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

COVID-19 Response Inquiry

Submission to Department of the Prime Minister and Cabinet

December 2023

ABOUT NACCHO

NACCHO is the national peak body representing 145 Aboriginal Community Controlled Health Organisations (ACCHOs). We also assist a number of other community-controlled organisations.

The first Aboriginal medical service was established at Redfern in 1971 as a response to the urgent need to provide decent, accessible health services for the largely medically uninsured Aboriginal population of Redfern. The mainstream was not working. So it was, that over fifty years ago, Aboriginal people took control and designed and delivered their own model of health care. Similar Aboriginal medical services quickly sprung up around the country. In 1974, a national representative body was formed to represent these Aboriginal medical services at the national level. This has grown into what NACCHO is today. All this predated Medibank in 1975.

NACCHO liaises with its membership, and the eight state/territory affiliates, governments, and other organisations on Aboriginal and Torres Strait Islander health and wellbeing policy and planning issues and advocacy relating to health service delivery, health information, research, public health, health financing and health programs.

ACCHOs range from large multi-functional services employing several medical practitioners and providing a wide range of services, to small services which rely on Aboriginal health practitioners and/or nurses to provide the bulk of primary health care services. Our 145 members provide services from about 550 clinics. Our sector provides over 3.1 million episodes of care per year for over 410,000 people across Australia, which includes about one million episodes of care in very remote regions.

ACCHOs contribute to improving Aboriginal and Torres Strait Islander health and wellbeing through the provision of comprehensive primary health care, and by integrating and coordinating care and services. Many provide home and site visits; medical, public health and health promotion services; allied health; nursing services; assistance with making appointments and transport; help accessing childcare or dealing with the justice system; drug and alcohol services; and help with income support. Our services build ongoing relationships to give continuity of care so that chronic conditions are managed, and preventative health care is targeted. Through local engagement and a proven service delivery model, our clients 'stick'. Clearly, the cultural safety in which we provide our services is a key factor of our success.

ACCHOs are also closing the employment gap. Collectively, we employ about 7,000 staff – 54 per cent of whom are Aboriginal or Torres Strait Islanders – which makes us the third largest employer of Aboriginal or Torres Strait people in the country.

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Acknowledgements

NACCHO welcomes the opportunity to provide a submission to the COVID-19 Response Inquiry.

NACCHO supports the submissions to this consultation made by NACCHO Members and Affiliates.

National Agreement on Closing the Gap

At the meeting of National Cabinet in early February 2023, First Ministers agreed to renew their commitment to Closing the Gap by re-signing the National Agreement, first signed in July 2020. The reforms and targets outlined in the National Agreement seek to overcome the inequality experienced by Aboriginal and Torres Strait Islander people, and achieve life outcomes equal to all Australians.

This Government's first Closing the Gap Implementation Plan commits to achieving Closing the Gap targets *through implementation of the Priority Reforms*. This represents a shift away from focussing on the Targets, towards the structural changes that the Priority Reforms require, and which are more likely to achieve meaningful outcomes for our people in the long term:

Priority Reform Area 1 – Formal partnerships and shared decision-making
This Priority Reform commits to building and strengthening structures that empower Aboriginal and Torres Strait Islander people to share decision-making authority with governments to accelerate policy and place-based progress against Closing the Gap.

Priority Reform Area 2 – Building the community-controlled sector
This Priority Reform commits to building Aboriginal and Torres Strait Islander community-controlled sectors to deliver services to support Closing the Gap. In recognition 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.

Priority Reform Area 3 – Transformation of mainstream institutions
This Priority Reform commits to systemic and structural transformation of mainstream government organisations to improve to identify and eliminate racism, embed and practice cultural safety, deliver services in partnership with Aboriginal and Torres Strait Islander people, support truth telling about agencies' history with Aboriginal and Torres Strait Islander people, and engage fully and transparently with Aboriginal and Torres Strait Islander people when programs are being changed.

Priority Reform 4 – Sharing data and information to support decision making
This Priority Reform commits to shared access to location-specific data and information (data sovereignty) to inform local-decision making and support Aboriginal and Torres Strait Islander communities and organisations to support the achievement of the first three Priority Reforms.

Review of Closing the Gap

In its recent review of the National Agreement on Closing the Gap, the Productivity Commission described government progress implementing the Agreement's Priority Reforms as mostly weak. It found no evidence of systemic change and that Government policy did not reflect the value of the community-controlled sector.

> 'Too many government agencies are implementing versions of shared decision-making that involve consulting with Aboriginal and Torres Strait Islander people on a pre-determined solution, rather than collaborating on the problem and co-designing a solution.'[1]

The Commission noted that few tangible steps had been taken to increase the proportion of services delivered by ACCOs and that there was a need to improve funding to ACCOs to provide more flexible and longer-term contracts that cover full costs of services and reduce reporting burdens.[1]

The review recommended designating leaders to promote and embed changes to public sector systems and culture, embedding a responsibility in conditions of employment for public sector employees to improve cultural capability and relationships with Aboriginal and Torres Strait Islander people, and improving accountability and transparency.

NACCHO recommends any interventions to address future pandemic responses align with the National Agreement and its four Priority Reform Areas.

Introduction

There have been several inquiries and reviews into the COVID pandemic. In 2024, NACCHO will undertake its own evaluation of its pandemic management and support to member services.

The community-controlled health sector, in partnership with governments, led a highly effective response to the COVID-19 pandemic. NACCHO was pleased with the strong partnership between NACCHO and the Australian Government Department of Health to manage the response to the COVID pandemic and the vaccine rollout across our communities. The strength in NACCHO's and our Sector's partnership was a good example of how the National Agreement was envisaged to operate.

NACCHO would welcome direct consultation on the sector response as part of this review.

Governance

The high level of collaboration with the sector by the Australian Health Protection Principal Committee (AHPPC) through the Aboriginal and Torres Strait Islander COVID-19 Advisory Group was instrumental in keeping case numbers low in the early stages of the pandemic. Responsiveness of the Department of Health staff working in genuine partnership with NACCHO, Affiliates and other Aboriginal and Torres Strait Islander health experts contributed significantly to the low case numbers and zero deaths in the first 18 months of the pandemic.

NACCHO supports this partnership approach, which is now embedded in the AHPPC. We would welcome an increase in the use of partnership approaches such as this in line with Priority Reform 1, including in the establishment of the Australian Centre for Disease Control. While there was a strong partnership approach at the Commonwealth level, our state and territory peak organisations reported this shared decision-making model was not always reflected at the level of jurisdictional governments and local health districts. Shared decision making in some jurisdictions only took place at crisis point, rather than in advance or in order to avoid the point of crisis.

[1] Productivity Commission 2023, Review of the National Agreement on Closing the Gap, Draft Report, Canberra, July.

Social determinants

The response failed to address or adequately consider the social determinants of health, in particular, issues around housing.

Aboriginal and Torres Strait Islander people are significantly more likely to live in overcrowded, poorly maintained housing than other Australians. Inadequate housing is a key indicator and driver of poverty and a critical social determinant of health.[2,3] Evidence demonstrating the powerful links between housing and outcomes for health is abundant.[4]

Adequate, safe and environmentally fit for purpose housing is a key primordial prevention measure for Aboriginal and Torres Strait Islander communities.[5] Improved hygiene facilities, water infrastructure and living conditions support prevention of communicable diseases such as COVID-19.

In many regions and communities there was, and remain, issues of overcrowding. This contributed to the rapid spread of the virus through Aboriginal and Torres Strait Islander communities. Overcrowding also made it extremely difficult to isolate or quarantine effectively. Throughout the pandemic, there were reports of Aboriginal and Torres Strait Islander people struggling to isolate to avoid spreading COVID to family members.[6,7] In Wilcannia, people were forced to isolate in tents to avoid spreading the virus to Elders and other vulnerable family members.[8]

Yet, there was an ongoing reluctance to invest in quarantine, and particularly in community-led quarantine facilities. Only after the impact of overcrowding in Wilcannia and other towns received widespread attention were some community quarantine facilities funded.

Funding and resourcing

Direct funding was provided to the sector, around $82 million to date, which supported capacity building under Priority Reform 2. The funding was delivered in a way that allowed flexibility, thereby enabling programs to be designed to meet the needs of the community at the local level.

Where funding was provided to the sector to support awareness raising, public health messaging was effective and contributed to low infection rates, particularly in the early stages of the pandemic. This funding was also crucial in supporting ACCHOs to lift immunisation rates after initial government funded immunisation clinics failed to immunize a high proportion of the Aboriginal and Torres Strait Islander population, despite them being identified as a priority population.

However, other grants funding often had a very narrow scope in terms of activities that could be delivered, including activities to support people with mental health concerns. Funding for mental

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[2] Australian National Audit Office. Indigenous Housing Initiatives: the Fixing Houses for Better Health program. Canberra: Department of Families, Housing, Community Services and Indigenous Affairs ; 2010.

[3] Baker E, Mason K, Bentley R. Exploring the bi-directional relationship between health and housing in Australia. Urban policy and research. 2014;71–84.

[4] Baker E, Mason K, Bentley R. Exploring the bi-directional relationship between health and housing in Australia. Urban policy and research. 2014;71–84.

[5] NACCHO, Core Services and Outcomes Framework https://csof.naccho.org.au/

[6] SBS, Wilcannia families struggling to isolate, 24 Aug 2021 https://www.sbs.com.au/nitv/the-point/article/wilcannia-families-struggling-to-isolate-in-overcrowded-housing/cjhm066sd

[7] ABC, Rising COVID-19 cases and overcrowded housing, 27 March 2022, https://www.abc.net.au/news/2022-03-27/remote-communities-wa-covid-19-cases-rise-overcrowding-isolation/100942312

[8] The Conversation, COVID in Wilcannia, September 2021, https://theconversation.com/covid-in-wilcannia-a-national-disgrace-we-all-saw-coming-167348

health support for Aboriginal and Torres Strait Islander communities was provided through PHNs, an approach which was of considerable concern. These concerns were borne out by the allocation of funding, none of which was provided to ACCHOs in the first instance. Delivery of health funding for Aboriginal and Torres Strait Islander communities through the PHN network remains on ongoing concern for NACCHO and for the sector more generally.[9]

Fundamentally, current PHN funding models do not align with the Priority Reforms of the National Agreement. Funding currently provided to PHNs to deliver services to Aboriginal and Torres Strait Islander communities should be transitioned to the ACCHO sector in line with Priority Reform 2 and actions recommended under the Primary Health Care 10 Year Plan.[10]

There were serious issues of timeliness in the provision of resources. The Primary Care Division of the Australian Government did not have a good understanding of the number of cases being seen in ACCHOs compared to other general practices, and failed to resource them appropriately early in the Delta and Omicron outbreaks. As a result, ACCHOs were poorly equipped in terms of appropriate PPE and rapid antigen tests at critical times in the pandemic. Supply of PPE through the PHNs was again an issue and supply of PPE was only resolved when the Commonwealth negotiated directly with the sector.

Targeted responses

There was good access to local data on immunisations, vaccine levels and other key information which supported local decision-making, consistent with Priority Reform 4.

Some key targeted measures delivered through the governance structures have set an excellent standard in terms of equity of access. Aboriginal and Torres Strait Islander people were prioritised for access to immunisations, boosters, and COVID antiviral treatments. Eligibility criteria for antivirals were adjusted to be at a lower age for Aboriginal and Torres Strait Islander people and include consideration of non-medical (geographical remoteness) criteria for treatment. This is a first in the conceptualization of equity of access through the Pharmaceutical Benefits Scheme.

Changes in scope of practice for Aboriginal Health Practitioners were also expanded in response to advice from the COVID-19 Advisory Group. Emergency orders through Chief Medical Advisors supported the use of this workforce in immunisation campaigns across all jurisdictions and these changes in scope of practice are now being embedded through changes to relevant Poisons Acts.

The expansion of telehealth during the pandemic included several items to support prevention and management of chronic disease for Aboriginal and Torres Strait Islander people. Following consultation with NACCHO through the GP Peaks group, the Aboriginal and Torres Strait Islander Health Assessment (Medicare item 715) and related follow-up items were also included in the expanded items. However, while consultation on expansion of telehealth items was excellent, there was limited consultation when the decision was taken to scale back these changes. The changes to MBS billing to remove longer telephone telehealth consultations have reduced equitable access to

[9] Coombs, D. (2018). Primary Health Networks' impact on Aboriginal Community Controlled Health Services. Australian Journal of Public Administration, 77(S1), S37–S46. https://doi.org/10.1111/1467-8500.12357 https://onlinelibrary.wiley.com/doi/full/10.1111/1467-8500.12357 (Accessed 6/12/2023)

[10] Primary Health Care 10 Year Plan 2022-2032, Action area C: Close the Gap through a stronger community controlled sector, https://www.health.gov.au/resources/publications/australias-primary-health-care-10-year-plan-2022-2032?language=en

telehealth. This is particularly the case for patients who do not have reliable internet access or access to the hardware or data for video telehealth for reasons of affordability.

Workforce

The pandemic has resulted in considerable workforce strain and shortages across the community controlled health sector as staff experienced burnout and state based clinics outcompeted for staff. Workforce data reported to the AIHW shows a decrease of FTE clinical staff per 1,000 population of around 20-30 per cent in ACCHOs and a 50 per cent increase in the number of unfilled positions since the start of the COVID-19 pandemic in 2020.[11] We are seeing consequences of these shortages in reduced screening rates for cancer, health checks and immunisations – these issues are worst in areas with the greatest workforce shortages.

The introduction of vaccine liaison officers in MM5-7 helped bridge the gap between services and ASPEN which many of our services benefitted from.

[11] Australian Institute of Health and Welfare (2022) Aboriginal and Torres Strait Islander specific primary health care: results from the nKPI and OSR collections viewed 16.11.2022 https://www.aihw.gov.au/reports/indigenous-australians/indigenous-primary-health-care-results-osrnkpi/contents/osr-introduction