

CLOSING THE GAP ON INDIGENOUS DISADVANTAGE:

An analysis of provisions in the
2013-14 Budget and implementation of
the Indigenous Chronic Disease Package

Dr Lesley Russell
Senior Research Fellow
Australian Primary Health Care Research Institute
Australian National University

Research Associate
Menzies Centre for Health Policy
University of Sydney

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NOTE

This paper presents the author's analysis of the Indigenous provisions in the Australian Government's 2013-14 Budget in the context of current and past strategies, policies, programs and funding support.

It also looks at the implementation and impact of the Commonwealth's Indigenous Chronic Disease Package.

This work has been done using only materials and data that are publicly available.

The opinions expressed are solely those of the author who takes responsibility for them and for any inadvertent errors. This work does not represent the official views of the Menzies Centre for Health Policy, the Australian Primary Health Care Research Institute (APHCRI) or the Commonwealth Department of Health and Ageing which funds APHCRI.

Lesley Russell

T: 61 2 6125 3021

E: Lesley.Russell@anu.edu.au

Lesley.Russell@sydney.edu.au

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Introduction

Total government expenditure on Indigenous health has risen significantly since the commencement of the National Partnership Agreement (NPA) on Closing the Gap in Indigenous Health Outcomes in 2009-10 and now represents about 5.1% of total government health expenditure.¹ This amounted to \$4.7 billion in 2010-11; of this, the Commonwealth provided about one-third (\$1.6 billion).²

However while there is a significant effort underway to close the gap in Indigenous disadvantage and life expectancy, in most areas this effort has yet to show real returns on the investments. The disadvantages that have built up over more than 200 years will not disappear overnight, and sustained and concerted efforts are needed to redress them. Chronic diseases, which account for a major part of the life expectancy gap, take time to develop, and equally, it will take time to halt their progress and even longer to prevent their advent in the first place. Programs will need to be sustained over decades if they are to have an impact on improving health outcomes.

On this basis, it is worrying to see that continued funding for the NPA on Closing the Gap in Indigenous Health Outcomes, as announced in April, will be less over each of the next three years than in 2012-13. At the same time, the Budget Papers show that expenses in the Aboriginal and Torres Strait Islander health sub-function will decline by 2.7% in real terms. This comes as states such as Queensland and New South Wales have made damaging cuts to health services and Closing the Gap programs.

Education is a significant determinant of health status³ so it is also concerning to see a reduced level of funding provided for Indigenous education over the next six years, especially when efforts to close the gap in education for indigenous students have stalled. These cuts in health and education commitments cannot be justified by saying that Indigenous Australians can access mainstream programs. In many cases these are absent, inappropriate, or perceived as culturally insensitive, despite recent efforts to improve these deficits.

It is a strength of the COAG commitment to close the gap on Indigenous disadvantage that it recognises that a whole-of-government approach is needed to deliver improvements in the lives of Indigenous Australians. However tackling disadvantage is about more than building houses, providing job training, implementing welfare reform, community policing and increasing access to health services; it requires that governments recognise and respect the complex social and cultural relationships that underlie the housing, economic, health and societal issues present in many Aboriginal communities and work with the communities to address these issues.⁴

¹ Indigenous Australians make up 2.6% of the population.

² <http://www.pc.gov.au/gsp/ier/indigenous-expenditure-2012>

³ <http://www.who.int/hia/evidence/doh/en/>

⁴ https://www.mja.com.au/journal/2011/195/11/closing-gap-and-indigenous-housing?0=ip_login_no_cache%3D54e45a2b073f701d2246d84b320acf43

There are several critical developments in 2013 that together will likely determine whether the goal of Indigenous health equality is achieved by 2030. These include the scheduled completion and implementation of a National Aboriginal and Torres Strait Islander Health Plan,⁵ the renewal - with adequate funding from all governments - of the NPA on Closing the Gap in Indigenous Health Outcomes,⁶ and the federal election that is scheduled for 14 September 2013.

⁵ <http://www.health.gov.au/natsihp>

⁶ The Commonwealth has announced funding of \$777 million / 3 years ahead of the expiry of the NPA on June 30, but the states and territories are yet to make their funding commitments.

National Partnership Agreements

There are currently six Indigenous-specific National Partnership Agreements. (See Table 1)

Table 1.

National Partnership Agreement	Federal funding and timing	State / Territory funding
Stronger Futures in the Northern Territory	\$3.4 billion / 10 years (to 2022)	\$40 million
Remote Indigenous Housing	\$5.5 billion / 10 years (to 2018)	-
Closing the Gap in Indigenous Health Outcomes	\$777million / 3 years (to 2016)	TBD
Indigenous Childhood Development	\$564.4 million / 6 years (to 2014)	-
Remote Service Delivery	\$291.2 million / 6 years (to 2014)	-
Remote Indigenous Public Internet Access	\$6.5 million / 3 years (to 2016)	TBD

From 2013-14 Budget Paper No 3

NPA on Closing the Gap in Indigenous Health Outcomes

In November 2008, the Council of Australian Governments (COAG) agreed to a **\$1.6 billion / 4 years** National Partnership Agreement (NPA) on Closing the Gap in Indigenous Health to address the first Closing the Gap target (to reduce close the life expectancy gap within a generation).

Within the NPA five priority areas were established:

- Tackling smoking;
- Primary health care services that can deliver;
- Fixing the gaps and improving the patient journey;
- Providing a healthy transition to adulthood; and
- Making Indigenous health everyone's business.

The Commonwealth's contribution to this NPA is the Indigenous Chronic Disease Package (ICDP) which provided **\$805.5 million / 4 years**, beginning in 2009-10. This contributes to the first three priority areas of the NPA; state and territory efforts contribute to all five priority areas. Each jurisdiction has developed implementation plans detailing the activities that will achieve the objectives of the NPA (although some of these from the States and Territories have proved difficult to find).

On 18 April 2013 the Commonwealth announced continuing funding of **\$777 million / 3 years** for the NPA which is due to expire 30 June.⁷ This was described as "an increase over

⁷ <http://www.pm.gov.au/press-office/777-million-renewed-effort-close-gap-indigenous-health>

previous per annum expenditure.” That is true, but this statement ignores the fact that funding over the last four years was ramped up and in 2012-13 it was **\$317.9 million**. So the reality is that funds for each of the next three years will be less than in 2012-13.

The Government’s media release says “While this work is encouraging we know there is more to be done. We need sustained investment and effort to continue the momentum and ensure continued progress.” And COAG said the “improving opportunities for Indigenous Australians requires intensive and sustained effort from all levels of government.”⁸ The (important) recognition that these efforts will require sustained investment and effort is not backed by the actions of Australian governments. As of May 2013, none of the States and Territories had announced their contributions to the NPA.

We await news of how these new federal funds will be allocated over the forward estimates (and which programs will be cut and where). The 2013-14 Budget provides no further information on this. The scheduled completion and implementation of a National Aboriginal and Torres Strait Islander Health Plan may provide the incentives for further Australian Government and COAG action.

The 2009-10 Budget Papers provided some insights into Commonwealth expenses in this NPA, but this information has not been provided in the following years. At that time it was interesting to note that administrative expenses were high (estimated at **\$112 million** in 2012-13) and they averaged 36% of expenditure over the forward estimates.

National Partnership Payments for Indigenous Health

In 2013-14 the Australian Government will pay **\$54 million** to the States and Territories through National Partnership payments (NPs) for work in 12 areas of Indigenous health. (See Table 2)

Of the **\$113.8 million** provided of the four years to 2016-17, over 50% (**\$68.8 million**) is allocated to the Northern Territory. However expenditure drops considerably over the forward estimates.

⁸ http://www.coag.gov.au/closing_the_gap_in_indigenous_disadvantage

Table 2.

NPs	2012-13 \$m	2013-14 \$m	2014-15 \$m	2015-16 \$m	2016-17 \$m
Sexual assault counseling in remote NT	1.3	-	-	-	-
Accommodation related to renal services in NT	-	10.0	-	-	-
CTG in the NT	0.4	-	-	-	-
Improving ear services for Indigenous children	6.5	0.7	-	-	-
Improving trachoma control services	3.9	4.4	4.1	4.2	4.2
Indigenous early childhood development – antenatal and reproductive health	24.3	24.4	6.0	-	-
Reducing rheumatic fever in Indigenous children	2.5	2.6	2.6	2.7	2.7
Renal dialysis services in Central Australia	1.6	1.7	1.7	-	-
Stronger Futures in the NT	9.0	9.8	10.3	10.2	10.8
Torres Strait health protection strategy	1.5	0.5	0.5	-	-
Total	51.1	54.0	25.1	17.1	17.6

From 2013-14 Budget Paper No 3

Support for Indigenous Education

Under the National Education Agreement (NEA), which began on 1 January 2009, all Australian governments have committed to three targets for Indigenous education:

- Lift the Year 12 or equivalent attainment rate to 90% by 2015;
- Halve the gap for Indigenous students in reading, writing and numeracy within a decade; and
- At least halve the gap for Indigenous students in Year 12 or equivalent attainment rates by 2020.

Several National Partnerships also contribute to achieving the NEA Indigenous objectives. These are:

- Early Childhood Education
- Indigenous Early Childhood Development
- National Quality Agenda for Early Childhood Education and Care
- Youth Attainment and Transitions
- Smarter Schools NPs: Literacy and Numeracy, Improving Teacher Quality and Low Socio-Economic Status School Communities

A national Aboriginal and Torres Strait Islander Education Action Plan⁹ which was endorsed by COAG in May 2011 and released in June 2011 commits all Australian governments to a unified approach to closing the gap in education outcomes between Indigenous and non-Indigenous students. It provides the priorities for collaborative work to be undertaken in the Government, Catholic and Independent school sectors until 2014.

The *Indigenous Education (Targeted Assistance) Act 2000* (IETA) is the Australian Government's major Indigenous specific education and training initiative. The objects of IETA are described under five themes:

- Involvement of Aboriginal and Torres Strait Islander people in educational decision-making;
- Equality of access to educational services;
- Equity of educational participation;
- Equitable and appropriate educational outcomes; and
- The development of culturally appropriate education services.

For the period 2009–2012, a total of around **\$600 million** was committed through IETA to fund a range of Indigenous education and training programs and projects. IETA funding is supplementary to mainstream funding, is targeted to areas of greatest need, and is intended for strategic interventions that will accelerate improvements in Indigenous student learning outcomes. In 2009, **\$173 million** was allocated to the States and Territories.¹⁰ This was split almost equally between government and non-government schools and educational bodies.

⁹ <http://deewr.gov.au/aboriginal-and-torres-strait-islander-education-action-plan-2010-2014>

¹⁰

http://foi.deewr.gov.au/system/files/doc/other/indigenous_education_targeted_assistance_act_annual_report_2009.pdf

The 2013-14 Budget allocates less funding to IETA initiatives over the forward estimates, providing **\$800 million / 6 years**. This is concerning as efforts to close the gap in education for Indigenous students have stalled.¹¹ In 2012, for 14 out of the 20 National Assessment Program - Literacy and Numeracy (NAPLAN) indicator, the gap has widened compared to 2011.¹² These results cast doubt on achieving the goal to halve the gap in literacy and numeracy skills between Indigenous and non-Indigenous students by 2018.

There is some good news in that the target to ensure that all Indigenous four-year-olds in remote communities have access to early childhood education within five years will likely be met in 2013.¹³ Data from the National Early Childhood Education and Care Collection shows that in August 2011, 91% of Indigenous children in remote areas were enrolled in preschool programs in the year before full-time schooling. However enrolment is not a sufficient measure for this target as data also show that in 2009, Indigenous attendance rates ranged between 74-78% in remote and very remote areas.¹⁴

There is also some possibility of meeting the target to halve the gap for Indigenous people aged 20–24 in Year 12 attainment or equivalent attainment rates by 2020. In 2011, 53.9% of Indigenous Australians in this age group had achieved Year 12 or an equivalent qualification compared to 47.4% in 2006.¹⁵ Census data also show that education participation rates for Indigenous 15–19 year olds have increased from 56.8% in 2006 to 61.6% in 2011. However continued rapid improvements will be required if progress towards meeting this target is to remain on track.

¹¹ <http://www.theaustralian.com.au/national-affairs/education/reforms-failing-to-close-indigenous-schools-gap/story-fn59nlz9-1226540025787>

¹² http://www.fahcsia.gov.au/sites/default/files/documents/02_2013/00313-ctg-report_fa1.pdf

¹³ Ibid

¹⁴

http://foi.deewr.gov.au/system/files/doc/other/indigenous_education_targeted_assistance_act_annual_report_2009.pdf

¹⁵ http://www.fahcsia.gov.au/sites/default/files/documents/02_2013/00313-ctg-report_fa1.pdf

2013-14 Budget

The 2013-14 Budget claims **\$1.6 billion** of new investment in Indigenous initiatives. Not included in this is the continued funding for the NPA on Indigenous Health (**\$777 million / 3 years**) or the **\$6.5 million / 3 years** committed as continued funding to the NPA for Remote Indigenous Public Internet Access Training and Maintenance.

However it seems that this figure has been inflated by the inclusion of all of the **\$655.6 million / 18 months** committed to the renewed NPA on Early Childhood Education¹⁶ when in fact only a portion of these funds will go to Indigenous children. It also includes **\$127.5 million** to extend the Youth Connections Program, the School Business Community Partnership Brokers Program and national career development initiatives but only about 20% of these funds go to Indigenous participants.¹⁷

The actual figure is therefore estimated to be **\$903.3 million / 4 years** (\$1.05 billion / 6 years). (See Table 3) Almost of all of this is to continue or extend funding for existing programs. There is new funding of **\$24.5 million / 4 years** for only four programs - **\$10 million** for the Australian Indigenous Education Foundation; **\$12 million** for additional scholarships through the Indigenous Youth Leadership Program (although this funding apparently comes from savings taken in this program in the 2012-13 Budget) ; **\$1.3 million** for research into a vaccine for acute rheumatic fever (a disease that affects predominately Indigenous Australians); and **\$1.3 million** to the Joint Select Committee on Constitutional Recognition of Aboriginal and Torres Strait Islander People to help establish a parliamentary and community consensus on referendum proposals.

Elsewhere in the Budget savings of **\$20 million / 4 years** are taken from the National Rural and Remote Health Infrastructure Program and future grant rounds will focus on projects in remote or very remote areas or Indigenous communities. The failure of the Northern Territory Government to proceed with two projects to provide short term patient accommodation at Katherine Hospital and Gove District Hospital (which would have been largely used by Indigenous patients and their families) means that **\$10.8 million** allocated to these projects , announced in the 2010 Regional Priority Round, is returned to the Health and Hospitals Fund.

¹⁶ See pages 4, 9 Budget Statement on Continued Investment to Close the Gap.

¹⁷ See page 14, Budget Statement on Continued Investment to Close the Gap

Table 3.

Initiative	Funding level
Extended funding under <i>the Indigenous Education (Targeted Assistance) Act</i> .	\$659 million / 4 years ¹⁸
Australian Indigenous Education Foundation	\$10 million / 1 year
More scholarships under Indigenous Youth Leadership Program	\$12 million / 4 years
Extension of Cape York Welfare Reforms	\$24.5 million / 2 years
Extension of Municipal and Essential Services Program	\$44.1 million in 2013-14
Continued funding Army Aboriginal Community Assistance Program	\$6 million / 1 year
Continued funding Aboriginal Hostels Limited	\$6.2 million / 2 years
Continued funding Remote Airstrip Upgrade Program	\$10 million / 2 years
Joint Select Committee on Constitutional Recognition of Aboriginal and Torres Strait Islander People	\$1.3 million / 2 years
Continued funding National Congress of Australia's First Peoples	\$15 million / 3 years from 2014-15
Continued funding Reconciliation Australia	\$14.4. million / 4 years
Continued funding Longitudinal Study of Indigenous Children	\$1.3 million / 2 years
Continued funding for Youth Attainment and Transitions	\$25.5 million / 1 year*
Continued funding for trachoma control	\$16.4 million / 4 years
Continued funding for mosquito control in Torres Strait	\$3.9 million / 4 years
Expanded funding Legal Assistance and Support	\$12 million / 2 years
Additional funding for Community Legal Centres	\$10.3 million / 4 years
Additional funding to Indigenous Visual Arts Industry Support Program	\$11.3 million / 4 years
Additional funding to Indigenous arts training organisations	\$1.7 million / 4 years
Expansion of Indigenous Languages Support Program	\$14 million / 4 years
Extended funding for the Community Development Financial Institutions pilot	\$3 million / 1 year
Research on development of acute rheumatic fever vaccine	\$1.4 million / 2 years
Total	\$903.3 million / 4 years

*20% of \$127.5 million

¹⁸ Note that in 2013-14 Budget Paper No 2 this is given as \$800 million / 6 years

Budget Initiatives

1. Health and Ageing

The 2013-14 Budget predicts that expenses in the Aboriginal and Torres Strait Islander sub-function will increase in 2013-14 but fall by 2.7% in real terms from 2013-14 to 2016-17. (See Table 4)

Table 4.

	Estimates			Projections	
	2012-13 \$m	2013-14 \$m	2014-15 \$m	2015-16 \$m	2016-17 \$m
Aboriginal and Torres Strait Islander health	752	851	826	854	890
Total health	62,249	64,636	68,081	71,597	75,493

From 2013-14 Budget Paper No 1

In 2013-14 spending on Indigenous health initiatives includes:

- \$380.8 million to improve the health and wellbeing of Indigenous people under the Stronger Futures in the Northern Territory package.
- \$4.5 million in grants through the Indigenous Suicide Prevention program and an estimated \$2 million from the Taking Action to Tackle Suicide package.¹⁹
- \$10 million (estimated) through Bringing Them Home and Link Up Services.
- \$65 million from the Substance Misuse Service Delivery Grants Fund will go to provide services in Indigenous communities.

Acute rheumatic fever vaccine

\$1.4 million / 2 years is provided for early research into the development of a vaccine to prevent acute rheumatic fever. The New Zealand Government will also provide \$1.4 million towards this effort. This was originally announced by the Prime Ministers of both countries as a \$3million effort.²⁰

	2012-13 \$m	2013-14 \$m	2014-15 \$m	2015-16 \$m	2016-17 \$m
NHMRC	-	0.6	0.8	-	-

Acute rheumatic fever is particularly prevalent among Aboriginal, Torres Strait Islander, Maori and Pacific Islander peoples. A recent AIHW report shows that almost all cases of acute rheumatic fever recorded in the Northern Territory between 2005 and 2010 were for Indigenous people (98%), with 58% of cases occurring in 5-14 year olds. These rates are among the highest in the world.²¹

¹⁹ On 23 May 2013 the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy was released, together with additional funding of \$17.8 million / 4 years.
<http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr13-mb-mb036.htm>

²⁰ <http://www.pm.gov.au/press-office/joint-statement-prime-ministers-key-and-gillard-february-2013>

²¹ <http://www.aihw.gov.au/media-release-detail/?id=60129542802>

Improving trachoma control for Indigenous Australians

\$16.4 million / 4 years is provided to continue trachoma control activities. This funding is expected to improve eye health for 20,000 Indigenous Australians in up to 160 remote communities. Allocation over the forward estimates is not provided.

This is renewed funding for provisions originally provided in the 2009-10 Budget. At that time **\$58.3 million / 4 years** was provided for improved hearing and eye services. Of this, **\$5.3 million / 3 years** went to four states (Queensland, NSW, Northern Territory and South Australia) under project agreements on improving trachoma control.

The National Trachoma Surveillance and Reporting Unit was established in 2010 to improve the quality of trachoma data collection and reporting in Australia. The most recent report is for 2010 (released in September 2012).²²

The 2012 annual update on the implementation of The Roadmap to Close the Gap for Vision estimates that **\$70 million** is needed to eliminate vision loss, which is 11% of the Indigenous health gap.²³

Mosquito control and cross border liaison in the Torres Strait

\$3.9 million / 4 years is provided to continue mosquito detection, control and elimination activities in the Torres Strait region. This funding goes to Queensland through a National Partnership on Health Services.

2. Attorney General's

Expansion of funding for legal assistance

\$12 million / 2 years is provided to the Aboriginal and Torres Strait Islander Legal Services.

	2012-13	2013-14	2014-15	2015-16	2016-17
	\$m	\$m	\$m	\$m	\$m
Attorney General's	-	6	6	-	-

The 2010-11 Budget provided an additional **\$34.9 million / 4 years** for Indigenous legal services (an average increase of \$8.7 million per year). This brought the total Commonwealth funding to ATSILS to **\$68.007 million** in 2011-12.²⁴ However ATSILS remains grossly under-resourced, lagging significantly behind the resource levels of mainstream legal aid service providers.

²² <http://mbsonline.gov.au/internet/main/publishing.nsf/Content/cda-cdi3603b.htm>

²³ http://iehu.unimelb.edu.au/_data/assets/pdf_file/0009/661869/2012_annual_update_roadmap.pdf

²⁴ Information provided in Supplementary Budget Estimates, 2012-13.

3. Education , Employment and Workplace Relations

Expansion and extension of Achieving Results Through Indigenous Education

\$4.4 million / 4 years (from 2012-13) is provided to extend and expand the Achieving Results Through Indigenous Education (ARTIE) program and support a two years extension to the end of 2015. Note that funding for this measure was included as a “decision taken but not announced” in the 2012-13 MYEFO.

Extension of Indigenous Education (Targeted Assistance) Act 2000

\$800 million / 6 years is provided to extend funding under the IETA to fund a range of Indigenous education and training programs and projects. This money flows through both the Department of Education, Employment and Workplace Relations and the Department of Industry, Innovation, Climate Change , Science, Research and Tertiary Education. Breakout over the forward estimates is not provided in the Budget Papers.

This is less funding than previously provided (\$600 million / 4 years). Some indication of how funds will be split between initiatives, States and Territories, and public and private schools and education and training bodies can be found in the IETA Annual Report 2009 (which appears to be the most recent available).²⁵

From 1 January 2014, programs previously funded under IETA will move to an annual appropriation. The stated aim is to ensure greater transparency.

Indigenous Education Scholarships

\$21.9 million / 5 years is provided for Indigenous education scholarships through the Australian Indigenous Education Foundation (AIEF) – which receives **\$10 million** in 2012-13 - and the Indigenous Youth Leadership Program (IYLP) - which receives **\$11.9 million / 4 years**.

	2012-13 \$m	2013-14 \$m	2014-15 \$m	2015-16 \$m	2016-17 \$m
DEEWR	10.0	2.1	4.1	3.3	2.5

Since 2008 the AIEF has provided more than 400 Indigenous students with scholarships to 34 schools; 90% of these students finish Year 12. The funding provided this year is on top of **\$20 million** provided in 2009-10, which is supporting by matching funds from private sources.

The new funding for IYLP will support 204 new scholarships for Indigenous students, providing scholarships for 68 students in 2014 in each of Years 7, 8 and 11. Since 2006, more than 1,500 secondary and tertiary students have been assisted under the IYLP. More than 86 per cent of students have been retained in the program or have completed Year 12.

The Budget Papers state that “this measure varies the 2012-13 Budget measure titled *Stronger Futures in the Northern Territory – Indigenous Youth Leadership program – suspension* which targeted students in Years 9, 10 and 11.” In 2012-13 savings of **\$22.8**

²⁵

http://foi.deewr.gov.au/system/files/doc/other/indigenous_education_targeted_assistance_act_annual_report_2009.pdf

million / 4 years were taken from IYLP to be “redirected to support other spending on Indigenous priorities in the Government's *Stronger Futures in the Northern Territory* package.”

4. Families, Housing, Community Services and Indigenous Affairs

Cape York Welfare Reform

\$26.3 million / 2 years is provided to continue welfare reform initiatives in the Cape York communities of Aurukun, Coen, Hope Vale and Mossman George until 31 December 2015. **\$1.8 million** of this funding is from redirection of savings taken in the 2012-13 Budget.

	2012-13 \$m	2013-14 \$m	2014-15 \$m	2015-16 \$m	2016-17 \$m
FaHCSIA	-	3.2	6.5	3.4	-
DHS	-	3.1	2.6	1.3	-
DEEWR	-	1.1	2.2	1.2	-
Total	-	7.3	11.4	5.8	-

In the 2012-13 Budget the Cape York Welfare Reform Trial was extended for 12 months with the provision of **\$11.8 million**. In September 2012 the Queensland Government announced it was spending **\$5.7 million** to extend this trial through to the end of 2013.²⁶

The Cape York Welfare Reform (CYWR) aims to reverse the deterioration of social and economic conditions in Cape York Indigenous communities over recent decades. It is founded on the premise that this deterioration has been brought about by passive welfare dependence and the erosion of individual responsibility as the unintended effects of well-meaning but misguided government welfare policies and service delivery. The 2012 Evaluation Report looked at the four-year period of implementation and modifications to projects between January 2008 and December 2011, with some data from early 2012.²⁷ It found that most progress in implementation has been made in relation to the Social Responsibility and Education streams and the slowest progress in the implementation of the trial has been in relation to implementing projects under the Housing and Economic Opportunity streams.

Income management in Western Australia

\$16.4 million / 2 years is provided to continue and expand income management in Western Australia. Of this, **\$11.8 million** will continue the current trials in the Kimberley region and areas of metropolitan Perth for one year. **\$4.5 million / 2 years** (provided from existing FaHCSIA / DHS resources) will expand income management into Laverton and Ngaanyatjarra Lands. This project commenced in April 2013.

²⁶ <http://www.budget.qld.gov.au/media-releases/2012-13/budget-funding-to-extend-cape-york-trial.pdf>

²⁷ <http://www.fahcsia.gov.au/our-responsibilities/indigenous-australians/publications-articles/evaluation-research/cape-york-welfare-reform-cywr-evaluation-report>

	2012-13 \$m	2013-14 \$m	2014-15 \$m	2015-16 \$m	2016-17 \$m
DHS	-	6.4	-	-	-
FaHCSIA	-	5.4	-	-	-
Total	-	11.8	-	-	-

A Background Paper produced by the Parliamentary Library in June 2012 concluded that, at that time, the evidence provided for or against income management was inconclusive.²⁸ A recent media article claimed that the scheme in the Kimberley was paternalistic and is being rolled out in a discriminatory fashion.²⁹

Funding for longitudinal surveys

Funding of **\$4.3 million / 2 years** is provided to continue three longitudinal surveys, including Footprints in Time, the Longitudinal Survey of Indigenous Children (LSIC).

The 2003-04 Federal Budget provided the initial resources for the LSIC study. The first phase, from September 2003 to June 2004, involved extensive consultation with Indigenous peoples and communities about the study. The design and development of the study commenced in December 2005, with pilot testing continuing through 2006 and 2007. Funding of **\$12.0 million / 4 years** to begin the surveys was provided in the 2007-08 Budget.

The first wave of surveys commenced in 2008. This year LSIC will have completed 6 waves of surveys, with plans already in hand for further waves through 2016. Given this – and the very nature of a longitudinal survey – leads to questions about why at least 4 years of funding was not provided. It also appears that this Budget provides less funding than in the past for this important work.

National Congress of Australia's First People

\$15.0 million / 3 years from 2014-15 is provided in continued funding to the National Congress of Australia's First People.

	2012-13 \$m	2013-14 \$m	2014-15 \$m	2015-16 \$m	2016-17 \$m
FaHCSIA	[8.3]*	[4.9]*	5.0	5.0	5.0

*Funds from 2010-11

The 2010-11 Budget provided **\$29.2 million / 5 years** (from 2009-10) to establish the National Congress of Australia's First Peoples.

²⁸

http://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/BN/2011-2012/IncomeManagement

²⁹ <http://www.abc.net.au/local/stories/2013/05/15/3759780.htm>

5. Infrastructure and Transport

Regional Aviation Access Program – airstrip upgrade

\$9.9 million / 2 years is provided to provide a further funding round for aviation safety upgrades at remote airstrips. This funding is provided on a co-funding basis, but up to 100% of funds will be available for work at priority remote Indigenous communities.

	2012-13 \$m	2013-14 \$m	2014-15 \$m	2015-16 \$m	2016-17 \$m
DIT	-	3.4	3.4	-	-

The Regional Aviation Access Program was allocated **\$28 million / 2 years** in the 2011-12 Budget for upgrading remote airstrips across Australia. This funding provided **\$22 million** to Remote Airstrip Upgrades, with the expectation of matching co-funding, and **\$4 million** that was specifically for further upgrades of aerodromes in remote Indigenous communities that currently receive a weekly passenger and freight air service subsidised under the Government’s Remote Air Services Subsidy Scheme.

6. Regional Australia, Local Government, Arts and Sports

The two provisions provide through DRALGAs are funding by raiding **\$12.2 million** from the Indigenous Communities Strategic Investment (ICSI) Program Special Account which was established in 2008. This is not the first time this has happened: for example, in the 2010-11 Budget **\$29.2 million** was taken from the ICSI to fund the National Congress of Australia’s First Peoples.

Creative Australia – Indigenous Language Support

\$14.0 million / 4 years is provided to expand the existing Indigenous Language Program and to enable applications for funding from projects based in the Torres Strait Islands. FaHCSIA will provide **\$6.6 million** for this measure from savings taken in the Indigenous Communities Strategic Investment Program.

	2012-13 \$m	2013-14 \$m	2014-15 \$m	2015-16 \$m	2016-17 \$m
DRALGAS	-	3.4	3.5	3.5	3.6
FaHCSIA	-	-1.6	-1.6	-1.7	-1.7
Total	-	1.8	1.8	1.9	1.9

Additional funding for this work was a recommendation of the Standing Committee on Aboriginal and Torres Strait Islander Affairs 2012 report on the inquiry into language learning in Indigenous communities entitled *Our Land Our Languages*.³⁰

³⁰

http://www.aph.gov.au/Parliamentary_Business/Committees/House_of_Representatives_Committees?url=/at/sia/languages2/report.htm

Before colonisation, 250 distinct Aboriginal and Torres Strait Islander languages were spoken on the Australian continent. Of these, only 18 or fewer languages are presently considered strong, in the sense that they are spoken by all generations of people within the language group. Of the 145 indigenous dialects currently spoken in Australia, 110 are at risk of being lost.³¹

In August 2009, the Australian Government announced its National Indigenous Languages Policy to coordinate action among the agencies involved in the maintenance and revival of Indigenous languages, including government, Indigenous languages organisations and educational and research institutions.³² In that year funding of **\$9.3 million** was announced. In 2012–13 a total of 72 activities were support with funding of **\$9.9 million**.³³

A recent study by the Australian Bureau of Statistics shows that young Indigenous people (15–24 years) who speak an Indigenous language are less likely to consume alcohol at risky levels, to report they had used illicit substances in the past 12 months or to have been the victim of physical or threatened violence.³⁴

Creative Australia - Indigenous Visual Arts Industry Support

\$11.3 million / 4 years is provided to continue the 2009-10 Closing the Gap component of the Indigenous Visual Arts Industry Support Program. **\$5.6 million** of this funding comes from existing FaHCSIA resources within the Indigenous Communities Strategic Investment Plan.

	2012-13 \$m	2013-14 \$m	2014-15 \$m	2015-16 \$m	2016-17 \$m
DRALGAS	-	2.7	2.8	2.8	2.9
FaHCSIA	-	-1.4	-1.4	-1.4	-1.5
Total	-	1.4	1.4	1.4	1.5

The 2009-10 Budget provided **\$9.9 million / 4 years** to increase operational funding for art centres and establish an Indigenous Australian Art Commercial Code of Conduct to guide ethical commerce in the sector. This commitment followed a report from the Senate Inquiry into the Indigenous visual arts sector, *Indigenous art — Securing the future*.³⁵

³¹

http://antar.org.au/sites/default/files/antar_submission_on_language_learning_in_indigenous_communities_final_0.pdf

³² <http://arts.gov.au/indigenous/languages>

³³ <http://arts.gov.au/topics/indigenous/indigenous-culture-languages-and-visual-arts-funding/funding-round-outcomes-2012-1>

³⁴ <http://www.abs.gov.au/ausstats/abs@.nsf/latestProducts/4725.0Media%20Release1Apr%202011>

³⁵ <http://arts.gov.au/indigenous/ivais/senate-inquiry-2007>

Progress in Closing the Gap in Health

My own previous analyses³⁶ and those of others³⁷ indicate that it is still not possible to accurately assess whether progress towards the life expectancy target of closing the gap within a generation (by 2030) is on track.

If current trends continue, the target to halve the gap in mortality rates for Indigenous children under five within a decade (by 2018) may be achievable, although more progress needs to be made on reducing the number and proportion of low birth weight babies if this is to occur.

What is becoming apparent is that the problem is as much about the difficulty of measuring the impact of interventions as it is about the effectiveness of the interventions themselves. The 2012 Report on the Aboriginal and Torres Strait Islander Health Performance Framework makes this point – that “data quality limitations hamper our ability to monitor Indigenous health and the performance of the health system.”³⁸

Indigenous life expectancy is estimated using a methodology adopted by the Australian Bureau of Statistics (ABS) in 2009 that relies on census data. Between now and 2030 there will be a census in each of the years 2016, 2021 and 2026, which provides only three points at which life expectancy can be assessed and programs adjusted as required.

The COAG Reform Council has adopted seven supporting, or proxy, indicators for life expectancy:

- Mortality rate by leading causes
- Hospitalisation rates by principal diagnosis
- Rates of current daily smokers
- Average daily alcohol consumption and associated risk levels; rates of alcohol consumption at long-term risky to high risk levels
- Levels of obesity
- Level of physical activity
- Access to health care compared to need.

To be effective, these require regular and timely data collection. The lag time is quite significant: the most recent report on the COAG Reform Council’s website is for 2010-11 and this has data only for the first two of these indicators.³⁹ It found that in 2010 only five jurisdictions (NSW, Queensland, Western Australia (except for the years 2007-09), South Australia and the Northern Territory) had reliable data on mortality and that there were no significant changes in Indigenous death rates between 2006 and 2010 in any of these states and territories. Admittedly this is a short time frame. However in a wider time frame, from

³⁶ See for example <http://inside.org.au/closing-the-gap-another-year-of-slow-progress/>

³⁷ <http://www.humanrights.gov.au/sites/default/files/OAus-CloseTheGapShadowReport-0212.pdf>

³⁸ <http://www.health.gov.au/indigenous-hpf>

³⁹ <http://www.coagreformcouncil.gov.au/reports/indigenous.cfm>

1998-2010, only Queensland and the Northern Territory showed significant decreases in Indigenous death rates.

The report further noted that hospitalisation data are only briefly reported and are difficult to interpret. However it is encouraging to see that a recent AIHW report finds that an estimated 88% of Indigenous patients were correctly identified in public hospital admission records in 2011-12.⁴⁰

There are additional data to show an improvement in deaths caused by circulatory disease (down 41% between 1997 and 2010) and respiratory disease. However there have been no improvements with respect to cancer deaths, kidney disease, injury and diabetes. It is disconcerting to see that there have been no significant changes in key risk factors such as smoking, levels of physical activity, obesity and high alcohol consumption.⁴¹

Tackling Chronic Disease

About 80% of the mortality gap for Indigenous Australian aged 35 to 74 years is due to chronic disease. The gap is caused by higher rates of chronic disease at younger ages as well as increased death rates associated with chronic disease.

The major contributors are:

- Heart diseases;
- Diabetes;
- Liver diseases;
- Chronic lower respiratory disease;
- Cerebrovascular diseases, such as stroke; and
- Cancer.⁴²

While over the period 1998 to 2009 there has been a significant decrease in Indigenous chronic disease mortality rates there has also been a significant decrease in non-Indigenous rates, resulting in no significant change in the gap.⁴³

Aboriginal and Torres Strait Islander Chronic Disease Fund

The aim of the Aboriginal and Torres Strait Islander Chronic Disease Fund (ATSICDF) is to improve the prevention, detection, and management of chronic disease in Indigenous people to increase life expectancy and contribute to the target of closing the gap in life expectancy within a generation.

⁴⁰ <http://www.aihw.gov.au/publication-detail/?id=60129543215>

⁴¹ <http://www.health.gov.au/indigenous-hpf>

⁴² <http://www.aihw.gov.au/indigenous-observatory-chronic-disease/>

⁴³ <http://www.health.gov.au/internet/annrpt/publishing.nsf/Content/annual-report-1011-toc~1011part2~1011part2.4~1011outcome8>

The majority of the funding for this Fund relates to grants programs from the Indigenous Chronic Disease Package.

\$834 million / 4 years (from 2011-12) has been allocated to the fund. Given that this does not include funding provided for higher utilisation costs for MBS and PBS, for subsidising PBS co-payments and for the Indigenous Health Practice Incentive Payment program, it can be inferred that at least **\$300 million** of this \$834 million is for continued funding of the included aspects of the Indigenous Chronic Disease package from July 2012 to June 2014.

Initiatives that were consolidated into the Aboriginal and Torres Strait Islander Chronic Disease Fund from 1 July 2011

- Indigenous Chronic Disease Package:
 - National Action to Reduce Indigenous Smoking Rates;
 - Helping Indigenous Australians Reduce Their Risk of Chronic Disease;
 - Local Community Campaigns to Promote Better Health;
 - Subsidising PBS Medicine Co-payments;⁴⁴
 - Care Coordination and Supplementary Services Measure;
 - Improving Indigenous Participation In Health Care Through Chronic Disease Self-Management;
 - Urban Specialist Outreach Assistance Program;
 - Medical Specialist Outreach Assistance Program - Indigenous Chronic Disease;
 - Monitoring and Evaluation;
 - Workforce Training and Support;
 - Expanding the Outreach and Service Capacity of Indigenous Health Organisations;
 - Engaging Divisions of General Practice⁴⁵ to Improve Indigenous Access to Mainstream Primary Care;
 - Attracting More People to Work in Indigenous Health; and
 - Clinical Practice Guidelines;
- Rheumatic Fever Strategy - National Coordination Unit.
- Improving Eye and Ear Health Services for Indigenous Australians for Better Education and Employment Outcomes - Training of Aboriginal Health Workers in ear health and hearing monitoring and screening.

The Practice Incentives Program (PIP) Indigenous Health Incentive funded under the Indigenous Chronic Disease Package has been consolidated into the Practice Incentives for General Practices Fund.

The 'Higher Utilisation costs for MBS and PBS' measure and special appropriation component of the PBS Co-payment measure funded under the Indigenous Chronic Disease Package are not consolidated in the ATSCDF as these are not grant programs.

⁴⁴ Note that while this is included on this DoHA-generated list (accessed at <http://www.health.gov.au/internet/publications/publishing.nsf/Content/flexible-funds-atsicdf-toc~flexible-funds-atsicdf-atta>), this webpage also states that "the special appropriation component of the PBS Co-payment measure funded under the Indigenous Chronic Disease Package is not consolidated in the ATSCDF as it is not a grant program. This raises the issue of whether the funding for this measure (\$88.7 million / 4 years) is included in the ATSCDF.

⁴⁵ Now Medicare Locals.

Indigenous Chronic Disease Package

The Commonwealth's Indigenous Chronic Disease Package, which commenced in 2009, was developed specifically to prevent and better manage chronic disease. Progress on implementing the provisions of this package is outlined in the following sections.

Activities Supported Under the Indigenous Chronic Disease Package

1. The Tackling Indigenous Smoking Initiative

Background

Tobacco use is the leading risk factor contributing to disease and death among Indigenous Australians and is the single biggest contributing factor to the life expectancy gap between Indigenous and non-Indigenous Australians. The great gains made in anti-tobacco campaigns in Australia in recent decades have not been reflected in Indigenous communities where smoking rates have not decreased over the past 15 years. Fifty-one per cent of Indigenous people smoke, compared with a 17% smoking rate across the general Australian population and in some communities rates are as high as 70-80%. Indigenous mothers are more likely to have smoked during their pregnancy than other mothers. Generally, Indigenous people take up smoking at an earlier age, smoke for longer and make fewer attempts to quit than non-Indigenous Australians. Tobacco use is responsible for 12.1 % of the total burden of disease and 20% of all Indigenous deaths. If the level of smoking among indigenous people were brought down to general Australian levels, health researchers say that 20 per cent of the life expectancy gap would close.⁴⁶

About this initiative

Tackling Indigenous Smoking is a key initiative of the Indigenous Chronic Disease Package. Commonwealth, state and territory governments have committed a total of almost **\$200 million / 4 years** (2009–13) to reduce the smoking rate and the tobacco-related burden of disease in Indigenous communities. This comprises **\$100.6 million** from the Commonwealth Government and **\$98.09 million** from the states and territories. This funding builds on the Commonwealth funds of **\$14.5 million / 4 years** for 18 Indigenous tobacco-specific projects under the Indigenous Tobacco Control Initiative which was launched in March 2008. This initiative concluded at the end of June 2012 and an evaluation and review is underway.

Fifty-seven regions have been identified and will generally receive one regional tobacco coordinator, three Tobacco Action Workers and two healthy lifestyle workers who will work as teams on the ground in communities, developing programs that suit local needs and providing one-on-one support.

The following federally-funded activities have been undertaken or are planned under the leadership of a National Coordinator for Tackling Indigenous Smoking:

⁴⁶ http://www.lowitja.org.au/sites/default/files/docs/policy20brief_smoking.pdf

- A staged roll-out of tobacco action workers (TAW) and Regional Tobacco Coordinators (RTC) across 57 regions (to work as part of teams with the Healthy Lifestyle Workers (HLWs) who are being funded through another component of the Indigenous Chronic Disease Package);
- Training to support these positions (TAWs and RTCs) to deliver smoking cessation programs and supports in Indigenous communities;
- Training for the new and existing workforce in providing brief interventions in smoking;
- Training, funding and supports to the TAWs and RTCs to develop and implement localised anti-smoking social marketing campaigns;
- Quit smoking role models and ambassadors at the local level to assist other smokers to quit;
- An enhancement of Quitline services to be more accessible to and appropriate for Indigenous people; and
- Social marketing campaigns for Indigenous people.

The aim is to halve smoking rates in Indigenous communities in urban, regional and remote areas by 2018.

Progress to date

The most recent report for the Indigenous Chronic Disease Package is from October 2011 for the year 2010-11.⁴⁷ At that time:

- Regional Tackling Smoking teams had been rolled out to 21 regions and the ACT had also received a Tobacco Action Worker.⁴⁸
- Over 200 health workers and community educators had received training in smoking cessation
- The ‘Break the Chain’ advertising campaign – Australia’s first Indigenous-focused anti-smoking campaign - was launched in March 2011 on national media. This was described as a **\$4 million** campaign. Two bursts of media activity occurred between 28 March and 26 June 2011. The initial burst of activity lasted for a total of 4 weeks from launch date and the second burst lasted from 22 May for a further 6 weeks. Both bursts of media activity included 40 TARPS, reducing to 30 TARPS in the final two weeks, with the media buy covering metropolitan and regional Australia, targeting areas with a high Indigenous population.

An evaluation of the “Break the Chain’ media campaign found that it ‘resonated well’ with the Indigenous target audience and delivered a call to action to encourage Indigenous smokers to cut down or quit smoking and to encourage recent quitters to continue not to smoke and put pressure on others to quit.⁴⁹

⁴⁷ http://www.healthinonet.ecu.edu.au/key-resources/bibliography?page=5&q=Closing%20the%20gap&q_exact=&q_author=&q_keyword=&sorter=year-DESC&year_start=2011&year_end=2011&lid=22883

⁴⁸ The DoHA 2011-12 Annual Report states that 16 Regional Tackling Smoking and Healthy Lifestyle Teams were rolled out in 2011-12, taking the total to 37 teams across Australia. [http://www.health.gov.au/internet/main/publishing.nsf/Content/B98FF8123610FF33CA257A8E0002B13B/\\$File/DOHA%202011-12%20Annual%20Report.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/B98FF8123610FF33CA257A8E0002B13B/$File/DOHA%202011-12%20Annual%20Report.pdf)

⁴⁹ <http://www.quitnow.gov.au/internet/quitnow/publishing.nsf/Content/btc-indsurvey-execsumm>

Since July 2010 nicotine patches and other pharmacotherapies have become available to Indigenous patients on an authority script for no cost to healthcare cardholders and at the concessional rate for others. This is available as part of the PBS co-payment measure of the Practice Incentives Program Indigenous Health Incentive. However while nicotine replacement therapy and other pharmacotherapies may become more available under this measure, they will not necessarily be more accessible as many of the barriers to accessing mainstream health services remain.

A report released by the AIHW in February 2011 showed that there had been a small decline (from 53% to 50%) in smoking rates among Indigenous Australians between 2002 and 2008,⁵⁰ but the rate of Indigenous mothers who continue to smoke in pregnancy had remained constant at 51% between 2001 and 2008.⁵¹ At this rate, reaching the target of 25% by 2018 is well out of reach. In the 2012 report of the ATSI Health Performance Framework, smoking rates are indicated as an issue of continuing concern.⁵²

State efforts

It has not proved possible to track state and territory budget commitments to this effort.

Many multi-component tobacco action programs have been, or are currently being, implemented in ACCHOs and Indigenous communities by the states and territories.⁵³ However publicly available evaluations of these are rare. Published evaluations of projects in the Northern Territory and North Queensland have found no measureable impact on smoking cessation, although one of the Northern Territory studies (The Tobacco Action Project, 1999–2000) found increases in knowledge of the health effects of tobacco and readiness to quit. This study and the other Northern Territory study (The Tobacco Project, 2007–08) also found that those communities with the most tobacco action activity measured the greatest decline in tobacco consumption.⁵⁴

Training programs such as SmokeCheck⁵⁵ have been rolled out in several states to address the lack of skills and confidence that health workers face in delivering smoking cessation advice and tobacco programs. The evaluation of the New South Wales SmokeCheck program found that there were significant increases in the confidence of health workers to talk to their clients about the health effects of smoking and the value of quitting. More Aboriginal health workers recognised the importance of offering smoking cessation advice to their clients after the training, and perceived that it was easier to offer this advice after having received the

⁵⁰ Note that ABS and AIHW analysis of the 2008 NATSISS data quoted in ATSI Health Performance Framework 2012 Report finds the smoking rate in 2008 to be 47%, down from 52% in 2002.
[http://www.health.gov.au/internet/main/Publishing.nsf/Content/E1C132BA79E38973CA2578CB001C217D/\\$File/hpf-2012.pdf](http://www.health.gov.au/internet/main/Publishing.nsf/Content/E1C132BA79E38973CA2578CB001C217D/$File/hpf-2012.pdf)

⁵¹ <http://www.aihw.gov.au/media-release-detail/?id=10737418259>

⁵² <http://www.health.gov.au/internet/publications/publishing.nsf/Content/oatsih-hpf-2012-toc>

⁵³ <http://www.tobaccoaustralia.org.au/chapter-8-aptsi/8-10-interventions-targeting-aboriginal-peoples-an>

⁵⁴ <http://www.tobaccoaustralia.org.au/chapter-8-aptsi/8-10-interventions-targeting-aboriginal-peoples-an>

⁵⁵ <http://www.smokecheck.com.au/>

training. Evaluations of the use of SmokeCheck in Queensland found that health workers were satisfied with the training, that it increased their confidence to deliver smoking cessation advice appropriately, and that it improved their clinical practice.⁵⁶

A study that examined trends in monthly sales to assess the impact of the income management on sales of tobacco and cigarettes in 10 remote Indigenous communities in the 18 months before and after the introduction of the Northern Territory Emergency Response found no beneficial effect in terms of sustained change in the sales tobacco resulting from the strategy.⁵⁷

2. Helping Indigenous Australians to reduce their risk of chronic disease

Background

Indigenous Australians experience a burden of disease two-and-a-half times that of other Australians. A large part of the burden of disease is due to chronic diseases such as cardiovascular disease, diabetes, cancer, chronic respiratory disease and chronic kidney disease. This can be reduced by earlier identification, and management of risk factors and better management of the disease itself.

About this initiative

The Australian Government will provide **\$37.5 million / 4 years** (2009-10 to 2012-13) for the rollout of a national network of Healthy Lifestyle Workers to reduce the lifestyle risk factors that contribute to preventable chronic disease in Indigenous communities. The stated at state goal is for around 25,000 individuals, families and community groups to benefit from this program by 30 June 2013.

Under this initiative:

- A network of Healthy Lifestyle Worker (HLW) teams will be established around Australia. These are non-clinical positions and the HLWs will receive accredited training through registered training organisations. The role of HLWs is to improve nutrition and physical activity and reduce the lifestyle factors that are the main contributors to preventable chronic disease. They will also work closely with new Tobacco Action Workers (TAWs) in a team-based approach. They will free up Aboriginal Health Workers to spend more time on clinical work and program management roles.
- HLWs will refer people who are at risk of developing a chronic disease to health services to help where necessary. People with established chronic disease will also be referred for help in managing their disease.
- To ensure this program is properly targeted, the Australian Government is receiving advice from external expert working groups. The Indigenous Health Forums in each state

⁵⁶ <http://www.tobaccoaustralia.org.au/chapter-8-apsi/8-10-interventions-targeting-aboriginal-peoples-an>

⁵⁷ <http://www.tobaccoaustralia.org.au/chapter-8-apsi/8-10-interventions-targeting-aboriginal-peoples-an>

and territory are also providing expert advice including on where the healthy lifestyle workers should work.⁵⁸

The roll out is planned to provide 136 HLWs in 57 regions. In addition, each region will receive **\$100,000 / year** to develop localized campaign activities and health promotion events for their local area.

Progress to date

The October 2011 report on the Indigenous Chronic Disease Package states that 43 HLW positions were funded in the past two years.⁵⁹ However the 2010-11 DoHA Annual Report states that while the 2010-11 target was to fill 42 HLW positions, only 30 positions were filled.⁶⁰ The DoHA 2011-12 Annual Report states that 16 Regional Tackling Smoking and Healthy Lifestyle Teams were rolled out in 2011-12, taking the total to 37 teams across Australia.⁶¹ Assuming all these teams had the required 2 HLWs, that would make a total of 74 such workers in the field in June 2012. The 2011-12 target was to complete the roll-out to all 57 regions.

A Healthy Lifestyle portal has recently been established⁶² and the Healthy, Deadly and Strong – Healthy Lifestyle Worker Toolkit for HLWs has been developed and distributed.⁶³

3. Local Indigenous community campaigns to promote better health

Background

This initiative is about ensuring that Indigenous Australians have a better understanding of the risk factors involved in chronic diseases and know how to access health services that can help prevent or better manage chronic disease. It is particularly about getting these messages through to some groups of Indigenous Australians who tend not to go to a doctor or health service, such as young men. Funding of **\$22.7 million / 4 years** is provided for this social marketing program.

⁵⁸ <http://www.health.gov.au/internet/ctg/publishing.nsf/Content/helping-indigenous-australians-to-reduce-their-risk-of-chronic-disease>

⁵⁹ [http://www.health.gov.au/internet/ctg/publishing.nsf/Content/home-1/\\$file/ICDP_2010-11%20ctg-report.pdf](http://www.health.gov.au/internet/ctg/publishing.nsf/Content/home-1/$file/ICDP_2010-11%20ctg-report.pdf)

⁶⁰

[http://www.health.gov.au/internet/annrpt/publishing.nsf/Content/CA2578FB00788D72CA25795A0003BB91/\\$File/Outcome%2010%20Health%20System%20Capacity%20and%20Quality.pdf](http://www.health.gov.au/internet/annrpt/publishing.nsf/Content/CA2578FB00788D72CA25795A0003BB91/$File/Outcome%2010%20Health%20System%20Capacity%20and%20Quality.pdf)

⁶¹

[http://www.health.gov.au/internet/main/publishing.nsf/Content/B98FF8123610FF33CA257A8E0002B13B/\\$File/DOHA%202011-12%20Annual%20Report.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/B98FF8123610FF33CA257A8E0002B13B/$File/DOHA%202011-12%20Annual%20Report.pdf)

⁶² <http://www.healthinonet.ecu.edu.au/healthy-lifestyle-workers>

⁶³ <http://www.healthinonet.ecu.edu.au/healthy-lifestyle-workers/toolkit#>

About this initiative

This initiative encompasses:

- An initial comprehensive research program to look at people's health behaviours and assess people's awareness of relevant health services and how they can be accessed.
- Funding for Indigenous media organisations to drive community involvement in developing and spreading health messages.
- By late 2010-11, an assessment of what partnerships and projects worked best. This will be passed on to states and territories, which can then undertake their own health promotion activities.⁶⁴

This initiative has now been branded as the Live Longer! Campaign in April 2011.⁶⁵

Progress to date

A report on *Developmental Research to inform the Local Indigenous Community Campaigns to Promote Better Health* was prepared for the Department in May 2010.⁶⁶ The report identified fatalistic beliefs about inevitability of experiencing chronic disease, low levels of health literacy and of the awareness of links between risk factors and chronic disease and low levels of proactive attitudes towards chronic disease prevention as barriers to change. Other barriers included the perceived 'acute treatment' focus of services, poor understanding of the existence or role of preventive health, and fear or a lack of trust.

Grant guidelines were released in March 2011 for both Phase 1: Targeted Funding (March – April 2011) and Phase 2: Open Competitive Funding (June – September 2011). Funding is available for communities which want to implement a Local community campaign in their area. The needs of communities vary and the amounts of funding provided will be flexible in addressing these different needs. Up to **\$17 million** is available from 2011 – 2013. DoHA has engaged communications consultants Cox Inall Ridgeway to provide national support to communities, and to assist applicants with the development and submission of grant applications.

In July 2011 38 successful Live Longer! Campaign grant projects, to a total of **\$10 million**, were funded under the targeted round.⁶⁷ In September 2012 the 36 successful competitive round grants were announced, with total funding (inferred) of **\$7 million**.⁶⁸

A Community Health Action Pack has been developed to assist communities and organisations with planning their own health promotion projects.⁶⁹

⁶⁴ <http://www.health.gov.au/internet/ctg/publishing.nsf/Content/local-indigenous-community-campaigns-to-promote-better-health>

⁶⁵ <http://livelonger.health.gov.au/about/>

⁶⁶ [http://www.health.gov.au/internet/ctg/Publishing.nsf/Content/home-1/\\$file/Local%20Community%20Campaigns%20final%20report.pdf](http://www.health.gov.au/internet/ctg/Publishing.nsf/Content/home-1/$file/Local%20Community%20Campaigns%20final%20report.pdf)

⁶⁷ <http://livelonger.health.gov.au/local-projects/grant-recipients/grant-recipients/>

⁶⁸ <http://livelonger.health.gov.au/grant-recipients-open-competitive-round/>

⁶⁹ <http://livelonger.health.gov.au/about-the-community-health-action-pack/>

State efforts

Although it was indicated that states and territories would have a role in the continuation of this initiative, no information on this has been found.

4. Subsidising PBS medicine co-payments

Background

Despite having two to three times higher levels of illness, PBS expenditure for Indigenous people is about half that of the non-Indigenous average. The cost of medicines has been identified as a significant barrier to improved access to medicines for Indigenous Australians.

In 2005 DoHA established a committee to provide advice on ways to improve the capacity of the PBS to meet the health needs of Indigenous Australians. As a result a number of medications were listed on the PBS to be available on authority specifically for Indigenous patients.⁷⁰ The rationale for subsidising these drugs is the higher rates of certain diseases seen in the Indigenous population.

The QUMAX program, which commenced in November 2008, aimed to overcome a range of known barriers to Indigenous peoples' access to medicines. It was jointly developed and managed by the National Aboriginal Community Controlled Health Organisation (NACCHO) and the Pharmacy Guild of Australia, and funded by the Australian Government under the Fourth Community Pharmacy Agreement (2005–2010). Patients could access the QUMAX program through ACCHSs in rural, regional and urban (ie, non-remote) areas. The cost of medicines for eligible needy patients was subsidised through co-payment relief arrangements between ACCHSs and participating community pharmacies. This was a capped program with approximately **\$2 million / year** provided to meet the co-payments for PBS medicines.⁷¹ It is unclear if QUMAX alleviated the PBS expenditure inequities, but the evaluation report states that there is “strong evidence that the QUMAX program has helped to overcome the financial barrier to accessing PBS medicines in non-remote areas”.⁷²

Indigenous patients in remote areas who are able to access essential medicines free of charge from Aboriginal Health Services through the special PBS supply arrangements enacted under the provisions of section 100 (s100) of the National Health Act 1953.⁷³ In 2001-12 the total expenditure on these s100 medicines was **\$42.7 million**.

⁷⁰ <http://www.australianprescriber.com/magazine/34/2/38/40>

⁷¹ <https://www.mja.com.au/journal/2011/195/2/improving-aboriginal-and-torres-strait-islander-people-s-access-medicines-qumax>

⁷²

[http://www.health.gov.au/internet/main/publishing.nsf/Content/5B1B138DA00BB9C7CA2578150083984E/\\$file/Final%20Report%20QUMAX%20Evaluation%20April%202011.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/5B1B138DA00BB9C7CA2578150083984E/$file/Final%20Report%20QUMAX%20Evaluation%20April%202011.pdf)

⁷³ <http://www.health.gov.au/internet/main/publishing.nsf/content/health-pbs-indigenous-info>

About this initiative

The Government will provide **\$88.7 million / 4 years** for assistance with the cost of PBS medicines for Indigenous patients living with, or at risk of, chronic disease. The assistance is in the form of lower co-payments - eligible patients who would normally pay the full PBS co-payment will pay the concessional rate and those who would normally pay the concessional price will receive their PBS medicines without a co-payment.

This measure covers those eligible Indigenous patients of both non-remote ACCHSs and general practices participating in the Indigenous Health Incentive under the Practice Incentives Program. Eligible patients are those with an existing chronic disease or chronic disease risk factor who, in the opinion of the doctor: (a) would experience setbacks in the prevention or ongoing management of chronic disease if the person did not take the prescribed medicine; and (b) are unlikely to adhere to their medicines regimen without assistance through the measure. The eligibility for this measure may be reviewed over the implementation period.

Around 70,000 people are expected to benefit by the end of 2012-13. Given that annually some 34,000 people received a benefit under QUMAX, this new program has not been planned to greatly expand the number of people covered, although these people will all receive substantially greater financial assistance.

Although the QUMAX program no longer includes the co-payment relief element, it has been extended until 2015 under the Fifth Community Pharmacy Agreement to continue to augment QUM within ACCHSs.

Progress to date

This program commenced on 1 July 2010. It is reported that more than 2,900 practices and Indigenous health services have signed on to the PIP Indigenous Health Incentive,⁷⁴ including 63 of 75 eligible ACCHSs, and 96% of pharmacies are participating.⁷⁵ Around 29,000 patients registered for the PIP Indigenous Health Incentive for 2012.⁷⁶

In its first year of operation subsidised medicines were provided to 79,076 people.⁷⁷ Up until 30 June 2012 2,729,929 prescriptions have been dispensed to 150,005 eligible patients.⁷⁸ This is double the number anticipated. Given the degree of under-recognition of Indigenous

⁷⁴ http://www.amlalliance.com.au/_data/assets/pdf_file/0006/45456/Rhonda-Stilling_DoHA_National-CCSS-Care-Coordinator-Forum-August-2012.pdf

⁷⁵ [http://health.gov.au/internet/main/publishing.nsf/Content/B98FF8123610FF33CA257A8E0002B13B/\\$File/DOHA%202011-12%20Annual%20Report.pdf](http://health.gov.au/internet/main/publishing.nsf/Content/B98FF8123610FF33CA257A8E0002B13B/$File/DOHA%202011-12%20Annual%20Report.pdf)

⁷⁶ http://www.amlalliance.com.au/_data/assets/pdf_file/0006/45456/Rhonda-Stilling_DoHA_National-CCSS-Care-Coordinator-Forum-August-2012.pdf

⁷⁷ [http://www.health.gov.au/internet/ctg/publishing.nsf/Content/home-1/\\$file/ICDP_2010-11%20ctg-report.pdf](http://www.health.gov.au/internet/ctg/publishing.nsf/Content/home-1/$file/ICDP_2010-11%20ctg-report.pdf)

⁷⁸ <http://www.health.gov.au/indigenous-hpf>

patients in private practice,⁷⁹ and the fact that a significant number of GPs apparently do not know about the PBS scheme,⁸⁰ it seems that this program is significantly under-funded if it is to meet the needs of all eligible Indigenous people.

5. Supporting Primary Care Providers to Coordinate Chronic Disease Management – Care Coordination and Supplementary Services Measure

Background

Effective management of chronic health conditions gives people improved health outcomes, provides better quality of life and keeps people out of hospital.

Care coordinators can:

- Assist people to understand their chronic health condition and how to manage it;
- Advise on the importance of following a care plan and provide assistance with care plan compliance; and
- Provide support in identifying signs that the patient's condition may require further assistance from a health professional.

A Care Coordinator can assist patients to access a range of services such as appointments with specialists and allied health professionals, make arrangements for home help, and provide connections with support groups.

About this initiative

The Care Coordination and Supplementary Services (CCSS) program will contribute to improved health outcomes for Indigenous people with chronic health conditions through care coordination and supplementary services to assist with this. Funding of **\$83.6 million / 4 years** has been allocated. This includes a flexible pool of funds that can be used to access medical specialist and allied health services that are in accordance with the patient's care plan and to assist with the cost of local transport to health care appointments. A variety of care coordination mechanisms can be used.⁸¹

To be eligible for care coordination under the CCSS program, Indigenous patients must:

- Have a care plan;
- Be enrolled for chronic disease management in a general practice or Indigenous Health Service participating in the Practice Incentives Program Indigenous Health Incentive; and
- Be recommended by their General Practitioner.

Priority is given to:

- Patients who are at greatest risk of experiencing otherwise avoidable (lengthy and/or frequent) hospital admissions;

⁷⁹ http://www.naccho.org.au/download/aboriginal_health_plan-natsihp_consultation/NATSHIP%20NACCHO%20Submission%20January%202011%202013.pdf

⁸⁰ <http://www.australiandoctor.com.au/news/latest-news/gps-unaware-of-free-meds-scheme>

⁸¹

[http://www.health.gov.au/internet/ctg/publishing.nsf/Content/0089DD35F92DAEE7CA2577F400033A87/\\$File/Indigenous%20Chronic%20Disease%20Package%20Care%20Coordination%20and%20Supplementary%20Services%20Program%20Guidelines.pdf](http://www.health.gov.au/internet/ctg/publishing.nsf/Content/0089DD35F92DAEE7CA2577F400033A87/$File/Indigenous%20Chronic%20Disease%20Package%20Care%20Coordination%20and%20Supplementary%20Services%20Program%20Guidelines.pdf)

- Patients at risk of inappropriate use of services, such as hospital emergency presentations;
- Patients not using community based services appropriately or at all;
- Patients who need help to overcome barriers to access services;
- Patients who require more intensive care coordination than is currently able to be provided by general practice or Indigenous Health Service staff; and
- Patients who are unable to manage a mix of multiple community-based services.

Care coordination services need to be associated with one of the five eligible chronic diseases – diabetes, cancer, cardiovascular, respiratory and renal. Only general practices or Indigenous Health Services participating in the PIP Indigenous Health Incentive are eligible to enrol patients in the CCSS Program

Progress to date

Funding of **\$29 million** in 2011-12 and **\$36 million** in 2012-13 has been provided. Care coordination services have commenced across all jurisdictions, with care coordinators using a variety of methods to increase referral rates and establish a patient base. There are some concerns about the administrative burden and a focus that is limited to service navigation.⁸²

In March 2012 it was reported that there were 86 care coordinators.⁸³ A report to the NSW Care Coordinators Forum in June 2012 indicated that at that time 199 GPs and 453 patients were involved and that 2,931 services had been delivered (it is assumed these are Australia-wide numbers). Of these services about 1/3 were allied health, 1/3 were specialist and 1/3 were transport.⁸⁴ The majority of allied health referrals were to dieticians / nutritionists, diatetic services / diabetes educators, podiatrists, and physiotherapists / exercise physiologists. The majority of specialist referrals were to endocrinologists, cardiologists, ophthalmologists, and respiratory physicians (although quite a range of other specialities were also represented).

An evaluation of the models of care coordination was completed in August 2012.⁸⁵ It found that policy frameworks are required to create supportive authorising environments for team-based care coordination and both a care coordination workforce plan and a care coordination (nursing) workforce capability framework are also needed.

⁸² http://www.amlalliance.com.au/_data/assets/pdf_file/0006/45456/Rhonda-Stilling_DoHA_National-CCSS-Care-Coordinator-Forum-August-2012.pdf

⁸³ http://www.amlalliance.com.au/_data/assets/pdf_file/0006/45456/Rhonda-Stilling_DoHA_National-CCSS-Care-Coordinator-Forum-August-2012.pdf

⁸⁴ http://www.gpnsww.com.au/_data/assets/aboriginalhealth/201205_workshop/DoHA-Indigenous-Chronic-Disease-Package-CCSS-program-update.pdf

⁸⁵ http://www.ahwi.edu.au/files/ahwi/docs/20120822_CCEval_ExecSummary_fin.pdf

6. Improving Indigenous Participation in Health Care Through Chronic Disease Self-Management

Background

Chronic disease self-management is defined as ‘the active participation by people in their own health care’.

The 2006–07 Federal Budget allocated **\$515 million / 5 years** for patient self-management activities although this funding was not specifically directed at Indigenous needs.

About this initiative

The Government will provide funding of **\$18.6 million / 4 years** for accredited training to be provided to 400 existing health professionals on how to support and educate their Indigenous clients so that they can manage their chronic conditions more successfully.

The health professionals receiving training will be existing employees (Aboriginal health Workers, nurses, and others) of Aboriginal Community Controlled Health Organisations, Medicare Locals and state and territory government Indigenous health services. Once accredited individual workers are expected to develop self-management plans with 5-10 patients and to provide up to 10 support sessions

Progress to date

The Human Behaviour and Health Research Unit at Flinders University has developed a Chronic Disease Self-Management (CDSM) support training program, building on the existing Flinders Program, designed for delivery to Indigenous Australians in a range of settings and circumstances.⁸⁶ In 2010-11, 130 health professionals participated in the training.

The program was piloted in Far North Queensland, SA and NSW. A remote CDSM project has been funded in the Pilbara and Kimberley regions of Western Australia. This is to be evaluated by the University of WA.⁸⁷ To assist with sustainability a ‘Train the Trainer’ model has been developed to increase the pool of accredited trainers, particularly in Aboriginal Medical Services.

No further up-to-date information about the implementation of this initiative could be found.

⁸⁶ <http://www.flinders.edu.au/medicine/sites/fhbhru/atsi-ccm/>

⁸⁷ [http://www.health.gov.au/internet/ctg/publishing.nsf/Content/home-1/\\$file/ICDP_2010-11%20ctg-report.pdf](http://www.health.gov.au/internet/ctg/publishing.nsf/Content/home-1/$file/ICDP_2010-11%20ctg-report.pdf)

State efforts

There is at least an indirect state role here as this program trains workers from state and territory government Indigenous health services. Some states also have their own CDSM programs⁸⁸ although these are not solely focused on Indigenous patients.

7. Increasing Specialist and Allied Health Follow-up Care

Background

Conducting more health assessments and improving screening and early intervention services for Indigenous Australians requires that the medical problems that are detected are addressed. Indigenous people who receive a health assessment are now eligible for up to follow-up 10 services per year. This may require referral to specialist medical and mental health services and / or allied health and dental services. Workforce shortages, lack of transport and cost mean these patients often have difficulty accessing specialist care.

About this initiative

Funding of **\$54.7 million / 4 years** has been allocated to increase the number of medical specialists, GPs and allied health professionals providing services to Indigenous communities in rural and remote Australia, and to increase access to specialist services in urban areas.

This is being done by:

- Expanding the Medical Specialist Outreach Assistance Program (MSOAP) to provide outreach services by multidisciplinary health teams in rural and remote Indigenous communities; and
- Developing specialist outreach services in urban areas.

The focus is on the provision of these services to people with, or at risk of, chronic disease. However the MSOAP expansion apparently also includes the MSOAP Maternity Services measure which also incorporates multidisciplinary teams including midwives, medical specialists, GPs including procedural GPs, health workers and allied health professionals.⁸⁹ It is presumed that the maternity services are not specifically for Indigenous patients.

The Commonwealth has contractual arrangements with suitably qualified organisations to deliver the Urban Specialist Outreach Assistance Program. Eligibility for the MSOAP-ICD and USOAP measures is determined by the ABS Australian Standard Geographical Classification - Remoteness Areas (ASGC-RA).

Progress to date

In 2010-11 multidisciplinary health professional outreach teams provided 541 services nationally in rural and remote Indigenous communities under MSOAP-ICD, up from 148 services delivered across NSW, QLD and WA in 2009-10.⁹⁰

⁸⁸ See for example, Western Australia <http://www.selfmanagement.health.wa.gov.au/> Queensland http://www.health.qld.gov.au/chronicdisease/documents/fw2008to15_full.pdf and NSW http://www0.health.nsw.gov.au/cdm/self_management.asp

⁸⁹ <http://www.health.qld.gov.au/orrh/html/msoap.asp>

⁹⁰ [http://www.health.gov.au/internet/ctg/publishing.nsf/Content/home-1/\\$file/ICDP_2010-11%20ctg-report.pdf](http://www.health.gov.au/internet/ctg/publishing.nsf/Content/home-1/$file/ICDP_2010-11%20ctg-report.pdf)

MSOAP-ICD services are now available in all states and the Northern Territory.⁹¹

The first Urban Specialist Outreach Assistance Program (USOAP) services were provided in Armidale, NSW in May 2010. The program was expanded to Queensland and Victoria in 2010-11.⁹²

No further up-to-date information about the implementation of this initiative could be found.

8. Monitoring and Evaluation

Background

The Government recognises that its commitment to improving chronic disease outcomes for Indigenous peoples requires monitoring and evaluation to ensure that the funding and programs contribute effectively to closing the gap on Indigenous health outcomes.

About this initiative

\$39.9 million is provided to fund a number of related elements that will work together to monitor implementation and assess the Indigenous Chronic Disease Package's effectiveness in achieving the Closing the Gap targets.

The elements are described on the DoHA website as:

- The development of a monitoring and evaluation framework to guide the package's monitoring and evaluation activities;
- Monitoring up to 32 sentinel sites to provide information about implementation and early outcomes;
- Introducing a web-based system for Indigenous health services to use in reporting data;
- Use of national survey information;
- Ongoing analysis and reporting by the Department of Health and Ageing including, for example, analysis of MBS and PBS data; and
- An overall evaluation of the package to be undertaken in 2012-13.⁹³

Progress to date

The Monitoring and Evaluation Framework was published on the department's website in December 2011 and a National Evaluator was appointed in June 2011.⁹⁴ The Framework was developed by consulting firm Urbis. There does not appear to be any publicly available reporting against this Framework. However there is some relevant reporting included in the

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http://www.ruralhealthaustralia.gov.au/internet/rha/publishing.nsf/Content/Medical_Specialist_Outreach_Assistance_Program_Indigenous_Chronic_Disease

⁹² [http://www.health.gov.au/internet/ctg/publishing.nsf/Content/home-1/\\$file/ICDP_2010-11%20ctg-report.pdf](http://www.health.gov.au/internet/ctg/publishing.nsf/Content/home-1/$file/ICDP_2010-11%20ctg-report.pdf)

⁹³ <http://www.health.gov.au/internet/ctg/publishing.nsf/Content/monitoring-and-evaluation>

⁹⁴ <http://www.health.gov.au/internet/ctg/publishing.nsf/Content/ICDP-monitoring-and-evaluation-framework>

annual Aboriginal and Torres Strait Islander Health Performance Framework reports and in AIHW reports.

The Menzies School of Health Research has been engaged to establish and manage the ICDP Sentinel Sites Project from March 2010 to January 2013. Twenty-four sentinel sites have been established in metropolitan, regional and remote locations. The aim of this Project is to identify barriers and enablers and early outcomes. Information to inform the evaluation is collected via health provider interviews (including the use of surveys), community focus group feedback and health service clinical indicator collations.

Progress on the roll-out of a web-based system to measure the Closing the Gap KPIs could not be established.

An overall national evaluation of the ICDP in 2012-13 is a key element of the evaluation strategy. Consulting firm KPMG, together with Winangali, Ipsos Social Research Institute and Baker IDI Heart and Diabetes Institute, have been contracted to undertake the national monitoring and evaluation of the ICDP. Much of this evaluation work should already be completed: forums and seven site visits were to be undertaken in mid-late 2012 and surveys were to be conducted in late 2012.

9. Workforce Education and Training

Background

The increased number of new workforce positions and increased responsibilities and initiatives for those already working in Indigenous health requires an increased focus on workforce education and training around specific Indigenous needs.

About this initiative

\$17.7 million / 4 years is provided for the allocation of 38 additional GP registrar training posts in Indigenous health, 50 additional nursing scholarships per year and 50 additional nurse placements per year. This initiative also requires the orientation, training and mentoring of 166 Aboriginal and Torres Strait Islander Outreach workers (ATSIOW).

Progress to date

In 2010-11:

- 46 GP registrar training posts were established in Indigenous health services – this is 8 more than the target.
- 39 Nurse Clinical Placement Scholarships and 21 Nurse Continuing Professional Development Scholarships were awarded.
- 84 Aboriginal and Torres Strait Islander Outreach Workers (ATSIOWs) received formal orientation training and 34 ATSIOWs were undertaking formal Vocational Education and Training.

Further information about progress beyond this time point could not be determined.

10. Expanding the Outreach and Service Capacity of Indigenous Health Organisations

Background

One way to help ensure that Indigenous Australians are more involved with their local health system, to remove barriers to access and to deliver culturally sensitive services is to use local people who have strong community links as outreach workers.⁹⁵

About this initiative

This initiative provides **\$68.42million / 4 years** to fund:

- 86 full time equivalent ATSIOW positions to be filled by local Indigenous Australians in ACCHOs.⁹⁶
- 43 practice managers.
- 33 additional health workforce positions to support rural and remote services meet expected increase in service demand.
- Capital infrastructure to house/accommodate the expanded workforce and fund clinic upgrades due to service expansion.⁹⁷

The aims are to:

- Free GPs and other health professionals from administrative coordination and community liaison tasks so they can focus on providing health care to their patients. Indigenous Australians.
- Ensure Indigenous health organisations can better manage specific Indigenous health needs and issues at the local level.
- Increase collaboration between ACCHOs, local GPs, hospitals and allied health providers.

The ATSIOW role is to work with the Indigenous Health Project Officers to help local Indigenous people make better use of available health care services. They may undertake the following tasks, under supervision:

- Community liaison to establish links with local Indigenous communities to encourage and support the increased use of health services; ,
- Administration and support to assist the Project Officer to identify barriers that may impact on access to health services by Indigenous Australians;
- Provide practical assistance to help people access and travel to health care appointments;
- Identify and remove barriers that prevent people from accessing health care.

These Workers are drawn from the local community and are not expected to have existing qualifications. Required training is provided.

Practice managers in Indigenous health organisations will be funded to:

- Maintain systems for individual client records and patient information and recall;

⁹⁵ http://www.cdc.gov/dhdsp/docs/chw_brief.pdf

⁹⁶ Note that the Indigenous Chronic Disease Package Monitoring and Evaluation Framework - Volume 2 states that the target is 'over 80 FTEs'.

⁹⁷ [http://www.health.gov.au/internet/ctg/publishing.nsf/Content/expanding-outreach/\\$file/Copy%20of%20DHA6136%20C2%20Factsheet.pdf](http://www.health.gov.au/internet/ctg/publishing.nsf/Content/expanding-outreach/$file/Copy%20of%20DHA6136%20C2%20Factsheet.pdf) Note that it is not clear if infrastructure costs come from these funds or elsewhere.

- Ensure people are assisted to access care and follow-up consistently on recommended treatments;
- Establish links with other health organisations to assist local health services, hospitals, specialists and allied health professionals to work together effectively in providing continuity of care for patients in accordance with their chronic disease management plans;
- Organise referrals and follow-up appointments for people to access health services as identified in their chronic disease management plans; and
- Supervise and support other staff such as Aboriginal and Torres Strait Islander Outreach Workers, as appropriate.

Progress to date

The 2010-11 progress report indicates:

- 128 ATSIOW positions had been filled;
- 20 Practice Managers had been employed; and
- 13 additional health staff had been employed.⁹⁸

Elsewhere figures as at June 30, 2011 are given more accurately as:

- 119.4 FTE ATSIOW positions recruited into ACCHOs and Divisions of General Practice (127.5 FTE funded);
- 19.5 FTE practice managers (20.1 funded); and
- 12.8 FTE additional health professionals recruited into ACCHOs.⁹⁹

As of 31 March 2012, the figures are given as:

- 117 ATSIOWs;
- 21 Practice Managers; and
- 16 additional health professionals.¹⁰⁰

However it is not clear that all these positions have gone to ACCHSs – it is likely that some have gone to MLs. This is certainly the case for the ATSIOW positions.

By June 2011, capital works projects had been funded in Wiluna (WA), Mooroopna (Vic), Bamaga (Qld), Grafton (NSW) and Tamworth (NSW) and construction of a staff house had been completed at Galiwinku (NT).¹⁰¹

⁹⁸ 2010-11 report [http://www.health.gov.au/internet/ctg/publishing.nsf/Content/home-1/\\$file/ICDP_2010-11%20ctg-report.pdf](http://www.health.gov.au/internet/ctg/publishing.nsf/Content/home-1/$file/ICDP_2010-11%20ctg-report.pdf)

⁹⁹ [http://www.health.gov.au/internet/ctg/publishing.nsf/Content/home-1/\\$file/ICDP_2010-11%20ctg-report.pdf](http://www.health.gov.au/internet/ctg/publishing.nsf/Content/home-1/$file/ICDP_2010-11%20ctg-report.pdf)

¹⁰⁰ http://www.amlalliance.com.au/_data/assets/pdf_file/0006/45456/Rhonda-Stilling_DoHA_National-CCSS-Care-Coordinator-Forum-August-2012.pdf

¹⁰¹ [http://www.health.gov.au/internet/ctg/publishing.nsf/Content/home-1/\\$file/ICDP_2010-11%20ctg-report.pdf](http://www.health.gov.au/internet/ctg/publishing.nsf/Content/home-1/$file/ICDP_2010-11%20ctg-report.pdf)

11. Engaging Medicare Locals to Improve Indigenous Access to Mainstream Primary Care

Background

It is important for Indigenous people to have better access to culturally sensitive mainstream primary care services and for these services to be better integrated with local ACCHSs.

About this initiative

Funding of **\$74.7 million / 4 years** is provided to engage MLs to improve Indigenous access to mainstream primary care. It appears that these funds are spent on new positions to be filled by ATSIOWs and IHPOs. The Evaluation Framework states that the funding is provided for over 80 FTE ATSIOW positions and 80 FTE IHPOs.¹⁰²

The ATSIOWs will be drawn from local Indigenous communities and will be directly supported by IHPOs and the ML they work with.

IHPOs will work in Medicare Locals to:

- Improve the capacity of mainstream primary care providers to deliver culturally sensitive services (through cultural awareness training, quality improvement, health promotion and education);
- Help the community, mainstream primary care providers and ACCHSs to work together; and
- Support Outreach Workers.¹⁰³

There is also funding for an IHPO position in the Australian Medicare Local Alliance to lead and coordinate Indigenous health activities at the national level.

Progress to date

To date 86 FTE ATSIOW positions have been provided in MLs (see previous section).

The following table from the Aboriginal and Torres Strait Islander Outreach Worker Workshop Report, 2011¹⁰⁴ shows the anticipated allocation of ATSIOW positions.

Anticipated allocation of ATSIOW positions across jurisdictions, June 2011

State/Territory	Number	ML (%)	ACCHS (%)
ACT	2	1 (50%)	1 (50%)
NT	9	3 (33%)	6 (66%)
TAS	4.5	3 (66%)	1.5 (33%)
NSW	34	26 (76%)	8 (24%)
QLD	32	23 (72%)	9 (28%)
SA	11	9 (82%)	2 (18%)
VIC	13	8 (62%)	5 (38%)
WA	22	13 (59%)	9 (41%)

¹⁰² <http://www.health.gov.au/internet/ctg/publishing.nsf/Content/icdp-eval-framework-vol2-toc~C3>

¹⁰³ <http://www.health.gov.au/internet/ctg/publishing.nsf/Content/access-to-mainstream-primary-health>

¹⁰⁴ www.ahmrc.org.au/index.php?option=com_docman&task=doc...

12. Attracting More People to Work in Indigenous Health

Background

An accessible and competent health workforce is vital for ensuring that the health system has the capacity to provide culturally safe services that meet the needs of Indigenous Australians and improve their health outcomes. A key way to achieve this is to increase the number and capacity of Indigenous people entering into and working in the health workforce.

While 2.3% of the Australian population are Aboriginal and Torres Strait Islander people, only 1.6% of the national health workforce is made up of Indigenous people.¹⁰⁵ The National Indigenous Health Equality Council (NIHEC) released a report in 2011 that presented a series of recommendations aimed at reducing the gap in health workforce participation between Indigenous and non-Indigenous Australians by 20% in the priority areas of medicine, nursing and allied health within 10 years and by 50% within 20 years.¹⁰⁶

The Australian Government aims to build a larger workforce to support the Indigenous Health National Partnership Agreements by encouraging uptake of skilled and semi-skilled roles within the Indigenous health sector, and by increasing the number of Indigenous people working in health.

About this initiative

The prime focus of this **\$7.2 million** initiative is a national marketing and communication program, to be developed by the Department of Health and Ageing based on market research, to attract more people to work in Indigenous health, and to attract more Indigenous people to work in health. The market research looks at the awareness, knowledge and interest of Indigenous secondary school students about working in health, as well as the barriers and motivators to pursuing a health career.

Additionally, a public relations / media campaign targeted at current and potential health professionals (both Indigenous and non-Indigenous) will raise the profile of the opportunities, roles and rewards involved in working in Indigenous health.¹⁰⁷

Progress to date

A **\$4.3 million** campaign featuring “health heroes” – Indigenous Australians currently working in health from around Australia – commenced in July 2012 with targeted television, radio, print and online advertising and a “Do Something Real” website. It was supported by secondary school visits and informational materials.¹⁰⁸

¹⁰⁵ <http://www.limenetwork.net.au/files/lime/Blueprint%20for%20action.pdf>

¹⁰⁶

[http://www.natsihcec.gov.au/internet/nihec/publishing.nsf/Content/9C39D2D324B7758ACA2578640083C52B/\\$File/Part%201%20-%20Indigenous%20Health%20Workforce.pdf](http://www.natsihcec.gov.au/internet/nihec/publishing.nsf/Content/9C39D2D324B7758ACA2578640083C52B/$File/Part%201%20-%20Indigenous%20Health%20Workforce.pdf)

¹⁰⁷ <http://www.health.gov.au/internet/ctg/publishing.nsf/Content/attracting-indigenous-health>

¹⁰⁸ <http://healthheroes.health.gov.au/>

Information about increases in the Indigenous health workforce

It appears that the aim is to provide 355 new positions around Australia.¹⁰⁹ However as of 31 March 2012, 422 ICDP positions had been filled. These included:

- 117 FTE ATSIOWs
- 84 Indigenous Health Project Officers (IHPOs)
- 86 Care Co-ordinators
- 21 Practice Managers
- 16 additional health professionals
- 22 Regional Tobacco Coordinators
- 33 Tobacco Action Workers
- 43 Healthy Lifestyle Workers¹¹⁰

Some additional information is available on how these positions have been distributed across initiatives and geographically in media releases from the Minister for Indigenous Health, Warren Snowdon.

In February 2010, 83 ATSIOW placements were announced.¹¹¹

In December 2010, it was announced that 82 positions (20 Regional Tobacco Coordinators, 21 Tobacco Action Workers, 41 Healthy Lifestyle Workers) had been rolled out in all the states and territories except Tasmania.¹¹² It was expected that this workforce would grow to 340 positions within three years.

In February 2011, a list of placements for 38 staff to 28 Victorian health services was announced.¹¹³

In April 2011 placements for 63 staff in 27 WA health services were announced.¹¹⁴

In May 2011 placements for 34 new positions in South Australia were provided.¹¹⁵

¹⁰⁹ This figure from 16 May 2011 media release from Minister for Indigenous Health.
<http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr11-ws-ws020.htm?OpenDocument&yr=2011&mth=05>

¹¹⁰ http://www.amlalliance.com.au/_data/assets/pdf_file/0006/45456/Rhonda-Stilling_DoHA_National-CCSS-Care-Coordinator-Forum-August-2012.pdf

¹¹¹ <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr10-ws-ws013.htm>

¹¹² <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr10-ws-ws082.htm?OpenDocument&yr=2010&mth=12>

¹¹³ <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr11-ws-ws004.htm?OpenDocument&yr=2011&mth=02>

¹¹⁴ <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr11-ws-ws015.htm?OpenDocument&yr=2011&mth=04>

¹¹⁵ <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr11-ws-ws020.htm?OpenDocument&yr=2011&mth=05>

In October 2011 the Minister announced 41 new positions across Australia, including ATSIOWs, practice managers, and health professionals.¹¹⁶

State efforts

While there is not an explicit role for the states and territories in this initiative, these governments are major employers of people who work in Indigenous health. So it is concerning to read that states budget cuts, such as those made in Queensland recently, have meant a reduction in the numbers of people working in this area.¹¹⁷ The exact extent of such cuts could not be determined.

13. Clinical Practice Guidelines – Primary Health Care Resource

Background

Good quality guidelines can lead to improved patient care. However existing mainstream guidelines for the management of chronic disease do not adequately address the burden of disease and health management needs specific to Indigenous Australians. They also do not outline culturally sensitive care for Indigenous people.

About this initiative

\$3.1 million is provided for the development of a comprehensive primary health care resource for use by health care professionals in the prevention and primary care management of key chronic diseases in the Indigenous population.

The states aim is for a resource that will collate and present in a single resource all the existing tools, guides and other information that promote best practice in the prevention, identification and primary care management of chronic disease in Indigenous Australians. It will cover the key chronic diseases contributing to the burden of disease including cardiovascular disease, diabetes, chronic respiratory diseases (asthma and chronic obstructive pulmonary disease), and cancer (lung, breast and colorectal cancer). The resource will be aimed at workers in mainstream and Indigenous health sectors including GPs, nurses and Aboriginal Health Workers, and will consider urban, rural and remote settings.¹¹⁸

Progress to date

A web-based health care resource was developed and initial testing took place in 2010-11. The final resource was to be available in 2011-12.¹¹⁹

This work does not appear to be able to be publicly accessed and it is not possible to determine progress.

¹¹⁶ <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr11-ws-ws052.htm?OpenDocument&yr=2011&mth=10>

¹¹⁷ <http://www.sbs.com.au/news/radio/episode/259064/Queensland-health-workers-say-cuts-fail-Gap-commit>

¹¹⁸ <http://www.health.gov.au/internet/ctg/publishing.nsf/Content/clinical-practice>

¹¹⁹ [http://www.health.gov.au/internet/ctg/Publishing.nsf/Content/publications/\\$file/ICDP-Booklet-Version-2.pdf](http://www.health.gov.au/internet/ctg/Publishing.nsf/Content/publications/$file/ICDP-Booklet-Version-2.pdf)

Other Initiatives that are Part of the Aboriginal and Torres Strait Islander Chronic Disease Fund

Rheumatic Fever Strategy – National Coordination Unit

RHDAustralia, which operates from the Menzies Centre for Health Research in the Northern Territory, was established in 2009 as the National Coordination Unit for the Rheumatic Fever Strategy. Acute rheumatic fever (ARF) is rare in most developed countries, but rates among Australia's Indigenous people are among the highest in the world. Rheumatic heart disease (RHD), which can be prevented by adequate treatment of ARF, also occurs at very high rates among Indigenous Australians.¹²⁰

In 2009, the Australian Government's Rheumatic Fever Strategy was established to improve detection, monitoring and management of ARF and RHD through register-based control programs in the Northern Territory, Western Australia and Queensland with funding of **\$11.2 million / 5 years** (2007-08 to 2011-12). In 2012 a further **\$10.4 million / 4 years** was provided for this work.¹²¹ Specific funding levels for the National Coordination Unit could not be determined.

Closing the Gap: Improving Eye and Ear Health Services for Indigenous Australians – training of Aboriginal Health Workers in ear health and monitoring and screening

In July 2009 the Australian Government announced a funding commitment of \$58.3 million through the *Improving Eye and Ear Health Services for Indigenous Australians for Better Education and Employment Outcomes* initiative to close the gap between Indigenous and non-Indigenous eye and ear health.

The ear health components of the measure include:

- Training of health workers for ear health and hearing screening;
- Maintenance and purchase of medical equipment for hearing screening;
- Additional ear surgery, particularly for remote Indigenous clients; and
- Ear and hearing health promotion activities.

NACCHO identified that training in ear and hearing health had been ad hoc and was not accredited, resulting in a lack of confidence among Aboriginal Health Workers in the use of equipment.¹²² An additional problem was that some of the existing equipment was old and not be in good condition.¹²³

¹²⁰ http://apo.org.au/sites/default/files/docs/AIHW_RheumaticHeartDisease1996-2001_March2013.pdf

¹²¹

http://www.federalfinancialrelations.gov.au/content/npa/health_indigenous/rheumatic_fever/national_partnership.pdf

¹²² http://www.naccho.org.au/download/projects-activities/ear_and_health_workforce/Promoting%20the%20national%20Aboriginal%20Ear%20and%20Hearing%20Health%20%20skill%20set.pdf

¹²³ A 2009 Access Economics report explored this issue and the need for updated equipment in ACCHSs and AMSs. This report does not appear to be publicly available.

NACCHO was funded to undertake the Ear and Hearing Training for the Aboriginal Health Worker (AHW) Workforce Project in July 2010. The project was designed in four phases:

- Phase 1: Equipment training
- Phase 2: Accredited training.
- Phase 3: National training rollout
- Phase 4: Evaluation

In early 2011 OATSIH began distributing new equipment - pneumatic otoscopes, video-otoscopes and/or tympanometers – to NACCHO members.

It is known that NACCHO has negotiated funding to support Phase 3 and 4 for the July 2011 - June 2013 period. The level of this funding support is not known.

Other initiatives that are part of the Indigenous Chronic Disease Package

Supporting primary care providers to coordinate chronic disease management

Background

While primary care use is similar for Indigenous and non-Indigenous Australians (approximately 5.63 and 5.55 services per person respectively), Indigenous people have a higher rate of long and complex consultations.¹²⁴ This is presumable due to both their health status and needs and cultural issues.

Furthermore, many GPs are often unaware of their client's Indigenous status. A recent BEACH report found that Indigenous people were identified at only 1.6% of total GP encounters. This is only marginally better than findings from 10 years ago, in the 2002-3 BEACH report, which found identification occurring at 1.2% of encounters.¹²⁵

About this initiative

The Government is providing payments through the Practice Incentives Program Indigenous Health Incentive (PIP-IHI) to support general practices and Indigenous health services to provide better health care for Indigenous Australians. This includes best practice management of chronic disease. **\$115.1 million / 4 years** is provided for this initiative.

The PIP-IHI has three components:

- **Sign-on payment:** a one-off payment of \$1,000 to practices that join the incentive and agree to undertake specified activities to improve the provision of care to their Indigenous patients with chronic disease;
- **Patient registration payment:** an annual payment to practices of \$250 for each Indigenous patient 15 years and over, registered with the practice for chronic disease management in a calendar year; and
- **Outcomes payment:**
 - Tier 1 - \$100 to practices for each registered patient for whom a target level of care is provided by the practice in a calendar year;
 - Tier 2 - \$150 to practices for each registered patient for whom the majority of care is provided by the practice within a calendar year.^{126 127}

All Indigenous patients registered for the PIP-IHI must have had or been offered a health assessment. Practices participating in this incentive will be able to refer those Indigenous patients identified as needing more complex chronic disease management to the CCSS Program.

¹²⁴ <http://www.nhpa.gov.au/internet/nhpa/publishing.nsf/Content/Healthy-Communities-Australians-experiences-with-primary-health-care-2010-11~Key-findings~Use-and-experiences-among-Aboriginal-and-Torres-Strait-Islander-peoples>

¹²⁵ <http://purl.library.usyd.edu.au/sup/9781743320204>

¹²⁶ <http://www.health.gov.au/internet/ctg/publishing.nsf/Content/improving-frontline-health>

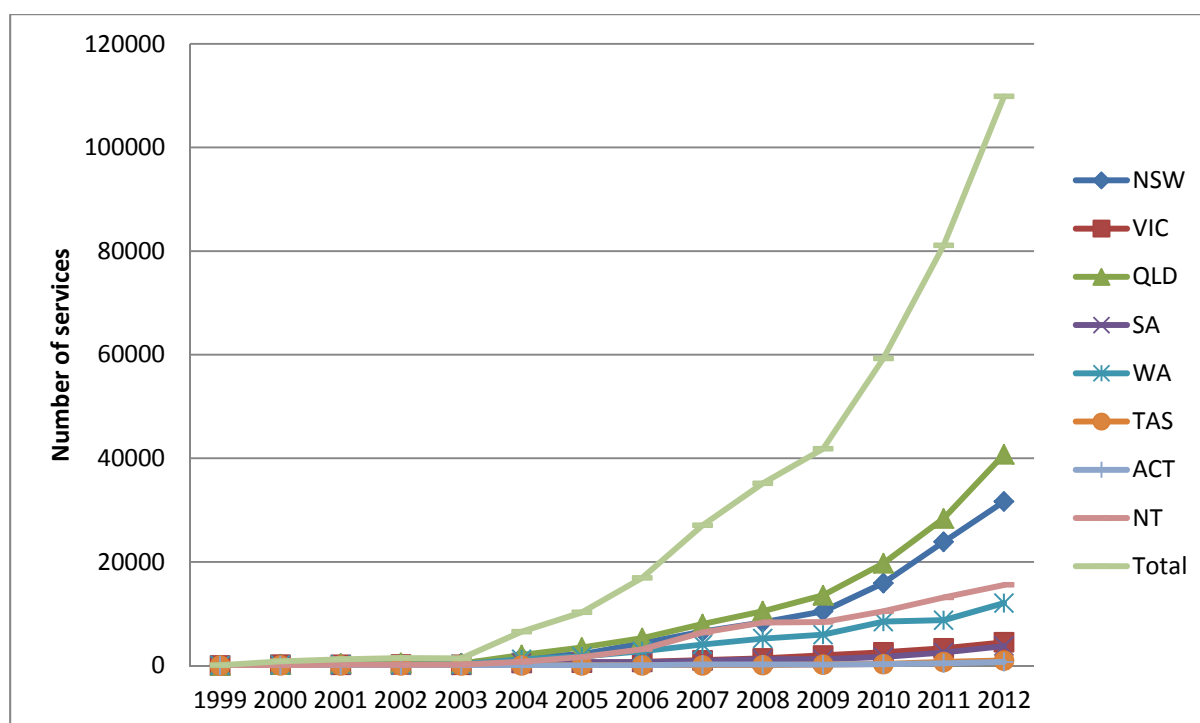
¹²⁷ <http://www.medicareaustralia.gov.au/provider/incentives/pip/files/indigenous-health-incentive-guidelines.pdf>

Progress to date

More than 2,900 practices and Indigenous health services have signed on to the PIP-IHI. Medicare data show 1796 practices (36.9%) have signed on to Tier 2 and 457 (9.4%) to Tier 1 by February 2012. The Tier 1 enrolment had risen to 642 (12.9%) by November 2012.

Around 29,000 patients were registered for PIP-IHI for 2012.¹²⁸ All Indigenous patients registered for the PIP-IHI must have had or been offered a health assessment. A total of 109,849 Indigenous Health Assessments (MBS item 715) were provided in 2012, so the majority of these were not done by PIP-IHI practices or Indigenous Health Services. Figure 1 shows the uptake of MBS item 715 over time. Northern Territory rates have increased since 2006, presumably in response to the NTER and there is evidence for an increase in uptake nationally since 2009.

Figure 1: Uptake of MBS item 715

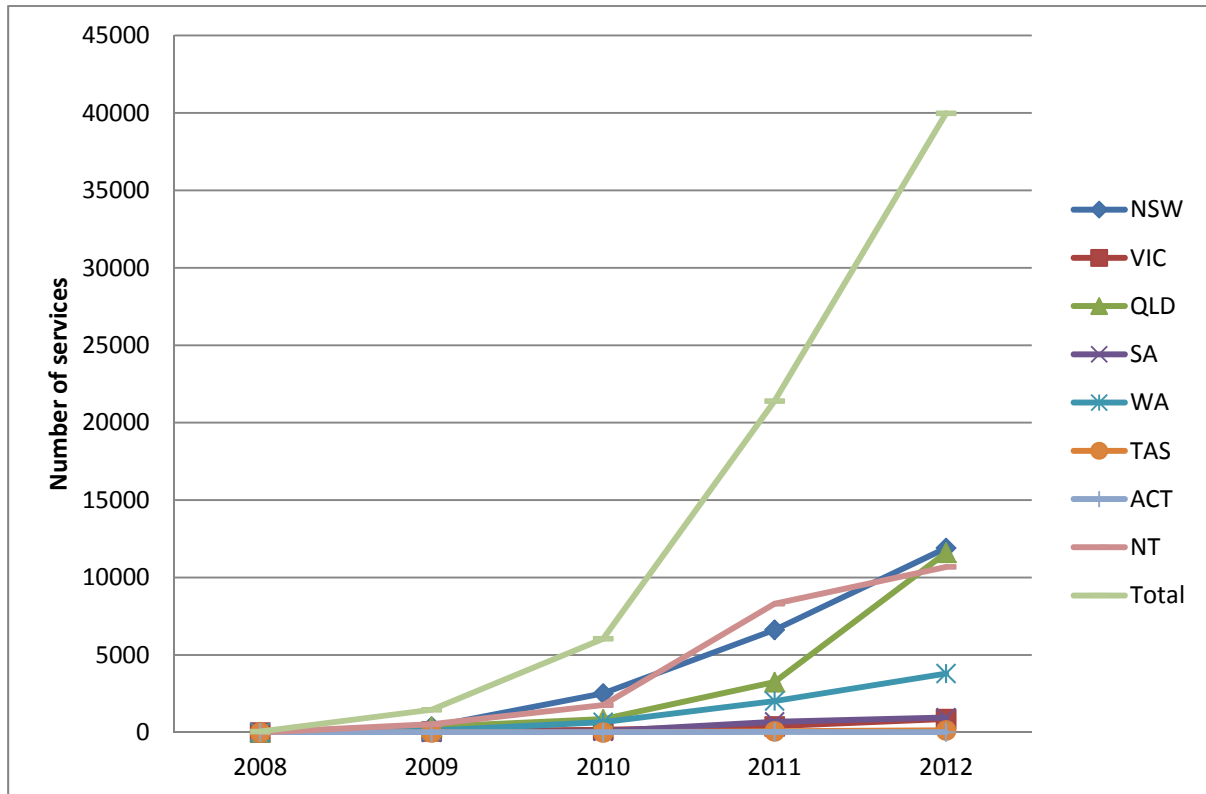


All Indigenous patients who have undergone a health assessment are also eligible for 10 follow up services per year (MBS item 10987) with either the practice nurse or registered Aboriginal Health Worker (AHW). In addition, they can also access five allied health services (Allied health MBS items 81300-81360) per calendar year if deemed necessary as part of the health assessment

¹²⁸ http://www.amlalliance.com.au/data/assets/pdf_file/0006/45456/Rhonda-Stilling_DoHA_National-CCSS-Care-Coordinator-Forum-August-2012.pdf

Analysis of Medicare data shows a continuing increase in the uptake of MBS item 10987 since 2009 in most jurisdictions. In 2012, 40,000 services were provided. But clearly only a fraction of Indigenous patients (who may or may not have had a health assessment) see a PN or AHW through this Medicare-subsidised mechanism.

Figure 2: Uptake of MBS item 10987



Elsewhere it has been quoted that 40,347 health assessments were provided from July 2011 to February 2012 and 16,003 Indigenous-specific follow-up services were provided in the same time frame.¹²⁹ It's surprising that so few follow-up services are apparently needed, given what we know about the health status of Indigenous patients.

¹²⁹ http://www.amlalliance.com.au/_data/assets/pdf_file/0006/45456/Rhonda-Stilling_DoHA_National-CCSS-Care-Coordinator-Forum-August-2012.pdf

