



**Central Australian
Aboriginal Congress**
ABORIGINAL CORPORATION | ICN 7823

The effectiveness of primary health care delivered through Aboriginal Community Controlled Health Services

8 November 2017

Three sets of evidence support continued and expanded investment in comprehensive primary health care (PHC) delivered through Aboriginal Community Controlled Health Services (ACCHSs) as a key strategy to improving Aboriginal and Torres Strait Islander health and wellbeing:

- population-level evidence about the importance of PHC, and the factors that make it effective, mainly from overseas but supported by consistent evidence within Aboriginal and Torres Strait Islander Australia;
- service or sector-level evidence from within Australia about the effectiveness of ACCHSs in relation to Aboriginal and Torres Strait Islander health and wellbeing; and
- evidence from the social and cultural determinants of health.

1. Population-level evidence about the importance of PHC

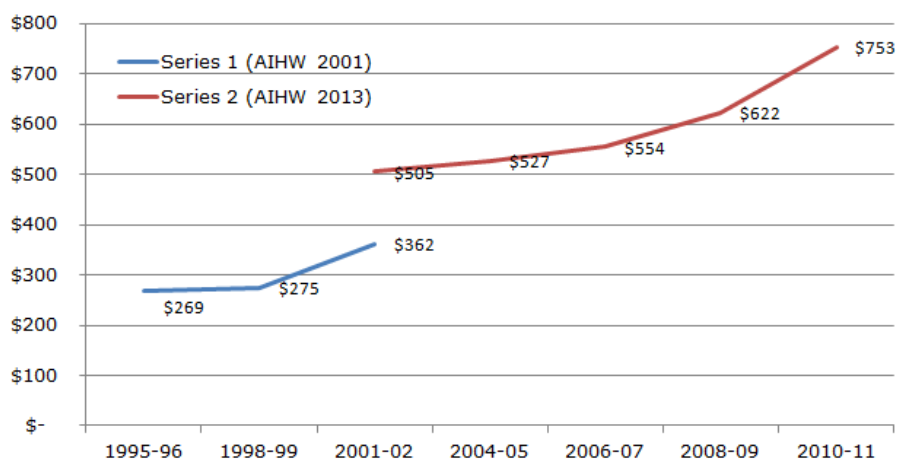
1. The social determinants of ill-health such as inequality; poverty; lack of access to education and employment; and social exclusion and racism exert a powerful effect on the health and wellbeing of all peoples [1].
 2. However, health care – and particularly primary health care – can offset the harmful health effects of the social determinants of health. The international evidence is clear that stronger primary health care systems are associated with:
 - better population health outcomes, especially relating to maternal and child health as measured by low birth weight and infant mortality [2] and to lower mortality rates including from heart disease, kidney disease and cancer [3, 4];
 - more equally distributed health outcomes across a population, a finding especially significant where 'closing the gap' in health outcomes is a priority [5];
 - lower hospitalisation rates for conditions managed by or prevented by PHC, including especially chronic conditions which currently account for about 80% of the health gap between Aboriginal and non-Aboriginal Australians [6]; and
 - lower national health care costs and greater economy in resource use [2, 5].
 3. Particular features of primary health care systems and the policies that underpin them are critical to their effectiveness. These features include: universal financial coverage under government control or regulation; equitable distribution of resources; a comprehensive model of service delivery; and low or no co-payments for access to care [5]. The ACCHSs service model embodies these principles, and closely aligns with the most effective, evidence based international systems of PHC.
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- The picture in Aboriginal and Torres Strait Islander Australia is consistent with the international evidence, as the following demonstrates.

Increased investment in PHC delivered by the ACCHS sector

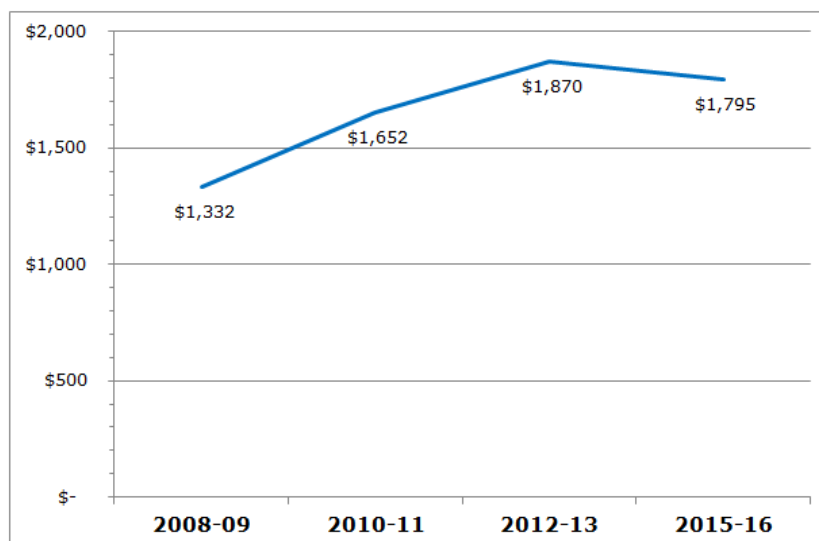
- The 1995 transfer of responsibility for Aboriginal and Torres Strait Islander primary health care from the Aboriginal and Torres Strait Islander Commission (ATSIC) to the Commonwealth Department of Health was a critically important reform. Beginning under the leadership of the former Federal Coalition Minister for Health, Dr Michael Wooldridge (1996-2001) and continuing thereafter, this reform led to increases in national funding for PHC directed through ACCHSs (see *Figure 1*).

Figure 1: National Commonwealth funding of ACCHS, 1995-96 to 2010-11, \$ per Indigenous person (constant prices) [7, 8]



- Unfortunately the gains described below flowing from this increased investment are now under threat, with per capita Indigenous specific funding for public and community health services (excluding subsidies) falling in recent years (see *Figure 2* noting that this is a different, though related funding measure to that in *Figure 1*).

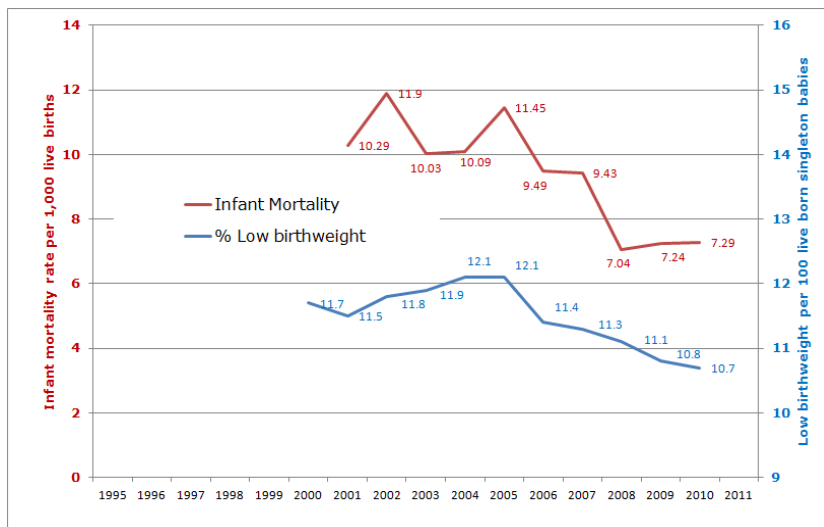
Figure 2: All Government Indigenous specific direct expenditure on Aboriginal and Torres Strait Islander Australians (\$ per person), 2008-09 to 2015-16 (2015-16 dollars)



Population health outcomes

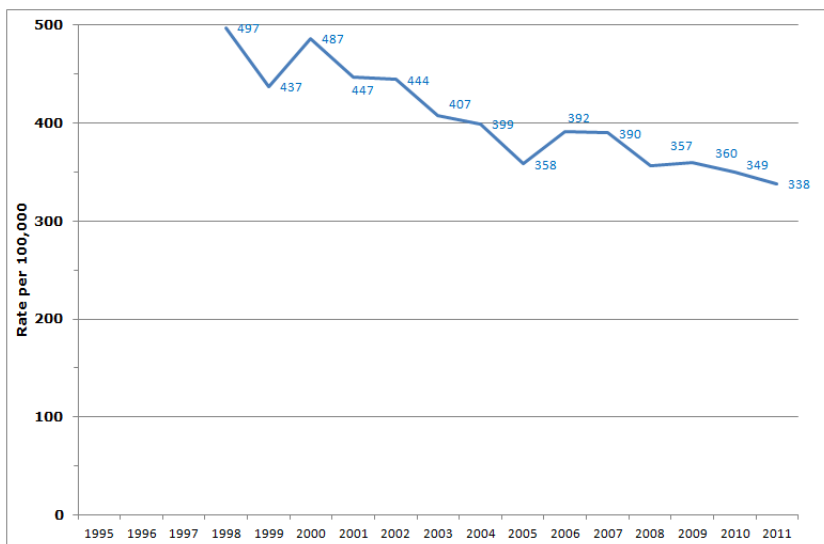
7. Low birth weight and infant mortality rates in the Aboriginal and Torres Strait Islander community have declined significantly over the period of increased investment in PHC delivered through the ACCHS sector.

Figure 3: Aboriginal and Torres Strait Islander infant mortality and low birth weight rates, 1995 to 2011 [9, 10]



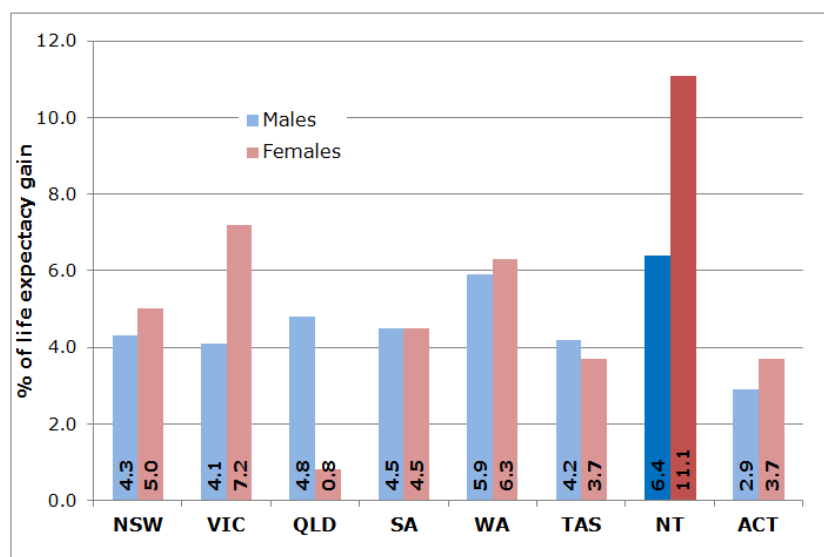
8. Mortality rates for avoidable conditions for Aboriginal and Torres Strait Islander people have also fallen significantly over this period.

Figure 4: Age-standardised avoidable mortality rates for Aboriginal and Torres Strait Islander people, 1995 – 2011 [11]



9. As well as the national evidence, there is powerful data from the Northern Territory, where the gains in life expectancy over the twenty years from 1995 are disproportionately concentrated amongst infants (aged less than 1 year) (Figure 5). These above average falls in infant mortality are consistent with the increased investment in PHC delivered through ACCHSs because, compared to other jurisdictions, the ACCHS sector provides a significantly greater proportion of the NT’s primary health care.

Figure 5: Proportion of life expectancy gain for infants, 1995 to 2015, by state / territory [12]



10. While formal research to confirm the link is needed, what the publicly available data shows is clearly consistent with the international evidence: increased investment in Australia and in the Northern Territory in PHC delivered through ACCHSs has led to significant improvements in Aboriginal and Torres Strait Islander health outcomes, particularly in the areas of child and maternal health and avoidable mortality.

2. Evidence from within Australia about the effectiveness of ACCHSs

11. Assessing the effectiveness of ACCHS in comparison to mainstream primary health care is hampered by the fact that the ACCHS service population has significantly more complex health needs and is more likely to live in rural, remote or outer-suburban areas where private practice business models struggle and service access is a particular challenge.

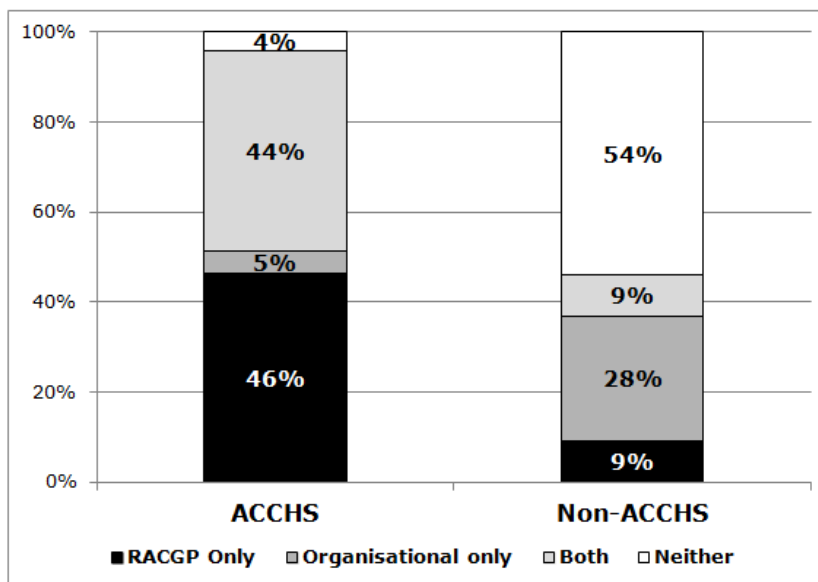
12. In addition, unlike mainstream general practice, the comprehensive model of PHC offered by ACCHSs goes beyond the treatment of individual clients for discrete medical conditions to include a focus on cultural security; patient transport; patient advocacy; population health programs including health promotion and prevention; public health advocacy and inter-sectoral collaboration; participation in health planning processes; structures for community engagement and control; and significant employment of Aboriginal and Torres Strait Islander people.

13. Despite the difficulty of the comparison, the evidence shows that within Australia:

- ACCHSs contribute significantly to improved health outcomes through reductions in communicable disease, improved detection and management of chronic disease, and better child and maternal health outcomes including reductions in preterm births and increases in birth weight [13] – see also *Figures 1, 2 and 3* above and accompanying text.
- ACCHS are more effective in delivering outcomes than mainstream PHC, achieving comparable outcomes, but with a more complex caseload [14];

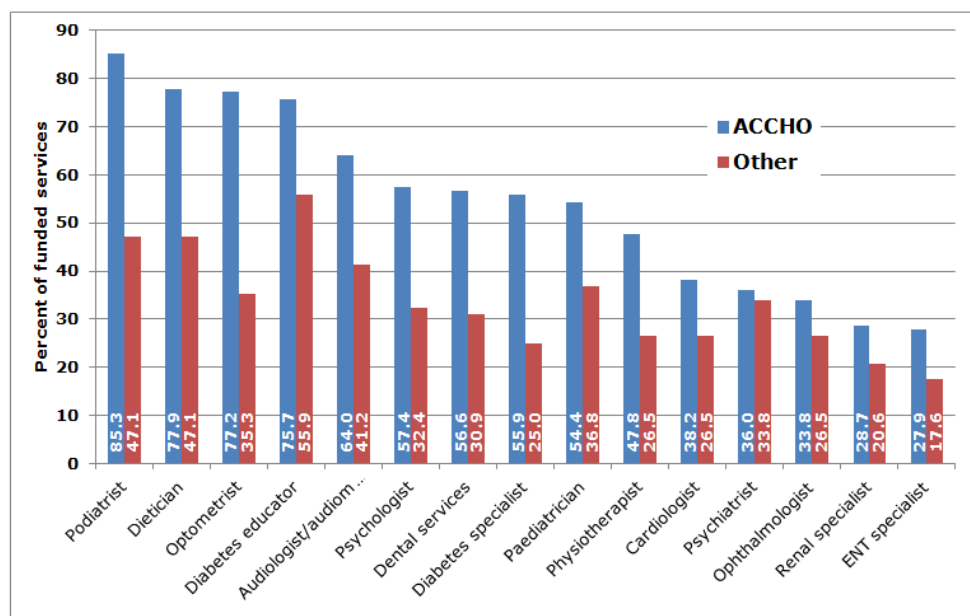
- ACCHSs perform better on clinical best practice than mainstream services [15]. Driven by their focus on Continuous Quality Improvement (CQI), this is reflected in much higher rates of accreditation against RACGP or other standards such as ISO. Almost all (96%) of ACCHSs receiving Commonwealth PHC funding are accredited compared to less than half for non-ACCHS organisations (46%).

Figure 6: Proportion of Commonwealth funded PHC services, by accreditation status and type [16]



- ACCHSs are more effective in supporting the delivery of specialist and allied health services, providing integrated, co-located services to, for example, manage chronic disease in the community[17].

Figure 7: Proportion of primary health-care organisations providing onsite specialist services, 2015-16 [16]



- ACCHSs are significantly more cost effective, with a major study concluding that: *up to fifty percent more health gain or benefit can be achieved if health programs*

are delivered to the Aboriginal population via ACCHSs, compared to if the same programs are delivered via mainstream primary care services [18].

14. Aboriginal and Torres Strait Islander people show a clear preference for the use of ACCHSs, leading to greater access to care and better adherence to treatment regimes [18, 19]. The capacity of ACCHS to deliver culturally safe care is fundamental to this preference, which in turn is founded upon formal processes that guarantee Aboriginal community input into the design and delivery of services (see *Addressing the 'control factor'* below)

3. Evidence from the social and cultural determinants of health

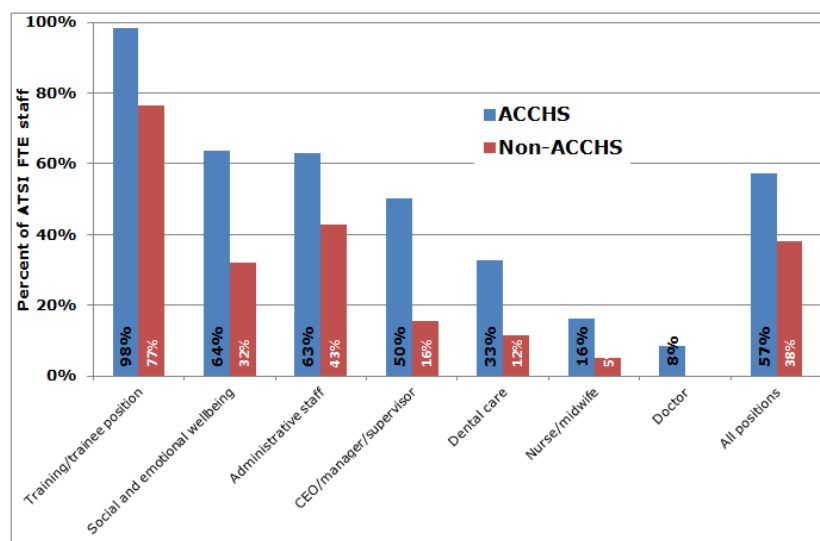
15. It is estimated that between one-third and one-half of the health gap between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians is the result of the social determinants of health, particularly relating to socio-economic status [20]. The ACCHS sector addresses the social determinants of health in ways that other sectors are unable to do, through the following factors.

Aboriginal and Torres Strait Islander employment

16. The ACCHS sector employs almost 3,500 Aboriginal and Torres Strait Islander workers, making it the largest industry employer of Aboriginal and Torres Strait Islander people in Australia [19]. This is in a context where the health and social care sector employs 15% of the total Aboriginal and Torres Strait Islander workforce; almost four times as many as the mining industry (4%) [21].

17. ACCHSs are significantly more effective in employing Aboriginal and Torres Strait Islander people than government or mainstream NGOs – overall 57% of the Commonwealth-funded ACCHS PHC workforce is Indigenous, compared to only 38% in non-ACCHS organisations. Particularly significant is the much greater commitment of ACCHS organisations to employing Aboriginal and Torres Strait Islander people in training positions, and in leadership roles such as CEOs, managers or supervisors.

Figure 8: Proportion of Aboriginal and Torres Strait Islander FTE staff, by selected position type and organisation type, 2015–16 [16]

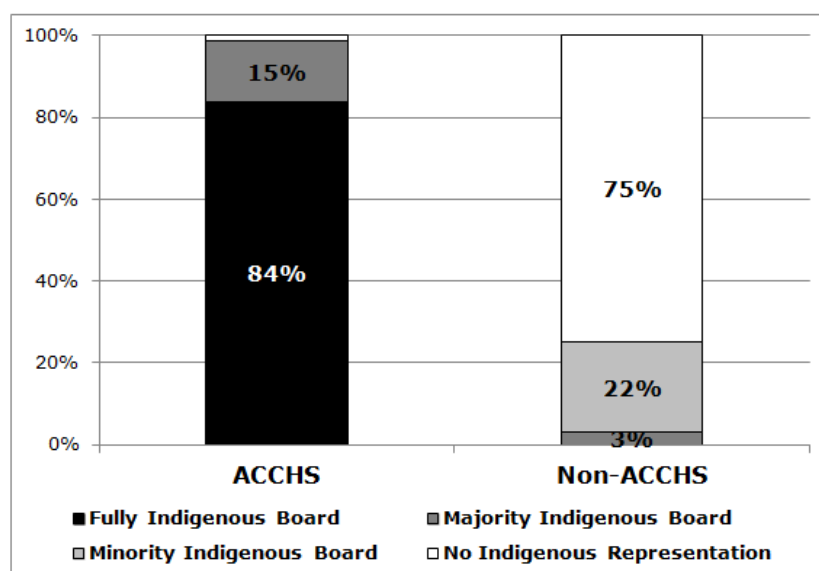


Addressing the 'control factor'

18. The less control people have over their lives and environment, the more likely they are to suffer ill health [22] and powerlessness has been shown to be a risk factor for disease in the Australian Indigenous context [23].

19. ACCHSs embody an empowered model of service delivery that guarantees community input into decision-making and high levels of Aboriginal leadership across the organisation. As well as employing much higher numbers of Aboriginal and Torres Strait Islander people, including in leadership positions, ACCHSs have governance structures that ensure community input into decision-making. Of PHC organisations receiving Commonwealth funding, 99% of ACCHSs have Boards composed fully or of a majority of Aboriginal and Torres Strait Islander people; by contrast 75% of non-ACCHS organisations have no Aboriginal and Torres Strait Islander formal community input into decision making, either having no Board, or no Aboriginal and Torres Strait Islander representation on a Board (see Figure 7).

Figure 9: Proportion of Commonwealth funded PHC organisations by Board composition and type, 2015-16 [16]



Advocacy on the broader social determinants of health

20. ACCHSs were formed by Aboriginal communities from the 1970s onwards with a dual role as both service delivery organisations and advocates for addressing the broader social determinants of health driving poor health and wellbeing advocates, including the experience of racism both within and outside mainstream health services.

21. In the years since, the ACCHS sector has continued to work at all levels to address the health and social effects of the social determinants of health, including racism and social exclusion, housing, access to land and out-stations, and availability of alcohol and other drugs.

22. The ACCHS sector has also been a key advocate for collaborative health system planning which is key to developing a strategic approach to closing the gap in health and wellbeing.

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