

WORKING PAPER No. 3

Alcohol and Other Drug Treatment Financing in Australia: Funding Flows

Jenny Chalmers

Alison Ritter

Lynda Berends

December, 2013

Drug Policy Modelling Program
National Drug and Alcohol Research Centre
University of New South Wales
E: Alison.ritter@unsw.edu.au

Working Paper

This working paper has been prepared as part of the Commonwealth Department of Health and Ageing (DoHA) commissioned review of alcohol and other drug treatment service funding, being undertaken by the Drug Policy Modelling Program. The review aims to inform the distribution of Commonwealth government alcohol and other drug treatment funding.

Comments and feedback on this Working Paper are welcome, and can be made via email to Alison Ritter (Alison.ritter@unsw.edu.au).

Citation: This paper should be cited as

Chalmers, J., Ritter, A. & Berends, L. (2013) Alcohol and other drug treatment financing in Australia – funding flows. Working Paper No 3 – Review of AOD prevention and treatment services. Sydney: Drug Policy Modelling Program, National Drug and Alcohol Research Centre, UNSW.

Alcohol and Other Drug Treatment Financing in Australia: Funding Flows

Table of Contents

1. Introduction	3
2. Australia’s health system	6
3. Commonwealth Government funding of AOD treatment	8
3.1 National Health Funding Pool	8
3.1.1 Public hospital services	9
3.1.2 Public health activities	9
3.2 National Partnership Payments	9
3.3 Grants Schemes.....	10
3.4.1 The Department of Health (DoH).....	10
3.4.2 The Department of Social Security (formerly the Department of Families, Housing, Community Services and Indigenous Affairs	11
3.3.3 Attorney General’s Department	12
3.4 Pharmaceutical Benefits Scheme (PBS)	13
3.5 Medicare Benefits Scheme	13
3.6 Other Commonwealth funding not represented in the diagram	13
4. State/Territory Government funding of AOD treatment.....	13
5. Individuals	14
6. Philanthropy.....	14
7. Other funding sources.....	15

1. Introduction

Purpose

The aim of this working paper is to illustrate the source of alcohol and other drug (AOD) treatment funding in Australia using a funding diagram.

It will: 1. Provide a shared language for participants in the review of the drug and alcohol prevention and treatment services sector 2. Ensure the research team identifies all possible funding sources; 3. Enable some analysis of the relative contributions of the various funding sources.

The diagram and accompanying notes should be seen as a research tool, rather than definitive statement about AOD funding. It is our intention to document all sources of AOD treatment funding within the current project scope¹. As data are collected over the life of the project, the diagram and accompanying notes may be revised.

The diagram has been shown to peak bodies and departments of health throughout Australia during rapid assessment interviews conducted by the research team. Amendments have been made in line with the feedback received. The diagram and notes have also been reviewed by the Review Advisory Committee.

We acknowledge the potential for confusion in the diagram and its explanatory text, which arises from the complexity of the system we are attempting to portray. This is the first attempt to describe the AOD funding system. There were few diagrams of funding flows in the health system to guide us.

One notable finding of this exercise was that we were not alone in struggling to accurately depict the AOD funding system. There is much confusion and lack of clarity. Another notable finding was the tendency for money to flow around the system before distribution to treatment providers. The obvious example is money that flows from the Commonwealth to state and territory governments for distribution. Another more complicated example is where a state or territory government receives money from several different sources and provides those funds to a third party for it to distribute to service providers.

Orientation to the diagram

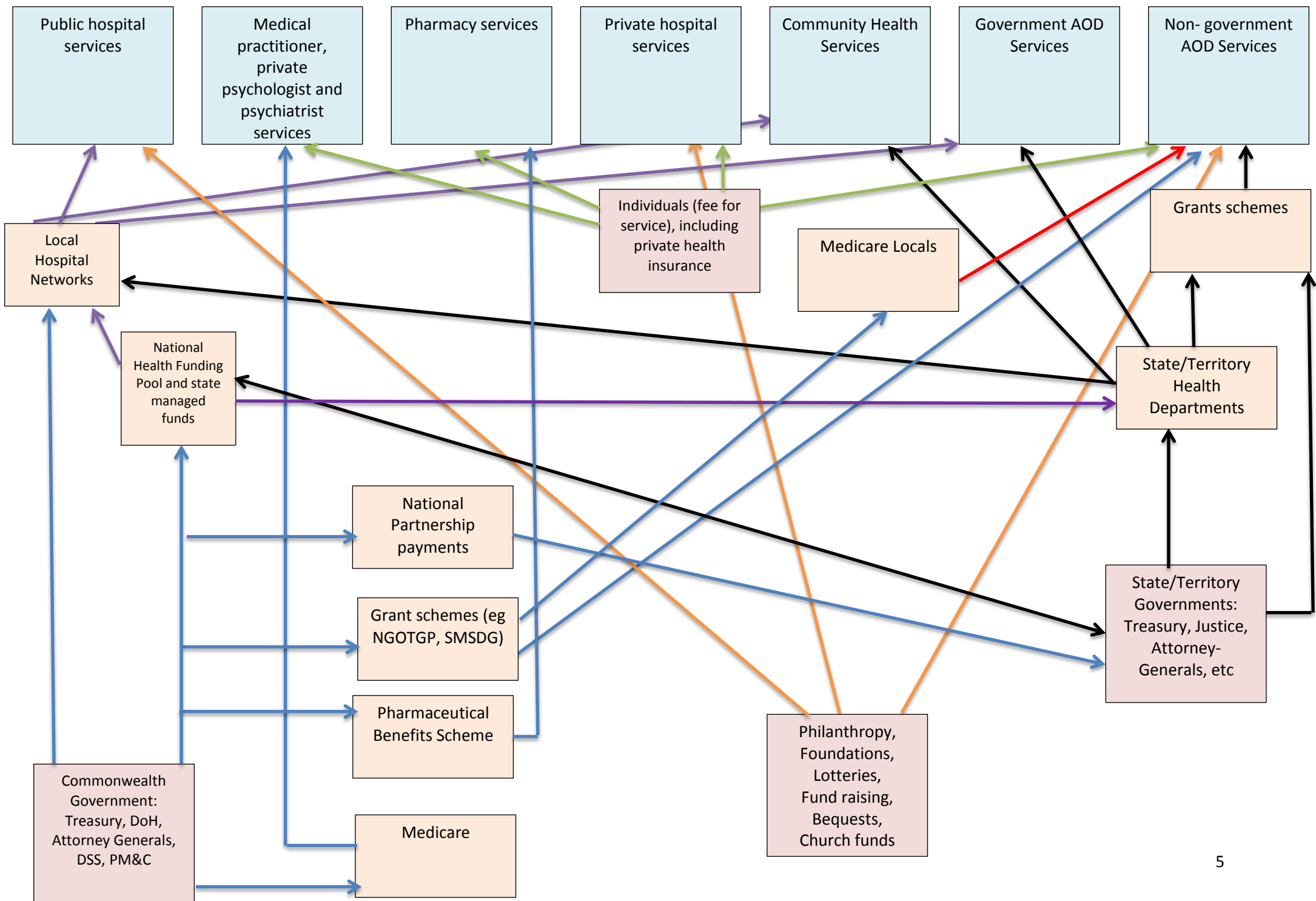
Along the top of the diagram are blue boxes representing AOD services provided through Australia's health system. There is a mixture of non-government, government, and mixed government and non-government service providers. These include public hospital services, medical practitioner services, pharmacy services, government AOD services, NGO services and so on. The services may be provided in a range of locations. For example, a private medical practitioner may provide her services in a private practice, at a public hospital, at a private hospital, or at an NGO². Likewise NGO services may be associated with a government funded community health service and so on. The diagram's purpose is not to describe governance arrangements or settings for AOD treatment but to describe the flows of funding from various funding bodies (as listed in subsequent tiers of the diagram) to a range of service providers.

¹ The review does not cover prison-based AOD treatment, nor harm reduction, including NSP, nor primary prevention activities.

² We consider government (or public) providers to be establishments directly controlled by the government. Non-government providers (including not-for-profit and for-profit agencies/programs) are agencies not controlled directly by the government, regardless of their reliance on government funding.

Below the blue boxes in the top row are boxes representing the various sources of funding that we have identified. In the diagram, the flow of funds follows the arrows, and as can be seen, there are multiple complex funding flows. We have focussed on what we believe are the primary funders and funding flows for AOD treatment. There have been some necessary simplifications to the arrows. For example we are aware that some state governments provide funds to community pharmacies for opioid maintenance treatment (Opioid Substitution Treatment, OTP pharmacotherapy maintenance), but this arrow has been omitted for simplicity. Similarly, the Commonwealth Government provides funds to private health insurance but we have not included an arrow showing this. Another example is that philanthropic funds can be directed towards Government AOD services.

The text below provides some context and detail for the various funding flows depicted in the diagram.



2. Australia's health system

According to the Australian Institute of Health and Welfare (AIHW) (2012, 16)

The Australian health system comprises a set of public and private service providers in multiple settings, supported by a variety of legislative, regulatory and funding arrangements, with responsibilities distributed across the three levels of government, non-government organisations and individuals. This web of public and private providers, settings, participants and supporting mechanisms is nothing short of complex. Those who provide health services include medical practitioners, nurses, allied and other health professionals, hospitals, clinics, and government and non-government agencies. Funding is provided by all levels of government, health insurers, non-government charitable organisations and individual Australians.

As part of Australia's health system the Australian and State and Territory governments play significant roles in financing treatment services and in ensuring equity of access to treatment services and treatment outcomes. Individuals (patients) also contribute through for example, paying any gap between what Medicare covers and the cost of treatment provided by medical practitioners or hospitals, or by paying dispensing fees for OTP. Other sources of funding include non-government charitable organisations.

Central to an understanding of the split between Commonwealth and State/Territory financing is the Commonwealth's financial relationships with the states-territories in relation to healthcare services. We outline this in some detail before commencing in Section 3 our description of the various sources of AOD funding depicted in the diagram.

The Council of Australian Governments (COAG) agreed to the Intergovernmental Agreement on Federal Financial Relations (IGAFFR) in November 2008, establishing a new framework for financial relationships between the Commonwealth and State/Territory governments. According to COAG:

Rather than seeking to control how States deliver outcomes, the IGAFFR aims to improve the quality and effectiveness of government services by reducing Commonwealth prescription, aligning payments with the achievement of outcomes and/or outputs and giving States the flexibility to determine how to achieve those outcomes efficiently and effectively (http://www.coag.gov.au/the_federal_financial_relations_framework).

Under this new framework the Commonwealth agreed to provide the states/territories with:

- general revenue assistance (including GST payments), to be used by the States for any purpose;
- National Specific Purpose Payments (National SPPs) and National Health Reform funding to be spent in the key service delivery sectors; and
- National Partnership payments to support the delivery of specified outputs or projects, to facilitate reforms or to reward those jurisdictions that deliver on nationally significant reforms.

Under the IGAFFR, there are two main types of agreements between the two levels of government: National Agreements and National Partnership Agreements. According to the Standing Council on Federal Financial Relations,

National Agreements define the objectives, outcomes, outputs and performance indicators, and clarify the roles and responsibilities that will guide the Commonwealth and the States and Territories in the delivery of services across a particular sector.³

Currently there are six National Agreements which cover key service areas - healthcare, education, skills and workforce development, disability services, affordable housing and Indigenous reform. Each National Agreement, except the National Indigenous Reform Agreement and the National Healthcare Agreement (NHA)⁴, is associated with a National SPP. These agreements require that the payments be spent in the relevant sector. States have budget flexibility to allocate funds within that sector in a way that ensures they achieve the mutually agreed objectives and outcomes of the associated National Agreement.

Healthcare services are covered by two umbrella agreements, the 2012 National Healthcare Agreement (NHA: with no money attached) and the associated National Health Reform Agreement (NHRA) (with money attached, ie National Health Reform Funding). The NHRA was entered into by all states, territories and the Commonwealth in August 2011.⁵

The overarching objective of the NHA is to 'improve health outcomes for all Australians and ensure the sustainability of the Australian health system' (NHA para. 12). The National Health Reform Agreement (NHRA)⁶ sets out governments' commitments in more detail in relation to public hospital funding, public and private hospital performance reporting, local governance of elements of the health system, policy and planning for primary health care, and rearrangement of responsibilities for aged care (NHRA para. 3).

National Partnership agreements set out mutually agreed performance benchmarks in relation to the achievement of reforms or improvement in service delivery.⁷ These sit attached to the NHA.

Underneath the broad objectives of the NHA sit the following National Partnerships on healthcare. Most of these have money attached: National Partnership Payments.

- National Partnership on Improving Public Hospital Services (2/8/11 to 30/6/17)
- National Partnership on Preventive Health (1/1/09 to 30/6/15)
- National Partnership on Essential Vaccines (1/7/09 ongoing)
- National Partnership on Hospital and Health Workforce Reform (20/2/09 to 30/6/13)
- National Partnership on Health Services (7/12/9 ongoing)
- National Partnership on Health Infrastructure (7/12/9 ongoing)
- National Partnership on e-Health (7/12/09 to 30/6/12)
- National Partnership on Closing the Gap in Indigenous Health Outcomes (1/7/09 to 30/6/13).⁸

Under the IGAFRR, all National SPPs and National Partnership Payments are paid by Commonwealth Treasury to each State Treasury on a monthly basis. State Treasuries are then responsible for distributing the funding within their jurisdiction.⁹ The Commonwealth's contribution to National

³ http://www.federalfinancialrelations.gov.au/content/national_agreements.aspx

⁴ <http://www.federalfinancialrelations.gov.au/content/npa/healthcare/national-agreement.pdf>

⁵ While we focus on agreements relating to healthcare services the National Affordable Housing Agreement is also of relevance. It funds specialist homelessness services, a precursor to these being the Supported Accommodation Assistance Program (SAAP).

⁶ http://www.federalfinancialrelations.gov.au/content/npa/health_reform/national-agreement.pdf

⁷ <http://www.budget.gov.au/2013-14/content/bp3/html/index.htm>

⁸ <http://www.coagreformcouncil.gov.au/agenda/healthcare>

⁹ http://www.federalfinancialrelations.gov.au/content/funding_framework.aspx

Health Reform funding is paid to the National Health Funding Pool, the term for the combined pool accounts of all states and territories.¹⁰

3. Commonwealth Government funding of AOD treatment

As noted in the diagram, we identify Commonwealth Government funding sources as including:

- The National Health Funding Pool (which states/territories also contribute to)
- National Partnership payments
- Grants Schemes
- Pharmaceutical Benefits Scheme
- Medicare Benefits Scheme

Each of these is described in turn.

The Commonwealth Government also funds the Australian Defence Force and the Department of Veterans Affairs, both of which purchase/provide AOD treatment.

3.1 National Health Funding Pool

Under the NHRA the states, territories and the Commonwealth are jointly responsible for funding public hospital services, using activity based funding (ABF)¹¹ where practicable and block funding in other cases. The first two years of the new NHRA funding arrangement (2012–13 and 2013–14) are transitional. In the transition period, the Commonwealth's contribution to public hospital services funding will be equivalent to what would otherwise have been payable through the former National Healthcare Special Purpose Payment (SPP). From 2014/15 the level of funding will be directly linked to the level of services delivered by the public hospital.¹²

Commonwealth contributions flow to the National Hospital Funding Pool, as do the portions of the states' contributions to public hospital services which are to be distributed on an activity funding basis. From March 2013, all states and territories had the necessary legislation in place to enable them to participate in the National Health Funding Pool to process National Health Reform funding and payments.

Local Hospital Networks (LHNs) have been created as independent legal entities in each of the states/territories, with varying degrees of reorganisation of health service administration. They comprise single or small groups of public hospitals with a geographic or functional connection. LHNs manage public hospital services and may, at the discretion of States, also be responsible for delivering other health services. They receive Commonwealth and State financial contributions for delivery of services, as agreed under the Service Agreement entered into with the State (NHRA, Schedule D).

For example, in NSW eight Area Health Boards (the NSW name for LHNs) have been replaced by 15 Local Health Districts. Similarly, Queensland has created 17 Hospital and Health Services (HHSs), ie statutory bodies with Hospital and Health Boards.¹³ Tasmania has established three Tasmanian

¹⁰ The Pool is administered by the National Health Funding Pool Administrator, an independent statutory office holder distinct from Commonwealth and State/Territory governments.

¹¹ Activity based funding means that providers are funded based on the activity they undertake.

¹² <http://www.budget.gov.au/2013-14/content/bp3/html/index.htm>

¹³ <http://www.health.qld.gov.au/hhsserviceagreement/>

Health Organisations, the geographic boundaries mirroring the old Area Health Services.¹⁴

3.1.1 Public hospital services

The scope of public hospital services that are funded on an activity or block grant basis and are eligible for a Commonwealth funding contribution currently includes:

- All admitted and non-admitted services
- All emergency department services provided by a recognised emergency department
- Other outpatient, mental health, sub-acute services and other services that could reasonably be considered a public hospital service.

These are inclusive of AOD treatment.

The care for patients admitted to public hospitals for AOD treatment is funded through ABF funding.¹⁵ Non-admitted patients receiving alcohol and other drug treatment from an allied health professional or clinical nurse are funded on a similar basis, costed in relation to Outpatient Clinic definitions (40.30 AOD). ABF funding applies to acute admitted public, acute admitted private, non-admitted, and emergency department service categories.

Block funding provides for mental health services, small rural and metropolitan hospitals, sub-acute, teaching, training and research, and other categories, which are funded through state managed funds and subsequently paid to local hospital networks.

3.1.2 Public health activities

The Commonwealth also delivers block funding through the National Health Funding Pool for non-hospital public health activities managed by states and territories. The States have “full discretion” over the allocation of these funds within the bounds of the NHA.¹⁶ For example, Commonwealth funds attached to the Illicit Drug Diversion Initiative (IDDI) and Needle and Syringe Program funding¹⁷ flow through the National Health Funding Pool.

3.2 National Partnership Payments

The Commonwealth also provides funding to the States under National Partnerships, some of which may be directed to AOD treatment. It is difficult to trace specific AOD treatment funding that flows through the national Partnerships payments, but review of the 2013-14 Budget Papers revealed some relevant projects.

Examples from the National Partnership on Health Services are:

- Early Intervention Pilot Program (EIPP), under the National Binge Drinking Strategy: \$0.2 million provided to NSW in 2012-2013 for early intervention and diversion programs for

¹⁴

http://www.dhhs.tas.gov.au/about_the_department/our_plans_and_strategies/national_health_reforms/local_hospital_networks

¹⁵ The cost of AOD treatment is calculated in relation to the following AR-DRG codes (V60A V60B, V61Z, V62A, V62B, V63Z, V64Z) (<http://www.ihoa.gov.au/internet/ihoa/publishing.nsf/Content/ABF-Price-Model-Reference-Classifications-for-2012-13>). According to Australia’s Independent Hospital Pricing Authority, an independent government agency established to implement ABF in Australia, AR-DRGs are an Australian admitted patient classification system intended to relate the types of patients treated by a hospital to the resources required by a hospital. They consist of a manageable number of diagnosis based classes that are differentiated on the basis of clinical content and resource consumption. Patient episodes of care are allocated on the basis of patient diagnosis and procedures undertaken during the episode of care. Codes from ICD-10-AM (the 10th revision of the World Health Organisation’s International Statistical Classification of Diseases and Related Health Problems) form the foundation of AR-DRG.

¹⁶ <http://www.budget.gov.au/2013-14/content/bp3/html/index.htm>

¹⁷ NSP funding is not in scope for this project.

young people under the age of 18 years who are at risk of developing alcohol-related problems.

- Innovative flexible funding for mental health component: \$4.2 million provided to Tasmania over four years from 2012-13 to fund packages of care to support people not served well by mainstream care approaches, including those affected by alcohol, drug and other complex mental health issues.

An example from the National Partnership on Stronger Futures in the Northern Territory:

- Tackling alcohol abuse: \$18 million provided to the NT over 5 years from 2012/13.

A raft of other National Partnership Agreements may have relevant AOD treatment funding, especially those in the ATSI area (for example, National Partnership Agreement on Indigenous Early Childhood Development).

3.3 Grants Schemes

The Commonwealth also contracts the non-government sector to provide AOD treatment services. The purchase and contracting of these services has occurred through the Department of Health (DoH), the Department of Social Services (DSS) and the Attorney-General's Department (AG's).

The recent Machinery of Government changes have brought together many of the Indigenous policies and programs under the Department of the Prime Minister and Cabinet (PM&C). PM&C now has responsibility for some of the DoH and DSS programs which had purchased AOD treatment, as noted below (http://www.dpmc.gov.au/indigenous_affairs/index.cfm).

3.4.1 The Department of Health (DoH)

DoH operates the following three grants programs which directly fund treatment provision, support, and capacity building of the treatment sector, and integration and coordination of primary health care, which potentially includes treatment provision¹⁸:

- NGO Treatment Grants Program (NGOTGP)

The "objective" of the fund is to "improve drug and alcohol treatment service outcomes; increase the number of treatment placements available; fill geographic and target group gaps". Grants can be provided to NGOs (and in some cases has been provided to state government departments of health for government treatment services) and may include but are not limited to: counselling, outreach support, peer support, home detoxification, detoxification and withdrawal, rehabilitation, therapeutic groups or communities.

Funded services (projects) are publicly listed on the DoH website (the name of the organisation/service/project receiving the funds). On the website there are currently 124 projects listed.

For example, one NGOTGP funded service is Fresh Hope Association Incorporated (Qld.) a Therapeutic Community with a family-orientated rehabilitation program designed for mothers and their children who have become dependent on the use of drugs and alcohol. According to its website it is the only residential home in Queensland that allows mothers to keep their children with them while accessing rehabilitation.

- Substance Misuse Service Delivery Grants (SMSDG)

The priority areas of this fund (as listed in the Fund Guidelines) are:

¹⁸ There are other flexible funds, such as the Substance Misuse Prevention and Service Improvement Grant, however this does not provide any funds for AOD treatment per se.

- Priority 1: “support non-government drug and alcohol treatment services to deliver quality, evidence based services and build capacity to effectively identify and treat coinciding mental illness and substance misuse”
- Priority 2: “assist indigenous communities to provide service delivery”
- Priority 3: “support those services targeting ATSI people”
- Priority 4: “reduce the prevalence and impact of petrol sniffing”
- Priority 5: “support people from culturally and linguistically diverse backgrounds”
- Priority 6: “support the development and implementation of a range of social marketing campaigns”

As an example, the Tasmanian-based Cornerstone Youth Services Inc. receives SMSDG funds. According to its website it aims to work closely with other youth services crossing the boundaries of health, social services and youth justice systems, ensuring that young people who may pass through such systems are provided with integrated services and supports to maximize their capacity for social recovery.

PM&C now has responsibility for Indigenous Drug and Alcohol Services, which could include some of the priority areas of the SMSDG program.

- The Regionally Tailored Primary Care Initiatives Through Medicare Locals Fund

This Fund established 61 Medicare Locals (MLs) Australia wide, non-government organisations that coordinate and integrate primary health care services, including after-hours GP services, immunisation, mental health support, targeted and tailored services for those in need, and eHealth. They are also responsible for needs assessment. MLs are intended to be the primary care partners of the Local Hospital Networks and can be seen as an evolution of Divisions of General Practice: a Commonwealth Government initiative to bring independent medical practitioners into an organisational framework to educate, inform and implement new general practice initiatives.

Medicare Locals are responsible for service coordination and integration across a defined geography. They coordinate all health care needs (not just medical needs) and support GPs, as well as physiotherapists, speech therapists, psychologists and nurse practitioners. They are fund holders (with access to flexible funds to purchase primary health care based on the needs of the local community) and can receive competitive grants in a coordinating or auspicing role.

In relation to AOD treatment, the New England Medicare Local (NSW) is in receipt of SMSDG funding and the Barwon Medicare Local in Victoria received NGOTGP funding. The New England Medical Local Drug & Alcohol Service Team deliver community based, non-residential support and intervention and advocate for local Aboriginal communities with other service providers. (<http://www.neml.org.au/programs-services/aboriginal-health/community-drug-and-alcohol-service-da>).

3.4.2 The Department of Social Security (formerly the Department of Families, Housing, Community Services and Indigenous Affairs - FAHCSIA)

FaHCSIA operated some programs which could be funding AOD treatment, for example:

- Breaking the Cycle of Alcohol and Drug Abuse in Indigenous Communities.¹⁹

¹⁹ <http://www.fahcsia.gov.au/breaking-the-cycle-of-alcohol-and-drug-abuse-in-indigenous-communities-activity>

The Commonwealth Government committed \$20 million over three years from 2011–12 to this program, which is intended to assist communities in remote and regional areas to develop and implement local solutions to alcohol and substance misuse issues through the development and implementation of Community Alcohol and Substance Abuse Management Plans.

- Alcohol Management Plan Community Fund (part of Stronger Futures in the Northern Territory)²⁰

The Commonwealth Government allocated \$23.6 million over eight years (from 2013–2014) in the Alcohol Management Plan Community Fund for community-based projects to support harm reduction and supply and demand reduction strategies as part of an alcohol management plan, and for governance and leadership support for people involved in alcohol management planning. Types of activities funded may, for example, include support for greater uptake and participation in alcohol rehabilitation and treatment services and assessment services, and early intervention, harm reduction and prevention activities (page 4).

Both these programs have been transferred to PM&C.

Another DSS funded program is “Kids in Focus”, which provided intensive support services to families, including parents /carers and children dealing with substance-using parents in the community; support for parents to parent more effectively and overcome their substance misuse; support for children to normalise their lives (school, sport, and other regular routines) and build resilience; targeted counselling and intervention through the child protection system where necessary; and to support other services funded by the program to identify and support children at risk.²¹

3.3.3 Attorney General’s Department

The National Crime Prevention Fund has funded AOD treatment. Subsection 298(1) of the *Proceeds of Crime Act 2002* allows the Australian Government to use money confiscated under the Act and the proceeds of confiscated assets (held in the Confiscated Assets Account, CAA) to fund crime prevention and law enforcement measures, measures relating to drug addiction treatment and diversionary measures relating to illicit drug use. While the Australian Government has continued to draw on the CAA to make a series of small grants, it deferred payments of \$32 million in the 2011–12 Budget and \$58.3 million in the 2012–13 Budget so funds could be diverted to other priorities. The 2013–14 Budget allocated \$40.9 million to be spent on grants for projects aiming to prevent street crime and gang violence over the four years to 2015–16.

The last year that an AOD specific project was funded was 2007. Since then the focus of funding has shifted to crime prevention and law enforcement measures. An example of an AOD specific project that received funding under this scheme was Triple Care Farm (Mission Australia), which was funded to expand the farm’s residential rehabilitation program for young people with AOD.

(<http://www.ag.gov.au/CrimeAndCorruption/CrimePrevention/Documents/POCA%20Funded%20Projects.PDF>)

²⁰

http://www.fahcsia.gov.au/sites/default/files/documents/06_2013/alcohol_cope_ip_final_approved_by_minister_2.pdf

²¹ <http://www.formerministers.dss.gov.au/14392/kids-in-focus-helping-drug-affected-families/>

3.4 Pharmaceutical Benefits Scheme (PBS)

The Commonwealth Government:

- Funds methadone and buprenorphine for the treatment of opioid dependence through the PBS. Both drugs are provided free of charge to the body responsible for dispensing (public clinic, private clinic, hospital or community pharmacy).
- Subsidises the price of prescription drugs used for AOD treatment (incorporating the cost of the drug and dispensing) listed on the Australian Government's PBS. Low income earners have access to cheaper prescription medicines.

3.5 Medicare Benefits Scheme

Through the Medicare Benefits Scheme, the Commonwealth Government covers a fee it has scheduled for a list of health services that it deems to attract a Medicare Benefit, if the service is provided by a health provider registered with Medicare. Relevant health service providers are private GPs, psychiatrists and psychologists. Many GPs provide counselling/advice for AOD problems, and psychologists access Medicare under the Better Access Scheme which can include AOD counselling interventions. GP's role in Australia's opioid maintenance program (prescribing methadone and buprenorphine) is funded through Medicare.

3.6 Other Commonwealth funding not represented in the diagram

Both the Department of Veteran's Affairs and the Australian Defence Force purchase treatment directly for current and past members of Australia's defence force.

Aboriginal Hostels Limited (a Commonwealth owned NGO) contributes to the accommodation costs in some residential rehabilitation services for Indigenous Australians (<http://www.ahl.gov.au/>), for example FORWARD in the Northern Territory (<http://www.forward.com.au/Treatments.html>).

4. State/Territory Government funding of AOD treatment

State and Territory governments provide treatment services themselves and contribute funds to

- community health services
- mental health programs
- public hospital services

They also purchase treatment services from NGO treatment providers.

National Health Funding Pool and State Managed Fund

The state or territory government contribution to the funding of public hospital services and functions is calculated on an activity basis or provided as block funding. As the system managers of the public hospital system, states and territories determine the amount they pay for public hospital services, and the mix and functions of those services. They also meet the balance of the cost of delivering public hospital services and functions over and above the Commonwealth contribution.

Community Health Services

State/territory governments cover the cost of AOD treatment provided through publicly funded Community Health Services, even when provided by medical practitioners and registered psychologists.

Government-provided treatment

The bulk of government AOD treatment services are provided by state departments of health; some of whom contract their Local Hospital Networks to plan and deliver those services.

NGO Services

Departments of Health in each state/territory provide funding to NGO treatment providers through grant programs. In some states and territories the Department of Health contracts Local Hospital Networks to undertake the job of purchasing NGO services; in others there is direct contracting/purchasing between the state government and the NGO; in some states both arrangements exist.

State/territory departments other than Health also fund NGOs to provide treatment. For example, diversion funding can flow from Attorney-General's & Justice departments, Police Departments etc. In NSW, the Department of Attorney General and Justice fund community-based AOD treatment for offenders.

5. Individuals

Treatment recipients can also contribute to the financial cost of treatment through:

- Paying the difference between what treatment providers (medical practitioners, other allied health services and hospitals) charge for treatment and what private health funds and Medicare cover.
- Paying a service fee for treatment provided by NGOs. For example, it is common for income support recipients in residential rehabilitation facilities to be charged a significant proportion of their income support entitlement as contribution towards their accommodation and food costs.
- Buying private health insurance.
- Paying dispensing fees for medications.

6. Philanthropy

Philanthropy and other such funding sources, including bequests, NGO fund-raising, lotteries, Clubs Australia and foundations all contribute to AOD treatment, although the amount of funding is very difficult to ascertain.

For example, the Sir David Martin Foundation contributes to Mission Australia's Triple Care Farm, which runs a residential rehabilitation service for young people (<http://www.sdmf.org.au/>). A recent mapping of the grants of 12 leading philanthropic foundations over the three year period 2009-2011 identifies funds directed towards "addiction and substance abuse" (Anderson, 2013). Nine in ten of all the grants (91%) were for less than \$100,000.

Another example of a non-government funding body, Lotterywest provided funding to Hope Community Services Inc in Western Australia to assist transitional support homes for clients moving out of residential rehabilitation (<http://www.lotterywest.wa.gov.au/grants/approved-grants>).

Other aspects of the provision of AOD treatment through the NGO sector not commonly thought of as philanthropy are voluntary labour and unfunded infrastructure provided by the sector. One example of the use of voluntary labour are peer based services such as the Family Drug Helpline (<http://www.familydrughelp.org.au/Volunteering.htm>). It is not uncommon for NGOs, even governments themselves, to provide infrastructure in the form of buildings to house treatment services, for example, as in-kind contributions to treatment provision.

7. Other funding sources

The diagram represents the major funding sources and those which we can confirm as funders of AOD treatment. Other funding sources, however, have been mentioned to us (without any details as to the specificities of the funding). These include:

- Mental health funding
- State-based mining royalties
- Local government

While Mental Health (MH) funding is not separately represented in the diagram, all the relevant funding bodies in the diagram also represent mental health service funding flows. There is overlap between mental health services and AOD services to the extent that individuals receive care for the AOD problems via MH funded services. Examples of relevant MH services are those funded through state/territory governments (see section 4); those funded through the Partners in Recovery (PIR) initiative; private hospitals that provide mental health services (with funding accessed via the national health funding pool, see section 3.1), and so on.

There are mining “royalties for regions” programs in WA, Qld and NSW (for example: <http://www.dsdp.qld.gov.au/about-the-program/regional-development/about-the-royalties-for-the-regions-program.html>). There is also the Aboriginal Benefits Account <http://www.dss.gov.au/our-responsibilities/indigenous-australians/programs-services/land-native-title/aboriginals-benefit-account-aba>). The account is responsible for distributing mining royalties from mining on Aboriginal Land in NT to Aboriginal people

References

- Anderson, G. (2013). *Where the Money Goes: Private wealth for public good*. Centre for Social Impact, University of New South Wales.
- Australian Institute of Health and Welfare (2012). *Australia’s Health 2012*. Australia’s health series no.13. Cat. no. AUS 156. Canberra: AIHW.