SUBMISSION:
Inquiry into the provision of primary, allied and private health care, aged care and NDIS care services and its impact on the Queensland public health system

INSTITUTE FOR URBAN INDIGENOUS HEALTH, BRISBANE
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Acknowledging:

- National Agreement on Closing the Gap 2020 (CTG Agreement) gives commitment and explicit priority to expanding community-controlled service delivery as the only way to address past closing the gap failures.
- The life expectancy gap between Indigenous and non-Indigenous Australians remains intolerably high (8.6 years for males and 7.8 years for females)
- The rapid urbanisation of Indigenous communities in Queensland, with the fastest and largest Indigenous population residing in South East Queensland (SEQ), has resulted in increased demand for health and wellbeing services.

The IUIH Network contends that the government commit to giving priority to ensuring that:

- Community Controlled Health Services (CCHS) are the preferred provider of health, aged care and disability services and programs aimed at closing the gap and achieving health equity. This will have the biggest impact on addressing social isolation and loneliness among Queensland's Indigenous population.
- CCHSs are funded holistically to allow for holistic service provision. Currently much of the funding allocated is siloed and does not allow adequate flexibility to provide necessary wrap-around services. CCHSs must be supported to ensure that comprehensive and integrated care models can be efficiently delivered, which are shown to have the biggest impacts on Indigenous health and wellbeing.
- Indigenous-led service planning and design, commissioning and decision making about investment for closing the gap initiatives is undertaken at a regional level.
- Accountability mechanisms are implemented that measure the impact of, and outcomes achieved from, close the gap initiatives implemented by whole-of-population services/programs system, and their direct impact on Indigenous health and wellbeing

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Introduction

The Institute for Urban Indigenous Health (IUIH) Network welcomes the opportunity to provide input to *Inquiry into the provision of primary, allied, and private health care, aged care and NDIS care services and their impact on the Queensland public health system.*

As part of the Closing the Gap National Reform Federation Council reforms, the Prime Minister has now called for a radical new approach to addressing Indigenous disadvantage. In his 2020 Closing the Gap Statement to Parliament, the Prime Minister clarified that continued reliance on existing programs and policies will no longer deliver the required outcomes. Instead, the new CTG Agreement acknowledges that Aboriginal and Torres Strait Islander community-controlled services are better for Indigenous people, achieve better results, and employ more Indigenous people over mainstream services. Accordingly, the Agreement commits all jurisdictions to an entirely new approach, including giving preference to community-controlled organisations to design and deliver community-led solutions to achieve close the gap targets. This submission is structured in two sections:

- Section one provides an overview of the demographic and health challenges experienced by Aboriginal and Torres Strait Islander people living in SEQ
- Section two highlights critical actions undertaken by IUIH and the IUIH Network to address these challenges and key recommendations against each of the focus areas relevant to this inquiry.

About the IUIH Netwok

The Institute for Urban Indigenous Health (IUIH) was established in 2009 as a regional strategic response to the significant growth and geographic dispersal of Indigenous people within SEQ. As Australia's largest Aboriginal Community Controlled Health Service (CCHS), IUIH represents a network of four CCHS entities in SEQ, Australia's largest and fastest-growing Indigenous region and home to close to 40% of Queensland's and 11% of Australia's Indigenous population. Since 2011, it is estimated that the regional IUIH Network population footprint population has dramatically increased by 70%, from 59,483 people in 2011 to over 100,000 Indigenous people in 2021.

The IUIH regional network provides care to around 35,000 Indigenous people through 19 community-controlled primary healthcare clinics operated by IUIH Network Members in SEQ. This includes:

- Aboriginal and Torres Strait Islander Community Health Service (ATSICHS) Brisbane Limited
- Kalwun Development Corporation Limited (Kalwun Health Service)
- Kambu Aboriginal and Torres Strait Islander Corporation for Health (Kambu)
- Yulu-Burri-Ba Aboriginal Corporation for Community Health Yulu-Burri-Ba)

IUIH also directly operates clinics across the Moreton Bay region through the Moreton Aboriginal and Torres Strait Islander Community Health Service (Moreton ATSICHS).

As the regional lead, IUIH has driven the development and implementation of transformational change to the way health care services are delivered for Indigenous Australians. Through pioneering ground-breaking Indigenous designed and delivered services, this has led to unprecedented improvements in health access and outcomes – with IUIH recognised as having made one of the most significant impacts of any Indigenous health organisation in Australia in the shortest period, and with a national best standard of care.

Since 2009, the IUIH Network has developed into an integrated regional ecosystem, delivering health and social support services across SEQ. This one-stop-shop model of integrated health, aged care and social support services for Aboriginal and Torres Strait Islander families is known as the IUIH System of Care. IUIH's System of Care has been showcased as an international exemplary best practice model which has achieved significant improvements in access and outcomes, including closing the preterm birth gap for the first time in Australia.

In both the health and aged care sectors, IUIH has been recognised as having an increasing national leadership role in implementing evidence-based models to close the gap faster for Indigenous Australians. This included a significant contribution to informing the Aged Care Royal Commission's recommendations to reform the sector for Indigenous Elders.

It is well documented that many of the key drivers of health reside in our everyday living and working. These determinants of health (including inequity, stigma and discrimination, environmental and socio-cultural factors, including exposure to trauma and violence) are largely outside the direct influence of the health system but are collectively responsible for around one-third of the health gap (AIHW). They are critical to achieving the Closing the Gap targets, particularly the headline target of closing the life expectancy gap.

SECTION ONE

The urban Indigenous experience

- In SEQ, the Health Adjusted Life Expectancy (HALE) Gap is 1.5 times greater than in remote Queensland (Queensland Health, 2017)
- According to the Burden of Disease data:
  - The majority (74%) of the health gap between mainstream and First Nations people also occurs in urban areas. In addition, 76% of the total Indigenous burden of disease in Queensland is also in urban areas (Queensland Health, 2017)
  - The relative disadvantage between Indigenous and non-Indigenous people is greater in urban areas, with Indigenous people in major cities experiencing 2.1 times the rate of health disadvantage compared to non-Indigenous people in the same area. For a similar comparison in very remote areas, Indigenous people experience 1.9 times the rate of disadvantage (AIHW, 2016)
  - The leading contributors to the burden of disease and injury amongst Queensland's Indigenous population vary by remoteness. Mental disorders contributed 28.8% to the Indigenous burden of disease in Queensland's Major Cities, 21.19% in Regional areas and 9.1% in Remote/Very Remote areas. In SEQ, mental disorders are the largest contributor to the Indigenous burden of disease, whereas cardiovascular disease is the leading contributor in Remote/Very Remote areas (Queensland Health, 2017).
  - Suicide rates amongst Indigenous Queenslanders in the 25–34 and 35–44 age groups are more than double those of Queensland's non-Indigenous population (AIHW, 2021)
- Nationally, according to the latest (2019) Aboriginal and Torres Strait Islander Health Survey (Australian Bureau of Statistics, 2019):

- The proportion of people with one or more selected chronic conditions was higher for people living in non-remote areas (48%) than in remote areas (33%)
- the proportion of people with a mental or behavioural condition was around three times higher for people living in non-remote areas (28%) than remote areas (10%)
- the proportion of people who did not see a General Practitioner when needed in the last 12 months was higher for those living in non-remote areas (14%) compared to remote (8%)
- Indigenous people in non-remote areas were more likely than those in remote areas to feel that they had been treated unfairly in the last 12 months (35% compared with 28%).

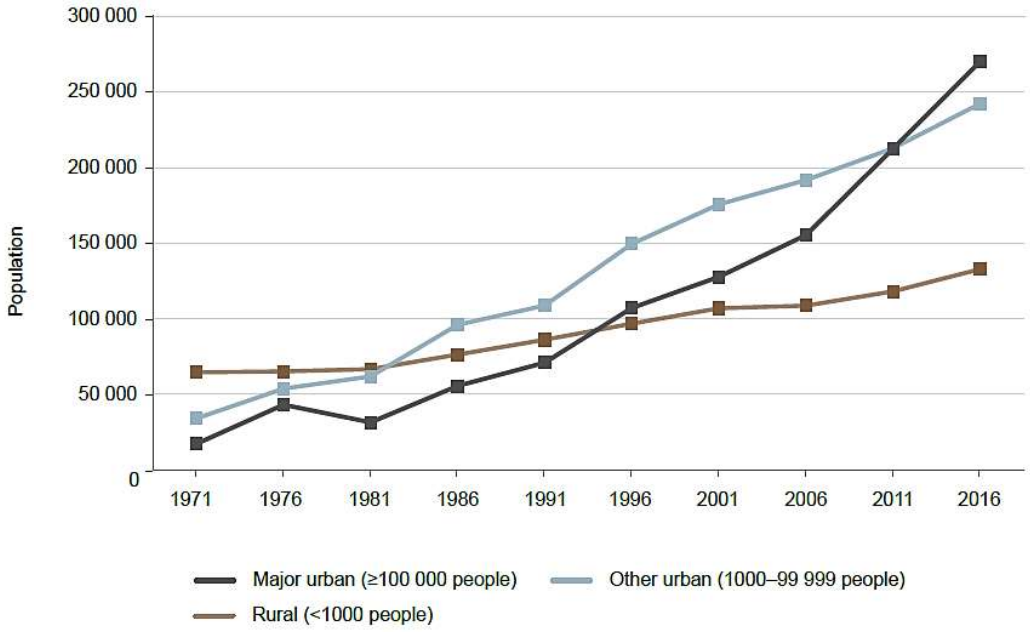
Urban Indigenous people also experience other challenges relating to dislocation, racism, and disempowerment (Eades, et al., 2010). Racism continues to have a significant impact on Aboriginal and Torres Strait Islander people's decisions about when and why they seek health services. According to a report on *Addressing Institutional Barriers to Health Equity for Aboriginal and Torres Strait Islander People in Queensland's Public Hospital and Health Services,* that reported on levels of institutional racism within Queensland Hospital and Health Services (HHSs), 10 of the 16 HHSs rated within the extreme range of institutional racism, with the remaining six in the very high range. Therefore, all HHSs in Queensland rated in the very high to extremely high levels of institutional racism (Marrie, 2017).

Measuring the impact and outcomes for Closing the Gap must be consistent with Indigenous population levels and need. This includes responding to the urbanisation of the Indigenous population, which represents one of the most striking demographic trends since Indigenous populations were first counted. The fastest-growing Indigenous populations are in these major urban areas, with population decline or slowed growth in remote and very remote regions.

Figures 1 highlights this increasing urbanisation trend.

FIGURE 1. NATIONAL INDIGENOUS URBAN POPULATION TRENDS 1971-2016 BY THE SIZE OF TOWN/CITY

(Markham & Biddle, 2018)



To address these demographic and geographic challenges, priority must be given to addressing urban Indigenous disadvantage, including:

- Examining the need for increased funding of, and access to, community-controlled health services for urban Indigenous Australians, relative to disease and disability burden and projected population growth and
- Examining the need for allocating specific infrastructure funding to support enhanced service accessibility in urban settings, including expanded clinic development.

The previous paragraphs and data highlight the urgent need for an urban Indigenous focus when addressing the issues and drivers associated with Indigenous health and wellbeing. This imperative to prioritise the needs of urban regions has not been reflected in funding and commissioning frameworks for addressing urban Indigenous health.

SECTION TWO

Primary health care

Physical, mental, and social and emotional health and wellbeing for Indigenous people sit within a holistic and whole-of-life view of health, which recognises the importance of connection to land, culture, spirituality, ancestry, family and community, and the significance of these connections for individuals (Dudgeon, Milroy, & Walker, 2014). When these domains are not met or disrupted, this will likely lead to poorer outcomes, including an increased risk of depression and suicide (Gayaa Dhuwi Australia, 2021).

Cultural determinants of health originate from and promote a strength-based perspective, acknowledging that stronger connections to culture and country build stronger individual and collective identities, a sense of self-esteem, resilience, and improved outcomes across the other determinants of health, including education, economic stability, and community safety. In this way, culture is a protective factor for health and wellbeing, and cultural expression is healing and has health benefits.

It is well documented that many of the key drivers of health reside in our everyday living and working conditions, and often sit outside the health system (Queensland Health, 2016). These social determinants of health (including inequity, stigma and discrimination, environmental and socio-cultural factors, including exposure to trauma and violence) are mostly responsible for health inequities and are critical to achieving the Closing the Gap targets, particularly the headline target of closing the life expectancy gap. Addressing the social determinants of health will also require a focus on addressing the issue of pay parity for the CCHS sector. IUIH has observed several issues with IUIH's ability to compete with the Queensland public health system for pay parity. Queensland heath pay bands are so far outside the National award, it makes it nearly impossible for non-government organisations (NGOs) like IUIH to be competitive. For example, IUIH has observed that Queensland Health allied health staff receive between $10,000 and $40,000 more than staff from NGOs. IUIH is seen as an attractive employer for new graduates and early career therapists. However, as their years of experience increase, it is not uncommon for them to move to roles in Queensland Health. This is either for pay increases or other benefits such as maternity pay, as most of the health workforce are

women. Consequently, there is an ongoing shortage of experienced staff in the CCHS sector. This is also impacted by the draw of the NDIS, where health staff can charge much higher rates.

Cultural determinants

Central to the effectiveness of any health reform on the health outcomes of Indigenous people should be an understanding of the cultural determinants of health, including the reciprocal and cyclical relationship between culture and wellbeing. This calls for a recalibration of focus in the design, delivery, and reporting of government programs, highlighting the centrality of culture in best practice. It invokes an accountability architecture that requires the development of tools and indicators which measure the strength of health and wellbeing through the lens of culture, family, and community. However, most current outcome measurement tools have been developed with participants from Western backgrounds and reflect a medical model. A recent articulation of this approach is detailed in the Lowitja Institute's 2020 report to the Close the Gap Steering Committee 'We nurture our culture for our future, and our culture nurtures us'.[1]

The CCHS sector has contributed to resourcing significant continuous quality improvement capability. This has seen IUIH's National Key Performance Indicator (nKPI) data demonstrate a range of best practice results, making substantial progress towards meeting the National Aboriginal and Torres Strait Islander Health Implementation Plan's 2023 nKPI targets and delivering validated improved health outcomes, including a narrowing of the health gap in SEQ.

The ability of mainstream government programs to achieve similar improvements in outcomes is questionable. For example, there is a quantum difference in the monitoring of mainstream GP practice performance and the CCHS sector, with only 233 organisations nationally (mainly CCHSs) regularly reporting against the 28 nKPIs. There is no real accountability for demonstrating continuous improvement in outcomes for Indigenous clients for most mainstream practices. A substantive redesign of the current performance monitoring and evaluation processes for mainstream providers is required if governments wish to perpetuate funding these providers for Indigenous health outcomes. Accordingly, establishing a suitable accountability architecture for all mainstream programs commensurate with relevant performance reporting requirements of CCHSs and CCHOs is considered a priority.

From the Closing the Gap perspective, while the priority is to ramp up community control through the CCHS sector, there remains a need to focus on reform in the mainstream primary health care sector. This is important because, until access to best practice community-controlled services is made significantly more available, around 57% of all Indigenous health care clients continue to access care from mainstream primary health care providers.

Cultural safety

Improving cultural safety within mainstream services and programs will require a consistent Access and Equity Framework through which, at a minimum, all mainstream programs would be required to report levels of access by Indigenous clients. Currently, there is no consistent transparency and accountability in this regard across health, aged and disability care and related sectors. For example, mainstream providers who are successful in the Aged Care Approval Rounds (ACAR) in gaining funding

[1] https://antar.org.au/reports/we-nurture-our-culture-our-future-and-our-culture-nurtures-us

for Indigenous places are subsequently not held to account for their performance against Indigenous client numbers. Similarly, there are no accountabilities for NDIS providers to ensure equitable access by Indigenous clients.

In contrast, CCHSs are making a unique contribution to the delivery of best practice health care for Indigenous people - care which is intrinsically characterised by a strong cultural integrity framework. The CCHS model affirms the evidence that Indigenous people will access services and actively engage in, and benefit from, health-improving, independence-promoting, and capacity-building behaviours when they are culturally connected to community-controlled providers and can develop trusting relationships with Indigenous staff. Equally important for CCHS is that all aspects of care planning and delivery are designed and operate from an Indigenous worldview, where:

- concepts of holistic health and wellbeing are recognised in health practice
- Indigenous knowledge, values, beliefs, and cultural needs inform clinical decisions, pathways and ongoing care and
- Cultural identity, cultural connection/responsibility to family/community and cultural healing represent the critical success factors in supporting goal attainment and improved health and wellbeing, including the prevention and management of chronic disease.

Regional CCHS commissioning models

The Queensland Productivity Commission (2017) finds that 'to make material progress, evidence suggests the current decision-making model for service delivery must move closer to the people it serves. Transferring decision-making closer to communities is more likely to:

- meet community needs and priorities
- empower people to have greater control over their lives
- create incentives for providers to be more responsive and drive innovation and efficiencies in service delivery and
- be more effective in improving outcomes and wellbeing'.

Further, the QPC report concludes that 'Although grant funding and contracting arrangements aim to ensure accountability, manage risk, and encourage competition, the system does not appear to facilitate the outcomes it aims to achieve. Short-term grant funding and contracting methods lead to rigidity in program delivery (as opposed to focusing on the needs of the individuals or place) and high administration costs. It contributes to uncertainty and is a barrier to long term planning and innovation to meet better service user needs and build local capability.'

In contrast, the Commonwealth Department of Health is increasingly using the PHN network as its commissioning agent of choice for targeted Indigenous health funding. In addition to the IAHP's Integrated Team Care (ITC) program, this includes the transition of substantial levels of targeted Indigenous mental health, substance use and suicide prevention funding from direct contracting arrangements with CCHSs (and other NGOs) to the PHNs.

IUIH has significant concerns about the effectiveness of some of these commissioning arrangements as they apply to Indigenous health and wellbeing, given the variable level of sophistication across PHNs and the absence of a consistent commissioning framework for Indigenous health services. These concerns relate to the procurement strategies adopted by PHNs, including market-driven and competitive tendering processes for targeted Indigenous funding and a failure to accommodate the

stated policy position of all governments expressed in the Close the Gap Agreement 2020, which preferences CCHSs through the following statements:

- Clause 43. The Parties acknowledge that Aboriginal and Torres Strait Islander community-controlled services are better for Aboriginal and Torres Strait Islander people, achieve better results, employ more Aboriginal and Torres Strait Islander people, and are often preferred over mainstream services.
- Clause 55. Government Parties agree to implement measures to increase the proportion of services delivered by Aboriginal and Torres Strait Islander organisations, particularly community-controlled organisations, including by implementing funding prioritisation policies across all Closing the Gap outcomes that require decisions about the provision of services to Aboriginal and Torres Strait Islander people and communities to preference Aboriginal and Torres Strait Islander community-controlled organisations and other Aboriginal and Torres Strait Islander organisations.
- Clause 66. Government Parties' investment in mainstream institutions and agencies will not come at the expense of investment in Aboriginal and Torres Strait Islander community-controlled services.
- Priority Reform Two: Increase the amount of government funding for Aboriginal and Torres Strait Islander programs and services going through Aboriginal and Torres Strait Islander community-controlled organisations. The current commissioning approach by many PHNs is not aligned with the Australian Government's *National Aboriginal and Torres Strait Islander Health Plan (2013-2023),* which acknowledges the unique contribution of CCHSs in delivering holistic, comprehensive, and culturally appropriate health care to meet closing the gap targets.

IUIH has been a commissioning body since before the creation of PHNs and commissions tens of millions of dollars of services every year across Queensland and nationally. For some time, IUIH has advocated for establishing an Indigenous-led and designed regional funding and governance model, which could be the mechanism to effect reform and maximise the impact of the current health investment. The establishment of such commissioning structures must be led by Aboriginal and Torres Strait Islander people to ensure that the structures, boundaries, scope, and measures of success are culturally appropriate. Lessons learned from non-Indigenous commissioning bodies such as PHNs and Indigenous commissioning bodies in overseas jurisdictions such as Canada, and New Zealand should be built upon.

The key feature of this new regional funding and governance model would be regional CCHSs taking on the role of regional Indigenous Commissioners to lead and drive collaboration with Primary Health Networks (PHNs) and Local Hospital Networks (LHNs). This would require the current investment, across both Indigenous-specific and mainstream program areas, to be channelled through these Regional Indigenous Commissioners. This approach would see the 'Indigenous share' of the whole of population health services investment across primary health, transition care, mental health, aged and disability care (which is currently administered through various mainstream commissioners such as PHNs, Outreach Fund Holders, NDIS and Aged Care) apportioned and redirected to Regional Indigenous Commissioners.

In turn, this new regional funding and governance model would facilitate integrated and holistic models of care delivered by local CCHSs, and mainstream partners where appropriate, under a single

integrated and culturally safe regional model of care. Through adequate investment in sector development and support, local CCHSs would also become registered Aged Care and NDIS providers – offering a culturally capable choice of health, aged and disability care to their local Indigenous communities.

To reform the health and social care system in this way, governments will need to commit to working in partnership with each other and with Indigenous people to create a new Indigenous-led and designed regional funding and governance model which is not constrained by constitutional, legal, or jurisdictional barriers. This new flexibility in funding and governance arrangements is required to cater to vulnerable Indigenous populations at a regional level and give effect to the objectives of the National Aboriginal and Torres Strait Islander Health Plan (NATSIHP) and the new National Close the Gap Agreement 2020.

This proposed regional funding and governance model would support the integration of primary healthcare services (including mental health and social support services) with aged care and disability services.

From the outset, the scope of community-led commissioning should embrace health and the social determinants of health. The government policies and programs are often designed to focus on a particular issue (e.g., reducing smoking rates), rather than focusing holistically on the needs of a person and their family. This program-centred approach is not conducive to placed-based and tailored-made solutions to local problems. As a result, government programs are often found to be of limited success.

The regional Indigenous-led funding and governance models proposed by IUIH, which would be informed by and responsive to local community contexts, are more likely to achieve success in supporting diverse groups within the Aboriginal and Torres Strait Islander population.

In IUIH's experience, the current funding and commissioning arrangements of health, aged care, and disability services through mainstream commissioning entities such as the Primary Health Networks (PHNs), the National Disability Insurance Agency (NDIA) and current aged care arrangements:

1. are out of step with the principles of an Indigenous-led reform process
2. are not evidence-based and undermine the effectiveness of Indigenous health expenditure to close the gap and
3. increase the potential for inefficiency and fragmentation in the health system.

Care Coordination

IUIH recognises that significant points of risk in a patient's journey through the healthcare system arise at times when care is transferred – in particular, at hospital entry and discharge, and in transit from primary care into and out of outpatient specialist and allied health services, rehabilitation, mental health, and other specialised services.

Strengthening the way secondary and tertiary systems communicate and interact with primary health is crucial. A cause of the frequent breakdown of the health system and lack of follow up revolves around poor communication and notification between the primary health care sector and the hospital system. Creating a single system environment would be beneficial, but there will need to be

accountability that all practitioners are utilising this system to ensure the current breakdowns in communication do not persist under a new system.

The IUIH Connect Plus program provides a strong blueprint for the development of Indigenous-designed regional care coordination services in suitable locations across Australia. IUIH Connect Plus targets the transition of care points across primary, secondary, and tertiary sectors and the broader regional social services system.

IUIH Connect assists the patient, their family and referring providers to link up care no matter where the care is provided. Working closely with Queensland's Hospital and Health Services (HHSs), PHNs, Indigenous clinics, mainstream general practices and community-based social support services in South East Queensland, IUIH Connect is a program that transcends traditional silos and boundaries. Evaluated in 2016, IUIH Connect has proved to be very successful in coordinating care and supporting Indigenous clients with complex clinical and social needs in urban areas.

IUIH believes that the model has application in regional centres where there is a concentration of potential clients and a strong network of referring organisations (organisations that refer clients to IUIH Connect) and available connecting organisations (services and programs with which clients are connected).

IUIH Connect is a single contact point for individuals, carers, families, community members and service providers who require assistance in identifying available health and social support services for Aboriginal and Torres Strait Islander people. The program focuses especially, but not exclusively, on supporting people through the transition from tertiary to primary care by utilising a network of referring organisations and connecting service providers. It accepts referrals from a range of organisations; it assesses clients to determine the types of community-based services they require and are potentially eligible for and connects clients to these services.

While the program initially focussed on coordinating services associated with chronic disease and aged care, IUIH Connect now engages with any client with complex needs, including clients referred by the Queensland Police Service. It also receives referrals connected to the justice system, domestic and family violence and child protection. Case conferencing is employed to ensure the needs of clients with complex interagency needs are met. Another important feature of the model is rapid follow-up for clients that miss appointments and courtesy emails are sent to referring organisations to advise them of what action has been taken to support the client.

IUIH Network Recommendations: Primary health care

- Established Indigenous-led and designed regional funding and governance models. Regional CCHSs would take on the role of regional Indigenous Commissioners to lead and drive collaboration with Primary Health Networks (PHNs) and Local Hospital Networks (LHNs)/Hospital and Health Services (HHS). They would also facilitate integrated and holistic models of care delivered by local CCHS, and mainstream partners where appropriate, under a single integrated and culturally safe regional model of care.
- Key sector leaders, including state and Commonwealth public servants, led by consumers, carers and those with lived experience, should be brought together on an annual basis to encourage a more coherent and organised approach to the design of the Australian health system. Planning

should not be an exclusive club but a well-informed team with the best health outcomes within available resources as their singular goal. Practically, this means at a minimum, including CCHS leaders in conversations about funding flows with PHNs and LHNs/HHSs.

- A suitable accountability architecture for all mainstream programs is established, which is commensurate with the relevant performance reporting requirements of CCHSs.
- IUIH suggests there needs to be a process to address the major service access gap to community-controlled health services in population growth regions such as major cities. This will help refocus resource allocation to urban priority areas like IUIH's footprint in SEQ. Setting an equity target across all regions would be a good start, with a practical next step to refresh the Australian Institutes of Health and Welfare's (AIHW) spatial variation in Aboriginal and Torres Strait Islander peoples' access to PHC reports. In 2017, this showed that Indigenous Specific PHC services were six times more accessible in Very Remote locations than in Major Cities. Current estimates are that 26% of Indigenous people access a CCHS in capital cities compared to over 90% in remote regions.
- Additional investment is required in reducing fragmentation of care, including Aged Care, Disability and Primary Health Care integration. While significant progress is underway in Aged Care flowing from the Royal Commission, structural reforms that promote Indigenous-led integrated PHC and National Disability Insurance Scheme (NDIS) models are yet to gain traction.
- Ensuring all funding agreements with both CCHSs and mainstream providers have an additional allocation, over and above that required for service delivery, to support data collection and evaluation of outcomes about meeting CTG objectives at community/regional levels. Such data and evaluation of outcomes should then be reported to the Joint Council on Closing the Gap, together with the recommending remedial actions where the outcomes are underachieved.
- Investigate solutions to address pay parity for the CCHS sector.
- Ensuring that centralised data collection portals are of high quality and accessible to CCHSs to support program monitoring and evaluative efforts.
- Ensuring that economic and social impact evaluation principles are intrinsic to building the evidence base about 'what works,' including providing value for money in delivering programs for Indigenous Australians. Incorporating these principles would also maximise the benefits of health care spending and help overcome regional variations in access.
- Calling for PHN/HHS (LHN) regional planning to have formal inclusion of CCHS at the planning table
- Universal requirement for all GP practices (with a minimum number of Indigenous clients) to report against national CTG KPIs (nKPIs), compared to the current incentivised approach administered by PHN through the Practice Improvement Program (PIP) quality improvement Incentive)
- Significant tightening of PIP IHI (Indigenous Health Incentive) requirements so that PIP IHI is conditional on providing evidence related to how the practice addresses the six Indigenous-specific actions in the National Safety and Quality Health Services Standards (Second edition). Currently, these only apply to hospitals.
- Consideration should be given to the centrality of culture in determining health outcomes, including the development of tools and indicators which measure the strength of health and wellbeing through the lens of culture, family, and community.

Medicare Benefit Schedule (MBS) and Commonwealth Distribution Priority Areas (DPAs)

Medicare rebates remain a top priority for CCHSs, and changes to bulk-billing policies and practices can significantly impact urban CHHSs such as IUIH. According to the *General Practice Health of the Nation 2021* report, the average patient out-of-pocket costs for all GP non-referred attendances have increased by 49% over the past decade, and the value of MBS patient rebates continued to decline [2].

This growing gap between the Federal Government's contribution to the cost of primary health care and the cost of providing care poses significant risks to the sustainability of the primary health sector, and particularly the CCHS sector, which relies on MBS rebates to provide high-quality medical and culturally centred care. Furthermore, policy changes to MBS rebates can impact bulk billing in private practice, resulting in increased gap fees and associated access barriers for non-Indigenous people. Within an urban environment, this can result in more non-Indigenous people living within the vicinity of a CCHS using those services as they are bulk billed. This directly impacts the access for Aboriginal and Torres Strait Islander people.

In addition to the increasing trend of out-of-pocket costs, the MBS is not structured in a way that supports the delivery of high-quality and culturally safe care for our clients and does not fund the full suite of services we need to provide our patients. Our clients often have complex comorbidity, requiring extensive time and skill from a GP, nurse, health worker and other allied health professionals. The MBS does not cover many of the costs associated with enabling this care.

Continuation of MBS for telehealth, allied health, mental health and specialist care and supplementation of health grant funding through Section 19:2 Directions under the Health Insurance Act (the Section 19:2 Direction) in association with the Voluntary Patient Registration (VPR) is also critical to CCHS' ability to provide integrated person-centred care and to achieve the Closing the Gap targets.

Indigenous people are currently not benefiting from the same levels of universal access to Medicare as non-Indigenous Australians. Targeted health grant funding available through the Commonwealth's Indigenous Australians' Health Program (IAHP) and state/territory grant programs are insufficient to provide the level of service responses required to accelerate closing the health gap. The current items for mental health visits of 20 minutes also fail to support clients with significant mental health needs, especially during the acute phases of care. People needing support in their mental health should be given the same level of access as people presenting with physical concerns. Access to dental/oral health services is a significant issue for Aboriginal and Torres Strait Islander people, and inadequate funding models leave best practice oral health models being delivered in CCHSs financially vulnerable. In recognition of the high burden of dental disease among Aboriginal and Torres Strait Islander people, and current barriers to access, MBS items for dental services must be expanded.

Under the Health Act Section 19(2) Direction, CCHSs have independent status as services addressing the needs of Indigenous people regardless of where they are located, and therefore systems such as DWS and DPA are overridden. This is not generally well understood by entities processing provider number applications, and IUIH has experienced instances where these applications have been

[2] The Royal Australian College of General Practitioners. (2021). The Health of the Nation 2021. RACGP.

declined due to this lack of understanding. For example, when changes were made to DWS and DPA terminology, this resulted in provider number applications being rejected as processing staff were not aware of Section 19(2)-exemption allowing IUIH to employ non-VR GPs to receive a provider number even though they were not in a non-DPA area. Other CCHSs have reported similar experiences, resulting in delays to application processing and associated disruptions in continuity of care to urban Indigenous people.

IUIH Network Recommendations: MBS and DPAs

- MBS rebates should be evidence-based and reflect the time and effort required of all health practitioners to meet the patients' needs, particularly of Aboriginal and Torres Strait Islander people with complex comorbidity.
- Increase the minimum time for mental health consultations beyond 20 minutes.
- The current evaluation of the IAHP should consider the level of funding required to fully meet the health and wellbeing needs of Aboriginal and Torres Strait Islander people.
- Any policy decisions related to DPAs should consider the specific context of the CCHS sector, particularly in urban areas, to ensure any unintended consequences are avoided that may impact on service delivery or staffing options.
- Expand MBS items for dental services, for example, oral health items for dentists, dental hygienists or dental therapists following an item 715, and the provision of additional consultations, in addition to allied health services accessible following completion of an item 715.

Allied health services

The contribution of allied health in our efforts to close the gap is strong. There are also economic benefits relating to avoided health system costs, avoided productivity costs and years of life saved attributed to interventions by allied health professionals. For example, a Deloitte report on the *Value of Accredited Exercise Physiologist in Australia*[3] has identified a high return on investment for accredited exercise physiology services in treating people with chronic conditions, notably pre-diabetes and diabetes, mental illness, and congestive heart failure. For example:

- Combining the direct costs with the burden of disease avoided annually, the total annual wellbeing gains due to accredited exercise physiologist interventions in Australia for people with pre-diabetes and type 2 diabetes are estimated to be $6,115 and $7,967 per person, respectively.
- Deloitte Access Economics (2013) estimated the financial costs per case of depression were $9,622 per year. Translating this to 2015 dollars indicates that each case of depression averted through exercise, as delivered by accredited exercise physiologists, saves society $10,062 per year.
- The total lifetime burden of disease savings resulting from exercise interventions in people with congestive health failure, as delivered by accredited exercise physiologists, is estimated to be $11,847 per person annually.

A multidisciplinary approach to patient care is more cost-effective and yield better outcomes than separate discipline approaches. However, better outcomes for Aboriginal and Torres Strait Islander people critically rely on service providers aligning their goals and working together, supported by financial models that support incentivised coordination. IUIH contends that the continued uptake and availability of Medicare-funded services, and other schemes such as increased funding through private health insurers and referral schemes, are necessary for addressing barriers to accessing individualised, evidence-based care for people with chronic conditions.

IUIH allied health services

IUIH, through our Member Services, has one of the largest networks of allied health services in SEQ. IUIH employs and provides necessary allied health support to our Member CCHSs across South East Queensland, helping them meet the health needs of the region's Aboriginal and Torres Strait Islander population.

IUIH's range of allied health services includes:

- Exercise Physiology
- Occupational Therapy
- Audiology
- Psychology
- Dietetics
- Podiatry
- Physiotherapy
- Speech Pathology
- Diabetes Education

Our allied health staff work collaboratively within a multidisciplinary team of health care professionals, including GPs, Aboriginal Health Workers, and Care Coordinators. Through IUIH's Cultural Integrity Investment Framework and the Ways Statement, staff learn about and embed strong cultural values

[3] Deloitte Access Economics (2015). *Value of Accredited Exercise Physiologists in Australia.* Deloitte.

and philosophical understanding across every aspect of their work. This is a comprehensive and highly sophisticated in-person and virtual program that requires significant effort to administer.

Broadly, there is also a national supply issue for allied health training placements, particularly occupational therapy, and podiatry, which has a flow-on impact on workforce supply. There is also a lack of effective training pathways into allied health. Entry requirements into allied health courses are competitive, limiting the available pool of staff at any point in time.

It is also difficult to transition from one allied health profession to another, which could be a potential strategy for alleviating current workforce shortage issues. A prerequisite for transition from an allied health profession to another is the completion of a graduate-entry Master's degree. The degree takes two years to complete and is not subsidised by the government. Furthermore, there is no recognition of prior learning. For instance, for some allied health professions, such as diabetes education, the occupational therapy undergraduate degree is not recognised.

A lack of appropriate refresher and upskilling programs also presents a barrier to adequate workforce supply. For example, if your registration lapses, significant re-training is required to re-obtain your registration. Depending on how long your registration has lapsed, you may be required to complete an entirely new degree.

There is also an identified shortage of allied health services delivered in the state schools. Currently, in Queensland, students who require speech or occupational therapy must have a diagnosis to receive therapy through Queensland Department of Education therapists. Instead, in SEQ, for Indigenous students, the Department of Education expects this service to be delivered by IUIH. As IUIH has significant waitlists for allied health services, this is a particular issue for literacy intervention with Indigenous students.

In some locations across SEQ, there is also a complete lack of allied health staff in hospital settings to provide service for non-Indigenous staff. This results in ongoing requests from non-Indigenous people requesting the services of IUIH staff.

IUIH Network Recommendations: Allied health

- Investigate the issues relating to the national allied health workforce shortage, including solutions to address training pathways.
- Investigate opportunities to increase the availability of undergraduate training courses in allied health disciplines. For instance, Queensland universities offer many places for medical training courses. Still, apart from James Cook University, they are all offered through postgraduate pathways, and an undergraduate degree is the entry prerequisite to enter.
- Investigate increasing training opportunities for a culturally responsive medical and allied health workforce in urban settings. Currently, adequate training opportunities are allocated to rural clinical training schools. However, there is no specific allocation for urban locations, which is where most Indigenous people live.

Aged care

Rates of Indigenous Elders accessing aged care services are extremely low, and Indigenous Elders experience multiple barriers in accessing culturally safe care. This lack of cultural safety has demonstratively had as great an impact on poor care outcomes as other quality and safety issues highlighted by the Royal Commission into Aged Care Quality and Safety (Royal Commission). For example, compared to non-Indigenous Australians, Indigenous people are:

- 2.3 times more likely to die early or live with poor health (AIHW, 2016).
- 2.1 times more likely to have a profound/severe core activity limitation (AIHW, 2015)
- 3 to 5 times more likely to have dementia (AIHW, 2015)
- 2.7 times more likely to live in disadvantaged areas (ABS, 2016)

The Royal Commission Final Report set out a blueprint for long advocated transformational change in Indigenous aged care. For the first time, Indigenous Elders were listened to – most clearly through the Royal Commission's ground-breaking recommendations to create specific Indigenous aged care pathways.

Addressing the needs of urban Indigenous Elders through community-led solutions, such as the highly successful COVID-19 Elders Response, are premised on the overwhelming evidence that Indigenous-led, designed, and delivered solutions are the only way forward if efforts to close the gap are to succeed. This highlights the critical role of CCHSs in engaging and supporting the most vulnerable and hard-to-reach Elders living in urban settings, whose physical and mental health would have been severely compromised in the absence of this measure. CCHSs must be funded as aged care providers to provide genuine choice for Indigenous Elders to receive culturally safe care from Indigenous community-controlled organisations through fully integrated models of health, aged and disability care. This includes a priority focus and direct investment to respond to the rapid growth of Indigenous Elders in urban regions, including fixing a significant shortfall of Indigenous providers in capital cities.

Appropriate access to aged care services is key to addressing the health and wellbeing of Indigenous Elders. This includes accessing a range of culturally appropriate services - from entry-level supports such as the Commonwealth Home Support Program (CHSP) to permanent residential aged care.

The Royal Commission Final Report laid bare the systemic failure of the aged care system to respect and care for older Aboriginal and Torres Strait Islander people (Indigenous Elders). The Royal

Commission's recommendations included a blueprint for transformational change in Indigenous aged care to remedy these failures. This included the need for a 'cultural rebuild' of Indigenous aged care through the creation of specific Indigenous aged care pathways, where responsibility for access, assessment, and service delivery for Indigenous Elders is placed in the hands of the Indigenous community.

In response to the Commonwealth Minister for Health's invitation, IUIH, on behalf of the National Advisory Group for Aboriginal and Torres Strait Islander Aged Care (NAGATSIAC), has produced *the Our Care, Our Way, Our Future - 5 Year Plan for Aboriginal and Torres Strait Islander Aged Care (2021 -2026) (the 5-Year Plan)*

The 5-Year Plan describes practical calls for immediate action by the Commonwealth and includes the following six reform areas:

- Indigenous Access Pathways
- Indigenous Assessment Pathways
- Indigenous Service Delivery Pathways
- Indigenous Urban/Regional Strategy
- Integrated Service Delivery
- Indigenous Direct Care Workforce.

IUIH aged care services

Before the establishment of IUIH's aged care programs in 2015, very few Indigenous Elders were accessing the care they needed. In 2020-21, the growth in the elderly Indigenous population of SEQ and demand for services required IUIH to focus on removing the barriers of entry into the Aged Care service system and to provide safe and appropriate care.

Supporting more than 3,670 Elders across the SEQ, Wide Bay and Sunshine Coast regions in 2020-21, IUIH is now the largest community-controlled provider of aged care services in Australia, operating under a unique and nationally recognised service delivery and financial model integrating aged care with comprehensive primary health care.

To protect vulnerable Elders who had become socially isolated from family and community supports due to the COVID-19 pandemic, IUIH has led a national COVID-19 Elder's response in every capital city of Australia, including throughout SEQ to provide critical welfare checking, meals and other supports. Through leveraging the existing and trusted client relationships with the CCHS Sector and a fully integrated aged, health and disability model of care, this successful measure has highlighted the strength and capability of the CCHS sector for identifying and addressing the needs of most vulnerable Elders.

Text box 1 provides a case study from one client.

TEXT BOX 1: Case study from the COVID-19 Elders Response, 'Gordon's story'.

Gordon had minimal support from family and friends and had lost his job due to health issues, which were also heavily impacted due to COVID-19. Gordon had been struggling with his mental health and had been experiencing financial issues for some time. He had expressed concerns about becoming homeless and being unsure of what the future held. Before receiving help, he was unable to store food safely due to lack of facilities and would often go without food or resort to purchasing unhealthy options that lacked nutritional value. Through assistance from the National Elders COVID Response, Gordon now has better information regarding COVID-19 through his weekly check-ins and his overall mental health has improved. Gordon has been placed into more suitable accommodation, is receiving meal support, and has commented how much better he feels having nutritious meals. Gordon has expressed that his life has improved significantly due to the COVID Elder's program and is very thankful for the support. He is looking forward to transitioning back into being independent again.*

**Name changed to protect privacy*

IUIH Network Recommendations: Aged care

IUIH has made the following recommendations to the Aged Care Royal Commission:

- Set and fund access targets to address the massive underrepresentation of Indigenous Elders in aged care. This will require increasing current aged care recipient numbers by at least 2.4 times to support an additional 42,000 Elders with life-changing care.
- Fund Indigenous assessment services in every aged care planning region so that assessments for Indigenous Elders are done by Indigenous assessors.
- Fund a major expansion of Indigenous aged care providers to provide genuine choice for Indigenous Elders to receive culturally safe care from Indigenous community-controlled organisations.
- Direct investment to respond to the rapid growth of Indigenous Elders in urban and regional areas, including to fix a significant shortfall of Indigenous providers in capital cities.
- Implement best practice integrated aged and primary health care models, including leveraging existing partnerships and the national network of 150 Aboriginal Community Controlled Health Services
- Expand the Indigenous direct care workforce, including training and wage subsidy funding to support mandated qualifications.

NDIS and disability services and learnings from the aged care sector

IUIH points to the community-controlled health sector, where, for 50 years, Indigenous-specific care pathways have delivered substantively better access for Indigenous people compared to the aged care and disability sectors.

This longstanding and evidential health experience should be the template for shaping the reforms required in the NDIS - as is now the emergent example of aged care, where the Royal Commission

Final Report, in acknowledging that the aged care system had failed Indigenous Australians, has recommended the implementation of Indigenous-specific pathways within the aged care system. [4]

The Aged Care Royal Commission's recommended aged care Indigenous pathways include:

- a priority to resource and promote more flexible arrangements for expanded community-controlled access, assessment, and service provision
- funding the systematic rollout of Indigenous Care Finders to support Indigenous Elders navigate the entry, assessment, and service delivery pathways
- implementing Indigenous-specific assessment teams where there was regional scale, and that in smaller populations, at least one Indigenous assessor be part of any assessment team
- improving access for Indigenous Elders through leveraging the nationwide network of 150 CCHSs who already have trusted and established cultural relationships with a substantial proportion of Indigenous Australians.

These recommended aged care reforms have direct relevance and replicability for the NDIS, where even greater access barriers exist for Indigenous people with disabilities. Recent and preeminent research studies have poignantly highlighted these barriers.
For example:

- The Lowitja Institute commissioned research by the University of Melbourne's Centre for Health Policy (May 2019), which found significant impediments for Indigenous people accessing NDIS. The research recommended strengthening cultural brokerage to facilitate access and strengthening existing provider-participant relationships in the engagement and planning processes, including capitalising on these relationships to build trust with participants (such as Aboriginal community-controlled organisations). This includes elevating cultural safety in considering respective roles of assessment/planning/service provision agencies and recommending that potential conflicts of interest can be managed in this context[5]
- The Australian Social Policy Association commissioned research by the University of Melbourne and Western Sydney University, which found that fear and mistrust of mainstream services are major deterrents to accessing care, resulting in twice the rates of discrimination and avoidance of service access experienced by Indigenous people with disability (compared to Indigenous without disability). By contrast, the one exception was within the Aboriginal communities themselves, where disabled Indigenous individuals are included and participate in the community at the same rate as those without a disability. When Indigenous people control the decisions that affect their lives, they have better health and wellbeing. Unlike other sectors such as health, this research further highlighted the current absence of an overarching self-determining framework guiding the policy and program development of the NDIS and the urgent need to privilege Indigenous voices in the redesign of the NDIS. [6]

[4] Final Report, Aged Care Royal Commission, February 2021. Volume 3A, Chapter 7, Aged Care for Aboriginal and Torres Strait Islander People. Available at: https://agedcare.royalcommission.gov.au/publications/final-report-volume-3a
[5] Ferdinand et al. Understanding disability through the lens of Aboriginal and Torres Strait Islander people – challenges and opportunities. Melbourne, Australia: Centre for Health Policy, University of Melbourne, 2019
[6] Temple et al. *Exposure to interpersonal racism and avoidance behaviours reported by Aboriginal and Torres Strait Islander people with a disability*. Aust J Soc Issues

IUIH disability services

IUIH NDIS Pilot Project of National Significance

In April 2019, the NDIA funded IUIH to conduct an NDIS Pilot Project of National Significance (NDIS Pilot). In contracting IUIH , the NDIA made, what was at the time, an unprecedented commitment to a partnership aimed at reforming Access and Plan Development pathways into the NDIS for Indigenous people with disability in South East Queensland (SEQ) – pathways which would run in parallel to the NDIA's 'mainstream' Local Area Coordination (LAC) and Early Childhood Early Intervention (ECEI) Partners.

Notably, the NDIS Pilot was aptly ascribed as having 'nationally significant' objectives, viz. to build the requisite evidence to reshape NDIS program architecture so that the needs of Indigenous people with disabilities across Australia could, for the first time, be systematically supported in an accessible and culturally safe manner.

In a 'recast' of the current NDIS LAC and ECEI partner arrangements, the NDIS Pilot replaced the LAC model by establishing a **parallel Indigenous pathway** - alternate teams of Indigenous staff connecting with potential Participants through the engagement, eligibility testing, pre-planning and Plan build stages. Critically, this new approach was built on cultural integrity, trusted relationships and complete integration with the health care, family support, aged care and disability systems operated by IUIH. Anchored in culturally trusted health providers (the IUIH Network), the Pilot supported a seamlessly navigable service system and provided support during the critical plan building stage. These have both proven to be critical success factors in achieving outcomes.

On completion in August 2020, the NDIS Pilot had engaged over 900 Indigenous participants in South East Queensland. Overwhelmingly, the experience of these participants is that they would not have accessed needed disability supports if left to the usual mainstream NDIS pathways.

Significantly, analysis by the NDIS itself showed that the NDIS Pilot achieved an astonishing three times better 'access met' rates and ten times better 'plan approval' rates than standard NDIS arrangements. This represented a cogent validation of the proposition that efforts to realise improved NDIS participation will fail for Indigenous people unless there is cultural adaptation and apposite Indigenous-led program redesign and delivery. When Indigenous people control the decisions that affect their lives, they have better health and wellbeing.

Despite these life-changing outcomes, the NDIA ceased funding for the project and did not progress evaluation and translation of this success story into a replicable national model - which was the intention of the Pilot and commitment given by the NDIA. However, the learnings from the project are analogous and directly relevant to informing how the implementation of the NDIS Independent Assessment should proceed.

IUIH Network Recommendations: NDIS and disability services

- The Government must immediately cease the rollout of the National Disability Insurance Scheme (NDIS) Independent Assessments reforms for Indigenous people with disability
- The Government must honour its commitments under the *National Agreement on Closing the Gap* (2020), which mandate that systems change of this nature must be undertaken as an outcome of shared decision-making with Indigenous Australians. Consistent with this CTG Agreement, the government and the NDIA must give Indigenous Australians a leadership role in co-designing all current and future NDIS arrangements, including any proposed assessment changes as they apply to Indigenous people with disability.
- Consistent with its commitments under the CTG Agreement, the recent Aged Care Royal Commission recommendations relating to Indigenous Elders, the evidence-based from 50-years of experience in the Indigenous health sector, and the successful outcomes of the IUIH NDIS Pilot Project of National Significance, the Government should, through a co-design process:
    - Give preference to and ensure priority NDIS funding of Indigenous community-controlled organisations, acknowledging the evidence-based that Indigenous designed and delivered services will close the gap faster
    - Establish specific and Indigenous-led Pathways for Indigenous Australians with disability, which operate in parallel to 'mainstream' NDIS programs. These should include:
        - Funding the systematic rollout of Indigenous Care Finders to support Indigenous people navigate through the entire NDIS access, assessment, and service delivery journey
        - Implementing Indigenous-specific NDIS assessment arrangements where there is regional scale (e.g. greater than 2,000 Indigenous people), and that in smaller populations, at least one Indigenous assessor be part of any assessment arrangement
        - leveraging the 150 nationwide network of CCHSs who already have trusted and established cultural relationships with a substantial proportion of Indigenous Australians. This will promote integrated care and includes utilising the considerable assessment expertise of health professionals within the CCHSs, and, consistent with best practice, acknowledging that culturally acuity and trusted relationships are equally if not more important, than notions of 'independence'

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