



Submission to the Australian Government, Attorney-General's
Department on the Common Core Document:

*Fourth report under the International Covenant on Economic,
Social and Cultural Rights*

From the National Aboriginal Community Controlled Health Organisation
February 13th 2007

This submission is a response from the National Aboriginal Community Controlled Health Organisation (NACCHO) to the call for public comments regarding the Australian Governments 'Core Document' containing its reports to the United Nations (UN) treaty bodies. In particular, this submission relates to Australia's Fourth report under the International Covenant on Economic, Social and Cultural Rights which is part of the Core Document. In the Fourth report, the Australian Government has included reference to the health of Aboriginal peoples and Torres Strait Islanders and this submission addresses some of those claims and makes recommendations to enhance reporting on Indigenous Australians right to health.

There are four sections to this submission:

- 1. The Fourth Report, and consultation on health matters pertaining to Aboriginal peoples**
- 2. Violations to the International Covenant on Economic, Social and Cultural Rights (ICESR, 1966)**
- 3. Specific reference to the Common Core Document which exemplify reporting violations as defined by the CESCR**
- 4. Recommendations to improve the Core Document and Fourth Report**

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1. The Fourth Report, and consultation on health matters pertaining to Aboriginal peoples

- 1.1 The National Aboriginal Community Controlled Health Organisation (NACCHO) is the peak body representing the interests of Aboriginal Community Controlled Health Services (ACCHSs) in Australia, providing comprehensive primary health care services to the vast bulk of Indigenous Australians. The ACCHS sector provides more primary health care to Indigenous Australians than the private general practice sector.^{1 2}
- 1.2 NACCHO was established over 30 years ago by Aboriginal peoples as their own representative health structure and is the only national body in Australia with the legitimacy to speak on behalf of their constituency on health matters.³
- 1.3 We bring to your attention that the Australian Government did not include NACCHO in the list of non-government organizations invited to comment/or input into the Core Document and hence the Fourth report, which may have been an unintended oversight.
- 1.4 It appears that no body representing the health interests of Aboriginal peoples was invited to input into the Fourth report.

2. Violations to the International Covenant on Economic, Social and Cultural Rights (ICESR, 1966)

- 2.1 In the ICESCR, the “right of everyone to the enjoyment of the highest attainable standard of physical and mental health” (Article 12) was recognised.
- 2.2 It is clear that Indigenous Australians have substantially worse health and still have a long way to go before they reach a standard of health that is equal to that enjoyed by other Australians (defined as the highest attainable).⁴
- 2.3 If Indigenous Australians have a right to reach that same standard of health as other Australians, then the Australian Government must explain why health expenditure is less per person for Indigenous Australians than for other Australians.
- 2.4 In the Fourth Report, the Australian Government has not explained why health expenditure continues to be less for Indigenous Australians than other Australians, despite being aware of this for some time.
- 2.5 In addition, the Fourth Report conceals this inequitable pattern of health expenditure, which is in violation of the core reporting obligations of state parties to the Covenant.
- 2.6 Violations to the Covenant, as defined by the UN Committee on Economic, Social, and Cultural Rights (CESCR), include “insufficient expenditure or misallocation of public resources which results in the non-enjoyment of the right to health by individuals or groups, particularly the vulnerable or marginalised; the failure to monitor the realisation of the right to health at the national level, for example by identifying right to health indicators and benchmarks; the failure to take measures to reduce the inequitable distribution of health facilities, goods and services...and the failure to reduce infant and maternal mortality rates.”⁵
- 2.7 The CESCR clarified that “Indigenous peoples have a right to specific measures that improve their access to health services and care...States should provide

- services for Indigenous peoples to design, deliver and control such services so that they may enjoy the highest attainable standard of physical and mental health”.
- 2.8 In this submission, NACCHO will refer to violations to the Covenant by the Australian Government as defined by the CESCR, and particularly in reference to the following, where a: “State which is unwilling to use the maximum of its available resources for the realization of the right to health is in violation of its obligation under Article 12”.⁶
- 2.9 In 2000, the CESCR’s concluding remarks to Australia’s third report were that: “The Committee expresses its deep concern that, despite the efforts and achievements of the State party, the Indigenous populations of Australia continue to be at a comparative disadvantage in the enjoyment of economic, social and cultural rights, particularly in the field of employment, housing, health and education.”
- 2.10 The CESCR recommended that the next Australian report “provide additional, more detailed information, including statistical data which is disaggregated according to age, sex and minority groups, concerning the right to ...health.”⁷
- 2.11 Moreover, since 1991 the UN Economic and Social Council has provided guidelines for government reporting on Article 12 of the ICESCR, which makes it very clear that quantitative data is required on resource allocation to primary health care, health status, and programs developed for population groups whose health situation is significantly worse than the majority.^{8 9}
- 2.12 The Australian Governments Fourth Report still fails to address the recommendations of the CESCR made in response to the Third Report.
- 2.13 According to the 2006 Harmonised Guidelines to International Human Rights Instruments, the treaty-specific document of the States reports “should contain all information relating to States’ implementation of each specific treaty ...This part of the report allows States to focus their attention on the specific issues relating to the implementation of the respective Convention. The treaty-specific document should include the information requested by the relevant committee in its most current treaty-specific guidelines....”.¹⁰ The Fourth Report fails to contain this element of the submission according to the 1991 Economic and Social Council guidelines alluded to earlier.

3. Specific reference to the Common Document which exemplify reporting violations as defined by the CESCR.

Item 116: Addressing underlying disadvantage for Indigenous Australians (page 31).

“The Australian Government is committed to addressing the underlying disadvantage confronting many Indigenous people, and spent a record \$3.3 billion on Indigenous-specific programs in 2006–2007, with a focus on the key areas of housing, health, education and employment, and targeting resources to those Indigenous people in greatest need, particularly those in remote areas. These programs are in addition to other social benefits such as *universal health coverage* and income support, *which are available to all Australians*, and Indigenous programs and services funded by State and Territory governments. Information on programs to address Indigenous disadvantage is available under subject-specific parts of this document.”

In relation to health, the above statement is misleading. Of the funds expended, no estimate of the proportion directed towards *health systems* for Indigenous Australians was reported by the Australian Government. Moreover, Indigenous Australians unfortunately cannot access the universal health coverage alluded to (see below).

For example, in May 2006, the Australian Government released its second whole-of-government Budget in Indigenous Affairs. Of the \$3.3 billion for Indigenous programs, only \$500 million was new funding¹¹ and less than 15% of this was directed to the health care sector in some form. None of the funding was allocated to Indigenous-specific primary health care services.¹² An amount of \$39.5 million was allocated (to 2010-11) for 'brokerage' to urban and regional primary health care services, consistent with the Australian Governments focus on enhancing mainstream services access for Aboriginal peoples and Torres Strait Islanders.¹³ The premise was that referral agencies can enable Aboriginal peoples to access existing services by brokering the process although there is a lack of evidence of the cost-effectiveness of this approach.

Item 525-528. Right to enjoy the highest standard of physical and mental health (Indigenous Health, page 144)

The Core Document allocates one page to describe the Australian Governments responsiveness to the disparities in health systems access and health status between Indigenous Australians and other Australians. In this page, the following is described: the Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework; National Strategic Framework for Aboriginal and Torres Strait Islander Health; the Aboriginal and Torres Strait Islander Health Performance Framework, and two sexual health strategies from WA and Qld.

The above is clearly insufficient given that the standard of health for Indigenous Australians is not equal to that enjoyed by other Australians and far from the highest which is attainable. Moreover, the Statistical Annex to the Core Document provides inconsistent information regarding access to population health programs and primary health care by Indigenous Australians relative to other Australians.

4. Recommendations to improve the Core Document and Fourth Report

According to the core obligations of the ICESCR and what would constitute a violation of the obligation to fulfil under the ICESCR (as defined by the CESCR and described earlier), the following should be considered in the Fourth Report to the UN:

- if there is sufficient expenditure towards measures that may bridge the gap in health standards between Indigenous and non- Indigenous Australians,
- how the realisation of the right to health at the national level will be monitored, by identifying right to health indicators and benchmarks,
- measures taken to reduce the inequitable distribution of health facilities, goods and services
- measures taken to reduce infant and maternal mortality rates

- measures taken to provide services for Indigenous peoples to design, deliver and control such services so that they may enjoy the highest attainable standard of physical and mental health
- evidence that “the maximum of its available resources” have been allocated for the realization of this right to health.

NACCHO has provided information on each of the above issues and brings them to the attention of the Attorney-General’s Department for consideration in the Fourth report on Australia’s obligations under the ICESCR.

Importantly, according to the ICESCR and article 17, ‘reports may indicate factors and difficulties affecting the degree of fulfilment of the obligations under the present Covenant’. Thus, NACCHO has suggested that where there is progress yet to be made in fulfilling those obligations to Indigenous Australians, that comment be made to that effect.

4.1 If there is sufficient expenditure towards measures that may bridge the gap in health standards between Indigenous and non- Indigenous Australians

The Australian Governments relative per capita expenditure for health services to Indigenous Australian was reported by the Australian Institute of Health and Welfare (AIHW) in 2005.¹⁴ Global health expenditure per-person was estimated as being only 18% higher for Aboriginal people, making up only 2.8% of national health expenditure for all Australians. Around half of this expenditure (2001-02) was for hospital services which was proportionately greater than hospital utilisation by other Australians. Of hospital expenditure for Indigenous Australians, the majority was for dialysis, yet utilisation of dialysis and health care for end-stage kidney disease (ESKD) remains less than that for other Australians with ESKD.¹⁵ The high rate of hospitalisation for Indigenous Australians (and higher still if access were optimised) is expensive for the health care system and devastating to individuals, families, and communities and manifests excess levels of preventable morbidity.

In comparison, estimated total health care spending for non-hospital services is substantially lower for Indigenous Australians. Indigenous Australians share of expenditure on Medicare Benefits Schedule (MBS) benefits was only 34% of that for other Australians, for pharmaceuticals it was only 30%, for dental services it was only 24%.¹⁶ (see also primary health care expenditure for Indigenous-specific services below).

There are a number of other reports that could be cited that outline how mainstream health systems expenditure does not target Indigenous Australians. For the purposes of this submission, there is clear evidence from the AIHW of insufficient health expenditure to bridge the gap in health standards.

Economic analysis has estimated the shortfall in expenditure for primary health care services to Aboriginal peoples to be of the order of \$400 million per annum.¹⁷ (Box 1) Other analyses including that from the Commonwealth Grants Commission have suggested average per capita annual government expenditure for Aboriginal peoples and Torres Strait Islanders to be at least double that of non-Indigenous Australians,^{18 19} and not just 18% higher.

Unless there are efforts to address this shortfall, the gap in health standards will not be breached and Australia will remain in violation of Indigenous Australians right to health by a systematic failure to make health systems accessible to them.

One of the most important agreed mechanisms to enhance the accessibility of the health system is the Australian Governments support of ACCHSs as underwritten in the National Strategic Framework for Aboriginal and Torres Strait Islander Health (NSFATSIH).²⁰ However, the level of Australian Government funding for ACCHSs and other Aboriginal health services, is still insufficient and does not offset the inequitable primary health care expenditure between Aboriginal and non-Aboriginal Australians.^{21 22} (see below).

Box 1.Shortfall in primary health care spending for Indigenous Australians²³

The Additional Primary Care costs

	2004/5
Medicare + other medical	\$130m/year
PBS	\$85m/year
Dental and other health professions	\$115m/year
Medical consumables, non-PBS medicines and appliances	\$65m/year
Total on Integrated PHC (Including prevention)	\$400m/year
Training (additional to Total on PHC)	\$36.5m/year (\$167m over 6 years)

4.2 How the realisation of the right to health at the national level will be monitored, by identifying right to health indicators and benchmarks

Recently, the National Aboriginal and Torres Strait Islander Health Performance Framework (HPF) and COAG indicators of disadvantage^{24 25} measure health status to gauge Aboriginal people’s health improvements over time, including select health determinants and some health systems. Important as they are, and an improvement on earlier indicators, they lack ‘right to health’ indicators, targets and benchmarks to assess the health systems responsiveness to Indigenous Australians. For example, while the burden of Aboriginal children’s hearing loss is a measure in the HPF, federal government expenditure towards hearing services provision as a response to this problem is not.

The Fourth Report should outline reasons against the use of goals and targets in monitoring processes to account for the health systems responsiveness to Indigenous Australians or indicate if measures are underway to develop them.

In particular, measures of the responsiveness of the health system as a whole to Indigenous Australians are necessary and this includes hospital services, population health programs under the Public Health Outcome Funding Agreements, general practices, the MBS and PBS, specific health schemes such as the Commonwealth

Hearing Services Program and their contractual partners, State health funded Aboriginal health services, ACCHSs, and other Indigenous-specific services.

4.3 Measures taken to reduce the inequitable distribution of health facilities, goods and services

The Core Document has noted that the Australian Government understands the importance of the responsiveness of the mainstream health sector to provide appropriate services that are accessible to Indigenous Australians. Part of the Australian Governments efforts also include supplementary services in the form of Indigenous-specific services²⁶ (see below). These act to provide services in a way that is receptive to Aboriginal peoples needs but also act as mediators for other health services and a conduit for Indigenous Australians to access the mainstream health sector.

However, there is evidence of an inequitable distribution of health-related goods and services for Indigenous Australians. This ranges from poorer access to hospital procedures,^{27 28 29} to population health programs developed for all Australians (such as breast cancer screening and cervical cancer screening)^{30 31} to general practice programs.³² Whilst this may be indisputable, it is necessary to refer to these inequities in the Fourth Report for the purpose of communicating that efforts will be made to address them.

At present however, there appear to be no efforts to enhance the responsiveness of the mainstream health system (such as through the above programs) to Indigenous Australians, with a heavy burden falling on the under resourced Indigenous-specific services to fill the gaps.

It would be instructive if the Fourth Report was to identify measures taken to enhance the responsiveness of the mainstream health system to Indigenous Australians.

4.4 Measures taken to reduce infant and maternal mortality rates

The Fourth Report would need to refer to the 2005 Federal Budget provision of funds under the Healthy for Life initiative³³ towards maternal and child health for Indigenous Australians. However, this program is another vertical funded program with competing priorities for chronic disease prevention in the population other than mothers and babies, and a substantial quality assurance component that provides capacity for data collection. Thus, the proportion of funds allocated to maternal and child health is not as implied in the Budget, and falls short of that required to support core primary health care for this purpose.³⁴

This is important because it diverts attention from the need to enhance core maternal and child health programs. For example, immunisation levels are suboptimal, there is evidence of continuing poor growth in Aboriginal children, there are very high levels of acute rheumatic fever in some communities, and so on. All these health problems are addressed by appropriately resourced primary health care.

The Fourth Report should not mislead the UN with respect to Australian Government efforts to correct the maternal and child health of Aboriginal peoples and might correctly refer to the competing priorities in the above federal budget allocation. It might also admit the consideration of additional investment in this important area in the near future.

4.5 Measures taken to provide services for Indigenous peoples to design, deliver and control such services so that they may enjoy the highest attainable standard of physical and mental health

The Australian Government is in agreement over the importance of ACCHSs and their role in increasing the standard of health for Indigenous Australians³⁵ and funds over 130 ACCHSs. They play a vital role in servicing the health needs of Aboriginal peoples far in excess of other primary health care providers such as private general practices. This is evident not only in the 'episodes of care' delivered but also in the scope of service provision which is significantly more comprehensive.³⁶

The Fourth Report should acknowledge the contribution ACCHSs have made as supported by the Australian Government in enhancing access to primary health care, and in the provision of quality services to many Aboriginal peoples across Australia, as well as reductions in tertiary health sector costs. In the NT alone, it has been estimated that withdrawal of OATSIH grants to ACCHSs would increase total health costs on other parts of the health system by \$136 million over five years, and \$470 million over 10 years.³⁷

Whilst the overall expenditure towards Indigenous specific primary health care services has increased from an estimated \$190 million by 2000–01,³⁸ to \$287 million in 2004-05,³⁹ increasing proportions of OATSIH funding is now being apportioned to greater numbers of State and Territory government health services, as well as funding for alternative models of primary health care that function to enhance Aboriginal peoples access to mainstream services, such as through urban brokerage⁴⁰ even though the evidence for the cost-effectiveness of this approach is not publicly available. This reflects new directions within OATSIH towards improving access to, and the responsiveness of, mainstream health systems.

In 2004, analysts commissioned by the Australian Government reported that funding for Indigenous-specific primary health care services should be of the order of \$1244 per capita.⁴¹ In reality, only \$306 per capita was expended through Indigenous specific primary health care services by OATSIH in 2001-02.⁴²

Core funding to ACCHSs, insufficient to meet the costs of comprehensive primary health care, has led to greater ACCHS reliance on the MBS, but this is insufficient to meet the costs of the medical workforce.⁴³

During 2001-02, the OATSIH budget was \$224 million and 73% of that went towards the ACCHS sector.⁴⁴ OATSIH administered grants had increased to nearly \$300 million in 2005-06, but the proportion of funds that was allocated as core ACCHS grants was not reported in the Australian Governments Annual report. Out of Australia's total health expenditure of \$38.4 billion in 2005-06, the OATSIH budget comprised only 0.8%.⁴⁵

Overall, most Australian Government health expenditure on Aboriginal people is via this comparatively small, capped program and while modest increases have been achieved, it is still unable to meet the needs of Aboriginal people across Australia for adequate access to an acceptable level of primary health care. This is a fundamental oversight in Australian Government policy and given the underspend in health for each Aboriginal person, it is far from equity generating.

The importance of highlighting these matters in the Fourth Report is for the Australian Government to notify that there are shortfalls and that efforts will be underway to address them.

4.6 Evidence that “the maximum of its available resources” have been allocated for the realization of this right to health.

This submission has described the evidence that the Australian Government is not allocating sufficient funds to bridge the gap in health status between Indigenous and non-Indigenous Australians. Australia has available resources to meet this need⁴⁶ as exemplified by PBS spending for one type of medicine alone (atorvastatin, a lipid lowering agent), which exceeded \$510 million dollars in 2005-06.⁴⁷

It is preferable that the Australian government through the Fourth Report outline measures towards substantially increasing funding for comprehensive Indigenous-specific primary health care, particularly through ACCHSs, until the health status of Aboriginal peoples approaches that of other Australians.

Notes:

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⁴ Social Justice Commissioner. Social Justice Report, 2005. Human Rights and Equal Opportunity Commission, Australia, 2006.

⁵ Committee on Economic, Social, and Cultural Rights. General comment No.14. The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social, and Cultural Rights. United Nations doc E/C.12/2000/4, 4th July 2000.

[http://www.unhcr.ch/tbs/doc.nsf/\(symbol\)/E.C.12.2000.4.En?OpenDocument](http://www.unhcr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En?OpenDocument)

⁶ Ibid

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⁹ UN Economic and Social Council. Revised general guidelines regarding the form and contents of reports to be submitted by states parties under articles 16 and 17 of the International Covenant on Economic, Social and Cultural Rights, 17/06/91. E/C. 12/1991/1. (basic reference document) UN, Geneva, 1991.

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- ⁴³ Urbis Keys Young. *Op. cit*
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