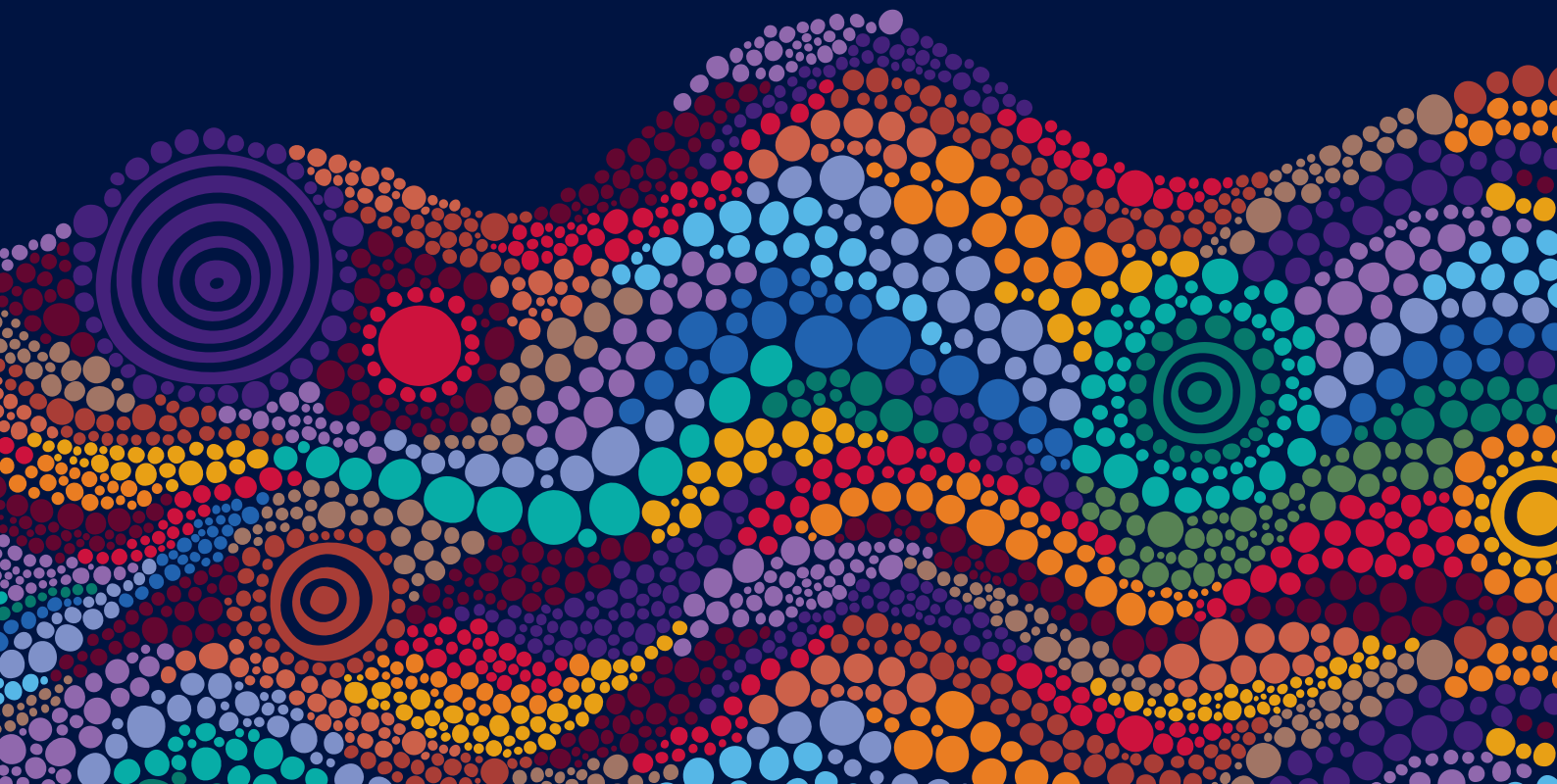
NACCHO
National Aboriginal Community Controlled Health Organisation

NACCHO Key Facts

November 2024



Our Story

The first Aboriginal community controlled health organisation (ACCHO) was established at Redfern in 1971 as a response to the urgent need to provide decent, accessible health services for the largely medically uninsured Aboriginal population of inner Sydney. Mainstream medical services were not working. This is how, more than 50 years ago, Aboriginal people took control and designed and delivered their own model of health care.

ACCHOs quickly sprang up around the country. In 1974, a national representative body was formed. This has grown into what NACCHO is today. All this predated the introduction of Medibank in 1975.

The primary health care approach developed in the 1970s by Redfern and other early ACCHOs was innovative. It mirrored international aspirations at the time for accessible, effective and comprehensive health care with a focus on prevention and social justice. It even foreshadowed the WHO Alma-Ata Declaration on Primary Health Care in 1978.

Closing the health gap

Men

71.9 years

Aboriginal and Torres Strait Islander

Women

75.6 years

Aboriginal and Torres Strait Islander

80.2 years

Other Australians

The life expectancy gap.
Aboriginal and Torres Strait Islander people can expect to live 8 years less than other Australians.

Closing the Gap requires the **rate of improvement** in Aboriginal and Torres Strait Islander health to be faster than the rate of improvement in the health of other Australians.

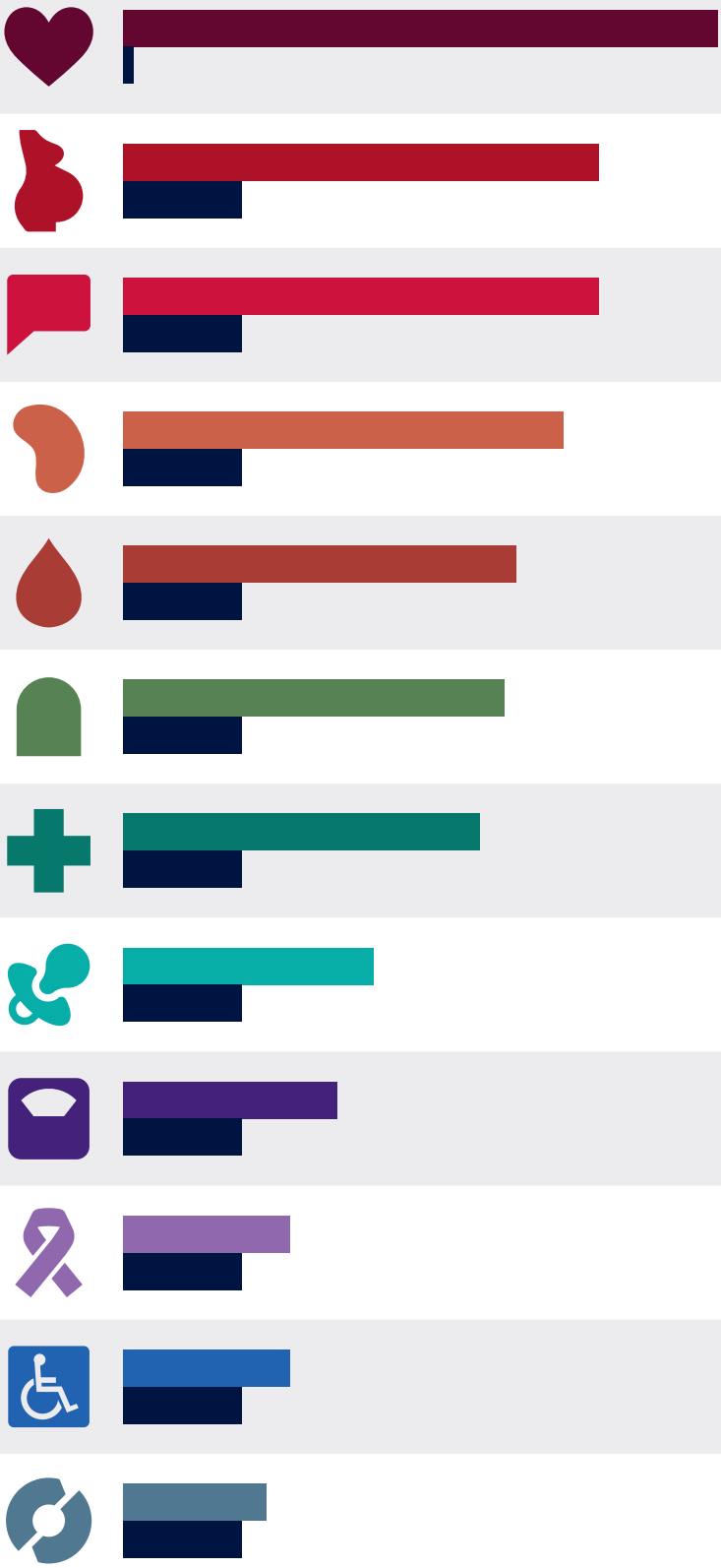
83.4 years

Other Australians

Source: AIHW, *National Health Performance Framework*

The health gap

Aboriginal and Torres Strait Islander people are:



×55 more likely to die as youths from **rheumatic heart disease**

×4.0 more likely to **smoke during pregnancy**

×4.0 more likely to experience **racism in health settings**

×3.7 more likely to have **kidney disease**

×3.3 more likely to have **diabetes**

×3.2 more likely to **suicide as youths**

×3.0 more likely to have a **preventable hospitalisation**

×2.1 more likely to **die in infancy**

×1.8 more likely to be born with **low birthweight**

×1.4 more likely to **die from cancer**

×1.4 more likely to have a **disability**

×1.2 more likely to have **circulatory disease**

Aboriginal and Torres Strait Islander
Other Australians

Sources:
ABS; NATSIHS; AIHW, *National Health Performance Framework*

Preventable hospitalisations and avoidable deaths

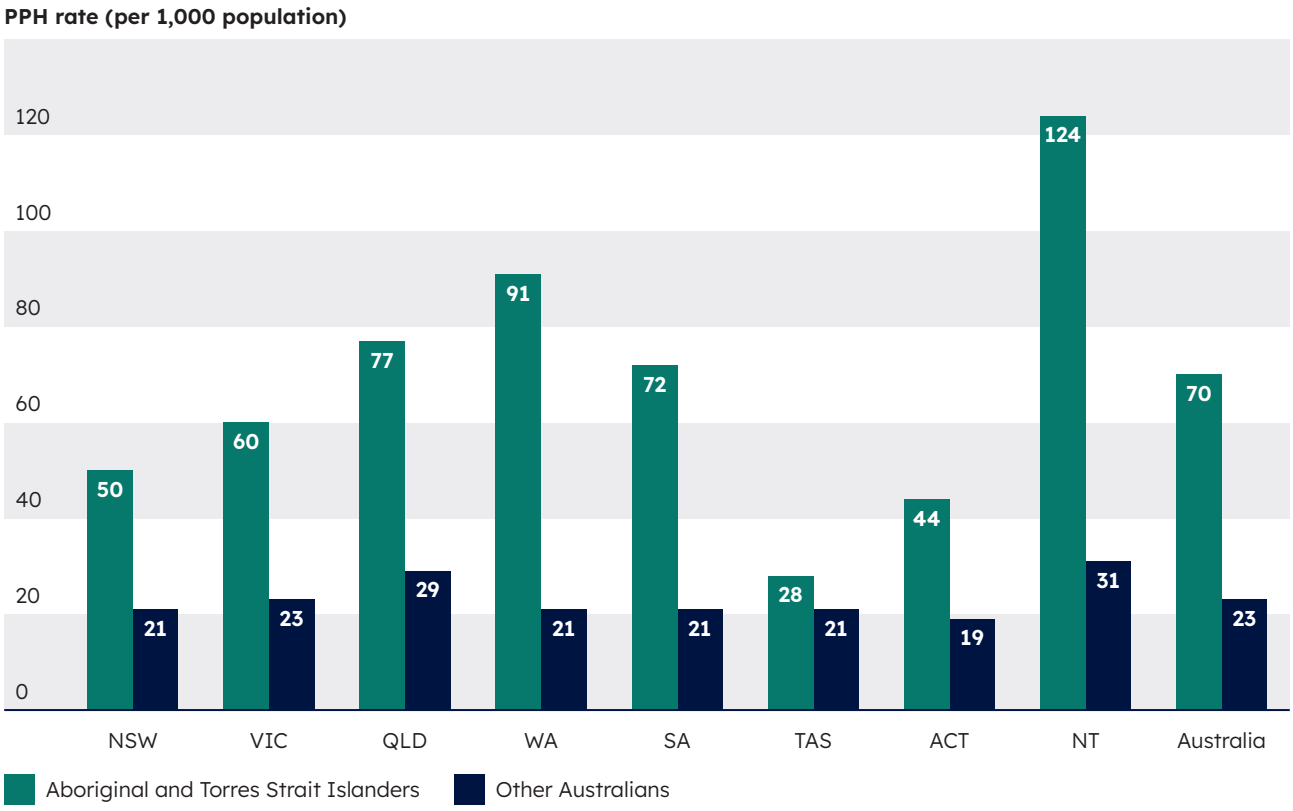
Preventable hospitalisations

91,700

In 2019–21, there were 91,700 hospitalisations of Aboriginal and Torres Strait Islander people which were preventable

×3 higher

The rate of preventable hospitalisations per 1,000 was three times higher for Aboriginal and Torres Strait Islander people than for other Australians



Source: AIHW, 3.07 Selected potentially preventable hospital admissions

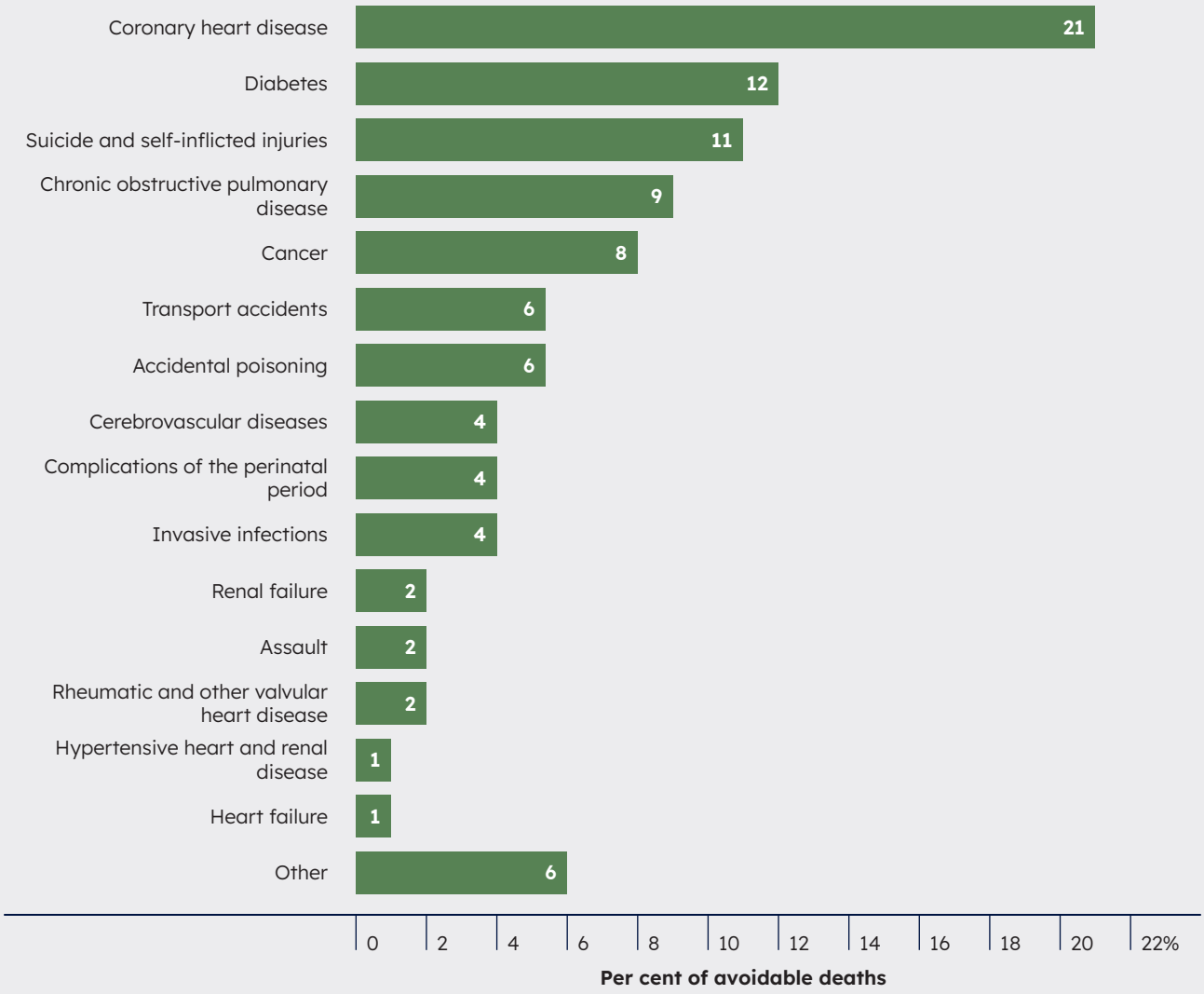
Avoidable deaths

×4 higher

Avoidable deaths are four times higher for Aboriginal and Torres Strait Islander people than for other Australians in remote areas and twice as high in urban and regional areas

21%

The top cause of avoidable death was coronary heart disease



Source: AIHW, 1.24 Avoidable and preventable deaths

Social and emotional wellbeing challenges for Aboriginal and Torres Strait Islander people

39%

eat **enough fruit** and only 4 per cent eat **enough vegetables**

~20%

of children under 15 drink **sweetened soft drinks** every day

1/5

About 19 per cent (or 146,700 people) did not go to the **dentist** when they needed to in 2019

37%

smoke every day

28%

have **used substances** for non-medical purposes in the last 12 months

1/10

individuals have reported **depression** in the past 12 months

×3.2

The **youth suicide rate** for Aboriginal and Torres Strait Islander people is 3.2 times higher than the rate for other Australians

Sources: ABS, NATSIHS; AIHW, *National Health Performance Framework*

What our sector looks like

We are here for the long haul

54 years+

The **ACCHO model** was developed more than 54 years ago (since the first Aboriginal medical service was established at Redfern in 1971)

~7,000 staff

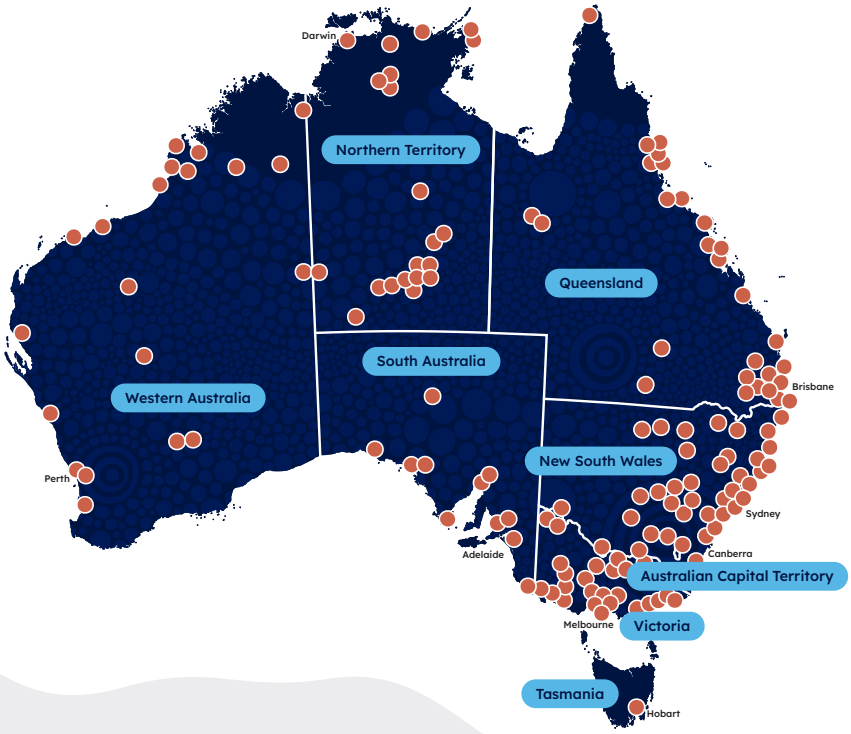
of whom **54 per cent are Aboriginal or Torres Strait Islander people** (in excess of 3,700), work in more than 550 clinics

Top 3 employers

The ACCHO sector is among the top three **employers of Aboriginal and Torres Strait Islander people** in Australia.

146 members

in a **national footprint**



Sources: NACCHO data; AIHW, *Aboriginal and Torres Strait Islander Health Organisations: Online Services Report*

Our client base is expanding rapidly

In **2014** ACCHOs collectively serviced about

420,000 people

In **2022** ACCHOs serviced about

590,000* people

In eight years, our client base has increased by

40%

We need more ACCHOs

Nationally, 20% of Aboriginal and Torres Strait Islander people said they wanted to access an ACCHO but were unable to do so, where they were living.

***NB:** this includes increased COVID coverage during the pandemic.

Sources: AIHW, *Aboriginal and Torres Strait Islander Health Organisations: Online Services Reports*

ACCHOs providing value for money

We punch above our weight

We deliver almost 3.6 million episodes of care per year.

We deliver almost 1 million episodes of care per year in remote areas.

We contact each client, on average, 13 times per year

We are doing more than our mainstream counterparts, even with 62 per cent less funding than they receive per clinic.

Compared to similar-sized GP clinics, ACCHOs receive $920,000 less in mainstream funding each year ($0.56 m vs $1.48 m), yet our caseload has greater health needs and 2.3 times the burden of disease and, therefore, higher costs.

Sources: AIHW, *Aboriginal and Torres Strait Islander Health Organisations: Online Services Report*; Department of Health: *Review of General Practice Incentives*

Cost benefit

$1.19 : $1	Our cost benefit per dollar spent is $1.19. In remote areas our cost benefit can be **fourfold**
+50%	The **lifetime health impact** of interventions delivered by ACCHOs is 50 per cent greater than that of mainstream health services
Not-for-profit	All revenue is **re-invested** into our clinics

Sources: Vos, et al. *Assessing Cost Effectiveness in Prevention*; Ong, et al., 'Differences in Primary Health Care Delivery to Australia's Aboriginal and Torres Strait Islander Population', *BMC Health Services Research*

Community control and community trust

Our COVID success story: proving the impact of community control

COVID-19

has highlighted the unique capacity of the ACCHO sector to respond rapidly and effectively in a national health crisis. Fears of the catastrophic effect of the virus in Aboriginal and Torres Strait Islander communities led to a response that has since been recognised internationally. Well before the pandemic was declared by the World Health Organization (WHO), the sector had mobilised.

2,000

lives saved during the pandemic

It was estimated that, in the first 30,000 deaths from COVID-19, that over 2,270 of these would be Aboriginal and Torres Strait Islander people (based on population share and burden of disease). In the first 30,000 deaths only about 250 Aboriginal and Torres Strait Islander people, tragically, lost their lives. The sector's unique community-controlled response saved over 2,000 lives.

Overseas

Indigenous populations (with similar rates of comorbidity) have been the worst affected. For example: the Navajo have the highest death rate in the USA.

Sources
Department of Health, *Coronavirus (COVID-19) case numbers and statistics*; F. Stanley in *Australian*, 11 August 2021; Prime Minister's Closing the Gap statement, 5 August 2021; J. Arrazola, M. M. Masiello, S. Joshi, et al., 'COVID-19 Mortality Among American Indian and Alaska Native Persons: 14 States, January-June 2020' in *Centre for Disease Control and Prevention MMW Report*, no. 69, 2020, pp. 1,853-6

Women, children and families trust our service

90%

Aboriginal community control ensures accountability and value at the local level

53%

of our clients are women

Aboriginal community control ensures accountability and value at the local level

Sources: Vos, et al. *Assessing Cost Effectiveness in Prevention*; Ong, et al., 'Differences in Primary Health Care Delivery to Australia's Aboriginal and Torres Strait Islander Population', *BMC Health Services Research*

1 in 3

Aboriginal and Torres Strait Islander people have experienced racism in Australia's health care system

50%

of the ACCHO sector's workers are Aboriginal or Torres Strait Islander people compared with 1% of health workers across Australia

Our clients 'stick'

Utilisation rate and adherence rate is higher for ACCHOs (73.2% and 95.7% respectively) compared to mainstream GP services (60% and 77.8%)

Regional and remote communities

	Metropolitan Aboriginal	Regional Aboriginal	Remote Aboriginal	Likelihood factor (remote : metro)
Population	41%	44%	15%	n/a
Health factors				
Life expectancy	74.5	74.8	69.3	5.2 years less; or 7% less
Avoidable deaths	142/100,000	182/100,000	329/100,000	2.3 times
Preventable admissions	40/1000	48/1000	94/1000	2.4 times
Hospital – no 'procedure'	70%	67%	57%	1.2 times
Birth weight	8.3%	9.3%	13.2%	1.6 times
Cancer deaths		90/100,000	126/100,000	1.4 times
ARF/RHD hospitalisation		30/100,000	330/100,000	11 times
Respiratory hospitalisation	27%	34%	61%	2.3 times
Diabetes		12.5%	19.5%	1.6 times
Kidney failure		17.5/100,000	128.5/100,000	7.3 times

Sources: Sources: ABS, AIHW

We know our mob

~1,000,000

ACCHOs deliver about 1 million **episodes of care** per year in remote areas

Local jobs

We provide some of the **best local jobs** in remote communities

We are the only health network with a

truly national footprint

In the wake of the catastrophic 2019–20 bushfires in south-eastern Australia, ACCHOs stepped in to

support their communities

We ran the **vaccinations**, closed remote communities when necessary, and did the

contact tracing

Sources: NACCHO; AIHW, *Aboriginal and Torres Strait Islander Health Organisations: Online Services Report*; Deloitte Access Economics (*Report for Danila Dilba*)

Funding shortfalls

How can the health gap close if the funding gap persists?

$4.4 billion

In 2022 Equity Economics estimated that the current gap in health expenditure is $4.4 billion per year

$2.6 billion

The Commonwealth's share of this funding gap is $2.6 billion

$7,365 per year

Current health expenditure per capita for other Australians

×2.03

Aboriginal and Torres Strait Islander people experience disease burden at 2.3 times the rate of other Australians, which translates into 2.03 times the cost-of-service delivery for Aboriginal and Torres Strait Islander people

Conservatively estimating the need for two times the expenditure to take account of this greater prevalence of disease

$14,967

(2.03 × $7,365)

Health spending for Aboriginal and Torres Strait Islander people should be in the order of $14,967 per person per year (2.03 x $7,365)

$9,925

per capita

But current expenditure per capita for Aboriginal and Torres Strait Islander people is $9,925

$5,042 gap

($14,967 – $9,925)

The gap in expenditure to achieve equitable spending based on need is $5,042 per person per year ($14,967–$9,925)

863,576

There are an estimated 863,576 Aboriginal and Torres Strait Islander people in Australia, based on latest ABS projections

$5,042 × 863,576 = $4.4 billion

Therefore, the additional expenditure required to achieve equitable health spending based on need for Aboriginal and Torres Strait Islander people is approximately $4.4 billion per year ($5,042 per person per year x 863,576)

Source: Equity Economics

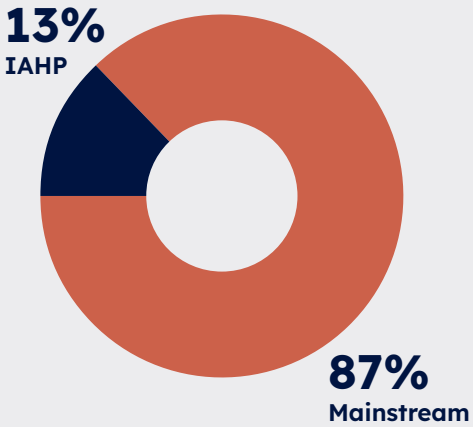
The mainstream must do more

$6.3 billion

Total **expenditure** on Aboriginal and Torres Strait Islander health

$800 million

The Indigenous Australians Health Program (IAHP) accounts for about 13 per cent of government expenditure on Aboriginal and Torres Strait Islander health, or around $800 million per annum



This means that other programs are responsible for 87 per cent of expenditure on Aboriginal and Torres Strait Islander health

The mainstream must do more.

Sources: Productivity Commission, *Indigenous Expenditure Report*; Department of Health, PBS; AIHW, *National Health Performance Framework*

Ageing infrastructure needs urgent investment

50 years old

Some of our **ACCHOs** are over 50 years old.

$900 million

Based on a national survey of members in 2019, we estimate that our sector needs an investment of $900 million to **bring infrastructure up to modern standards**

$255 million

NACCHO welcomes the injection of $255 million announced as part of the August 2021 **Australian Government Implementation Plan for the new National Agreement on Closing the Gap**

$645 million

More needs to be found

↗ 70%

Building costs have skyrocket almost 70% since the 2019 estimate of the $645m shortfall was made. This means that the figure is more likely over $1 billion

Source: NACCHO survey of members, 2019

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