torres Strait Islander health and related services funded by the Department. They also have a liaison role with communities and in State/Territory planning and funding issues. In particular, project officers are the contact officers with, and provide support for, the funded organisations[10].

Objective and scope of the audit

1.22 The objective of the performance audit of Aboriginal and Torres Strait Islander Health Care was to evaluate the administrative effectiveness, efficiency and accountability of DHAC's delivery of health services to the Aboriginal and Torres Strait Islander population via mainstream and supplementary health services.

1.23 The focus of the audit was the Department's implementation of the 1995-96 Federal Budget initiatives which accompanied the transfer of responsibility for the Aboriginal and Islander health program from ATSIC. Two initiatives were announced in 1996-97 which developed the Department's role: additional health services in isolated communities which did not have access to health care; and implementation of coordinated care trials, involving state/territory governments. The scope of this audit predominantly covers the Office of Aboriginal and Torres Strait Islander Health Services (OATSIHS). Reference is made to the work of other parts of the Department and of the Health Insurance Commission (HIC) where necessary.

1.24 While DHAC retains responsibility for Commonwealth primary health care programs, ATSIC has responsibility for environmental health programs. The latter include Commonwealth funding of water supplies, sewerage systems and housing for Indigenous Australians. The relevant ATSIC program is the Community Housing Infrastructure Program (CHIP). ANAO has commenced an audit of CHIP, and will report to Parliament on the program in mid-1999.

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[10] OATSIHS has a Business Plan which details the Aboriginal and Torres Strait Islander Health Program's aim, vision and objectives. OATSIHS' policy and procedures are set out in the OATSIHS Program Management Guidelines manual. This is a publicly available document which was released in January 1997. In discussions with project officers and funded organisations the ANAO was informed that the guidelines were considered a useful reference. OATSIHS advised the guidelines were revised and issued in March 1998.

Audit methodology

1.25 The ANAO established an Advisory Group to enable the audit team to gain a sound understanding of the complex area of Aboriginal and Torres Strait Islander health, and to receive comments on audit findings and proposed recommendations. The Advisory Group comprised representatives of the following stakeholders in Aboriginal and Torres Strait Islander health:

- ATSIC;
- National Aboriginal Community Controlled Health Organisation, (NACCHO);
- Heads of Aboriginal Health Units (HAHU) in State/Territory Departments of Health;
- the Australian Medical Association (AMA); and,
- a representative of DHAC joined the Group as an observer.

1.26 In addition, a senior Commonwealth Government administrator with extensive experience in Aboriginal Affairs and Aboriginal health was invited to join the Advisory Group.

1.27 On the Advisory Group's formation, members were asked to provide comments on the audit, including its scope. The Advisory Group met in October 1997 to offer comments and to discuss issues papers prepared by the audit team. The draft audit report was provided to members for comment in 1998. A consultant, Mr C. Conybeare, provided comments on an earlier draft of the audit report.

1.28 Audit fieldwork was conducted between May 1997 and February 1998 and involved the following methods of inquiry:

a) interviews with key stakeholders, including:

- officers of DHAC in Canberra, State Offices in Sydney, Brisbane, Darwin and Perth, and Regional Offices in Townsville and Alice Springs;
- officers of ATSIC in Canberra, and State Offices in Sydney, Brisbane, Darwin and Perth;
- chief executive officers and/or senior personnel at selected Aboriginal Health Services (AHSs) and Substance Misuse Services in New South Wales, Queensland, the Northern Territory and Western Australia. A total of 19 Services were visited;
- NACCHO which represents AHSs;
- NACCHO affiliates in New South Wales, Queensland, the Northern Territory and Western Australia; and

- Aboriginal Health Units in State/Territory Departments of Health in Sydney, Brisbane, Darwin and Perth.

b) a review of relevant DHAC documents and files in Canberra and in State/Territory offices;

c) a review of relevant publications pertaining to Aboriginal and Torres Strait Islander health, particularly including data on the health status of the Aboriginal and Torres Strait Islander population; and

d) discussions with recognised experts in Aboriginal Affairs and particularly Aboriginal health, namely the Aboriginal and Torres Strait Islander Health and Welfare Information Unit[11], the Centre for Aboriginal Economic Policy Research (CAEPR) and the National Centre for Epidemiology and Population Health (NCEPH). Their advice assisted with the content and presentation of the status of Aboriginal and Torres Strait Islander health depicted in this Chapter.

Audit criteria

1.29 Audit criteria assist development of an audit opinion. As part of this audit, criteria were developed to consider whether:

- DHAC had effective and efficient processes to implement Government policy for Aboriginal and Torres Strait Islander health;
- DHAC had implemented effective and efficient information systems which measured its achievement against the objective of raising the health status of Aboriginal and Torres Strait Islander people;
- DHAC was meeting performance standards set by the Government and by the Department itself in relation to equity, access and service delivery of health services to Aboriginal and Torres Strait Islander people;
- DHAC had established effective working arrangements with stakeholders; and
- DHAC was accountable for the administration of the Aboriginal and Torres Strait Islander Health program.

1.30 The audit was conducted in accordance with ANAO Auditing Standards, and cost $486 000.

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[11] This Unit is part of the ABS National Centre for Aboriginal and Torres Strait Islander Statistics. The Unit is a joint program of the ABS and AIHW. It receives funding from DHAC as part of the Commonwealth Government's efforts to improve statistics and information about Aboriginal and Torres Strait Islander health following the 1994 evaluation of the National Aboriginal Health Strategy.

Audit conclusion

1.31 The ANAO found that DHAC had shown leadership in the Aboriginal and Torres Strait Islander health program; was in the process of bedding down in OATSIHS its program administration; and met the Government's and the Parliament's external accountability requirements. However, management processes could be enhanced by greater attention to allocation of program resources on the basis of need; improved data collections; clearer identification of Indigenous Australians as a special needs group in the Department's mainstream programs; clearer specification of the health outputs and outcomes or performance standards the Department expects from its programs; information systems which measure the level of its achievement of raising the health status of Aboriginal and Torres Strait Islander people; greater cooperation with ATSIC in environmental health; and provision of more information to stakeholders about the Department's role.

2. Departmental Objectives and Role in Indigenous Health

This Chapter comments on the Department's objectives for Aboriginal and Torres Strait Islander health, its role and that of other stakeholders in Indigenous health and how it might learn from efforts in other countries to improve Indigenous health.

Departmental objectives

2.1 The 1997-98 Corporate Plan includes Aboriginal and Torres Strait Islander Health and Well Being as a Cross Program Key Result Area for departmental programs. It is one of five such cross program key result areas. The associated goal is:

> *To provide national leadership in the development and implementation of policies and programs to raise the health status and well being of Aboriginal and Torres Strait Islander peoples.*

2.2 The strategies to address this goal include reference to:

- improve the support, quality and accountability of funded organisations;
- improve accountability of mainstream programs and services;
- develop strategies to unite the effort of funded organisations and mainstream services to address the poor health status of Aboriginal and Torres Strait Islanders;
- forge cross program linkages in key areas of the Department, and
- play a leadership role with other Commonwealth agencies and State and Territory agencies.

2.3 This cross program approach embraces all the mainstream services and places responsibility for addressing the health status of Aboriginal and Torres Strait Islander people on all departmental programs, rather than just being perceived as an Office for Aboriginal and Torres Strait Health Services (OATSIHS) responsibility. This has raised the profile of Aboriginal and Torres Strait Islander health within DHAC.

2.4 What remains is for DHAC to identify the results, impact and consequences of its strategies and report its performance in addressing this cross program goal in Aboriginal and Torres Strait Islander health.

Program objectives

2.5 DHAC has a specific Aboriginal and Torres Strait Islander Health program. Its 1998-99 objective is[12]:

> *To raise the health status of Aboriginal and Torres Strait Islander peoples by ensuring access to effective high quality health care and population health programs.*

2.6 In line with the cross-program goal, the program objective includes a strong reference to DHAC's aims to raise the health status of Aboriginal and Torres Strait Islander peoples. However, DHAC is only one of several stakeholders in raising the health status of Indigenous people. Other major stakeholders are the State/Territory governments and the health care providers, including Aboriginal Health Services (AHSs) which directly deliver health care services to Aboriginal and Torres Strait Islander communities. In addition, there are other factors affecting Indigenous health such as living conditions (environmental health), employment and education, each of which may also involve different government agencies. To distinguish the program's effect on Indigenous health status from the efforts of other stakeholders and effects of these other factors has not been achieved to date and therefore will be a challenge for DHAC in 1998-99.

2.7 The program's objective is not specific regarding what is meant by high quality health care nor does it include a target for achievement. It is unclear whether high quality simply means a higher standard of primary and secondary health care than what many Indigenous Australians presently receive, or whether it means the same quality of health care as other Australians receive.

2.8 To enable DHAC to demonstrate its achievements in administering the Aboriginal and Torres Strait Islander health program, there is a need for clarification in the program objective of the desired results, impact and consequences in a form that can be monitored and assessed. This is in line with the Government's emphasis on outputs and outcomes in public sector reporting of program performance.

2.9 DHAC's program description of its desired outputs and outcomes in its 1998-99 Portfolio Budget Statements is a move towards such clarification.

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[12] Commonwealth of Australia, Portfolio Budget Statements 1998-99, Health and Family Services Portfolio, Budget Initiatives and Explanations of Appropriations 1998-99, Budget Related Paper No. 1.8, AGPS, Canberra, 1998.

Roles of the Commonwealth, States/Territories and other stakeholders

2.10 DHAC's role is to fund health services to the Aboriginal and Torres Strait Islander population largely through funding other organisations, such as state and territory health departments and AHSs. State and territory health departments play an important and more direct role in the delivery of Aboriginal and Torres Strait Islander health services than DHAC. On a financial basis, state and territory governments contribute approximately 50 per cent of total public sector expenditure as shown in the following Table 2.1.

Table 2.1

Net Public Expenditures on Health Services to Indigenous people, by Level of Government, 1995-96. [13]

Source	$m	%
State/local	**420**	**51.9**
Commonwealth		
-direct through AHSs	90	11.1
-indirect through		
Medicare agreements	222	27.4
Medicare/PBS benefits	42	5.1
Other programs	36	4.5
Sub-Total Commonwealth	**390**	**48.1**
Total	**810**	**100.0**

2.11 To pursue the Commonwealth's objectives, between 1996 and 1998 the Commonwealth Minister for Health signed Framework Agreements on Aboriginal and Torres Strait Islander Health with his counterparts in the states and territories. Other signatories to the Agreements are ATSIC and representatives of the Indigenous community controlled primary health care network. These Agreements are discussed in more detail in Chapter 5.

2.12 These Agreements, generally referred to by DHAC as Framework Agreements, identify the roles of the Commonwealth and the States/ Territories as follows:

> *Primacy for the delivery of mainstream services resides with the State. The Commonwealth Department of Health and Family Services is responsible*

[13] Department of Health and Family Services, Australian Institute of Health (AIHW) and National Centre for Epidemiology and Population Health (NCEPH), ANU, Expenditures on Health Services for Aboriginal and Torres Strait Islander People. AIHW Catalogue No HWE 6, May 1998, Canberra. Totals are rounded.

for administering the Medical Benefits Scheme and the Pharmaceutical Benefits Scheme. For a range of health and health related services, the roles and responsibilities of the Commonwealth Department of Health and Family Services and the (State) Department of Health have evolved over time and are encapsulated in a number of agreements.

2.13 Other clauses identify that the Commonwealth and the States/Territories are jointly responsible for responding to the health needs of all Australians, including Aboriginal and Torres Strait Islander peoples and have complementary roles in doing so. Specifically, the Agreements refer to:

- the Commonwealth having a leading role in the development of national policy whilst working in partnership with the States/Territories;
- ATSIC having a responsibility under the ATSIC Act (1989) for monitoring the effectiveness of programs for Aboriginal and Torres Strait Islanders including programs conducted by bodies other than the Commission; and
- States and Territories having primary responsibility for the provision of and, in conjunction with the Commonwealth, funding hospital services, mental health and other health services.

2.14 Identification of such joint responsibility and complementary roles in Indigenous health leaves some uncertainty as to the extent of accountability for service delivery each level of government has to the Aboriginal and Torres Strait Islander population.

2.15 The Agreements also recognise local Aboriginal and Torres Strait Islander community control as a culturally valid means for delivering Aboriginal and Torres Strait Islander specific health and substance misuse services. Further, the Aboriginal and Torres Strait Islander community controlled health and substance misuse services are specifically identified as providing a legitimate form of health care and having a responsibility, as do mainstream health care services, for the provision of a range of appropriate and effective health services to Aboriginal and Torres Strait Islander communities. Such joint responsibility does not translate always to a complementary role between community controlled and mainstream services, including those of state governments, with the result that there is scope for duplication of service delivery.

2.16 The Department commented in its Submission to the Inquiry into Indigenous Health[14] that:

> *Approaches which have focused on clearly delineating roles and responsibilities have not facilitated significant improvements in Aboriginal health. As a consequence the current Commonwealth approach has shifted to focus on the importance of formally acknowledging and committing to shared responsibility and partnership in bringing about improvements in the health of Aboriginal and Torres Strait Islanders. This approach draws on the collaborative principles articulated in the* National Aboriginal Health Strategy *(1989).*

2.17 It remains to be seen whether, in practice and flowing from the Framework Agreements, the collective efforts of the Commonwealth, the States/Territories and the community controlled sector are fully effective in implementing initiatives to address the ill health of the Aboriginal and Torres Strait Islander population where roles are not clearly defined. This is an area which will need to be kept under review by DHAC and addressed prior to the expiration of the current Agreements and as part of negotiation of further Agreements.

Indigenous health in other countries

2.18 The all causes mortality rate for Australia's Indigenous population is twice as high as the Maori rate, 2.3 times the United States Indigenous rate and 3.1 times the total Australian rate. The Maori death rate declined by 44 per cent between 1974 and 1994, and the United States Indigenous rate by 30 per cent in the same period. In contrast, there was no significant reduction in the death rate for Australia's Indigenous population between 1985 and 1995[15].

2.19 DHAC indicated that it had made some study of the role in Indigenous health of national health agencies in the above countries. However, DHAC was unable to identify lessons it had learned about the success of health programs which the respective governments promoted for Indigenous minorities. The ANAO considers that there would be value in DHAC reviewing the approaches of health agencies in the United States, Canada and New Zealand to determine what combination of program objectives, resources, program administration and delivery, and action in other sectors such as employment and education, led to improvements in Indigenous health in those nations.

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[14] Department of Health and Family Services Submission to the House of Representatives Standing Committee on Family and Community Affairs Inquiry into Indigenous Health, Canberra, 1997, page 30.

[15] AMA, Public Health Association of Australia Inc., Submission to the House of Representatives Standing Committee on Family and Community Affairs Inquiry into Indigenous Health, Canberra, 1997.

2.20 Such a review may also involve state and territory government health agencies as part of action to address joint responsibilities for improving the health status of Aboriginal and Torres Strait Islander people.

Recommendation No. 1

2.21 The ANAO recommends that DHAC identify better practice in terms of program objectives, delivery mechanisms and efficient resource usage in Indigenous health programs in comparable countries and adopt, where justified, to improve overall program performance.

DHAC Response

2.22 Agreed. The Department has, and will continue, to study and learn from the experience of indigenous health programs in countries like the US, Canada and New Zealand, and monitor its significance to policy development and service delivery within the Australian context. However, any international comparison must take account of the differences in Federal-State relations, resource allocations, the considerably earlier development of indigenous health policy and infrastructure, and the differences in the relative size and definition of indigenous populations in these countries.

Conclusion

2.23 DHAC's current objective for the Aboriginal and Torres Strait Islander health program and its cross program goal for Indigenous health both have an aim to raise the health status of Aboriginal and Torres Strait Islander peoples. Agreements between the Commonwealth and the States/ Territories identify joint responsibilities and complementary roles in addressing the health needs of all Australians, including Aboriginal and Torres Strait Islander peoples.

2.24 There is a need for clarification in the program objective of the desired results, impact and consequences in a form that can be monitored and assessed. This is in line with the Government's emphasis on outputs and outcomes in public sector reporting of program performance.

2.25 It is too early to determine whether the Framework Agreements wil be effective in addressing the ill-health of Indigenous Australians, or whether DHAC must adopt other roles. The Commonwealth's funding of the Aboriginal and Torres Strait Islander health program has increased significantly — from $85.4 million in 1994-95, the last year of ATSIC's responsibility, to $165.6 million in 1998-99 (including transfers of $9.5 million from other programs). DHAC's research found that, for all services and all sources of funds, total health expenditures for and by Indigenous people were estimated at $854 million in 1995-96, some 2 per cent of total Australian health expenditure. DHAC should review strategies implemented in other countries to improve the health status of their Indigenous peoples in order to improve Australian health programs.

3. Data and Performance Information

This Chapter identifies the difficulties that the Department confronts in measuring the level of its achievement in raising the health status of Aboriginal and Torres Strait Islander people and makes recommendations to address those difficulties.

National Census

3.1 At the 1996 Census, 386 000 individuals self-identified as Indigenous Australians. This 33 per cent increase in the Indigenous population since the 1991 Census was very high and unexpectedly so[16]. This rapid population growth was faster in urban than in rural and remote areas. The 1996 Census showed that 37 per cent of Indigenous Australians lived in urban areas, 34 per cent in rural areas and 29 per cent in remote areas.

National data on Indigenous health

3.2 In 1997, the Australian Bureau of Statistics (ABS) and the Australian Institute of Health and Welfare (AIHW) cooperated to analyse the quality of data on Indigenous health. The resulting report highlighted the importance of a concerted national effort to improve data[17]. Specifically, the ABS-AIHW review highlighted the main deficiencies with current health data at the national level as follows:

- poor and uncertain levels of identification of Indigenous peoples in existing collections;
- inconsistent data classification standards and data collection protocols;
- limited systematic efforts towards validating data and quality control mechanisms;
- a general lack of guidelines or protocols concerning the ownership, usage and confidentiality of data — for the exchange of information between Indigenous communities and health services and other agencies;

[16] Taylor, J., Changing numbers, changing needs? A preliminary assessment of Indigenous population growth 1991-96, Centre for Aboriginal Economic Policy Research, Australian National University, Discussion Paper, No. 143/1997, ANU, Canberra, 1997.

[17] Aboriginal and Torres Strait Islander Health and Welfare Information Unit. A joint program of the Australian Bureau of Statistics and the Australian Institute of Health and Welfare, Aboriginal and Torres Strait Islander Health Information. This Time Let's Get It Right. Final Report to the Australian Health Ministers' Advisory Council, October 1997.

- little attention to the information needs of Indigenous communities;
- a general dearth of appropriate information management skills amongst community health staff in both mainstream and community-controlled services;
- a reluctance and few mechanisms to share relevant data between levels in the health system, and also between agencies at the same level in health systems; and
- little appreciation, with some exceptions, amongst communities and services of the potential power of information and how it can be used to effect change and to generate resources.

3.3 The report identified the importance of national leadership in data collection, and highlighted the key role of the Department in conjunction with AIHW and ABS. The report and its recommendations was reviewed in October 1997 by the Australian Health Ministers' Advisory Council (AHMAC), and was being considered for public release.

3.4 DHAC has previously indicated that it is aware of these problems. For example, its 1996-97 Annual Report included a number of comments by mainstream program areas regarding a lack of data and/or management information for the Aboriginal and Torres Strait Islander population in relation to:

- the inadequate identification of Aboriginality across all data sources available to the Public Health Division including data for measuring access, use and service provision;
- no data being available on the level of satisfaction of Aboriginal and Torres Strait Islander people with the administration of Medicare; and
- not being possible to report on an equity target for mental health, which included Aboriginal and Torres Strait Islander people as a special needs group, due to fully validated data not yet having been provided by state and territory governments and the AIHW.

3.5 The ANAO recognises that improvements in the quality of Indigenous health data are crucial to enable DHAC to monitor health status, evaluate health programs, and measure achievements in addressing the poor health status of Aboriginal and Torres Strait Islander peoples. The ANAO also appreciates that other stakeholders, particularly the States and Territories, have the major role in taking action to improve the quality of Indigenous health data. However, DHAC has identified for itself a national leadership role in Indigenous health and this includes in relation to health data.

3.6 The ANAO found that DHAC has taken action to address problems in the adequacy of the national data collection in Indigenous health, including, working with other agencies, such as ABS, and the collection of data from AHSs and Substance Misuse Services. The ANAO considers that DHAC's involvement will need to be maintained for significant improvements in data quality and quantity to be achieved. However, such improvements will require the continued support and participation of the other stakeholders, particularly the States and Territories, and service delivery agencies such as AHSs and Substance Misuse Services.

OATSIHS financial data

3.7 In 1995-96 and in 1996-97, DHAC distributed $114.8 million and $112.6 million respectively through the Office of Aboriginal and Torres Strait Island Health Services (OATSIHS). The ANAO could not obtain a clear idea from any published source of how these funds had been distributed. Therefore, the ANAO requested from OATSIHS details of the distribution of this 1995-96 and 1996-97 funding. This data was recorded on financial management systems with limited financial and analytical capacity, inherited from the program's early days in the Department. It took several months for OATSIHS to produce data that could be reconciled back to total program funding as reported in DHAC annual reports.

3.8 The Department initiated planning in 1996/97 of a computer application tailored for management of OATSIHS' funding of the community controlled sector and to support its project officers. A new financial management system (ORAC) was developed for gradual implementation from 1 July 1997 to facilitate grant management and payments. Additional financial reports were implemented from November 1997, and enhancements are scheduled during 1998.

3.9 The ANAO recognises that DHAC will be in a better position to report on its financial management of the Aboriginal and Torres Strait Islander Health Program for 1997-98 and subsequent years than for previous years. However, at the time of audit, DHAC was not in a position to report fully for all years, particularly in view of the evaluation of its program administration for 1995-2000, to be conducted in accordance with a Government requirement.

3.10 The Department acknowledged that the financial systems used by the Program during its first two years did not facilitate easy analysis of financial data. Notwithstanding, those systems provided an accurate and effective method of making payments to health and substance misuse services. The Department did not consider that it would be cost-effective, nor a priority, to commit additional resources to undertake the task of back-capturing further payment level data from other financial systems.

National performance indicators and targets for 1998-2000

3.11 A significant step forward in addressing the need to monitor governments' efforts to improve Aboriginal and Torres Strait Islander health was taken in August 1997 at the Australian Health Ministers' Conference (AHMC). Ministers endorsed a set of National Performance Indicators (NPIs) and targets that governments should report against to monitor improvements in Aboriginal and Torres Strait Islander health, subject to further refinement. Following further work, the Australian Health Ministers' Advisory Council (AHMAC) agreed to a refined set of NPIs in March 1998. DHAC has played a leading role in this work.

3.12 Currently there are 58 NPIs across a wide range of measures of Indigenous health status and factors that impact the delivery of health services to the Aboriginal and Torres Strait Islander population. They can be broadly grouped as follows:

- life expectancy, mortality, morbidity and risk factors;
- health service impacts;
- access and quality of service provision; and
- community involvement, intersectoral issues, and workforce development.

3.13 Targets have been established for a number of indicators, particularly those relating to health status. These include:

- an increase in life expectancy consistent with a 20 per cent reduction in age-standardised all causes mortality rate ratios over ten years;
- a 50 per cent reduction in ten years in the age-standardised mortality rates of Aboriginal and Torres Strait Islander people for the main causes of death, namely, heart disease, injury and poisoning, pneumonia, and cervical cancer, and a 20 per cent reduction for diabetes; and
- a 50 per cent reduction within ten years in the death rate for infants.

3.14 The currently agreed set of NPIs identify that further research and development is required in relation to the usefulness of self reported health status as a valid and reliable indicator and the development of indicators of mental health. DHAC advised that this work and further refinement of indicator definitions is to be undertaken by the National Health Information Management Group, a sub-committee of AHMAC.

3.15 The Commonwealth, States and Territories are required to report annually on performance against the NPIs to Health Ministers through AHMAC. Reporting against the current NPIs was due at an AHMAC meeting in October 1998. This reporting requirement is an important accountability mechanism which will test the extent to which the Commonwealth, States and Territories have translated the agreed NPIs into appropriate objectives, performance indicators and targets, and implementation strategies to address the poor the health status of the Aboriginal and Torres Strait Islander population in their area of responsibility. It will also serve to highlight the extent to which data is available to measure changes in Indigenous health status and other factors which impact Indigenous health status.

DHAC performance indicators and outcomes reporting

3.16 In DHAC's report titled '*Commonwealth Programs for Aboriginal and Torres Strait Islander People, 1995-96*', completed and provided to ATSIC in April 1997, the Department identified that it had a limited capacity to report on its program outcomes for Aboriginal and Torres Strait Islanders. This report is requested each year by ATSIC in pursuance of its statutory responsibility under section 7(1)(b) of the ATSIC Act, for monitoring the effectiveness of programs for Indigenous people, including programs conducted by bodies other than the Commission.

3.17 The ANAO found that the DHAC had acted to improve its capacity to report on its program outcomes for Aboriginal and Torres Strait Islander people in the Annual Report and the Portfolio Budget Statements. Initial steps were taken in 1996-97, particularly in relation to the identification of performance information and evaluation as priorities for the Department. The Departmental Management Committee reaffirmed the requirement for all programs to include an Aboriginal and Torres Strait Islander equity indicator in the 1997-98 and subsequent Portfolio Budget Statements.

OATSIHS' performance indicators

3.18 DHAC Portfolio Budget Statements for 1998-99[18] identify in relation to the Aboriginal and Torres Strait Islander Health Program that:

- the Program is guided by a plan to address the underlying causes of continued poor health status among Aboriginal and Torres Strait Islander peoples which has been developed in close consultation with the States and Territories, the Aboriginal community controlled health sector and other stakeholders under the Aboriginal and Torres Strait Islander Framework Agreements;
- overall improvements in Aboriginal and Torres Strait Islander health will be measured through the NPIs and that improvements in overall health status will depend on a coordinated approach across a range of sectors, including the Department; and
- effectiveness indicators for the Program focus on the Department's achievements in implementing key elements of its plan responsibilities.

3.19 DHAC has adopted two key NPIs as its overall program effectiveness performance indicators. One indicator addresses life expectancy at birth by sex (mortality), and has a target consistent with a 20 per cent reduction in age standardised all-causes mortality rate ratios over ten years. The ABS has advised the ANAO that this approximates a 3.7 year gain in Indigenous life expectancy for males and females by 2008-2009. The second indicator is the age standardised all-causes hospital separation rate ratio by sex (morbidity) with a target of a 20 per cent reduction over ten years. DHAC proposes to report against these indicators by way of an annual update and three year trend analysis.

3.20 Identification of movements in the indicators and progress towards the targets will depend on data quality, particularly on the quality of data on Indigenous identity in hospital records. Earlier in this chapter the ANAO referred to major deficiencies with current national Indigenous health data reported to AHMAC by the ABS and AIHW in October 1997. Without an improvement in the quality of Indigenous health data it will be difficult for DHAC to measure achievements against these two effectiveness indicators for the Aboriginal and Torres Strait Islander Health Program.

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[18] Portfolio Budget Statements 1998-99, Health and Family Services Portfolio, Budget related Paper No. 1.8, May 1998, pages 123-135.

3.21 The Portfolio Budget Statements for Aboriginal and Torres Strait Islander health identify priority outcomes, key outputs (for administered funds and departmental outputs) and performance indicators for 1998-99. The ANAO reviewed the performance indicators against the NPIs and found that they addressed similar priorites, including the establishment of stakeholder forums, cooperative community planning through regional planning processes, access to primary health care services and workforce training. The ANAO considered that the reflection of the NPIs in the performance indicators for the Aboriginal and Torres Strait Islander Health Program was appropriate to DHAC's role as a national leader and coordinator in Indigenous health rather than having a direct responsibility for health service delivery.

3.22 The ANAO also reviewed the 1998-99 performance indicators for a direct relationship to the program objective of raising the health status of Aboriginal and Torres Strait Islander peoples by ensuring access to effective high quality health care and population health programs. The ANAO identified two performance indicators that directly related to access, namely:

- the number of communities provided with additional primary health care services, for which the target was 35 rural and remote Aboriginal communities; and
- the number of social and emotional well-being centres established, for which the target was at least 12 regional centres fully operational.

3.23 These are intermediate output indicators, rather than true output indicators because they measure the provision of health care facilities rather than the usage of those facilities. Without usage data, the indicators can only identify an increase in the availability of Indigenous health services rather than demonstrate that access has improved.

3.24 The Portfolio Budget Statements for the Aboriginal and Torres Strait Islander Health Program for 1998-99 provide a clearer link than previously across performance indicators, key outputs, priority outcomes and overall performance indicators of program effectiveness. However, DHAC is yet to report on its performance in the achievement of the program's objective:

> *to raise the health status of Aboriginal and Torres Strait Islander peoples by ensuring access to effective high quality health care and population health programs.*

Progress on the development and refinement of the NPIs during 1997-98 has enabled DHAC to demonstrate an alignment of its Aboriginal and Torres Strait Islander Health Program with the national focus of all jurisdictions in addressing Indigenous health issues.

Recommendation No. 2

3.25 The ANAO recommends that DHAC measure the achievement of its Aboriginal and Torres Strait Islander Health Program objective of raising health status by ensuring access to effective high quality health care and population health programs.

DHAC Response

3.26 Agreed. The Department is adopting a staged approach. This is because of the long timeframes over which improvements in health status are expected to occur, the need to use intermediate indicators to measure performance over shorter time periods, and the requirement to establish mechanisms to collect data to enable measurement over time. It is anticipated that data on service needs and the utilisation of AHSs will become available during 1998-99, following the introduction of service activity reporting arrangements. Further work is being done in conjunction with key stakeholders to improve information through other data collections, including those managed by ABS, mainstream DHAC program areas and State/ Territory governments.

Performance indicators in other parts of DHAC

3.27 Other DHAC divisions also have a role in raising the health status of the Indigenous population. In 1995-96, DHAC's first year of responsibility for Indigenous health, there was one direct indicator of program performance in Indigenous health for other than OATSIHS. By 1998-99, the DHAC Portfolio Budget Statements, for other than OATSIHS, has ten direct indicators where Indigenous persons are identified clearly, and eight indirect indicators. The indirect indicators include references to target groups and special needs groups, rural/remote areas and community based services that could include Aboriginal and Torres Strait Islanders.

3.28 The ANAO reviewed the performance indicators for these other DHAC programs. The ANAO found that none of the ten performance indicators with a focus on Aboriginal and Torres Strait Islander people are directly related to the NPIs. In particular, one NPI regarding 'expenditure on health promotion programs specifically targeting Aboriginal and Torres Strait Islander people' is considered to be relevant to the work of DHAC's Public Health Program. However, the ANAO found that this is the only program that does not have any performance indicators that specifically reference Aboriginal and Torres Strait Islander people. Rather, indicators refer to 'specified target groups' and 'specified high needs groups'.

3.29 Of the Portfolio's $23.2 billion in appropriations for 1998-99, there were two Indigenous health performance indicators for the $16.4 billion Health Care and Access program which includes Medicare benefits (Medicare), pharmaceutical benefits and the public hospital agreements with state and territory governments. These related to Aboriginal and Torres Strait Islander access to Medicare and access to acute health services by Aboriginal and Torres Strait Islander people. In both cases DHAC states, in its Portfolio Budget Statements, that there are no current indicators and identifies that it will work towards improving its reporting during 1998-99, including the development and implementation of agreed performance indicators for access to acute care by June 1999. The importance of efforts in these areas cannot be understated with 77 per cent of the Commonwealth's expenditure on Indigenous health through programs such as the former Medicare Agreements for acute care in public hospitals, Medicare and the Pharmaceutical Benefits Scheme (PBS).[19]

3.30 The ANAO considers that the increase in the number of Indigenous performance indicators demonstrates an increased focus on the poor health status of Aboriginal and Torres Strait Islander people. However, DHAC is yet to report on its performance in addressing this poor health status, in particular, the achievements against its cross-program goal of national leadership in policies and programs to raise the health status and wellbeing of Aboriginal and Torres Strait Islander peoples. Some indicators require further development to clearly identify what will be measured. In addition, improvements in the availability and quality of Indigenous health data is also required.

3.31 Further, the ANAO considers that the development of performance indicators for mainstream programs with respect to Indigenous health is particularly significant in light of the forthcoming evaluation of the performance of the Portfolio in Aboriginal and Torres Strait Islander Health between 1995-96 and 1999-2000.

Monitoring and evaluation of portfolio performance

3.32 The ANAO found that OATSIHS has developed a plan for 'Monitoring and Evaluating the Performance of the Portfolio in Aboriginal and Torres Strait Islander Health' between 1995-96 and 1999-2000. Within the plan there is an Evaluation Strategy which addresses the Government's requirement for a final evaluation to be reported in 1999.

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[19] Expenditures on Health Services for Aboriginal and Torres Strait Islander People, Op Cit.

3.33 The Department's Performance Assessment Committee[20] has endorsed the rolling together of separate reporting requirements into a single monitoring and evaluation process. An evaluation report is to be completed by December 1999 to contribute to the 2000-2001 Budget process. Following discussion with ATSIC and NACCHO, DHAC has agreed to contract out the evaluation to ensure independence from Departmental operations.

3.34 The evaluation and monitoring process is designed to support:

- regular reporting to ATSIC, to the AHMC, and to the Aboriginal and Torres Strait Islander Health Council;
- regular reporting against the national performance indicators and targets for Aboriginal and Torres Strait Islander health, and annual reporting of significant Portfolio initiatives prospectively in the Portfolio Budget Statements, and retrospectively in the Annual Report; and
- the evaluation of the Portfolio performance in Aboriginal and Torres Strait Islander health.

3.35 A reference group is to be established to advise the monitoring and evaluation of the Portfolio. Membership of the group will represent key stakeholders with an interest in the funding of and administrative arrangements for the delivery of health services for the Aboriginal and Torres Strait Islander population by the Commonwealth. The Evaluation Reference Group will be chaired by a Departmental deputy secretary.

Evaluation strategy

3.36 The Department identifies, in its plan for monitoring and evaluation, broad outcomes that will be used to indicate whether the Portfolio is meeting its stated objectives. These outcomes, which will ultimately be reported against in the final evaluation report, are:

- improved health outcomes for Aboriginal and Torres Strait Islander people[21];
- improved access for Aboriginal and Torres Strait Islander people to effective health and family services;

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20 The Performance Assessment Committee is a committee chaired by the Secretary and comprised of members from the Executive to oversee the development of performance information in the Portfolio.

21 Additional comment on this outcome in the Monitoring and Evaluation Plan - 'This long term outcome cannot be realised fully within the five years of this strategy. It is recognised that it could take a generation before improved health outcomes can be measured. However, incremental outcomes that ultimately lead to improved health outcomes are measurable and reportable. These include reducing the incidence and consequences of particular diseases and health problems prevalent among Aboriginal and Torres Strait Islander people or detecting change in behaviour, knowledge, or attitudes'.

- more equitable distribution of health and family service resources between Aboriginal and Torres Strait Islander people and the broader community and within Indigenous communities;
- increase in Aboriginal and Torres Strait Islander people's participation in decision making about their health and well being, and about health and family services;
- increases in the number of skilled health staff trained to provide appropriate health and family services to Aboriginal and Torres Strait Islander people, and the number of such staff who are retained in the workforce;
- better data and reporting on Aboriginal and Torres Strait Islander health and well being, and on health and family service delivery; and
- improved co-ordination and collaboration with stakeholders.

3.37 The ANAO considers that key parts of the evaluation will be difficult to conduct because of the indirect nature of DHAC's role in achieving improved health outcomes and the limited data available on health status and access to health services.

3.38 The ANAO acknowledges that OATSIHS has developed a monitoring and evaluation plan which draws together, and addresses, the principal reporting requirements of DHAC in relation to Aboriginal and Torres Strait Islander health. However, the delay in implementing a monitoring and evaluation process will result in a limited timeframe for DHAC to collect the necessary information to measure its performance in meeting its objectives for Aboriginal and Torres Strait Islander health. At the time of audit, monitoring processes had not been established to provide information to support the evaluation.

3.39 The evaluation will require adequate information on program inputs, both for OATSIHS and other DHAC mainstream programs. The report on 'Expenditures on Health Services for Aboriginal and Torres Strait Islander People'[22] will provide a useful starting point. From that point, there will be a need for further analysis of Departmental expenditure, for example, on the costs of funding Aboriginal Health Services and Substance Misuse Services in urban, rural and remote areas.

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[22] Op. Cit..

3.40 DHAC has to date not reported on Portfolio performance in Indigenous health and 1998-99 is four years into the five years of the initial transfer of the Aboriginal Health Program to the Department. This is not likely to allow for any significant analysis of data over time in order to assess the extent to which the Department has contributed to raising the health status of Aboriginal and Torres Strait Islander people. There will be insufficient time to use the evaluation data to improve Departmental administration before the review of the effectiveness of the Department's role is reported in 2000.

3.41 The ANAO concludes that at the end of the five year period of the transfer of responsibility for the Indigenous health program to DHAC, it is unlikely that the Department will have the data to know whether the transfer of responsibility has reduced Indigenous morbidity rates and increased Indigenous life expectancy.

Conclusion

3.42 DHAC confronts major challenges in measuring the level of its achievement in raising the health status of Aboriginal and Torres Strait Islander people. The lack of data on the health status of Aboriginal and Torres Strait Islander people is being addressed by stakeholders, including DHAC. At the time of audit, DHAC management information systems did not yet have the capacity to report on the distribution of funding of the Aboriginal and Torres Strait Islander health program for 1995-1998.

3.43 For the first time, National Performance Indicators for Aboriginal and Torres Strait Islander health have been jointly developed by Commonwealth and State/Territory government officials, and endorsed by Australian Health Ministers. DHAC's own program performance indicators highlight how the Department's role is indirect, that is, to seek to deliver health services to Indigenous Australians through other agencies.

3.44 DHAC is yet to measure the achievement of its Aboriginal and Torres Strait Islander health program objective and cross-program goal of raising the health status of Aboriginal and Torres Strait Islander people. To assist in that measurement task, this chapter has drawn attention to the need for DHAC to strengthen its relevant financial management information system, the importance of the Australian Health Ministers Advisory Committee which will review the National Performance Indicators, and the need for DHAC to develop measures of the usage of those community controlled health care facilities which DHAC funds.

4. The Aboriginal Community Controlled Primary Health Care Sector

This Chapter assesses the Department's administration of that part of the Aboriginal and Torres Strait Islander Health Program which affects the Aboriginal and Torres Strait Islander community controlled primary health care sector. Specifically addressed are issues of:

- *the basis and security of funding of Aboriginal Health Services (AHSs) and Substance Misuse Services;*
- *grant management and the assessment of administrative capacity and support to funded organisations;*
- *performance reporting by funded organisations; and*
- *workforce initiatives aimed at the development of a skilled and available workforce.*

Classification of health care

4.1 The health services sector consists of services that deliver primary, secondary and tertiary health care. The common elements of the various definitions of primary health care are health promotion, early diagnosis, intervention and the prevention of disease. As well as public health services, primary health includes the services of general practitioners and other health care workers who provide first contact care.

4.2 Of fundamental importance to Aboriginal primary health care are the Aboriginal community controlled health sector and health services administered by state/territory departments of health. Primary health care is defined in the Department of Health and Aged Care's agreements with state and territory governments as follows[23]:

> *primary health care is the first point of health care between the community and the health care system including Aboriginal community controlled*

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[23] Agreement on Aboriginal and Torres Strait Islander Health between the New South Wales Minister for Health, the Aboriginal Health Resource Co-operative Ltd, the Commonwealth Minister of State for Health and Family Services and the Chairperson of the Aboriginal and Torres Strait Islander Commission, 8 August 1996.

health services which operate primary health care according to the working definition of primary health care as described in the National Aboriginal Health Strategy Working Party Report[24].

4.3 Secondary services include hospital and specialist care, and diagnostic services that patients are referred to by general practitioners. Tertiary services include specialised, highly technical functions, such as diagnosis and treatment of disease and disability in sophisticated, large research and teaching hospitals. The latter offer highly centralised care to the population of a large region. State and Territory governments play a major role in the provision of secondary and tertiary health services.

4.4 An Aboriginal Health Service (AHS) is a community controlled health service with a governing board elected by members of the local Indigenous community. These community services evolved in order to provide innovative clinical and health development services where cultural imperatives, social realities and technical necessities are taken into account.[25] They employ health professionals, such as doctors and nurses, and provide primary health services to Aboriginals and Torres Strait Islanders. They may also provide health services to other Australians, particularly in rural and remote areas.

4.5 In the Department's 1997 submission to the House of Representatives Standing Committee on Family and Community Affairs Inquiry into Indigenous Health, the major roles of AHSs were identified as to provide:

- clinical services and referrals, as appropriate, to other elements of the health care system - in response to the immediate needs of Aboriginal and Torres Strait Islander peoples;
- population health services, including screening programs which can detect conditions for which an effective intervention is available;
- culturally appropriate health promotion programs to the Aboriginal and Torres Strait Islander community of which they are a part;
- a coordination and health monitoring role; and
- a framework through which local and regional community health action is developed.

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[24] The National Aboriginal Health Strategy offers a modified definition to the World Health Organisation Alma Ata Declaration of 1978:

Primary health care is 'essential health care based on practical, scientifically sound, socially and culturally acceptable methods and technology made universally accessible to individuals and families in the communities in which they live through their full participation at every stage of development in the spirit of self reliance and self determination.'

[25] A National Aboriginal Health Strategy', National Aboriginal Health Strategy Working Party, March 1989.

4.6 Substance Misuse Services are primary health care facilities which provide a range of prevention, treatment and rehabilitation services for persons who have problems with the use of alcohol, kava and chemical substances such as drugs and petrol. There is considerable diversity within these projects in terms of the type of service, the range of activities conducted and the linkages with other health providers and services. OATSIHS directly funds a number of AHSs which also undertake some prevention and early intervention work in relation to substance misuse. OATSIHS has reviewed the operation and funding of Substance Misuse Services. At the date of preparation of this audit report, a final report on this review was yet to be released.

4.7 Since 1995, DHAC has addressed:

- the health needs of Indigenous communities served by an AHS through development of a more relevant needs based approach to funding and new three year funding agreements; and
- the recruitment, training and employment of health personnel to support AHSs, including the employment of additional staff while permanent staff attended training.

4.8 The current Government has continued to support these initiatives. DHAC's progress in addressing them is reported in the remainder of this chapter.

Funding of Aboriginal Health Services

4.9 OATSIHS has a funding agreement with each community controlled organisation. The funding agreement is on an annual rather than a longer term basis. Unless otherwise specified in the agreement, organisations are paid quarterly in advance.

4.10 In the 1996-97 financial year, OATSIHS funded 120 health projects and 59 Substance Misuse projects involving 163 different Aboriginal Health and Substance Misuse Services. Of the $112.6 million program expenditure in 1996-97 (Table 1.1):

- $69.6 million was directly paid to AHSs;
- $13.1 million was directly paid to Substance Misuse Services; and
- $17.4 million for capital works projects.

4.11 This $100.1 million was paid directly to health and substance misuse services. The remaining $12.5 million was paid to other organisations not directly involved in service delivery including for consultancies, feasibility studies, support of committees, specialist research and publishing costs. Table 4.1 provides data on OATSIHS' funding of AHSs and Substance Misuse Services by state/territory for 1996-97.

Table 4.1

Summary of the distribution of OATSIHS' funding by State/Territory to AHSs and Substance Misuse Services, 1996-97

State (Aboriginal population, 1996 Census)[1]	Health Services ($)	Substance Misuse Services $	Total $
WA (54 055)	15 414 996	2 186 240	17 601 236
NT (49 556)	13 311 929	2 201 096	15 513 025
Queensland (100 504)	12 046 639	2 570 276	14 619 915
NSW (106 294)	12 643 369	2 448 646	15 092 015
SA (21 271)	8 331 007	2 424 101	10 755 108
Victoria (22 574)	6 967 960	641 397	7 609 357
Tasmania (14 651)	747 554	664 884	1 412 438
ACT (2 952)	135 023	0	135 023
Total (372 052)	**$ 69 598 477**	**$ 13 136 640**	**$ 82 735 117**

Notes:

1. At the 1996 Census, a total of 352,970 self-identified as indigenous Australian. This figure was adjusted by the ABS for underenumeration to arrive at an estimated resident population (ERP) of 372 052.[26] In March 1998, ABS issued revised population estimates.

4.12 Table 4.1 does not indicate a relationship between the size of the Indigenous population and OATSIHS allocations for AHSs and Substance Misuse Services. The ANAO considers that DHAC should review the distribution of funding to develop a more relevant needs based approach to funding AHSs and Substance Misuse Services.

4.13 Table 4.2 presents further 1996-97 data on OATSIHS funding of AHSs and Substance Misuse Services by regional classification.

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[26] Taylor, 1997, page1, The 1996 Indigenous population count..

Table 4.2

Summary of the distribution of OATSIHS' funding by metropolitan, rural and remote areas classification to AHSs and Substance Misuse Services, 1996-97

Region	Health Services ($)	Substance Misuse Services ($)	Total ($)
Capital City	18 727 382	3 455 234	22 182 616
Other Metropolitan	3 222 975	503 898	3 726 873
Subtotal Urban	**21 950 357**	**3 959 132**	**25 909 489**
Large Rural	5 634 915	761 528	6 396 443
Small Rural	7 010 810	2 455 320	9 466 130
Other Rural	3 147 612	1 635 380	4 782 992
Subtotal Rural	**15 793 337**	**4 852 228**	**20 645 565**
Remote Centre	12 806 202	2 024 932	14 831 134
Other Remote Area	19 048 581	2 300 348	21 348 929
Subtotal Remote	**31 854 783**	**4 325 280**	**36 180 063**
Total	**$ 69 598 477**	**$ 13 136 640**	**$ 82 735 117**

Legend for Classification of Regions[27]:

Capital city	statistical division
Other metropolitan centre (one or more statistical sub divisions)	population > 100,000
Large rural centre	pop. 25,000 - 99, 000
Small rural centre	pop. 10,000 - 24,999
Other rural area	population < 10,000
Remote centre	pop. 5,000 - 9,999
Other remote area	pop. < 5,000

4.14 Table 4.2 shows that nationally, OATSIHS distributed the most funding to services in remote areas, followed by urban services and rural services. OATSIHS distributed $56.8 million to rural and remote primary health care services compared to $25.9 million distributed to urban services. Further data regarding distribution by regional classification within each state/territory and average funding are in Appendix 3.

4.15 The following sections of this Chapter will address in more detail the various aspects of AHS funding.

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27 Rural, Remote and Metropolitan Areas Classification, 1991 Census Edition, DPIE & DHFS, November 1994, page 4.

Rationale for funding of organisations

4.16 Prior to the transfer of responsibility for the Aboriginal health program to the DHAC from 1 July 1995, ATSIC funded AHSs on an annual grants basis following submission of applications. Decisions on funding levels and control of payments generally rested with ATSIC Regional Councils and were administered through ATSIC Regional Offices. Funding from ATSIC was just one of a number of sources of funds for many organisations.

4.17 One of the broader aims of the 1995-96 Budget initiatives was to provide funded organisations with more secure funding. However, this could not be implemented immediately because applications for ATSIC annual funding had already been received prior to the Federal Budget in May 1995, which announced the transfer of administrative responsibility to the Department. Relevant program administration documentation was provided to the Department by ATSIC to assist the former to administer the funding program once it assumed responsibility on 1 July 1995.

4.18 DHAC's funding for 1995-96 was generally based on the 1994-95 ATSIC grant, plus an indexation adjustment. Some subsequent adjustments were made to allow for increases in award payments or replacement of motor vehicles where necessary.

Needs-based funding

4.19 Once the task of processing 1995-96 funding was completed, DHAC addressed, in late 1995, the Budget initiative in relation to needs-based funding and three-year funding agreements. DHAC's original strategy was to invite AHSs to take part in a cooperative assessment exercise to plan for the health needs of their areas. However, that strategy was not pursued by DHAC. The planning for needs-based funding was integrated into broader planning processes as part of the Commonwealth's approach to bilateral agreements with state and territory governments. There was an expectation by DHAC that these agreements, which were being negotiated in 1995-96, would be signed in 1996.

4.20 A State Forum established under the relevant Framework Agreement negotiated in relation to each State and Territory was considered by DHAC to be the appropriate means to address community health needs amongst all interested stakeholders. These State Forums were asked by the Commonwealth to identify Indigenous persons' health needs on a regional basis within the relevant State or Territory.

4.21 As a result, the DHAC strategy for addressing a needs-based approach to funding changed in early 1996 from a focus on Commonwealth funded AHSs to a focus on State Forums taking account of all health service delivery to Indigenous persons in a planning area. The current target for the development of regional health plans by State Forums for all regions is 1 July 1999, although progress in some States will result in those States completing all their plans before that target. However, a timeframe is yet to be established by DHAC for the implementation of need-based funding of AHSs and Substance Misuse Services.

Recommendation No. 3

4.22 The ANAO recommends that DHAC establish a suitable timeframe for the implementation of funding AHSs and Substance Misuse Services on the basis of the health needs of the Aboriginal and Torres Strait Islander communities to whom they deliver services.

DHAC Response

4.23 Agreed. The Department has been gradually implementing mechanisms to enable the allocation of funds based on health needs. For example, during 1996-97 the Department used a regional planning approach, with criteria linked to indicators of community health needs, in allocating funds for new service development as part of the Remote Communities Initiative.

4.24 The Department has since established a formal process for ongoing regional planning through the State Forums to identify gaps and priorities for health service development, taking account of community needs, environmental factors, and current Indigenous and mainstream health service provision. Also, the expected introduction of service activity reporting during 1998 will, for the first time, enable base models to be formulated for services based on populations serviced and levels of active service intervention. These two strategies together should ensure greater rigor in the allocation of primary health care funding in addressing needs.

Rebasing exercise

4.25 With the strategy for a needs-based approach to funding changing to longer term regional planning, the OATSIHS was faced in early 1996 with reviewing funding levels and developing a more rational basis to distribute $82.7 million in funding for 1996-97. In order to review funding levels, the OATSIHS undertook a project, known as a 'Rebasing Exercise',

particularly to address consistency in funding AHSs and Substance Misuse Services.

4.26 The Rebasing Exercise looked at the operations of the services and collected data on staffing levels, medical costs associated with service delivery and administration costs. A formula was then applied to the data so that services providing a similar level of service received comparable funding. As such the focus was on existing staffing levels and was not designed to address need or growth which were to be addressed under regional planning. The new base level of funding took into account the award salaries of the type and number of staff employed by a service, overhead costs based on location and area serviced and the consumables and equipment used in providing the various health and substance misuse services. Funding to each service was established with some room for variation from year to year and services were able to make supplementary applications for additional funding for a specific purpose.

4.27 This exercise did not review the adequacy of the proportion of funds provided for primary health care and substance misuse. With the exception of a few services which may have received less DHAC funds in real terms following the application of the Federal Government's three per cent efficiency dividend in 1996-97, all services benefited from additional Budget funding distributed on the basis of the Rebasing Exercise.

4.28 The ANAO recognises that in July 1995, when DHAC received the Aboriginal Health Program from ATSIC, it was under pressure to promptly process grants for 1995-96. At the same time, DHAC was also involved in a 'due dilligence' review, jointly managed by ATSIC and OATSIHS, which assessed the appropriateness of the transfer of services and resulted in a number of projects returning to ATSIC at the start of 1996-97. Subsequently, DHAC addressed the consolidation of multiple grants and equitable distribution of funding for 1996-97. The pressure under which the Department's OATSIHS Central Office staff were working may not have been readily understood by funded organisations, nor initially appreciated by OATSIHS' State Office staff who were recruited during 1995-96. The ANAO found that such pressure resulted in a number of difficulties arising during that first year.

4.29 The ANAO found, from discussions with funded organisations and DHAC State Offices visited during fieldwork, that:

- Central Office devolution of the process of data collection for the rebasing exercise was cursory, with insufficient support given to State Office staff to enable them to understand the rationale for rebasing, and a lack of appreciation of environmental factors affecting project officers' ability to visit AHSs, eg, the Northern Territory "wet" season;

- a majority of DHAC project officers interviewed did not feel confident in gathering data because they did not fully understand the project and all the implications of the use of the data they were collecting. Some project officers were not familiar with the operations of the services that they were visiting, which reduced their ability to assist the services adequately in providing data;
- funded organisations were uncertain about the process and were not always able to gain consistent and reliable advice from DHAC's project officers. AHSs with good administrative structures were better positioned to present their case; less structured organisations often had difficulty differentiating those assets and services funded from health grants from other grants from ATSIC. This affected the accuracy of the data they supplied to DHAC;
- average costs used in DHAC's new funding formula did not take account of those services that used a substantial amount of overtime, or which had a very experienced staff and were paying higher incremental levels. In addition, the formula appeared complicated thus clouding the transparency of the process to AHSs; and
- in some locations, costs rose faster than the wage cost index used by DHAC in its funding formula. In the Northern Territory, for example, AHS staff believed that changes in awards would increase labour costs by an estimated $2 million across funded organisations.

4.30 OATSIHS advised that issues to do with wage increases arose after the Rebasing Exercise and that current government policy for grant funding programs requires funded services to manage cost and price impacts with existing funding levels (plus prospective indexation supplementation). OATSIHS did concede that current health financing arrangements did not adequately address the rising demand and cost drivers of health services. It identified to the ANAO that general primary health care costs as reflected in Medicare and Pharmaceutical Benefits Scheme (PBS) costs, had risen by more than 5 per cent in recent years (and were expected to rise by 2.6 per cent in the future). However, health financing for AHSs had only increased at the margin and was projected to rise by less than one per cent, despite an increase in the Indigenous population of more than 3 per cent per annum. The ANAO noted that increased funding for AHSs in the 1998-99 Budget included a component for the Indigenous population increase identified in the last national Census.

4.31 The ANAO found that virtually all services benefited from the Rebasing Exercise and there were improvements in levels of equity and in establishing a reasonable resource baseline. However, the above shortcomings lead to some negative outcomes, including:

- an expectation gap between the analysis of health needs that organisations understood would occur soon after the transfer of responsibility to DHAC, and the review of existing service delivery undertaken, leaving funded organisations waiting for a follow-up review of health needs;
- errors made by the services and not identified by OATSIHS, such as not identifying all costs, have become embedded in the OATSIHS funding system; and
- the equity of funding may still be balanced toward the well organised, politically astute AHSs which were better positioned to demonstrate their levels of service delivery.

4.32 As well as the review of funding levels for 1996-97 and subsequent years, the OATSIHS moved to a system of an annual letter of offer to funded organisations instead of the annual application system that was in place previously. In addition, OATSIHS amalgamated multiple grants into one operational grant. The ANAO found that the annual letter of offer for one operational grant allowed streamlining of administration in funded organisations, thereby reducing administrative overheads.

Security of funding of organisations

4.33 One aim of the 1995 Budget initiative was to introduce security of funding for AHSs so that they could more confidently plan their service delivery over a longer period than had been possible under the yearly application based funding model. A term of three years was identified and referenced in the Budget initiative. Since the Government gave OATSIHS responsibility for Aboriginal and Torres Strait Islander health programs, funding of primary health providers and substance misuse services has moved towards a model of providing base funding for recurrent expenditure plus indexation.

4.34 DHAC attempted to introduce three year term agreements for AHSs in time for the 1997-98 funding year. The issue of longer term funding for Substance Misuse Services had been set aside to be addressed after the completion of a review of these services. The DHAC advises that the Substance Misuse Review report is yet to be released.

4.35 In addressing how longer term funding agreements might be implemented, DHAC conducted a risk assessment exercise to identify those organisations with the administrative capabilities to manage three year term funding. The ANAO found that the exercise was not completed in time to enable the introduction of three year funding agreements for 1997-98 because:

- many project officers were newly appointed and were not familiar with AHSs' operations;
- many project officers did not feel that they had been adequately briefed on how to conduct the risk assessment, and
- other activities resulting from DHAC's devolution of the program meant that the risk assessment could not always be given a high priority.

4.36 As a result there was no change from annual funding agreements for 1997-98.

4.37 OATSIHS advises that risk assessments of primary health care providers were completed by October 1997. The assessments will be used in conjunction with other information to identify the most appropriate means of progressing to multi-year funding agreements. The risk assessments will also be used to identify services experiencing difficulties which would benefit from management support assistance. With the form of multi-year funding agreement still being considered, funding arrangements will not change for 1998-99.

4.38 The ANAO noted that while funded organisations still receive their funding on a yearly grants basis, they have been placed on a more secure financial footing than the previous applications based funding because:

- they know the baseline level of funding that they will receive each year until the 1999-2000 financial year;
- the payments are regular throughout the year; and
- administrative requirements have been reduced with the removal of application based grants.

4.39 In summary, the ANAO found that longer term funding arrangements are yet to be implemented by DHAC. Notwithstanding, DHAC has moved funded organisations closer to a more predictable and secure funding position.

Relationship with funded organisations

4.40 The majority of Aboriginal Health and Substance Misuse Services visited by ANAO stated that they considered they were better placed to deliver health and health related services under OATSIHS for a variety of reasons, including:

- more security of funding, including not competing with other non-health related Aboriginal organisations;
- more guidance, eg., in program management guidelines;
- more frequent contact with project officers;
- more flexibility in the rollover of funds;
- more health expertise in DHAC; and
- a stronger voice in government with the responsible Minister being in Cabinet.

4.41 The ANAO recognises that as part of the transfer of Aboriginal health to DHAC, increased funding was provided in the Federal Budget, and it could be suggested that this was one reason for funded organisations to consider themselves better off. However, this was not a reason put forward to the ANAO by funded organisations visited.

4.42 Organisations generally commented that they were still waiting for the issue of the level of funding appropriate to the health needs of the Aboriginal community they served, to be addressed. The Department's view is that community health needs were being addressed through the regional planning process.

4.43 The ANAO found that the development of working relationships with funded organisations provides the opportunity for State Office staff to address in a timely manner any problems associated with the management of, and accountability for, Commonwealth funds expended by these organisations. From ANAO discussions with funded organisations and OATSIHS staff in New South Wales, Queensland, Western Australia and the Northern Territory, the ANAO concluded, in the main, good working relationships had been developed between funded organisations and State Office staff.

Multiple sources of funding

4.44 The Department provided funding for Aboriginal and Torres Strait Islander health in several ways, namely:

- specific funding to AHSs and Substance Misuse Services, administered by OATSISHS;
- direct funding to AHSs from other program areas in the Department, eg, some Public Health program funding;
- funding to the States and Territories to deliver Aboriginal health programs within their jurisdictions, which may include the funding of AHSs to implement national public health strategies in priority areas (especially relevant to the Aboriginal population) such as sexual health, women's health and nutrition;
- funding to the States and Territories under Medicare Agreements for public hospitals; and
- funding through Medicare and the PBS.

4.45 As well as the funding sources initiated from other parts of the Department, various sections in OATSIHS have offered special purpose grants for specific health issues. Examples include initiatives in Child Health Centres, Mental Health and Hearing. As part of the move to outcomes based funding, specific performance indicators have been developed for some of these grants. OATSIHS funding of the community controlled sector to deliver these initiatives on behalf of the Commonwealth is based on submissions or applications from AHSs and Substance Misuse Services. In other words, the Department funds the community sector through a mix of annual grants which are not application based, and applications from the community sector.

4.46 Individual AHSs and Substance Misuse Services may receive funding from non-Commonwealth sources, including from state/territory governments. The ANAO analysed financial data from a sample of AHS and Substance Misuse Service annual reports. The analysis identified that in the sample, the OATSIHS grant ranged between 47 per cent and 92 per cent of total grants and 33 per cent and 69 per cent of total income. The audit did not examine whether there was any link between the proportion of funding and level of influence able to be exerted by OATSIHS.

4.47 The analysis also indicated that the number of organisations from which individual AHSs received grants ranged from two to six. However, one organisation may provide multiple grants for specific purposes. This is particularly the case for state/territory departments of health. The detail of individual grants was not included in all the annual reports for the sample organisations reviewed. The ANAO noted that where such

information was available, the total number of grants was in the range 10-12. The ANAO considers that multiple grants with associated multiple acquittal arrangements place a strain on AHS administrative costs.

4.48 The Aboriginal and Torres Strait Islander Health Council raised the issue of multiple grants at its third meeting in July 1997. The Council resolved that:

> *funds intended for primary health care intervention on specific conditions (including 'body part' programs[28]) be integrated, with a view, in the longer term, to being incorporated into the core funding and responsibilities of Aboriginal community controlled health services, with the development of reporting and accountability at a number of levels to include outcomes on these diseases, public health, risk factors and service delivery issues, and other underlying health issues.*

The Council, which is an advisory body, also resolved that:

> *OATSIHS take particular responsibility for facilitating such integration, with agencies both within and outside the Department.*

4.49 The ANAO found that, due to the number of grants received by DHAC funded organisations, OATSIHS staff in Central Office and the states/territories did not have a complete picture of either DHAC or other funding received by them. Funded organisations provided an annual audited account of how OATSIHS funding was spent, but often this was not as part of the full financial statements of the organisation. Therefore, DHAC has very little information about the level of funds obtained by AHSs and the Aboriginal community controlled health sector as a whole from other funding sources.

4.50 From discussions with State/Territory government Aboriginal Health Units, the ANAO identified that State/Territory Health Department program areas, in the main, did not have information on the level of DHAC funding provided to funded organisations, and there was a need for more information exchange between the States/Territories and the Commonwealth on funding provided to AHSs.

4.51 The issue of the exchange of information and coordination between governments is being addressed under the various Framework Agreements negotiated between the Commonwealth and the State/Territory governments. The focus of this interaction is regional planning being conducted by the State Forums. Specifically, the regional planning process is intended to draw together all aspects of Aboriginal health service delivery

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28 The expression 'body parts programs' refers to the tendency of governments to fund programs for particular parts of the body, such as eyes and ears.

in a planning area, in order to develop a complete picture of service provision to compare with identified health needs. In order for this needs-based planning to be effective, a total funding picture for each service will be required. Once a total funding picture for each service has been developed, it will need to be updated on a regular basis to be of ongoing value.

Recommendation No. 4

4.52 The ANAO recommends that, as part of the health needs-based planning process, DHAC identify, in conjunction with stakeholders:

- a means by which a total funding picture of AHSs can be obtained and revised on a regular basis for the information of decision-makers; and
- the most effective methods of funding Aboriginal Health and Substance Misuse Services.

DHAC Response

4.53 Agreed.

The Department as funder or purchaser of health services

4.54 Generally speaking, where the Commonwealth is a purchaser of services, it can specify its requirements in greater detail than when it is a funder of services. Also, its accountability requirements are more likely to include requirements for the body in receipt of Commonwealth funds to provide information to acquit its performance as well as its funds received.

4.55 The history of the Aboriginal Health Program under ATSIC, and since 1 July 1995 under the Department's OATSIHS administration, indicates a Departmental relationship with AHSs and Substance Misuse Services as a funder rather than as a purchaser of Aboriginal health and related services. OATSIHS' financing of the Aboriginal community controlled health sector is based on a funding formula rather than on a service level agreement. It is recognised that this relationship is in keeping with the concept of community control, where the community, represented by the management board of an AHS, determines the most appropriate means of utilising funds.

4.56 The ANAO identified during the audit that various States/Territories enter into different types of relationships with AHSs, including that of purchaser/provider. It may be that AHSs are willing to enter into purchaser/provider arrangements for specific services with States/Territories because they have base funding provided by the Commonwealth.

4.57 The ANAO considers that as part of the current developments in Aboriginal health, DHAC address the issue of the appropriate financial relationship with community controlled organisations, having regard to effective health service delivery and appropriate accountability requirements.

Funded organisations' administrative capacity and the assessment role of OATSIHS

4.58 AHSs and Substance Misuse Services are central to the delivery of primary health care to Aboriginal and Torres Strait Islander people. Consequently, administrative and financial stability of these organisations is essential because if they fail the services may not be delivered effectively. OATSIHS has a responsibility to ensure that there is adequate accountability by the organisations for the Commonwealth funds received.

4.59 The ANAO was advised by some OATSIHS State Office staff of concern that, in relation to a number of funded organisations, there were insufficient administrative and financial skills and experience to support their operations. Funded organisations also advised of the pressure to direct funding away from administrative areas towards the delivery of health services to satisfy community demand.

4.60 In an April 1997 position paper addressing health service delivery for remote area Aboriginal communities, the Aboriginal and Torres Strait Islander Health Council made the following comment on administration issues[29]:

> *There are many examples of poor administration in remote Aboriginal communities (this also applies to State and Territory administered services). This is due, at the community level, to the limited educational levels and management skills of local people, and difficulties in recruiting people from outside the community with appropriate skills. Better employment practices, training and support are needed.*

4.61 The ANAO considers that where public funds are involved there is a need for a system of accountability to be put in place to ensure that organisations in receipt of funding have an adequate administrative structure to manage the funds effectively and efficiently.

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[29] A paper prepared by the Remote Area Issues Sub-Committee of the Health Council.

OATSIHS' accountability and support role

4.62 OATSIHS' requirements for the accountability of funded organisations involve the submission of quarterly financial returns and an annual acquittal of grants. The ANAO found, in visits to OATSIHS State Offices, that:

- the receipt of funded organisations' quarterly and annual information was generally later than OATSIHS' requirements in grant agreements;
- there was a variable quality of work relating to the quarterly review of financial information; and
- following the OATSIHS devolvement of grant administration to its State Offices in late 1995 and early 1996, project officers were on a learning curve in relation to involvement with, and knowledge of, funded organisations.

4.63 At the time of interstate visits in mid to late 1997, the ANAO found that in State Offices where staffing levels were settled, project officers were becoming familiar with their organisations and their level of contact with and support of funded organisations was improving. However, the ANAO considers that the combination of the need to meet expanding work loads and inadequate skills is affecting the quality of State Office staff work. This means that in some cases there is limited contact and support for funded organisations, and also that the review of financial information is potentially not as thorough as it should be.

4.64 The ANAO also considers that some assessment of the quality and timeliness of work across State Offices should be undertaken. The ANAO noted that for 1998-99, OATSIHS has set itself a target of 95 per cent of periodic financial statements, annual acquittals and annual activity reporting to be received on time and to be accurate. In order to achieve this target DHAC will need to put systems in place to monitor the timing of receipt and quality of financial returns and take prompt corrective action.

Recommendation No. 5

4.65 The ANAO recommends that DHAC:

- follow-up late financial returns and review them in a timely fashion in accordance with departmental procedures; and
- assess this review activity across State Offices for greater program effectiveness.

DHAC Response

4.66 Agreed. Compliance with financial reporting activity is now able to be monitored nationally using the Program's management information system. The Program also plans to review its reporting and accountability requirements to better target administrative activity, consistent with risk management principles.

4.67 While funded organisations themselves have a primary responsibility for development of their own administrative capacity, DHAC has a responsibility to ensure that Commonwealth funding is used to best effect. In addition, the ANAO considers that community controlled organisations with a strong administrative capacity are more likely to deliver sound health services than those with weaker administrations.

4.68 OATSIHS has provided instructions to staff, through the OATSIHS Program Management Guidelines, on action to be taken when funded organisations experience difficulties in the delivery of services, management of resources or in meeting reporting requirements. The Guidelines included a reference to the fact that it was critical that problems were quickly identified and that remedial action was taken to prevent them from developing into major issues of concern. However, the ANAO found that there was a need for more emphasis to be placed on strategies for early detection of potential problems. The risk management strategy being redrafted in the Guidelines includes reference to early detection strategies, along with additional intervention and follow-up strategies.

4.69 Departmental procedures include provision for the appointment of a Funds Adviser where an organisation demonstrated that it was not capable of managing a project funded by OATSIHS. The Funds Adviser is a financial consultant employed by DHAC to ensure that the organisation meets its reporting and service delivery requirements as defined in its grant agreement conditions, and to assist the organisation to implement procedures and/or training so that it can continue to meet these requirements.

4.70 OATSIHS has also taken steps to provide support to funded organisations through the management support and management development schemes which may be used by funded organisations for:

- training in staff management skills;
- training in administrative and financial skills;
- development of strategic plans;
- development of policies and procedures (eg, staff selection); and
- the education of management boards in their roles and responsibilities.

4.71 In 1996-97, OATSIHS allocated $870 000 for expenditure on 37 such developmental schemes. Also, as referred to earlier in this chapter, OATSIHS has completed a risk assessment exercise to introduce longer term funding for AHSs and Substance Misuse Services. This exercise will assist with the identification of those organisations that might need assistance in the above areas.

4.72 DHAC suggested to the ANAO that NACCHO and State/Territory affiliates also have a role to play in supporting the development of strong administrative and management skills in the community sector. One example was quoted whereby one State NACCHO affiliate was already an active player in delivering management support to services. The Department advises that it has held preliminary discussions with ATSIC regarding opportunities to collaborate on management support projects.

4.73 As well as playing a direct role in developing, where necessary, organisations' administration, the ANAO considers that OATSIHS can also play an indirect role. For example, funded organisations have common client identification, record keeping and accounting tasks to manage, and identification of a range of appropriate computer software and hardware would reduce the amount of time such organisations devote to these tasks.

4.74 OATSIHS has advised the ANAO of an initiative to develop a panel of recommended computer system suppliers for AHSs. The establishment of the panel is intended to provide AHSs with an effective means of making an informed choice of an appropriate supplier of a relevant, patient information and recall computer system. Once the panel of recommended suppliers is established, AHSs will be able to apply for the funding required to install a patient information and recall system offered by suppliers on the panel. The ANAO considers that DHAC should look to extend this concept to finance and administration computer systems.

4.75 The ANAO considers that DHAC has taken important steps to assist the Aboriginal community controlled health sector develop its capacity to manage service delivery to Aboriginal and Torres Strait Islander communities.

Performance reporting by funded organisations

4.76 Development of output and outcomes focused performance indicators for health service delivery organisations has been an issue for a number of years and was attempted, but never successfully implemented, under ATSIC.

4.77 While some information about the operations of these funded organisations was collected by OATSIHS as part of the 'rebasing exercise', information was not collected about the size and health needs of the Aboriginal and Torres Strait Islander communities being served by these organisations. As a start in developing appropriate performance indicators, during 1996-97 OATSIHS developed a service activity reporting questionnaire to be completed by funded organisations, as part of their reporting requirements under the 1997-98 funding agreements. Importantly, the initiative included consultation with stakeholders prior to OATSIHS' development of its questionnaire.

4.78 Despite this consultation, funded organisations visited by the ANAO made comments in relation to:

- uncertainty about OATSIHS' use of their data and their concerns about the privacy and confidentiality of data they provide to OATSIHS;
- uncertainty about whether OATSIHS would provide them with the collated information derived from the questionnaires;
- the large amount of administrative effort to collect the data for small organisations without formal data collection systems and for large organisations which had a wide range of service types to report on;
- some services had multiple funding sources, complicating the process; and,
- the activity reporting questionnaire was designed for AHSs. It did not include specific operational information relevant to Substance Misuse Services which could have been used to gain a greater understanding of their activities. OATSIHS advised that this would be taken into consideration in the revision of the questionnaire for 1998-99.

4.79 NACCHO was concerned about the nature of these service activity reporting requirements and a meeting between OATSIHS and NACCHO was held to discuss these requirements in October 1997. NACCHO presented an alternative draft Service Activity Reporting Questionnaire which OATSIHS agreed would be jointly refined. A steering committee was formed to facilitate the joint involvement of NACCHO and OATSIHS.

4.80 The draft questionnaire was designed to provide both qualitative and quantitative measures of quality and level of activity in Aboriginal primary health care work. In addition , it had a dual focus on effective use of resources on the part of the AHS and to provide an accountability mechanism for OATSIHS in transparent needs-based resourcing. The important features of this approach to service reporting identified in the introduction to the Questionnaire was:

- two-way accountability flows from the service reporting information;

- the reporting should ideally be part of a continuous quality improvement cycle. The indicators therefore capture elements of quality in those areas valued by AHSs and their Aboriginal and Torres Strait Islander client populations;
- resource implications are based on a combination of both Aboriginal population base and Aboriginal client contacts. This helps overcome problems arising from relying on one of these figures alone; and
- the questions are indicators not a comprehensive survey. This means that the questionnaire is relatively short and easily completed by health services.

4.81 The draft questionnaire was piloted in 60 AHSs in January 1998, for which ten responses were received. Any other comments received were used, as appropriate, by DHAC. NACCHO and OATSIHS have not approved a final form of the questionnaire. When approved for issue, the questionnaire will be completed by funded organisations initially for the 1997-98 financial year. The ANAO considers that the development of a data base to analyse reported information should be a high priority.

4.82 Following agreement on the form of data collection of service activity information, OATSIHS and NACCHO intend to address the reporting by AHSs of data on morbidity and specific health problems in the Aboriginal and Torres Strait Islander communities they deliver services to. Such local data has not been collected previously and complements available national and State/Territory Indigenous health data.

4.83 The ANAO found that OATSIHS has invested substantial time and resources in the development of a questionnaire for AHSs to provide information on the level of activity in Aboriginal primary health care work, including consultation with stakeholders. Problems in the initial consultation appeared to result from NACCHO's concern regarding the linking of reporting to 1997-98 funding, and that the consultation process appeared to NACCHO and to AHSs, visited by the ANAO, to be rushed.

4.84 The ANAO considers that after some initial problems, OATSIHS is now working effectively with the Aboriginal community controlled health sector to achieve service activity reporting by AHSs for 1997-98 and subsequent years. However, until a reporting framework is established, OATSIHS has:

- little information on activities it funds in AHSs and their performance;
- not yet established a data collection from AHSs which would enable reporting against relevant national performance indicators; and
- very little data on the health needs of Aboriginal and Torres Strait Islander communities which AHSs deliver health services to.

Recommendation No. 6

4.85 The ANAO recommends that DHAC collect and analyse information from funded organisations, which would enable it to report effectively against relevant national and departmental performance indicators.

DHAC Response

4.86 Agreed. It is anticipated that service activity reporting will be introduced during 1998 to provide, for the first time, baseline information on service utilisation and activities performed. It is expected that the annual collection will provide data for accountability purposes, improved resource allocation decisions and program management, and contribute to meeting the Program's national and departmental performance information reporting obligations.

Management devolution to administer primary health care funding

4.87 Initially all OATSIHS operations to administer primary health care funding were performed from Canberra. Once the level of grants to organisations was determined for 1995-96, OATSIHS established State Offices to take over grant management responsibilities. State Offices became operational to varying degrees from December 1995. At the time of audit, responsibility for grants processing, the project support functions for the workforce initiatives, and some special health issues had been devolved to the State offices.

4.88 The ANAO found that the devolution process was problematic in that, due to competing priorities and the need to address several major issues simultaneously:

- some State Offices were neither fully staffed nor functional at the time of the grants devolvement;
- the transfer of grants management files from Central Office to State offices was a protracted and unstructured process; and
- there was a delay in development and dissemination of policy with the Program Management Guidelines not being available until January 1997.

4.89 At the time of ANAO visits to DHAC State Offices, the ANAO identified a need for OATSIHS to address deficiencies in program administration, in particular:

- State program delegations for the administration of grants and expenditure releases required revision to reflect increased program management responsibilities;
- unclear delineation of grant management responsibilities, with Central Office having maintained an informal grant management role and had sometimes bypassed State Offices in dealings with organisations; and
- there was insufficient State Office involvement at the development and planning stages of initiatives prior to devolvement to the States. The ANAO found no evidence of consultation on the priority, impact of the implementation workload in terms of resource requirements and training, or the appropriate timing of implementation.

4.90 Program authorisations were revised and subsequently approved by the Minister in November 1997. OATSIHS advised that communication and protocols were discussed at three monthly national Directors meetings which bring together Central Office Directors and State/Territory OATSIHS coordinators. In addition, OATSIHS referred to the frequent use of secondments of State Office staff to Central Office and movement of Central Office staff to State Offices in the previous twelve months. The ANAO considers that such action should assist in reducing the difficulties identified during the audit.

4.91 As a consequence of the devolution process and OATSIHS' State Offices taking on a greater part of their longer term role, the ANAO found that their operations have increased since they were established in late 1995. The ANAO found that, with an increasing workload in State Offices, a change has occurred in the skills expected of project officers. Original recruitment requirements were generally directed at communication and liaison skills. One particular requirement needed following devolution are financial skills in order to maintain a 'watching brief' on, and provide advice to funded organisations, as well as reviewing quarterly financial returns and the end of year acquittal of grants.

4.92 The ANAO identified, from discussions with project officers, that in the main they were not clear as to what their role should be and that some officers were performing jobs for which they did not possess adequate skills. The ANAO considers that this is a particularly important issue in relation to the level of support that OATSIHS is providing to funded organisations with project officers being the first point of contact for them.

4.93 The ANAO considers that OATSIHS needs to ensure that the skills of individual project officers are sufficient to satisfy their job responsibilities and to identify appropriate training and support to enhance their skills.

4.94 OATSIHS has advised that a staff skills audit has been completed and a draft OATSIHS specific human resource development plan has been developed. The plan includes strategies in improving administrative planning and health content knowledge and skills. In addition, OATSIHS commented that progress is well advanced in tailoring specific training in project/contract management and negotiation skills.

Workforce initiatives - provision of a skilled and available workforce

Budget initiative

4.95 As part of the transfer of responsibility for Aboriginal health from ATSIC to DHAC, the 1995-96 Federal Budget initiative aimed at addressing workforce issues provided for the establishment of a National Indigenous Employment Corporation to recruit, train and employ health personnel to support AHSs. The health personnel targeted were medical practitioners, nurses and health workers. The Corporation was to be supported by the introduction of a relief staff scheme, where AHSs would be funded to employ additional staff while permanent staff attended training.

4.96 Subsequently, as a result of community consultation initiated by a Joint Health Planning Committee (of stakeholders), there was a change in focus from the National Indigenous Employment Corporation to the use of state based Recruitment Services, each employing a recruitment manager. This consultation and proposal for change occurred during the latter half of 1995.

4.97 Consultation commenced in January 1996 between representatives from NACCHO and OATSIHS which sought to clarify future directions for workforce issues. This led to NACCHO preparing a proposal to establish a recruitment service in each state and the Northern Territory. The Minister for Health approved the establishment of Aboriginal and Torres Strait Islander Recruitment and Promotion Services in each state and territory in June 1996.

Workforce data

4.98 At the time DHAC took over responsibility for Aboriginal and Torres Strait Islander health in July 1995, it had little information on the size and nature of the Aboriginal community controlled health sector workforce. As part of the Rebasing Exercise undertaken in 1996 and referred to earlier, DHAC collected information on the workforce employed by the AHSs and Substance Misuse Services. Subsequently OATSIHS has developed a workforce planning strategy with the aim of determining the appropriate number and mix of skill levels required in a range of Aboriginal and Torres Strait Islander primary health care settings for all health care workers delivering services.

4.99 A workforce modelling project was identified by OATSIHS as a first stage in the workforce planning strategy. This was given a high priority by the Workforce Issues sub-committee of the Aboriginal and Torres Strait Islander Health Council. Workforce modelling is described as:

> *the determination of the appropriate number and mix of skill levels required in a range of Aboriginal and Torres Strait Islander primary health care settings.*

The project has been developed in consultation with stakeholders and is expected to run for 12-18 months from July 1998.

ANAO coverage

4.100 The ANAO reviewed the implementation of OATSIHS' workforce initiatives in the following areas[30]:

- Recruitment Strategy;
- Training and Support; and
- ABSTUDY — barriers to access.

4.101 The Department commented in its 1996-97 Annual Report that progress on health workforce initiatives was slower than expected, primarily due to:

- slow progress negotiating a Memorandum of Understanding with the Department of Employment, Education, Training and Youth Affairs; and
- community controlled service sector disagreement over national competency standards for Aboriginal health workers.

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[30] Other OATSIHS projects not reviewed by the ANAO included:
• a review of mainstream health training (eg. doctors, nurses) in relation to a focus on Aboriginal health;
• competency development for Aboriginal Health Workers; and
• a national strategy to improve access to specialist medical services in rural and remote Aboriginal and Torres Strait Islander communities.

Recruitment strategy

4.102 NACCHO received OATSIHS funding to employ a Project Co-ordinator to assist with the establishment of the recruitment services. This assistance included:

- development of local outcomes and performance indicators;
- development of job descriptions for State recruitment managers based on local needs; and
- co-ordination of recruitment and training for State recruitment managers funded by DHAC and the purchase of equipment to support their role.

4.103 The project was undertaken between July 1996 and April 1997 to provide support and assistance to recruitment managers and to finalise specific national tasks included in the project. A strategic plan for recruitment managers was agreed during this project.

4.104 Recruitment managers were appointed in all States (except Tasmania) and the Northern Territory by November 1996. Due to recruitment difficulties the Tasmanian Recruitment Manager was not appointed till October 1997. OATSIHS' funding for these officers was directed through a State sponsor, in most cases the NACCHO State affiliate, which had the responsibility for managing the service and for providing the administrative support for the officer. Grant management for the recruitment services was devolved to State Offices for the 1997-98 financial year.

4.105 The ANAO found many problems in the administration of the recruitment managers project, including:

- inadequate grant acquittal and periodic reporting for 1996-97. Letters requesting financial statements and progress reports were sent to sponsoring organisations (NACCHO State affiliates) in November 1997;
- delay in establishing a line and form of reporting with recruitment managers. In December 1997, the OATSIHS and NACCHO reached agreement to trial a reporting document;
- no provision for periodic reporting, including against agreed performance indicators, in letters of offer to sponsors for 1997-98 funding. A form, designed to collect activity data, subsequently was sent from the Central Office to sponsor organisations with a request for quarterly completion and return in 1997-98;
- State Offices did not receive any formal documentation, eg, guidelines or guidance on the management of the projects at the time responsibility was devolved for 1997-98. They each received an email directive to

issue a letter of offer to the sponsoring organisation using salary, recurrent and capital funding categories. No breakdown within these categories was provided despite negotiations having occurred between Central Office staff and the recruitment managers. DHAC advises that all State Offices have now received full formal documentation;

- no documentation of the approval of the level of funding for each organisation for 1997-98, nor documentation as to how funding was calculated; and
- no apparent rationale for the levels of funding for 1997-98. All States/ Territories received the same funding even though greater travel costs would be incurred in some States to attend quarterly national meetings and for travel within the State, and there was a varying number of AHSs across the States that recruitment managers worked in.

4.106 In addition, regarding the establishment of the recruitment manager function in each State/Territory, the ANAO found that:

- progress achieved by recruitment managers was variable and overall was not as advanced as expected by DHAC, more than two years after the Budget initiative was announced;
- a three month project was initiated by OATSIHS in July 1997 to address some of the issues impeding progress; and
- one outcome of the project involved each recruitment manager being funded to develop, in conjunction with a consultant, an individual action plan and related performance indicators, in order to focus their actions.

4.107 OATSIHS has agreed to a NACCHO proposal to fund a NACCHO Health Workforce Policy Adviser, in part to work with recruitment managers funded by OATSIHS. This position was filled in April 1998.

4.108 In summary, the ANAO found at the time of audit that:

- the administration of the Recruitment Services project was poor and required a rationale for funding, adequate support to State Offices, grant acquittals and periodic reporting; and
- AHSs were still waiting to receive the appropriate support in terms of recruitment services that the particular Budget initiative was aimed at delivering.

4.109 The ANAO notes the recent progress made by the OATSIHS in clarifying with NACCHO agreed lines of responsibility for the management and reporting on the Recruitment Services. DHAC funding of a Health Workforce Policy Adviser position in NACCHO will, inter alia, facilitate more effective monitoring of, and support for the work of State/Territory recruitment officers, and provide a direct line of contact for early resolution of difficulties.

4.110 DHAC advised that in April 1998, NACCHO and the Department agreed to review the recruitment manager program to commence in April 1999, allowing all managers a full 12 months to operate. One of the draft evaluation objectives is to make recommendations on appropriate funding arrangements for these positions in each State and the NT. DHAC also advised that data collected from recruitment managers (excluding NSW and Qld) between January and June 1998 shows that nine of 13 doctor positions were filled, all 15 vacancies for Aboriginal Health Workers were filled, four of five nursing positions were filled, eight of nine allied health positions were filled and 21 advertised administrative positions were filled.

Training and support

4.111 The 1995-96 Federal Budget allocated $8.3 million over four years specifically to support funded organisations in employing relief staff while permanent staff, namely medical practitioners, nurses and health workers, attended training. Initially this initiative was implemented as the Staff Training Relief Scheme, and is now referred to as Staff Training Support.

4.112 Staff Training Support funding was not fully utilised in 1995-96 and 1996-97. The main reasons given by funded organisations for this under-expenditure were that:

- relief staff were not always available, especially in remote locations; and
- funded organisations' overall budgets had limited capacity for training expenses, especially in remote locations, with associated difficulties of course availability.

4.113 From 1997-98 funding for staff training support was rolled into the annual funding of organisations at a rate of 2.6 per cent of their base funding for greater flexibility and to simplify administration. This funding was separately identified in the letter of offer to each organisation.

4.114 The ANAO considers that DHAC needs to review its training and support strategy in terms of identifying the training needs of AHS staff and how to address these needs. It is considered that the Workforce Modelling project will provide a useful start in identifying the skills required in Aboriginal primary health service delivery, against which to compare available skills.

4.115 In summary, due to problems in the implementation of the training and support initiative, Aboriginal Health Service staff, especially in remote locations, remained in a position where they were unable to access appropriate training

Recommendation No. 7

4.116 The ANAO recommends that DHAC:

- use its Workforce Modelling project to identify the skill profiles required by AHSs to deliver primary health care to Aboriginal and Torres Strait Islander communities;
- assess the level of skills available in AHSs and any skill gaps; and
- identify an appropriate strategy to address the skill gaps.

DHAC Response

4.117 Agreed. The Workforce Modelling project is part of a larger workforce planning strategy and was identified as a priority by the Workforce Issues Sub-Committee of the Aboriginal and Torres Strait Islander Health Council. The project aims to develop a profile of the current workforce providing services to Indigenous communities and their skill levels. The project will also identify future workforce requirements in order to provide adequate levels of primary health care to Indigenous communities. In addition to this, the Department is working with stakeholders to assess skill requirements and identify training needs for this workforce. Much of the work at present is centred around health workers, for whom the development and implementation of appropriate training strategies is seen as a priority.

ABSTUDY - barriers to access

4.118 In discussions with the ANAO, AHSs identified particular difficulties in accessing training for Aboriginal Health Workers. They claimed that in addition to problems associated with the availability of relief staff and the limited capacity of budgets to meet training and associated travel costs, there were difficulties in access to the ABSTUDY Program of the Department of Employment, Education, Training and Youth Affairs (DEETYA).

4.119 DEETYA commenced a review of ABSTUDY in early 1998, particularly in relation to support mechanisms for Aboriginal and Torres Strait Islander students in the health field (medical, nursing and other health profession students are also affected). DHAC advised that a submission was lodged with DEETYA in February 1998, with the primary recommendation that ABSTUDY be retained as a separate scheme for Aboriginal and Torres Strait Islander students. A report by DEETYA on its review is awaited by DHAC.

Conclusion

4.120 AHSs and Substance Misuse Services have more secure funding under current portfolio arrangements since these organisations do not have to reapply annually for funding. However, the Department has yet to implement funding agreements for longer than one year's duration. Funding continues to be distributed basically on an historical basis. The identification of the health needs of Aboriginal and Torres Strait Islander communities has not been completed to enable DHAC to distribute funds to AHSs and Substance Misuse Services on the basis of health need in the communities they deliver health services to. AHSs and Substance Misuse Services felt they were better placed to deliver health and health related services under DHAC's administration.

4.121 DHAC is yet to put in place a management information system that identifies the outputs and outcomes achieved by AHSs and Substance Misuse Services, nor does it have a complete picture of their total funding. DHAC needs to improve the timeliness of its review of financial returns from AHSs and Substance Misuse Services.

4.122 DHAC must still address the problem of how to develop a skilled and available workforce to support AHSs. Further, DHAC is yet to identify the skill profiles required by AHSs to deliver primary health care to Aboriginal and Torres Strait Islander communities, to assess the level of skills available in AHSs, to identify any skill gaps and to devise a strategy to address the skill gaps.

5. Cooperation with State/ Territory Departments of Health, ATSIC and NACCHO

This Chapter addresses the Department's implementation of its program responsibilities in Indigenous health through the Aboriginal and Torres Strait Islander Health Council, arrangements with ATSIC, and through framework agreements with the States, Territories, ATSIC and NACCHO. A focal point was whether the Department had established effective and efficient working relationships with stakeholders.

5.1 The Government expected that the transfer of responsibility for Aboriginal and Torres Strait Islander health programs to the Department, including implementation of the 1995 Budget initiatives,

> *would be implemented in full consultation with Aboriginal and Torres Strait Islander people[31].*

The Government envisaged that such consultation would be central to the successful implementation of the initiatives.

5.2 Recognising the importance of broad participation in service planning, the Department included in its strategies for 1995-96 the development of new national and local consultation arrangements, which would promote the involvement of all parties in identifying community needs and determining priorities for service provision. Specifically:

- a national Aboriginal health advisory body was to be established to advise the Minister for Health on broader policy issues;
- a Memorandum of Understanding (MOU) was to be developed with ATSIC to ensure that all primary health and environmental health programs were effectively coordinated; and
- agreements were to be developed with the States and Territories on improved access to culturally appropriate mainstream health services for Aboriginal and Torres Strait Islander people.

5.3 The Department identified as a key result area for 1995-96, the establishment of appropriate national advisory mechanisms in consultation with ATSIC and the National Aboriginal Community Controlled Health Organisation (NACCHO).

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31 Media Release Budget 95-96, Dr Carmen Lawrence, Minister for Human Services and Health, 'New Commitment to Aboriginal Health', 9 May 1995.

The consultation process

5.4 In 1994, prior to the transfer of responsibility for Aboriginal health programs from ATSIC to the then Department of Human Services and Health, a Joint Health Planning Committee (JHPC) was established to approve funding allocated from the Health Portfolio for Aboriginal health projects. The Committee provided a joint decision making body linking the Health and ATSIC portfolios and involved NACCHO.

5.5 With the transfer of responsibility for Aboriginal health to the Department in July 1995, the role of the JHPC was broadened to:

- monitor the transfer of community controlled Aboriginal Health Services (AHSs) and Substance Misuse Services from ATSIC to the Department;
- provide advice on the development of the MOU between ATSIC and the Department;
- provide broad policy advice to the Minister for Health, pending the establishment of the national Aboriginal health advisory body; and
- assist in the consultative process to develop the national Aboriginal health advisory body.

5.6 Following the Federal Government's 1995 Budget, the Minister for Health invited nominations from stakeholders in Aboriginal health to participate in consultative panels in each State and Territory to advise the Minister on Aboriginal and Torres Strait Islander health issues. In addition to views on the form and composition of the national Aboriginal health advisory body, the Minister sought community opinions on particular Budget initiatives regarding the workforce, mental health and hearing services. Nominations were invited from NACCHO, a State based representative of Aboriginal health organisations, ATSIC and State Health, with the Federal Department of Health coordinating the process.

5.7 The panels reported to OATSIHS, and a composite report was prepared. The final form of the national Aboriginal health advisory body was determined following:

- advice from the State/Territory Consultative Panels;
- consideration and a recommendation by the JHPC; and
- consultation with stakeholders by the Minister and OATSIHS.

The ANAO concluded that the Department had consulted broadly and effectively on the structure for ongoing consultation with stakeholders and the implementation of specific Budget initiatives.

Aboriginal and Torres Strait Islander Health Council

5.8 The form and composition of the national Aboriginal health advisory body was approved by the Minister for Health in May 1996. It was to be known as the Aboriginal and Torres Strait Islander Health Council (Health Council), with the role of being the primary source of advice to the Minister on matters related to Aboriginal and Torres Strait Islander health and substance misuse. Specifically, the Health Council was to provide advice to the Minister on:

- strategies applicable within the Health Portfolio to improve health outcomes for Aboriginal and Torres Strait Islander people including specific mainstream programs administered by States/Territories and the Commonwealth directly; and
- ways to improve cross sectoral linkages and coordination with environmental health programs and other health and DHAC programs.

5.9 The 17 person membership of the Health Council is drawn from a range of stakeholders in Aboriginal health, including DHAC, ATSIC, NACCHO, and a representative of State/Territory Aboriginal Health Units. DHAC provides secretariat support to the Health Council. The initial period of appointment was for three years, with a review of the Council's structure and function planned after 12-15 months.

5.10 The ANAO found that OATSIHS had attempted to balance the need to meet the Aboriginal and Torres Strait Islander community desire for a wide ranging representation with the importance to keep the Health Council to a workable size. It learned from the experience of previous efforts to form a representative advisory body, including the former Council of Aboriginal Health, which was beset by a number of difficulties, one being a large membership of 29.

5.11 DHAC, through the Health Council has succeeded in bringing stakeholders together in a collaborative manner to discuss issues and address areas of disagreement in relation to the implementation of initiatives to raise the health status of Aboriginal and Torres Strait Islander peoples.

5.12 The Health Council first met in June 1996 and met approximately every six months up to the third meeting in July 1997, as set out in the terms of reference for the Health Council when its establishment was approved by the Minister for Health.

5.13 In November 1997, the full membership of NACCHO voted to withdraw its eight members from the Health Council. NACCHO indicated that the reasons for the decision included DHAC's non-disclosure to the Health Council of $10.4 million in funding provided to the States and Territories by the Commonwealth, and the level of Aboriginal health related funding provided by DHAC to mainstream organisations not specifically involved in service delivery to the Aboriginal and Torres Strait Islander population.

5.14 The Department convened meetings , including with the Health Minister, aimed at resolving the issues of concern to NACCHO regarding the functioning of the Health Council. NACCHO's membership of the Health Council is critical for the latter to operate as an effective meeting of stakeholders.

5.15 In addressing the concerns of NACCHO, DHAC agreed in February 1998 that:

- the Health Council meet quarterly and subsequently the Minister be briefed personally on the outcomes by the Chairman of NACCHO and the Chair of the Health Council (DHAC Secretary);
- the role of the Health Council in advising the Minister on national policy and priorities in Aboriginal health be reviewed, especially regarding how it could be strengthened, including information to members to enable them to monitor and comment on the allocation of funds; and
- the need to clarify the respective roles and responsibilities of OATSIHS and NACCHO and processes of information sharing.

5.16 NACCHO agreed to rejoin the Health Council and a meeting was held in June 1998. DHAC advised the ANAO that one item addressed by the meeting was the need to review the operation of the Health Council. In establishing the Health Council, the Minister had identified a need for such a review.

National priorities

5.17 At the Health Council's second meeting in December 1996, members agreed that the Health Council would play a more significant role in the directions and matters for consideration for future meetings. In considering a report on partnership priorities for 1997-98 at the Council's third meeting in July 1997, members confirmed some national priorities for the Health Council, including:

- making the partnerships within each State and Territory succeed, and monitoring performance of the forums and specifically the regional planning process;
- seeking status reports on progress against core elements of the framework agreements;

- developing proposals for the Minister to consider adding to the capacity of existing Aboriginal community controlled health services;
- developing policy options for consideration by the General Practice Strategy Review and discussion with the Review regarding where best to provide advice; and
- developing longer term strategies for mental health, in addition to those in the current Emotional and Social Well-Being Action Plan, and exploring options to link the Social Health Working Party to the Council.

5.18 The Minister approved the establishment of sub-committees of the Health Council to provide it with the capacity to address key issues of service delivery in remote areas, workforce initiatives and substance misuse. These sub-committees were to meet on a needs basis, which in the main has been quarterly.

5.19 The Health Council has noted the activities of each of the sub-committees without any specific recommendations for action flowing from the work undertaken. Members were asked at the Health Council meeting in July 1997 to provide comments on a position paper *Health Service Delivery in Remote Aboriginal Communities* out of session. The difficulties with NACCHO membership of the Health Council in late 1997 has resulted in limited progress of issues to be addressed by the Health Council over the 12 months to June 1998. The move to quarterly Health Council meetings provides increased opportunities to progress Health Council business.

Arrangements with the Aboriginal and Torres Strait Islander Commission (ATSIC)

5.20 A Memorandum of Understanding (MOU) was developed in November 1995 as a basis for cooperation between the Department and ATSIC. It will be recalled that ATSIC has responsibility for environmental health programs. These include the construction of housing, water, sewerage and related infrastructure in Aboriginal and Torres Strait Islander communities.

Memorandum of Understanding (MOU)

5.21 The MOU will operate until 30 June 2000. The MOU's goal is for DHAC and ATSIC to:

> *work together to improve outcomes for Aboriginal and Torres Strait Islander peoples by improving access to culturally appropriate, needs based and cost effective health care, community services and environmental services and facilities equal to that enjoyed by non-Indigenous Australian.*

The MOU does not state the level of outcomes expected.

5.22 The ANAO found that the MOU reflects the essential and relevant elements of the 'National Commitment to Improved Outcomes in the Delivery of Programs and Services for Aboriginal Peoples and Torres Strait Islanders' endorsed by the Council of Australian Governments in Perth in December 1992. This multilateral national commitment was developed following Heads of Government agreement in May 1992 on the need to achieve greater coordination of the delivery of programs and services by all levels of government to Aboriginal peoples and Torres Strait Islanders.

5.23 One of the specific purposes of the National Commitment was to provide a framework for bilateral agreements between governments for the delivery of specific programs and services. Prior to the development of the MOU and the Framework Agreements with the States and Territories, the National Commitment had existed but with little evidence of it being addressed in the Aboriginal health area. That is, there were no agreements or arrangements in place aimed at achieving greater coordination between levels of government to produce improved outcomes in the delivery of health programs and related services to Aboriginal and Torres Strait Islander peoples.

5.24 The framework for cooperation set out in the MOU has two focal points, namely national policy development and program planning.

National policy development - Joint Committee

5.25 To facilitate national policy development, including an effective basis for cooperation between ATSIC and DHAC, a Joint Committee was established. Membership comprises the Commission's Chief Executive Officer and the Health Portfolio Commissioner, and the Departmental Secretary and the First Assistant Secretary of OATSIHS.

5.26 Specifically, the Joint Committee was established to:

- set policy directions generally and for Commonwealth/State negotiations on health services and environmental health programs;
- discuss the outcomes being achieved across the range of health, substance misuse and community services programs, including those delivered by the States; and
- provide a forum for discussing policy issues in environmental health and other Commission programs to ensure that the activities of each were complementary.

5.27 The frequency of meetings of the Joint Committee was not addressed in the MOU. Three meetings have been held between November 1995, when the MOU was signed, and March 1998, the date of the most recent meeting.

5.28 The central issue of links between primary and environmental health programs was discussed at the Committee's first meeting and members agreed to further discuss coordination that had palpable benefits for agencies. The ANAO found that the Joint Committee was yet to establish a formally agreed framework for coordination of primary and environmental health programs between the Commission and DHAC more than two years after the MOU was signed.

5.29 The ANAO found, at the time of the audit, that this lack of an agreed framework was reflected:

- at the national level, where there was no exchange of program information regarding organisations/projects being funded and their locations. An exchange of information would assist to coordinate funding of primary health and environmental health in communities and/or regions; and
- at the State level, where there was little or no liaison between ATSIC and DHAC staff on Aboriginal health and environmental health programs.

5.30 A meeting of OATSIHS and ATSIC officers in September 1997 agreed that information on funded organisations would be exchanged. The ANAO found that there was contact between ATSIC and the Department at the project level, in particular, in regard to the ATSIC Army Community Assistance Program, the Health Infrastructure Priority Projects (HIPP), and in relation to the Housing and Infrastructure Needs Survey. There were also instances where details of planned environmental health projects were provided as part of the regional planning process. However, the ANAO considers that such contact is no substitute for the agreed framework for cooperation envisaged in the MOU.

5.31 DHAC's resource allocation to primary health care providers in the community controlled sector will be better informed once the Department has adequate national information about ATSIC's funding of housing and infrastructure, mostly in the same communities as those funded by DHAC. In order to demonstrate what adequate whole-of-government financial data to guide resource allocation can look like, the ANAO calculated combined total Commonwealth expenditure on DHAC's primary health care and ATSIC's environmental health programs. The data are shown in Table 5.1.

Table 5.1

Expenditure On Primary Health (DHAC) And Major Environmental Health Projects (ATSIC) By ATSIC Region, 1996-97

ATSIC REGION	DHAC PRIMARY HEALTH EXPEND ($)	% OF TOT	ATSIC CHIP EXPEND ($)	% OF TOT	TOTAL EXPEND ($)
Cooktown	1 087 729	32	2 275 000	68	3 362 729
Cairns	2 932 002	88	395 000	12	3 327 002
Mount Isa	306 329	12	2 251 000	88	2 557 329
Townsville	2 603 918	100	0	0	2 603 918
Rockhampton	925 013	89	110 000	11	1 035 013
Roma	1 465 595	66	740 000	34	2 205 595
Brisbane	5 296 329	100	0	0	5 296 329
Sub-Total Qld	**$14 616 915**	**72**	**$5 771 000**	**28**	**$20 387 915**
Coffs Harbour	2 698 949	74	924 700	26	3 623 649
Tamworth	1 482 947	70	633 000	30	2 115 947
Bourke	2 816 174	72	1 100 000	28	3 916 174
Wagga Wagga	1 036 386	81	240 000	19	1 276 386
Sydney	5 369 384	73	2 000 000	27	7 369 384
Queanbeyan	1 823 198	48	1 950 000	52	3 773 198
Sub-Total NSW	**$15 227 038**	**69**	**$6 847 700**	**31**	**$22 074 738**
Wangaratta	5 411 947	96	200 000	4	5 611 947
Ballarat	2 197 410	92	200 000	8	2 397 410
Sub-Total Victoria	**$7 609 357**	**95**	**$400 000**	**5**	**$8 009 357**
Hobart (Tas)	**$1 412 438**	**76**	**$435 500**	**24**	**$1 847 938**
Adelaide	4 457 725	100	0	0	4 457 725
Ceduna	1 910 167	65	1 009 000	35	2 919 167
Port Augusta	4 387 216	62	2 650 000	38	7 037 216
Sub-Total South Aust	**$10 755 108**	**75**	**$3 659 000**	**25**	**$14 414 108**
Aputula	2 634 391	45	3 163 250	55	5 797 641
Alice Springs	4 135 158	100	0	0	4 135 158
Tennant Creek	2 073 884	55	1 685 000	45	3 758 884
Katherine	1 350 240	13	9 400 000	87	10 750 240
Nhulunbuy	1 814 368	34	3 530 000	66	5 344 368
Jabiru	241 855	10	2 250 000	90	2 491 855
Darwin	3 263 129	47	3 610 000	53	6 873 129
Sub-Total NT	**$15 513 025**	**40**	**$23 638 250**	**60**	**$39 151 275**

ATSIC REGION	DHAC PRIMARY HEALTH EXPEND ($)	% OF TOT	ATSIC CHIP EXPEND ($)	% OF TOT	TOTAL EXPEND ($)
Kununurra	3 083 348	54	2 607 580	46	5 690 928
Derby	1 971 688	24	6 204 000	76	8 175 688
Broome	1 734 064	26	4 850 000	74	6 584 064
South Hedland	2 081 063	80	525 000	20	2 606 063
Warburton	2 202 217	24	7 001 000	76	9 203 217
Geraldton	1 456 412	59	1 020 000	41	2 476 412
Kalgoorlie	1 739 269	95	100 000	5	1 839 269
Narrogin	166 760	100	0	0	166 760
Perth	3 166 415	94	200 000	6	3 366 415
SUB-TOTAL WA	**$17 601 236**	**44**	**$22 507 580**	**56**	**$40 108 816**
TOTAL AUSTRALIA	**$82 735 117**	**57**	**$63 259 030**	**43**	**$145 994 147**

5.32 ATSIC expenditure in the above table relates to major environmental health projects under the Community Housing Infrastructure Program (CHIP) that were readily identifiable by ATSIC Region in ATSIC information systems. This was only part of the total CHIP expenditure in 1996-97 of $203 million. The majority of the other $140 million was spent on smaller projects through Regional Council Budgets.

5.33 The above Table identifies that, across Australia, funding of approximately $146 million was provided for primary health and major environmental health projects in 1996-97. The ANAO analysed the location of the funding and matched ATSIC's major environmental health project funding to the closest community controlled Aboriginal Health Service (AHS). This analysis identified that:

- 185 organisations received DHAC health and substance misuse funding in 1996-97, and ATSIC major environmental health project funding was matched to 46 of these; and
- the 46 organisations were widely spread with three in capital cities, 13 in rural areas and 30 in remote locations.

5.34 A more complete analysis might identify funding trends over more than one year, for instance, funding on a three or five year basis. The budgets for ATSIC's HIPP, and ATSIC's National Aboriginal Health Strategy (NAHS) over the five year period 1995-96 to 1999-2000 would be a better basis because in 1996-97, the year for which data were shown in Table 5.1, NAHS expenditure was just beginning and there was only a relatively small number of projects, while HIPP expenditure was concentrated in Western Australia.

5.35 Notwithstanding these limitations on the data, the above Table, by highlighting the ATSIC regions which receive primary health and major environmental health project funding, demonstrates the use to which program funding data from DHAC and ATSIC can be put. The ANAO found that at the time of audit, DHAC's primary health funding did not take account of ATSIC's funding of environmental health programs and vice versa.

5.36 DHAC advised that the allocation of new funding, such as the Remote Communities Initiative in 1996-97, has been undertaken in collaboration with ATSIC's environmental health programs. The ANAO sees this as a start to broader collaboration on primary and environmental health programs.

Recommendation No. 8

5.37 The ANAO recommends that DHAC and ATSIC more effectively coordinate their primary and environmental health programs by sharing data on the level, nature and geographical location of their expenditures.

DHAC Response

5.38 Agreed. ATSIC and the Department are both members of the State Forums established under the Aboriginal and Torres Strait Islander Framework Agreements, and exchange information on program activity and service delivery in these forums. The Department has published data on the location of funded services and is considering the publication of aggregate details of funding to further promote information sharing and analysis. ATSIC has also provided the Department with information on its environmental health programs.

5.39 Whilst the Department strongly advocates information sharing amongst stakeholders, it is just as important that this information describes what is being funded or purchased in different communities if it is to be of value in resource allocation decisions.

ATSIC Response

5.40 Agreed. ATSIC is committed to the consultative and coordination arrangements under the MOU. ATSIC is committed to the spirit of cooperation that the arrangements envisage, and to ensuring that its environmental health programs and primary health care programs of both State and Commonwealth Governments are coordinated.

Framework agreements with States/Territories, ATSIC and NACCHO

5.41 An important element of the 1995-96 Federal Budget initiatives was that the Department would work closely with ATSIC to develop bilateral agreements with the States and Territories on improved access to culturally appropriate mainstream health services for Aboriginal and Torres Strait Islander people.

5.42 Australian Health Ministers agreed to an approach, framework and timelines for bilateral negotiations in June 1995, before the Department formally assumed responsibility for Aboriginal and Torres Strait Islander health. The Health Ministers agreed that the agreements were to aim for improved health outcomes for Aboriginal and Torres Strait Islander peoples and were to be underpinned by the principles underlying the National Aboriginal Health Strategy, namely:

- acceptance of Aboriginal and Torres Strait Islander peoples' holistic view of health;
- recognition of the importance of local Indigenous community control and participation; and
- intersectoral collaboration.

5.43 The timeframe proposed by the Health Ministers recognised that the Memorandum of Understanding (MOU) between ATSIC and the Department needed to be finalised prior to consultation with the States/ Territories. The MOU was signed in November 1995. A draft Commonwealth/State Agreement on Aboriginal and Torres Strait Islander health was developed following a joint meeting of ATSIC, NACCHO and the Department in April 1996.

Progress of agreements

5.44 A Commonwealth negotiating team, comprising representatives from the DHAC and ATSIC, consulted with community controlled health organisations and ATSIC Regional Councils in each State and Territory. Framework Agreements were signed in six of the eight States and Territories by November 1996. Due to legal issues, the Agreement for Tasmania was not signed until March 1998, while the Northern Territory Government did not sign an Agreement until April 1998. The Agreements were signed by the Commonwealth Minister for Health, the State Minister for Health, and by the Chairperson of the Aboriginal and Torres Strait Islander Commission, with involvement in all agreements of the State NACCHO affiliate.

5.45 Negotiations with the Queensland Government are also proceeding regarding a suitable mechanism to embed the principles of the Framework Agreements for the Torres Strait region. These negotiations commenced subsequent to the signing of the Queensland Framework Agreement.

Content of agreements

5.46 The ANAO found that DHAC played a leading role in the development of the Framework Agreements. The ANAO also found that the Framework Agreements were developed in line with the principles espoused in the 'National Commitment to Improved Outcomes in Delivery of Services for Aboriginal Peoples and Torres Strait Islanders, 1992' and are in line with guidance provided through the Joint Health Planning Committee. Major issues such as ATSIC involvement, community control of service delivery, culturally appropriate mainstream delivery, intersectoral collaboration, and Aboriginal and Torres Strait Islander involvement in planning, management and service delivery are addressed. The ANAO identified that there are minimal variations in wording across the various signed State/Territory Agreements, reflecting State/Territory preferences and conditions.

5.47 Each Agreement will operate, unless otherwise agreed, until 30 June 2000. The aim of the Agreements is to improve health outcomes for Aboriginal and Torres Strait Islander peoples through:

- improving access to, and appropriateness of, both mainstream and Aboriginal and Torres Strait Islander specific health and health related programs;
- increasing the (or maintaining an adequate) level of resources to reflect the higher level of need of Aboriginal and Torres Strait Islander peoples, including within mainstream health services, and transparent and regular reporting for all services and programs; and

- joint planning processes which allow for full and formal Aboriginal and Torres Strait Islander participation in decision making and determination of priorities, improved cooperation and coordination of current service delivery by all spheres of Government, increased clarity with respect to the roles and responsibilities of the key stakeholders and enhanced effectiveness and efficiency of resource development and application.

5.48 The ANAO considers that the Framework Agreements are 'in principle' agreements, without any detail committing the parties to undertake specific action, provide a level of funding or achieve quantifiable outcomes within an agreed timeframe. Furthermore, there is no recourse for DHAC where States and Territories do not comply with the requirements of the Agreements. The ANAO considers the value of these Agreements as being in clarifying expectations of State and Territory governments.

5.49 Initially, the development of action plans was planned to underpin the Framework Agreements but these were not progressed as a result of consultation with State Governments. It would now appear that such a level of detailed planning will be undertaken when particular issues are addressed by the parties to the Agreements, eg, as part of joint planning.

State forums

5.50 A State Forum is a consultative body established in each State/ Territory under the respective framework agreement. The role of the Forum as set out in the Framework Agreement is threefold, namely to decide on key issues about regional planning, to contribute to policy and planning development, and to evaluate implementation of the Framework Agreement. Membership of a Forum includes representatives from DHAC, the State/Territory Department of Health, the State affiliate of NACCHO, and ATSIC. The size of each Forum was left for the relevant stakeholders to determine based on guidance from OATSIHS Central Office.

5.51 The ANAO found that DHAC continued to play a leading role in bilateral arrangements in establishing a formal network between stakeholders through each State Forum, and that:

- each State Forum had considered its role and had emphasised regional planning as an immediate priority;
- some policy issues have been considered;
- there has been no action regarding the evaluation of the implementation of the framework agreement;

- regional planning had progressed in different ways in the States and Territories, with the completion of the Central Australia regional plan, and South Australia and Queensland having made good progress in developing regional plans;
- unlike in other agreements, the Queensland Framework Agreement did not include a specific requirement for funding of the State Aboriginal community controlled health organisation, Queensland Aboriginal and Islander Health Forum (QAIHF), by the Queensland Government. Despite DHAC's representation, funding has not been provided by the State. DHAC has looked to provide some funding to enable QAIHF to, among other things, participate in the regional planning process; and
- the formation of the Forums has created linkages between the parties and has focussed their attention on the need for collaboration on a range of issues. In some States this is occurring routinely other than in the Forum meetings.

5.52 The ANAO found that senior OATSIHS staff had played a very important role in advancing issues when barriers had been encountered in dealings with stakeholders at officer level. That is, DHAC had done all it could to ensure the success of bilateral arrangements.

5.53 The ANAO also found that OATSIHS had supported the joint planning aspect of the framework agreements by making single payments, totalling $2.425 million, to state health departments and payments totalling $365 000 to the relevant NACCHO affiliates. Payments were approved by the Minister for Health, subject to agreement in principle by States/ Territories to sign the relevant Framework Agreement.

5.54 In addition to the funding under the framework agreements, some States/Territories received OATSIHS funding of $8 million. This was aimed at increasing the level of health services available to the Aboriginal and Torres Strait Islander community. The $8 million was allocated to the Northern Territory, Western Australia, South Australia, and Queensland Governments for 1996-97. The allocations were determined on the basis that these States and the Northern Territory already provided health services in Aboriginal communities through salaried medical officers (District Medical Officers).

5.55 The on-going costs of new primary health care services established with the funding were to be provided through bulk-billing of these medical officers in agreed communities only. The funded States were requested to develop plans on how and where new services would be established, how communities would be involved in the process, and how the seeding funds would be applied. DHAC approved Queensland's proposal in March 1997 and activity commenced shortly afterwards. Discussions were continuing with the other jurisdictions at senior levels.

5.56 With the regional planning process in progress it is too early to identify what impact the signing of Framework Agreements and the establishment of State Forums have had on the level of health services and on Aboriginal health in general.

5.57 The ANAO considers that timely evaluation of the implementation of a framework agreement will identify the impact of the agreement on the delivery of Aboriginal health services and the working relationships of the stakeholders. An evaluation may also address ways of improving the effectiveness of working arrangements under the agreement and any subsequent negotiation of the agreement. More effective working arrangements and associated improved collaborative effort will facilitate a cohesive approach to addressing health service delivery needs of the Aboriginal and Torres Strait Islander population.

Regional planning

5.58 Under the Framework Agreements the Commonwealth and the States/Territories agree to joint planning processes at the National, State and local level that include the following consultation mechanisms:

- the Aboriginal and Torres Strait Islander Health Council;
- a viable and independent Commonwealth funded NACCHO;
- a State/Territory Forum that includes representation from any State/ Territory Aboriginal community controlled health organisations, the Commonwealth and State/Territory Departments of Health and ATSIC; and
- a viable and independent Aboriginal community controlled health organisation, in the main, with specific reference to it being funded by the State/Territory.

5.59 The planning process included an initial meeting of the State/ Territory forum to decide on the level and most appropriate means to be used for regional and/or local planning. Subsequent meetings were timed to support the regional planning process. The aim of the regional and/or local plans is to identify gaps and opportunities in health service provision and priorities to improve health services (including mainstream services) and environmental health.

5.60 This approach to the needs assessment has enabled a focus on:

- better targeting of mainstream services;
- any expansion of existing services to perform new functions; and
- any establishment of new services.

5.61 The ANAO found that:

- regional planning of Aboriginal and Torres Strait Islander health service provision by the State Forum in each State and Territory is the only means by which the health needs of the Aboriginal and Torres Strait Islander population are currently being addressed;
- progress across the States and Territories has been variable. For example by May 1998, South Australia had developed a regional plan and Queensland had completed the development of its profiles of communities of interest but had not developed an agreed regional plan. In NSW, an Aboriginal Regional Working Group had been established which had met with mixed results, and Western Australia had established regional planning teams which were meeting separately to work on the plans. In the Northern Territory, a regional plan had been developed for Central Australia, while with the delayed signing of the Framework Agreement in Tasmania on 30 January 1998, regional planning had not progressed; and
- the issue of addressing these health needs was a major component of the 1995 Federal Budget Initiatives and the Aboriginal community controlled primary health care sector had an expectation that funding on the basis of need would occur earlier than 1999-2000 (at the earliest).

5.62 DHAC advised that OATSIHS is making progress on a further review of funding for AHSs. OATSIHS plans to develop base models from data collected in the service activity reporting process to ensure AHSs are adequately resourced (based on populations, activities and service utilisation). OATSIHS is also examining various health financing options, in conjunction with other parts of the Department, to improve the basis of funding for Indigenous health.

5.63 The ANAO considers that if the regional planning process in each State/Territory is not effective in achieving desired outcomes, the health needs of the Aboriginal and Torres Strait Islander population or parts of the population will not be addressed.

5.64 Where the progress of regional planning in particular States/ Territories is relatively slow, DHAC should consider what action is required to facilitate faster progress. This may include developing incentives through the State Forum to facilitate progress on regional planning. In addition, DHAC may need to review other options to address the health needs of the Aboriginal and Torres Strait Islander population in those areas. DHAC believes it would be inappropriate to provide incentives to state/ territory health agencies, but supports the notion of developing incentives through the State Forums to facilitate progress on regional planning.

Recommendation No. 9

5.65 The ANAO recommends that DHAC:

- emphasise in State Forums the importance of a focus on health status outcomes as a key component of regional planning;
- take action, through its State Forum representatives, to establish a timeframe for the implementation of needs-based funding;
- examine the feasibility of providing suitable incentives to stakeholders to complete regional planning; and
- where the progress of regional planning is likely to unduly delay the health needs of the Aboriginal and Torres Strait Islanders being identified, address other suitable options and take action to identify those health needs as a matter of priority.

DHAC Response

5.66 Agreed with qualification. The target date for the development of regional plans is July 1999. As new policy funding announced in the May 1998 Federal Budget is linked to needs identified through the regional plans, an incentive does exist for each State Forum to move quickly to establish their regional plans.

5.67 The Department also supports the inclusion of health status in the development of regional plans, though it should be noted that in most cases, health status data is not available at the local level and would be expensive and time consuming to collect.

5.68 The Department agrees that alternative arrangements need to be considered for the allocation of resources should regional plans be unduly delayed. Service delivery and community needs data is already being drawn together under the State Forums and could, if required, be used to allocate resources in the absence of an agreed plan. The Department has already demonstrated its ability to allocate resources through alternative regional planning approaches, such as the Remote Communities Initiative in 1996-97, and the allocation of resources for specific health strategies targeted at major causes of excess mortality and specific risk factors.

5.69 In addition, Budget funding in 1998-99 was also provided for the implementation of best practice measures. It is anticipated that service quality enhancement information will become available using the Service Activity Reporting arrangements, complementing the regional planning approach currently underway.

5.70 The advent of regional planning provides a new opportunity for DHAC to provide leadership in addressing Indigenous health needs at the state and local levels. It can do this by providing examples of best practice in community controlled primary health care. For example, in conjunction with stakeholders, DHAC could identify an effective national anti-smoking project, drawing the attention of state and territory health authorities and state forums to the combination of project design, objectives and resources which make a particular project successful. Another way in which DHAC could assist state and territory government health agencies through state forums is by identifying and promoting particularly successful models of primary health care for Indigenous Australians. This is particularly important where no best practice models exist.

Recommendation No. 10

5.71 The ANAO recommends that DHAC, in its national role, work with other stakeholders through State Forums to identify models of best practice in primary health care which could be applied to relevant programs.

DHAC Response

5.72 Agreed. The 1998-99 Budget provided funding for the promotion of best practice in primary health care service delivery and the Department has already started to develop strategies in partnership with stakeholders to implement a best practice/quality improvement program. Best practice models for specific conditions will be widely disseminated, including through a nationally funded internet clearing-house.

Reporting arrangements

5.73 The Framework Agreements include reporting and monitoring arrangements, with an evaluation of the implementation of each agreement at two levels, namely, state/territory (through a State Forum established under each agreement) and national (through the Aboriginal and Torres Strait Islander Health Council).

5.74 In addition, the Commonwealth and the State/Territory governments under each agreement agreed to report regularly (generally on a six monthly basis) on progress in implementing their commitments at each Australian Health Ministers' Conference (AHMC). This reporting is to include, as a minimum, data on:

- funding for community controlled health services;
- improved outcomes for mainstream services; and
- linkages between community controlled and mainstream services including innovation in coordinated care.

5.75 The ANAO found that to date, other priorities at AHMCs, including the Medicare/Health Care Agreements, had resulted in minimal reporting under the Framework Agreements. DHAC advised that reporting under the Framework Agreements was on the agenda for the AHMC on 30 July, including to address the need for regular reporting in future.

Recommendation No. 11

5.76 The ANAO recommends that, as part of its national role, DHAC meet its reporting obligations under the Framework Agreements and work with state/territory health agencies to assist them to fulfill their reporting obligations.

DHAC Response

5.77 Agreed. The Commonwealth has recently provided a progress report against its Framework Agreement obligations to the July 1998 AHMC. At that meeting, the Commonwealth, States and Territories agreed to report annually to AHMC on progress towards implementing the Framework Agreements. The Commonwealth will be working with the States and Territories in developing a consistent format for these jurisdictional reports.

Conclusion

5.78 DHAC had consulted broadly and effectively with stakeholders on the implementation of 1995 Federal Government initiatives for Aboriginal and Torres Strait Islander health. As a result, a basis has been established to facilitate effective cooperation of stakeholders. The framework includes an MOU with ATSIC, an Aboriginal and Torres Strait Islander Health Council and agreements with the States and Territories on improved access to culturally appropriate mainstream health services for Aboriginal and Torres Strait Islander people.

5.79 The MOU is yet to achieve effective coordination of primary health and environmental health programs. There have been some difficulties encountered in the operation of the Health Council which are being addressed by DHAC.

5.80 The agreements with the States/Territories are 'in principle' agreements without any detail committing the parties to undertake specific action. The first major issue being addressed is the identification of the health needs of Aboriginal and Torres Strait Islander communities through State/Territory based regional planning. This is currently the only means by which these health needs are being addressed. Progress on regional planning across each State and Territory is variable.

5.81 The implementation of the Framework Agreements remains to be evaluated from both a State and Commonwealth perspective, and effective reporting by the Commonwealth and the States/Territories is not yet in place.

6. Commonwealth Mainstream Health Programs

This Chapter addresses the Department's implementation of Federal Budget Initiatives for Aboriginal and Torres Strait Islander health that targeted its mainstream health programs.

6.1 Mainstream health services are interpreted in the Framework Agreements signed by the Commonwealth, States/Territories, ATSIC and NACCHO affiliates as health and health related services which are available to, and accessed by, the general community. Various statements on funding for Aboriginal and Torres Strait Islander health, past and present, by governments, ministers and departmental management, have generally emphasised the intention that specific funding for Aboriginal health was a supplement to health services available through mainstream programs.

6.2 A major reason for the transfer of responsibility for Aboriginal and Torres Strait Islander health programs from ATSIC to the Commonwealth Department of Human Services and Health was to bring about a greater focus on Aboriginal and Torres Strait Islander health needs in mainstream health programs. The Department put this administrative shift of responsibility in perspective in its 1995-96 Annual Report by identifying that while the shift was aimed at developing a greater focus in mainstream programs, AHSs would continue to be the main model for Commonwealth-funded primary health care for Aboriginal and Torres Strait Islander people.

Focus on Aboriginal and Torres Strait Islander health in departmental mainstream programs

6.3 As part of addressing the 1995-96 Budget initiative, in August 1995 departmental senior program managers were tasked with identifying the following in relation to each program:

- Commonwealth and State roles and responsibilities for Indigenous health;
- barriers to access for Aboriginal and Torres Strait Islanders, including identifying those that may be addressed through the Framework Agreements;
- how access and equity outcomes could be developed and reported for mainstream health programs for Aboriginal and Torres Strait Islanders;

- proposals for initiatives which would improve access to services by Aboriginal and Torres Strait Islanders, and
- the involvement of Aboriginal and Torres Strait Islanders in decision making roles.

6.4 In August 1996, OATSIHS briefed the DHAC senior program managers on progress in negotiating agreements with State/Territory governments and highlighted the resultant obligations placed on the managers. In addition, the OATSIHS identified structural barriers within DHAC that impeded access by Aboriginal and Torres Strait Islander people to programs, services or resources. Common barriers were identified at the portfolio level and specific barriers were identified for specific programs.

6.5 At the end of 1996 each senior program manager developed an action plan to improve departmental capacity to provide an appropriate service for Aboriginal and Torres Strait Islanders. These action plans incorporated key issues, next steps, performance indicators, and targets.

6.6 During 1997 OATSIHS worked with mainstream program staff to develop policy and implementation plans to make mainstream services more accessible to Aboriginal and Torres Strait Islander people.

6.7 The ANAO found a greater focus in DHAC mainstream health programs on the Aboriginal and Torres Strait Islander population than in earlier years. This greater focus included:

- the 1997-98 Departmental Corporate Plan introduces Aboriginal and Torres Strait Islander Health and Well Being as a Cross Program Key Result Area, one of five such key result areas across programs;
- twelve sub-programs across six divisions include an equity performance indicator for 1997-98 which is either a direct (8) reference to Aboriginal and Torres Strait Islander people or an indirect reference (4) to target groups, special needs groups or population sub-groups;
- the Health Insurance Commission (HIC) review of access to the Medical Benefits Scheme (Medicare) and Pharmaceutical Benefits Scheme (PBS);
- $8 million in payments to Queensland, South Australia, Western Australia and the Northern Territory in July/August 1996, as a result of issues raised by State/Territory governments during negotiations of Framework Agreements, for additional medical services to be provided to Aboriginal communities;
- four Aboriginal and Torres Strait Islander Coordinated Care Trials have been approved covering six sites across New South Wales, Western Australia and the Northern Territory;

- expenditure of $8 million in 1996-97 for remote housing to attract more doctors to remote areas as part of the general practice workforce adjustment program;
- expenditure of $1.7 million in 1997-98 from the Rural Health budget for eye health initiatives in Aboriginal and Torres Strait Islander communities;
- the development of a strategy to improve access to specialist medical services in rural and remote Aboriginal and Torres Strait Islander communities; and
- development of the previously mentioned report on 'Expenditures on Health Services for Aboriginal and Torres Strait Islander People' commissioned by OATSIHS in late 1996 to estimate the level of public funding and expenditure for Aboriginal and Torres Strait Islander people, across the Commonwealth and States/Territories.

6.8 The ANAO considered that the action to address the Budget initiative to increase the access of Indigenous Australians to mainstream health programs was slow to commence but that the level of activity has increased in more recent times. No benchmarks exist to identify whether this level of activity is adequate.

6.9 The ANAO identified that very little of the above activity has been reported to stakeholders and Aboriginal and Torres Strait Islander communities. The ANAO considers that DHAC should look at the means by which it can provide progress reports on action to address the Budget initiative, as part of addressing the client service needs of the Aboriginal and Torres Strait Islander population.

Access to Medicare and the PBS

6.10 In late 1996, DHAC commenced a project to estimate public funding allocations and expenditures on health services used by Aboriginal and Torres Strait Islander people. The final report of January 1998, released publicly in August 1998, included estimates of *Net Public Expenditures on Health Services to Indigenous People, by Level of Government for 1995-96*[32]. The report estimated that average per capita expenditures through Medicare and PBS on Aboriginal and Torres Strait Islander people was one quarter of the average expenditures on other Australians.

[32] Op cit.

6.11 The HIC commissioned research into Aboriginal and Torres Strait Islander access to Medicare and the PBS. The report to the HIC in November 1997, referred to the research as demonstrating that Aboriginal and Torres Strait Islander peoples everywhere face considerable barriers which impede full access to both Medicare and the PBS[33]. This report is being considered by the HIC regarding implementation of its recommendations.

6.12 The barriers to access referred to in the HIC report predominantly related to:

- an enrolment process based on voluntary registration and developed to ensure that ineligible people (eg, tourists and illegal immigrants) were not able to access the schemes. In particular this resulted in rigorous identification requirements;
- varying levels of enrolment of Aboriginal and Torres Strait Islander peoples, especially in rural and remote areas. For example Aboriginal and Torres Strait Islanders with no effective Medicare number ranged from 15-38 per cent in rural areas to 15-20 per cent in urban areas; and
- extensive administrative demands on AHSs in relation to Medicare, particularly those located outside urban areas. As a result, a number of AHSs decide not to use Medicare.

6.13 Steps taken by DHAC to address the barriers for Aboriginal and Torres Strait Islander people and so increase access to these schemes have been:

- approval from 1 July 1996 for all existing AHSs to bulk-bill Medicare. New AHSs required to submit applications for approval;
- approval from 1 July 1996 for some State health department services to bulk-bill for salaried medical officers and to return the additional funds to the community for expanded services;
- approval in April 1997 for the development of an implementation plan for the Commonwealth to fund PBS medicines to remote area AHSs under Section 100 of the National Health Act;
- approval for an ophthalmologist to operate from public hospitals in the Torres Strait and to bulk-bill; and
- the establishment of a Joint NACCHO/Departmental Working Group in October 1997, to review the access of Aboriginal people to Commonwealth Health Program Funding.

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33 'Market Research into Aboriginal and Torres Strait Islander Access to Medicare and the Pharmaceutical Benefits Scheme', Keys Young, 3 November 1997, Canberra.

6.14 While DHAC has taken steps to improve access to these Commonwealth mainstream programs for Aboriginal and Torres Strait Islander people, it has identified that there is more to be done to overcome the barriers. The ANAO found that the Department's management information systems provided very little information regarding the usage of mainstream programs by the Aboriginal and Torres Strait Islander population. As a result the Department had not yet assessed the impact of the steps already taken.

6.15 DHAC advised that:

- there are no Indigenous indicators in the Medicare enrolment file to monitor use of Medicare and the situation is the same for the PBS;
- since such indicators may be inconsistent with HIC legislation, the HIC has raised this matter with the Privacy Commissioner with no resolution to date;
- the recommendations of the 1997 HIC report will be pursued after consideration by the HIC regarding its response; and
- separate expenditure reporting measures from Medicare payments are being explored.

6.16 The HIC report made 48 recommendations for consideration by the HIC and other stakeholders. Most of the recommendations are very specific and cover a range of issues including the Medicare environment, accessing Medicare numbers, Medicare rebates, affordability of and access to medication, improving medication compliance, provision of information on Medicare and the PBS systems to AHSs and implementation of the report's recommendations. The HIC and the Department are preparing final responses to the report.

6.17 Two of the recommendations in relation to implementation address firstly, the need for a mechanism to be set in place to ensure that the issues raised in the report are considered and that appropriate action is taken, and secondly, that a process of consultation with peak bodies and community representatives should be established to facilitate feedback on the report and its recommendations.

6.18 The ANAO considered that DHAC had not yet addressed the issue of incentives for AHSs to use the Medicare system, or the overall benefit to the Commonwealth and AHSs in maximising use of Medicare as an alternative to total Commonwealth funding through DHAC.

6.19 The Department advised that it considered that the access to Medicare agreed by the Minister was to increase the resources made available for Aboriginal and Torres Strait Islander health, and to establish an incentive for AHSs to provide additional medical services. The Department also advised that this access was viewed as supplementary to grant funds and not subject to the conditions of grants. In addition, the Department advised that, although data is incomplete, up to 40 per cent of eligible AHSs and Substance Misuse Services have made use of the Medicare arrangements, but with low levels of payments noted.

6.20 Further, the Department advised that action is underway to remove administrative burdens and address enrollment problems, with a Memorandum of Understanding being developed for a Queensland project and with the Nganampa Aboriginal Health Council. Additional information will be provided to services, and along with streamlined arrangements, the Department expects that there will be an increase in Medicare usage.

6.21 The Department has taken the initiative to address the above issues of Indigenous access to mainstream health programs by forming a Joint NACCHO/Departmental Working Group. This Group, which was referred to earlier, is due to report in late 1998 on the following matters:

- current arrangements for access to health program funding for Aboriginal and Torres Strait Islanders, clearly identifying the interface with Commonwealth/State funding arrangements;
- recent innovative methods trialed in specific locations to increase such access and comments on the applicability of these more widely for the Aboriginal and Torres Strait Islander population; and
- options for future funding arrangements which would assist in improving the provision of health services to Aboriginal and Torres Strait Islander people.

Coordination between OATSIHS and departmental mainstream programs

6.22 Discussions with AHSs and departmental State Office staff highlighted the need for DHAC to review the most effective means of coordinating the variety of funding for Aboriginal and Torres Strait Islander health. A number of examples were referred across the AHSs visited by the ANAO which involved similar experiences where:

- funding had been provided by DHAC mainstream programs direct to funded organisations without consultation with, or knowledge of, the OATSIHS project officers working with those organisations; and

- funding provided by DHAC mainstream programs to States/Territories to manage and distribute without OATSIHS State Office staff being aware of the availability of the funding.

6.23 In the examples discussed with the ANAO, State Office staff suggested that funding had been distributed in other than the most effective manner, with other interested stakeholders alienated by DHAC mainstream funding decisions. In addition, State Office staff referred to instances where funded organisations had applied for grants directly to DHAC mainstream program areas for similar purposes for which they were already receiving funding from OATSIHS. The State Office staff became aware of the potential duplication of funding by chance and were able to take appropriate action.

6.24 Further, State Office staff commented that there was a need for increased liaison between OATSIHS and the General Practice Rural Incentive Program area regarding the funding of new rural and remote AHSs. One suggested means of addressing these problems was through service agreements between OATSIHS and mainstream program areas.

6.25 The ANAO found that there was a general perception amongst OATSIHS' state based staff that the Public Health Agreements[34] were being negotiated by DHAC mainstream program areas (on behalf of the Commonwealth) directly with the States/Territories, and were going into place, without OATSIHS advice on the health needs of Aboriginal and Torres Strait Islander people. The ANAO also found that a representative from OATSIHS participated in the development of the Public Health Agreements, and considers that the State Offices of the Department should be better informed of developments affecting Commonwealth-State relationships and therefore their work environment.

6.26 At the time of reporting, the ANAO was advised that Public Health Agreements had been signed with all States and Territories except Western Australia, where negotiations were at an advanced stage. The ANAO had reviewed the content of these Agreements and identified that they recognised the Aboriginal and Torres Strait Islander Framework Agreements, and sought to reflect the commitments made by the parties. The Agreements do not identify specific funding for Aboriginal and Torres Strait Islander health, but do require the State/Territory to provide a yearly progress report against activities relating to Aboriginal and Torres Strait Islander people.

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34 Public Health Outcome Funding Agreement between the Commonwealth and each State and Territory. These Agreements were preceded by a single Memorandum of Understanding between the Commonwealth and the States and Territories. These established a National Public Health Partnership aimed at better coordinating and integrating national public health strategies, whilst strengthening national public health infrastructure and capacity.

Recommendation No. 12

6.27 The ANAO recommends that DHAC coordinate the efforts of OATSIHS and mainstream programs in order to deliver the most effective and efficient funding to AHSs, including in relation to streamlining their accountability arrangements to make them more effective.

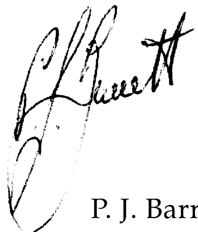
DHAC Response

6.28 Agreed.

Conclusion

6.29 DHAC has initiated action in a number of areas targeting more equitable access to mainstream programs for the Aboriginal and Torres Strait Islander population. In the main, action in most areas is at an early stage of implementation. Therefore, the outcomes of these initiatives remain to be assessed by DHAC and it was too early for any detailed ANAO review.

6.30 DHAC needs to better coordinate funding arrangements and associated accountability requirements for Aboriginal and Torres Strait Islander health and mainstream program funding of AHSs and Substance Misuse Services.



Canberra ACT
12 November 1998

P. J. Barrett
Auditor-General

Appendices

Appendix 1

Aboriginal and Torres Strait Islander population and their health

The 1996 Census of Population and Housing counted 18 310 700 people in Australia of whom 386 000 (2.1 per cent) identified as being of Indigenous origin.[35] The number of people who identified as being of Indigenous origin increased by 33 per cent between 1991 and 1996.

In April 1997 the Australian Bureau of Statistics (ABS) and the Australian Institute of Health and Welfare (AIHW) launched a new report, 'The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples'. This report has provided the most up-to-date statistics about Indigenous health and welfare[36]. The statistics and much of the commentary on those statistics included in this audit report are taken from that publication.

The major indices of Aboriginal and Islander health status reveal the following patterns in relation to the most recently available data, which is from 1994[37]:

- death rates for Indigenous people that were 3-4 times the rate for the rest of the Australian population;
- higher death rates for Indigenous people than non-Indigenous people in every age group, with the largest gap among adults aged 25-54 where death rates were 6-8 times higher;
- little improvement in death rates for Indigenous people between 1985 and 1994;
- Indigenous babies were 2-4 times more likely to die at birth than babies born to non-Indigenous mothers;
- Indigenous people were 2-3 times more likely to be hospitalised than Australian people in general;

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[35] ABS, Experimental Estimates of the Aboriginal and Torres Strait Islander Populations, Cat.3230.0, March 1998, Canberra, ABS.

[36] 'The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples', ABS and AIHW, ABS Catalogue No. 4704.0, AIHW Catalogue No. IHW2, AGPS, Canberra, April 1997. A summary is in 'The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples', ABS and AIHW.

[37] The Health and Welfare report commented that national statistics on deaths of Indigenous people were not available because of incomplete recording of Indigenous status in death records. At the time of publication in April 1997, the identification and recording of whether someone is Indigenous was reported as adequate in Western Australia, South Australia and the Northern Territory. Therefore, these data apply to those locations. This provides only part of the national picture because only one third of Indigenous people live in these areas. Chapter 3 of this audit report addresses the issue of the quality of data available and action being taken to improve the quality.

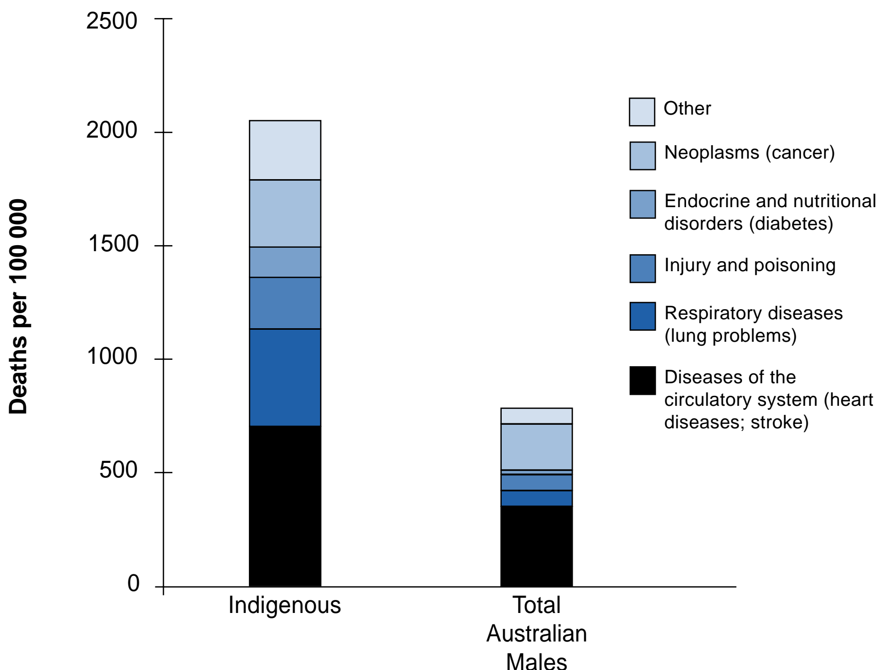
- life expectancy at birth for Indigenous people (58 years for males and 63 years for females[38]) was 15-20 years lower than that for the rest of Australians (75 years for males and 80 years for females), and there has been little improvement in the last 10 years; and
- life expectancy for Indigenous people was lower than for most countries of the world with the exception of some central African countries and India.

Causes of death

The graphs at Figures 1.1 and 1.2 compare causes of death for Indigenous and non-Indigenous people. They clearly show the much higher death rates experienced by Indigenous people for almost every group of conditions. It can be readily seen that more Indigenous females died (per 100 000) from diseases of the circulatory system than total Australian females died (per 100 000) from all causes of death.

Figure 1.1

Cause of Death — MALES 1992-94

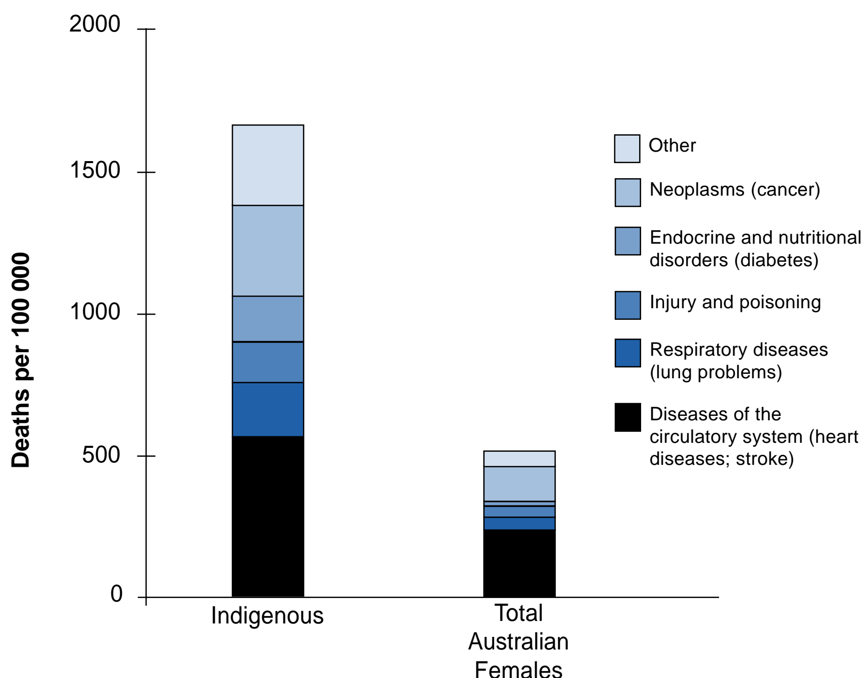


Source: Anderson P, Bhatia K & Cunningham J, 1996, Mortality of Indigenous Australians, ABS cat. No. 3315.0, ABS, Canberra

[38] Average across South Australia, Western Australia and the Northern Territory for the period 1992-94. Life expectancy for Indigenous males ranged between 56.7 and 61 years and for Indigenous females the range was 61.1 to 64.6 years.

Figure 1.2

Cause of Death — FEMALES 1992-94



Source: Anderson P, Bhatia K & Cunningham J, 1996, Mortality of Indigenous Australians, ABS cat. No. 3315.0, ABS, Canberra

Age-Standardised Death Rates

Little improvement in deaths rates has been observed between 1985 and 1994. The graphs at Figures 1.3 and 1.4 show the Age-Standardised Death Rates[39], All Causes, for Males and Females for the period 1984-1994. It should be noted that only data from Western Australia, the Northern Territory and South Australia was available.

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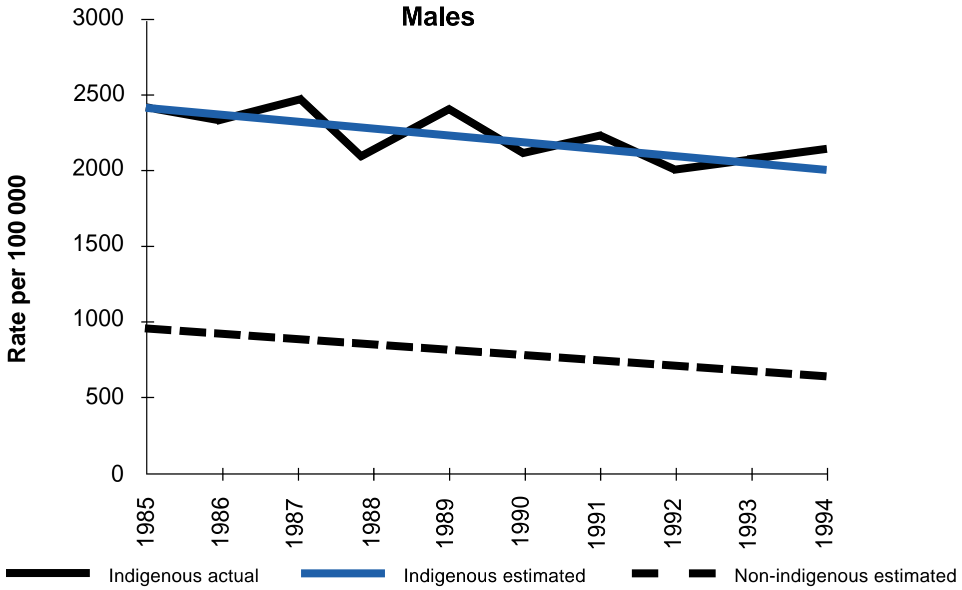
[39] A death rate which has been adjusted for differences in age distributions is called 'age-standardised death rate'. Death is strongly related to age and the age structure of the Indigenous population is very different to that of the non-Indigenous population. It is important to take this difference into account. An 'age-standardised death rate' represents the theoretical death rate which would have been observed if the population of interest had the same age structure as a particular reference population. (The standard population used is the 1991 mid-year Australian population). By using the same reference population, the age-standardised death rates for different populations can be compared, such as Indigenous and non-Indigenous populations.

Figure 1.3

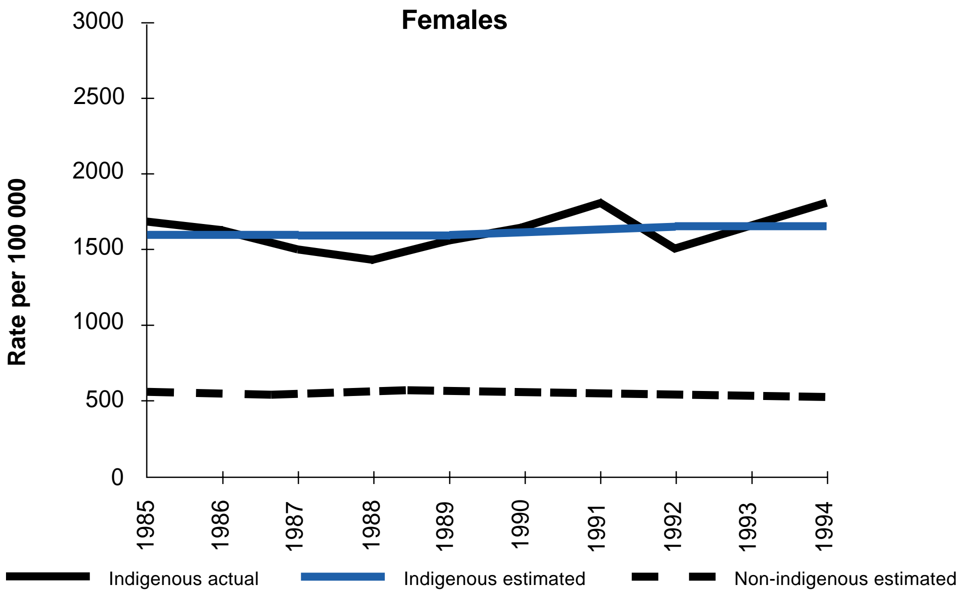
Age-standardised death rates — All Causes



Source: Anderson P, Bhatia K & Cunningham J, 1996, Mortality of Indigenous Australians. ABS cat. No. 03315.0, ABS, Canberra

Figure 1.4

Age-standardised death rates — All Causes



Source: Anderson P, Bhatia K & Cunningham J, 1996, Mortality of Indigenous Australians. ABS cat. No. 03315.0, ABS, Canberra

Mothers and babies

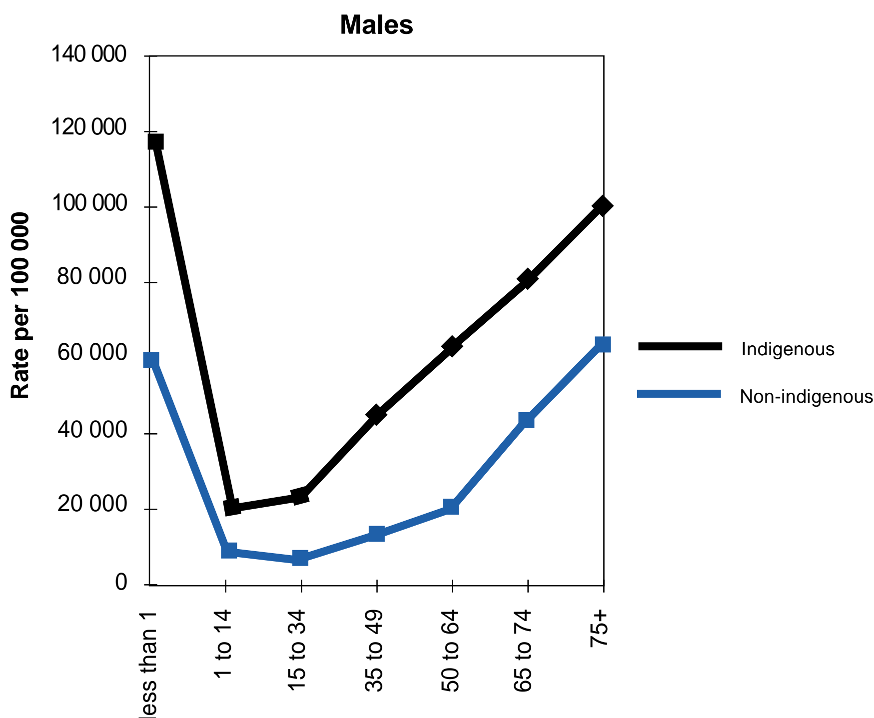
Poor health starts early for Indigenous people. On average, Indigenous mothers give birth at a younger age than non-Indigenous mothers. They are also more likely to have a medical condition complicating the pregnancy. In most States and Territories, Indigenous babies are about 2-3 times more likely to be of low birth weight (under 2.5 kg). They are also 2-4 times more likely to die at birth than babies born to non-Indigenous mothers.

Sickness

Indigenous people are about 2-3 times more likely to be hospitalised than all Australians. The graphs at Figures 1.5 and 1.6 show the number of hospital separations per 100 000 people for all causes combined[40]. The graphs do not include New South Wales, Tasmania or Victoria because in those States, the hospital records did not have reliable information about whether people were Indigenous. The graphs show that for both males and females, Indigenous people in every age group were more likely to go to hospital than non-Indigenous people.

Figure 1.5

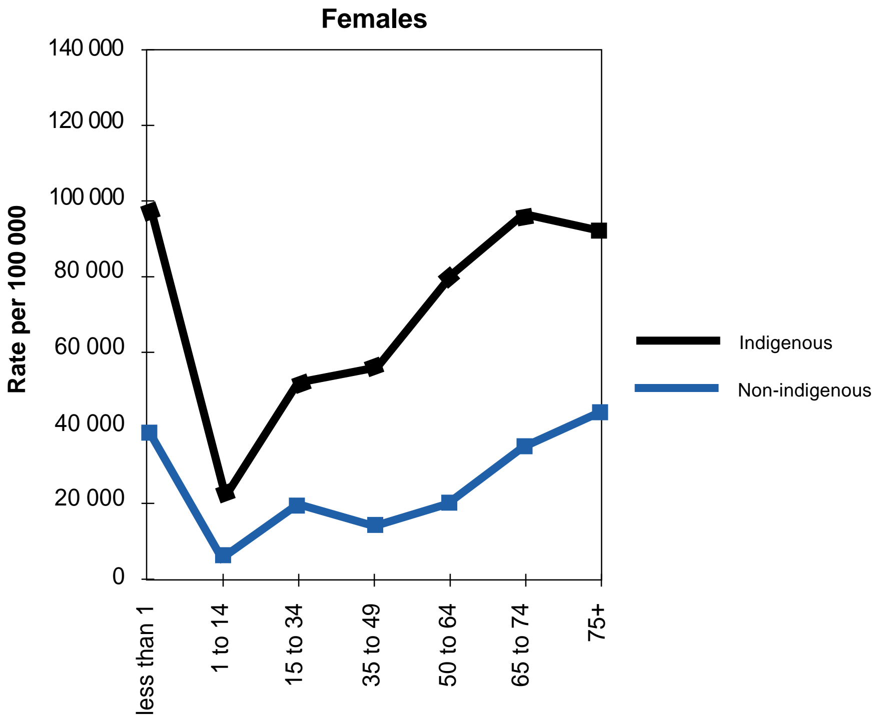
Hospital Separations — All Causes 1992-93



[40] Hospital separations are records of the times when people 'separate' from (leave) hospital, that is, they either go home, are transferred to another hospital or they die. As well as other details, the records should include information about whether a person is Indigenous or not.

Figure 1.6

Hospital Separations — All Causes 1992-93



Source: Australian Bureau of Statistics & Australian Institute of Health and Welfare, 1997 The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples, ABS cat. No. 4704.0, ABS, Canberra

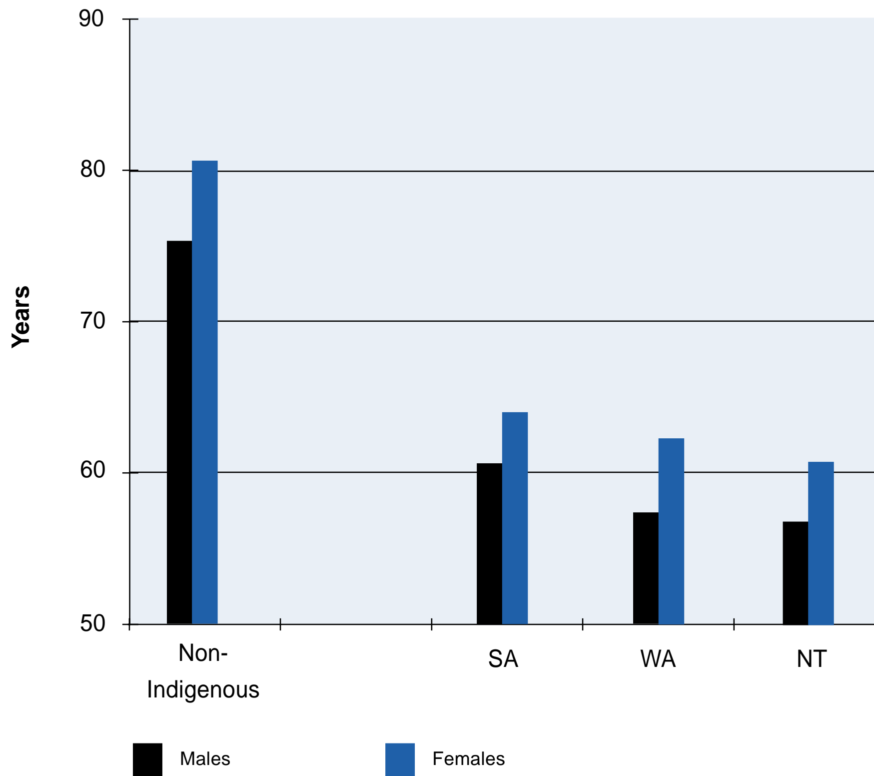
Indigenous Life Expectancy

Overall, Indigenous Australians are more likely to be sick and die at a younger age than non-Indigenous Australians, and this is true for almost every type of disease or condition for which information is available. One way of summarising what this all means is to look at life expectancy. Life expectancy at birth represents the average number of years a newborn baby could expect to live if the death rates of today were to continue throughout the baby's life.

In the period 1992-94, life expectancy at birth among non-Indigenous people was 74.9 years for males and 80.6 years for females. As the graph at Figure 1.7 shows, life expectancy at birth was 15-20 years lower for Indigenous people in Western Australia, South Australia and the Northern Territory. Data was only available for these jurisdictions.

Figure 1.7

Indigenous Life Expectancy at Birth — 1992-94



Source: Anderson P, Bhatia K & Cunningham J, 1996 Mortality of Indigenous Australians
ABS cat. No. 3315.0, ABS Canberra

Appendix 2

History of the Commonwealth's role in Indigenous health

Many times in the past Commonwealth Government spokespersons have remarked on the poor state of Aboriginal health and vowed that concerted action would be taken to bring about improvement.

An early example was in 1951, when Sir Paul Hasluck, Minister for Territories, toured the Northern Territory and promised a new deal for Aboriginals[41]. In March 1973 the Commonwealth Minister for Health approved a 'Ten Year Plan for Aboriginal Health' prepared by his Department. That Plan proposed that the Australian Government through the Commonwealth Department of Health be responsible for a national campaign to raise the standard of Aboriginal Health in 10 years[42].

These are a few notable examples of attempts to focus on improving the health of Aboriginal Australia.

In order to provide a brief history of the Commonwealth's role in Indigenous health, the ANAO has drawn on work previously undertaken on this subject. Most notably the following papers were used as major references:

- Aboriginal health and institutional reform within Australian federalism[43]; and
- Innovation without change?: Commonwealth involvement in Aboriginal health policy[44].

Early government involvement in Aboriginal and Torres Strait Islander health and the emergence of the Aboriginal Health Service

In the Aboriginal health area, constitutional responsibility in the Australian federal system was, as for health generally, initially left primarily with the States. From 1911, the Commonwealth developed a regional involvement in Aboriginal health through its administration of the Northern Territory; but this was through its Territories rather than through the federal health

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41 Health of Aboriginal Australia, Centre for Cross-Cultural Studies in Health and Medicine, University of Sydney,

42 Ibid.

43 Aboriginal health and institutional reform within Australian federalism, I. Anderson and W. Saunders, Centre for Aboriginal Economic Policy Research (CAEPR) Discussion Paper No. 117/ 1996, October 1996.

44 Innovation without change?: Commonwealth involvement in Aboriginal health policy, John Gardiner-Garden, Department of the Parliamentary Library - Information Storage and Retrieval System (Social Policy Group), December 1994, Commonwealth of Australia, Canberra.

administrative system. From the 1930s and 1940s, the Commonwealth came under increasing pressure to expand its role in Aboriginal affairs. However, the presence of a specific exclusion relating to 'the aboriginal race in any State' in the Commonwealth's race power at section 51 (xxvi) of the Constitution was often an impediment to such greater involvement. Following a referendum in 1967, the Commonwealth's race power came to include Aborigines.

There was an expectation following the 1967 referendum that the Commonwealth would play a much greater role in Aboriginal affairs in the States. Further, there was some suggestion of the creation of a new Department to help in Aboriginal housing, health, education, employment and other problems associated with state government departments.

The Commonwealth Goverment established a new Office of Aboriginal Affairs rather than a department and through it began to make specific purpose grants to the States for 'Aboriginal advancement'. Health was one of four major functional areas identified for such grants and State government health departments began in the early 1970s to establish Aboriginal health units, or special services units, to receive and make use of the funds.

About this time Aboriginal community controlled organisations were beginning to emerge in the health area and other policy and service areas as well. The Aboriginal Medical Service was established in Redfern, Sydney, in 1971, and the Victorian Health Service began around the same time. While in one sense these health services were small medical and dental clinics, they were also early evidence of self-determination among the Aboriginal population. These services became the launching pad for Aboriginal control and participation in both health care policy and service delivery and made strong claims for financial and other government support.

The Commonwealth Department of Aboriginal Affairs (DAA) was established following a change of government in December 1972. The Commonwealth Government continued to make specific purpose grants for Aboriginal advancement to the States in areas such as health, but also began making direct grants to the newly emerging Aboriginal community organisations such as the community controlled Aboriginal Health Services (AHSs). This support for the AHSs allowed their numbers and their share of expenditure from the Commonwealth's Aboriginal health program to begin to grow.

National Plan for Aboriginal health

In the early 1970s the Commonwealth Department of Health developed a National Plan for Aboriginal health and established an Aboriginal Health Branch within its Public Health Division. The National Plan, which was approved by the Commonwealth Minister for Health in March 1973, required the Department of Health to launch an immediate campaign 'to raise the standard of health of the Aborigines of Australia to the levels enjoyed by their fellow Australians'[45]. The aim was to achieve this goal at the end of ten years. The Department of Health also, however, argued that 'practical responsibility' for Aboriginal health was 'shared' and that its own efforts could only 'attempt to knit together' those efforts of others.

The Department claimed that the Aboriginal Health Branch would both 'stimulate a uniform, national approach' and encourage 'active participation of Aborigines themselves'. In addition, the Department claimed the Branch would 'provide a comprehensive nationally-oriented advisory service' and develop a 'close working relationship' with DAA to ensure that 'all efforts' were 'co-ordinated and achieve maximum effectiveness'[46].

A report on Aboriginal health by the House of Representatives Standing Committee on Aboriginal Affairs (HRSCAA) in 1979 suggested that the 'standard of health of Aborigines was still far lower than the majority of Australians' and that 'little progress had been made in raising it'[47]. The HRSCAA argued that one reason for the lack of progress had been insufficient attention to the 'physical environmental' conditions in which Aboriginal people lived as a determinant of health status, but also insufficient attention to 'social' and 'cultural' factors relating to Aboriginal health[48]. The HRSCAA was critical of the States in relation to the funding of the Aboriginal health units within their health departments. It argued that the States had not accepted any 'financial responsibility for improving the health of Aboriginals as citizens of the State'[49].

In 1983, at the time of a change of Commonwealth Government, two dimensions of competition within the institutional arrangements of Aboriginal health were evident and growing[50]. These were between:

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45 Commonwealth Department of Health 1973, Annual Report 1972-73, AGPS, Canberra, as reported in CAEPR Discussion Paper 117/1996, Anderson and Sanders.

46 Ibid.

47 Aboriginal Health, Report of the HRSCAA, AGPS, Canberra, 1979.

48 Ibid.

49 Aboriginal Health, Op. Cit..

50 CAEPR Discussion Paper 117/96, Op. Cit.

- the Commonwealth Department of Health and DAA over which should have responsibility for the Commonwealth's Aboriginal health programs' expenditure; and
- the newly emerging AHSs and the Aboriginal health services of the State/Territory health departments, over which were better placed to use the Commonwealth's Aboriginal health program money.

In December 1984, in an attempt to resolve the tension within the Commonwealth, the Government transferred the emerging funding role in relation to AHSs, along with four Aboriginal health staff positions, from the Department of Health to the DAA. As a result, DAA developed a fairly clear role in Aboriginal health within the Commonwealth's administrative system. However, at that time the Department restructured, with one office that disappeared being the Aboriginal Health Branch.

National Aboriginal Health Strategy

In December 1987 a combined meeting of Commonwealth, State/Territory Health and Aboriginal Affairs ministers agreed to establish a broad working group to develop a National Aboriginal Health Strategy (NAHS). Subsequently, a third joint meeting of ministers in June 1990 endorsed the work of the NAHS Working Party and a development group that had reviewed the Working Party report. The NAHS became official Commonwealth government policy and moves were begun towards implementing its major recommendations. A National Council of Aboriginal Health was to be established and so too were its counterpart State and Territory level tripartite forums. The Office of Aboriginal Health within the Aboriginal and Torres Strait Islander Commission (ATSIC), which replaced the DAA from March 1990, was to be enhanced, and an ATSIC Commissioner was specifically designated as having health responsibilities.

In December 1990 the Commonwealth Ministers for Health and Aboriginal Affairs announced a budgetary commitment to the NAHS of $232 million over five years with an evaluation to be undertaken prior to funding for a further five years. The Commonwealth's intention was also, however, to secure broadly matching expenditure from the States and Territories through formal Aboriginal health agreements. Subsequently, eliciting formal agreements and matching expenditure from the States and Territories proved to be a difficult process.

In 1992, the ATSIC Board of Commissioners determined that Commonwealth NAHS funds would be allocated directly to AHSs on the advice of ATSIC regional councils, and that this would occur independently of the further pursuit of agreements with the States and Territories in Aboriginal health. The negotiation of such agreements was to be referred to the Council of Aboriginal Health. The Council was also to address the issue of Aboriginal health 'goals and targets' which were supposed in some way to underlie the agreements.

By 1992-93, many AHSs were beginning to express considerable dissatisfaction with the implementation of the NAHS for several reasons, namely:

- the tardy establishment of the Council of Aboriginal Health and the State/Territory tripartite forums;
- the vast majority of the Commonwealth's NAHS funds, some $171 million of the projected $232 million, was not to flow to AHSs but to Aboriginal community organisations involved in housing provision and infrastructure; and
- the perception that in gaining access to funding primarily through ATSIC and its regional council structure, the AHSs were increasingly being drawn into unwanted competition for resources with other Aboriginal community-controlled organisations.

During the latter half of 1994 an evaluation of the NAHS was undertaken under the direction of a Steering Committee comprising representatives of NACCHO, ATSIC, the Commonwealth government, State/Territory government and a health academic. A major finding of the evaluation was that the NAHS was never effectively implemented. The evaluation report concluded that:

> *The Committee established to evaluate the National Aboriginal Health Strategy found little evidence of it. Instead, the Committee found only traces of where the Strategy had been — small amounts of money (compared with the need) spent on housing and health services.*

Further:

> *it found minimal gains in the appalling state of Aboriginal health*[51]*.*

[51] The National Aboriginal Health Strategy, An Evaluation, Aboriginal and Torres Strait Islander Commission, Canberra, 1994.

One element of the lack of effective implementation related to the national and State/Territory tripartite forums. The national Council of Aboriginal Health and its State/Territory counterparts faced establishment difficulties, made slow progress, and did not function as expected.

Another finding of the NAHS evaluation was that, following an ATSIC decision to allocate Commonwealth NAHS funds without pursuing formal agreements with the States and Territories seeking matching expenditure, no subsequent agreements were negotiated. This was despite the fact that one of the early outcomes of the Council of Australian Governments processes had been the signing by all levels of Australian government in December 1992 of a general, *National Commitment to Improved Outcomes in the Delivery of Programs and Services for Aboriginal Peoples and Torres Strait Islanders*. This National Commitment also foreshadowed the making of more specific bilateral agreements in areas such as health. The NAHS evaluation committee also found that work on Aboriginal health 'goals and targets' had not been significantly progressed either.

In May 1997, the Human Rights and Equal Opportunity Commission released the Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families.[52]

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[52] Human Rights and Equal Opportunity Commission, Bringing them Home Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children From their Families, Sterling Press, Sydney, 1997.

Appendix 3

Selected DHAC Financial Data

TABLE NO.1

DHAC Total AHS Funding by State/Territory and Region Classification 1996-97

SITE	NSW		Vic		QLD		W.A.		S.A.		TAS.		N.T.		A.C.T.	
	Exp. $	No of AHSs	Exp. $	No of AHSs	Exp. $	No of AHSs	Exp. $	No of AHSs	Exp. $	No of AHSs	Exp. $	No of AHSs	Exp. $	No of AHSs	Exp. $	No of AHSs
Capital City	4 138 092	6	2 969 778	5	3 322 387	5	2 740 942	3	2 940 310	3	661 616	1	1 819 234	2	135 023	1
Other Metro	1 298 150	3	64 157	1	1 860 668	2	0	0	0	0	0	0	0	0	0	0
Large Rural	435 465	2	774 957	2	4 424 493	11	0	0	0	0	0	0	0	0	0	0
Small Rural	3 530 017	11	1 821 311	5	327 486	2	410 869	1	921 127	2	0	0	0	0	0	0
Other Rural	1 363 097	4	1 227 606	6	556 909	2	0	0	0	0	0	0	0	0	0	0
Remote Centre	0	0	0	0	217 377	2	7 864 694	11	52 223	1	0	0	4 671 908	2	0	0
Other Remote Area	1 878 548	7	110 151	1	1 337 319	2	4 398 491	9	4 417 347	4	85 938	1	6 820 787	17	0	0
Total	**$12 643 369**	**33**	**$6 967 960**	**20**	**$12 046 639**	**26**	**$15 414 996**	**24**	**$8 331 007**	**10**	**$747 554**	**2**	**$13 311 929**	**21**	**$135 023**	**1**
	AUST															
Capital City	18 727 382	26														
Other Metro.	3 222 975	6														
Large Rural	5 634 915	15														
Small Rural	7 010 810	21														
Other Rural	3 147 612	12														
Remote Centre	12 806 202	16														
Other Remote Area	19 048 581	41														
Total	**$69 598 477**	**137**														

TABLE NO.2

DHAC Total Substance Misuse Service Funding by State/Territory and Region Classification, 1996-97

	NSW		VIC		QLD		W.A.		S.A.		TAS.		N.T.		A.C.T.	
	Exp. $	No of SMSs	Exp. $	No of SMSs	Exp. $	No of SMSs	Exp. $	No of SMSs	Exp. $	No of SMSs	Exp. $	No of SMSs	Exp. $	No of SMSs	Exp. $	No of SMSs
Capital City	80 530	2	15 200	1	814 445	4	425 473	1	714 125	2	664 884	1	740 577	2	0	0
Other Metro	0	0	0	0	503 898	2	0	0	0	0	0	0	0	0	0	0
Large Rural	196 761	1	46 852	1	517 915	2	0	0	0	0	0	0	0	0	0	0
Small Rural	994 392	4	520 797	4	0	0	65 007	1	875 124	3	0	0	0	0	0	0
Other Rural	971 316	3	58 548	2	438 889	2	0	0	166 627	1	0	0	0	0	0	0
Remote Centre	0	0	0	0	295 129	1	929 602	6	0	0	0	0	800 201	5	0	0
Other Remote Area	205 647	1	0	0	0	0	766 158	6	668 225	5	0	0	660 318	8	0	0
Total	**$2 448 646**	**11**	**$641 397**	**8**	**$2 570 276**	**11**	**$2 186 240**	**14**	**$2 424 101**	**11**	**$664 884**	**1**	**$2 201 096**	**15**	**0**	**0**
	AUSTRALIA															
Capital City	3 455 234	13														
Other Metro.	503 898	2														
Large Rural	761 528	4														
Small Rural	2 455 320	12														
Other rural	1 635 380	8														
Remote Centre	2 024 932	12														
Other Remote Area	2 300 348	20														
Total	**$13 136 640**	**71**														

TABLE NO.3

DHAC Average Expenditure on AHSs by State/Territory and Region Classification, 1996-97

	NSW		VIC		QLD		W.A.		S.A.		TAS.		N.T.		A.C.T.		Australia Wide	
	Exp. $	No of AHSs	Exp. $	No of AHSs	Exp. $	No of AHSs	Exp. $	No of AHSs	Exp. $	No of AHSs	Exp. $	No of AHSs	Exp. $	No of AHSs	Exp. $	No of AHSs	Exp. $	No of AHSs
Capital City	689 682	6	593 956	5	664 477	5	913 647	3	980 103	3	661 616	1	909 617	2	135 023	1	720 284	26
Other Metro.	432 717	3	64 157	1	930 334	2	0	0	0	0	0	0	0	0	0	0	537 163	6
Large Rural	217 733	2	193 739	2	2 212 247	11	0	0	0	0	0	0	0	0	0	0	375 661	15
Small Rural	32 100	11	364 262	5	327 486	2	410 869	1	460 564	2	0	0	0	0	0	0	333 848	21
Other Rural	340 774	4	204 601	6	278 455	2	0	0	0	0	0	0	0	0	0	0	262 301	12
Remote Cent.	0	0	0	0	108 689	2	714 972	11	52 223	1	0	0	2 335 954	2	0	0	800 388	16
Other Remote Area	268 364	7	110 151	1	668 660	2	488 721	9	1 104 337	4	85 938	1	401 223	17	0	0	464 600	41
State Wide Average	**$383 132**	**33**	**$348 398**	**20**	**$463 332**	**26**	**$642 292**	**24**	**$833 101**	**10**	**$373 777**	**2**	**$633 901**	**21**	**$135 023**	**1**	**$508 018**	**137**

TABLE NO.4

DHAC Average Expenditure on Substance Misuse Services by State/Territory and Region Classification, 1996-97

	NSW		VIC		QLD		W.A.		S.A.		TAS.		N.T.		A.C.T.		Australia Wide	
	Exp. $	No of SMSs	Exp. $	No of SMSs	Exp. $	No of SMSs	Exp. $	No of SMSs	Exp. $	No of SMSs	Exp. $	No of SMSs	Exp. $	No of SMSs	Exp. $	No of SMSs	Exp. $	No of SMSs
Capital City	40 266	2	15 200	1	203 611	4	425 473	1	357 063	2	664 884	1	370 289	2	0	0	265 787	13
Other Metro.	0	0	0	0	251 949	2	0	0	0	0	0	0	0	0	0	0	251 949	2
Large Rural	196 761	1	46 852	1	258 958	2	0	0	0	0	0	0	0	0	0	0	190 382	4
Small Rural	248 598	4	13 019	4	0	0	65 007	1	291 708	3	0	0	0	0	0	0	175 380	14
Other Rural	323 772	3	29 274	2	219 445	2	0	0	166 627	1	0	0	0	0	0	0	204 423	8
Remote Cent.	0	0	0	0	295 129	1	154 934	6	0	0	0	0	160 040	5	0	0	168 744	12
Other Remote Area	205 647	1	0	0	0	0	127 693	6	133 645	5	0	0	82 540	8	0	0	115 017	20
State Wide Average	**$222 604**	**11**	**$80 175**	**8**	**$233 661**	**11**	**$156 160**	**14**	**$220 373**	**11**	**$664 884**	**1**	**$146 740**	**15**	**0**	**0**	**$185 023**	**71**

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