NACCHO

National Aboriginal Community Controlled Health Organisation

NACCHO Submission

Inquiry into Human Services: Identifying sectors for reform

July 2016

To: Productivity Commission

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Aboriginal health in Aboriginal hands
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Preamble

This initial submission has been prepared in response to the Productivity Commission's request for submissions into their Inquiry into Human Services: Identifying sectors for reform. NACCHO is happy to discuss this submission or elements of it in person and equally happy to provide additional information on request.

Where the term "Aboriginal" is used in this submission it implies Aboriginal and Torres Strait Islander people.

Introduction

NACCHO appreciates the opportunity to make a submission to the Commission for its Inquiry, Human Services: Identifying sectors for reform. NACCHO and our Member Services' area of expertise is Comprehensive Primary Health Care (CPHC) for Aboriginal people. NACCHO has over 140 Member Organisations across Australia. Providing services in over 300 fixed, outreach and mobile sites. Our Sector has direct interaction with over 50% of the total Aboriginal population nationally and close to 100% of the Indigenous population living within a 60 minute access in those areas in which an ACCHO is located.

In the sense of market penetration ACCHO's hold a unique position and, by virtue of them being Community Controlled, their Boards of Directors have direct responsibility and accountability to their communities, as well as their accountabilities for governance and contract compliance with the Commonwealth and funders. ACCHO's have the greatest demonstrated ability of any network of organisations to reach Aboriginal people and to engage with them in relation to their healthcare and broader human service needs.

As mentioned in the Productivity Commissions' Issues Paper, Commonwealth Government taxpayers fund Human Services through direct service delivery or through contracted third parties. ACCHO's are funded directly through grants and program funds along with re-imbursement for clinical and eligible services via the MBS. In contract terms the "partner" of the ACCHOs' core businesses is the Commonwealth Government on behalf of which contracted health and related services are supplied to Aboriginal people.

All businesses seek to establish sustainable income and clients to survive, plan, grow and improve their competitive standing. When supplying services on behalf of the Commonwealth the ACCHO businesses income is dependent on the government. Changes in policy, regulation and levels of funding create opportunities and threats. ACCHO's have developed their business model over the last 45 years surviving and growing in fluctuating policy and funding environments. Adaptation, through innovation and dedicated officers and staff, has seen the ACCHO's become agile and resilient through fluctuations in policy direction and funding.

It is important to highlight here the different understanding of health in western context and Aboriginal culture. The western understanding of health is an absence of disease, someone is healthy if they do not have a disease or illness.

The Aboriginal understanding of health is holistic and includes land, the physical body, clan, relationships, and lore, it is the social, emotional and cultural wellbeing of the whole community not just the individual.

It is well understood that the factors that most affect a person's long and short-term health are the socio-economic and environmental conditions in which they reside. Their health is a determinant of the uptake and access to education, employment, participation and contribution to the broader society and economy. The socio-economic determinants of health are those Human Services defined in the Issues Paper, namely, health, education, community services, job services, social housing, prisons, aged care and disability services. These services encompass the interdependencies of the Aboriginal cultural concept of "health".

ACCHO's are uniquely positioned to be educators and brokers of other Human Services encouraging informed choice of complementary providers.

NACCHO and its Member Services (ACCHO's) with their market penetration, resilient business model, dedicated officers and staff, unique model of care (products and services) have insights, cumulative experience to contribute to the work of the Commission in its Inquiry. We also believe that our knowledge, experience and innovations in the application of computer and internet based technologies to primary health and interventions in the broader Human Services, as defined for this Inquiry, should be considered when targeted, cost-effective and outcome driven strategies and implementations are being defined and developed as the Inquiry progresses.

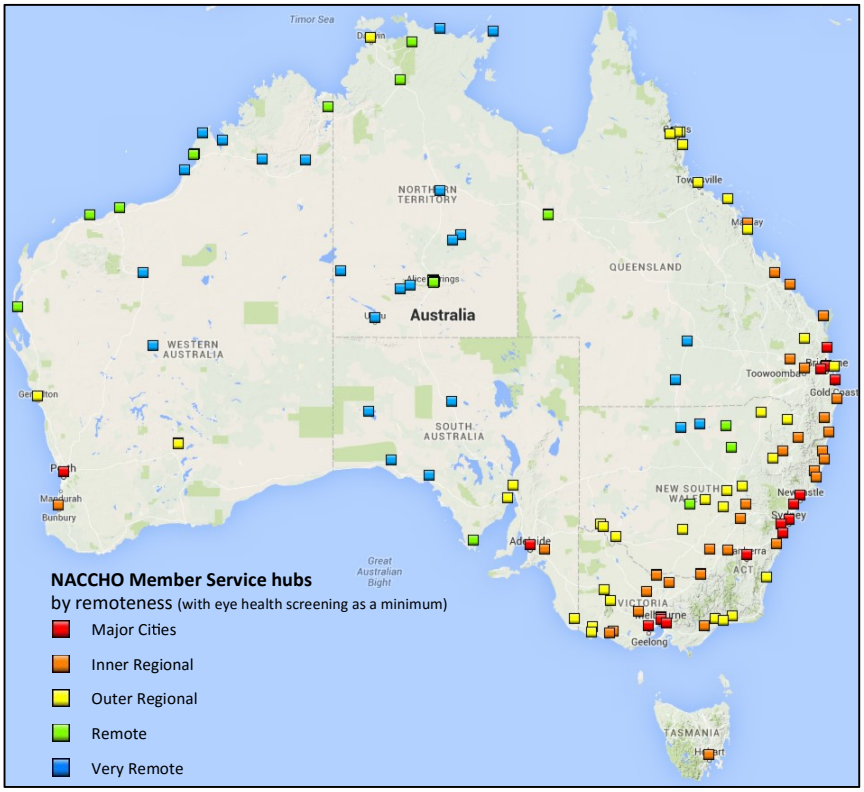
About NACCHO

National Aboriginal Community Controlled Health Organisations (NACCHO) is the national authority on Aboriginal comprehensive primary health care representing over 140 Aboriginal Community Controlled Health Services (ACCHO'S) across the country on Aboriginal health and wellbeing issues.

An ACCHO is a primary health care service initiated and operated by the local Aboriginal community to deliver holistic, comprehensive and culturally appropriate health care to the community which controls it, through a locally elected board of directors. The first ACCHO was established in Redfern in 1971 because mainstream services were not dealing adequately with the health needs of Aboriginal people. This problem with mainstream health services continues to the present day.

ACCHO's operate in urban, regional, remote and very remote Australia. They range from large multi-functional services employing over 100 medical professionals and health workers providing a wide range of services in urban and regional centres, to small services which still provide the bulk of comprehensive primary care services, often with a preventative, health education focus along with early childhood development and chronic disease management. ACCHO's form a network, but each is autonomous and independent both of one another and of government. The ACCHO model of service is in keeping with the philosophy of Aboriginal community control and the Aboriginal holistic view of health.

Map of NACCHO Member Services



The ACCHO sector is the largest private employer network of Aboriginal and Torres Strait islander people within Australia, estimated at 3,215 (ABS 2012). The ACCHO'S provide 2.8 million episodes of care to an estimated 342,299 Aboriginal and Torres Strait Islander people and their families this is an increase 19% and 8% respectively (AIHW ACCHO'S Report Card 2016- Non published).

ACCHO's are enduring examples of community initiated and controlled responses to issues in relation to health and social needs. Local solutions are developed in response to the deep rooted social, political and economic conditions that prevail in many Aboriginal communities and these make up the ACCHO's comprehensive primary health care model. Because of the development of this unique model ACCHO's represent the only effective and culturally valid mode of delivering tailored and sustainable comprehensive primary health care services to Aboriginal people.

Major reductions in Australian government Indigenous health expenditure occurred in 2012-13, with a reduction of 2.1% compared with a net 4% increase in overall expenditure. (Australian Government Budget Papers 2011-12: 6:25; 2011-11 6). The reasons provided by government were that the Northern Territory Emergency response expenditure ended in 2012 and government wished to encourage Aboriginal people to use mainstream services.

NACCHO would like to highlight the following critical areas for consideration by the Commission in relation to this Inquiry.

1. A Unique Model of Care

The ACCHO's unique model of care creates an ongoing relationship with each of their clients. This model is distinct from a "health service" as it responds to Aboriginal focused individual, family and community health and wellbeing needs. ACCHO's provide holistic, comprehensive and culturally appropriate primary health care, they deliver health and broader social outcomes that are not matched by mainstream services. ACCHO'S are regarded as unique and culturally informed model of primary health care.

ACCHO'S are community controlled and run by Indigenous boards of directors, elected by community members. More than half the staff in ACCHO'S are Aboriginal, this makes ACCHO'S uniquely placed to provide Aboriginal focused health and wellbeing services.

Rather than being an "Aboriginal model" of a western health service, ACCHO'S take an entirely different approach. From the first appointment the ACCHO provides holistic care that aims to provide the client with a seamless patient journey. As the client progresses through their life course they may experience different challenges including; homelessness, substance abuse, diabetes, pregnancy and or obesity, their local ACCHO'S will work with their client to achieve their goals or help them manage their condition.

A typical ACCHO offers a range of clinical services including general practitioners, practice nurses, midwives, child health nurse, dentists, psychiatrists, drug and alcohol workers, psychologist, pharmacist, physiotherapist, dietician, podiatrist and a range of visiting specialists. A social health team will provide counselling, advocacy, social and emotional wellbeing support and health education. They may also run a diabetes clinic, a smoking cessation program, a parenting group, men's and women's groups and healthy cooking groups. There may also be a needle exchange program, an opiate nurse, a youth diversion program, a home maintenance program and prison outreach.

Transport is provided for clients as required to get them to and from appointments, follow ups are made after specialist appointments or hospital stays, and reminders are given for routine testing or renewals of scripts.

Many ACCHO's particularly in remote areas provide breakfast programs, elder's lunches, aged care facilities, and homelessness assistance. They respond also to community needs and have strong links with the justice system and mentor and support offenders and their families, they may operate a night patrol service and crèches and have links to schools, TAFE and sporting organisations.

The challenge for the Commonwealth is to extend the supply of this unique and proven primary health and wellbeing model to those Aboriginal people who currently do not have geographic access to ACCHO services.

2. The ACCHO'S model of care is uncontested in the health sector.

ACCHO represents a human services market environment posing unique opportunities in relation to contestability and competition, if government investment is to lift Aboriginal health outcomes and achieve enhanced efficacy.

A long standing barrier that governments have been unable to address is cultural acceptability for Aboriginal people. Cultural competency issues pervade the mainstream health system with little evidence of improvement. Recognition of the problem has not resulted in its resolution. ACCHO's are the dominant choice of Aboriginal people in all geographical areas where they are located

Aboriginal people's demand for ACCHO services is growing rapidly and even faster than population growth (Alford 2014). Where ACCHO exists the community prefer to and does use them, suggesting patterns of use reflect patchy supply (Panaretto et al.2014). Moreover, in geographical areas with relatively more Aboriginal primary health care services on a population basis, proportionately more Aboriginal people use them (AIHW HSR 2013:40). Case studies of three ACCHO's in very different geographical areas indicate heavy demand from local communities as well as from communities further afield. Many Aboriginal people travel considerable distances to access their ACCHO's bypassing a number of mainstream GP services on route. The proportion of the Aboriginal population accessing GPs, dentists and hospital services has not increased to the same extent as the demand for ACCHO'S services. (Alford 2014)

Four A Barriers – Availability, Affordability, (Cultural) Acceptability and Appropriateness (to health need) are directly addressed and access enhanced by a range of ACCHO services that are rarely if ever provided by mainstream primary health care services, for example all services provide patient transport when needed, 92% track clients needing follow-up, 68% arrange free provision of medical supplies or pharmaceuticals as well as a range of group and community services. (Alford 2014)**.**

ACCHO's mental health services are highly culturally competent, and they cater for wide spread inter-generational trauma and high rates of psychological distress by those affected by forced removal, dislocation and other social and emotional wellbeing issues. These services are also linked to alcohol, drug and substance misuse services.

The ACCHO'S hub and spoke model of delivering primary health care services is unique and effective. Over 140 ACCHO services across Australia operate up to 300 outreach services for smaller and more dispersed communities. Comparisons between the costs of using a mainstream GP as opposed to an ACCHO's are not particularly useful or valid, because of the significantly different service model applied within our sector. The ACCHO model is based on a multi-disciplinary team dealing with complex health and social needs that combines professional and clinical expertise with a culture and community based approach.

ACCHO's best practice culturally safe model of care and community based accountable governance structures have not been replicated by other service providers whether government public health services, private for profit primary care clinics or other not for profit providers.

3. The ACCHO Sector's Model of Care as Drivers of Quality in Government Resource Investment

NACCHO acknowledges that the concepts of quality, equity, efficiency, responsiveness and accountability identified in the Productivity Commission's Issues Paper are pivotal in framing improvements in human services including the Aboriginal primary care space. The ACCHO Sector's unique model of care actively reflects these five concepts in their routine service provision to Aboriginal people, their families and communities.

The ACCHO's model of care reflects distinctive mixes of local community and cultural authority blended with a broad span of multidisciplinary services. These include the promotion of healthy life choices, chronic disease prevention and management to enable personal empowerment and smooth patient journeys supported by comprehensive electronic health records. These syntheses of service design remain unique in the broader picture of the Australian health care system.

The draft National Continuous Quality Improvement Framework for Aboriginal and Torres Strait Islander Primary Health Care sees cultural safety and competence as a safe environment where there is no assault, threat or challenge to a person's identity, which promotes shared respect and meaning and integrates culture into health service delivery. When present these cultural attributes enable a trusting relationship between patient and service provider and set up the conditions for success in service delivery. The extent to which an ACCHO readily engages with its surrounding Aboriginal population catchment as the preferred provider of service is an indicator of both its perceived experience as culturally safe environment and its market penetration.

ACCHO's and RACGP have a long established partnership surrounding standards of quality and cultural safety in clinical provision for Aboriginal patients. This work helps to ensure ongoing clinical innovation in the Sector is always safe and effective. Moreover it forms the basis for ACCHO's to achieving formal primary care practice accreditation in alignment with the RACGP standards.

Two examples of this collaboration are the RACGP and NACCHO Interpretative Guide to the RACGP Standards for General Practice and the RACGP and NACCHO National Guide to a Preventive Health Assessment for Aboriginal and Torres Strait Islander People. Both publications which are subject to periodic updating and continue to break new ground. They focus on the field application of contemporary evidence base guidelines for prevention and treatment of chronic and complex conditions across the life cycle infused with an appreciation of the cultural safety and competency issues that support meaningful engagement with Aboriginal people.

The multidisciplinary make up of an ACCHO enables it to function as a "one stop shop" for patients to access various health care supports and interventions documented in a personal care plan.

This plan is usually prepared soon after the patient's needs have been assessed on presenting at the service. A safe, trusting and personally empowering environment for the patient to engage with an ACCHO's team of workers is enabled by the assignment of a culturally appropriate worker to support and accompany the patient as they are introduced to new practitioners and treatment methodologies required in their care plan. This worker will also have care coordination responsibility to ensure the plan suitably triggers the multidisciplinary supports required. Coordination issues include enabling the patient to receive timely health care expertise from the various team members listed in the plan and without being asked to unnecessarily retell their personal health story, ensuring good clinical handover arrangements between workers, reviewing plan progress and making changes where required, and evaluating whether the patients end goals have been met. Accurate and timely entries into the patient record by the entire team are essential for the care plan's success.

NACCHO its state and territory based peak affiliates and local services have been engaged in the development and use of a National Continuous Quality Improvement (CQI) Framework for Aboriginal and Torres Strait Islander Primary Care Services. The Framework was collaboratively prepared by the Lowitja institute under Commonwealth contract funding. All ACCHO's have prepared 3 year CQI plans aligned with this framework. These plans provide an evidence base for confirming the efficacy of local interventions and where gaps exist.

Three critically important dimensions contribute to the rich understanding of how quality is expressed in ACCHO'S. These are:

(a) the key role of trusted relationships between the patient and service practitioners based on cultural safety and competence,

(b) clinical competence and safety and in professional practise, and

(c) the seamless patient journey experience. No other health care providers offer this culturally appropriate model.

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4. The Commonwealth acknowledges the unique model of care provided by ACCHO'S and fund them directly through closed funding rounds.

The introduction of the IAS has seen the overall funding for Aboriginal health reduced, including the removal of social and emotional wellbeing and substance abuse funding from the Department of Health to PM&C. However, the Commonwealth acknowledges the unique model of care provided by ACCHO'S and fund them directly through closed funding rounds.

Government health funding is critically important to Aboriginal Australians. Government provides 95% of all Aboriginal health expenditure, compared with 68% for non-Aboriginal people. An estimated 51% to 61% of Aboriginal and Torres Strait Islander people visit ACCHO's annually. The sector faces increasing pressure on staff and capacity due to increasing demand, supply shortages and funding constraints. The lack of a clear policy and funding commitment for Aboriginal health has resulted in inadequate and poorly distributed government expenditure on Aboriginal health and in particular on ACCHO's. (Alford 2014).

Current joint analysis by NACCHO and AIHW (yet to be published) of the most recently available data shows extraordinary market penetration by ACCHO of their surrounding populations.

This indicative analysis shows that nationally 82 % of Aboriginal people who live 60 minutes' drive time from their nearest ACCHO are likely to seek health care from it at least once per year.

These robust patterns of indicative market engagement remain very strong when the ACCHO sector performance is segmented by Major City, Inner Regional, Outer Regional, Remote and Very Remote geographical service location. The lowest average market catchment penetration being 37% for people living 60 minutes' drive time from Major City services and the highest being 380% for populations living less than 60 minutes from Very Remote ACCHO's.

The Australian Health Ministers Advisory Council noted that while health expenditure on Aboriginal and Torres Strait Islander people in 2009 was 39% higher than other Australians, they experience rates 200% higher on a range of health measures such as mortality rates and prevalence of disease.

Government should move to a long term funding model for ACCHO's as the only provider of culturally appropriate primary health care services. Not only would this provide certainty for ACCHO's and communities it would also represent economies of scale enabling ACCHOs to focus on their core function of delivering holistic health and social wellbeing services to the most disadvantaged population group in Australia.

5. ACCHO's represent cost effective service delivery and value for money and are the largest private employers of Aboriginal people in Australia.

ACCHO's function with strong community participation and accountability, perform at high levels of competence in clinical and culturally safe multidisciplinary health care for both remedial and preventative activities. They possess highly experienced professional expertise, operate with cost efficient administration to direct service ratios, and have remarkably high levels of market engagement within their population catchments.

ACCHO'S deliver value for money and are based on a combination of local knowledge, culture and professional health skills. Investing in ACCHO'S provides a better return on investment than mainstream services. Not only cost effective, they add substantial economic value to Aboriginal communities and generate flow on effects to education, business and other sectors.

ACCHO'S also provide a channel for employment and economic growth in communities. As a relatively large-scale employer of Aboriginal people and the main source of employment in many communities, an investment in ACCHO'S generate a range of local, regional and national multiplier effects, as an initial investment leads to more jobs and more income which creates more jobs and income and so on. (Alford 2014).

In 2014-15, data was collected by 278 organisations funded to provide health services to Aboriginal people. 203 (73%) were funded to provide primary health care services and 138 (68%) were ACCHO'S. These organisations employed 7,359 full time equivalent staff and just over half (53%) were Aboriginal. The workforce was made up of 4,454 health staff (61%) and 2,905 other staff (39%). Nurses and midwives were the most common type of health worker, representing 15% of employed staff. This was followed by Aboriginal health workers (11%) and doctors (6%). (AIHW Online Service Report 2014-15)

Investing in ACCHO'S is highly effective in meeting government policy goals and targets.

The Closing the Gap Standing Committee acknowledged that ACCHO'S provide pathways to employment for community members through internships and 'in-house' training. This reduces welfare dependency and connects individuals, families and communities to the wider economy. Flow on benefits include the enabling of healthy norms and routines for community members and their families.

Government should recognise that ACCHO's are more than Aboriginal health services. They provide a multitude of health and social services and are a major employer of Aboriginal people. They create real economies in communities where they exist, employing local people in a range of roles, providing training opportunities and internships. ACCHO's have had greater and continued success in Aboriginal employment (real jobs) than CDEP or other employment programs.

6. Acknowledging the Social Determinants of Health and Wellbeing

According to the Centre for Research Excellence in the Social Determinants of Health Equity the social, cultural and economic forces that shape people's daily living conditions are called the 'social determinants' or the 'causes of the causes' of health. When these determinants result in an unfair and avoidable distribution of health in society, for example between the rich and poor, between men and women, or between Indigenous and non-Indigenous peoples, they are considered health inequities. Many of these determinants and health inequities are affected by political and policy processes outside of the health sector. For example, education, employment, the built environment, access to healthful commodities (e.g. nutritious food), as well as health care all affect the distribution of health/ well-being in society.

The World Health Organization also confirms that the structural determinates and conditions of daily life affect the social determinates of health and are responsible for a major part of health inequalities between and within countries.

The disproportionate health disadvantages Aboriginal people experience today can in part be traced back to colonisation, however the ongoing nature of this disadvantage is embodied in the social determinants of health. education, housing, employment, racism and other social conditions influence individuals, families, communities and societies. Add to this the effects of policies of forced protection, dislocation and removal of children and the disadvantages become starker.

It is important to highlight here the different understanding of health in western cultures and Aboriginal culture. The western understanding of health is an absence of disease, someone is healthy if they do not have a disease or illness. The Aboriginal understanding of health is far more sophisticated, it is holistic and includes land, the physical body, mind, clan, relationships, and lore, it is the social, emotional and cultural wellbeing of the whole community not just the individual.

Aboriginal people are more likely to seek health services from a provider that understands the multi-layered concept of Aboriginal health.

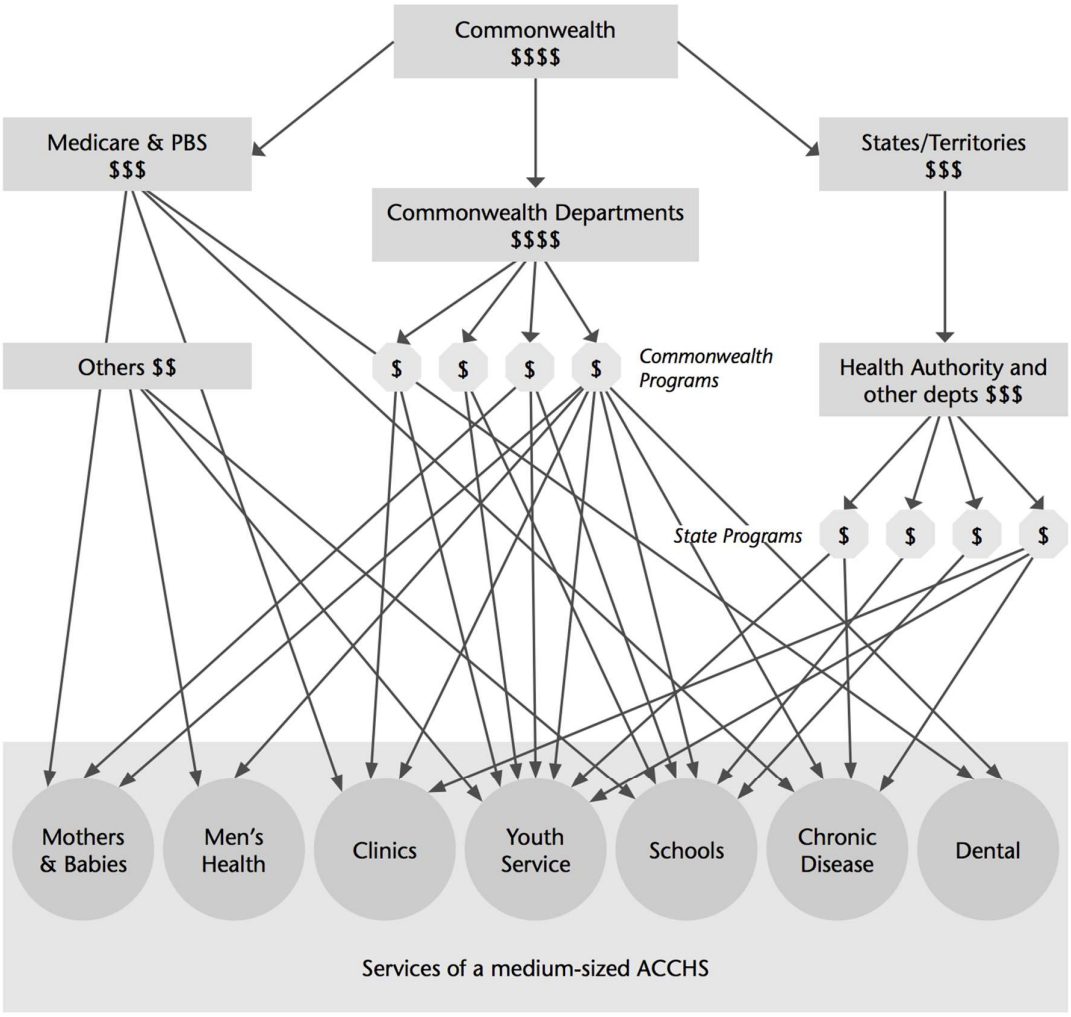
ACCHO'S are controlled by Aboriginal communities and provide Aboriginal health services focussed on Aboriginal people and their families. Despite previous intentions and injections of funds by governments to make mainstream health services more acceptable and culturally appropriate, Aboriginal people continue to use ACCHO'S or delay seeking medical advice if these services are not available to them.

Government should move towards a holistic funding model for Aboriginal people acknowledging that responding to the health of Aboriginal people requires more than health programs it encompasses the range of "human services".

7. Duplication of effort and multiply suppliers reduces the effectiveness of ACCHO'S.

ACCHOs face perennial funding shortages and multiple short-term funding contracts. One large ACCHO has more than 90 funding agreements and compliance requirements, only 16% of which are recurrent grants. (Alford 2014).

Diagram one: Complexity of the funding environment



In 2009 the Overburden report: Contracting for Indigenous Health Services stated:

"The funding and regulatory practices of Australian governments are complex and fragmented, and bring a heavy burden of acquiring, managing, reporting and acquitting funding contracts to both sides of the funding relationship. These problems arise partly from a lack of consistency in the reporting requirements of national and State/Territory government funders, and are compounded, in the majority of health authorities, by internal structures that separate responsibility for policy and relationship development from responsibility for contract management. These arrangements complicate communication tasks and reduce the knowledge management capacity of the funder."

Over the last few years there has been an increasing trend to fund non-Aboriginal organisations to provide Aboriginal health services. This situation has been further compounded by recent administrative changes at a number of levels most notably the 2013 establishment of the Indigenous Advancement Strategy (IAS)

In 2013 a number of Aboriginal policies and programs were transferred to PM&C, the Social and Emotional Wellbeing Program and the Indigenous substance-use rehabilitation, treatment and related support services programs. On 1 July 2014 the IAS was introduced to replace 140 existing Aboriginal specific programs. From 2014-15 social and emotional wellbeing services and substance use rehabilitation and treatment services were funded under the IAS Safety and Wellbeing Programme. (AIHW Online Services Report 2014-15). Much of the funding received under this distribution went to non-Aboriginal providers.

There are two significant problems with this arrangement. Firstly, splitting Aboriginal health related funding over multiple departments reduces the ACCHO'S ability to access funding. Different departments have different funding cycles and different procedures for applying for funding. Over stretched ACCHO'S are missing funding opportunities because there are multiple rounds and limited staff resources to complete the applications.

Funding is being awarded to non-Aboriginal providers and because funding is coming from multiple departments there are no checks to ascertain what services are currently being provided or by whom. This situation can result in multiple services providing similar programs, however we know that where access to an ACCHO'S exists they will be the preferred provider for Aboriginal people but by missing out on funding the ACCHOs responsiveness is being diminished to the detriment of patients, families and communities.

In many remote communities non-Aboriginal newly funded providers, rely on help or assistance from the local ACCHO'S to deliver assistance to clients because they are unaware of local culture, unaware of the client's history and clan obligations. The ACCHOs provide this assistance as they are part of the community and have the client and the community's best interests at heart. A negative outcome would affect not only the client but could negatively affect the community. This is an unacceptable risk for the patient and ACCHO as they are a significant and respected part of the community and it is likely the non-Aboriginal provider is new to the community, has no relational ties to the community and may well not be a long term provider in the community.

It must be remembered that any assistance the ACCHO'S provides the non-Aboriginal provider is not paid for by either the non-Aboriginal provider, the MBS or by government funding.

Not only does this leave the ACCHO'S out of pocket in time and effort but their efforts are not acknowledged or counted in anyway and the non-Aboriginal provider is paid under the MBS, when interventions are time dependant, i.e. MBS 715.

Government needs to acknowledge the unique role ACCHO's play in the delivery of appropriate health and wellbeing services in their communities and move to a single provider arrangement. This will result in efficiencies in service delivery, data collection and reporting.

8. ACCHO'S Data Expertise and Challenges

ACCHO'S deliver primary care largely from government funding. A stringent condition of the funding is prescribed through the Standard Funding Agreements. This requires ACCHO'S providers to collect extensive service performance information. This obligation has a history dating back to 1997 has resulted in ACCHO'S acquiring advanced expertise in the complex and often challenging tasks of data gathering and measuring population health outcomes. Currently this work centres on the Online Service Reports (previously Service Activity Reports) along with the capture of 21 of an ultimate 24 Australian national key performance indicators (nKPIs). The Health Ministers' Advisory Council (AHMAC) approved the national key performance indicators (nKPIs) covering maternal and child health, preventative health risk factors, and certain chronic diseases, to help assess the outcomes of the National Indigenous Reform Agenda (COAG)

New market entrants, without the high levels of competence pose a serious risk to the continuity of patient data collection, statistical consistency of service level activities and outcomes.. It is unlikely that new market entrants into the Aboriginal primary health care domain will have the acquired competence at levels held by ACCHOs to readily proceed with this data capture, interpret and assess as a routine part of everyday service delivery. For instance the patient records data entries exceed the present norms of private general practice, including the requirements for extensive data recording that are not part of regular Medicare Claims record keeping. Similarly not for profit providers are likely to require a considerable developmental lead time to build satisfactory operational competence in this field. Without these competencies vital data and data collection on Aboriginal health care will be compromised or lost.

Government needs to recognise the extensive and significant expertise ACCHO's have developed in the collection and management of data. This data is of significant value to government in providing a clear picture of the current health and wellbeing of Aboriginal people and any improvements over time. It is also important for reporting progress to parliament, committees, and international bodies like the Human Rights Commission, Amnesty International, and International Conventions that Australia is a signatory to.

9. Some History of the Findings in Senate Inquiry into Commonwealth Indigenous Advancement Strategy tendering process

Streamlining of the government's Indigenous programs was suggested as an efficiency measure by the National Commission of Audit (NCA) in its Phase One report of February 2014. The 2014-15 Budget announced that all of the government's programs, grants and activities for Indigenous Australians would be rationalised and streamlined under the new IAS which would be administered by PM&C.

The 2014-15 Budget reported a $534.4 million savings to the Indigenous Affairs portfolio through the rationalisation of Indigenous programs. According to the 2014-15 Budget papers, the rationalisation would eliminate duplication and waste. Savings from the health portfolio measures were to be reinvested in the Medical Research Future Fund, with the other savings redirected to repair the Budget and fund policy priorities.

From 1 July 2014, over 140 programs previously delivered across a range of government portfolios were consolidated into five IAS funding streams, administered by PM&C;

- Jobs, land and economy,
- Children and schooling,
- Safety and wellbeing,
- Culture and capability, and
- Remote Australia strategies.

The stated objective of the IAS was to improve the lives of Indigenous Australians.

Funding for social and emotional wellbeing programs that were funded from the Department of Health were now transferred to PM&C to be delivered under the IAS.

The Senate Committee into the Indigenous Advancement Strategy tendering process announced its findings in June 2016. The Committee was critical of most aspects of the IAS including, program design, program delivery, lack of consultation, additional red tape, and the short lead in time.

Conclusion 3.91 of the Commission's report stated "the Committee heard that the reality was that the timetable to bed down the policy and administrative changes involved in a shift of this magnitude was too ambitious. There was little to no consultation or engagement with communities and organisations on this fundamental change to Aboriginal and Torres Strait Islander programs and no input sought at the start of this process. In addition to implementing a completely new and untested way of doing business, the process was further complicated by machinery of government changes and budget cuts."

The outcome for the Aboriginal health sector has been a significant reduction in funding, particularly in funding for social and emotional wellbeing programs as these programs have been transferred out of the Department of Health and are no longer considered part of the health portfolio.

Government needs to recognise that the continual reduction in funding for Aboriginal programs can only reduce the health and wellbeing of Australia's most disadvantaged population group. Despite the commitment to Closing the Gap in 2008 little progress has been made against the targets, reducing funding for Aboriginal programs will ensure the targets won't be met.

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