AMA DISCUSSION PAPER 2004 – UPDATE

ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH HEALING HANDS – ABORIGINAL AND TORRES STRAIT ISLANDER WORKFORCE REQUIREMENTS

Aboriginal and Torres Strait Islander Health Service Funding

AMA

In 2005 Australian Institute of Health and Welfare (AIHW) published *Expenditures on Health for Aboriginal and Torres Strait Islander People, 2001-02*,[1] the third comprehensive analysis of such expenditures. It estimated expenditures in 2001-02 on health for Indigenous people and compared it with health expenditures for the rest of the Australian population. The analysis showed that the relative position of Indigenous Australians compared with non-Indigenous Australians had changed little since the previous report for 1998-99. The ratio of Indigenous to non-Indigenous estimated expenditures per person in 2001-02 was 1.18:1. This is slightly ***lower*** than in 1998-99 when it was 1.22:1.

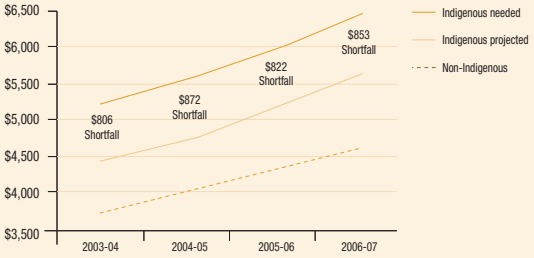
Despite the very poor health status of Australia's Aboriginal and Torres Strait Islander peoples, health expenditure per person was only slightly above that for the much healthier non-Indigenous population. **Overall, the fastest growing health spending programs are the PBS and Medicare. These are the programs Indigenous peoples have too little access to.**

Since 2001-02, the Government has increased quite significantly its expenditure under Health Budget Outcome 7 - Aboriginal and Torres Strait Islander Health which is the main funding stream for the Office for Aboriginal and Torres Strait Islander Health. Indeed, the $400m in projected Outcome 7 spending in 2006-07 is more than double the $184m it spent in 2001-02. Furthermore, the Government has heeded advice from stakeholders and has emphasised solutions to improve access to primary health care through this spending. These initiatives have been welcomed and supported by the AMA. Similarly, the AMA supports the introduction of enhanced primary care item numbers in the MBS to support Indigenous adult health checks.

The shortfall between spending and actual need is, however, very large.

In 2004, Access Economics calculated a shortfall in primary care spending of $400 million or, at that time, $806 per capita. Has the gap been closed? **The following chart seeks to answer this question.**

ESTIMATED SHORTFALL IN PER CAPITA HEALTH SPENDING ON ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES



Comparisons of gross expenditure are very misleading. The non-Indigenous population is projected to grow by only 1% to 1.1% per annum whereas Australian Bureau of Statistics projections have the Indigenous population growing in the range of 1.8% per annum to 3.4% per annum (mid-point 2.6% per annum). After adjusting for the much faster population growth and projecting current spending trends as best we are able (including the quite fast growth in Outcome 7 spending), **the AMA concludes that the gap between spending and needs is continuing to widen and now stands at $460 million a year.**

Government initiatives to increase spending and emphasise primary health care are heading in the right direction but the speed of change is too slow to close the gap.

The AMA calls on the Federal Government to commit to close the gap within five years and to—jointly with the National Aboriginal Community Controlled Health Organisation and other relevant Indigenous representatives—set standards for provision of primary health care services and core fund these at actual cost.[2] This would significantly close the gap and greatly improve the funding situation of Aboriginal Community Controlled Health Services, which struggle to provide essential services funded from a variety of sources, including core funding that does not represent current core costs.

Aboriginal Health painting **Jillie Nakamarra**

1. Australian Institute of Health and Welfare & Commonwealth Department of Health and Ageing. July 2005. *Expenditures on Health for Aboriginal and Torres Strait Islander People, 2001-02 Health and Welfare Expenditure Series No.23* **2.** Australian Medical Association. 2005. *Position Statement on Aboriginal and Torres Strait Islander Health, 2005.*

AMA DISCUSSION PAPER 2004 – UPDATE

ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH HEALING HANDS – ABORIGINAL AND TORRES STRAIT ISLANDER WORKFORCE REQUIREMENTS

Aboriginal and Torres Strait Islander Health Professionals

In 2004, the AMA called upon the Federal Government to commit to ensuring a minimum of 2.4% of each health professional group is Indigenous, by actively recruiting into training programs over 10 years.

The Australian Indigenous Doctors Association (AIDA) undertook a Best Practice in recruitment and retention of Indigenous medical students project in 2004/05 and released their findings in *Healthy Futures – Defining best practice in the recruitment and retention of Indigenous medical students.* The report found there were 76 Indigenous doctors in Australia in 2004/2005. In the same year, 102 Indigenous medical students were in training.[1]

The table shows that some medical schools are attracting more Indigenous students than others, in particular the University of Newcastle and James Cook University. If all medical schools achieved these levels of admissions within four years, Australia would be close to meeting the target of an additional 350 Indigenous medical students by 2010, and the more ambitious target of 2.4% of doctors to be Indigenous by 2014.

The *Healthy Futures* report found various ways to attract and retain Indigenous students. Such initiatives include Indigenous health support units; Indigenous staff; scholarships; recruitment workshops; role models and bridging programs. The more successful schools in terms of percentage of indigenous students had a wider range of initiatives.

University	Indigenous medical students (BPP 2004/05)*	Medical students overall (CDAMS, 2004)	Proportion of Indigenous to non-indigenous students (%)
Bond University	0	n/a**	n/a
Flinders University	2	387	0.5
Griffith University	1	n/a	n/a
James Cook University	16	388	4.1
Monash University	1	993	0.1
Notre Dame University	0	n/a	n/a
The University of Adelaide	12	809	1.5
The University of NSW	10	1274	0.8
The University of Newcastle	24	455	5.3
The University of Queensland	6	1029	0.6
The University of Sydney	7	935	0.7
The University of Tasmania	2	479	0.4
University of Melbourne	2	1533	0.1
University of Western Australia	19	869	2.1
Australian National University#	0	82	0.0
Total	**102**	**9233**	**1.1**

* Data based on voluntary identification. Numbers may have altered since the course of the Project.
** CDAMS does not carry data on privately funded medical schools.
# The Australian National University did not participate in the Best Practice Project (BPP) survey.

Healthy Futures Best Practice Framework Headline targets for 2010:

- Medical schools will have specific pathways into medicine for Indigenous Australians.
- Medical schools will fully implement the Committee of Deans of Australian Medical Schools (CDAMS) Indigenous Health Curriculum Framework.
- 350 extra Indigenous students will be enrolled in medicine.

Principles

- All Australian medical schools and principal stakeholders have a social responsibility to articulate and implement their commitment to improving Indigenous health and education; and must
- make the recruitment and retention of Indigenous medical students a priority for all staff and students and show leadership to the wider university community;
- ensure cultural safety and value and engage Indigenous people in all their work;
- adopt strategies, and initiate and coordinate partnerships that open pathways to medicine from early childhood through to vocational training and specialty practice; and
- ensure all strategies for Indigenous medical student recruitment and retention are comprehensive, long term, sustainable, well resourced integrative and evaluated.

1. **The AMA endorses the *AIDA Healthy Futures Best Practice Framework* and calls upon Australian medical schools and governments to adopt and implement the Framework.**
2. **The AMA calls on the Federal Government to fully fund the implementation of the Framework, which we estimate would cost approximately $16 million a year.**

In 2004, the AMA identified three types of funding required, but we have not yet seen the necessary investment:

a) Fully funded training places: this is already covered by mainstream fully funded medical school places;

b) Living expenses: which were identified as either scholarships or through more innovative and culturally appropriate residential provision, and would cost approximately $20,000 per person per year or $6 million a year rising to $10 million; and

c) Support units: at least 10 new units are required with an approximate cost of $10 million a year.

1. Australian Indigenous Doctors Association. September 2005. *Healthy Futures – Defining best practice in the recruitment and retention of Indigenous medical students.*