ANALYSIS OF INDIGENOUS HEALTH BUDGET 2008-09

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PREFACE

The Rudd Government has set ambitious targets for closing the gap on Indigenous disadvantage with respect to life expectancy, child mortality, access to early childhood education, educational attainment and employment outcomes and stated that this will be done in a new partnership with our Indigenous people.

Since coming to power the new Government has committed $1.2 billion in new and redirected funding to Indigenous initiatives, including ***$718.7 million / 5 years*** *in the 2008-09 Budget. The majority of the funding allocated in the Budget* ***($426.6 million / 5 years****) is provided for activities in the Northern Territory (NT), including $320.9 million in 2008-09 for activities that are part of the Northern Territory Emergency Response (NTER).*

But 'closing the gap' will require a focus well beyond the NT and substantial new long-term resources for a range of national programs.

Allowance should be made for the consultative and review processes currently in train that will inform the ongoing funding requirements of the NTER and other policies. There is also an important commitment to building the evidence base to support evidence-based policy, albeit with minimal funding at this point.

However future Budgets will need to demonstrate this ongoing commitment with new policies and additional resources. Given the Government's long-term goals for Indigenous disadvantage, especially in areas such as health, housing and education and training, and the predicted funding levels required, this is an area which should be included in future Intergenerational Reports and be subject to review by the Productivity Commission.

The highlight of the 2008-09 Indigenous Budget *is the recognition, through a number of programs to improve maternal and child health and children's early development that investing in giving children the best start in life provides them with the greatest opportunities in the future. The link between how well most children develop and their future health, wellbeing and social participation is clearly demonstrated in all recent long-term studies of child development.*

The lowlight of the 2008-09 Indigenous Budget *is the list of small one-off grants - $700,000 for playgroups, $400,000 for early childhood programs, $1.7 million for surveys and an information clearing house. This is no way to solve an entrenched problem.*

INDIGENOUS BUDGET 2008-09: OVERVIEW

The new Rudd Government's performance on indigenous policy in relation to the 2008-09 Budget must be judged against the backdrop of the continuing commitment, at least in the short-term, to the NT intervention and the promise to 'close the gap' on Indigenous disadvantage.

The Intervention

This month marks the first anniversary of the Northern Territory Emergency Response (NTER). As a response to the *Little Children are Sacred* report into the protection of Indigenous children from child abuse in the NT, the former Howard Government implemented a raft of emergency measures that went well beyond ensuring the protection of Indigenous children from harm to encompass the acquisition of township leases, the abolition of the permit system and the introduction of market-based rents.

The focus was solely on the NT, despite concerns about the welfare of children in communities in other states, and ignored the huge unmet needs of Indigenous people of all ages in both remote and urban communities around Australia.

The Howard Government, through legislation supported by the Labor Opposition, made a special appropriation to support the NTER of $587.3 million for 2007-08. No funding commitments were made beyond June 2008. More than half this appropriation ($320.8 million) was for departmental expenditure and capital items to meet the costs of increased personnel, staff accommodation, infrastructure upgrades and improved IT capacity. A total of $266.4 million was for administered expenses to implement welfare payment measures ($52.2 million), child-health check teams, follow-up medical teams and drug and alcohol teams ($72.7 million), improved childhood support services and alcohol diversionary programs ($91.2 million), improved teacher workforce capacity and increased classrooms ($16 million), and extra legal services and night patrols ($10.7 million).

Despite the hype, the roll-out of the emergency response was slow. Questions in Senate Estimates in February this year revealed that only $168.6 million of the $587 million allocated for the NTER had been spent in the six months since the appropriations legislation was passed.

Expenditure was given as:

- Employment and welfare reform $2.4 million.
- Promoting law and order $23.7 million.
- Enhancing education $1.3 million.
- Supporting families $7.0 million.
- Improving child and family health $14.9 million.
- Housing and land reform $30.4 million.
- Coordination measures $18.9 million.

The Rudd Government's approach

The Rudd Labor Government came to power in November 2007 having committed to continue the Emergency Response for at least 12 months. But the overall tone and focus was different, as exemplified when the Prime Minister said Sorry and then when the Government pledged to 'Close the Gap' on Indigenous disadvantage.

The Rudd Government has set ambitious targets for closing the gap on Indigenous disadvantage with respect to life expectancy, child mortality, access to early childhood education, educational attainment and employment outcomes:

1. To close the gap in life expectancy between Indigenous and other Australians within a generation, by 2030.
2. Ensure that the Indigenous population has the same access to health services as the rest of the population by 2018.
3. To halve the rate of infant and early childhood mortality by 2018.
4. To provide all Indigenous four-year-olds in remote communities with access to a quality preschool program within 5 years.
5. To halve the gap in literacy and numeracy achievement by 2018.
6. To at least halve the gap in attainment at Year 12 schooling (or equivalent level) by 2020.
7. To halve the gap in employment outcomes for Indigenous people by 2018.

The Prime Minister and all his Cabinet, together with outside experts, now must begin the long-term task of addressing social justice and economic independence, the medium-term task of building capacity, sustainable services and infrastructure, and the short-term task of delivering needed public health measures and primary care. And they must do all of these things simultaneously.

A 'whole of Government' approach is essential, especially in areas such as health, where meeting the targets will require more than just investment in more health services. Meeting the targets will also require a national focus beyond the NT. Only 11 percent of Indigenous Australians live in the Territory; greater Western Sydney is estimated to have the largest single Indigenous community in Australia, and these people also suffer great disadvantage.

At the national level, Indigenous funding and policy is now coordinated by the Office of Indigenous Policy Coordination within the Department of Families, Housing, Community Services and Indigenous Affairs (FHCSIA).

This Office has the following functions:

- Collaboration with other agencies in developing Indigenous policy;
- Leading negotiations on bilateral agreements with State and Territory Governments;
- Facilitating other inter-governmental processes through the COAG Working Group on Indigenous Reform and the Ministerial Council on Aboriginal and Torres Strait Islander Affairs;
- Coordinating a single Indigenous Budget; and

- Monitoring and evaluating outcomes from whole-of-government processes in Indigenous Affairs.

The Rudd Government has indicated that it will undertake discussions with Indigenous people about the best process to develop a new representative body. This follows the disbandment of ATSIC by the Howard Government and of the National Indigenous Council by the Rudd Government.

Minister Macklin announced in January 2008 that the council's term would not be renewed because "*the interests of indigenous people would be better served through a different approach*". *It would be replaced by a representative body, but the new advisory group would not be "another ATSIC*", she said.

Election commitments

The commitments to Indigenous health in the lead up to and during the campaign included:

- $92.2 million / 4 years for comprehensive Mothers and Babies Services, including home visiting (matching funding of $75 million to be sought from the States and Territories);
- $10 million capital funding pool to establish new hostels and expand existing accommodation facilities for Indigenous women who need to leave their communities when they have their babies;
- $10.3 million to tackle rheumatic fever;
- $10 million to upgrade and expand remote health care facilities in the NT;
- $5 million to establish renal dialysis facilities in remote NT communities;
- $4.6 million for sexual assault counselling in remote areas; and
- $15.9 million for alcohol rehabilitation services committed by the Howard Government in 2006.

2007-08 Additional Estimates

In the 2007-08 February Additional Estimates, the Rudd Government committed $580.0 million / 5 years in new funding and $222.5 million / 5 years in redirected funding to Indigenous issues. Of this, $313.5 million was specifically for the NTER, and another $21.9 million was for an election commitment to boost hospital and community health in the NT.

The Budget

The 2008-09 Budget provides additional funding of **$718.7 million / 5 years** for a package of 37 initiatives and programs across eight departments that are described as being about ‘closing the gap for Indigenous Australians’. Some of this funding was previously announced in February.

The majority of the funding allocated in the budget (**$426.6 million / 5 years**) is provided for activities in the NT, including $320.9 million in 2008-09 for activities that are part of the NTER.

In total, new and re-directed funding for Indigenous measures following the 2007 election and the 2008-09 Budget is **$1.2 billion/ 5 years**. Just over half this ($637.4 million) is specifically for the NTER. In this $1.2 billion package there is **$335.0 million / 5 years** for health, nutrition, alcohol and drugs, and related programs, and $151.5 million of this is for specific programs within the NTER.

The Report Card to date

The Northern Territory Emergency Response Taskforce delivered its final report to Government in June (http://www.facs.gov.au/nter/docs/reports/taskforce_report.htm). With respect to health, this report emphasized that child health checks should not be seen as a one off and recommended that the primary health care system is adequately resourced so that all children could have these on an annual basis. The report also identified the workforce side of the health intervention as critical.

Much of the focus - and the cynicism - has been on the children's health checks done as part of the NTER. A recent report (http://www.health.gov.au/internet/main/publishing.nsf/Content/NTER%20CHCI%20Progress%20Report) finds that these have been done for 63 per cent of the 17,182 children who live in eligible communities. Only 0.5 percent of children were referred to Family and Community Services on the basis of suspected instances of abuse, but physical health problems were very common and 67 percent of children were referred for at least one type of follow-up service.

Dr Bill Glasson, a member of the NTER Taskforce wrote:
"We already knew that the children in many of these communities had very high rates of chronic diseases, but have found that the situation is even worse than the official picture. … Probably 80 per cent of the Indigenous children have middle-ear diseases. Intestinal parasites and skin infections are rife. An absence of water for washing — taps don't run, toilets don't flush, there is no soap — has led to skin hygiene so poor that pathogens thrive. This in turn contributes to the devastating levels of renal disease and heart disease, the latter particularly associated with rheumatic fever. Type 2 diabetes is also increasingly common in children." (http://www.mja.com.au/public/issues/187_11_031207/gla11279_fm.html)

Most of the health checks thus far completed were done by volunteer medical professionals flown into the NT for brief periods. The call has now gone out for health professionals, doctors, specialists and nurses, to help out with the follow-up, but this type of approach to the delivery of needed health services is truly an emergency response and is not sustainable.

Only 11 percent of the Indigenous population lives in the Northern Territory, but new spending on national programs for Indigenous health in the 2008-09 Budget averages less than $40 million a year over the next five years. This level of commitment is not sufficient to make any great inroads into the Prime Minister's commitment to 'close the gap'.

The Centre for Aboriginal Economic Policy Research at ANU estimates that the funding required to achieve ‘normalisation’ and sustainable improvements in outcomes in education, housing, health and employment for Indigenous people in the Northern Territory is $4 billion / 5 years. Gavin Mooney, Professor of Health Economics at Curtin University, says that if the Government is prepared to pay up to $40,000 on pharmaceuticals to extend an Australian’s life by one year, then logic, fairness and justice would suggest that the Government is prepared to spend up to $340 billion to bridge the 17 year mortality gap for all Indigenous people.

The fact is that a lot of money, manpower, effort and goodwill over a time-frame that spans more than one generation will be needed from all levels of government and from both black and white communities if we are to finally to close the gap and eliminate endemic Indigenous disadvantage.

On that basis, this Budget makes a very small down-payment on a major debt.

2008-09 INDIGENOUS BUDGET: ANALYSIS

In the 2007-08 February Additional Estimates, the Rudd Government committed **$580.0 million / 5 years** in new funding and **$222.5 million / 5 years** in redirected funding to Indigenous issues. Of this, **$313.5 million** was specifically for the Northern Territory Emergency Response (NTER), and another **$21.9 million** was to boost hospital and community health in the Northern Territory (NT) (an election commitment).Many of these initiatives are also included in the 2008-09 Budget, and every care has been exercised to ensure that spending is not double counted.

In total, new and directed funding for Indigenous measures following the 2007 election and the 2008-09 Budget is **$1.2 billion/ 5 years**. Just over half this **($637.4 million**) is specifically for the NTER. In this $1.2 billion package there is **$335.0 million / 5 years** for health, nutrition, alcohol and drugs, and related programs, and **$151.5 million** of this is for specific programs within the NTER. This means that new spending on national programs for Indigenous health averages less than **$40 million / year** over five years.

The 2008-09 Budget provides additional funding of **$718.7 million / 5 years** for 37 measures across 7 policy priorities (see Table 1) for a package of initiatives and programs that are described as being about 'closing the gap for Indigenous Australians'. This package is set out separately in the Budget under the heading 'Whole of Government", acknowledging the way in which Indigenous issues will be delivered by the Rudd Government.

The majority of the funding allocated in the Budget **($426.6 million / 5 years**) is provided for activities in the NT, including **$320.9 million in 2008-09** for activities that are part of the NTER. Provision has been made in the Contingency Reserve for ongoing costs associated with the NTER (BP2 p.299). Ongoing funding requirements for the NTER are to be reviewed prior to the 2009-10 Budget and will be based on an evaluation due for completion by the end of the year.

On June 6 2008, the Federal Indigenous Affairs Minister, Jenny Macklin, announced an 11-member board, headed by the former head of the Kimberley Land Council, Peter Yu, to review the progress and impact of the NTER. The board will report at the end of September, 2008.

Other evaluations are also underway. In May, the Department of Health & Ageing (DoHA) called for tenders for a consultant to conduct an evaluation of the NTER Improving Child and Family Health and Expanding Health Service Delivery, Drug and Alcohol Response Measure. The contract period is from 7 July 2008 to 30 June 2009.

Table 1 New Funding by portfolio

This is not an inclusive list of all funding announcements

Area	2007-08 Additional Estimates	2008-09 Budget	Total commitment following the 2007 election	Total spending on national programs
Health, including substance abuse	$304.5m	$30.5m	$335.0m	$183.5m
Child protection and welfare reform	$160.4m	$164.4m	$324.8m	-
Education and early childhood development	$115.4m	$107.8m	$223.2m	$101.9m
Employment and training	$97.6m	$4.4m	$102.0m	$102m
Law and order	$22.4m	$29.3m	$51.7m	-
Social justice, legal rights, native title	$21.2m	$6.8m	$28.0m	$21.2m
Administration, personnel costs	-	$70.2m	$70.2m	-

The only national health programs funded are those included in the 2007-08 February Additional Estimates – Maternal and Child Health ($90.3m); Reducing Rheumatic Fever ($11.2m); Expansion of Drug and Alcohol Services ($49.3m); Indigenous Health Workforce ($19m); Indigenous Tobacco Initiative ($14.5m) – a total of **$184.3 million / 5 years, or an average of $37 million / year**.

This level of funding, if sustained over the forward estimates, is clearly inadequate if the Prime Minister's 'closing the gap' goals are to be effectively addressed in the given time frame. Substantial new funds will be required over the next decade**.**

BUDGET SPENDING ON HEALTH AND RELATED MEASURES THAT ARE PART OF THE NTER

Continuation of early childhood program ($400,000 in 2008-09)

This funding is for the continued operation of four early childhood services that provide early intervention support for families, including addressing violence, child development and wellbeing needs, and links to assistance with housing, health and education services.

The four services are:

- the Council of Aboriginal Alcohol Program Services in Darwin, NT;
- the NPY Women's Council Child Nutrition Program in the NT;
- Let's Start: Exploring Together for Indigenous Preschools in the NT; and
- Core of Life across Australia.

Around 90 Indigenous children and their families will be helped by the ongoing funding.

This funding, at $100,000 per service, per year, seems minimal, with little room for further expansion of services.

Crèches ($2.3 million in 2008-09)

This funding is to provide for the operating expenses of 10 crèches in the NT. It is expected that these crèches will assist in the delivery of childhood immunization and health screening, parenting support, nutrition programs, and child abuse prevention.

School nutrition programs ($7.4 million in 2008-09)

School nutrition programs aim to improve school attendance, student performance and health, and provide employment opportunities for local Indigenous people. Providers of these programs for breakfast and lunch may include aged care centre, child care centre, NGOs, and private businesses.

School nutrition programs are currently in place in 49 communities and 7 town camps.

It was the policy of the previous Government that parents will contribute to the cost of this program through income management if they are on welfare, and that income management would be linked to school attendance in 2008. It is not clear if this policy still applies.

Youth alcohol diversion activities ($9.5 million in 2008-09)

These activities are directed at young people aged 12 to 18 years. This funding is for:

- the establishment and operation of a NT Regional Youth Development Network to improve the quality, quantity and coordination of diversionary activities such as sport;
- the continuation of the Alice Springs Town Youth Diversion Project; and
- the Central Australia School Holiday Program.

Some of the funds for these activities have gone to Mission Australia which has recently admitted that high staff turnover has meant it has struggled to deliver youth services in

Central Australia.

Follow-up care for problems identified through health checks ($13.6 million in 2008-09)

This funding is for follow-up services for those children identified through health checks as needing further care. Current figures suggest that this is 67 per cent of the total eligible population of 17,182 children. On that basis this funding provides $1,181 /child. On average each child was referred for 1.4 services, so this is equivalent to $843, per child, per procedure.

The adequacy of this funding level depends on the services each child requires. But given that this money is available only for those children who have been examined and referred for further services which will be provided in 2008-09, it leaves open the question of where is the funding to address every child's need and to provide all the follow-up and treatments required in future years.

NTER Child Health Checks Initiative

Voluntary health checks for all Indigenous children under the age of 16 years were highlighted as a key component of the Howard Government's emergency response to the *Little Children are Sacred* report. There are an estimated 22,000 children under the age of 16 in the NT, and about half of these are in the communities that have been identified as within scope of the NTER.

The purpose of a child health check is to identify significant health issues and to plan follow-up treatment. It will be comprehensive and evidence-based. Specifically, the check includes:

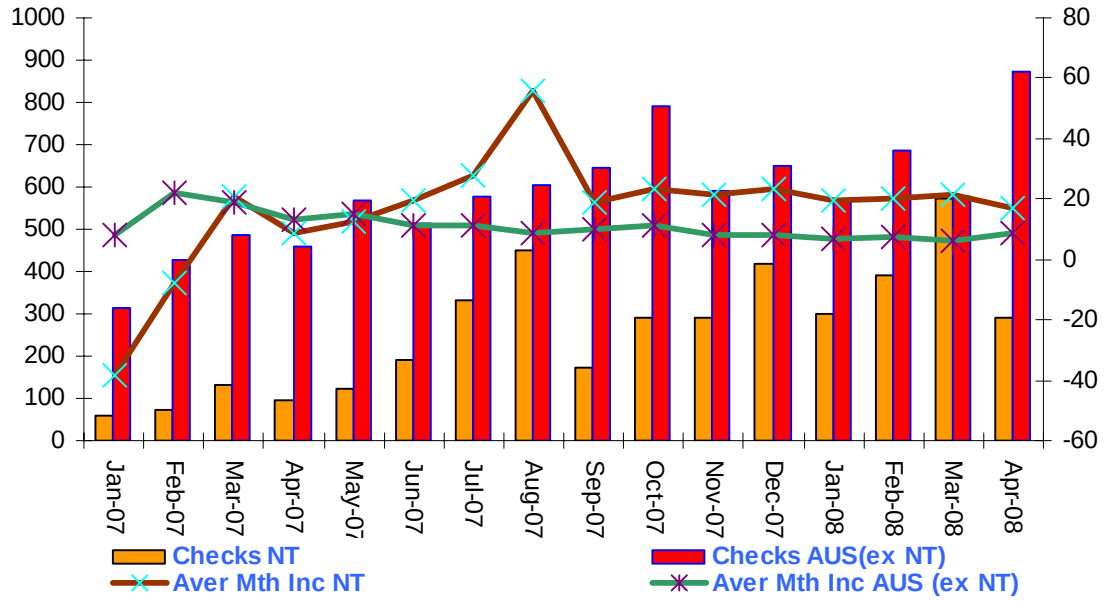
- A history of medical conditions including general health, immunisations and development;
- A family history including living conditions and any relevant social problems;
- An examination as routinely done by doctors in general practice including height, weight, eyes, ears, teeth, skin, heart sounds, lungs, abdomen;.
- A finger prick blood test for anaemia, and possibly glucose in older children; and
- Other tests or investigations as indicated, such as a full blood count, urine for infection and hearing testing.

Forensic examinations are not part of the health check. If evidence of sexual abuse is elicited in the history or examination, it will be reported as per mandatory Northern Territory requirements.

The child health checks conducted under the NTER are the same as the Aboriginal and

Torres Strait Islander Child Health Check (Medicare Item 708) that has been in place since May 2006. An analysis of the number of services delivered under MBS item 208 for the NT and all the other States shows that there was an increase in the average monthly rate of increase for the use of these check in the NT that was not sustained in the following months. No similar increase was observed for the rest of Australia (see Chart 1).

Chart 1 Average monthly increase in ATSI child checks



Results of the NTER Child Health Checks Initiative

A recent report by DoHA has analysed the results of checks undertaken between July 2007 and May 2008 (http://www.health.gov.au/internet/main/publishing.nsf/Content/healthoatsih-nt).

The report shows that by 15 May 2008, approximately 10,900 Child Health Checks had been undertaken in the prescribed areas of the NTER, representing 63 per cent of the 17,182 children who are eligible for the checks. Most of these health checks were carried out as part of the NTER, but some Medicare health checks are included (although from the data, clearly very few). The information provided in the report relates to 7,733 children for whom the Australian Institute of Health and Welfare (AIHW) had entered information into the Child Health Check Initiative database.

Key findings in the report:

- Over 77per cent children were identified as living in a household with a smoker;
- 71 per cent of children aged less than 1 year were at risk of Sudden Infant Death Syndrome (SIDS) due to bed sharing, while 37per cent were at risk due to exposure to tobacco smoke and 33per cent due to soft sleeping surfaces and loose bedding;
- 40 per cent of children had untreated dental decay and 6 per cent had gum disease;
- 29 per cent of children had disease;
- 16 per cent of children were identified as having anaemia and this rate was higher for children aged 0 to 5 years (25 per cent);
- Immunisations were due for 16 per cent of children;

- 10 per cent of children were reported to have 4 or more skin sores;
- 8 per cent of children had scabies; and
- 5 per cent of children were considered to be stunted (i.e., short for their age); 10 per cent were assessed to be underweight (light for their age) and 5 per cent of children were overweight (heavy for their height).

Of the 7,733 children for whom CHC forms have been analysed to date, 0.5 per cent (42) forms documented a referral to Family and Community Services on the basis of suspected instances of abuse (physical, emotional, sexual, or neglect).

A summary of referrals and treatment is as follows:
- 67 per cent of children seen were referred for at least one type of follow-up service;
- 38 per cent of children required a primary care clinic follow-up;
- Dental referrals were made for 32 per cent of children and the percentage of children aged 6 to 11 years (45 per cent) referred for dental services was twice that of children 0 to 5 years of age (22 per cent);
- 12 per cent of children were given a paediatric referral;
- 12 per cent of children received a referral for tympanometry and audiology;
- 8 per cent of children had a referral to an Ear, Nose and Throat (ENT) specialist;
- 3 per cent of children were referred to a cardiologist or for cardiac investigations; and
- 6 per cent of children received a vaccination during their health check.

Some of these figures, particularly those for ENT problems, seem at odds with the report published in the Medical Journal of Australia in late 2007 by Dr Bill Glasson, a member of the NTER Taskforce.
He wrote*:*
"We already knew that the children in many of these communities had very high rates of chronic diseases, but have found that the situation is even worse than the official picture. … Probably 80 per cent of the Indigenous children have middle-ear diseases. Intestinal parasites and skin infections are rife. An absence of water for washing — taps don't run, toilets don't flush, there is no soap — has led to skin hygiene so poor that pathogens thrive. This in turn contributes to the devastating levels of renal disease and heart disease, the latter particularly associated with rheumatic fever. Type 2 diabetes is also increasingly common in children."
(http://www.mja.com.au/public/issues/187_11_031207/gla11279_fm.html)

What else needs to be done for children's health?
Most of the health checks thus far completed were done by volunteer medical professionals flown into the NT for brief periods. The call has now gone out for health professionals, doctors, specialists and nurses, to help out with the next phase of the intervention in Indigenous communities.

This type of approach to the delivery of needed health services is truly an emergency response and is not sustainable. Research by the Darwin-based Menzies School of Health has found that health checks as part of the Northern Territory emergency response will not be successful unless follow-up checks are done. Dr Jonathan Carapetis says initial

medical checks might successfully identify a problem, but ongoing programs are needed to deal with that problem over the longer term.
"*So the idea of flying a whole team in undertaking health checks and then just having a once-off simple follow up for kids with ear infections and kids with teeth problems which is the current major plan is not enough.*"

BUDGET SPENDING ON HEALTH AND RELATED MEASURES THAT HAVE A NATIONAL APPLICATION

Most of these programs are funded for five years (2007-08 to 2011-12) or four years (2008-09 to 2011-12), some are funded for less than this, including a number of programs which have no funding provided for 2011-12.

Bringing Them Home counsellors and Link-Up services ($15.7m / 4 years)

This funding is to provide for 20 additional Bringing Them Home (BTH) counsellors by 2010-11, targeted to areas of need, and is described as enabling over 1000 members of the Stolen Generations to reunite with their families through access to Link-Up services. The new funding has the potential to increase the number of counsellors by 100 percent, but there may be problems in recruiting this many new staff.

The BTH counsellors program currently provides funding for over 100 counsellor positions in approximately 70 Aboriginal and Torres Strait Islander Community Controlled Health Services across Australia to provide counselling to individuals, families and communities affected by past practices regarding the forced removal of children from Indigenous families.

The majority of BTH counsellors is Indigenous, though the proportion has declined slightly over the years, from 72 per cent in 2001-02, to 62 per cent in 2004-05. For 2006-07, 23 per cent of BTH services reported operating without a BTH counsellor. This was a significant decrease over the 29 per cent reported for 2002-03. At least in part, these data reflect the difficulties of recruiting and retaining appropriate counselling staff.

The Link-Up program funds 11 Link Up Services across the country – 5 in Western Australia, 2 in NT, and 1 each in Queensland, New South Wales, Victoria and South Australia.

About the Bringing Them Home program

The Bringing Them Home Program was established in 1997 as a part of the Australian Government's response to the Human Rights and Equal Opportunity Commission's publication Bringing Them Home.

The Australian Government's initial allocation of $63 million over the four year period 1998-2001, provided:

- $16m for the BTH Program;
- $17m for education and training, including the Social and Emotional Wellbeing Regional Centres (SEWB RCs);

- $11.25m for the establishment of a national network of Link-Up services;
- $5.9m for parenting support programs;
- $9m to support Indigenous languages and culture; and
- the remainder to support smaller projects relating to archiving, preservation of records and oral history recordings.

Funding for the BTH Program, the Link-up Program and the SEWB RCs has now been rolled into the base funding of DoHA, and is allocated on an annual basis. For 2006-07, $24 million was allocated for the four programs: BTH Program, Link-Up Program, the SEWB RCs, and the Mental Health Programs. Of this, $11.1 million is allocated to the BTH Program.

The BTH Program was included in an independent evaluation undertaken by Urbis Keys Young for OATSIH. The report 'Evaluation of the Bringing Them Home and Indigenous Mental Health Programs' was publicly released in May 2007. The evaluation found that there is a significant level of unmet demand for the services, services are under-resourced for the high workloads currently experienced, and the demand for services is likely to continue to be at least the same level for the foreseeable future.

Child and maternal health services ($90.3 million / 5 years)

The funds provided include $58.0 million to expand health education, treatment and care services to Indigenous mothers, babies and children. This includes funding for the screening and treatment of sight, hearing and other development issues through primary school.

A further $32.2 million is provided for home visits by nurses to Indigenous children in rural areas for children up to 8 years of age. This will build on current funding for the Health @ Home Plus program.

Infrastructure support, up to $14.2 million, will be provided (presumably from the $32.2 million) to fund additional accommodation for health professionals and home visiting services in rural and remote locations.

The plan, involving 1900 indigenous families being seen by nurses over the next five years would initially establish up to 10 sites across the nation to support the program, which is based on the Nurse Family Partnership, pioneered in the US by Professor David Olds, the Director of the Prevention Research Centre for Family and Child Health at the University of Colorado.

A contribution of $75 million will be sought from State and Territory Governments to provide further child and maternal services. Most of the States and Territories have maternal and child health programs targeting Indigenous families. Reports on maternal and child health services in Queensland, Central Australia and Victoria are available at http://www.health.gov.au/internet/h4l/publishing.nsf/Content/respackscopingreports .

Related initiatives

This funding package builds on a number of initiatives set up by the previous Government.

- Healthy for Life was announced in the 2005-06 Budget, with funding of $102.4 million / 4 years to improve the health of Indigenous mothers, babies and children and the quality of life of people with a chronic condition.

- Health@Home was funded with $37.4 million / 4 years in the 2007-08 Budget to deliver nurse-led home visiting services to Indigenous children in targeted areas, from birth to two years of age. The initiative also provides home-based child and family health support for high need Indigenous children aged two to eight years.

- The 2007-08 Budget also provided $38.2 million / 4 years for Family Centred Primary Health Care, to expand existing Indigenous primary health care service delivery by funding up to 45 additional health professionals, new and upgraded buildings and clinics in six rural and remote areas and business management training for 100 Indigenous health service managers. The Howard Government had not rolled any of this funding out. In April Health Minister, Nicola Roxon, announced six sites at a cost of $18 million, but total funding for this initiative was then given as only $28.5 million / 4 years.

Reducing rheumatic fever ($11.2 million / 5 years)

This funding is to establish a national unit to coordinate efforts to tackle rheumatic fever in Indigenous children and establish program sites in NT, WA and Queensland to provide diagnosis and improved access to antibiotics.

The incidence of acute rheumatic fever among Indigenous children aged 5-14 years in the Top End of the Northern Territory is about 250 per 100,000 and in Central Australia it is about 150 per 100,000. High incidence rates have also been reported in the Kimberley Regions of WA and in Far North Queensland. There is some evidence of increasing rates in Central Australia. Recurrent infections of rheumatic fever lead to long term heart damage, so it is necessary to take prophylactic doses of antibiotics routinely for some years after an initial infection.

The prevalence of rheumatic heart disease is around 17 per 1,000 among Indigenous people in the NT and less than 2 per 1,000 among other Australians. In Central Australia the prevalence is around 13 per 1,000 Indigenous people compared to less than 1 per 1,000 for other Australians living in the region. Cases of rheumatic fever in non-Indigenous children are now almost unknown.

Indigenous people are 6-8 times more likely to be hospitalised for acute rheumatic fever and rheumatic heart disease and 20 times more likely to die from these diseases as other Australians. Among Indigenous people receiving heart valve surgery for rheumatic heart disease, nearly 45 per cent are less than 25 years of age. By contrast, just 4 per cent of these procedures are performed on other Australians of the same age.

Expansion of drug and alcohol services ($49.3 million / 4 years)
This funding is to expand current rehabilitation and treatment services, especially in remote areas. It will enable the construction or expansion of residential rehabilitation facilities, increased staff and staff accommodation, and the establishment of community-based multidisciplinary teams to counter substance abuse.

The 2007-08 Budget increased the funding for the National Illicit Drug Strategy - Indigenous Communities initiative to a total of $14.6 million / 4 years. These funds were to assist communities to develop and implement local solutions to address drug and alcohol abuse needs to be sustained and supported by alcohol and drug services.

Finding up-to-date data on Indigenous-specific funding and commitments for drug and alcohol services is difficult. A 2002 report from the Centre for Aboriginal Economic Policy Research at the Australian National University found that through the Office for Aboriginal and Torres Strait Islander Health (OATSIH), the Commonwealth was then funding 26 residential rehabilitation programs in rural and urban areas for Aboriginal people with alcohol and/or other drug problems. These programs were designed for individuals with problems of dependence or long-term use, and provide stays of varying periods, from a few weeks to several months.

There were three more OATSIH-funded programs, located in outback Central Australia. They are outstation-based, and target petrol sniffers. In addition, there are Indigenous residential programs which are primarily State-funded, and which may receive additional small grants from OATSIH. Altogether across Australia in 1999–2000 there were 33 residential facilities for Indigenous drug and alcohol treatment.

Indigenous tobacco initiative ($14.5 million / 4 years)
The cost of this measure is being met from within the existing resources of DoHA.

This funding represents the first significant effort to tackle the high rates of Indigenous smoking. Funding will be used to support research into effective anti-tobacco strategies, trialing innovative interventions and community activities, and offering smoking cessation training to staff working in Indigenous health.

Half the adult Indigenous population smokes and smoking rates are even higher in younger age groups, reaching 57 percent for men aged 35-44 and 54 percent for women aged 25- 44. In some remote communities up to 80 percent of the population, across all age groups, smokes. More than half of Indigenous mothers report having smoked during pregnancy.

Indigenous smoking is linked with higher rates of disability and long-term health problems, psychological distress and illicit substance use. Mothers who smoke increase the likelihood of having low birth weight babies, and there are significant links between low birth weight and hypertension and renal disease in later life.

Much of the chronic disease burden borne by Indigenous people can be attributed to tobacco use. The cardiovascular disease death rate for Indigenous people aged between 25 and 54 years is at least eight to ten times higher than for other Australians. There are higher rates of smoking-related cancers.

Tobacco use is responsible for more Indigenous deaths than alcohol. About one in ten deaths of Indigenous people is due to respiratory disease, a rate that is 30 percent higher than the Australian average, and hospitalisations for respiratory disorders are twice as high in the Indigenous population.

Indigenous mothers' accommodation fund ($10 million / 3 years)

This initiative will provide $10 million through capital funding grants over the next three years for accommodation for Indigenous women from remote communities who need to travel to regional and urban centres to have their babies. The funds will be used to establish new hostels and expand existing accommodation.

Closing the evidence gap ($1.7 million / 2 years)

It is encouraging to see specific funding provided to address data gaps to improve Indigenous policy making, but disheartening to see that these funds are so little, are only for 2 years, and will come too late to inform decisions for around ongoing funding requirements for the NTER which must be made prior to the 2009-10 Budget.

The Budget papers state that this measure will include an extension to the National Aboriginal and Torres Strait Islander Social Survey to provide more data on the wellbeing of Indigenous children. A clearing house will also be established to gather and disseminate evidence on effective policy interventions for Indigenous children.

Interestingly, there is no reference to 'Footprints in Time', the proposed Longitudinal Study of Indigenous Children managed by the DFHCSIA.

As it currently stands, the data on health outcomes for Indigenous people is not very robust. For example, that Australian Bureau of Statistics estimates that only 56 per cent of Indigenous deaths are registered accurately as Indigenous. AIHW analyses into the quality of Indigenous identification of hospital admitted patient statistics has shown that while the quality is good in some jurisdictions, in other jurisdictions it is not sufficiently comprehensive or robust. Consequently, Indigenous hospitalisation data are only available for Queensland, WA, SA and the NT. Data from NSW, Victoria, Tasmania and the ACT were considered to be of insufficient robustness.