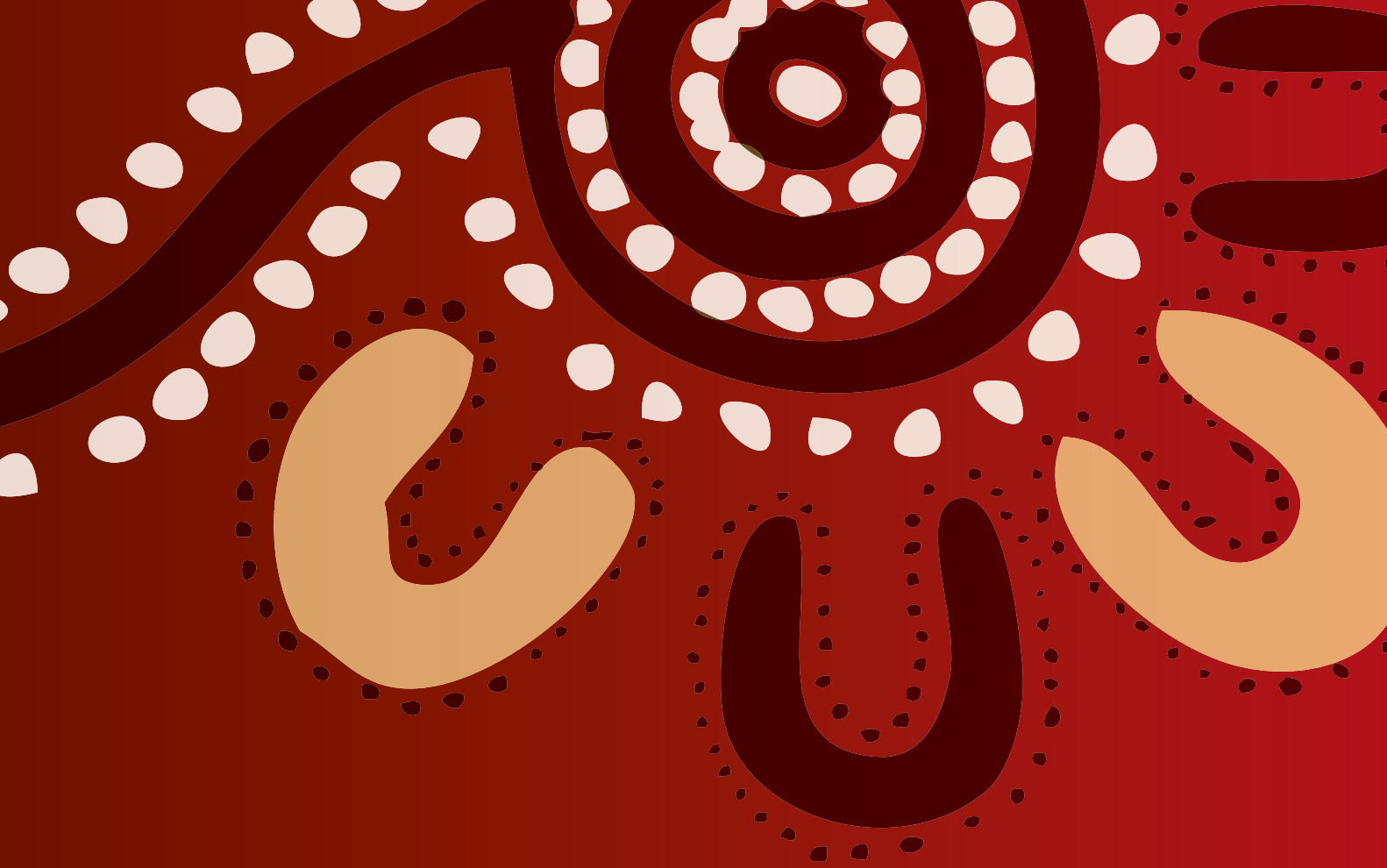

Aboriginal Community Controlled Health Service Funding

Report to the Sector

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Aboriginal Community Controlled Health Service (ACCHS) Funding

This report gives the results of an analysis of funding received by a group of ACCHSs in 2006–07. This study aimed to bridge an important knowledge gap we encountered in the Overburden Project, as we were unable to identify an available source of consolidated information about the funding received by ACCHSs.

According to our inclusion criteria (i.e. Aboriginal and Torres Strait Islander community-controlled agencies providing a range of PHC services), we identified 145 ACCHSs across Australia. Table 6 shows the distribution of these agencies, and the distribution of those included in our study sample.

Financial information (audited statements) from 42 ACCHSs was available from the Office of the Registrar of Indigenous Corporations (ORIC). We also collected financial/audit reports for 2006–07 from a convenience sample of ACCHSs that had published detailed financial reports or provided them directly to the project team. Financial reports with limited information about programs, funding amounts and sources of income were excluded from this aspect of the study. We were able to acquire detailed financial statements for the 2006–07 financial year in 21 cases, representing 14 per cent of the total number of agencies.

Table 6: ACCHSs providing comprehensive PHC in 2008

	ACCHSs in the sector (n=145)		ACCHSs in the sector (n=21)	
State/Territory	**Number**	**Percentage**	**Number**	**Percentage**
New South Wales	53	37	5	24
Queensland	25	17	4	19
Victoria	20	14	2	9.5
Western Australia	20	14	4	19
Northern Territory	15	10	3	14
South Australia	10	7	2	9.5
Australian Capital Territory	1	1	1	5
Tasmania	1	1	0	0
TOTAL	**145**	**101***	**21**	**100**

*Error due to rounding

Figure 3: Total income of sample ACCHSs

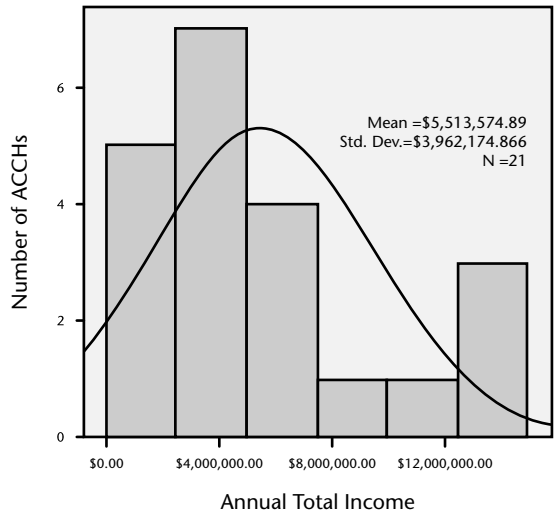
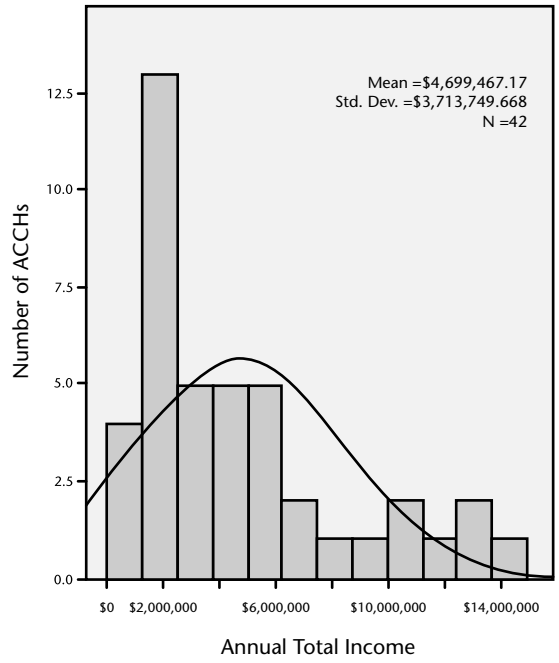


Figure 4: Total income of ACCHSs in ORIC reports



We analysed this information to generate a profile of the scale and complexity of separate allocations received by the ACCHS sector.

The sample is close to being representative of the sector geographically, although New South Wales and Victoria are under-represented (See Table 6). We were also able to compare the total income of the sample organisations with the 42 that had their financial reports for the year 2006–07 on the ORIC website. The sampled ACCHSs have larger average incomes than those reporting on the ORIC database, although the range is similar (see Figures 3 and 4).

Income from internal businesses, membership fees, grants carried forward from the previous year, and income without a clear source of funding (such as sundry, miscellaneous or recovered costs from project funding) were excluded from the data. The source of income was then categorised as being either Commonwealth, State/Territory, local government or other (donations and other NGOs). Programs or projects reported by ACCHSs were categorised as health service, community service, or infrastructure and support (capital, management, human resources (HR) or information and communication technology (ICT)). The distinction between health service and community service is sometimes difficult to make, but we included it because of some important observed differences in the funding processes.

Amount and range of funding to sample ACCHSs

More than half the ACCHSs in the sample reported income of between $1 million and $2 million, comparable to the ORIC sample. The *average* amount of income reported was about $5 million, slightly higher than in the ORIC sample (by 17 per cent). The income profile of the sample ACCHSs is shown in Figure 3 (ranging from just under $600,000 to $14 million), virtually the same as the ORIC sample (see Figure 4).

The number of separate funding grants received by ACCHSs in our sample ranged from six to 51, as shown in Figure 5, with an average of 22 funding grants per ACCHS.

This complexity in number and types of grants used to fund ACCHSs could theoretically be typical of the situation for those NGOs in Australia funded by government for health and other services. Although we have not found any national data that compare ACCHSs and mainstream providers, the following graph illustrates an analysis on this question conducted by DHS Victoria in 2005/06. DHS compared the types and amounts of funding that it allocated to Aboriginal, community health, non-government and local government agencies. Different types of funding are categorised as *activities*, and the numbers of different types of activities are shown on the horizontal axis. The vertical axis shows the total amount of funding in dollars for those activities. This analysis demonstrates that, dollar for dollar, Indigenous agencies provide a broader range of services and face a higher administrative burden than mainstream agencies.

Figure 5: Number of grants reported by each sample ACCHS

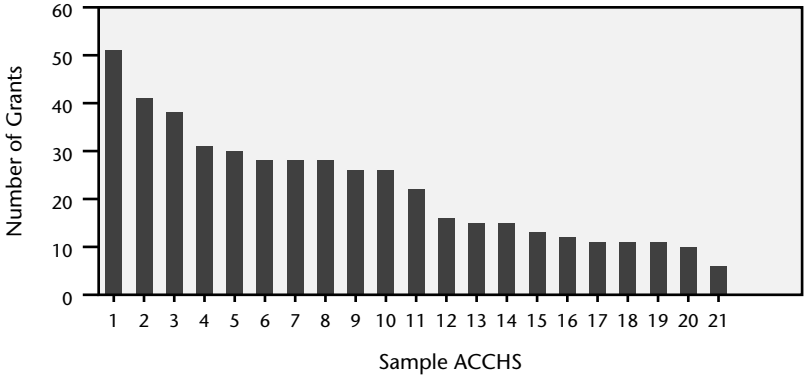
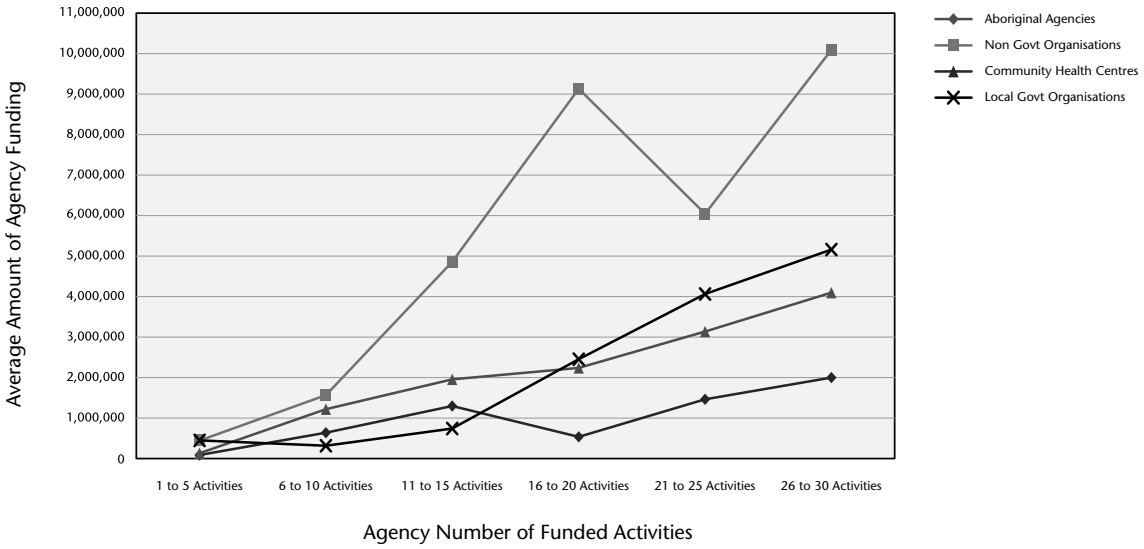


Figure 6: Activity funding to Aboriginal and other agencies (DHS Victoria)



Source: Data supplied by DHS, Victoria, and used with permission. The graph was produced as part of the department's efforts to improve the way it works with Aboriginal community-controlled organisations.

Note: An *activity* is a type of service, regardless of how much of that service is funded.

Sources of funding

In 2006–07 about 80 per cent of *total funding* to sample agencies was provided by the Commonwealth, with 19 per cent coming from States and Territories and the remaining 1 per cent from local and non-government sources. The *number of separate funding grants* received by ACCHSs ranged from six to 51, with 66 per cent of programs being funded by the Commonwealth and 29 per cent being funded by States/Territories (see Figures 7 and 8).

The Department of Health and Ageing and the Department of Families, Housing, Community Services and Indigenous Affairs are the top two Commonwealth funding departments. About 70 per cent of total grants were funded by these departments. Some Commonwealth departments, such as the Department of Sport and Recreation, allocated funding from just one program. Others, such as the Attorney General's Department and the Department of Education, Employment and Workplace Relations (DEEWR), supported between two and 20 programs.

On average, Commonwealth grants were larger. Some program allocations were very small, with 2 per cent of health and non-health program grants to ACCHSs in our sample being for amounts of less than $1000, mostly for one-off purposes. A further 13 per cent of allocations were between $1000 and $2000. As shown in Figure 9, and consistent with the findings of the *Red Tape* report (Morgan Disney and Associates 2006:44), nearly 60 per cent of programs allocated less than $100,000 to agencies in the sample. Smaller allocations (less than $100,000) may still bring onerous reporting requirements, and lower compliance from recipients, as demonstrated in a Victorian study of funding to Aboriginal community-controlled organisations funded by DHS (Effective Change 2008:12). Allocations that exceeded $1 million were primarily core funding to operate comprehensive PHC services or to operate nursing homes.

Figure 7: Percentage of funding programs by main sources

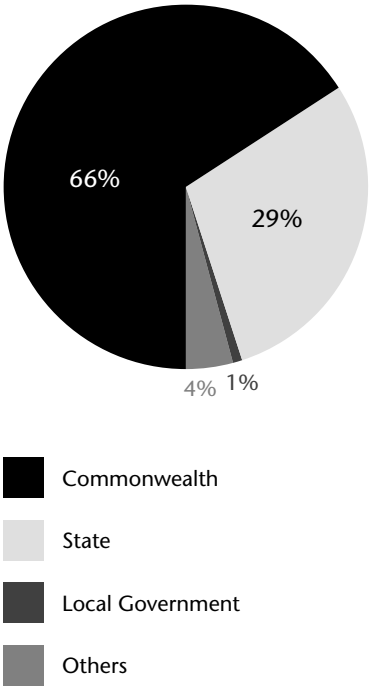
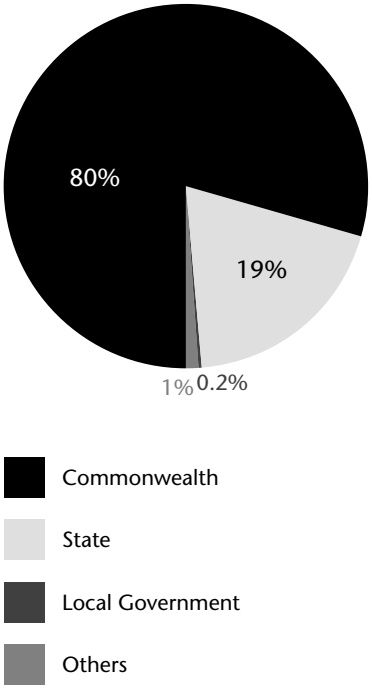


Figure 8: Percentage of funding amount by main sources



Range of services/ purposes

Just over half (52 per cent) of the grants (but 71 per cent of total funds) came from health-specific programs, and 30 per cent of grants (but 20 per cent of total funds) were for broader community or social programs. These included grants relating to family violence or family reunion, child protection, child care, youth services, community housing or hostels, cultural or art performances, advocacy, employment support, or assistance for people with financial difficulties. Health grants included community aged care or nursing homes; home and community care; dental services; eye health; hearing health; chronic disease management or prevention, including diabetes and asthma; mental health; sexual health; AIDS or blood-borne diseases; nutrition; women's, children's, adolescent or men's health; substance use; health promotion; and patient transport assistance. Around 16 per cent of grants were designated for infrastructure and support services, such as educational programs for workers or training or incentive payments, or for specific grants for particular operating costs, such as the impact of the Goods and Services Tax. This amount also included capital grants (3 per cent of all program funding) ranging from $3000 to $700,000 for maintenance, new buildings or to buy equipment (Figure 10).

There were 68 different programs from which funds were received by one or more of the 21 agencies in our sample.

Just over half (11) of the 21 agencies received funding that was identified as core funding for PHC and/or clinical services. The remaining 10 were funded from various specific-purpose programs. Of those that received core funding, it made up about half of their total funding (46 per cent) on average, with a range of 14 per cent to 73 per cent.

Figure 9: Percentage of grant allocations by amount of grant

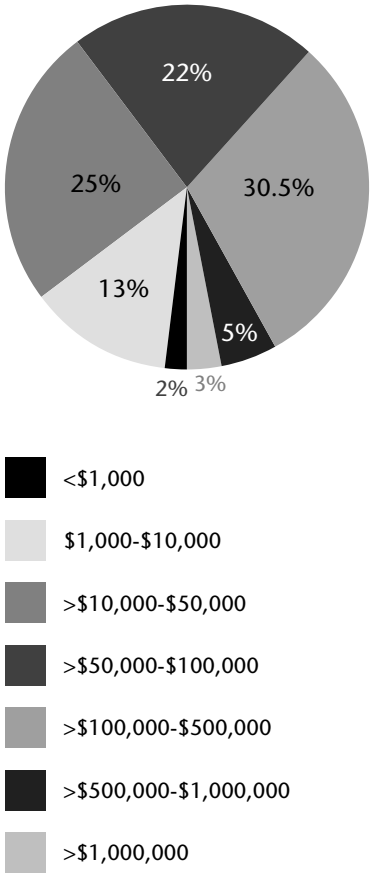
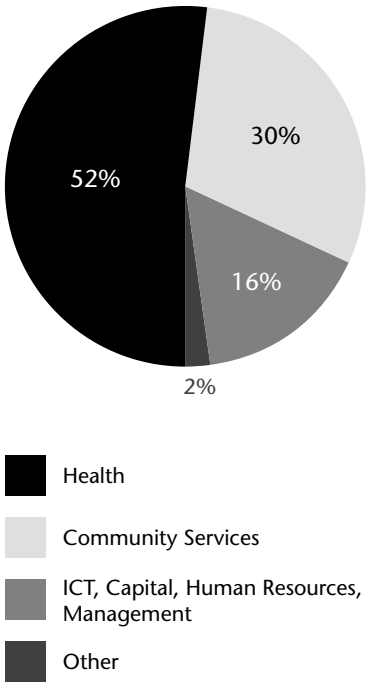


Figure 10: Grant categories



Ongoing, short-term and one-off funding programs

Security of funding for ACCHSs providing PHC is an important factor affecting their ability to recruit and retain staff, to invest in service development and to plan for future community needs. The current funding regimes are almost entirely constructed as short- to medium-term contracts. But the underlying practice in health authorities and in ACCHSs is often to treat much of this funding as 'ongoing unless…'. We examine the question of funding security in this section.

In our sample it was common for a single health activity to receive ongoing funding, as well as one-off funding (e.g. a mothers and babies program with funding from another source to provide baby gift packs). One activity can also be funded by more than one source, such as when the Commonwealth and a State or Territory provide funding to support the same service (see Appendix 2 for examples). This pattern—the majority of program funding being ongoing in practice, but providers having to contend with yearly funding applications—has also been documented in the Indigenous services field more broadly (Morgan Disney and Associates 2006). The pattern indicates that ACCHSs are active and successful in their pursuit of multiple funding sources. But it also indicates fragmentation of funding, which tends to work against integration of service delivery, and a level of insecurity, which works against confident planning and development.

Funding for programs that constitute what is normally understood to be comprehensive PHC—such as sexual health, immunisation, maternal and child health, hearing, nutrition, chronic disease, eye health, mental health and substance use—was more likely to be regarded as ongoing (as reported by ACCHSs in their annual reports and financial statements). Funding for programs often considered as broader community or social programs (although often still central to comprehensive PHC)—such as those that address family and community issues, domestic violence, child protection, financial assistance and youth programs—were less likely to be ongoing, as were management services such as ICT support. Cultural or art performance, transportation and quality improvement programs tended to be funded as one-off projects.

Figure 11 shows the breakdown of reported ongoing funding versus one-off funding for the small number of agencies that provided this data (about 37 per cent of all grants reported).

This proportion can be compared to the 89 per cent effectively ongoing or recurrent funding to Aboriginal organisations (including but not limited to ACCHSs) found in the Red Tape report (Morgan Disney and Associate 2006:49) and shown in Table 7 opposite.

Figure 11: Ongoing funding versus one-off funding

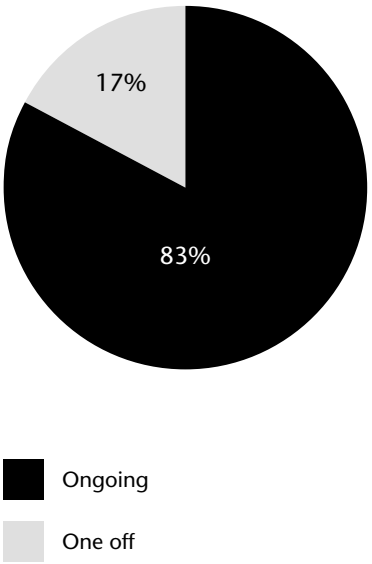


Table 7: Funding and allocation categories in the *Red Tape* report

Stability	Type of program funding grants	Percentage
More stable funding	**Recurrent:** recurrent grant on formula basis (e.g. for municipal services)	7%
	Multi-year: ongoing program with three-year funding allocation and annual budget submission	16%
	Yearly renewable: ongoing or multiple year programs with annual application process and one-year funding grant	66%
	Sub-total: ongoing or renewable funding	89%
Less stable funding	**One-off:** one-off grants for projects of fixed duration	10%
	Capital grant	1%

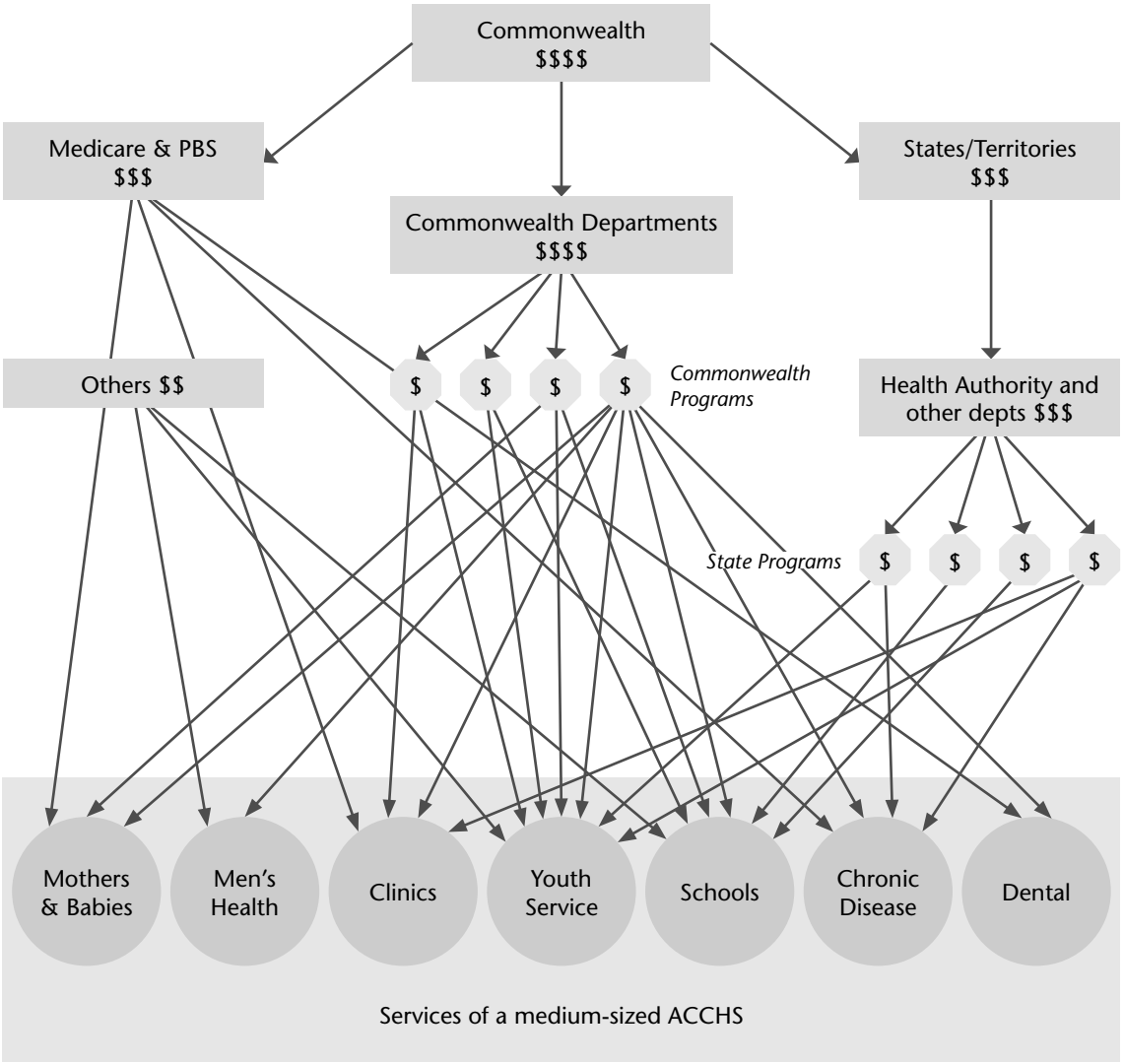
A Victorian study (Effective Change 2008:16) found a comparable level—a 74 per cent/26 per cent breakdown between ongoing and fixed-term funding. Although there are differences in the terms used in each of these sources, it seems that the majority of funding is effectively (but not contractually) ongoing, provided organisations meet contract obligations in service delivery and are seen to be operating efficiently and effectively. One-off funding seemed generally appropriate in our sample, in that it was provided for genuinely short-term purposes (such as a community ceremony). However, it is likely that smaller ACCHSs, in particular, are more likely to rely on inappropriate short-term funding, and our sample was probably not representative for this problem.

Although both funders and ACCHSs regard much of the annually or triennially renewed funding as effectively ongoing, and act accordingly (e.g. in appointing staff), this situation is acknowledged as problematic. It also raises the question of the value of constructing funding as short to medium term if in reality most of it is long term.

Conclusion

The data reported above present a picture of a complex funding and contractual environment, characterised by fragmentation and duplication in relation to the purposes, reporting and monitoring of funds and their application to service delivery and corporate support functions. In Figure 12 below, we illustrate the funding aspect of this situation for a typical ACCHS in receipt of funding from 25 different sources, for seven separate services or programs on the ground. Please note that the categorisation of funding at source by governments does not match the way services are delivered in practice, so the financial and activity reporting realities are even more complex.

Figure 12: Typical funding to a medium-sized ACCHS



In summary, these data are consistent with previous analysis (Morgan Disney and Associates 2006; Effective Change 2008) and indicate that:

- although core funding for PHC is provided to some agencies, there are many *add-ons* requiring separate contracting provisions, separate accounting and reporting;
- some ACCHSs undertake a very broad range of health and community service roles for their communities, and attract funding from several portfolios;
- there is insufficient adjustment of reporting requirements related to the size and purpose of grants;
- ACCHSs need to devote significant resources to acquiring and managing money, which is likely to be disproportionately high compared to mainstream agencies; and
- the effort required by all parties arising from the construction of virtually all funding as short to medium term, and the lack of security it entails for ACCHSs and their PHC services, may be unnecessary given that most funding is effectively ongoing.