Aboriginal health care and public administration: Could a framework of reciprocal accountability reset the relationship?

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Contents

List of Tables and Figures (excluding those in published papers)

Summary

Primary Health Care (PHC) for Aboriginal and Torres Strait Islander people, compared to PHC for other Australians, is more often funded through complex, short-term contracts for tightly specified services; and is more likely to lack a legislative base that provides continuity and certainty. Relationships between the Aboriginal Community Controlled Health Organisation (ACCHO) sector (that provides PHC to approximately one half of all Aboriginal people) and government funders are characterised by the lack of trust that is built in to the contracting methods, and by systemic racism (discriminatory practices that are built in to the health care system with or without the intention of the individuals working within it). The work in this thesis explores these problems at the intersection of public administration and Aboriginal health care, and aims to articulate the basis for a resetting of the relationship, as a necessary precondition for the achievement of universal access to good PHC for all Aboriginal people and as an enabler for better care in the mainstream health system.

Public administration in health care and the ACCHO sector are shaped by two very different conceptual frameworks that are in tension and sometimes conflict. The ACCHO sector was founded on voluntary activism by Aboriginal communities as an expression of self-determination. Australian governments have adopted the thinking and methods characterised collectively as ‘New Public Management’ (Pollitt 1995), a program of reform of the public sector that applies agency theory to contracting for services with the non-government sector and a mechanistic approach to the accountability relationship. The tension between these frameworks is played out in a post-colonising society that fails to recognise adequately the status of its First Peoples or the impacts of dispossession and colonisation.

This thesis brings together studies that explore the funding and regulatory environment of the ACCHO sector and government funders; the lack of legal foundations for government stewardship for Aboriginal health care; and the problem of systemic racism in the mainstream health system. It suggests that government approaches to Aboriginal health are characterised by ambivalent stasis, in which policy support for the ACCHO sector is

undermined by distrust and concern about the financial and reputational risks of funding Aboriginal organisations in an environment of systemic racism.

The potential for an alternative approach to accountability, based on the concept of reciprocal accountability by both governments and the sector to Aboriginal communities, is suggested as basis for resetting the relationship and resolving a policy/program standoff.

Declaration

I certify that this thesis does not incorporate without acknowledgment any material previously submitted for a degree or diploma in any university; and that to the best of my knowledge and belief it does not contain material previously published or written by another person except where due reference is made in the text. I further certify that the wording of the descriptions of my role in relation to all of the publications included in this thesis is as accurate as possible, and has been circulated to my co-authors and approved by them.

Judith Dwyer

Acknowledgments

The research in this thesis was conducted over a period of ten years and includes the work of many co-authors and research partners, acknowledged in each of the publications, and deeply appreciated. I am grateful to the Lowitja Institute for enabling much of the research reported here by providing the authorising environment as well as the funding. The reports (Chapter 5 and Appendices) have been greatly improved by the work of various editors, and given visual identity by the work of several artists and graphic designers, also acknowledged in the publications.

My supervisors, Professor Eileen Willis, Dr Melissa Lindeman and Professor Dennis McDermott, have been unfailingly supportive and critical as needed, and have helped me to form and articulate the story told here. I am always grateful to my colleagues in Australia, New Zealand and Canada who have shaped my thinking and writing and enabled me to see my work in an international context, even though it is deeply grounded in the unique circumstances of this country. Bree Atkins, a skilled librarian, assisted me with the literature searches, and Bernadette Noonan with the required permissions and the final production of this thesis. I have borrowed the concept of ‘resetting the relationship’ for the title of this work from Social Justice Commissioner Mick Gooda and his predecessors.

My partner Gregg Ryan was my fiercest editor and best supporter. Thank you always.

Abbreviations and terminology

ACCHO/ACCHS	Aboriginal Community Controlled Health Organisation/Service
AMSANT	Aboriginal Medical Services Alliance of the Northern Territory
AHHA	Australian Healthcare and Hospitals Association
AIHW	Australian Institute of Health and Welfare
ANAO	Australian National Audit Office
ATSIC	Aboriginal and Torres Strait Islander Commission
CC	Cultural competence
CRC/ CRCAH	Cooperative Research Centre/ Cooperative Research Centre for Aboriginal Health
DFD	Department of Finance and Deregulation
DoHA	Department of Health and Ageing
DHB	District Health Board
EMS	Emergency Medical Service
FAR	Funding, Accountability and Results for Aboriginal health services
FDA	Facilitated Development Approach
ICANN	International USA Corporation for Assigned Names and Numbers
KPI	Key Performance Indicator
LMICs	Low and Middle Income Countries
NACCHO	National Aboriginal Community Controlled Organisation
NHS	National Health Service
NGO	Non- Government Organisation
NTAHF	Northern Territory Aboriginal Health Forum
NPM	New Public Management
NPV	New Public Value
OATSIH	Office for Aboriginal and Torres Strait Islander Health
OECD	Organisation for Economic Cooperation and Development
PHC	Primary Health Care
PHO	Primary Health Organisation
PHI	Private Health Insurance
PSO	Public Sector Organisation
PVM	Public Value Management
QH	Queensland Health
QAIHC	Queensland Aboriginal and Islander Health Council
RBV	Resource-based View
SME	Small to medium enterprise
TCE	Transaction Cost Economics
UNDRIP	United Nations Declaration of the Rights of Indigenous Peoples
WHO	World Health Organisation

A note on terminology

In keeping with usage in the Aboriginal community controlled health sector, the term ‘Aboriginal’ is sometimes used in context to include Torres Strait Islander people. The term ‘mainstream’ is used to mean non-Indigenous institutions and organisations.

List of Publications

Chapter 2

1. **Dwyer, J**, Lavoie, J, O'Donnell, K, Marlina, U & Sullivan, P 2011, 'Contracting for indigenous health care: towards mutual accountability', *Australian Journal of Public Administration,* vol. 70: no. 1 pp. 34–46. doi:10.1111/j.1467-8500.2011.00715.x.
2. Lavoie, J, Boulton, A & **Dwyer, J** 2010, 'Analyzing contractual environments: Lessons from Indigenous Health in Canada, Australia and New Zealand', *Public Administration*, vol. 88 no. 3 pp. 665-79. doi: 10.1111/j.1467-9299.2009.01784.x

Chapter 3

3. **Dwyer, J**, Willis, E & Kelly, J 2014, 'Hospitals caring for rural Aboriginal patients: Holding response and denial', *Australian Health Review*, vol. 38 no. 5 pp. 546-51, view at, http://www.publish.csiro.au/view/journals/dsp_journal_fulltext.cfm?nid=270&f=AH14060
4. Kelly, J, **Dwyer, J**, Willis, E & Pekarsky, B 2014, 'Travelling to the city for hospital care: access factors in country Aboriginal patient journeys', *Australian Journal of Rural Health*, vol. 22 no. 3 pp. 109-13.
5. Howse, G & **Dwyer, J** 2015, 'Legally Invisible: Stewardship for Aboriginal and Torres Strait Islander Health', *Australia and New Zealand Journal of Public Health*. Online doi: 10.1111/1753-6405.12358, view at, http://onlinelibrary.wiley.com/doi/10.1111/1753-6405.12358/pdf

Chapter 4

6. **Dwyer, J**, Boulton, A, Lavoie, J, Tenbensel, T & Cumming, J 2014, 'Indigenous peoples' health care: new approaches to contracting and accountability at the public administration frontier', *Public Management Review*, vol. 16 no. 8 pp. 1091-192. DOI: 10.1080/14719037.2013.868507.
7. Tenbensel, T, **Dwyer, J** & Lavoie, J 2014, 'How not to kill the golden goose: Reconceptualising accountability environments of community-based third sector organisations', *Public Management Review*, vol. 16 no. 7 pp. 925-44. DOI:10.1080/14719037.2013.770054.

Chapter 5

8. **Dwyer, J**, Martini, A, Brown, C, Tilton, E, Devitt, J, Myott, P & Pekarsky, B 2015a, *The road is make by walking: Towards a better primary health care system for Australia's First Peoples - Summary Report*, Lowitja Institute, Melbourne.

9. Lavoie, J & **Dwyer, J** 2015, 'Implementing Indigenous community control in health care: Lessons from Canada', *Australian Health Review*. Published online November 2015, view at, http://dx.doi.org/10.1071/AH14101#sthash.l90phqOg.dpuf

Appendix A

10. **Dwyer, J,** Silburn, K & Wilson, G 2004, *National strategies for improving Indigenous health and health care*, Office of Aboriginal and Torres Strait Islander Health, Canberra.

Appendix B

11. **Dwyer, J**, O'Donnell, K, Lavoie, J, Marlina, U & Sullivan, P 2009, *The Overburden Report: Contracting for Indigenous Health Services*, Cooperative Research Centre for Aboriginal Health, Darwin, viewed at, http://www.lowitja.org.au/crcah/list-crcah-publications

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12. **Dwyer, J,** Kelly, J, Willis, E, Mackean, T, Battersby, M, Pekarsky, B & Glover, J 2011, *Managing Two Worlds Together: City hospital care for country Aboriginal patients; Study 2 – Staff perspectives on care for country Aboriginal patients*, Lowitja Institute, Melbourne, viewed at, http://flinders.edu.au/medicine/sites/health-care-management/research/mtwt/

Appendix D

13. **Dwyer, J**, Martini, A, Brown, C, Tilton, E, Devitt, J, Myott, P & Pekarsky, B 2015b, *The road is make by walking: Towards a better primary health care system for Australia's First Peoples – Report*, Lowitja Institute, Melbourne.

Other relevant work not included as part of the thesis

Peer-reviewed articles

14. Willis E, **Dwyer J**, Mackean T and Kelly J (in press), Hybrid cultures: Creating a Third Space in Aboriginal Healthcare, *Journal of Australian Indigenous Issues*, accepted October 2015.
15. Willis E, **Dwyer J**, Owada K, King D and Wainer J. (2011) Indigenous women's expectations of clinical care during treatment for a gynaecological cancer: rural and remote differences in expectations, *Australian Health Review,* **35**(1): 99-103.
16. **Dwyer J** 2004, 'Australian health system restructuring: what problem is being solved?' *Australia and New Zealand Health Policy,* 2004, vol. 1, no. 6, viewed, http://www.anzhealthpolicy.com/content/1/1/6

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17. Kelly, J, **Dwyer, J**, Pekarsky, B, Mackean, T, Willis, E, de Crespigny, C, Perkins, S, O'Donnell, K, King, R, Mackean, L, Brown, A, Lawrence, M & Dixon, K 2015, *Managing Two Worlds Together Stage 3: Improving Aboriginal Patient Journeys— Study Report*, Lowitja Institute Melbourne, viewed, http://www.flinders.edu.au/medicine/sites/health-care-management/research/mtwt/
18. Kelly, J, **Dwyer, J**, Pekarsky, B, Mackean, T, McCabe, N, Wiseman, J, de Crespigny, C, O'Donnel,l K 2015, *Managing Two Worlds Together Stage 3: Improving Aboriginal Patient Journeys— Workbook (Version 1)*, Lowitja Institute Melbourne, viewed, http://www.flinders.edu.au/medicine/sites/health-care-management/research/mtwt/
19. Baum, F & **Dwyer, J** 2014, 'The accidental logic of health policy in Australia', in *Australian Public Policy: Progressive Ideas in the Neo-Liberal Ascendancy*, Orchard L and Miller C (eds), ch 11, pp. 187-208, Bristol: The Policy Press.
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21. Lewis, V, Marsh, G, Hanley, F, Macmillan ,J, Morgain, L, Silburn, K, Kalucy,L, **Dwyer, J**, Rostant, J, & Mead, K, 2013, *Understanding vulnerability in primary health care: Overcoming barriers to consumer transitions through the primary health system*, Australian Primary Health Care Research Institute, Canberra , viewed, http://files.aphcri.anu.edu.au/reports/Lewis.Final.Report.25.pdf
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23. **Dwyer, J**, Kelly, J, Willis, E, Mackean, T, Battersby, M, Pekarsky, B & Glover, J 2011, *Managing Two Worlds Together: City hospital care for country Aboriginal patients; Study 2 – Staff perspectives on care for country Aboriginal patients*, Lowitja Institute, Melbourne, viewed, http://flinders.edu.au/medicine/sites/health-care-management/research/mtwt/
24. Kelly, J, **Dwyer, J**, Willis, E, Mackean, T, O'Donnell, K, Battersby, M & Pekarsky, B 2011, *Managing Two Worlds Together: City hospital care for country Aboriginal patients; Study 3 – The experiences of patients and their carers*, Lowitja Institute, Melbourne, viewed, http://flinders.edu.au/medicine/sites/health-care-management/research/mtwt/
25. Kelly, J, Pekarsky, B, **Dwyer, J**, Mackean, T, Willis, E, Glover, J & Battersby, M 2011, *Managing Two Worlds Together: City hospital care for country Aboriginal patients; Study 4 – Complex Aboriginal Patient Journeys,* Lowitja Institute, Melbourne, viewed, http://flinders.edu.au/medicine/sites/health-care-management/research/mtwt/

26. Martini, A, Marlina, U, **Dwyer, J**, Lavoie, J, O'Donnell, K & Sullivan, P 2011, *Aboriginal Community Controlled Health Service Funding: Report to the Sector 2011*, The Lowitja Institute, Melbourne.
27. **Dwyer, J,** Shannon, C & Godwin, S 2007, *Learning from action: Management of Aboriginal and Torres Strait Islander Health Services*, Cooperative Research Centre for Aboriginal Health, Darwin.

Chapter 1: Introduction

> *It is not credible to suggest that one of the wealthiest nations in the world cannot solve a health crisis affecting less than 3% of its citizens. Research suggests that addressing Aboriginal and Torres Strait Islander health inequality will involve no more than a 1% per annum increase in total health expenditure in Australia over the next ten years. If this funding is committed, then the expenditure required is then likely to decline thereafter. Tom Calma, Social Justice Report 2005:12*

The published work in this thesis is the product of an extended enquiry at the intersection of two important challenges for Australia – good public administration for the health system and the need for improvement in the health and wellbeing of Australia's First Peoples. The work was motivated by the conviction that success in both is essential for the future wellbeing of all Australia's people. In this chapter, I first outline my personal investment in the enquiry that gave rise to the published work, and then briefly explain the framework I have used for understanding the problems it addresses, and the theoretical propositions that have guided the research. The chapter concludes with an explanation of the structure of this thesis.

Personal statement: why this research?

These matters have occupied my research work since the turn of the 21st century, when I became an academic, but my interest in both aspects goes back a lot further in my life. Until I turned 50 my work for more than 20 years was in health services, mostly in management and leadership roles, and contributing to health policy development. I lived through the wave of public sector reform known as New Public Management (NPM), which arrived like a virus from the UK and the USA in the late 1980s. It had an irresistible power, and while resistance by health care providers including me was quite strong, it was largely futile. Working relationships between the health care 'provider' agencies, where I held progressively more senior leadership roles, and their government funders became increasingly fraught. I became very interested in understanding that working relationship, the policies and structures that shape it, and how it might be improved.

Thus like a lot of mature age doctoral students, my research has focused on an important question in my working life. The question of why a non-Aboriginal person would decide to focus on Aboriginal affairs is a matter that also requires explanation. My personal interest in relationships between Aboriginal and other Australians also has a long history, starting from a vicarious experience of racism when I was in the early years of primary school. Growing up in a Catholic family in a rural community, I also had reasons to become aware of discrimination against girls and women at an early age. The example of my mother, who had a concern for what we would now call social justice, and a willingness to stand up for her beliefs, and particularly for the interests of women, gave me an understanding that acceptance of the world as it is was not the only way. Thus in my life, the experiences and thinking that led me to become a feminist are linked to my interest in racism, and also to whatever empathy I have for those who are discriminated against for any reason.

My interest in the situation of Aboriginal and Torres Strait Islander people[1] has continued, and is motivated at least partly by self-interest. I am convinced that the country needs to come to a settlement that does not deny our history; and that provides an honoured place for Aboriginal Australia and its varied cultures; and that we need to act to support the pursuit by Aboriginal people and communities of a good future, in the interests of all of us. To put that more personally, I want to be able to relate to Aboriginal people, and benefit from their continuing cultures and their unique contribution as custodians of the Australian ecosystem, on a proper basis. This may be a way of convincing myself that I can avoid or at least manage the moral hazards of the do-gooder, but if so it is also more than that. This perspective – that we need to resolve our relationship in the interests of all of us – also informs my stance as a researcher and my analysis.

My perspective is necessarily a non-Aboriginal one. The metaphor I use to characterise that perspective is that I seek to ‘stand beside’ the Aboriginal perspective, in order to see

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[1] In this thesis, I generally use the shorter term ‘Aboriginal’ to include ‘Torres Strait Islander’, consistent with usage within the Aboriginal health sector. I generally avoid the term Indigenous to mean Australian Aboriginal or Torres Strait Islander, in keeping with the preference of many people (who find it too generic to express their identities).

policies, programs and practices approximately as they look from there. To use a post-modern idiom, I seek to turn an enquiring gaze on mainstream Australian health policy and practice (and on the Aboriginal Community Controlled Health sector). I also seek to use my position as a participant in public administration and the mainstream health system, and the insights I have thereby gained, in a constructive way – and specifically to look for strategies to improve the structural and working relationships between the sector and its government funders that will be acceptable and functional for both sides.

The arena of health policy and health care is an appropriate place in which to pursue these interests. Health and health care are strong priorities for action in Aboriginal communities. In health care, the impacts of disadvantage and exclusion are played out in vivid and compelling terms, as are approaches to inclusion and support.

And so, my research came to be focused on the structure and processes of the relationship between government funders and the community-based providers of health care for Aboriginal people. It seems that there are enduring barriers that compromise the implementation of apparently strong government policies for Aboriginal health. This problem comes to a sharp point in the relationship between the Aboriginal Community Controlled Health Organisations (ACCHOs) and their multiple government funders. The relationship is enacted in a plethora of committees and forums; and in the methods by which governments contract with ACCHOs for the provision of primary health care (PHC) for Aboriginal people. The relationship is also deeply shaped by the character of Australian inter-cultural relationships.

In this work, I have benefited enormously from my engagement with the Cooperative Research Centre for Aboriginal Health (CRCAH), now the Lowitja Institute, in which I had the opportunity to participate soon after I took up an academic appointment at La Trobe University. From 2010 to 2014 I served as a Research Program Leader (co-leading the ‘Enabling Policy and Systems’ program). The role required me to contribute to determining a research agenda for the Institute, and gave me experience in commissioning research.

The CRC provided an authorising environment, in which the priorities and topics for research were determined in a partnership between Aboriginal and non-Aboriginal participants. This is important for a non-Aboriginal researcher, who inevitably incurs the classic risk facing those who seek to do good for others – that of mistaking one's own interests and priorities for those of the recipients of one's good intentions.

The CRC also provided much of the funding that enabled my research. The very applied nature of the CRC program, and of the kinds of research sought by the CRCAH's industry partners - the ACCHO sector and its government funders – were a good match for my interests. Thus the research reported in this thesis has been very much applied to the policy problems confronting the sector and their government funders, and it has been informed by my deep and broad working experience of both the development and the implementation of policy for health care.

Tension between two frameworks, resting on unfinished business

Officially, Aboriginal and mainstream Australia are united in seeking to improve Aboriginal health, but the questions of what that means, how to do it, and with what resources, have different answers for community and government. These differences are founded on two very different conceptual frameworks, and are played out in a post-colonising environment. Each of these critical elements that have framed my research are briefly outlined below.

Aboriginal approaches to Primary Health Care and the role of the sector

The ACCHO sector was founded on voluntary activism by Aboriginal communities and the health professionals who supported them. The first Aboriginal Medical Service was established in the large urban Aboriginal community of Redfern in 1971, with others opening in urban, regional and remote areas over the following decades (Anderson & Sanders 1996). Government funding commenced in the early 1970's following the election of the Whitlam government in December 1972 (see Australian Indigenous HealthInfoNet 2010 for an excellent policy chronology). There are now approximately 150 ACCHOs around the country, and the sector makes a critical contribution to Primary Health Care (PHC) for

Aboriginal people. The sector is increasingly regarded as an essential part of the health system (National Aboriginal and Torres Strait Islander Health Equality Council [NATSIHP] 2013:17), and ACCHO services are used by between one third and one half of all Aboriginal people every year (National Health and Hospitals Reform Commission [NHHRC] 2009:87; National Aboriginal Community Controlled Health Organisation [NACCHO] 2009:2-3).

The Aboriginal health movement was a necessary response to exclusionary practices (current and historical) that made access to health care difficult for Aboriginal people throughout the country. It gave expression to Aboriginal concepts of health and health care (National Aboriginal Health Strategy Working Party [NAHSWP] 1989) that have remained influential. And it was also an expression of self-determination, of Aboriginal communities taking control of access to health care, based on their values and priorities and owned by communities.

The ACCHO sector, with community and political support, sees itself as the representative voice of the community on health, and as the provider of choice. This 'dual role' of representation and service delivery is by no means unique – it is also a characteristic of the women's health movement (Dwyer 1992) among others. But in the case of Aboriginal health, the representative role can more clearly be seen to bring with it the moral standing (if not the power) to hold the government accountable for its policy and program effectiveness and its stewardship performance (Sullivan 2009).

The founding of the sector predates the success of the current guiding public administration framework (neoliberalism and the NPM program), and the sector has never accepted the construction of its role and purpose as being agents of government policy and providers of government-defined health care. However, their relationships with government funders have been strongly shaped by NPM for about 25 years.

Relationships have also been shaped by problems of governance and episodes of lack of accountability within the ACCHO sector, and the perception of such problems being widespread. The inevitable presence of a few 'rogue CEOs' who commit fraud is one aspect, along with problems with the capacity and performance of Aboriginal boards and management (Office of the Registrar of Indigenous Corporations 2010). While I am not aware of any hard evidence that the level of failure in Aboriginal health corporations is worse than in mainstream health non-government organisations (NGOs), that hardly matters given the strong perception by government and the general public that it is so. The sector has moved on from an early defensive response, and is actively engaged in efforts to address this problem through constitutional reform, capacity-building, and active support by the state peak bodies and National Aboriginal Community Controlled Organisation (NACCHO) (NACCHO, undated).

The New Public Management program: markets, measurement and management

Since the late 1980s/early 1990s, the dominant public administration approaches taken by Australian and other governments, particularly in the English-speaking world, have been characterised collectively as 'New Public Management' (Pollitt 1995). This term is used to describe a program of reform of the public sector, arising in the Thatcher-Reagan era of small government, and sometimes informally summed up as the application of 'markets, measurement and management'. While this label is now regarded in academic circles as passé (see Chapter 4), the methods brought into Australian public administration based on its ideas remain strong in the relationship between government agencies and those with whom it contracts for services in general, and with the ACCHO sector in particular.

NPM is based on the proposition that governments should only do what the private sector can't or won't do; and that government should adopt the practices of the private sector as much as possible in the pursuit of both efficiency and quality. Thus market-like mechanisms should be used to get the 'best buys' for the government dollar. Services delivered to citizens as 'consumers' should be measured for cost, quality and effectiveness, a goal that almost inevitably requires services to be commodified into measurable units. And public administration itself should be focused on 'execution' as distinct from 'policy' which is the role of the elected government.

There have been positive impacts at program level, for example in the care of the aged. Guided in part by NPM principles, state governments increasingly withdrew from direct provision of institutional aged care services (in favour of private and non-government providers), and the Commonwealth introduced reforms to the funding and regulation of both residential and home-based aged care services that have profoundly shaped the way the frail and ill elderly are supported. There have been shifts towards output-based funding, by differentiating the fees and standards required for people with different levels of dependence (‘high’ or ‘low’ care), as opposed to differentiating according to the category of facility (‘nursing home’ or ‘hostel’).

The role of the former Aged Care Standards Agency (known in the industry simply as ‘the Agency’) was also an important change, with quite strict detailed standards and more vigorous, and often very public, enforcement. The standards have been important, for example by codifying the rights of residents to retain the expression of their religious beliefs, sexual orientation and some aspects of their life styles (eg whether they prefer a drink before dinner) regardless of the preferences or religious beliefs of the aged care provider. There is a general view that the range and quality of the services has improved during the relevant period (Productivity Commission 2011:XVIII).

For the central public service, the methods introduced in the name of NPM have included performance contracting for public servants, ‘flatter’ structures, reduced middle management and outsourcing. This latter includes the outsourcing to consulting firms of analytical capacity, and of ‘non-core’ service delivery and support activities to the private sector or NGOs, as in the aged care example above.

This program of reform of the public sector arose as part of the ideology of neo-liberalism, which has origins in conservative thinking from the late 1930s (see Davis 2014:29). Neoliberalism has sought to make profound changes in the way we think about ourselves as citizens, and the relationships between the state, capital and the citizenry. With its focus on the individual rather than the collective, and the market rather than government, neoliberalism rejects the claims of minorities, and of women, for intervention by the state in support of their rights and interests. It does so on the basis that individual merit and hard work are the prerequisites for advancement; and that alternative policy approaches are the work of ‘leftist elites’ out of touch with the realities of life for ‘ordinary people’. This way of thinking has permeated Australian culture, and shapes policy and public administration. It incorporates a perspective on Aboriginal affairs that is essentially assimilationist (Altman 2014).

Current public managers have grown up in the era of neoliberalist thinking and the NPM program, and are often so steeped in its precepts that they cannot see any alternative. However, as always, the deeply held values and beliefs encoded in the culture of the public service have retained some of their power, and the tension between NPM precepts and public service approaches have resulted in compromised implementation and sometimes, perverse outcomes. For example, restructuring of government departments came to be justified on the basis of the goals of 'leaner, flatter structures'. Career structures were flattened, by reducing the number and complexity of classifications (Littler, Wiesner & Dunford 2003). However, at least in Australian health departments, there has been no evidence of shortening of the chain of command (ie the number of layers between workers and final decision-makers). This apparent paradox was achieved through significant reductions in the decision-making delegations allowed to lower levels in the hierarchy. Increasingly centralised structures (not part of the NPM agenda, at least in theory) and risk-averse leadership (political and bureaucratic) saw the widespread withdrawal of operational autonomy from service providers (Dwyer 2004).

For the NGO sector, NPM brought significant opportunities in the form of government action to outsource the provision of services that were not 'core business'. But it also brought a new approach to contracting for those services, inspired by agency theory and the classical methods of commercial contracting. The operating assumption supplied by agency theory is that health care providers cannot be trusted to pursue mutual goals, but must be controlled through rigorous specification, accountability requirements and monitoring. The approach included an ideal of 'best buys' for government through competition among providers, and through tight specification of what is to be provided, at what cost and quality, and often where, when and to whom.

For Aboriginal health service providers, both the opportunities and the constraints have been critical. The methods of NPM have been applied vigorously to Indigenous health services in several countries, in spite of the fact that governments enter into contracts with the Indigenous third sector precisely because of recognition that the Indigenous organisations have greater knowledge of what is required.

People working on both sides of the ACCHO-government funding relationship readily acknowledge that the (still) current fragmentation and complexity, and the accompanying onerous accountability requirements, need to change. The methods for bundling much of the funding, and improving the usefulness of data, are reasonably clear. The missing piece of the puzzle, that I would suggest gets in the way of implementation of these available methods, is the design of meaningful approaches to accountability. What is needed are methods and measures that are more focused on health gain, and less on ‘counting widgets’; that are conducive to the long-term development of a robust system, rather than simply responding to short-term reporting requirements; and that better fit the nature of the relationship between Aboriginal community-based providers and government funders, and work for both sides.

While current Australian political thinking seems to be in the full grip of neoliberalism, there is consensus among many scholars that NPM has run its course as a guiding framework for governments, as it has failed to deliver on its promises (O’Flynn 2007; Hood & Dixon 2015). Much current thinking in public administration is focused on what will come next, and the terms in use are Public Value (Management) and New Public Governance. There are also signs in the Australian public sector and its discourses that there is acceptance of the need for change. However, if NPM is in its dying days, that does not (yet) mean any loosening of the tight strings attached to the funding of NGOs.

The unresolved post-colonising environment

In the context of these opposing conceptual frameworks and the methods that give them expression, it is inevitable that there will be tension between ACCHOs and their government funders. The situation is not helped by the social and historical context of colonisation and its continuing effects. Interactions between Aboriginal and other Australians, and the structures within which interactions occur, are shaped by the unfinished business of colonisation, as well as the pervasive impact of racism. In spite of the good will and skill of many of those involved, this applies no less in the context of health policy and program implementation. Each of these influences is explained below.

Post-colonising Australia

There is an extensive literature on 'post-colonising' societies, focused on the legacy of colonisation and its continuing practice – how it continues to shape the lives of the colonised, but also the coloniser, populations (Young 2001). The Australian situation is stark, with the doctrine of terra nullius only overturned in the late 20th century *(Mabo v Queensland (No 2) (1992) 175 CLR)*, enabling legal recognition of prior occupation, and effectively recognising for the first time that Aboriginal society pre-existed settlement. This is a cruel irony, given the very long tenure of Australia by Aboriginal people. Recent DNA evidence indicates that ancestors of Aboriginal people left Africa and made their way to Australia as long as 75,000 years ago, thousands of years before later migration to Asia (Rasmussen et al. 2011). This evidence supports the citing of Aboriginal cultures as the world's oldest living cultures.

It is hard for modern mainstream Australians to grasp the thinking behind our shameful history of colonisation. In her fascinating historical and social study of Kangaroo Island, Rebe Taylor (2002) illuminates the thinking of a settler society that experienced the question of their identity as colonisers in a heightened way. She describes the complex make-up of the Island's population prior to the arrival of official settlers in 1834, including (often absconded) sealers, sailors and whalers, the Aboriginal women whom they had brought forcibly from Tasmania and from mainland South Australia, and the children of those unions. The way of life of these white men depended in many ways not only on the labour of the Aboriginal women, but also on Aboriginal skills the men had learned (like trapping wallabies). Their way of life and the men themselves were seen as a bit 'native'; and their status relative to the newly-arrived official settlers – coloniser or colonised? – was equivocal. In this perhaps unique situation where 'civilised whiteness' was not a simple proposition, Taylor suggests it became essential for the settlers and their descendants to distinguish even more clearly than usual between themselves as legitimate and civilised colonisers and the colonised, whose future was assumed to be annihilation.

While this was perhaps a unique situation, it is instructive. For our settler ancestors to take the land and all its resources, and to forcibly require the existing owners to vacate, and to comply with the wishes and laws of the new owners, they needed a powerful rationale. Its nature was a denial of the full humanity of the Aboriginal people, and a contempt for their knowledge, their social structures and way of life, their custodianship of their estates and the spiritual and social meanings of land, the environment, history and community. It was both literally and figuratively a murderous project.

The point here, as Professor Marcia Langton (2012) has argued cogently in relation to constitutional change, is that the claim of Aboriginal and Torres Strait Islander peoples to be recognised as the First Peoples of the country we now share (however unequally), is not primarily based on race, but rather on the long history of prior occupation. For the settler society, racism was a method of justifying colonisation, as well as a rationale for ongoing discrimination in other ways and other settings.

This history remains relevant for all the usual reasons, and particularly because it is embedded in current law, in public policy, in institutions and in daily life. The post-colonising society is one in which the structures and processes of exclusion and discrimination continue in modern, more subtle forms; along with the impact on the colonised of both current and past experiences of dispossession, exclusion and discrimination. There is also an impact on the coloniser society, as it finds ways to justify the obvious continuing injustice of the terms of Australia's unresolved settlement – racist attitudes draw on, continue and reinforce the rationale on which colonisation was originally justified. And foundational problems remain - we still don't have a legal framework that recognises Aboriginal and Torres Strait Islander people as the First Peoples rather than simply as a marginalised group.

In thinking about this history and the current realities it has shaped, it is important not to overlook the important gains made by Aboriginal people and communities, or the policies and programs that aim to work against exclusion and discrimination. It is also important to acknowledge that much of mainstream Australia would like to see life chances improved for Aboriginal people. A recent poll of public opinion reported strong support for constitutional recognition and strong majorities agreeing that self-determination, welfare dependence and social disadvantage are important issues 'for Australia' (Gray & Sanders 2015:9-10). Nearly 60% agreed that Aboriginal people should have special cultural protection as 'the first Australians' (p11).

The question of racism

While the positive public opinion results reported above are encouraging, a series of surveys conducted by Reconciliation Australia have consistently reported low levels of trust and high levels of prejudice between Aboriginal and other Australians. About 70% of both groups acknowledge the prevalence of prejudice against the other (Reconciliation Australia 2012:9).

Racism is defined as the processes by which members of a racial group are treated unfairly on the basis of their membership of that group (Krieger 2001). It is sometimes defined as 'prejudice plus power', thus emphasising the elements of belief (that people's characteristics - intelligence, honesty, athletic ability etc – can be predicted on the basis of race) and of action (discrimination, oppression, exclusion and responses by those affected). Theories of racism tend to focus on either the systemic level (the structures and policies that constrain or advantage the opportunities of different racial groups) or the individual level (the agency of both perpetrators and victims in enacting and responding to racism) (Ziersch et al. 2011; Baez 2000:336).

Systemic or institutional racism are terms for the 'built-in' discriminatory effects of policies, programs and practices that have differential impacts on people of non-white races. Both kinds of racism – systemic and personal – are relevant in health care. Health professionals require skills and knowledge to 'see' their own cultural assumptions and racist attitudes and to redress the impact on their effectiveness at the point of care and in the workplace generally. Organisations and the health system as a whole need policies and programs that require and enable effective responses to the health care needs of Aboriginal patients and communities. At both levels, the conceptual parallels with indirect discrimination on the basis of gender, disability or sexuality are very strong. However, as with each of these other sources or types of discrimination, the particular impacts, and the goals and strategies required to prevent or redress them, are different.

In the leadership and management of the Australian health system and health policy, it is difficult to confront systemic discrimination against Aboriginal people, for several reasons that can be grouped in two categories. First, no-one wants to be labelled as racist, or to acknowledge that their daily practice may be (directly or indirectly) discriminating against anyone on the basis of their race (or indeed their gender, sexuality etc). The term 'racism anxiety'[2] is sometimes used to describe the discomfort non-Aboriginal people feel both about interacting with Aboriginal people (in case the way they interact might be seen as racist) and in acknowledging or discussing the possibility of systemic or personal racism in their work domain.

Second, discrimination against Aboriginal people (in distinction from that experienced by other non-white populations) is rooted in the dispossession on which modern Australia was founded and its continuing denial. I suggest that this historical fact with continuing ramifications makes us all uncomfortable, and is something about which the dominant culture seeks silence. Discussion is difficult in these circumstances, and if you can't talk about it, you can't manage it or change it.

There is a related but separate challenge in health care and health policy work focused on the Aboriginal community. In the delivery of health care to Aboriginal patients by non-Aboriginal staff, both patient and worker take on the challenge of intercultural communication. For Aboriginal people, this is usually a daily task. For some non-Aboriginal staff, the challenge is to recognise first that there are cultural differences, and then that dealing with this reality is a legitimate requirement for effective health care. Willingness to take it on, and the skills brought to the task, are variable in both staff and patients.

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[2] I am grateful to Jenny Hunt, a staff member of the New South Wales ACCHO peak body, the Aboriginal Health and Medical Research Council (AHMRC) who brought this term to my attention. In April 2015, it did not come up in the first few pages of a google search.

The situation is somewhat similar in health policy and public administration work, where the framing of policy agendas or management problems, the choice of language and strategies, and the necessary conversations to determine these matters is also an intercultural enterprise. In these interactions, perhaps more of the burden is taken on by the professional and skilled Aboriginal participants, although many non-Aboriginal participants also engage in considerable effort. Attempts to address the impacts of racism on health care have generated a broad range of concepts, methods and terms for both the goals and the strategies (cultural awareness, cultural safety, cultural competence etc), which are discussed in Chapter 3.

The working relationship between the ACCHO sector and their government funders is a particular case of intercultural work, and both systemic and interpersonal kinds of racism have an impact. Personal racism (and racism anxiety) affect trust and communication between the people involved, and their individual decision-making.

Different priorities and concerns among the participants are the inevitable outcome of both structural and cultural factors. Funders and providers of health care always have different structural interests; and the impact of both kinds of racism (and racism anxiety) amplifies the differences. Systemic racism influences the structures and the formal processes of the relationship, and the mechanisms and levels of funding and accountability requirements. Individual-level racism, and racism anxiety (its ‘other face’), impede communication, heighten tensions, distort perceptions of risk and benefit, and increase the interpersonal effort and costs of the interaction. Thus in a self-reinforcing vicious cycle, the negative effects of institutional discrimination and the interpersonal aspects of the working relationship each reinforce the other, and affect the day-to-day decisions of those involved.

In summary, I suggest that there is a form of elective affinity (McKinnon 2010) between NPM-based approaches to contracting with the ACCHO sector and the systemic racism of Australian society, enacted in the public administration of the health system (as well as in health care more generally). Meanwhile the alternative framework that inspires and guides the ACCHO sector, including its focus on self-determination, inevitably conflicts with the mainstream

NPM-inspired thinking and practices of public administration, reinforcing the lack of mutual trust or a shared sense of purpose that in turn impairs interpersonal relationships as well as the development of policy improvements and their implementation. This is truly a wicked policy problem (Hisschemöller & Hoppe 1995).

Theoretical propositions

In the published work that constitutes the body of this thesis I and my co-authors have sought to make a contribution to understanding underlying barriers to the development of the ACCHO sector and recognition of its significance for health and health care; and to more effective implementation by governments of policies and programs for Aboriginal health. It has articulated, but not solved, the accountability puzzle. This is attempted in the final chapter, which is a new synthesis of recent literature and my existing body of work.

The published work in this thesis is my attempt to test four propositions:

1. That the fragmentation and complexity of arrangements for funding and regulating ACCHOs are based in the application of New Public Management methods; and that those methods reinforce rather than counteract the difficulties of the relationship between the sector and its funders.
2. That the inadequacy of operational responses in the mainstream health system to the particular needs of Aboriginal patients (in spite of high level policy that requires such responses) constitutes systemic racism; and that the absence of a legislative base on which such responses could be reliably built in to the system reinforces the problem.
3. That current Australian approaches to accountability, based on New Public Management methods and founded in agency theory, are inappropriate to the Aboriginal Community Controlled Health Organisation sector and an alternative is needed.
4. That a framework of reciprocal accountability could provide the basis for resetting the relationship between Aboriginal communities, the sector and government funders.

Literature review methods

Relevant literature was reviewed for each chapter. As is suitable for much of the health policy field, I have not attempted a systematic literature review – and certainly none of the questions I am interested in are amenable to meta-analysis. Rather I have used an organised search strategy to produce what I hope are three inter-related 'good quality literature reviews' (Aveyard 2014: 3) presented in narrative style, with papers grouped and analysed thematically. A search of electronic databases was conducted by a librarian under my direction, using the timeframe 2009 to the search date of May 2014. I also conducted hand searches of selected references in the articles reviewed, and updated the search results to the time of writing via hand-searching of relevant journals. Important earlier papers identified in hand-searching were included where they added to the existing literature reviews in the published work. Australian government and policy institute, World Health Organisation (WHO) and Organisation for Economic Cooperation and Development (OECD) websites were also searched for relevant policy and review documents. Where up-to-date literature reviews based on systematic searching were available they have been relied upon. Only English language papers were reviewed.

This method was chosen to avoid the hazards of more traditional literature searching methods, and support the inclusion of evidence regardless of disciplinary basis or my ideological preferences. Three separate methodical searches were conducted, focused on contracting (most relevant to Chapter 2), systemic racism and Indigenous health care (most relevant to Chapter 3) and governance and accountability (most relevant to Chapters 4 and 5). The details of each of these searches are provided in the relevant chapters. However, the topics are closely related, given my interest at the intersection of these matters, and the searches were in fact overlapping.

Structure of the thesis

The rest of this thesis is structured as follows:

Chapters 2 to 5 incorporate the published work. Each of chapters 2 to 4 consists of an introduction, a review of recent literature, the published work, and a conclusion. The introductions describe the context of the work, and my role in it. The structure of Chapter 5 is somewhat different (see below).

In keeping with modern practice in qualitative research generally (Grbich 2007:12-13), and in Indigenous post-colonising research (Smith 1999), the contextual statement is both personal (positioning the researcher in the research) and situational (positioning the research in its intellectual, organisational and political context). This approach also enables me to track the linkages and development between the papers in a concrete way. The role statement explains my contribution, along with those of my co-authors or the lead author. Each of these statements has been provided to my colleagues, refined on the basis of their responses, and endorsed by them as correct.

The published work is presented in its published form (and in 2 cases, as 'author manuscript' due to publisher requirements). The conclusion to each chapter contains a statement about the contribution the published work makes to the propositions above; and suggestions about further research or development.

Chapter 2: The funding and regulatory relationship sets out the funding relationship problem, in the form of a paper reporting the results of research into Australian government and sector practice in funding and accountability (Dwyer et al. 2011); and the paper that established the international analytical framework on which this research was based (Lavoie, Boulton & Dwyer 2010). This chapter also refers to a commissioned report reviewing the effectiveness of the sector (Dwyer, Silburn & Wilson 2004) which is included as Appendix A, and the original *Overburden Report* (Dwyer, O'Donnell, Lavoie, Marlina & Sullivan 2009, included as Appendix B. This chapter addresses my first proposition.

Chapter 3: Holding response and denial – post-colonising accommodation explores the gap between policy and implementation in the mainstream health system, and examines the impact of systemic racism on mainstream thinking about and efforts for Aboriginal health. It commences with two papers based on a study of the ways in which the health system responds to the particular needs of rural and remote Aboriginal patients (Dwyer, Willis & Kelly 2014; Kelly, Dwyer, Willis & Pekarsky 2014). This chapter also includes a paper that explains the (lack of a) legislative base for stewardship for Aboriginal health (Howse & Dwyer 2015). The Managing Two Worlds Together Report (the industry report of the larger project on which the first two papers are based) is included as Appendix C, along with links to the other industry reports published from this major project. This chapter addresses my second proposition.

Chapter 4: Accountability and the mystery of reform examines the problem of accountability, and the foundations for new models, in the form of two published papers (Dwyer, Boulton, Lavoie, Tenbensel & Cumming 2014; Tenbensel, Dwyer & Lavoie 2014). This chapter addresses my third proposition.

Chapter 5: Conclusion – Reciprocal accountability as the basis for resetting the relationship addresses my final proposition, and seeks to synthesise the implications of this body of work. It includes the final two published papers (Dwyer et al. 2015a; Lavoie & Dwyer 2015), which address the sector development that is needed to realise the long-established community and policy goal of equitable access to PHC for Aboriginal and Torres Strait Islander people. It presents an original framing of the structural tension in accountability relationships for ACCHOs; and articulates implications for a novel approach to accountability regimes. On the basis of both this analysis and the literature review, the implications of that approach are outlined in the form of possible methods that could be tested and used to guide the development of new arrangements.

I hope that this work will contribute to the continuing efforts of those on both sides of the funding relationship to find better ways of managing the tensions in their roles and relationships, and thus to establish a solid basis for equitable access to essential PHC for Aboriginal and Torres Strait Islander people.

Chapter 2: The funding and regulatory relationships

In this chapter, the published work addresses the first of my four propositions: that the fragmentation and complexity of arrangements for funding and regulating Aboriginal Community Controlled Health Organisations (ACCHOs) are based in the application of New Public Management (NPM) methods; and that those methods reinforce rather than counteract the difficulties of the relationship between the sector and its funders. I first outline the context in which the research was funded and conducted, and briefly describe the papers and relevant appendices. The papers themselves are then presented, preceded by a statement of my role in their production, and followed by a brief statement of their impact. The more recent literature on contracting between governments and non - government organisations (NGOs), particularly for Primary Health Care (PHC), is then reviewed, and the implications of subsequent evidence are considered. Finally, the chapter concludes with an analysis of how this work tests and confirms the proposition above, and contributes to the larger project of this thesis.

The research story

The articles in this chapter established the directions of my research over the last decade. This journey commenced with my involvement in the Cooperative Research Centre for Aboriginal Health (CRCAH), which was first established in 1997 (under the title CRC for Aboriginal and Tropical Health) as a joint venture of its industry and university partners, with a majority-Aboriginal board chaired by Dr Lowitja O'Donohue. It arose as a joint initiative between the Menzies School of Health Research in Darwin (led by Professor John Matthews) and leaders of the ACCHOs in the Northern Territory (represented by Dr Pat Anderson and Ms Stephanie Bell). The story of the development of the CRC is a long and interesting one, told by Dr Anderson in one of her many memorable speeches (Anderson 2011) and documented more formally in Dunbar, Arnott & Scrimgeour et al. (2003).

My involvement commenced in 2001 during the bid for the second round of funding, following my move from a senior executive position in the Victorian public health system to an academic role in the School of Public Health at La Trobe University. By 2005, the 'new'

CRC, led by Dr Pat Anderson (Chair) and Mick Gooda (CEO) had replaced a traditional funding model (of competitive grant application among the CRC partners) with the Facilitated Development Approach (FDA) (Brands & Gooda 2006). The FDA process commenced with identifying research priorities (within established research program areas) and then developing researchable propositions through joint discussions among community, industry and research representatives, using 'round table' workshops. Sometimes, those who had contributed to the process (among others) were then offered opportunities to develop a fundable proposal, with CRC staff and Program Leaders identifying and inviting a potential project leader to lead the development. For other projects, an expression of interest process open to all CRC partners was used.

This method was seen to offer several benefits, including enabling the CRC to determine a research agenda based more on community and industry priorities and less on those arising de facto from the research interests of staff of the academic partners. A cartoon that hung on the back of a door in the CRC building illustrated the idea. The tagline was 'Aboriginal people in the driver's seat', and it showed research as a utility vehicle with Aboriginal people in the front and researchers sitting somewhat uncomfortably in the back.

However, there were benefits to 'taking a back seat' in the agenda setting. For non-Aboriginal researchers, the arrangement gave us an ethical authorising environment for our work – that is, we could have some confidence that our work was focused on questions that mattered for Aboriginal health, and we were much less liable to the accusation of simply using Aboriginal people and communities to further our careers or to focus on our obsessions.

Nevertheless, the method brings its own challenges in the task of getting from a statement of a knowledge problem to a truly researchable proposition, while maintaining the necessary fidelity to meet the end-users' needs. This is perhaps a common experience in CRCs, all of which must grapple with this issue in some way. In the case of the Aboriginal Health CRC, it was definitely complicated by the fact that the 'industry' partners represented two distinct and often opposing structural positions – provider and funder of PHC. While it may be argued that funders and providers share high order goals (ie for health advancement), it is also almost inevitable that their strategic goals are in tension if not opposition. For example, public hospitals seek to grow and expand their treatment capacity; the health department wants to operate within a usually tight budget and (mostly) keep hospitals off the front page. As will be shown in this thesis, this structural tension applies in the relationship between the ACCHO sector and its government funders, which also has additional tensions such as the need to work across cultures.

This was an important problem for the research represented in this chapter, as it focuses on precisely this relationship. With hindsight, it was perhaps predictable that the development process for this work was complicated by unclear communication from the industry partners about what they really wanted. The brief was expressed in language that papered over differences (and was not thereby made more incisive), and thus the time for its development process was made longer.

The papers

The first paper below documents important aspects of the funding relationship problem in Australian government and ACCHO sector practice, in particular its fragmentation and complexity. These characteristics are analysed against a framework that contrasts quasi-classical contracting approaches (inspired by New Public Management thinking) with relational contracting. The second paper presents the theoretical framework in detail, drawing on contract theory.

There are two appendices of relevance to this chapter. The first is the product of a commissioned research assignment that was important in the development of my work with Aboriginal health services. During 2003, I was commissioned by the Commonwealth Department of Health and Ageing (through the Office of Aboriginal and Torres Strait Islander Health (OATSIH)) to write the lead paper for a Cabinet review of PHC for Aboriginal people. The impetus for this assignment arose in an Inter-Departmental Committee established at the instruction of the Minister for Health (Mr Tony Abbott) as part of a bid for increased funding for the ACCHO sector.

The role of the PHC review (of which my project was the central piece, among 6 others) was to provide advice as to the value and soundness of investment in PHC, in the light of scepticism in the Howard government that health care focused on Aboriginal people was a worthwhile investment at all. This scepticism was expressed in a letter from a member of the inter-departmental committee (not in the health portfolio) who suggested that while he felt enormous sympathy for the poor health of Aboriginal people, perhaps the money currently going into health care should be withdrawn and redirected into housing or other infrastructure instead, where it would bring more benefit. While the question of benefit is critical in relation to all government expenditure, it would not be acceptable to suggest that, for example, the people of Sydney should no longer have access to general practitioners so that the security of their water supply could be improved. While I found the writer's sentiment shocking (not even a palace will manage your diabetes), the letter clarified the task – nothing could be assumed.

This assignment, undertaken with considerable assistance from OATSIH, gave me an opportunity to inform myself in detail about the role of the sector and the challenges it faced. Ultimately, Mr Abbott's bid for additional funding in the 2003/04 budget was only modestly successful, and in apparent frustration at this outcome, he directed that the papers (which had been confidential because they were produced to support a Cabinet submission) be published. The resulting publication, *National strategies for improving Indigenous health and health care,* is attached to this thesis as Appendix A. This publication proved useful as a record of the role of the sector, and as a resource for policy-makers and other researchers, and has 40 citations (Google Scholar 14 October 2015.)

Appendix B is the 'industry report' that was the first publication from the Overburden Project, known as *The Overburden Report* (Dwyer, O'Donnell, Lavoie, Marlina & Sullivan 2009). The story of its genesis is told below.

PAPER ONE – Contracting for Indigenous health care: towards mutual accountability

The study on which this paper (Dwyer et al. 2011) is based from priorities identified by CRCAH industry stakeholders (representatives of the ACCHO sector and Commonwealth and NT government funders) and endorsed by the Board of the CRC (August 2005). It was developed using the Facilitated Development Approach designed by the CRC (Brands & Gooda 2006). I was invited, in early 2006, to consider leading the project through its development and implementation. Initially entitled *Frameworks for best practice in the organisation and resourcing of PHC services for Aboriginal and Torres Strait Islander people* (Dwyer et al. 2006), it eventually became known as the Overburden Project.

I had initially responded to an invitation to be involved (in September 2005), and was subsequently nominated by the CRC as the project leader. I led the writing of an initial draft proposal, and participated in a Round Table (held in Melbourne in February 2006). The project team was then formed, the project design was further developed and tested, and a formal funding agreement was ready for signing in April 2007. The data collection stages were completed by the end of 2008; and the final report was launched by Dr Tom Calma, Social Justice Commissioner, in August 2009.

Knowledge exchange activities were conducted during the following 2 years (presentations at workshops and conferences, publication of opinion pieces in the popular and industry press, participation in discussions and seminars with government funding bodies and industry organisations). Other work also continued, including a follow-up survey of ACCHOs regarding their funding and reporting requirements (Martini et al. 2011), and the peer-reviewed paper that follows. Dr Kim O'Donnell also conducted a related follow-up study for her professional doctorate of Public Health, entitled *Split three atoms and report tomorrow: The funding relationship between Aboriginal Community Controlled Health Organisations and Government Departments* (O'Donnell 2015), for which I was an associate supervisor.

Statement of my role

I wrote this paper, and was primarily responsible for the design and conduct of the research, and the drafting, revision and final approval of the manuscript. I also negotiated with government stakeholders and the ACCHO sector to maximise their participation in the study.

The contribution of other authors is significant. Professor Josée Lavoie was engaged in all aspects of the study, and her doctoral thesis (Lavoie 2005) was an important influence on the project, providing the basis for its theoretical framework. Professor Lavoie brought an international comparative perspective to the study, and contributed in particular to the research design. Dr Kim O'Donnell was employed as a research associate for the duration of the project, co-managed the project and its complex stakeholder relationships, conducted many of the interviews, and played a major role in coding and thematic analysis, as well as in the drafting of *The Overburden Report* on which the paper is based. Dr Uning Marlina conducted the analysis of funding sources for the ACCHOs that participated in a financial aspect of the study; and contributed to thematic analysis of the interviews. Professor Patrick Sullivan contributed to the design of the study and the writing of the paper, bringing a broad policy perspective.

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RESEARCH AND EVALUATION

Contracting for Indigenous Health Care: Towards Mutual Accountability

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In Australia and other industrialised countries, governments contract with the non-government sector for the provision of primary health care to indigenous peoples. Australian governments have developed policies and funding programs to support this health sector, but the current arrangements are unduly complex and fragmented. The results of our study show that the complex contractual environment for Aboriginal Community-Controlled Health Services (ACCHSs) and their funders is an unintended but inevitable result of a quasi-classical approach to contracts applied by multiple funders. The analysis in this article highlights potential policy and program changes that could improve the effectiveness of funding and accountability arrangements, based on the use of an alliance contracting model, better performance indicators and greater clarity in the relative roles of national and jurisdictional governments.

Key words: *contracting*, *Indigenous health care*, *accountability*

Community-based primary health care (PHC) services for Aboriginal and Torres Strait Islander people[1] were initiated in the 1970s, and now constitute a significant sector of the Australian health system. Australian governments, like their counterparts in comparable countries, have established a range of funding programs and contractual arrangements to support this sector. ACCHSs now provide PHC services to between one third and one half of the Aboriginal population (NHHRC 2009:87; NACCHO 2009:2-3) in rural, remote and urban settings.

The guiding national health policy document is the National Strategic Framework for Aboriginal and Torres Strait Islander Health, signed by all Australian health ministers in 2003 (NATSIHC 2003). It affirms:

> Within the health system, the crucial mechanism for improving Aboriginal and Torres Strait Islander health is the availability of comprehensive primary health care services. . . . These services should maximise community ownership and control, be adequately funded, have a skilled and appropriate workforce and be seen as a key element of the broader health system (NATSIHC 2003:1).

Several studies have investigated the appropriate level of funding for PHC services for Aboriginal and Torres Strait Islander people (Deeble et al. 1998; Jan 2000; Mooney, Jan and Wiseman 2002; Beaver and Zhao 2004; Econtech 2004) and all have recommended significant increases to the community controlled sector and other providers, to achieve equity of access according to need. We estimate the funding received by the community controlled sector to be less than 1% of total Australian health expenditure.[2]

PHC funding provided to Aboriginal agencies is intended to improve the health of Aboriginal people by supporting good health care, while also meeting the need for accountability to communities and to governments. However, the current arrangements for funding are much criticised for being fragmented and complex, and having excessive administrative and reporting requirements (Morgan Disney and Associates 2006; Effective Change 2008).

The experience of the sector has much in common with other government-funded nonprofit organisations (Flack and Ryan 2005; AIHW 2006; McGregor-Lowndes and Ryan 2009; Productivity Commission 2010), but there are several important differences. Firstly, the ACCHSs sector occupies a unique position as a major provider of essential PHC to Aboriginal and Torres Strait Islander communities, providing approximately 1.5 million episodes of care to Aboriginal and Torres Strait Islander Australians in 2005–06 (DoHA and NACCHO 2008). This is the only sector of the health system where fragmented contracting is a predominant method by which Australian governments fulfil their responsibility for essential PHC.

Secondly, ACCHSs incorporate principles of self-determination with PHC principles in their approaches to governance and management, priority setting and health care delivery. Efforts to implement funding programs and accountability arrangements based on government policy and incorporating these principles are characterised by conflicting goals among multiple parties and by implementation difficulties. These difficulties arise in a context of underlying contestation regarding claims for collective participation and control over health care resources by Aboriginal communities, in spite of official policy pronouncements that support those claims (Anderson 2006).

Contracts in this context are arrangements by which government funders specify the services or other activities they are ‘purchasing’ on behalf of the community, the amount of funding, and the reporting and other accountability requirements. These arrangements are specified in service or funding agreements (contracts) between the funder (generally, government) and the provider (in this case, the ACCHSs). The resulting contractual environment is characterised by ‘a multiplicity of fragmented, often proposal-driven, contracts with high administrative costs’ (Lavoie 2005:2).

In Australia the relative roles of the national and jurisdictional (state/territory) governments in funding health care for Aboriginal people are overlapping and unclear. Both levels of government provide direct funding for Aboriginal-specific health care providers in remote, regional and urban settings. Unlike the situation in comparator countries (including New Zealand, Canada and the USA) legislative responsibility for indigenous health is not specifically defined for any level of government (Ring and Firman 1998; Alford 2005:35).

This study is part of a larger research program which documented the complexity of current funding and accountability arrangements. In a nationally representative sample of ACCHSs, most funding (approximately 80%) was allocated by the national government, with state/territory governments providing the rest (19%). The number of separate funding grants received by individual ACCHSs ranged from six to 51, with an average of 22 grants per ACCHS, and a total of 461 grants in all, as shown in Table 1.

Typically, funding guidelines specify purposes, activities and reporting requirements,

Table 1. Number of Grants Received by Sample ACCHSs in 2006–07

No. of grants	*No. of agencies*	*Total grants*
1-10	3	26
11-20	8	101
21-30	4	106
31-40	4	136
41-50	1	41
>51	1	51
	21	461

and the related contracts tend to be constructed as if there were a simple one-to-one alignment between the funding guidelines and the services ACCHSs provide. However it is common for a single health service or program to draw on more than one source of funding, over different timelines and with different data collection requirements. Figure 1 illustrates in a simplified way the complexity this lack of alignment involves.

In this article, we aim to analyse the sources and impact of these problems as experienced on both sides of the funding relationship, and suggest a potential approach to reform of the contracting methods, using an analytical framework based on contract theory.

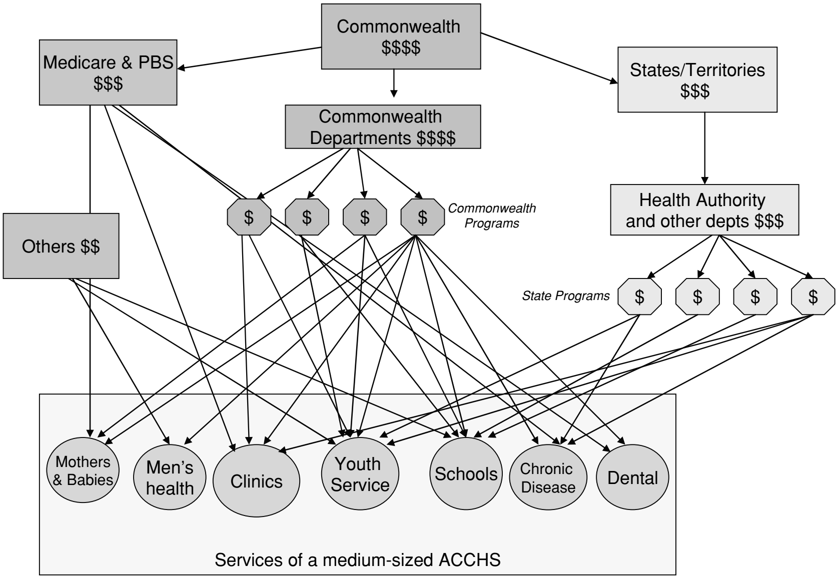
Contracting and Accountability

Macneil (1978) articulated the distinction between classical and relational contracts which has informed this study. Classical contracting is the traditional model for an exchange of goods or services for money, and is characterised by discrete highly-specified transactions, limited flexibility, and often short duration.

Relational contracting recognises the interdependence of contractor and supplier, and seeks to maximise the common interests of the parties in the enterprise. It is characterised by greater flexibility and cooperation, as well as reliance on trust. Relational contracting assumes that transactions are likely to recur, and recognises that the nature of the contracted services makes it difficult to specify and monitor outputs, which are therefore less detailed (Palmer 2000). These contracts more often rely on self-enforcing mechanisms to guarantee the fulfilment of the terms, as each party wants to maintain its reputation as well as good relationships (Perrot 2006).

In the commercial sphere (including public/private partnership arrangements between government and the private sector), this approach has become more common with the

Figure 1. Typical Funding to a Medium-Sized ACCHS



move to outsourcing of aspects of businesses, and is usually called alliance contracting. Alliance contracting was first used in Australia in the 1990s for major infrastructure projects, and since then for many public–private partnering projects and outsourced functions of businesses. In alliance contracting the participants have incentives to focus on what is best for the project or service and on better risk management, and to ensure transaction cost reductions. However, alliance contracting requires more involvement from senior managers than traditional contracts, brings increased risk of decision-making deadlock and needs acceptance of risk by all participants (Department of Treasury and Finance Victoria 2006; Queensland Government Chief Procurement Office 2008). Ruuska and Teigland (2008) found that alliance contracting works better in environments where there is a joint problem-solving task, where communication is continuous, and where alliance members have the capacity to resolve conflicts through discussion.

Both contracting styles are applied in the health sector. Palmer and Mills (2003, 2005) found that contracting in health services tends to be more relational and less formal in situations where government is the purchaser and there is a lack of competition, and thus a degree of mutual dependency between the provider and the purchaser. When the services to be provided under the contract are broad ranging, contracts are more likely to be relational than when, for example, a specific service such as diagnostic testing is being purchased (Parker, Harding and Travis 2000; Palmer and Mills 2003, 2005; Macinati 2008).

The increasing use of contracts and contract-like mechanisms by governments has fundamentally changed the nature of accountability arrangements (Cribb 2006). Influenced by the principles of New Public Management (NPM), governments have moved away from what Hughes Tuohy (2003) describes as the role of a 'principal' in a trust-based principal-agent relationship. The shift to contract-defined relationships has reshaped the role of the state to purchaser and contract monitor, focused on deliverables (indicators of outputs and ideally of outcomes) that can be audited. In the process, the state is increasingly defining how care should be provided while, as Peter Shergold, former Secretary of the Department of Prime Minister and Cabinet, put it 'the delivery of public policy has been outsourced' (Shergold 2003).

Nevertheless accountability is also about power and the discharging of responsibility between stakeholders. ACCHSs, like many other organisations in the non-government sector, also carry direct accountabilities to their communities and consumers. While the need for accountability for public funds is accepted, there is a need to ensure that the compliance, monitoring and reporting arrangements justified on the basis of accountability are meaningful and proportionate, and address accountabilities to consumers as well as funders.

In this study, we sought to analyse the contracting practice of Australian governments in health care for Aboriginal people, including the way that accountability is operationalised in the contractual relationship, using the framework of classical and relational contracting theory.

Results

This article reports results from a combination of desk-review of documents, and interviews with participants from both sides of the funding relationship. Twenty senior health department staff with responsibility for Aboriginal health (executive level heads of head-office Aboriginal policy/program units and their senior financial officers) in all but one jurisdiction participated, along with 23 senior staff of a national sample of ACCHSs (located in all states and territories except Tasmania, in urban, rural and remote areas, and ranging in size and duration of operation). Interviews (designed to elicit information and opinion about the elements of the contracting relationship) were audio-recorded, transcribed, and coded thematically, using an inductive analysis approach (Grbich 2007). Illustrative quotes from the interviews are included in the results below. The results confirm the complexity of funding arrangements, and suggest that current contracting practice entails several significant problems.

Complex Contractual Environments: Unplanned and Unmanaged

The complexity and fragmentation of funding arrangements (documented in Dwyer et al. 2009) was confirmed by all those interviewed for this study. Funding is administered through multiple contracts from many sources, and most of them are short term (one to three years):

> There are lots of buckets of money from lots of different programs from the same funder that are addressing the same issues, but with a different name (ACCHS CEO).

> The Commonwealth rolls something out every week, it's challenging then for us to put things on the ground . . . It took a year to get the program funding to us for a three- to four-year program, we've already lost a year before we even get on the ground. We're a year behind in our reporting, a year behind in our achievements . . . Because we're behind, the funding to our [ACCHSs] is behind (Health Authority Finance Officer).

ACCHS interviewees reported that short term funding is often for small amounts, brings low salary levels, difficulties in recruiting to short term positions, and a heavy burden of administration and reporting. There are problems when services must be discontinued at the end of a funding period in spite of community expectations, and short timeframes make it difficult to demonstrate outcomes, or engage in planning and strategic direction setting. ACCHS staff also noted some advantages of short term funding – such as additional resources for short term health promotion activities, for projects such as evaluations, and for developing new programs.

Complexity is increased by variation in allocation pathways within and between government departments. While the national and two jurisdictional health authorities distribute the bulk of health funding through Aboriginal health units, the majority of jurisdictions (and virtually all non-health departments that fund ACCHSs) distribute funding through mainstream program or procurement divisions.

This variation in allocation pathways is problematic for two reasons. Firstly, program areas and procurement divisions design their procedures and reporting requirements primarily to suit larger mainstream services, and they are generally not 'scaled down' for smaller contracts. Secondly, the dispersion of responsibility for funding ACCHSs reduces the likelihood that those managing funding programs will be informed about the overall funding pattern and its complexity.

This problem is also illustrated by the fact that it was not possible for any health authority participants to provide a comprehensive listing of the funding their department provided to the ACCHS sector. While such problems are also encountered in other sectors of the health system where contracting is common, there is evidence that it is worse for the Aboriginal health sector (Lavoie, Boulton and Dwyer 2010).

Fragmented Funding in Tension with Integrated PHC

Interviewees contrasted core PHC funding (funding that enables the operation of clinics, other PHC services, and related support, management and infrastructure services) with program or 'body part' funding (funding that is directed to specific conditions or health risks). Core funding for comprehensive PHC was seen to enable more independence and flexibility, allowing ACCHSs to continuously implement and adapt programs to meet local needs.

Interviewees identified three main problems with the current extent of targeted funding programs for specific conditions or interventions. The first concerns the need for an adequate base of core PHC funding, so that agencies can respond to the presenting needs of patients and families:

> unless you've got core primary health care money to deliver the basic minimal level of primary health care, you can't deliver a health service based on programmatic, organ-specific, disease-focused programs . . . unless you've got core primary health care you're never going to be in a position to offer other relevant programs based on the community needs (ACCHS CEO).

The second set of problems relates to the inevitable tension between local and national priority setting. Governments seek to direct funding to national or jurisdictional health priorities, and to modes of care or interventions that are seen to be effective. On the other hand, local and regional providers of care for Aboriginal and Torres Strait Islander communities seek flexibility to respond to the pattern and priorities of need in their communities, and to take up local opportunities to make a difference. Tension between these goals is inevitable, and both are important.

Several ACCHS interviewees commented on the problem of top down decisions without consultation on local priorities or without regard to the strategic approach of the organisation. Some also reported good negotiations with funding bodies in deciding on programs and approaches, and good alignment between some program grants and agency activities.

Three-quarters of the health authority staff said that priorities are set centrally, and based, among other things, on nationally aggregated data that necessarily glosses over local and regional differences. They noted recognition in policy statements of the importance of locally determined priorities, but the lack of a consistent approach by government that is inclusive of ACCHSs in setting these priorities. The mutual recognition of value in both approaches suggests that there is room for more negotiation; for example through government contract managers having more flexibility to vary the application of targeted funds.

The third set of problems is financial and administrative. ACCHS staff commented on the tendency for funding program grants not to include funding for essential components of service delivery, such as transportation and human resources capacity building, a problem that was also acknowledged by some health authority staff. The complexities arising from, for example, the need to allocate components of individual staff salaries to different program grants for the same or like purposes was noted to be both difficult conceptually and time consuming.

Comprehensive PHC must be responsive to the needs of patients, and therefore cannot be fully specified. Contracts should therefore allow for negotiation and cooperation between purchasers and providers to accommodate uncertain futures, such as the possibility of sudden changes in service demand, while maintaining the quality and continuity of care.

Transaction Costs are Seen as High

Transaction costs in this context are the resources that are used in planning, negotiating, monitoring and accounting for the use of contracted funding, and are incurred by both funders and providers. There was general agreement among health authority and ACCHS staff that transaction costs are too high, and that the level is linked to the nature of the funding programs and the reliance by ACCHSs on two levels of government and multiple portfolio areas.

Current moves towards streamlining data collection and reporting requirements are yet to be consistently implemented. Further, the tendency in recent years for governments to tighten reporting requirements for all recipients of funding has worked in the opposite direction:

> It's a serious problem. It affects the efficiency and effectiveness of the programs offered by the recipient. In one ACCHS, the manager has to manage twenty-seven quarterly reports and financial statements and annual reports. When does she get time to run the organisation? (Health Authority Manager).

ACCHS staff commented on a lack of collaboration among state and national funding authorities, and the lack of a standard reporting format, which is particularly burdensome for activity (rather than financial) reporting. About two-thirds of health authority staff said the administration associated with the provision of programs and reporting requirements is not factored into the funding allocated to ACCHSs. The move by some health authorities to consolidate funding agreements into a single annual agreement is welcomed, but does not necessarily reduce the burden of reporting, as separate schedules or numerous variations impede the promised simplicity.

Similarly, interviewees on both sides acknowledged that lack of consistency among funders in setting data requirements, and lack of effective information systems, adds to the burden of data collection and reporting. They also agreed that reporting is too focused on 'heads through the door' to the detriment of capacity for monitoring health impact. Health authority staff were generally positive about the use of the data collected, while ACCHS managers complained about a lack of useful timely feedback on the reports they submit.

Progress is being made in data collection and reporting systems, with some consolidation of systems for data extraction and analysis, and some progress at the policy level towards measures of health service output and impact that are both valid and meaningful (Sibthorpe 2004; AHMAC 2006; SCRGSP 2009:5–11). Further, a recent Office for Aboriginal and Torres Strait Islander Health (OATSIH) review of reporting requirements (OATSIH 2009) foreshadows a reduction in duplication, a focus on outputs and outcomes in relation to OATSIH-funded work, and more timely feedback.

However, our analysis suggests that the problems noted above are an almost inevitable result of the nature of the approach to funding. That is, reporting on tightly specified short term funding for specific activities is likely to focus on those things that can be counted immediately (usually, the activities themselves) and specifically attributed to the relevant grant, to the detriment of a focus on indicators of intermediate or longer term outcomes, or broader measures of health and wellbeing.

Barriers to Trust and Mutual Accountability

The problems with burdensome accountability arrangements were seen by some participants as evidence that ACCHSs are subjected to higher levels of scrutiny than other contracted providers, because of a relative lack of credibility and trust. This is an important problem in a contracting relationship, making the 'soft accountability' (Cribb 2006) of good working relationships harder to achieve.

Interviewees on both sides of the funding relationship reported on good, as well as poor, relationships and experiences of trust. ACCHS staff were more likely to note good relationships with OATSIH than with state funding bodies. When ACCHS interviewees spoke about problems with health authority staff showing distrust or withholding information, or being reluctant to assist ACCHSs with problems on the ground, they suggested that this arose when funding bodies saw ACCHSs as isolated or not being part of the whole health system:

> It would be great to have a different relationship with OATSIH ... where we were viewed as an integral part of the health system, that we are playing an important role in our region (ACCHS CEO).

We suggest that mistrust is reinforced by the political sensitivity of Aboriginal issues, which touch the raw nerve of foundational ideas of national identity (see, for example, Dixson 1999:43; Sullivan 2009). Aboriginal representative organisations are in a double-bind: political sensitivity provides a way of getting attention for their members' needs, but it tends to lead to the kind of over-administration documented here. Similarly, government policy and program staff confront a heightened need to demonstrate value for money; as well as the challenges of political sensitivity when they respond to non-compliance by ACCHSs with accountability measures.

The current approach to accountability does not recognise an important additional role of indigenous community-controlled organisations. These organisations can represent and, in a sense, embody the clients. As Rowse (2005) points out, indigenous people require community sector organisations in order to become visible as citizens (see also Sullivan 2010). These organisations are not simply providers (the intermediary between clients and purchasers). As the representative voice of clients they, themselves, can require accountability from the government that purchases the services. They have the right to this downwards accountability not only as the representative of citizens, but as the representative of a unique kind of citizen – indigenous people. Contractual accountability arrangements for these organisations may require more emphasis on reciprocity between government and providers, as well as the need for providers to report meaningfully to their communities (Auditor General of Canada 1996).

The Classical Relational Paradox: Short Term Contracts but Ongoing Funding

While all government (and most other) funding is constructed as short term contracts, the predominant reality is that the bulk of funding is ongoing, provided that organisations meet their obligations and are seen to function effectively (Morgan Disney and Associates 2006:49; Effective Change 2008:16; Dwyer et al. 2009:34). However, uncertainty about the continuity of funding was reported to cause several problems for ACCHSs, including periods of operating without knowledge of funding allocations, cash flow difficulties, problems in meeting timelines for the spending of funds, and the effects of uncertainty on planning and operational decision-making, on workforce sustainability and on the quality or volume of service provision.

Health authority staff reported on plans to move to longer term contracts (eg, three years instead of one), and to consolidate grants into single contracts where possible. They also generally agreed with the perspectives of ACCHS staff, while noting that short term funding provides greater flexibility for the funder. They reported that most funding is expected to be ongoing in practice, but they also acknowledged the problem of insecure funding:

> There is a reasonable assumption that an ACCHS will receive continual funding but this is not contracted in a way that would make them feel secure (Health Authority Manager).

This situation brings into question the value of constructing funding as short to medium term. It seems that this may be a ‘worst of both worlds’ accommodation, and the effort involved seems disproportional to the benefits:

> All we want is funding certainty so that we can really start to give some long term commitments to our programs on the ground (ACCHS CEO).

Thus while the complex contractual environment for ACCHSs and their funders is largely shaped by a classical contracting model, there is often a vocabulary and management environment that invokes relational contracts. This situation tends to undermine the benefits of both forms. Those involved think and behave in ways that belie the intentions of classical contract provisions (such as avoiding expectations of ongoing funding and capacity for strict holding to account for outputs); but the advantages of relational contract forms (such as reduced transaction costs) are not realised either. The same phenomenon has been reported elsewhere (Allen 2002; Palmer and Mills 2003).

Discussion and Conclusions

This study of the funding and regulatory practices of Australian governments confirms the complexity and fragmentation of funding arrangements, and the heavy burden of acquiring, managing, reporting and acquitting funding contracts for those on both sides of the funding relationship. The complex contractual environment in which ACCHSs work is acknowledged by funders, but not monitored or managed in any consistent way. It has emerged from a series of unlinked policy and program decisions, and has simply grown over time. Heightened political sensitivity, and the related need to demonstrate strong accountability, tend to reinforce burdensome reporting requirements that seem to have limited utility. Although the goals of ensuring value for money and its use as intended are sound, the impact of the measures enacted in pursuit of these goals is counterproductive.

It must be noted that complexity is not axiomatically a bad thing, and the current complex funding arrangements for ACCHSs are partly evidence of their success in attracting resources from multiple funders. However, this study, along with several others, has documented a level of complexity that is not productive. As noted above, recognition of the administrative overburden has led funders in most jurisdictions to make plans to simplify and consolidate contracts, and to lengthen the standard funding term to three years. Progress has been made, particularly by OATSIH, but there are many problems in the current funding models that seem intractable, and we suggest that a different framework is needed.

Complexity is Inevitable with Quasi-Classical Contracting and Multiple Funders

Given that these problems have been recognised for many years, the question arises as to why effective action has not been taken. The problems have several sources. Complexity and fragmentation are unintended but inevitable results of the use of quasi-classical contracting methods by multiple funders acting independently. The observed lack of consistency in the reporting requirements of national and state government funders is one clear example. Establishing a single reporting regime, and perhaps even a single report, seems to be an obvious solution. However, our informants reported a sense of powerlessness to affect the proliferation of separate reporting requirements attached to each new funding initiative, and this problem requires further examination.

Within the technical/bureaucratic sphere, the problems are compounded (in the majority of health authorities) by internal structures that separate responsibility for policy and relationship development from responsibility for contract management. Although these arrangements may have other advantages for the health authorities, we suggest that in relation to Aboriginal health services they complicate communication tasks and reduce the knowledge management capacity of the funder (ie, its ability to ensure that information about agencies and funding issues is shared and available to all who might need it).

There is also evidence of general awareness of these problems and a widespread intention to address them. However, it seems that the implementation of intended reforms is slow and patchy, particularly where cooperation between two levels of government, or different government departments, is required. The intractability of this problem is also at least partly an outcome of the NPM-style contractual practice of all Australian governments in appropriation of funds for social programs and definition of output-based reporting requirements (Productivity Commission 2010). We suggest that the costs of this approach outweigh the benefits, and it is time to reassess.

Who is in Charge Here?

The lack of clarity in the responsibilities of state and federal governments which is an acknowledged problem in the mainstream health system, and the subject of current COAG reform initiatives (Australian Government 2010), also applies in relation to primary health care for Aboriginal people. While ACCHSs may benefit from being able to call on multiple potential funders, the lack of overarching responsibility enables the same kinds of blame- and cost-shifting activity in this field that has been the subject of considerable policy attention generally (NHHRC 2008). However, recommendations to this end by the National Health and Hospitals Reform Commission (NHHRC 2009:24) have been set aside.

Heightened Political Sensitivity in Aboriginal Health and the Need for Trust

While not often acknowledged or openly discussed, it seems that lack of trust and concerns about governance and competence in the sector underlie the focus on strict accountability requirements (see, for example, Hudson 2009). The experience of indigenous health care providers indicates that governments find it difficult to reconcile their concern for accountability with the need for forms of contracting that are appropriate for PHC, and consistent with the relative autonomy of the non-government sector, including indigenous health care providers. The current classical approach to contracting arises partly from a rejection of old approaches to funding based on trust. It is thus unlikely to provide a way to develop trust. If concerns about accountability and competence are to be resolved, an approach that requires both trust and appropriate accountability may provide a better way.

In reality, government purchasers and contracted providers are mutually dependent on each other in Aboriginal PHC. Governments depend on the ACCHSs to fulfil their mandate to provide equitable access to care. ACCHSs depend on the contracts for funding and recognition of their legitimacy in the broader health system. Further, indigenous healthcare organisations, on behalf of their communities, claim a role in advocacy, in determining local needs, setting priorities, adjusting the service mix, and engaging consumers; claims which are endorsed in policy statements by governments, but not fully supported in practice.

Relational contracting offers an alternative approach that may meet the concerns of both sides of the contracting relationship for meaningful mutual accountability. Balancing autonomy and accountability is an important challenge, but one that cannot be avoided.

Towards a Framework of Good Practice in Funding and Accountability

Current practice in funding and regulation is derived from a classical contracting model, which we argue is wrongly applied to the ACCHS sector. Although the classical contracting approach may be appropriate for some subcontracting of specific aspects of care by government, it is not adequate for the development of a robust comprehensive PHC sector. There are three important grounds for reform of the complex contractual environment in which ACCHSs operate:

1. Aboriginal and Torres Strait Islander communities experience poor health and poorer access to PHC. There is a continuing imperative to improve access to culturally safe, effective care as part of efforts to close the gap;
2. The sector occupies a unique position, endorsed in policy and practice, as a provider of essential PHC care, but current funding methods are not appropriate to this role; and
3. The additional investment in PHC that is acknowledged as needed should be made in ways that offer better efficiency and effectiveness than the current arrangements.

As noted in the introduction, governments in Australia are committed to supporting the sector (NATSIHC 2003:1–3). This echoes international trends since Alma-Ata (WHO 1978), and the World Health Organisation's renewed commitment to the principle of community participation in PHC (WHO 2008:6). We suggest that implementation of these commitments will require a different way of thinking about the relationship between government and the sector, with implications for both sides. We further suggest that the framework of relational (or alliance) contracting provides methods for improving both efficiency and effectiveness.

No administrative arrangement is perfect, or perfectly implemented. Any approach will solve some problems, and create or exacerbate others. We do not suggest that relational contracting is a cure-all, but rather that it offers a sound alternative framework for redesigning the funding and accountability relationship for this critical sector of the Australian health system, with potential to reduce administrative costs, enable improved performance, manage political risk, and, ultimately, maximise the PHC contribution to closing the health gap between Aboriginal and non-Aboriginal Australians.

Endnotes

1. The analysis in this article relates to Aboriginal people of the mainland. It may also apply to Torres Strait Islanders, particularly those resident on the mainland. The term 'Aboriginal' is used, but this is not intended to exclude Torres Strait Islanders.

2. Estimated from information on government funding to ACCHSs (Deeble, Shelton Agar and Goss 2008); data from the authors' survey of ACCHS sources of funding and total Australian health expenditure (AIHW 2008).

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PAPER TWO – Analyzing contractual environments: Lessons from Indigenous Health in Canada, Australia and New Zealand

I became involved with this paper (Lavoie, Boulton & Dwyer 2010) late in its drafting, as a result of the Overburden Project and other research collaborations with its co-authors. These collaborations have been coordinated through the *Contracting at the Margins Research Group*, a network of researchers in Canada, New Zealand and Australia, established at the initiative of Professor Lavoie, with whom I have continued to work on various grant applications, project teams and other papers.

The paper addresses the theoretical basis for making sense of the observed problems in contracting between funders and community-based providers of PHC for Indigenous people in the three countries, with relevance to other settings. Working on this paper brought a significant opportunity for me to develop my theoretical understanding and to refine my capability to apply this important theoretical framework to the work represented in this thesis.

Statement of my role

I suggested and drafted a revised structure for the paper, and contributed to re-drafting, and particularly to the writing of the Australian case study, supplying up-to-date data and analysis.

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ANALYSING CONTRACTUAL ENVIRONMENTS: LESSONS FROM INDIGENOUS HEALTH IN CANADA, AUSTRALIA AND NEW ZEALAND

JOSÉE LAVOIE, AMOHIA BOULTON AND JUDITH DWYER

Contracting in health care is a mechanism used by the governments of Canada, Australia and New Zealand to improve the participation of marginalized populations in primary health care and improve responsiveness to local needs. As a result, complex contractual environments have emerged. The literature on contracting in health has tended to focus on the pros and cons of classical versus relational contracts from the funder's perspective. This article proposes an analytical framework to explore the strengths and weaknesses of contractual environments that depend on a number of classical contracts, a single relational contract or a mix of the two. Examples from indigenous contracting environments are used to inform the elaboration of the framework. Results show that contractual environments that rely on a multiplicity of specific contracts are administratively onerous, while constraining opportunities for local responsiveness. Contractual environments dominated by a single relational contract produce a more flexible and administratively streamlined system.

INTRODUCTION

Over the past decades, indigenous people in Canada, Australia and New Zealand have sought to secure more control over community based health services in the hope of improving access and responsiveness (United Nations 2002). Governments in Canada, Australia and New Zealand have responded by developing contractual relationships with indigenous health organizations that now provide a spectrum of primary health care services, ranging from health promotion and prevention, to primary intervention and rehabilitative services. This shift echoes the Alma-Ata Declaration and the Ottawa Charter's commitment to popular engagement in service planning and delivery (World Health Organisation 1978, 1986; World Health Organisation Department of Communicable Disease Prevention and Health Promotion 1997).

In Australia, since they first emerged in 1971, the number of Indigenous primary health care providers has grown to approximately 150. Health Canada reports that 79 per cent of eligible communities, representing over one-half of the eligible First Nation population, are now engaged in delivering on-reserve primary health care services (Health Canada (FNIHB) 2007). In New Zealand, the sector grew from 23 providers in 1993 to 240 in 2007 (New Zealand Ministry of Health 2007). The opportunity to contract in health is seen by indigenous peoples as an expression of their Treaty right (as in New Zealand) and/or indigenous rights to self-determination (Laing *et al*. 1994), rights that survived colonization (especially in Canada and New Zealand; for a detailed discussion, see Havemann 1999).

The contractual environments that emerged as a result are complex, and range from a multiplicity of smaller highly specific contracts (known as classical contracts) to the implementation of a single more flexible contract (known as a relational contract). The

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multiplication of small contracts has been associated with the establishment of internal markets (New Zealand) or a reliance on vertical strategies (Australia and Canada) to fund services aimed at improving health outcomes and equity in nationally defined priority areas. Relational contracts have been used to some extent in Canada, and emerged in Australia in the late 1990s, where they have been the subject of somewhat patchy implementation.

The literature is clear on the advantages and disadvantages of classical versus relational contract models from the funder's perspective. However, the literature however provides no analytical framework to explore the effectiveness of contractual environments where providers depend on a multitude of classical contracts, or a mix of relational and classical contracts. This paper presents a framework suitable for analysing, and assessing the fit between, policy objectives and funding practices in the complex contractual environment within which indigenous primary health care (PHC) providers operate. We suggest that the framework also has relevance for other non-government or private sector providers that operate in such contracting environments.

The development of the framework is based on the experience of indigenous providers in Canada, Australia and New Zealand, which is used to illustrate the framework, and to explore the strengths and challenges associated with classical, relational and mixed contractual environments. Studies were conducted in Canada, Australia and New Zealand, and data are reported in detail elsewhere (Lavoie 2005; Lavoie *et al*. 2005; Boulton 2007). Contractual case studies conducted in Australia and New Zealand were based on an extensive review of literature and key documents, and a period of fieldwork ranging from six weeks to three months on-site (Lavoie 2005). This framework also builds on fieldwork conducted with Māori mental health providers (Boulton 2007) and on preliminary results from the Australian *Overburden Project*, that is in the process of documenting the funding and reporting burden that the Aboriginal-controlled health sector faces. The Canadian material is largely derived from information garnered in the context of the 2005 National Evaluation of the Health Transfer Policy, a policy adopted in 1989 that provides First Nations and Inuit communities with the opportunity to shoulder the administrative responsibility for the planning, administration and delivery of community-based primary health care services (Lavoie *et al*. 2005).

The article is divided into four sections. The first reviews the application of contract theory to contracting in public administration of health care, and the second briefly discusses the emergence of indigenous providers in Canada, Australia and New Zealand. The third section addresses the need for a theory of contracting in health and presents our analytical framework and supporting evidence. The final section discusses the implications for policy.

FROM SINGLE CONTRACTS TO CONTRACTUAL ENVIRONMENTS

The literature identifies two broad categories of contracts: classical and relational. The vocabulary varies considerably depending on authors. Classical contracts are often called short term (Lane 2001), explicit and transparent (Cumming *et al*. 1998), or complete (Allen 2002). Relational contracts are at times described as complex, cooperative or trust-based contracts (Goddard *et al*. 1998). Whether classical or relational, contracts define the relationship between purchaser and providers. The neoclassical economic literature has generally framed the contract (in the public sector) as the purchasing of discrete, well-defined transactions in a market-like environment, where both parties enter into an agreement freely, and in which the purchaser or commissioner controls the power to define, and the provider competes for the mandate to provide. This focus has generally side-stepped the context in which purchasers and providers operate and also set aside the question of transaction costs. This approach has led to the development of an extensive and formal theory of exchange (Deakin *et al*. 1997). Work in contract theory has continued to focus on incentives, information and financial institutions (Bolton *et al*. 2005).

A corresponding theory of contract that acknowledges the context for providers as well as purchasers has yet to emerge, but Williamson's New Institutional Economics provides valuable insights (Williamson 2000). Institutional economics is interested in the larger context in which economic activities occur. This requires broadening the theoretical base drawing from legal and organizational theories. In that context, it is not possible or particularly productive to isolate the contractual environment from its larger context of production. Williamson describes four layers of social analysis that provide the larger context in which contracts occur, including,

1. Embeddedness: the context of informal institutions, customs, traditions, norms and religion;
2. Institutional environment: formal rules in which institutions operate, including the legal framework;
3. Governance: the regulatory context of transactions, especially the contract;
4. Resource allocation and employment (Williamson 2000).

He suggests that the fourth level is where neoclassical analysis is most relevant. In contrast to neoclassical contract theory, Williamson defines the contractual environment as being constrained by bounded rationality – a concept that suggests that contractual environments are far too complex to be fully comprehended and reflected in contractual agreements. This, coupled with limited access to information, results in incompleteness and governance by opportunism. The 'human factor' is thus central.

Building on Williamson's work, Macneil formulated a theory of relational contracts that reframed the contract as '*relations* in which exchanges occur' (Macneil 2000, p. 878; original italics). This approach is gaining support in health contracting research as a framework for analysis (Allen 2002; Palmer *et al*. 2003), and is particularly apposite to contracting for services with indigenous health providers. What Macneil acknowledges is that contracts do not occur in a social and relational vacuum. Rather, contractual relationships are best understood as extensions of social relationships. Indeed, for indigenous providers, the relationship that envelops that contract is as important as the document or the agreement itself (Boulton 2005). In this context, the contract becomes a microcosm of the overall relationship between the funder/state and the provider. This relationship is generally articulated through contractual provisions for accountability that define performance and reporting requirements. These requirements make accountability visible in public administration. They also enact seamless power relationships and specify the discharging of responsibility 'between' stakeholders, in this case the state and indigenous organizations.

In the indigenous health context, a funder's choice between relational and classical contracts must be analysed in the context of policy goals and administrative needs, situated in the broader context of the relationship that exists between indigenous peoples, the health system and the nation-state. At the administrative level, both relational and classical contracts carry advantages and challenges. Classical contracts are generally tightly specified, which facilitates contract monitoring. They are more appropriate for, and tend to promote, individual-focused and short-term interventions (Howden Chapman *et al*. 1994) that the funder is able to define and measure. As a result, they are useful for testing the effectiveness of varied or competing approaches. Well-defined contracts with clear responsibilities and deliverables have the advantage of clarifying stakeholders' roles, making monitoring more tangible. They may also be used to support the development of service delivery capacity (and markets). Classical contracts however have many limitations. Neatly defined deliverables are inherently inflexible. Because of their short lifespan, they lack incentives to settle disputes, and purchaser-provider conflicts may be addressed by changing provider. If used to fund ongoing services, as is the case for indigenous providers as will be discussed below, the lack of commitment to continuous funding can create challenges for recruitment and retention of qualified staff.

Relational contracts generally broadly define service provision, and are thus more flexible and more appropriate for funding ongoing services. They have the potential to improve responsiveness to local priorities. Long-term contracts more readily accommodate population-based, longer term strategies. Stable funding may facilitate the recruitment and retention of qualified staff. The security attached to the funding may, however, lead to complacency and the delivery of substandard services. The lack of specificity in service description may also cause monitoring challenges. According to Lane, long-term contracts inherently carry 'massive moral hazard' (Lane 2001, p. 35), as they hinge on long-term purchaser-provider relationships. Considerable risk also exists for the provider, who may feel compelled to accept contractual provisions or risk losing the contract and a substantial part of its budget (Lavoie 2005). As a result, both the funder and the provider may feel compelled to seek an amicable resolution in times of dispute.

Evidence suggests that the above classical-relational dichotomy is an over-simplification. For example, Goddard *et al*. (1998) note that even in the context of yearly contracts, purchasers and providers invest in the development of long-term trust-based relationships as a way to minimize risk. Thus, the potential anti-competitive aspect of long-term contracting may be overstated. Lane (2001) contextualizes the 1990 shift from long- to short-term contracting in the United Kingdom, Scandinavia, Australia, New Zealand and Canada as having occurred in pursuit of increased efficiency in public administration. This was associated with the rise of the New Public Management (NPM), and its application of private sector techniques to government operations (Pollitt 1995). The literature suggests that this trend was short lived, at least in the UK (Goddard *et al*. 1998). Factors such as fragmentation, increased administrative costs and inequitable distribution of providers have led the National Health Service back to adopting a collaborative system based on long-term contracting partnerships (Koperski *et al*. 1999). The NPM had a profound effect in Australia, where market mechanisms, output funding and extensive use of contracts and contract-like arrangements were vigorously pursued by governments and central health authorities (Mickan *et al*. 2006). In New Zealand, a subsequent set of reforms in 2001 re-emphasized the need for collaboration in the health sector. However, amongst community-based non-government organizations (many of which are indigenous health services), elements attributed to the introduction of the NPM, such as the so called 'purchaser-provider split' and the competitive tendering of contracts for service, remain (Ashton 2007). While talked about extensively in Ottawa, Savoie has argued that the NPM's impact on Canada's bureaucracies was in fact much more limited (Savoie 1994).

While helpful, the literature does not entirely meet the theoretical needs of contractual environments: mainly because authors tend to focus their discussions on purchaser-provider relations in the context of a single contract. The attempt to create a seamless primary health care system through highly specific contractual agreements will necessarily require complex contractual environments. Dividing the responsibility for the health care system between competing providers will also require extensive performance monitoring. Transaction costs will necessarily rise (Ashton 1998; Goddard *et al*. 1998). The choice thus seems to be between designing and managing a complex single relational contract, or designing and managing complex contractual environments resulting from a collection of classical contracts or a blend of classical and relational contracts.

INDIGENOUS HEALTH POLICIES AND CONTRACTING ENVIRONMENTS

In the present context, contracts between the government-purchaser and indigenous health organizations build on either a long-term relationship between a single or primary purchaser and a single provider in a non-competitive environment, or on a multiplicity of contracts in a quasi-market environment, or more likely a combination of the two. The governments of Canada, Australia and New Zealand have adopted policies that support 'by indigenous for indigenous' primary health care services, and promote the development of indigenous providers. These providers may be aligned with traditional forms of governance (notably in Canada and New Zealand), and are designed to serve an indigenous constituency and enable cultural safety and responsiveness (Health Canada 2001; New Zealand Ministry of Health 2002; National Aboriginal and Torres Strait Islander Health Council 2003). Thus contracting in indigenous health may not be primarily a mechanism to promote competition, choice and effectiveness, but rather to promote participation and responsiveness (with accountability). However, this use of contracting coincides with the widespread use of contracting and contract-like funding arrangements in the Australian and New Zealand public sector generally, driven by funder goals of enhancing the accountability of providers for both quality and quantity of services, and the ability of the funder to direct resources according to policy priorities rather than historical funding patterns (Liang *et al*. 2006). Thus the administration of contracts for indigenous organizations has been shaped by the application of classical contract thinking (see, for example, Morgan Disney and Associates 2006). This disjuncture between the policy intention and implementation methods is an important feature of the contracting environment in these countries (Lavoie 2005).

Since 1989, Canadian First Nations have been provided with the opportunity to administer and deliver on-reserve primary health care services spanning prevention, health promotion, public health and treatment services. The Health Transfer Policy provides First Nation communities, ranging from a few hundred to 15,000 members, the option to deliver services previously offered by the First Nation and Inuit Health Branch of Health Canada. The contractual arrangement initially put in place for this transfer of responsibility was a relational contract with funding largely based on historical expenditures. New programs were introduced after 1994, all outside the scope of this relational contract. Instead, Health Canada has preferred to use classical contracts that are program-specific, reflecting national health priorities. This shift reflects an overall trend in public administration hinging on a narrow concept of accountability (Auditor General of Canada 1997, 2000). One feature of this shift is a fragmented contractual environment that carries significant transaction costs for both the funder and First Nation providers (Lavoie *et al*. 2005).

In Australia, it was community mobilization that led to the emergence of indigenous providers in the early 1970s. Clinics opened with a volunteer workforce in donated facilities to provide free medical care to indigenous people mainly in urban centres. Some public funding was gradually extended to Aboriginal Community Controlled Health Services (ACCHS) through the Department of Aboriginal Affairs and subsequently the Aboriginal and Torres Strait Islander Commission (ATSIC). Those involved in Aboriginal health at the time recall that the grants were awarded yearly (with an expectation of renewal), and that the demand for these grants far exceeded ATSIC's budget and forced ACCHS to compete among themselves to secure funding (Anderson *et al*. 1996, p. 12). Under ATSIC, organizations were funded as health projects rather than as health services (Lavoie 2005). The transfer of national administration of the sector to the Commonwealth Department of Health in 1995 opened opportunities for the sector's budget to increase. Findings from the *Overburden Project* shows that some ACCHS are now usually funded partly by a core operating grant from the Office for Aboriginal and Torres Strait Islander Health (OATSIH) within the Department of Health and Ageing, and/or from the relevant state government health authority; and partly from proposal-driven vertical strategies that are highly specific and do not guarantee continuity in funding. In recognition of the administrative burden of multiple accountability and reporting requirements, federal health funding contracts with some ACCHS's have been extended to 3-year terms and have some characteristics of relational contracts (Dwyer *et al*. 2009).

The contractual environment nevertheless remains complex because ACCHS's are funded from national, state and local sources (health-specific or broader social program funders), each defining their own funding mechanisms, priorities and accountability frameworks. The administrative burden of financial and activity reporting resulting from these arrangements has been identified as a barrier to effective service delivery in recent government-commissioned reports (Morgan Disney 2006; Effective Change 2007). Analyses conducted by the Victorian Department of Human Services suggests that the reporting and compliance burden is disproportionate compared to that imposed on other small- and medium-size funded agencies, as shown in figure 1. This analysis charts the number of distinct types of activity for which various sectors are funded in relation to the total funding received. Aboriginal organizations are funded at a lower level for equivalent ranges of activities, and thus bear a heavier reporting and compliance burden, dollar for dollar, than other sectors.

In New Zealand, Māori providers emerged following the introduction of the purchaser-provider split in the early 1990s. Māori organizations responded to the announcement with a mixture of apprehension and hope, anticipating that opportunities for greater involvement in service delivery would develop. At the same time, Māori organizations were concerned that such participation would imply a degree of support for the commercial overtone of the reform (Durie 1998). The purchaser-provider split resulted in the fragmentation of services into relatively small contracts for health promotion and prevention activities. The original intent was that small providers would compete for these contracts. In reality, the competitive framework proved impractical and onerous, and at least some Māori providers performing to a satisfactory level found themselves designated 'preferred providers' by the funder, and extended the same complement of contracts year after year. It is worth noting that the 'preferred provider' status was never defined in policy nor the designation conferred in writing. Although three more reforms have been implemented since that time, Māori providers still continue to access primary health care funding through a multiplicity of small short-term contracts that are highly specific and limit opportunities for innovation and local priority setting (Lavoie 2004). Indeed, the introduction of a new Primary Health Care Strategy has further complicated contracting arrangements in the NGO sector.

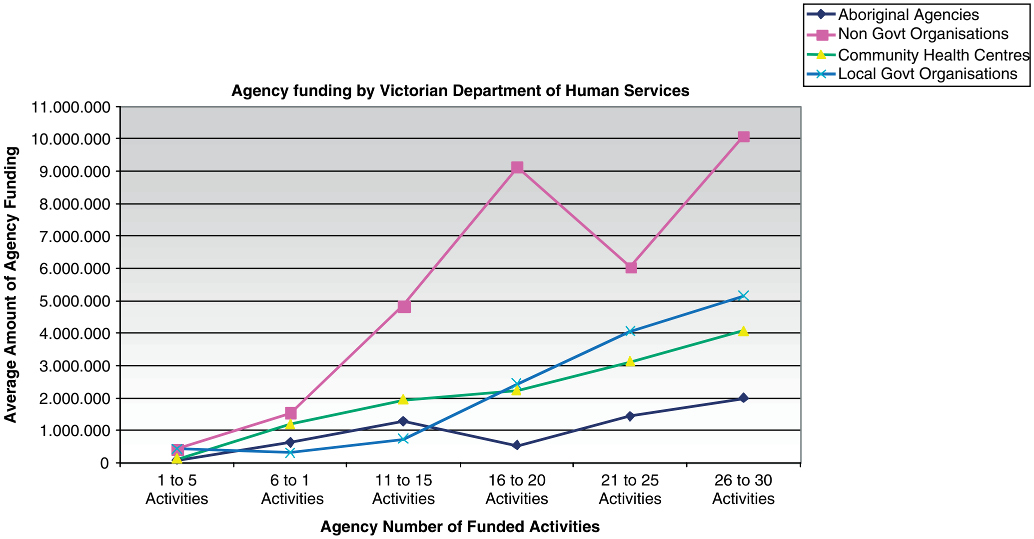

FIGURE 1 *Funding for types of activities, Victoria 2005/06*
Note: An 'activity' is a type of service, regardless of how much of that service is funded.
Source: Data for 2005/06 supplied by Department of Human Services, Victoria, and used with permission. The chart was produced as part of the Department's efforts to improve the way it works with Aboriginal Community Controlled Organizations

Māori providers have indicated that contracting has become even more complex with the introduction of Primary Healthcare Organizations (PHOs), not-for-profit entities charged with delivering and co-ordinating primary health care services (Pere *et al*. 2007).

THE BASIS FOR A THEORY OF CONTRACTING IN HEALTH

The classical-relational dichotomy apparent in the literature does not adequately reflect how contractual environments operate, neither those that rely on a number of classical contracts, nor those that blend classical and relational contracts. We argue that the important problems and challenges described above demonstrate the need for a theory of contractual environments, building on the classical-relational dichotomy. Specifically, we conceptualize contractual environments as existing on a continuum. On the classical side of the continuum, organizations access funding for programs through a number of separate classical contracts to fund a complement of primary health care services, many of which are ongoing, or address ongoing needs. On the relational side of the continuum, the funding agency engages with a provider in a long-term flexible contract to fund an ongoing core set of primary health care services. The analytical framework we present utilizes five key characteristics, which are summarized in table 1. We describe the characteristics below, and evaluate the suitability of classical and relational characteristics for the funding of indigenous primary health care.

TABLE 1 *Contract characteristics*

	Classical contractual environments	**Relational contractual environments**
Description	Organizations access funding for programs through a number of separate classical contracts to fund a complement of primary health care services	Funding agency engages with a provider in a long-term flexible contract to fund a core set of ongoing primary health care services
Nature of funding	Short term, competitive, unstable from year to year	Long term, non-competitive, population-based, stable
Priority setting	Funder allocates funding to meet nationally defined priorities	Promotes priority setting based on the pattern of needs experienced by patients and their relationship with the provider
	Funding agreements focus on individual interventions (e.g. number of immunizations) or single activities (e.g. workshops)	Promotes comprehensive primary health care and population approaches
Transaction costs	High administrative costs associated with a single contract are compounded with multiple contracts	Relational contract carries lower transaction costs for both the funder and provider, may be partly offset by relationship-building and negotiation costs
Risk	Higher risk for the provider, who bears the responsibility to secure and acquit funding	Considerable for purchaser in case of non-performance, and the provider in case the contract is not renewed
Monitoring	Explicit output requirements facilitate contract monitoring for single contracts	Contract monitoring more challenging and costs may offset transaction cost savings
	Reporting requirements associated with multiple contracts are onerous	Reporting requirements can be lower

Nature of funding and priority setting

In the context of classical contractual environments, funders set priorities based on areas of documented or perceived emergent needs or inequities. Competitive tendering and contracting processes are designed to select the providers best able to deliver services to meet those needs. Competition is thus intended to drive both effectiveness and efficiency. Contracts are generally short-term (one or more years) and tightly specified to address the priorities defined by the funder. In relational contractual environments, funding is longer term and more stable, and funding is allocated to the community-owned and recognized provider of PHC for a core set of primary health care services, with or without additional funding programs designed to meet funder-defined priorities.

In the context of primary health care for indigenous populations, we suggest that efficiency through competition is not a credible purpose for classical contracting. It is axiomatic that high entry barriers (such as the need for a substantial capital investment) in a market reduce competitiveness. Likewise, the cultural capital of indigenous providers – that is, their cultural affiliation to the community they serve, shared values, belief system and language – works against the development of a true competitive model, since providers are set up to provide responsive and culturally appropriate health services to members of their own culture. Thus, in this context, the competition is not between providers competing for a larger segment of population. Competition is instead related to opportunities for securing funding for the provision of primary health care services to different communities. Failure to secure contracts simply limits access to services for a given population. This is particularly problematic in remote areas of Australia and Canada, where alternatives, whether culturally appropriate or not, do not exist. A competitive model of access to service contracts, then, serves to limit access to primary health care for segments of the indigenous population. In the Canadian context, studies have shown that this contributes to shifting utilization to secondary and tertiary care, increased health care costs and to inefficiency of the health care system (Martens *et al*. 2002, 2005; Shah *et al*. 2003; Lavoie *et al*. 2006). The picture is similar in Australia, with low utilization of 'universal' primary care services and hospitalization rates of approximately 2.8 times the national average (Australian Institute of Health and Welfare 2008).

Theoretically, providers funded through multiple classical contracts offer a patchwork of services that is defined by the contracts secured (Lavoie 2005). In reality, services are offered beyond the scope of contractual agreements as theoretical boundaries clash with common sense and community expectations (Boulton 2007). This however means that providers on the classical side of the contractual spectrum assume a larger part of the risk associated with their moral-cultural-political obligation to align services with local expectations: the wider the gap between local expectation and contractual specifications, the higher the risk for the provider. In New Zealand, Māori providers regularly and routinely undertake additional work over and above their contracts in order to deliver services which are more closely aligned with the values and norms enshrined in Mâori culture (Boulton 2007). Similarly, in Australia, the need to manage tension between contractual obligations for national priority areas and the community requirement to meet local needs has been acknowledged (Dwyer *et al*. 2004). The literature calls this the 'harnessing of community goodwill', defined as a provider's willingness to go beyond contractual obligations to ensure that appropriate services are available (Lane 2001). This outcome is portrayed as desirable, but carries financial risks for providers.

In contrast, providers who benefit from some flexible funding associated with relational contracts are able to use this flexibility to mitigate financial and other risks (Lavoie *et al*. 2005). Relational contract obligations are, by definition, broadly defined, outlining the responsibility of the providers to offer comprehensive primary health care, and leaving them with the responsibility to allocate services, human and financial resources accordingly. Reliable funding opens the door to long-term planning, and increases the possibility of recruiting and retaining qualified staff. Flexibility in resource allocation allows for local priority setting, and provides the opportunity for alternative programming that not only draws on cultural expertise but incorporates cultural mores, values and processes, a key concern for indigenous providers.

Transaction costs and risk

Multiple classical contracts involve high transaction costs in specifying, tendering and monitoring for the funder; and in tendering, accounting and data collection for the provider. Relational contracts involve significant costs in relationship-building and negotiation, but tend to have lower transaction costs for both parties. Evidence from the *Overburden Project* shows that, in Australia, a majority of indigenous providers access funding through multiple classical contracts (Dwyer *et al*. 2009). Similar results have been noted for Canada (Lavoie *et al*. 2005), and for New Zealand (Ashton 1998; Lavoie 2005). Providers accessing a number of classical contracts manage a complex contractual environment with highly defined outputs, which involves higher transaction costs, and an overall higher cost of coordination of the system, which may or may not be recognized or shouldered by the purchaser. Although contracts lack provisions for automatic renewal, indigenous providers in all three countries reported that between 75 to 80 per cent of their funding was relatively stable from year to year. The purpose of these contracts appears to be twofold: to direct providers to deliver services according to externally defined health priorities; and to reduce risk of non-compliance. The first objective seems to be somewhat successful, with the pattern of service delivery tending to reflect national priorities (for example, Effective Change 2007, p. 19).

The pursuit of the second objective is more problematic. In Canada and New Zealand, provider audits have emerged as oversight mechanisms. These processes typically focus on assessing the fit between activities undertaken by the provider and a single contract. Activities funded by the contract but that fall outside the terms defined in the contract are highlighted, and associated expenditures disallowed. While intuitively reasonable, this process is problematic in the context of multiple classical contracts. For example, First Nations in Canada can access funding from a number of separate funding sources to address the current diabetes mellitus epidemic, including funding under: (1) a Health Transfer Agreement (relational contract) that funds public health interventions (screening and education) and primary care (blood sugar monitoring); (2) the Aboriginal Diabetes Initiative, a classical contract that funds specific interventions as defined by proposal; and (3) the Home and Community Care program, a classical contract that funds home care services for qualifying individuals. These programs co-exist in most communities. As Canadian First Nations communities have average populations of 500, the services provided under these three separate programs are often delivered by the same nursing and community staff. Disentangling activities that were provided on a given day, by a nurse to a single diabetic patient for the sake of fitting accountability requirements is challenging, onerous, meaningless in relation to quality of care and outcome, yet may be essential to fit reporting obligations and auditing.

In contrast, relational contracts reduce transaction costs, but carry substantial risks for the provider as well as the funder. Providers funded with contracts of a more relational nature benefit from a single or primary purchaser–provider relationship, with streamlined contracting and reporting requirements. Contracts are longer term, three to five years, meaning lower negotiation costs for the purchaser and provider. The literature suggests that this situation creates a shared responsibility on the part of the purchaser and the provider to ensure that the relationship is protected, and that disagreements are addressed (Stewart 1993; Goddard *et al*. 1998). At least in the indigenous environment, the single funder/single provider relationship carries significant risks for the provider since, for example, unilateral decisions by the funder cannot be side-stepped by finding alternative funding. The moral-cultural-political obligation of indigenous organizations to provide responsive services simply compounds the situation.

Monitoring and performance

Reporting requirements are pragmatic extensions of accountability, and a primary form of contract monitoring. In practice, the use of multiple classical contracts multiplies reporting requirements for providers. Reporting requirements in both environments generally focus on activity reporting rather than outcomes, providing little information to funders on the overall performance of the system in achieving health gains. This is most evident in New Zealand, where a single Māori provider may be required to provide 30 to 36 reports annually to fulfil their reporting requirements. In Canada, an assessment documented that

126 First Nations communities in the province of British Columbia produced an estimated 5,815 reports in 2003–04 to fulfil their accountability obligations to the First Nations and Inuit Health Branch, responsible for the funding of health services provided on reserves (Lavoie *et al*. 2005). In Australia, a review commissioned by the Victorian Department of Human Services highlighted one (not atypical) Aboriginal Health Service which received approximately $2 million in funding in one year through 13 programs operated by this single Department, and was required to produce 59 separate reports in relation to this funding alone (Effective Change 2008).

While it is clear that a single classical contract may be easier to monitor than a single relational contract, it is also clear that monitoring a multiplicity of classical contracts can become onerous for the funder. The Victorian Review cited above found that nearly three-quarters of the total reporting requirements under program guidelines were either being changed or were ‘under development’ (Effective Change 2008, p. 20), indicating a high administrative burden in specifying and maintaining reporting requirements.

In New Zealand, where a single purchaser system exists for primary health care, government interviewees suggested that both historical and contemporary funding agencies lack the human resources to ensure an appropriate oversight (Lavoie 2005). The same was documented in Canada (Auditor General of Canada 2002; Lavoie *et al*. 2005). This suggests that in health care, a classical contractual environment can lead to high monitoring costs. These findings echo concerns expressed by Ashton and Howden Chapman (Howden Chapman *et al*. 1994; Ashton 1998). In other words, multiple simple contracts generate a complex contractual environment that is also difficult to monitor, not for a lack of specific contractual provisions, but rather because of multiple specific contractual provisions. It appears that the costs have been borne by both the purchaser and the providers, and that funders have been slow to recognize this reality, and have largely failed to predict and manage its costs.

In all three countries, funders are government agencies bound by government-defined legislation, policies and regulations that are intended to apply across a wide range of contractual and procurement activities. The resulting contractual instruments, anti-monopolistic procurement policies and accountability frameworks are at times ill-suited to the context of providing primary health care services to a marginalized population. As a consequence, contract managers may be caught between their personal commitment to support indigenous providers’ work, and their obligations to apply government-defined financial regulations (Lavoie 2005). In Canada, the Auditor General of Canada has acknowledged these issues (Auditor General of Canada 2002). Partly as a result, the contractual environment appears to have recently shifted slightly towards an increased reliance on relational contracts (Health Canada (FNIHB) 2008).

Gilson’s (2003) extensive review of the role of trust in health care suggests that classical contracts are costly to implement and monitor, and reflects that trust can assist in reducing transaction costs associated with a multiplicity of classical contracts, and enhance the possibility of managing complexity.

The contractual continuum

The framework summarized in table 1, above, characterizes the differences between classical contractual environments, and environments where a relational contract dominates, for the indigenous health sector. Based on this framework, it appears that the latter environment provides a better match with the stated policy goals of governments (emphasizing self-determination and local responsiveness) and with the aspirations of indigenous communities. In addition, we contend that this may yield a better environment for addressing the persistent health inequalities which exist between indigenous and non-indigenous peoples.

In the general contracting literature, trust-based contracts are seen as replacing classical contracts once providers are established and have secured some credibility. The picture in the indigenous health field is not clear, with movement in both directions along this continuum at various stages of provider development, or as a result of government policy shifts or of changes in the funder:provider relationship. The reasons for the movement between classical and relational contracting arrangements are probably varied, as the following examples show:

1. New funding models are usually designed and implemented by a central agency that is distant from the day-to-day challenges of contract monitoring. Indigenous buy-in is important since uptake is generally voluntary, and low levels of uptake may reflect poorly on the government agency and carry political risks. Relational contracts, because they are flexible and can promote local approaches to service delivery, are more appealing.
2. All possible future contingencies could not be known at the time of deployment of new funding models. As a result, relational contracts may be used until sufficient experience has been gained to make the drafting of more specific contracts practical.
3. Once a model is established, the funder's initial enthusiasm may be replaced with a pragmatic need to anticipate challenges related to service delivery and performance monitoring, and to limit them. The advantages of classical contracts over relational contracts may be weighted differently when implementation is left to mid-level administrators working in regional organizations and tasked with the monitoring of contracts.
4. In the indigenous environment, trust between the funder and indigenous providers is vested with the collective as well as with the individual provider. Non-performance of some indigenous providers may lead to shifts in risk management practices affecting all.

As a result, contractual environments shift along the classical-relational contractual continuum over time, thereby shifting risks, increasing or decreasing transaction costs and opportunities for responsiveness. Shifts in this contractual continuum are related to pressures affecting funders: while some may be related to the perceived or actual performance of providers, others may be unrelated altogether (elections, isolated problems in the sector or in another sector that become news, and so on). The framework we propose acknowledges the fluidity of contractual environments, and provides reference points for assessing their performance.

The challenges associated with contractual environments in primary health care are not unique to indigenous providers. They potentially apply to all agencies working in small or remote communities which are funded through contracted programs (with the important exception of GP funding) as well as all non-government organizations that provide services for specific sub-populations considered at higher risk (the poor, women, immigrant populations, refugees, the gay-lesbian and transgendered community, the HIV positive community, those who live on the street or close to the street, and so on). Our analysis serves to underline the inappropriateness of classical contracting as a method of funding for comprehensive primary health care, and also challenges the 'efficiency through competition' rationale. We note that there are other barriers to coordination of care, applying within and between organizations that are not subject to fragmented contracts. We suggest that 'fragmentation by contract' adds to the difficulty of achieving coordination of care.

IMPLICATIONS FOR POLICY

Overall, the framework we present is a useful tool to assess the responsiveness of diverse contractual environments and their alignment with the literature on contracting in health, efficiency and responsiveness. It facilitates the analysis of contractual environments that blend classical and relational contracts and allows researchers and policy-makers to explore the experience of organizations that operate with multiple and diverse contracts. The framework clearly indicates the limitations of relying on a number of small and fragmented classical contracts. The limitations of classical contracts, including higher transaction costs, are compounded once contracts multiply and their advantages, including cost-effective monitoring, are eroded.

There are three broad conclusions to be derived from this analysis. First, it is clear that contractual environments are worthy of scrutiny. The results of this study show that classical-relational contractual environments do not necessarily replicate the classical-relational dichotomy reported by other authors (Goddard *et al*. 1998; Lane 2001). All research encountered has focused on analysing single contracts, rather than the contractual environment, or on looking at contracting from the purchaser's perspective. We note instead that contractual environments show a continuum from classical to relational. More research is required in contractually fragmented areas to identify whether the conclusions presented here are unique to the indigenous environment, or reflect the context of multiple contracts.

Second, classical contractual environments appear ill-equipped to meet the needs of contracting in health for continuous service delivery. This analysis supports an apparent trend towards relational contracts because their flexibility can better accommodate the needs of community-based health services (Allen 2002; Palmer *et al*. 2003).

And third, more work is required to identify optimal contractual environments. This may be a single relational contract, or a single blended contract with defined benchmarks to focus attention on key priorities, supported by a relational component for core functions (essential services) to ensure that flexibility and responsiveness to local needs are protected. It is unclear why the two perspectives have yet to be embodied into a single contract.

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Impact of the papers

Dwyer et al. (2011), and *The Overburden Report* on which it is based (Appendix B: Dwyer et al. 2009), have had a significant impact in the field. The Commonwealth Department of Health initiated reform of its funding of ACCHOs, citing *The Overburden Report* as a main source of evidence for change (Department of Health and Ageing [DoHA] 2010:1). In 2013, the Department commissioned the Deeble Institute and the Western Australian Centre for Rural Health to analyse 'reporting efficiency' for ACCHOs (Martin 2014), and to conduct a survey of the reporting burden on ACCHOs. The survey report specifies *The Overburden Report* and its recommendations as the criteria against which current practice was to be assessed (Haynes, Holloway & Thompson 2013). The research results have also been taken into account by funders and the sector in efforts to streamline funding and accountability arrangements, notably in the NT, Victoria and Queensland.

The report was cited substantially by the Australian National Audit Office (ANAO), in an audit of government funding and regulation of Aboriginal affairs, describing *The Overburden Report* as 'a significant report which highlighted the impact of the Department of Health and Ageing's (DoHA) administrative approach on organisations in the health sector.' (ANAO 2012:91). The ANAO reported on the contracting practice of the three main relevant national government departments (Family and Community Services and Indigenous Affairs, Department of Education, Employment and Workplace Relations and Department of Health and Ageing), and documented continuing reliance on relatively small and short-term contracts (average duration: 15 months) in 2010-2011 (2012:19).

The audit found that the administrative load and uncertainty imposed by government contracting practices is significant, and has a negative impact on the capacity of Indigenous organisations (2012:20). It also documented the continuing problems, reporting for example that 820 Indigenous organisations funded through one major grant management system were required to submit 20,671 performance, financial and acquittal reports on 2323 funding agreements (2012:57) with a median size of about $60,000. The report also notes that while the departments require the funded organisations to engage in significant activity in compliance with risk management instruments, the focus is almost entirely on risks arising internally within the organisations (related to governance, probity, compliance with reporting requirements etc); and that the resulting risk management strategies tend to be focused on ever more requirements for reporting and monitoring (2012:20).

The Overburden Report (Dwyer et al. 2009) was also used in a major review of Commonwealth funding and programs for Aboriginal affairs (Department of Finance and Deregulation 2010:153-4), which was released to a national television network under Freedom of Information provisions. This report, the *Strategic Review of Indigenous Expenditure* also commented on the 'significant compliance burden documented in *The Overburden Report'* and recommended that DoHA take steps to reduce the administrative burden and work with State and Territory health departments to move towards a coherent performance and reporting framework. This report repeated the forlorn practice of recognising the need for fundamental change in the way governments engage with Aboriginal communities and organisations, while limiting its recommendations to modest measures consistent with 'business as usual', like reducing the number of funding programs and training public servants in consultation (Dwyer 2011).

The research thus contributed to an emerging focus in Canberra and elsewhere on the need to reconsider the use of critical aspects of quasi-classical contracting as the basis for ongoing funding for essential primary health care. However, it must be noted that the Coalition government elected in 2013 has restructured all funding to Aboriginal organisations, and fundamentally changed the portfolio arrangements, bringing some of the Commonwealth's role in policy and funding for Aboriginal health into the Department of Prime Minister and Cabinet. This process has meant that at least in the short term, much of the progress achieved in the preceding 4 years (such as a move by OATSIH to 5 year funding agreements for some ACCHOs) has been undone, or suspended in favour of temporary arrangements. The apparent impact of the Indigenous Advancement Strategy, which seems to have reduced funding to Aboriginal organisations in favour of funding mainstream institutions (Wahlquist & Davidson 2015) is a concurrent challenge.

Dwyer et al. (2011) was listed on the journal's website as one of its top 10 articles, and given temporary open access status (accessed 23 June 2015 at http://onlinelibrary.wiley.com/doi/10.1111/j.1467-8500.2011.00715.x/full). The academic impact of the project as measured by citations is substantial in its field, with 57 citations in

Australia and internationally (43 of *The Overburden Report*, two of the summary report, and 12 of this paper) (Google Scholar 14 October 2015). The journal has an impact factor of 0.416 (ISI Journal Citation Reports © Ranking 2014; 38/46 (Public Administration))

Lavoie, Boulton and Dwyer (2010) has 17 citations (Google Scholar 14 October 2015), in several international journals as well as locally. The journal has an impact factor of 1.518 (ISI Journal Citation Reports © Ranking 2014; 11/46 (Public Administration); 35/161 (Political Science)).

Recent literature on contracting as a method of funding and regulating PHC

Background: Contract theory

The modern practices of 'contracting out' in all its forms, vigorously deployed under NPM approaches, have their theoretical foundations in institutional economics, inter alia. Ronald Coase (1937) first articulated the insight that firms and markets are alternative ways of organising transactions, when he conceived of the firm as a governance structure, rather than simply a 'black box' production function (Powell 1990). Williamson (1975) and many others have since developed ways of understanding and predicting the best use of contracts vs internal production (when, why and how), given the trade-offs involved. Powell (1990) and many others have articulated a third form: networks, made up of individuals or groups that work together for mutual benefit because they are dependent on each other for resources of some kind.

Contracting is an exchange of goods or services for money or other considerations. Classical contracting seeks to specify the terms sufficiently to provide certainty and 'completeness'. But many transactions are uncertain in their cost and/or outcomes, and the quality and volumes required; and they involve significant investment in non-transferable resources (including expertise, equipment etc). When a simple contract cannot specify everything to a level of certainty that can be legally enforced, some form of governance of the contracting relationship is required – a structure for dispute management, requirements for information disclosure, regular reporting, etc.

While Macneil (1977) and others would argue that all contracts are relational (ie are embedded in social structures and interactions), it is nevertheless useful to conceive of contracts as being somewhere along a continuum between relational and classical (or transactional) characteristics. Thus the contract needs to be seen as consisting of both the document, and the governance of the contracting relationship. One of the important implications is that the contracting terms and relationships need to be seen as a coherent whole, and not as a set of free ‘mix and match’ choices.

Note that the terms ‘transactional’ or ‘agency’ contracting, as well as ‘classical’ or ‘quasi-classical’ are used in the literature and below. ‘Relational’ seems to be the dominant term for the alternative, although ‘alliance’ is also used.

Literature review questions and strategy

Selected research literature up to 2008 is reviewed in the published papers and Appendix B. Those reviews cover the evidence on government and sector approaches to the contracting relationship, and include the sources of the framework we used for the application of contract theory, a framework of more general relevance for other NGOs in many fields in Australia and elsewhere.

Research interest in this area has continued since that time, although studies of contracting for PHC seem to have peaked late in the first decade of this century. As described in Chapter 1 (under the heading *Literature review methods*), a methodical literature search was conducted, supplemented with hand searching. Please note that this approach is not intended to meet the criteria for a systematic literature review. Rather the search and review process was intended to ensure that relevant literature was found and included, regardless of philosophical preferences or other potential sources of bias. The aim of the review was to address these questions:

1. What is the recent evidence regarding the use of relational contracting for PHC services?

2. What frameworks for thinking about improvement in contracting methods are being used or proposed?

The search was limited to papers published after 2008, and terms were: *third sector OR NGO OR not-for-profit AND relational contracting OR alliance contracting AND primary care OR primary health care OR social care/services*. Various combinations were used to suit the requirements and utility of the data bases. The data bases searched were Science Direct, JSTOR, Expanded Academic ASAP, Medline, Proquest Health Management, PubMed, SCOPUS, Web of Science and SAGE. The search was broadly multidisciplinary, with economics, public administration and health social sciences well represented in the results.

In keeping with my review questions, my search was intended to find papers that addressed government-NGO contracting for PHC or other human services; and those that addressed relational contracting theories and methods in general, with potential relevance to the PHC context.

The exclusion criteria were:

- Papers that focused on the use of contracting with the individual client of health or social services; or between employees and their employing hospitals/health services.
- Papers that focused on corporate-NGO contracting, or on corporate-government contracting (and without relevance to relational contracting practice)
- Papers of little or no relevance to the review questions, in spite of using relevant key words in the description. While this criterion seems highly subjective, it arises because of inadequacies in either the search strategy or the data bases that led to the initial inclusion of papers that perhaps only mentioned a contract in passing, rather than being about contracting in any substantive way.

A total of 261 articles were found, of which 220 were excluded. Forty-one abstracts were read, and a further seven papers were then excluded. Of the 34 papers remaining, a further 16 were excluded after being read, and five were found to be more relevant to the accountability topic (see Chapter 4). Six papers initially found in the related search on 'governance and accountability' but more relevant to contracting were added. These 19 papers were supplemented with 8 peer reviewed articles and two government or parliamentary reports found by hand-searching of relevant journals and of reference lists in the papers, making a total of 29 papers.

Review results

The papers under review fall into five categories: five reporting on contracting out of PHC in low and middle income countries (LMICs); six reporting on contracting as part of NPM-inspired approaches to reform of public health systems in the UK; and three in New Zealand; four reporting on approaches to contracting for human services by local government authorities in Europe and the USA; five examining relational approaches in general; and finally four reporting on studies of health and human services in Australia, along with two Australian government policy papers.

Contracting for PHC in LMICs

Much of the literature on government contracting for PHC arises from studies in LMICs, conducted during the first decade of this century largely as a result of interest in the pro-contracting policies and programs of the World Health Organisation, the World Bank, donor countries and international NGOs. This literature may be relevant to the situation of rural and remote Aboriginal communities, due to common social and economic factors among the populations served (including poverty, low educational levels and little or no choice of provider). The contexts in many of the countries covered in this literature include the need to build or rebuild capacity (often in post- or continuing- conflict situations). Poor relationships and low levels of trust between the government and citizens are also often present.

A comprehensive review of the evidence on effectiveness of PHC contracting (Liu et al. 2008) found 16 papers that met inclusion criteria (for content and quality), reporting on 13 cases of contracting out of PHC services in 12 low and middle-income countries. Lui and colleagues found good evidence that contracting improves access to health services (measured in increased usage by the target populations), both in areas where there are no public sector providers, and where public services are available but unreliable or perceived as having poor quality. They also found that while improvements in quality were often reported, there is little consistency among the studies in the way quality of care is measured. Impacts on other performance criteria, such as equity and efficiency, are often unknown. Efficiency was an explicit objective for only two of the cases, and assessments were conducted in five, with very mixed results (p. 10). The authors conclude that little is known about the system-wide effects of contracting for PHC, and that contextual factors and design features of the interventions are likely to be strong influences on the chances for success. Liu and colleagues tentatively suggest that both managerial autonomy for contracted providers (i.e. more relational style) and payment for performance may be associated with better results.

Liu et al's (2008) call for more research seems not to have been effective. My search found only four further papers on contracting out of PHC in LMICs. Loevinsohn et al. (2009) found positive outcomes from relational-style contracting of management of publicly financed, basic curative PHC services in one province in Pakistan. They also report that this approach has since been scaled up to cover more than 40 million people. Zaidi et al. (2012) conducted a case study review of contracting out of HIV/AIDS programs in two provinces of Pakistan, with a focus on the influence of policy and political factors on contracting origin, design and implementation. They found strong stakeholder influence and a sophisticated approach to the design of the transactional contracts which were awarded competitively. However, implementation was troubled, with contracted providers focusing on quantified clinical targets in the contracts rather than other aspects of the comprehensive service that was intended. The more successful contracted NGOs became more skilled at bidding, and also reduced their responsiveness in service delivery. Government purchasers' skills were found wanting.

Arur et al. (2010) compared the utilisation of curative outpatient services under four different types of contracting in Afghanistan, and found that all four resulted in increased utilisation compared to matched control areas with continuing public provision. However, the costs of non-contracted services are not known, thus virtually ruling out comparison of efficiency. All four types of contracts had relatively high autonomy for the contracted providers.

Grundy et al. (2009) trace the Cambodian experience, where contracting of health care services to NGOs in the 1990s was reversed in 2009 following the realisation that the funding levels provided were unsustainable and there was little local capacity development.

This literature provides some support for the proposition that more relational approaches to contracting (on both sides of the relationship) are associated with increased effectiveness of PHC (Liu et al. 2008; Loevinsohn et al. 2009; Arur et al. 2010). It also tends to support payment of performance incentives (Liu et al. 2008), while identifying the dangers of poor contract management and the use of narrow performance measures (Zaidi et al. 2012).

The studies are of variable quality, and while the importance of context is recognised (Liu et al. 2008; Zaidi et al. 2012), no conclusions about contextual factors can be drawn, as the studies focused on the program rather than system effects. Taken together, the papers support contracting out of PHC per se in LMICs, and they confirm earlier evidence that relational contracting approaches work for PHC in this context. However, they are inconclusive on methods of contracting – they establish that it works but they do not explain why.

Contracting for health and social care in the UK, and the concept of 'braiding'

Recent studies on contracting of primary and secondary care in the National Health Service (NHS) document a modified approach to both competitive tendering and the development of a health care market compared to that generally intended in the NPM-inspired policies on which the reforms were based. A recent collection of papers demonstrates the persistence of relational approaches to both commissioning and contract management, although formal contract documents remain strongly transactional, particularly in England (Dickinson et al. 2013; Allen et al. 2012; Coleman et al. 2013; Hughes et al. 2013; Porter et al. 2013). As Dickinson et al. (2013:13) point out in their editorial on the collection, the papers 'offer remarkably similar conclusions about the limited potential of markets in health and social care to deliver aspirations for improvement in the both the quality and cost of care'.

Hughes et al. (2013) compared 'hard' and 'soft' contracting for secondary care in England and Wales respectively. They found that interdependency of local purchasers and providers fostered long-term relationships and cooperation (including some bending of the rules), while not obviating conflict at times. They note that relational approaches were partly necessitated by the fact that all providers were within the NHS, so resolution of differences by exit was not available. They also note the risk that dismantling relational networks will remove a mechanism that allows flexibility in times of trouble (eg financial or workforce problems) in a situation where continuity of care is needed.

Allen and colleagues (2012) conducted case studies on the introduction of non-NHS providers into four districts ('local health economies') served by NHS Primary Care Trusts in England, with a focus on orthopaedic surgery and home health care for the elderly. While they found little provision of care by external providers, and equivocal performance results, they make interesting observations on the non-government organisations involved in home health care. They are not on average more innovative or effective than NHS providers, but they do successfully engage with the needs of the communities they serve, and may be seen as more approachable. Overall, this study found substantial transaction costs of contracting out, loss of information about costs when contracting with private providers, and risks to the financial viability of local NHS providers; as well as a positive impact on NHS providers (driving them to make improvements). The authors are not convinced that the benefits justify the costs and risks.

Coleman et al. (2013) come to similar conclusions in their study of alternative providers in PHC. Higher transaction costs were incurred as contracts became more transactional. They suggest that most of the expected advantages are either disruptive (eg exit of provider disrupts care) or are offset by the transaction costs. They also observed that the presence of alternative providers put pressure on GP practices to 'lift their game'.

Porter et al. (2013) conducted an observational study of commissioning of care for people with three common long-term conditions in one Primary Care Trust in England. The (clinician-led) commissioning they observed was highly cooperative and relational, but was conducted separately from the financial and performance monitoring aspects of the contract negotiations (which were handled by finance staff). They found that the conditions for a working market were not met (eg little choice of provider), and transaction costs while uncertain were high. They suggest that the persistence of relational approaches to commissioning is adaptive, based on the need for continuity of provision, the interdependence of commissioners and contractors and their established relationships of trust.

These studies all reinforce the appropriateness of more relational commissioning and contracting for PHC in the NHS 'local health economies'. There are important characteristics of the approach to commissioning and contracting in the NHS that do not apply in Aboriginal health care, or more generally to NGO providers of health and social care in Australia. The most significant difference is the decentralisation of commissioning activity in the UK, even though it is driven by central policies. The concept of local health economies is not one that is used by government health authorities in Australia, although coordination of services within communities or regions is a commonly-expressed policy goal (as evidenced in the formation of Local Health Networks and Primary Health Networks on a regional basis (see Administrator National Health Funding Pool undated, and Department of Health, undated)).

Two further papers are relevant here. The final UK study takes a different approach. Roehrich and Lewis (2014) report on a study of contracts for complex services (a hospital and a waste management service). They analyse the use of exchange governance mechanisms (ie post-contract signing) in situations where simply making the contract more complex will not cover contingencies. Noting that contemporary contracting forms combine 'explicit and legally enforceable terms as well as implicit, socially embedded and legally unenforceable clauses' the authors suggest that organisations should manage complex contracted services through a combination of what they call 'both contractual and relational governance mechanisms', because neither will work alone (2013:222).

At one level, this is a statement of common knowledge, as encapsulated in the advice to 'get the contract right, then put it in a bottom drawer' often given to managers. But it suggests that the ongoing supplier-contractor relationship in the implementation phase should be structured and governed to enable both the relational activities that build common purpose and good information exchange, and at the same time, the compliance monitoring that keeps performance against the contractual terms in view. So, the advice is not to put the contract in the bottom drawer, but rather to combine a focus on making the contracted services work well with a focus on the contractual terms, thus perhaps keeping them more enforceable, even as contingencies are dealt with and their implications mutually understood.

Finally, in a relevant American legal studies paper, Gilson, Sabel and Scott (2010) call this combined approach 'braiding' - by which they mean the interaction between formal contracting and enforcement on the one hand, and informal contract management methods. They suggest that the relationship between the formal and informal is more correctly seen as a reinforcing 'braided' combination, rather than seeing the formal as replacing the informal (typically when the contractual relationship is in trouble).

The New Zealand studies

The available recent evidence about contracting for PHC in New Zealand is limited, and overall contributes little to my review questions, other than supporting the trend of interest in mixed methods in contracting. Cordery (2012) analysed the procurement approaches of NZ governments in three service sectors (health, social welfare and prisons). The author found a more relational approach to be associated with a focus on performance; while a more transactional approach was focused on process measures. Health sector contracting was more relational than other sectors. Cordery suggests that NGOs can influence contract management in order to improve relationships, support a stronger focus on performance, and reduce the transaction costs by being open, 'working tougher' and meeting expectations (2012:94). No suggestions for change on the part of government are offered.

Howell and Cordery (2013), examined the pattern of governance in primary health organisations (PHOs) contracting with District Health Boards (DHBs), based on available governance and ownership data. In a situation where government policy required DHBs to contract only with PHOs that were not-for-profit and where governance was shared between provider and consumer interests, the authors investigated whether control is exercised more by providers than consumers. Using Hansmann's price theory (Hansmann 1996), the authors test the proposition that consumer 'ownership' (or dominance in governance of the PHOs) is more likely when markets are too small or risky for private owners to invest (e.g. in small isolated communities). The authors found that PHOs in New Zealand continued to be dominated by providers in governance, except for Maori iwi-controlled PHOs, and a few other special cases.

Barnett et al. (2009), in a study focused primarily on governance, report that all community-based providers in their study believed that DHBs favoured their own services when allocating PHC contracts (p.124), perhaps reflecting the perception and/or the reality that commissioning functions were unduly influenced by the DHBs being in dual roles as providers as well as commissioners.

Local government contracting in Europe and the USA

The four papers included here are published in public administration, management accounting and local government/urban affairs journals, and address contracting of health and social services by local governments (Bromberg & Henderson 2014; Ditillo et al. 2014; Johansson & Siverbo 2011; Lamothe & Lamothe 2012). These papers are much more focused on understanding the contracting activity per se, how it works and why, compared to those in the health literature, which are more concerned with the effectiveness of PHC/health care delivered by contracted providers.

These studies all investigate the methods of managing contracts where the service is complex or unpredictable, and the use of both relational factors (like trust and openness) and more transactional factors (like the specificity of the contract and the intensity of monitoring). They reflect the increasing acceptance in the management literature not only of Macneil's (1977) position that all contracts are relational, but also that contracts for complex services are inevitably incomplete and therefore require attention to the governance of the exchange relationship, rather than simply attention to the specificity of the contract (Bromberg & Henderson 2014).

Bromberg and Henderson (2014) report on a study of contracting relationships between local governments and Emergency Medical Services (EMS) (paramedic/ambulance services) in Pennsylvania, USA, using an online survey of senior municipal managers involved in EMS contracting. They found that contract specificity and good vendor performance were associated with higher levels of trust between the public manager and the EMS provider. Neither sector of provider (public or NGO) nor length of relationship made a difference.

Bromberg and Henderson (2014) address the literature on trust in contracting, and point out the common view that trust is ‘an ex-post occurrence based on performance and repetition’ rather than an ex-ante structural factor (p. 3). They suggest that their finding, that government contract managers trust other public providers more than either NGO’s or private companies, is an argument for more emphasis on ex-ante structural factors. This finding also supports the idea that it is both performance and shared norms (built on the legal system and the contract itself) that provide the basis for trust. They suggest, citing Williamson, that ‘there is trust in the contracting instrument not the provider’ and that while all exchanges occur in a relational context, they are also rational – managers are both ‘calculative’ and ‘relational’ (2014:12).

The parallels with ACCHO contracts in Australia are that they share the complexity feature and the problems for public sector managers of lack of specificity (or spurious specificity), and lack of knowledge of performance (or spurious knowledge of performance). Lack of social solidarity (Macneil 1986) is heightened in the ACCHO context, as evidenced by the low levels of mutual trust between non-Aboriginal and Aboriginal Australians (Reconciliation Australia 2013), and the heightened political sensitivity of Aboriginal health (Sullivan 2009).

Two papers use the management accounting framework of inter-organisational management control research based on extended transaction cost economics (which acknowledges institutional and relational factors). Ditillo et al. (2014) explore whether the variables that explain contracting out choices also explain monitoring intensity; and the impact of control types (ie, market, hierarchy[3] and trust). The authors surveyed CEOs of Italian municipalities in relation to two contracted services – home-based care for the elderly and waste collection. They analyse whether associations between the types of

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[3] In this inter-organisational setting hierarchy refers not to internal control structures but rather emphasis on specifying and monitoring processes rather than or as well as outputs.

controls in use are associated with different service characteristics (asset specificity, task interdependence, uncertainty and output measurability), and whether types of control are associated with different relationship characteristics. However, their survey response rate was low (91/510).

Ditillo et al. (2014) found that the more politically visible and the more measurable the outputs of the service (waste management in this context), the more likely it is that market-based mechanisms will be used, a result that is consistent with the findings in the health care literature. They conclude that service characteristics are more effective in explaining market- and hierarchy- based mechanisms of control than relationship characteristics or the type of the provider organisation (private, NGO or other public sector). And they suggest that 'trust-based control patterns in the public sector may be more strongly influenced by the informality of the political processes' and their importance in decision-making about public services.

Johansson and Siverbo (2011) examine the cooperation problem (one aspect of control) in contracting by public sector organisations (PSOs) of activities that have 'low contractibility' (i.e. are hard to specify and measure; where there is little relevant knowledge within PSOs etc). They surveyed the Chief Finance Officers of Swedish local government authorities, and achieved a high response rate (234/290 – 81%).

Johansson and Siverbo (2011) use a framework that characterises the 'governance package' in the contact and control phases. In the contact phase, there is either a market- or trust-orientation. 'Trust orientation' has elements of competence trust (the potential supplier can do the job), contractual trust (reputation for honouring formal and informal agreements) and good will trust (they will put in extra effort when needed). In the control phase, there is results control (supplier is held accountable for results), action control (controls how activities should be performed) and social control (shared values and goals, in relationships that promote them). In this conceptual framework, it is expected that the greater the cooperation hazards, the more intensive and elaborated the governance packages will be.

They found three clusters or configurations of approaches. 'Intense bureaucrats' outsource more than average, and thus experience intense cooperation hazards. They tend to use private suppliers in a competitive market, and to exercise intense control, primarily focused on results. 'Ambivalent relation builders' are in municipalities that are characterised by weak supplier competition and substantial cooperation hazards. They outsource less than average, have a tendency to do so with NGOs and have a high trust orientation. They mix methods of control, and thus show ambivalence between the bureaucratic- or relational-approach. ‘Relaxed bureaucrats’ are in municipalities with low market competition, they outsource less than average and have low dependence, combined with high expectations of supplier task fulfilment, and are less active in the control phase. The ambivalent relation builders do less well on governance effectiveness, probably because of ‘mixed messages’ of ambivalence about trust and competition. Johansson and Siverbo’s paper is significant because of the configuration model that emphasises the need for consistent approaches across the contact and control phases of the contractual relationship; and the related emphasis on alignment in the governance of complex service contracting.

Lamothe and Lamothe (2012) studied the mix of formal and relational governance approaches in local government contracting, using a survey of local government authorities across the USA. This study finds that the written form of contracts and their management vary in ways that suggest the coexistence of relational and formal mechanisms in both the formulation and the management of service contracts, but that there are different influences at each stage. Local governments write formalistic contracts when services are perceived to have low transaction costs and vendor service markets are robust; and more open contracts in the reverse circumstances. However, these factors don’t influence management style. Rather, vendor reputation, and the authority’s own management capacity are more influential on control approach (e.g. frequency of contact). When problems arise, decisions to impose sanctions or negotiate are related to expectations of an ongoing relationship. This paper confirms the use of more relational styles for complex services, and suggests that a combination of what the authors call formal contracting with relational management is an effective mix.

Relational contracting in management, public administration and marketing studies

Four papers address relational contracting features in public administration, construction projects and professional services in the USA. They are included in this review because they offer some potentially relevant insights from outside human services. The most relevant is by Bertelli and Smith (2010), whose theoretical essay argues that relational contracting theory is important to understanding the role of public managers as the leaders of the policy networks (the ‘new’ set of players that are necessary to policy development in the contract state). They affirm the view that relational contracting is the method of choice for complex services with hard-to-measure outcomes, as is typically the case in health and community services, and argue that skilled public managers can maintain effective accountability in this context.

Crespin-Mazet and Portier (2011) report on a study of the factors that determine the project purchasers’ choice between relational and transactional contracting for construction projects, affirming the existing evidence that suggests the choice is more likely to be relational when the purchaser perceives high risks in the project. They find that transactional purchasing is dominant, and the choice is mainly determined by two purchaser characteristics. Purchasers are less likely to choose relational approaches when the project concerns their core activities or if they have rigid and elaborate internal procurement practices. Thus, firms will choose relational methods if the project is far from core business and they are less specialised for project purchasing – otherwise, internal factors almost require them to take more control.

The authors conclude that the higher the transaction costs to develop relational contracting in upstream stages of project development (time and resources to co-develop a solution, learn how to interact with providers and build trust) the less likely firms are to choose a relational approach. They also note that later behaviour may not be in line with the transactional nature of the contract. This study is relevant in shedding light on two potential impediments to use by governments of relational approaches at the contracting stage. Firstly, governments have particularly rigid internal procurement practices. Secondly, government funders may well perceive that they have the necessary knowledge to treat Aboriginal PHC as a core activity (and thus use transactional approaches), given the basis of their action in government policy, and their access to research evidence.

Day et al. (2013) examine the potential downside of trust-based contracting relationships, asking whether too much embeddedness in relationships with key suppliers can reduce performance (in value creation). They did a comparative case study between two firms in the USA, which took two different approaches to relational contracting with suppliers, and experienced different problems.

This study is useful for its examination of the concept of trust in contracted relationships. Trust ‘comprises the intangible attributes built over time to deal with the shared vulnerabilities in buyer/supplier relationships’ (Day et al. 2013:152). Trust enables buyers and suppliers to rely on one another despite the risk of opportunistic behaviour; and is seen to bring many benefits, including for learning and innovation. However, too much embeddedness based on trust can reduce the efforts of both parties to be vigilant against malfeasance; to capitalise on opportunities for leveraging existing relationships; or to monitor competing resource deployment options. Trust functions as both a complement to and substitute for contractual governance arrangements.

Gil (2009) investigates how infrastructure promoters can implement a relational contracting strategy, based on a case study of the redevelopment of Heathrow’s Terminal 5, in which a strong relational orientation was the starting point. Interviews with 100 participants on both sides of the contracting relationship were conducted, along with document review and observation. The author articulates five factors that need to be present for relational contracts like this to work: project suppliers need to be keen to reap reputational benefits; they need flexibility in their production processes; suppliers and clients need to choose the right people to conduct the relationship; clients need to learn in response to supplier feedback; and to align their practices aimed at controlling and improving performance with suppliers’ skills. These findings could be useful in the development of a framework for better contract governance and relationships.

The Australian papers

This is an eclectic set of papers, drawn from public management, health sociology, NGO sector and grey literatures. The most directly relevant to the work in this chapter is a study of the public financing of remote Indigenous settlements by Moran and Porter (2014). This paper addresses the corrosive impact of Australian government financing practices on governance capacity in remote Indigenous communities. In particular, the retention of strong upwards accountability in an administratively de-centralised system, as opposed to political devolution which would transfer decision-making powers to formal governance structures that are accountable downwards to citizens, is found to have led to disengagement by Indigenous people in their own governance. The authors suggest that devolution (through local government structures) should be used to catalyse the considerable capabilities within communities, and that any administrative and technical performance deficits can then be addressed.

Carson, Chung and Day (2012) evaluated a program for male perpetrators of family violence (funded by the correctional services authority in one Australian state). The study focused on four contracts, with different national NGOs (three of them church-based) for the delivery of the program, based on an established model (the Duluth model), in four different settings, two rural and two metropolitan. They found that model fidelity, variation in organisational culture (affecting commitment to the purpose of the program) and employment practices affected the quality of program delivery. The government contractors were found to have underspecified important program elements in the reporting and monitoring regime, favouring reporting of some elements of activity (number of participants, number of sessions) rather than less easily counted program outcomes and elements (like contact with the women in the clients' families, and participation in local service networks to facilitate family safety). The NGOs with existing male domestic violence programs, and using employed rather than sessional staff, were more likely to perform well (including on model fidelity).

These findings confirm the importance of both shared goals and good specification and monitoring when a proven model of intervention is to be implemented. The authors (Carson, Chung & Day 2012) characterise the government contractors as 'distant relations' (using relational approaches – which were in any case disrupted by staff turnover – but being insufficiently engaged).

Lack of capacity in government departments to manage and monitor the contracts (so that variation in quality was not detected) is a finding of relevance to the ACCHO context. So too is the impact of the approach taken by contracted NGOs – a targeted program is more likely to be implemented well if it addresses an existing agency priority (in this case due to both better staffing and broader commitment to performance against program goals). The findings are also consistent with those of Lamothe and Lamothe (2012) in relation to the value of good specification in the contracting stages; and with Bromberg and Henderson (2014) and Roehrich and Lewis (2014) in supporting the need for both formal and relational engagement in the monitoring stages. The results also reinforce the importance of goal commitment in agencies contracting for complex social programs, a finding that supports the claims of the ACCHO sector that commitment to Aboriginal health and cultural safety are critical for effectiveness.

Donato (2010) reports on an examination of the contracting principles and practices in use between Private Health Insurers (PHIs) and private hospitals in Australia. He suggests that a combination of the Transaction Cost Economics (TCE) framework and the Resource-Based View (RBV) of the firm is needed to understand the contractual relationships. Donato points out that the 'greater the degree of asset specificity, uncertainty and measurement difficulties, the higher are the exchange hazards' (2010:1990); giving rise to the need for both complex contracts and alternative (relational) contract governance arrangements – conditions that apply in the complex business of contracting for hospital care. In this qualitative study Donato found considerable variation, but a general pattern of incomplete contracts and relational features in hybrid contract governance approaches. The more innovative partners were moving to maximise the advantages of relational approaches through information-sharing, joint learning and taking advantage of synergies.

The author concludes that 'a combined TCE-RBV perspective, which recognises both exchange hazards and the dynamic processes of value-enhancing capabilities, provides greater insight for understanding the development of contractual and governance arrangements in the Australia private health care sector' (Donato 2010:1996). This conclusion is relevant to the challenges facing governments and the ACCHO sector in their contracting relationship. All of the contractual conditions for high exchange hazards apply. The findings reported in this chapter (Dwyer et al. 2011) also suggest that while formal contracts are highly transactional, they remain incomplete and are managed using relational approaches. The question of whether the RBV features highlighted by Donato (enhancing value through joint development of expertise and relational capability) also apply remains open.

The final research paper in this group (Kerr & Carson 2010) provides a useful review of the long history of engagement by NGOs in the delivery of government-funded community services in Australia; and the more recent move towards short-term contracts and tightly specified deliverables (often quantifying processes rather than outputs or outcomes). The authors report on a survey of sector managers regarding the sector's sustainability, particularly in relation to workforce.

Hand-searching identified two directly relevant government reports on outsourcing of government human services to the NGO and for profit sectors in WA and NSW (Economic Audit Committee 2009; Legislative Assembly of NSW 2013). The WA report is a clear example of neo-liberal/NPM approaches to the human services responsibilities of government. Entitled 'Putting the Public First: Partnering with the Community and Business to Deliver Outcomes', it recommends contestability for virtually all government services. The report recognises the contemporary excesses of existing NPM inspired reforms; and calls for a more relational approach to contract management, with simplified application and monitoring processes, longer contracts, fewer broader programs, a focus on outcomes etc. The NSW Legislative Assembly review (2013) makes similar recommendations in relation to the excesses of transactional contracting with NGOs in NSW. It is not clear in either report that effective methods of achieving reductions in red tape have been found.

Summary

In summary, the literature identified in this search tends to reinforce my conclusions that a more relational approach to contracting, with longer time-frames and broader definition of services in keeping with the nature of PHC, is appropriate to the government/ACCHO sector funding relationship; and would improve both effectiveness and efficiency.

There are several relevant theoretical frameworks emerging from the general and public management literature, that may be helpful for the design of better contracting methods. First, the increasing recognition of MacNeil's (1973) original proposition that all contracting is relational has led to more nuanced consideration of the value of blending elements of transactional and relational contracting approaches in both the design and letting of the contract and the implementation phase; and the need to focus on coherence and consistency in the whole governance package.

The potential for such methods to reduce the apparent reliance on trust in interpersonal and organisational relationships is also of interest. The concept of trust sounds vague and unreliable in a contracting relationship, but it has remained as a necessary explanatory concept. Perhaps Williamson’s (1993) alternative of calculativeness (how high are the risks of opportunism, incompetence or malfeasance?) rather than trust per se is the more useful concept in exchange relations.

This literature also suggests ways in which the framework for designing and analysing contractual environments that was proposed and applied in the published work in this chapter can be strengthened through a clearer distinction between the goals and methods in the contracting and operating phases. At the same time, our emphasis on the need for coherence (or alignment) in the various components of the contracting environment is reinforced. Perhaps the ideal form of contracting between ACCHOs and their funding bodies will be a combination of the best possible formal contracts (not necessarily the most specific) with effective conduct of the ongoing relationships between these interdependent parties.

Conclusion

The papers presented in this chapter document characteristics of the regime of funding and regulation practiced by Australian governments, as well as the costs and disadvantages of the application of NPM-inspired methods to the funding of PHC for Aboriginal people, among other populations. These papers establish a novel framework for analysing the way the ACCHO sector is funded and regulated by governments. The first paper (Dwyer et al. 2011) documents the fragmentation and complexity of government funding and regulatory practice; and the impact on both funded agencies and funders. It suggests that the current approaches incur all of the costs of fragmentation and complexity; but do not offer the theoretical benefits.

The second paper (Lavoie, Boulton & Dwyer 2010) argues that comparison between the merits and costs of a single classical and a single relational contract is not the right question in the case of Indigenous PHC, because the theoretical option of purchasing PHC through a single classical contract is not a real one. It argues for an alternative framework of analysis, focused on contracting environments and offering three options: a single relational contract, a set of classical contracts, or a blend of the two. Complexity is a feature of all options.

The first proposition of this thesis is that the fragmentation and complexity of arrangements for funding and regulating ACCHOs is based in the application of NPM methods; and that those methods reinforce rather than counteract the difficulties of the relationship between the sector and its funders. To support this proposition, these papers need to establish three things, each of which are addressed below.

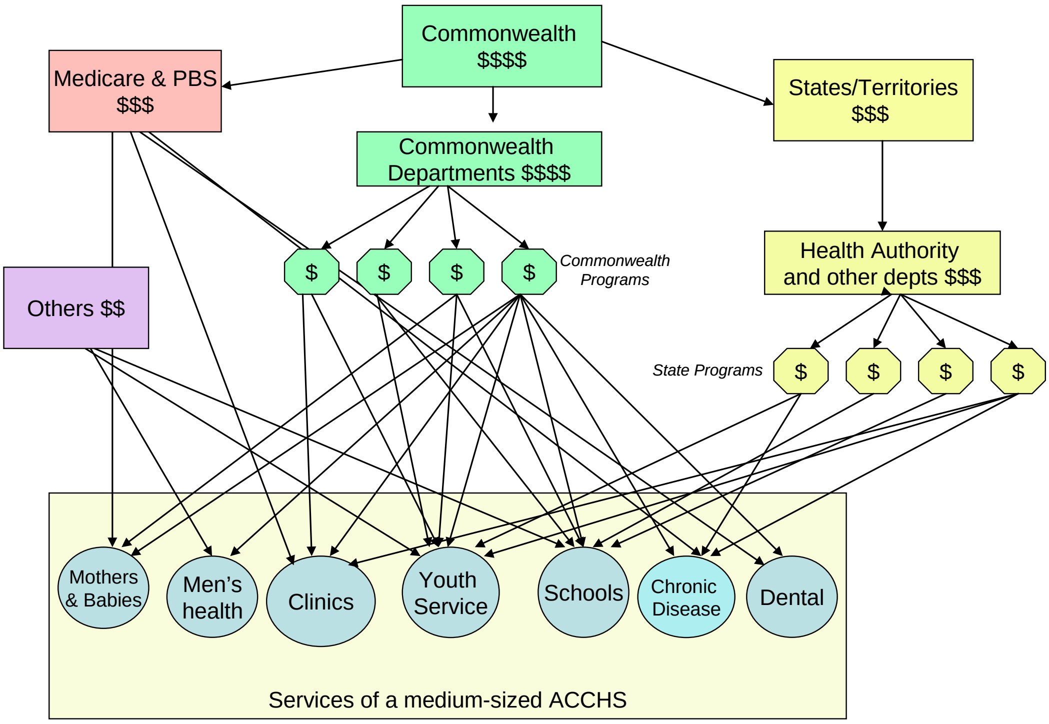
1. That the funding and regulation are complex and fragmented.

The first paper (and Appendix B) document a consensus among both funders and providers of Aboriginal PHC that the funding and regulatory regime (enacted in the form of NPM-inspired quasi-classical contracts and associated regulation) is indeed complex and fragmented, thus addressing the first point above. In one sense, the research merely confirmed what everyone involved already knew. However, it did more than that, in two main ways that highlight the contribution of NPM-based methods (enacted in contracting) to the situation – see below.

2. That this situation is based in the application of NPM methods.

Firstly, drawing on the theoretical framework articulated in the second paper, our research showed that the correct frame of analysis within which to assess the funding and regulatory methods was not primarily the quality of the contract (the main focus of the funder of each contract). Rather, the papers show that the effectiveness of funding and regulation needs to be assessed at the level of the contractual environment for service delivery (which is after all the purpose for which the funding is provided). The diagram reproduced below (Figure 1) illustrates this point.

Figure 1: Typical funding to a medium-sized ACCHS



I suggest that the upper echelons of policy makers at the top of this diagram did not intend to create the spaghetti bowl below. Rather, they imagined the money falling straight down like rain onto a receptive ground where the precise products they intended to purchase would prosper.

It needs to be noted here that many of the public servants who administered this funding knew better than that, and some of them took what action they could to ameliorate the resultant problems. In particular, the necessity for something other than program funding had not gone unnoticed, and both the Commonwealth and some of the states/territories have for many years provided 'core' funding (formally entitled Primary Health Care Program funding by the Commonwealth), intended to enable funded organisations to maintain the base of governance, management, systems, clinics etc necessary for PHC delivery, and to be in a position to use the 'body part' program funding so favoured by governments. The continuation of this core (PHC Program) funding has been challenged as recently as

2013/14[4], but it has survived. Thus for most ACCHOs, their contractual environment includes a mix of relational and classical contracts, within which maintaining the balance between 'core' and 'program' funding is a critical problem.

It is also true that many of the specific programs that make up the spaghetti strands in the diagram were designed and funded on the basis of evidence that the intended interventions were efficacious. But the working assumption when dropping program funding into a PHC system is that the PHC system exists and is functioning and can simply enhance its work by adding the specified program. This is a critical assumption for classical contracting – i.e. that the purchaser can commission the desired service from a market of willing and competitive providers.

Secondly, the second paper was able to show that a complex and fragmented contracting environment for Aboriginal PHC service delivery is not simply an unfortunate by-product but rather a design feature, an inevitable outcome of quasi-classical contracting by multiple funders for health programs.

3. That those methods add to the difficulties of the relationship between the sector and its funders.

The third element that needs to be established to support the proposition is that the NPM-based methods of contracting in use exacerbate difficulties in the working relationship between the sector and its government funders. The first paper (and Appendix B) provide evidence of tension, frustration and resentment on both sides of the funding relationship, attributed by participants to aspects of the contracts and their management – particularly the timeframes, the amount of submission- and report-writing required, related problems with compliance with reporting requirements and timelines, the focus on throughputs rather than indicators of effectiveness, and the lack of responsiveness to local conditions and priorities. This conclusion is supported by two relevant government reports (Australian National Audit Office [ANAO] 201; Department of Finance and Deregulation [DFD] 2010).

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[4] I was involved as an adviser to the review team, but the only publicly available reference to the work I have located is a consultation paper released at the commencement of the project (KPMG 2012).

It needs to be said however, that complexity, or at least the getting of funding from multiple sources is not always a bad thing, and may be necessary or inevitable in a situation of multiple and complex stakeholding (Anderson & Sanders 1996:16-20). There are other sources of difficulties in both the contracting and the working relationships, and my experience of doing the work represented in this chapter led me to consider two of them in detail – the issue of systemic racism in a post-colonising society (Ch 3) and the problem of meaningful accountability (Ch 4).

The next question

Following the release of *The Overburden Report* in 2009, I had a confidential conversation with two very senior public servants I knew well. It happened in the auspicious setting of the old Cabinet Room in Adelaide, and it sums up much of what I have learned in the last 10-15 years of studying the relationship between government agencies and Aboriginal health organisations. I asked them why government funding to ACCHOs was always so tied up with ‘nasty bits of red tape’.

They agreed on a simple explanation. They each explained that they worked in an environment where high policy endorses the principle of community control of health services, and yet the funding agencies don’t have confidence in the governance of ACCHOs. That dissonance between high policy and working assumptions is undiscussable, part of the ‘shadowside’ of the organisations (Egan 1994), and can’t be addressed or resolved directly in policy or management forums. And so, both politicians and public servants seek to mitigate their sense of risk by attaching lots of strings. Two important realities were implicit in that response: the dominance of NPM methods of public administration; and the (mutual) lack of trust that characterises inter-racial relationships, particularly (in Australia) those involving Aboriginal and Torres Strait Islander people and organisations.

The current chapter has addressed the use of NPM methods in the funding relationship between ACCHOs and governments. Doing the work represented in this chapter brought it home to me that the ‘wickedness’ (Hisschemöller and Hoppe 1995) of this aspect of the Aboriginal health policy problem also stems from the politically sensitive relationship between Aboriginal and mainstream Australia and its institutions (Sullivan 2009). The next chapter turns to this second underlying reality.

Chapter 3: Holding response and denial: post-colonising accommodation

This chapter addresses the second of my four propositions: That the inadequacy of operational responses in the mainstream health system to the particular needs of Aboriginal patients (in spite of high level policy that requires such responses) constitutes systemic racism; and that the absence of a legislative base on which such responses could be reliably built in to the system reinforces the problem. Each of three related papers are first introduced and presented, followed by a literature review on systemic racism in health and strategies to address it. The chapter concludes with a consideration of the contribution of the papers and the literature to my double-barrelled proposition above.

This thesis seeks to unpick the complex ways in which the legal, policy and social settings of post-colonial[5] Australia interact with the methods of public administration (based on New Public Management) to impede the development of an effective Primary Health Care (PHC) system for Aboriginal and Torres Strait Islander Australians. The goal is to articulate a feasible alternative approach to the purchaser/provider relationship between the Aboriginal Community Controlled Health Organisation (ACCHO) sector and their government funders.

This problem matters because changing some aspects of this relationship would itself be an important step towards improving the PHC system, and could also enable (or remove barriers against) other important changes, changes that would support better health care and better health for Aboriginal and Torres Strait Islander people. This chapter is focused on a critical component of the larger problem, that is, the impact of systemic racism, and its enduring sources in Australian law, institutions, policies and social practices, on the business of health care and on government stewardship for Aboriginal health.

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[5] This term arose as a critique of the thinking and actions of European colonisers (Said 1978). In relation to Indigenous peoples, it is used to signify the continuing theory and practice of colonisation of Indigenous peoples, their knowledge systems, cultures and resources, in settler societies (see for example Rigney 2001).

In this chapter, the focus shifts from the funding and regulation of ACCHOs to the question of Australian racism towards the First Peoples, and the ways in which the current consequences of past colonising actions, and the ongoing reality of colonising practices and institutional arrangements, are manifested in health policy and the health system.

Racism is a problematic term, as discussed in the first paper below. Discussing racism seems to induce a special kind of anxiety in those who are accused of it, or feel implicated in its practice, for several reasons that are worthy of serious consideration.

In the work on which this chapter is partly based, the Managing Two Worlds Together research team experienced the taboo on discussing racism in health care first hand, when our attempts to do so derailed conversations with some clinical unit teams in Adelaide hospitals, a phenomenon also confronting those who educate health professionals (McDermott 2012). On one memorable occasion, once the ‘r-word’ was mentioned, it was necessary to spend significant time and energy working through the proposition that ‘we are not racist’ before conversation on how this very good clinical unit responded proactively and effectively to the needs of Aboriginal patients could resume.

It seems that racism anxiety acts as a barrier against the very analysis and action that could reduce the impact of systemic racism in health care. The problem is that it is both necessary for systemic racism to be recognised and addressed; and difficult for those involved (both non-Aboriginal and Aboriginal people) to acknowledge the problem and move to address it in a systematic way. The work in this chapter represents my attempt (with colleagues) to understand not only systemic racism in health care, but what drives this (usually silent) denial and its effects, and to find ways to change both.

The research story part one

I initiated the *Managing Two Worlds Together* project, with a strong team of researchers and stakeholders, in response to a competitive grant round under the Strategic Health Research Program formerly operated by the Department of Health. The funding Program was intended to address issues of priority for the Department, through commissioned health services research. The Managing Two Worlds Together project was funded in the last call for submissions made by the Program, following the decision to allocate most of the Department's available research funding to the South Australian Health and Medical Research Institute which was established in 2009. In financial year 2008, the Program's call for applications included an opportunity to investigate the problems experienced by a number of marginalised population groups in Adelaide public hospitals. In discussions, it became clear that the need for a study investigating the way care is provided specifically for Aboriginal patients from rural and remote areas had been identified by the Aboriginal Health Services Division of the Department and other stakeholders. With colleagues, I submitted a successful application, with a funding contract (for close to $450,000) being signed in September 2008.

Notification of funding was received in August 2008; and the industry reports of Stage 1 (with a focus on analysing the challenges) were published in October 2011, with the report of Stage 2 (focused on a tool for use by health care providers) published in late 2012. Dr Janet Kelly, the research associate who had worked on the project since it was funded, was then successful in leading a team that acquired funding for Stage 3 from the Lowitja Institute. In Stage 3, patient journey mapping tools for use in health care planning, delivery, quality improvement and education were developed and tested. Stage 3 of the project was completed in late 2014 with the publication of several industry reports and a workbook in 2015 (also available on the website below). The main report from the Managing Two Worlds Together project, which summarises the 4 main studies, is included as Appendix C to this thesis (Dwyer J et al. 2011).

The 'Managing two worlds together' papers

The first and second papers in this chapter report on aspects of Managing Two Worlds Together. Several industry reports were written from this project, all of which are available on the Flinders Health Care Management website at: http://www.flinders.edu.au/medicine/sites/health-care-management/research/mtwt/managing-two-worlds-together_home.cfm.

PAPER THREE – Hospitals caring for rural Aboriginal patients: Holding response and denial

This paper (Dwyer, Willis & Kelly 2014) explores the reasons for the observed gap between the intentions of ‘grand policy’ for Aboriginal health care and its implementation in the mainstream health system, based on a study of the barriers encountered by hospital staff in their efforts to respond to the particular needs of rural and remote Aboriginal patients. This study is included for its insight into the ways by which systemic racism is allowed to apply in hospitals, and perhaps more broadly in mainstream thinking about Aboriginal health and health care.

Statement of my role

I wrote this paper, and took primary responsibility for the data analysis, and for the revision and final approval of the manuscript. I led the research team and the study design, as described above. Professor Eileen Willis contributed to drafting, review and revision of the paper, and to the theoretical understandings on which it is based. Dr Janet Kelly contributed to the collection and analysis of the data, and to drafting, review and revision of the paper.

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Hospitals caring for rural Aboriginal patients: holding response and denial

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Abstract

Objective. To investigate how policy requiring cultural respect and attention to health equity is implemented in the care of rural and remote Aboriginal people in city hospitals.

Methods. Interviews with 26 staff in public hospitals in Adelaide, South Australia, were analysed (using a framework based on cultural competence) to identify their perceptions of the enabling strategies and systemic barriers against the implementation of official policy in the care of rural Aboriginal patients.

Results. The major underlying barriers were lack of knowledge and skills among staff generally, and the persistent use of 'business as usual' approaches in their hospitals, despite the clear need for proactive responses to the complex care journeys these patients undertake. Staff reported a sense that while they are required to provide responsive care, care systems often fail to authorise or guide necessary action to enable equitable care.

Conclusions. Staff caring for rural Aboriginal patients are required to respond to complex particular needs in the absence of effective authorisation. We suggest that systemic misinterpretation of the principle of equal treatment is an important barrier against the development of culturally competent organisations.

What is known about this topic? The care received by Aboriginal patients is less effective than it is for the population generally, and access to care is poorer. Those in rural and remote settings experience both severe access barriers and predictable complexity in their patient care journeys. This situation persists despite high-level policies that require tailored responses to the particular needs of Aboriginal people.

What does this paper add? Staff who care for these patients develop skills and modify care delivery to respond to their particular needs, but they do so in the absence of systematic policies, procedures and programs that would 'build in' or authorise the required responsiveness.

What are the implications for practitioners? Systematic attention, at hospital and clinical unit level, to operationalising high policy goals is needed. The framework of cultural competence offers relevant guidance for efforts (at system, organisation and care delivery levels) to improve care, but requires organisations to address misinterpretation of the principle of equal treatment.

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Introduction

The poor health status of Aboriginal and Torres Strait Islander Australians is well documented, and has been the subject of official policy and program attention for many years, most recently under the rubric of 'Closing the Gap'.[1] The mainstream health system has responded to increased funding and clear portfolio responsibility,[2] with increasing attention to the burden of illness that Aboriginal people experience[3] and the need for effective health care.[4]

However, change is patchy. There is evidence that access and quality of care for Aboriginal people is compromised in relation to screening, prevention of complications and potentially preventable hospitalisations.[5] Although emergency department visits and hospitalisation rates for Aboriginal people are relatively higher than for the general population, procedure rates are lower and waiting times longer, and nearly double for some surgeries.[6] There is less access to supportive and rehabilitation services, such as cardiac rehabilitation,[7] and lower access to kidney transplantation,[8] and continuity of care across different health and support services is compromised.[9]

Engagement with the health system is made more difficult for Aboriginal people by their past and present experiences of exclusion, shaming and stereotyping.[10–14] Language and interpersonal communication breakdowns across the cultural divide lead to difficulty in assessing symptoms, reaching an accurate diagnosis and providing effective care.[11,15,16]

Aboriginal and Torres Strait Islander people living in rural and remote areas of South Australia often have English as a second (or subsequent) language, have little or no experience of the city and have limited financial resources. They are admitted to public hospitals in Adelaide, the capital city, more often (1.6-fold) than their non-Aboriginal counterparts and often need to stay longer.[17]

This situation persists, despite legislation and policy that authorises or requires tailored responses to the needs of Aboriginal patients.[18] The Department of Health has endorsed the Cultural Respect Framework,[19] which acknowledges that the health system 'does not provide the same level and quality of care to treat illness' for Aboriginal people, and the need to improve both performance and accountability.[19]

The South Australian Health Care Act 2008 (Part1:5(b), p. 7) places an obligation on the State's public health services to recognise and respect Aboriginal people and cultures, and provides a legislative basis for tailoring health care to meet the needs of Aboriginal patients.

The aim of the present study was to investigate barriers against the implementation of these requirements, as reported by staff in city hospitals who provide care for rural Aboriginal patients in South Australia.

Institutional racism and cultural competency

Some authors have concluded that the reasons for the observed disparities in care for Aboriginal patients are not clearly understood,[20] whereas others highlight the importance of recognising and addressing institutional racism.[21–23] Racism is generally understood to mean individual beliefs and actions that are unfair and oppressive to 'other' racial groups. Institutional racism refers to the overt and subtle ways in which the operation of institutions and organisations has the effect of discriminating against minority populations.[24] This is 'built-in' racial discrimination, occurring with or without direct intention by individuals. Given the evidence summarised above, it must be accepted that institutional racism exists in the Australian healthcare system, despite both good intentions and significant effort to improve care.

The framework of cultural competence supports systematic efforts to improve the effectiveness of care, and remove or reduce the impact of discrimination against minority groups, in health care.[25] The framework is multilayered, calling for attention at system, organisation, profession and individual levels.[26] Cultural competence is a characteristic of the healthcare system, rendering it more capable of delivering culturally safe care to patients.[27]

Methods

The present study, part of a larger action research project, received ethical approval from six institutional ethics committees, including the Aboriginal Health Council of South Australia. The partnership and project management arrangements are described elsewhere.[28]

Six clinical units (in all five major public hospitals in Adelaide) that admit significant numbers of country Aboriginal patients were approached to participate. In consultation with unit leaders, individuals with experience in providing care to rural Aboriginal patients and from a range of disciplines were identified and approached. All 26 agreed to participate, and interviews were conducted individually ($n = 22$) or in pairs ($n = 2$ pairs). One participant was Aboriginal, and eight were male. This purposive sample is not designed to be statistically representative.

Interviews (conducted in 2009–10) elicited staff views about the experience of providing city hospital care to country Aboriginal patients. Questions were open ended and asked participants about barriers and their underlying causes, as well as strategies for improving care, as shown in Fig. 1.

Interviews were audiorecorded, transcribed and coded using NVivo8 software (QSR International; http://www.qsrinternational.com/products_previous-products_nvivo8.aspx, accessed

Role: Please explain what you do in your job.

Barriers: Can you talk about your experiences of providing care for Aboriginal people from remote regions and what gets in your way in your efforts to provide effective care?

Causes and underlying issues: Why do you think this happens? When you identify an issue, do you have any way of raising it for resolution?

Enablers: Thinking about your experience of these problems or barriers, what are the factors in your working environment that have helped to make things better?

Strategies: Thinking back on your experiences, if you had the power, what are the important changes that would improve the care for Aboriginal people from remote areas?

Fig. 1. Interview and focus group outline.

17 July 2014). Text addressing systemic barriers and enablers and/or strategies was analysed using the framework of cultural competence. Cultural competence is usually defined as 'a set of congruent behaviours, attitudes, and policies in a system, agency or among professionals' that enable effective cross-cultural work.[25] Analysis focused on the ways participants conceptualised the underlying causes of difficulties. The practical challenges they discussed are presented elsewhere.[17,28–31]

Results

Participants discussed two major themes: (1) individual cultural (in)competence; and (2) the impact of 'business as usual' requirements. They offered strategies to address many of the barriers. The results are presented below, with representative quotes (a unique number and the profession of the participant are shown in parentheses after each).

Cultural (in)competence

The difficulties of establishing trust and good communication across cultures and among people with very different life experiences and worldviews, and the importance of making it work if clinical care is to be safe and effective, were discussed by most participants. They used several terms, such as 'cultural awareness', and focused on personal knowledge gained from experience and training.

> [I have had to ask] is my colleague suggesting the person's being aggressive because they're being aggressive or are they just a person in distress who doesn't understand and who is frustrated and it is being perceived as aggression because of my colleague's own personal views and values about that person's race or ethnicity and I've seen situations where that's occurred. . .and no-one really stopped to take the time to sort of think 'is this an issue actually with the patient or is this actually an issue with my colleague?' 'Who owns this issue here?' (4, receptionist)

> Cultural sensitivity isn't sort of being mamby pamby about it, it's understanding how to approach things. . .I just don't know what to say to make the interaction whereas some of the Registrars who have been up north have worked out what to do. (8, senior doctor)

> When we first wanted to get Ngangkaries [traditional healers] down, going through admin was a nightmare because they basically wanted ABN numbers and all that sort of stuff and then 'what are the qualifications of these people?' and it was an absolute nightmare. (3, psychologist)

The administrative staff referred to above were seen to change their own practice and interactions as a result of direct experience in an Aboriginal community:

> . . .and so admin staff going up [to the Lands] then recognise the importance of a Ngangkari and can see that it's the community that determines if a person is a good Ngangkari or not and that you don't need the ABN. (3, psychologist)

More confident staff emphasised the importance of respect, engagement and knowledge of their patients' home environments and country, and their use of language and health concepts. Although some participants criticised the quality of cultural awareness training, there was broad support for its use:

> . . .people that have had cultural training are usually quite aware and 'okay this reaction might be because of A, B and C' so they tend to work quite well with it but you do notice sometimes, I think, a difference between people that haven't had that sort of training. (13, social worker)

Managing two worlds together: business as usual often doesn't work

The second major theme, raised by almost all participants, was the requirement to apply 'business as usual' approaches even though they differentially restrict patients' access to care, undermine quality or simply don't work. Many of the problems are predictable; for example, discharge arrangements (including medications) and the inflexibility of appointment systems.

> I think because it's all too hard quite often a discharge plan doesn't get made as it would for anyone else. (7, senior nurse)

> They're now being asked to pay for that medication to go home with and that brings up all sorts of issues in terms of 'can I afford it?', 'I didn't sort of prepare ahead of time for this'. . .for people who are struggling, that means a large amount of money and for people who are remote, I guess in particular the Aboriginal patients that we see, it's very foreign to them. (13, social worker)

> People say they are non-compliant, but do they really understand in the first place, these tablets you have to keep taking forever. You have to go and get more tablets, do they actually understand that? I don't know. (16, doctor)

> She'd got herself organised, she'd got the bus organised and she'd got two little kids. She got there twenty minutes late, to the hospital, and they refused to see her and this woman had escaped violence, she was fleeing in a shelter, she was working really hard at maintaining her independence under huge, huge amounts of stress and a variety of things going on and then she got refused care. (23, midwife)

When staff spoke of the reasons for failure to adapt and accommodate the predictable challenges arising in complex care journeys for these patients, the problem of lip service and fine words not being backed by action was prominent.

> Unless you're going to mean something rather than look good because, you know, 'I'm the senior administrator who wrote this lovely document'. It's actually supposed to mean something and those sorts of ideas should be all flourishing around the hospital. But they don't and then you have to ask and so why don't they? Well talking the talk is – makes them feel fantastic, good Christians or whatever we're supposed to be feeling about ourselves, but actually

> doing that sort of thing is quite a different matter and that's where the barrier is. (24, doctor)

Others referred directly to the lack of a systematic approach, and the resulting loss of momentum for change.

> Probably the biggest barrier at the moment, is that there is no system in place really (14, coordinator)

> Yes I have been thinking about it and it is so big, there are so many issues, I don't even know where you begin. (16, doctor)

> It completely crashed out through lack of support. Absolute lack of management support and isolation and not having things sent up through the echelons. (23, midwife)

Although many of the participants expressed empathy with their patients, recognising the complexities of their health care journeys,[29] others articulated the principle of equal treatment as a barrier.

> . . .it was like you treated them like any other Tom, Dick or Harry that came through the ward. We did our normal treatment, did what we had to do and when it came to discharge, yeah. . .you just did the normal protocol for everybody and that's been my experience for 20 years. (9, nurse)

> I treat – all patients are the same so there wouldn't be any other treatments for Aboriginals or Muslims or – you know, there's difficulties with the language barrier but I've never come across that with the Aboriginal ladies, they've always spoken English to me or if we haven't the Aboriginal liaison is with them. . .I can't see there's any things that are being missed because the service we're giving is the same as anybody else. (22, ward clerk)

The adaptation of the system of care most often mentioned involved the roles of Aboriginal Liaison Officers (ALOs) and project staff.

> Having the Aboriginal Project Officer. . .is great in the way that he can actually communicate with all the different areas. He's familiar with all of the remote areas and he has the contacts so he'll often direct us to particular people. (20, allied health)

Participants also lamented the low numbers of ALOs employed, and the resultant difficulty for them to specialise in particular clinical areas, or to be involved pro-actively.

> They can only look after the disasters, and they don't have time to prevent the disasters from happening because they are too busy working on the disasters. (16, doctor)

Other adaptations included clinical coordinator roles. These were staff with time allocated for liaison and coordination with referring agencies and primary care providers. Participants also cited support services (accommodation and transport), and the use of outreach services and telemedicine, extra time for explanation and staff personally filling gaps.

> I think it's just taking that time, taking that time to go a bit further and find out. I suppose that's where my role comes into place and I guess I have that time to do that and I suppose I carry that responsibility as well, do that bit more. (14, care coordinator)

> . . .but we have [specialist] link nurses throughout the state as well. So yeah we have these nurses out there that come down, have done a small amount of training here, have regular meetings so they get updated. (12, care coordinator)

> [Pilot study of] teleconferencing to substitute for appointments for rural and remote families and it was really positively received by parents, saying that they'd love that service to be set up. (20, allied health)

> Having a longer amount of time to sit down and spend with someone, develop some kind of rapport and see what they understand about their health condition would be helpful. (5, doctor)

> Often if they're travelling back on the bus – I mean I probably shouldn't be saying this but we've all done it – we've all just taken out $20 and often we'll go and buy chicken and some bottles of water and some fruit and give it to them to take back with them on the bus. We've all done that out of our own pocket because, you know, you just think that's how you'd want one of your family members to be treated. (3, doctor)

Discussion

Staff interviews indicated widespread attention to the challenges of caring for country Aboriginal patients, as well as some lack of empathy. Cultural competence was generally understood only as a characteristic of individuals, to be developed through both training and direct experience, particularly exposure to the life circumstances of Aboriginal people in rural and remote regions.

This focus on the individual level is consistent with experience in the US, where cultural competence is a mandated requirement in healthcare. In a systematic review of instruments that seek to measure cultural competence, Kumaş-Tan *et al*.[32] found problematic assumptions about what it is, and a tendency to reduce it to the level of individual knowledge and skills. This focus on the individual, leading to an overemphasis on training, has been noted by others in this field[33] and in international development programs.[34]

Participants also discussed several strategies at the level of the hospital and/or the clinical unit that support a culturally competent care system. The roles of ALOs and clinical coordinators were most prominent, along with the availability of support services, like accommodation and transport assistance.

However, there was also a sense that the adaptations in use were largely those that could be constructed as 'bolt-ons' to normal systems of care. Problems that required flexibility in existing systems (e.g. appointment scheduling or the use of outreach modes of care) were less likely to be adopted.

The views and experiences of staff depict a system that functions at the edge of its capacity in seeking to meet the needs of country Aboriginal patients, so that relatively small problems (e.g. late planes) have consequences that reverberate in poorer health and additional costs. Although some clinical units have developed practical responses to patient needs, at the organisational level (and in the thinking of some staff) there seems to be a failure to acknowledge that such responses need to be reliably available. This situation persists despite policy that is intended to authorise the tailoring of care to the needs of Aboriginal patients.

It is always easier to write high policy goals than it is to implement effective action to achieve them; and the challenges of reliably providing good care and good access for rural and remote Aboriginal people are complex and serious. The patients (and their families and carers) undergo complex geographical and care journeys, and this complexity is predictable due to the interaction of rigidities and gaps in the system of care (e.g. communication gaps between acute and primary care) with underlying social factors (e.g. lack of financial resources and relatively poor health literacy).[17]

We note that non-Aboriginal people living in rural areas also experience complex care journeys, and both their access to care and its quality are affected by some similar barriers.[35] As Aboriginal observers often say, 'If we could fix care for Aboriginal people, we could fix it for everyone'.

But these considerations merely reinforce the reality that effective care for Aboriginal people (particularly those from rural and remote areas) requires both policy attention and modifications to the way care is provided. The policy is in place, but implementation is patchy at best. We suggest two explanations.

First, it is notable that high policy has not been systematically translated to the operational level. Staff expressed not only the usual need to find solutions to patient care problems, but also the lack of processes to embed those solutions or the ability to rely on operational protocols for positive authorisation and guidance. We contrast this situation with that confronting staff caring for people with blood-borne infections, another marginalised group. In that case, the principle of universal precautions (i.e. caring for all patients in a way that would prevent transmission) was quickly operationalised into protocols, suitable equipment, guidelines, training and resources for every predictable problem.

Second, we suggest that implementation is neglected because of misinterpretation of the principle of equal treatment. This principle (that all people should be treated equally in access to healthcare) has always included the clarification 'according to need'. The concept of equitable (rather than equal) care is used to emphasise this requirement.[36] The problem for (rural) Aboriginal patients seems to lie in denial that their particular needs are legitimate. We suggest that this difficulty has deep origins in a broader political problem; that is, the unresolved question of recognition of the place and role of Aboriginal and Torres Strait Islander people in Australian society and in law.[37] The framework and tools of cultural competency, with their emphasis on organisational as well as individual capacities,[38,39] offer a practical way to address this problem.

Competing Interests

The authors affirm that they have no competing interests and that the funder of this study had no influence on the writing or publication of this paper.

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PAPER FOUR – Travelling to the city for hospital care: access factors in country Aboriginal patient journeys

This paper (Kelly, Dwyer, Willis & Pekarsky 2014) is the second of two papers arising from the Managing Two Worlds Together project (Stage 1), as described above. It presents an analysis of one of the many practical barriers to access to health care experienced by Aboriginal people living in rural and remote South Australia (and in Central Australia) who need to come to city hospitals for care, i.e. the problem of travelling for health care.

Statement of my role

This paper draws on analysis in two of the project's industry reports. I led or participated in the data analysis and the first or second drafting of the relevant industry reports, then reviewed the draft of this paper prepared by Dr Kelly, contributed to the overall structure of the paper and suggested detailed revisions.

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Original Research

Travelling to the city for hospital care: Access factors in country Aboriginal patient journeys

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Abstract

Objective: *This study described the challenges for rural and remote Aboriginal people requiring transport to city hospitals for tertiary care.*
Design: *Semi-structured qualitative interviews.*
Setting: *South Australian rural and remote health services and tertiary hospitals.*
Participants: *Twenty-eight urban health professionals from six hospitals and 32 health professionals from four rural and remote regions were interviewed. Twelve patients, three carers, four people responding as patient and carers, and one patient and carer couple were also interviewed, with eight elder women meeting as a focus group.*
Main outcome measures: *The study identified specific structural barriers in urban health services or policy that prevented rural and remote Indigenous patients from receiving optimum care.*
Results: *Problems accessing transport were identified as the most significant factor affecting access to care by the majority of patients and staff. They reported that travel to an urban hospital was costly, and coordination of travel with care was poor. A further problem was travelling while unwell.*
Conclusions: *Travelling to a city hospital is a significant barrier for rural and remote Indigenous patients. Arranging and supporting travel is a time-consuming work that is not recognised by the health care system.*

KEY WORDS: *Aboriginal health, health services access, Indigenous health, patient issues, remote health delivery.*

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Introduction

This paper aims to highlight specific transport challenges for Aboriginal people requiring city hospital care, including planned, emergency, inpatient, outpatient and diagnostic care. This paper is part of a larger study, the Managing Two Worlds Together Project, which sought to enhance knowledge of what works well and what needs improvement in the system of care for Aboriginal patients from rural and remote parts of South Australia.[1] Other access barriers such as communication difficulties and cultural concerns are reported elsewhere. Approximately 30 000 Aboriginal people live in South Australia, about half in rural and remote areas.[2] Many Aboriginal people experience high levels of chronic illness such as diabetes, cardiovascular and kidney disease, and do not always have access to essential primary health care services. This is reflected in the high numbers of potentially preventable hospitalisations[3,4] and, paradoxically, in the observation of 'missing patients' by clinicians and statisticians (i.e. patients who present late in the course of their illness, or not at all).[1] While SA Health and Country Health SA have upgraded regional hospitals, the majority of specialist care is provided in Adelaide hospitals.

Travelling long distances from a rural or remote setting to a city hospital for medical treatment can be logistically challenging, tiring and at times frightening.[5,6] Access to safe transport is often restricted due to road conditions and poor access to public transport in rural and remote areas.[7] Each Australian state has in place some level of travel reimbursement and support, with differing eligibility criteria (see for example [8–11]). The experiences of patients and carers and the insights of staff provide an important perspective on existing problems and gaps, and possible strategies for improvement.

Methods

Recruitment

Six city hospital wards (cardiothoracic, renal, respiratory, maternity/neonatal, injury, mental health) that

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***What is already known on this subject*:**
- *Transport is a major factor in determining access to health care, particularly for people in rural and remote areas.*
- *Financial assistance schemes have strict eligibility criteria that can disadvantage patients leading to significant financial costs to them.*
- *Travelling to a city hospital for health care is highly disruptive for patients and their families.*

***What this study adds*:**
- *Aboriginal patients and health professionals agree that transport is a major barrier to access for health care, but identify different aspects and problems.*
- *Aboriginal people from rural and remote areas report that travel to urban hospitals for care can result in increased pain and discomfort, challenges to personal safety and unexpected costs. They note there is a lack of flexibility and coordination between travel arrangements and appointments with medical specialists.*
- *The extent to which travel and travelling is coordinated and supported directly affects access to care, but the work involved is not recorded or recognised within the health system.*

receive high numbers of rural and remote Aboriginal patients were identified. Ward leaders identified experienced nurses, doctors, managers, allied health and administration staff who were invited to participate in interviews individually or in small groups if preferred. Twenty-eight in total responded to flyers and email invitations. Four regional and remote areas were identified, and staff from hospitals, general practice, Aboriginal and mainstream community services, aged care and support services were invited to participate through staff meetings, flyers and email contact. The first thirty-two who responded were invited to participate in individual or group interviews. Sixteen staff overall identified as Aboriginal. One remote clinic and one city Aboriginal Liaison Unit declined the invitation.

During country visits, flyers and contact details were distributed through community groups and rural and remote staff, inviting Aboriginal people who had travelled to Adelaide for hospital care (and their carers) to participate in individual or group interviews. On return visits, researchers met with any interested patients and carers. Each participant chose whether to be interviewed as a patient ($n = 12$), carer ($n = 3$), as both a patient and carer ($n = 4$) or a patient and carer couple ($n = 1$ couple). One group of eight elder women chose a group interview ($n = 8$).

Interviews

Interviews were conducted at a time and location that best suited each participant, for 30–60 min. Staff were asked open questions about barriers and enablers, gaps and possible strategies of care, with the researchers using a set of prompt questions based on literature review to probe aspects mentioned by staff. Patients and carers were asked to describe their patient care journeys, with additional open questions, based on the main theme areas in the staff interviews, being used to prompt further discussion. See Table 1 for interview guides. Interview data were transcribed and inductively analysed using NVivo 8 (QSR International NVivo 8).

Ethics and agreements

Ethical approval was given by the Flinders University, Aboriginal Health Council of South Australia, The Queen Elizabeth Hospital, Child Youth and Women's Health Services, Royal Adelaide Hospital and Department of Health. Formal partnership agreements were negotiated with the Aboriginal Health Council of South Australia and all four major public health services in South Australia. A Project Management Group guided the research.

Results

Transport was highlighted by the majority of patients and staff as one of the most significant barriers to accessing tertiary health care in Adelaide. Approximately half of all patients and carers travelled to and from Adelaide in their own cars; the other half relied on family, local health services or public transport. Four of the 21 patients/carers interviewed said there was no public transport serving their towns or communities, and limited access was reported by eight elders in the focus group. Five patients reported cancelling trips to Adelaide due to transport problems.

Travelling long distances while unwell

Most patients and two thirds of city and country staff identified concerns about patients travelling long dis-

TABLE 1: *Interview guides for health staff and patient and carers*

Outline for Interview: Staff

1. Role – *please explain what you do in your job*
2. General discussion of barriers – *Can you talk about your experiences of providing care to Aboriginal people from remote regions and what gets in your way in your efforts to provide effective care?*
3. Discussion of perceived causes and picking up on underlying issues – *Why do you think this happens?*
4. Discussion of enablers – *Thinking about your experience of these problems or barriers, what are the factors in your working environment that have helped to make things better?*
5. Discussion of strategies – *Thinking back on your experiences if you had the power what are the important changes, in hospital care, that need to be achieved to improve the care for Aboriginal people from remote areas?*

Prompt questions derived from literature review:

Outline for Interview: Aboriginal patients and carers

Clarification of scope of experience a single episode, or experiences with repeat visits for same condition.

Invite patient or carer to tell their story

- *Can you talk about your last experience, or an important experience of going to hospital in Adelaide (or another centre) and then coming home? We are interested in what worked well for you, and what you found difficult.*
- *There are some things we would like to know more about what happens for patients and their carers when they go to Adelaide.*
- *You mentioned xx, could you talk some more about that?*

Specific areas for discussion (8 issues arising from staff interviews)

1. *Could you talk about your travel and accommodation during your last visit?*
2. *Did you feel that all of the people involved in your health care, from home to hospital and home again, were communicating with each other and working together?*
3. *Do you feel that you had particular needs as a country person, and as an Aboriginal person, and were these met?*
4. *Did you feel you could talk with the staff in the hospital and health services? Why or why not? Consider Aboriginal Liaison, interpreters, Ngangkaris (healers).*
5. *Did you understand what was happening to you? Did you have to agree to treatment and did you feel you had enough information to make these decisions?*
6. *Did you have a support person travel with you? Was this important to you, and what role did they play in the hospital? Did your support person have needs that were or were not met by the hospital and other services?*
7. *We are interested in what happens for Aboriginal patients in hospital. Could you please share whether you thought you were treated differently because you were Aboriginal?*
8. *If a new nurse or doctor was starting in a hospital or health service, what do you think they need to know about working well with Aboriginal patients from rural and remote areas?*

tances in private cars or on buses while unwell, in pain, feeling nauseous or immediately post discharge. Patients and carers reported travelled from 3 to 16 hours to Adelaide for appointments and admissions, with many travelling home again the same day if accommodation was unavailable or too expensive. The distances involved are significant. One man drove 1500 kilometres every 3 weeks for cancer treatment over an 18-month period. He drove alone, while nauseous with an underlying cardiac condition as his wife could not afford time off work, and the twice-weekly bus service did not coincide with his treatment regime. Another man stopped travelling by public transport when he became too unwell to climb onto the bus. He relied on family to transport him until it became too difficult and he refused to travel to Adelaide any more. City staff spoke of patients arriving exhausted and stressed, with negative impacts on their health and the quality of testing and consultation discussions. Rural and remote staff identified concerns when patients travelled long distances home immediately post treatment:

> If someone comes out of hospital with a broken leg you are worried about DVT [deep vein thrombosis. You're going to bus them out and you've got a 13 or 14 hour [journey] – and you can't [tell] the bus driver . . . 'every two hours pull up, I want to stretch my legs'.

A recent decline in availability of hostel or convalescent beds was reported to have made this situation worse.

Personal safety

Rural and remote staff and patients raised concerns about personal safety, particularly when buses dropped patients and carers off late at night or early morning, or at remote roadside locations. *(If they are really sick it is terrible . . . often it's really hot and they might not be allowed to stay inside in the airconditioning to wait.*) In one community, an Aboriginal health worker began meeting the five o'clock morning bus at the highway in her own car after seeing a newly discharged elder get off the bus and lie under a bench to wait until morning light when she could walk into town and arrange a ride to her own home community. She felt unsafe to get off at the next highway stop due to previous racial abuse and being unsure whether anyone was planning to meet her.

Financial concerns

The costs of travel were repeatedly raised as a significant barrier by patients and carers. Nearly all interviewees were pensioners or on low incomes (19 of 21), and most spoke of struggling to pay travel costs up front.

> . . . you've got to come up with the money for the travel first and then apply for the funding afterwards and that doesn't help very much, especially when you're on a pension and we've got the rent to pay.bills to pay, . . . kids to look after. putting petrol in the car. is $75.

Four patients identified difficulty with appointments booked in the 'off pension week', and two had cancelled their appointments because they did not have enough money to travel. Several patients and carers discussed wanting to travel together, *but the families were unable to afford the time off work for the carer.*

The Patient Assistance Transport Scheme (PATS) provides limited financial reimbursement but does not cover all out of pocket expenses. Some patients on low incomes discussed the difficulty of paying travel expenses up front, while others said, without the PATS they would not have been able to travel to the city. Many patients, carers and staff were unsure what the PATS funded or what other options for assistance were available.

Emergency and urgent travel

One unexpected finding was the significant impact of differing levels of system support for emergency and urgent travel. Patients (11) described their emergency travel and admissions as being well supported and gave positive accounts of feeling secure and well cared for by road and air ambulance staff.

In contrast, patients reported having to rely on their own limited resources for urgent (but not emergency) trips to Adelaide. One patient received a call in the middle of the night that her donor organ was ready and she needed to travel to Adelaide immediately. Their car was out of petrol and they had limited finances. In desperation, she went to the local hospital and her doctor gave her money to fill the car and drive to Adelaide with her husband. (New arrangements for fuel cards have since been organised.)

Similarly, a carer advised that when her husband was diagnosed in a regional centre with a suspected brain tumour, the general practitioner arranged admission that day, before the specialist left for the weekend. In a rush, they picked up their son from school and the husband drove to Adelaide as he was the only driver in the family. She explained:

> On the way down his driving was a bit strange, he would sit in the right-hand lane doing 50 kilometres an hour. My son said, 'Dad, get in the other lane'. So he changed, but further down the road, it happened again. We made it to the hospital by 4.30 p.m (PC24).

These examples highlight a serious disconnect between clinical and support services and transport assistance. In both cases, the families and other road users were at risk of accidents, and the stress experienced by the patients and their families was severe.

Both country and city staff highlighted that people travelling in emergency and urgent situations often arrive without needed paperwork, cards, money, clothes or an escort. This impacts on care and additional supports are required. In addition, some older remote people refused to fly due to their own or others' past experiences, a belief that the trip to Adelaide was a one-way trip (that they would die), or having never flown before.

Coordinating travel, appointments and cancellations

A third of all patients and carers spoke of difficulty in timing appointments to match fixed transport schedules, or in explaining to city receptionists the distance involved or bus and plane arrival times. Often, they had no choice but to stay overnight. Notice for appointments could arrive in the post close to the appointment date, making booking transport more difficult and expensive. Many rural and remote staff discussed the long hours they spent trying to arrange transport and accommodation for planned admissions or outpatient appointments. Two inflexible systems – the hospital appointment system and the transport system – collide, and a clinic running late can have major consequences:

> People in Adelaide don't realise if you miss the bus then you have to wait another 24 to 48 hours to catch the next one, find accommodation . . . some people don't have money or family down there (RC1).

Metropolitan staff also raised concerns about cancellation of appointments and admissions after patients had already begun their journeys and were unable to be contacted.

Discussion

Transport to the city can become a major access, health and safety issue for rural and remote Aboriginal patients and their families. The seemingly inevitable disconnect between health care, transport and support systems further complicates already complex and challenging journeys. Many staff strive to meet individual patient needs by either 'working the system' for maximum benefit of patients, or by working outside of the system, filling the gaps that exist between health and transport systems. This work is often time consuming, unrecorded and unrecognised by both the health care system and the patients themselves. Ongoing changes to PATS arrangements and transport support in South Australia and interstate in response to patient needs and adverse events have led to both improvements and new challenges for patients and staff coordinating journeys. This study, like others,[12] has identified that transport reimbursement schemes address only one aspect of supporting patient journeys; improved coordination and communication between health and support providers and culturally, personally and financially responsive arrangements are also necessary.

If equitable access to specialist services for Aboriginal patients from rural and remote regions is to be achieved, improvement in access to transport and support services is needed. Greater awareness about the realities of distance and transport, and more coordination of appointments (and flexibility to accommodate late arrivals) in city hospitals are also essential.

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Author contributions

Each author was involved in the original research and data analysis from the three studies this article is drawn from.

J.K. wrote the first draft of the article, with significant input and discussion by J.D., E.W. and B.P. Each author then contributed to developing specific themes within the article.

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Impact of the papers

It is too early to assess the academic impact of these papers. The first (Dwyer, Willis & Kelly 2014) has only two academic citations (Google Scholar 17 October 2015), but was 16th in the 'top 20 most read articles in the journal' for the previous 12 months in October 2015 (list accessed 17 October 2015). This Journal has a low impact factor (0.73, ISI Journal Citation Reports Ranking 2014). It is nevertheless the main journal in its field of health policy and management in Australia, with a high practitioner readership (including 3000 members of the Australian Healthcare and Hospitals Association) which is the desired audience.

It is also too early to assess the impact of the second paper (Kelly et al. 2014), which has four citations (Google Scholar 17 October 2015). The Journal has an Impact Factor of 1.225 (ISI Journal Citation Reports Ranking 2014) and is ranked 33/108 (Nursing (Social Science)); 37/110 (Nursing (Science)); 109/162 (Public Environmental & Occupational Health).

With Dr Kelly, I presented the results of the project to the SA Health Department's Aboriginal Health Strategy Committee, and we continue to work with major metropolitan hospitals, regional hospitals and health services and ACCHOs on improving the patient journey for rural and remote Aboriginal patients. A presentation on the project (Kelly, Dwyer, Pekarsky, Mackean, O'Donnell & Willis 2015) was awarded the Australian Journal of Primary Health prize for the best paper relevant to the interests of the journal. Increased uptake by Adelaide public hospitals of positions designed to support the coordination of care, with a focus on country Aboriginal people being transferred to the city, is another indirect indicator of the project's impact.

The research story part two

The paper below arose from a project that Dr. Genevieve Howse, an experienced public health lawyer, was commissioned to conduct on behalf of the Lowitja Institute (as part of the Research Program I led). The question Dr Howse was tasked to answer was focused on the options available to Australian governments for taking enduring responsibility for Aboriginal and Torres Strait Islander health and health care, should they decide to do so

(Lowitja Institute 2011) . The rationale was that if there was a good understanding about how this might be done, it would support advocates in their efforts to move Aboriginal health care from being a discretionary intervention (a funding program at the discretion of government agencies' decisions from time to time encoded only in annual budget bills) to a legislated responsibility.

I had started thinking about this problem when my colleague Professor Cindy Shannon (now Pro-Vice Chancellor, Indigenous Education at the University of Queensland) first brought the lack of any legislated basis for Aboriginal health care to my attention. My first reaction was to say 'why would there be?', and I subsequently heard that question, spoken or not, in conversations with other non-Indigenous people about this issue. Aboriginal people with whom I've discussed it give a different kind of response – along the lines of 'yes, not surprising'; and 'what would that look like and how might it help?'

The question of legislated government responsibility is complicated by current ambiguity about the relative responsibilities of federal and state/territory governments in relation to the health system as a whole and in relation to Aboriginal and Torres Strait Islander health care (NHHRC 2008, 2009). However, there are over 200 health acts of various Australian parliaments (see the paper that follows), some of them allocating enduring responsibilities for important areas within the health system largely to a single level of government. For example, the Commonwealth holds the major share of responsibility for aged care and that responsibility is legislated. Advocates for mental health have argued for several years that the same situation should apply in mental health care (Australian Health and Hospitals Association [AHHA] et al. 2008).

What Dr Howse found when she examined about 270 pieces of legislation in Australia's nine jurisdictions was another manifestation of silence and denial. I suggest that there is a collective cognitive dissonance in mainstream Australian thinking about the place and future of Aboriginal and Torres Strait Islander people. To generalise (and thus caricature) the non-Indigenous Australian view, the majority want Aboriginal Australians to have a good place and role, with recognition of their enduring cultures, and a good future, as part of this country. However, non-Indigenous Australians don't really want to acknowledge two important requirements for that to happen, or why they matter.

Firstly, we struggle to find a way to recognise the particular place of Aboriginal people as the First Peoples, which is not equivalent to the place of other 'minority' or 'ethnic' groups. As Professor Marcia Langton (2012) points out, this is not primarily about race (the First Peoples could have been blue-eyed and blond). This is about being the custodians and owners of the country, prior to European settlement, and being dispossessed, with little or no acknowledgement that it was even happening (an approach justified on the basis of the fiction of 'terra nullius'). This reality still needs to be acknowledged and resolved properly.

Secondly, we struggle to find a way to accept that the situation and health status of Aboriginal people is not 'their fault', but the result of history and politics as well as the life decisions of individuals and families taken within the deprivation and constraints thus imposed; and that it is a shared problem. The paradoxical reality is that Aboriginal people must be the active owners, not the passive recipients, of work to change that situation and at the same time non-Indigenous people, and mainstream institutions, need to help and support that effort, which will include change in mainstream policies and laws.

This matters for health. Because non-Indigenous Australians hold unresolved ambivalence about the relative roles of Aboriginal and non-Aboriginal Australia, and because there is a lack of trust between mainstream and Aboriginal Australians (Reconciliation Australia 2013), we (usually) get processes, policies and programs wrong, as so many formal reviews have concluded (e.g. DFD 2010; Morgan Disney & Associates 2006). The Chairman of the Productivity Commission acknowledged this reality when he called for greater uptake of four main requirements for success: co-operative approaches between community and government, community engagement in program design and decision-making (as opposed to 'top-down' direction), government commitment to sustaining good programs rather than short-term approaches, and good governance by government and by communities and community organisations (Banks 2009:14-15). These are precisely the kinds of changes to 'business as usual' that governments are reluctant to make (Dwyer 2011).

The paper

PAPER FIVE – Legally Invisible: Stewardship for Aboriginal and Torres Strait Islander Health (Howse & Dwyer 2015).

Dr Howse was commissioned by me in March 2011, and the discussion paper she wrote was launched by Dr Tom Calma, former Social Justice Commissioner (who had campaigned on the principle of health as a human right) in early December 2011.

Statement of my role

I initiated the writing of the academic paper below, based on the data and conclusions of Dr Howse's discussion paper, with her encouragement. I prepared the first draft of this paper, using text of the original paper and adding an extended analysis of the health system problems that are at least partly caused by the current lack of a specific legislative basis for government responsibility for the provision of health care for Aboriginal people. I am the corresponding author. Dr. Howse contributed to drafting and review of this paper and is correctly its first author.

Legally invisible: stewardship for Aboriginal and Torres Strait Islander health

Genevieve Howse,[1] Judith Dwyer[2]

Abstract

Objectives: The need to improve access to good health care for Aboriginal and Torres Strait Islander people has been the subject of policy debate for decades, but progress is hampered by complex policy and administrative arrangements and lack of clarity about the responsibilities of governments. This study aimed to identify the current legal basis of those responsibilities and define options available to Australian governments to enact enduring responsibility for Aboriginal health care.

Methods: This study used a framework for public health law research and conducted a mapping study to examine the current legal underpinnings for stewardship and governance for Aboriginal health and health care. More than 200 pieces of health legislation were analysed in the context of the common and statutory law and health policy goals.

Results: Very little specific recognition of the needs of Aboriginal people was found, and nothing that creates responsibility for stewardship and governance. The continuing absence of a legislative framework to address and protect Aboriginal health can be traced back to the founding doctrine of *terra nullius* (unoccupied land).

Conclusions: We considered the results applying both a human rights perspective and the perspective of therapeutic jurisprudence. We suggest that national law for health stewardship would provide a strong foundation for progress, and should itself be based on recognition of Australia's First Peoples in the Australian Constitution, as is currently proposed.

Key words: Aboriginal health care, stewardship, health law, constitutional recognition

Australian Aboriginal and Torres Strait Islander people die younger and carry a higher burden of disease than the general Australian population, with an average life expectancy gap of about 10 years.[1] The seriousness of the 'health gap' for Aboriginal people is universally acknowledged in policy and public debate, but progress has been slow, and implementation of policy and programs is often seen to be unsuccessful, although there is progress in some important areas (e.g. reduction in infant mortality).[1]

Community-based NGOs – the Aboriginal Community-Controlled Health Organisations (ACCHOs) – provide a major share of primary health care for Aboriginal people (estimated at between one-third and one-half of the Aboriginal population)[2] and are generally recognised as a successful component of the health system. However, there is also widespread concern about the effectiveness of current governance and stewardship arrangements, both by government and in the ACCHO sector.[3]

Why focus on stewardship and governance?

National stewardship for health has been defined as "the careful and responsible management of the wellbeing of the population"[4] and is the responsibility of government. In embracing stewardship of the health system, the responsible ministry of health must ensure the health sector is properly governed at national and sub-national levels based on government policy, legislated functions and duties, and applicable domestic and international standards and values.

In broad terms, governance can be defined as the "means adopted by a society to promote collective action and deliver collective solutions in pursuit of common goals".[5] Governance of the health system is founded in both legislative and administrative arrangements. An examination of these arrangements reveals the extent to which collective action is enabled through government leadership; and meaningful participation of non-government actors in ongoing decision making is supported.

In a federal system, where law-making and governance responsibilities are split between three levels of government (federal, state and local), statutory responsibility for governance creates the basis for accountability. The absence of statutory responsibility for governance enables those who might be accountable to shift blame for lack of action or for system failures to other levels of government or to other ministries with relevant portfolio responsibility.

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Sound governance also enables coherent observation of the efficacy of the system as a whole and of the use of system-wide mechanisms such as data collection, surveillance, monitoring, financing, planning, policy making and programming.

While the underlying causes of 'the health gap' are largely social, economic and political/cultural, the health system can play a leading role in addressing the health effects of these broad social determinants.[6] There is a growing body of evidence that Aboriginal people enjoy less than optimal access to care and less than optimal quality of care.[7] Aboriginal people were formally excluded from the mainstream health system in several jurisdictions during the 19th and early-mid 20th centuries,[8] and their access to services remains compromised in many ways. Lower screening rates and poorer prevention of complications for Aboriginal patients than for the general population have been documented in national health data, along with higher numbers of potentially preventable hospitalisations.[7,9] Although emergency department visits and hospitalisation rates for Aboriginal people are relatively higher, procedure rates are lower. Waiting times for surgery are longer than for non-Aboriginal patients, and nearly double for some types of surgery.[7,10]

Experiences of shaming, misunderstanding and stereotyping make engagement with the health system less effective than it can and should be.[11-13] Aboriginal patients sometimes receive care that is ineffective, insensitive or inappropriate.[14] Language and interpersonal communication breakdown across the cultural divide leads to difficulty in assessing symptoms, reaching an accurate diagnosis and providing effective care.[12,15-17]

There is also evidence that access for Aboriginal patients is compromised by barriers that affect them differentially.[7] These include resources for travel and accommodation; availability of supportive or rehabilitation care, such as cardiac rehabilitation;[18] and continuity of care across different health and support services.[19]

This evidence suggests strongly that action is needed to improve access to and quality of care for Aboriginal people, and that the causes of the documented differentials lie at least partly in the policy and program settings of the health system. A recent study of the experiences of public hospital staff in providing care to Aboriginal patients from rural and remote areas found that while some staff are energetic and creative in tailoring their care to the needs of this group of patients, they do so in the absence of operational policies and programs to authorise and guide such action, and experience some discomfort in the effort to reconcile their actions with prevailing norms.[20]

The funding and regulation of primary health care for Aboriginal people also provide cause for concern about the effectiveness of stewardship and governance. These problems are well-documented, and include arrangements that are fragmented and complex, short- to medium-term, with excessive administrative and reporting requirements.[21,22] This situation contrasts with the mainstream health system, where essential basic care is either provided directly by government or funded through long-term fee-for-service arrangements (which bring their own bureaucratic burden). The cost and efficiency problems caused by the complex contractual environment for Aboriginal services are also well documented.[23,24] The major national funding agency for Aboriginal-specific primary health care, the Department of Health, has made significant progress towards reducing complexity, but the overlapping roles of multiple funders remain problematic. One consequence is that funding for equitable access to PHC is not feasible (since no single agency has control – or even an overview – of the decisions of multiple funders).

Legal recognition

Establishing a legal basis for stewardship and governance for Aboriginal and Torres Strait Islander health is difficult for two reasons: first, the awkward, piecemeal and historically discriminatory approach to the legal recognition of Australia's First Peoples; and second, the inertia caused by current fragmentation of laws and administrative responsibilities in relation to their health and health care.

The legal relationship between the Commonwealth of Australia (including its predecessor colonial governments) and Australia's First Peoples began with a failure to recognise their rights and accommodate their needs, under the doctrine of terra nullius (land belonging to no-one). Subjects of a 'settled' colony became British subjects at settlement and only British common law applied. Since settlement, the progress of law-making that recognises Australia's First Peoples and is sensitive to their particular needs has been consistently slow. When the Constitution was drafted, it mentioned Aboriginal people twice: first, it prevented the Commonwealth making laws in relation to the Aboriginal race (Section 51 [26]) and second, it specifically excluded Aboriginal people from being counted in the census (Section 127). Census figures are used to make policy and planning decisions, so the effect of these two powerful exclusions was to make the Aboriginal population legally invisible to the Commonwealth Government. It took until 1967 for the Constitution to be changed by referendum to enable the government to make laws for Aboriginal people and include them in the census.

Terra nullius was disposed of by the High Court in the *Mabo v. Queensland (No. 2) (1992) 175 CLR* judgment of 1992. In recent years, four of eight jurisdictions (in which more than 70% of the total and Indigenous populations live: NSW, Queensland, Victoria and South Australia) have inserted recognition clauses into the body or preamble of their constitutions.

Anti-discrimination law is also relevant. This law incorporates human rights principles that would apply to the application and implementation of health and other legislation, providing a forum for complaint in the event of breaches. However, these protections are limited to redressing individual complaints and do not provide a structure for stewardship and governance for Aboriginal and Torres Strait Islander health.

Some local government laws, particularly in the Northern Territory, address some local governance issues for rural and remote communities,[25] but such arrangements apply only to a small proportion of the Aboriginal population and offer nothing towards stewardship and governance for Aboriginal and Torres Strait Islander health across Australia.

Australia's health policy and system

Responsibility for health care in Australia is divided between two levels of government. The Constitution allocates some limited powers to the Commonwealth to legislate with respect to health, with the remainder belonging to the states. The states and territories are directly involved in providing services, whereas the Commonwealth

Government is predominantly involved in funding services, most of which are privately provided.[2] As the National Health and Hospitals Reform Commission notes:

> *[the two levels of government] have different approaches to funding, different relationships with health service providers, and different responsibilities for various parts of health care. The two levels of government also have different capacities to meet the cost of services from their own revenue.*[2]

The levers of policy, administration, program development, funding and reporting requirements are spread across several laws, governments and ministerial portfolios. These features of Australian law create systemic constraints on good governance for health in general, and for Aboriginal and Torres Strait Islander health in particular.

The development of a health system for Aboriginal and Torres Strait Islander people post-contact was confused and piecemeal, with the Commonwealth only really becoming engaged with Aboriginal affairs after the 1967 referendum. Radical administrative change to the existing arrangements was suggested by the National Health and Hospitals Reform Commission,[2] in the form of a National Aboriginal and Torres Strait Islander Health Authority that would hold all funding for Aboriginal health and "actively purchase and commission the very best health services…". But this recommendation was promptly rejected by the government, which opted instead to 'continue to work closely with the Indigenous health sector in an effort to close the gap in Indigenous health outcomes.[26]

Recent commentary and academic literature point to the frustration caused by the current fragmentation and its effects on policy making and programming for Aboriginal health. For example, a recent Productivity Commission report noted that:

> *Poor government governance, such as a lack of coordination among agencies, duplication of services, failure to adapt to change, an unstable policy environment and ineffective processes, affect the governance of Indigenous organisations and outcomes for Indigenous people.*[27]

There appears to be a broad consensus among observers of the policy process about ways of addressing systemic failures, summed up by the former chair of the Productivity Commission as having four elements: co-operation between governments and communities; 'bottom up' involvement in services and planning; sustained, consistent government support; and good governance on both sides.[28] However, while these ideas are almost always supported in principle by government policy-makers, they have not been effectively implemented in practice.[22]

Governments do not always fulfil all statutory obligations, and statutory obligations do not always result in legal or administrative accountability. However, recognition in law is powerful. Even when laws do not create absolute obligations for governments, legislative duties and functions are the focus of public service departments and agencies. Ministers and secretaries must report compliance and progress against them. Agencies' recurrent funding is appropriated in budgets for legislated functions, and policy making and planning activities concentrate on them. International obligations, and the human rights-based approach to health, also favour legislation and national policy.[29]

This study examined existing Australian laws allocating responsibility for health in order to assess their adequacy to support system-wide stewardship and good governance for Aboriginal health.

Methods

We used the framework of public health law research for this study.[30,31] This framework guides the study of laws and legal practices and their (potential) outputs – changes in environments and behaviours that ultimately lead to changes in population health. In the typology of public health law research put forward by Wagenaar et al,[30] this study is a mapping study.

A search was conducted to identify all national and jurisdictional health law extant in December 2011, using publicly available information on government websites. For seven of nine jurisdictions, (the Commonwealth, Victoria, South Australia, Northern Territory, New South Wales, Queensland and the Australian Capital Territory), all Acts administered by health portfolios are listed on the portfolio website, enabling complete ascertainment. For the other two jurisdictions (Western Australia and Tasmania), hand searching was conducted examining lists of laws on publicly available websites that compile Australian laws and identifying those commonly administered by the health portfolio. While completeness cannot be assured, it is highly unlikely that substantially relevant Acts were overlooked. Each Act was examined to identify whether Aboriginal health was explicitly mentioned; and whether the Act could be seen to contribute to the development of a basis for stewardship and governance for Aboriginal health.

Based on this analysis, we considered options for strengthening the legal basis for stewardship and governance of Aboriginal health, with reference to relevant international comparators.

For the purposes of this paper, we have focused on the ways in which modern Australian law could address stewardship and governance for Aboriginal health. In doing so, we nevertheless recognise that Indigenous traditional law proceeds from a radically different basis,[32] and that legal pluralism is a necessary condition in post-colonial societies.

Results

A comprehensive review of existing health legislation in Australia found very little specific recognition of the needs of Aboriginal and Torres Strait Islander people in any of Australia's nine jurisdictions. Of 69 principal Acts administered by the Commonwealth Department of Health and Ageing,[33] three specifically refer to Aboriginal and Torres Strait Islander people: *Aged Care Act 1997* (Cth), Chapter 2, Division 1, Section 11-3; *National Health and Medical Research Council Act 1992* (Cth), Section 20(2)(d); and *National Health Practitioner Registration National Law Act 2009* (Cth), Part 5 Division 1 Section 31 (1); Division 10 Section 113(3); and Part 10 Division 3 Section 222(2). None create responsibility for stewardship or governance.

Of approximately 200 Acts administered by state and territory health authorities, only South Australia has included specific provisions in its public health law or health service delivery law that could be used to justify policy making, programming and financing decisions. The few instances of specific recognition of the needs of Aboriginal peoples generally fail to provide for a mechanism of input to decision making or implementation. Thus, among an estimated 269 principal Acts administered by Australia's nine health portfolios, there is no Australian law or series of laws that, taken together, create a legislative structure to secure stewardship and governance for the health of Aboriginal and Torres Strait Islander people. Instead, the current configuration of laws creates a need to negotiate through a bewildering array of jurisdictions, laws, policies, criteria for funding and funding streams, through and within which accountability for health outcomes is diffused and muddled.

South Australia provides leadership among the states and territories with its *South Australian Public Health Act 2011* and *Health Care Act 2008*, which establish objects and principles about health equity and access. Both Acts also include an object that specifically refers to the needs of Aboriginal and Torres Strait Islander people and that could be used to justify policy making, programming and financing decisions. These are progressive reforms.

Objectives can be found in some other recent state and territory health laws – *Public Health and Wellbeing Act 2008 (Vic.), Public and Environmental Health Act 2011 (NT), Public Health Bill (WA)* – that create obligations to assist communities with special needs and to advance equity and access. However, neither these nor any other state or territory health law specifically mentions Aboriginal people, despite state and territory health portfolios administering between 20 and 31 principal Acts each. Victoria, Western Australia, the Australian Capital Territory and the Northern Territory establish objects or principles in either their public health or health service laws that enable some consideration of the issues that might affect stewardship and governance for Aboriginal health, but do not specifically mention Aboriginal people. Tasmania and Queensland neither mention Aboriginal and Torres Strait Islander people nor create objects and purposes, in either their public health or health service laws, that require consideration of inequity in access to care or the special needs of particular communities.

The situation for each jurisdiction is summarised in Table 1.

This vacuum in governance persists, and despite reports, commentaries and calls for action for better stewardship and governance,[34-36] the pace of law reform in this area has been slow.

Discussion

The virtually complete absence of legislated attention to the need to improve Aboriginal health and health care and to allocate systemic responsibility for doing so shows up a stark gap at odds with universal recognition of the importance of reducing Aboriginal health inequity. In the historical context of the colonisation of Australia, the pervading legislative silence on Aboriginal health can logically be seen as a long-term effect of the *terra nullius* doctrine; and more proximately of the way that the Constitution was shaped at Federation (dealing with Australia's First Peoples only to exclude them from both national law and the census) and the enduring impact of this history on public policy generally.

Table 1: Summary of legal provisions for governance of Aboriginal health.

Jurisdiction	Health Acts	Mention	Provision for particular responsibility for Aboriginal health	Provision for Participation
Commonwealth	69	1. Aged Care Act 1997		
		2. National Health and Medical Research Council Act 1992		NHMRC Act requires 1 member with expertise in Aboriginal health
		3. Health Practitioners National Law Act	Provision for NATSIH Board to govern registration of Aboriginal Health Workers	
ACT	22	0		
NSW	31	0		
NT	24	Public and Environmental Health Act 2011 - No mention but apparent intention to apply particular public health protection to Aboriginal communities (S3, b), c))		
		Health Practitioners Act 2004 – registers AHWs (superceded)		
Queensland	26	Health Services Act 1991 – definition of 'parent' for Aboriginal child (S61 (3), (4))		
South Australia	23	Public Health Act 2011 Health Care Act 2008	Yes, in objects in both Acts	
Victoria	29	0		
Tasmania	25	0		
Western Australia	20	0		
TOTAL	269	8	3	1

Thus the mediators, or the current public health laws that might create a legislative infrastructure for governance in Aboriginal and Torres Strait Islander health, are almost completely silent and create no legal basis for accountability. The outputs, which would be changes in environments and behaviours that ultimately lead to changes in population health, are similarly robbed of substance.

Comparison with countries that have similar legal systems and colonisation histories, and ongoing problems arising from dispossession, discrimination, exclusion and relatively poor indigenous health, is instructive. Several researchers have compared the health of Indigenous peoples in Australia with the situation in Canada, the US and New Zealand. These analyses were reviewed by the Australian Institute of Health Welfare, which concluded that comparisons of the mortality gap are unreliable due to significant differences in the data collections. They conclude that the longevity gap in Australia is larger than in New Zealand; and that comparison with Canada and the US is not feasible.[37] What is clear is that the legal invisibility of Australia's First Peoples is not matched in the comparator countries. Table 2 summarises the legal basis for health care for indigenous peoples in the four countries.

The experiences of Canada, the United States and New Zealand add weight to the view that recognition of the existence, particular needs and special contribution of Indigenous people in a country's constitution provides a basis for the creation of other laws to give effect to the constitutional provisions in the area of health.

The potential role of legislation

From a health perspective, the question of why any population group's health should be the subject of legislation arises, particularly given Australia's universalist and relatively equitable approach to health care. However, the importance of legislation to health and health care is made clear by the very existence of more than 260 pieces of health legislation nationally, addressing a vast array of particular and general health issues, from the allocation of administrative and programming responsibility across state and territory health systems to laws about the needs of people with disabilities and the need to ensure safe food and water, to the roles of governments, the private sector and the non-government sector in operating health systems and providing safe health care.

Two lenses through which to examine the legal vacuum in laws about stewardship and governance

International treaties and their attendant obligations provide a relevant perspective. Australia has ratified the International Convention on Economic, Social and Cultural Rights and the International Convention on the Rights of the Child. Both these treaties impose obligations on Australia at international law to progressively realise the rights of all Australians to the highest attainable standard of health free of discrimination. Australia has also adopted the International Convention on the Rights of Indigenous Peoples, which "while it is non-binding and does not affect existing Australian law, it sets important international principles for nations to aspire to".[38]

Australia's commitment to these conventions brings obligations relevant to the governance and stewardship of health for Indigenous peoples. In his 2005 report, the then Social Justice Commissioner, Tom Calma, highlighted government obligations to "give sufficient recognition to the right to health in the national political and legal systems, preferably by way of legislative implementation".[29] Australia has fulfilled its obligations in this regard in relation to the general population, but it is not clear that it has done so in relation to the Aboriginal population.

The second perspective is therapeutic jurisprudence, a relatively recent concept first applied in the field of mental health law, and since expanded into many other areas of law including criminal law, family law, juvenile law, health law, preventive law, tort law, the law of evidence and the legal profession. Wexler and Winick describe therapeutic jurisprudence as:

> *An approach which seeks to assess the therapeutic and counter therapeutic consequences of law and how it is applied, and to effect legal change designed to increase the former and diminish the latter.*[39]

The idea of law itself having positive or negative therapeutic consequences is echoed in recent commentary on social disadvantage, including that experienced under the law, as having a direct effect on the health of Aboriginal and Torres Strait islander peoples, for example:

> *It is not possible, in our view, to understand the persistent poor health status of the original custodians of Australia since the time of European arrival and invasion, without situating this understanding within the history of dispossession, colonisation, failed attempts at assimilation, racism and denial of citizenship rights.*[36]

Such commentary sits well within a concept of therapeutic jurisprudence as it examines direct and indirect consequences of Australian laws on the health of Aboriginal and Torres Strait Islander people.

Using therapeutic jurisprudence as a lens through which to examine laws creating stewardship and governance for Aboriginal and Torres Strait Islander health, the lack of recognition and allocation of responsibility may itself have negative therapeutic consequences. The same concept applies to the history of *terra nullius* and the early lack of recognition in the Constitution, the law from which all other laws are made and from which every part of our Westminster system draws its power. From this perspective, recognition

Table 2: International comparison of legal basis for indigenous health care.
CANADA: Local treaties negotiated following European arrivals. Royal Proclamation of 1763 aimed to stabilise British holdings, and established some regulation and protection for First Nations and Inuit communities. Indian Act (1867) established formal relationships between the Federal Government and First Nations and Inuit communities. The Romanow report described responsibilities for indigenous health care as 'a confusing mix of federal, provincial and territorial programs and services as well as services provided directly by some aboriginal communities'.[a(p212)] The Romanow report also reported a consistent call for more active participation of aboriginal peoples in communities. Over the past 20 years, responsibility for provision of primary health care has largely transferred to local community governance in discrete First Nations and Inuit communities; with urban dwelling indigenous people mostly relying on the mainstream health system.
US: Tribal governments formally recognised as sovereign governments and almost 390 treaties were made, perhaps mainly to legitimise transfer of land from Indian tribes.[b] The doctrine of 'discovery' was used in the US to justify dispossession (Johnson v. M'Intosh, 21 U.S. [8 Wheat] 543 [1823)].[c] Most Indians did not become US citizens until 1924.[d] Congress has long had legislative authority to appropriate funds specifically for the health care of Indian people (Snyder Act of 1921 [25 USC 13] and the Indian Health Care Improvement Act [25 USC 1601] of 1976). Responsibility for Indigenous health care transferred in 1954 to the Department of Health and Human Services, which established the Indian Health Service, the principal federal health care provider and health advocate for Indian people (serving 1.9 million people in 35 states). The National Indian Health Board is a representative body that monitors, reports on and responds to federal legislation and regulations.
NEW ZEALAND: The Treaty of Waitangi (1840) effected a transfer of sovereignty from Māori to the British Crown;[e] and created obligations on the Crown to enable mechanisms for Māori self-governance and to protect Māori interests.[f] Improving health outcomes for Māori and other population groups is stated as one purpose of the NZ Public Health and Disability Act 2000. The relevant provisions recognise the Treaty; ensure Māori representation on District Health Boards and other ways of contributing to decision-making (Part 1, Cl 4).
AUSTRALIA: No treaties or formal agreements exist. Foundations in doctrine of terra nullius. This was overturned by Mabo decision and partly overcome by land rights legislation in the 1990s. Citizenship granted to Aboriginal people in 1940s. National law made possible by constitutional change in 1967. There is no specific legislative basis for policy or action on Aboriginal health.

Footnotes:

a. Romanow RJ. *Building on Values: The Future of Health Care in Canada* [Internet]. Saskatoon (CAN): Commission on the Future of Health Care in Canada; 2001 [cited 2011 Jun 7]. Available from: http://dsp-psd.pwgsc.gc.ca/Collection/CP32-85-2002E.pdf

b. Miller RJ. *American Indians and the United States Constitution* [Internet]. Portland (OR): Lewis and Clark Law School; 2006 [cited 2015 Mar 25]. Available from: www.flashpointmag.com/amindus.htm

c. Gallagher EJ. Johnson and Graham's Lessee v. William M'Intosh. In: *Literature of Justification Supreme Court*. Bethlehem (PA): Lehigh University; 2003 [cited 2011 Jun 20]. Available from: www.utulsa.edu/law/classes/rice/ussct_cases/JOHNSON_V_MCINTOSH_1823.HTM

d. Kappler CJ. Part 4: Indian citizenship. In: *Indian Affairs: Laws and Treaties*. Washington (DC): Government Printing Office; 1929 [cited 2011 Jun 20]. Available from: http://digital.library.okstate.edu/kappler/vol4/html_files/v4p1165.html

e. Orange C. *The Treaty of Waitangi*. Wellington (NZ): Port Nicholson Press; 1987.

f. Kingi Te KR. *The Treaty of Waitangi and Maori Health*. Palmerston North (NZ): Massey University; 2006 [cited 2015 Mar 26]. Available from: www.massey.ac.nz/massey/fms/Te%20Mata%20O%20Te%20Tau/Publications%20-%20Te%20Kani/T%20Kingi%20Treaty_of_Waitangi_Maori_Health1.pdf?95BAA6D4A43BA51CFFB9589A7660869D in the Constitution and in laws directly addressing governance and stewardship can address the present governance vacuum but may also have, in themselves, therapeutic consequences.

Options for a legal basis for stewardship and governance for Aboriginal health

In the light of our results, the important question is how best to establish a legal basis for stewardship and governance for Aboriginal health policy, programs and services; one that will enable improvements in health care and health outcomes. We suggest that the following criteria should be applied to the evaluation of options:

1. Is there allocation of overall government stewardship responsibility for Indigenous health?
2. Will there be consolidation/less fragmentation of government funding and regulation of health care for Indigenous people?
3. Is participation by Indigenous people built in?

We also suggest that the most effective option has two elements – constitutional recognition and national law.

Constitutional recognition is needed

Constitutional recognition of Australia's First Peoples will provide a basis for stewardship and governance for health, as has proved useful in both the US and New Zealand. It is also consistent with human rights obligations in the ICCPR and the Declaration on the Rights of Indigenous Peoples, and with therapeutic jurisprudence.

The absence of recognition of Australia's First Peoples in the Constitution is acknowledged as problematic by all major parties and the majority of the Australian population are supportive of change.[40] A referendum is to be held in the near future, in accordance with the provisions of the *Aboriginal and Torres Strait Islander Peoples Recognition Act 2013* (No. 18, 2013). We suggest that among many important outcomes, constitutional recognition will provide a genuine opportunity to address the legal invisibility of Aboriginal health by establishing a viable foundation on which health law can be built.

Law reform

There are a number of ways Australian law could be reformed to better address stewardship and governance for Aboriginal and Torres Strait Islander health, involving both national and state/territory governments. However it is done, we suggest that any law purporting to enable good governance for Aboriginal health would need to bring together the levers for policy making, programming and financing to one responsible ministry or entity. It should be clear about allocation of responsibility for policy making, planning, programming and service delivery. It should be supported by clear source/s of funding – preferably, aggregated funding – and include objectives and principles that enable participation of Aboriginal and Torres Strait Islander people in all aspects of governance.

The Commonwealth has the power to pass a law to protect and promote the health of Aboriginal and Torres Strait Islander people. Such a special measure would be justified on human rights grounds and would not be discriminatory.

A Commonwealth Act could establish government responsibility for policy, programming and financing; include recognition of the need for culturally safe care; and incorporate arrangements for active engagement of Aboriginal people at all levels of decision-making. It could also address the role of traditional medicine, and enable agreement-making with Aboriginal communities and organisations for health care provision.[41] A Commonwealth law is the only mechanism to achieve nationwide effect and establish clear responsibility for stewardship and governance. A practical alternative would be to adopt a uniform national approach through the enactment of matching laws in all states and territories. It could be passed in one State jurisdiction and then incorporated by reference into the laws of all the others. This is the mechanism used to create nationally uniform health practitioner registration law.[42]

This option would establish a uniform approach to enable cooperative and complementary legislative infrastructure nationwide. It would be able to cover health service delivery at state and territory level. However, this option is more difficult politically and administratively. It requires agreement to the application of a state and territory law and all jurisdictions would have to agree and to pass the law. It would also require considerable work on deciding how the law would interact with existing state and territory laws on public health and health service delivery, and the operation of existing mechanisms such as complaints mechanisms, health visitors, etc.

It also misses the opportunity for the Commonwealth to take the lead on what is manifestly a national issue and for which there is existing Commonwealth power, i.e. the establishment of stewardship and governance for the health of members of the Aboriginal and Torres Strait Islander population who live in every state and territory in Australia.

Conclusion

The legal document that created Australia as a nation specifically excluded Australia's First Peoples from being counted and from being the subject of Commonwealth laws. This review shows that the configuration of Australian laws allocating responsibility for the health of Aboriginal and Torres Strait Islander people fails to set up a structure in which system-wide stewardship and good governance may be undertaken. Instead, the current configuration of laws creates a need to negotiate through a bewildering array of jurisdictions, laws, policies, criteria for funding, and funding streams through, and within which, accountability for health outcomes is diffused and muddled.

While the doctrine of *terra nullius* and the legal invisibility it conferred on Aboriginal people is slowly shifting, the lack of recognition in Australian law generally means that approaches to governance and stewardship in Aboriginal and Torres Strait Islander health lack a basis of recognition and rights in Australian law. Such recognition has been shown to provide a basis for law-making in health in other comparable countries.

Laws and legal systems are capable of change. Recent shifts, and the continuing national conversation about recognition of Aboriginal and Torres Strait Islander people in our Constitution, encourage optimism that the national consciousness may be more open to reform.

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Impact

It is too early to assess the academic impact of this paper, which is yet to be cited. The Australian and New Zealand Journal of Public Health has an Impact Factor of 1.98 (ISI Journal Citation Reports: 2014); and is ranked 65/162 in the field of Public Environmental & Occupational Health (accessed 17 October 2015).

The Discussion Paper (*Legally Invisible – How Australian Laws Impede Stewardship and Governance for Aboriginal and Torres Strait Islander Health,* available at http://www.lowitja.org.au/legally-invisible-constitutional-recognition-and-health-law-reform) on which the paper below was partially based was submitted to the Expert Panel on Constitutional Recognition, and cited in its Final Report (Expert Panel 2012). It was also used by the Premier of South Australia in his statement to the media about the grounds for South Australia to include recognition of Aboriginal people in its Constitution when he said 'this is not merely symbolic, it goes to the health of people in the community' (Edwards 2012).[6]

The paper is also having an impact as part of a policy advocacy project that was initiated by me in my role as Research Program leader, working with my colleague Dr Kim O'Donnell. Partly inspired by Dr Howse's findings, we initiated the building of a health industry coalition in support of constitutional recognition for Aboriginal and Torres Strait Islander peoples, on the grounds of its relevance for efforts to improve Aboriginal health and health care. More than 130 major health organisations have signed a statement of support for constitutional recognition, which was launched in Parliament House Canberra in March 2015. Those organisations represent between them the entire Australian health workforce (or about 10% of the total national health workforce), the organisations focused on all the major diseases, and much of the organised consumer movement in health, and thus the coalition could have a significant impact on the planned future referendum. The paper is included in the package of evidence and information that is used to support advocacy and coalition building for this campaign entitled 'Recognise Health' (Lowitja Institute 2014).

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[6] I am confident that it was used by the Premier because I received a phone call from Ms Kay Anastassiadis, a senior policy officer in SA Health, a few days prior, seeking a briefing on the findings of the report for this purpose.

Literature Review

As described in Chapter 1 (under the heading *Literature review methods*), a methodical (but not ‘systematic’) literature search was conducted, supplemented with hand searching. The literature review reported in this chapter is focused on two questions – related to evidence of systemic racism in Australian health care; and the value of cultural competence[7] as a framework for improvement.

The search terms were *Indigenous health, Aboriginal health, institutional or systemic racism, discrimination and health, health care or health services*. Various additional subject terms were used to suit the requirements and utility of the data bases. The data bases searched were AIMMAT, Cochrane Library, Web of Science, Scopus, Expanded Academic ASAP International, and Australian Policy Online. I also searched pubmed using the LItsearch filter tool hosted by the Lowitja Institute[8] and available at http://www.lowitja.org.au/litsearch

The exclusion criteria were:

- Papers published before 2009
- Papers not available in English
- Papers focused on the impact of racism on health (as opposed to health care) – there is a vast literature and it is a critical concern, but not the focus of this chapter. See Paradies (2006) for a systematic review.
- Papers focused on institutional racism in settings other than health care
- Papers focused on internalised or interpersonal racism only – my interest in this chapter is in institutional or systemic racism, manifested in organisations, systems, practices and health programs
- Papers evaluating training interventions focused solely on the skills and knowledge of individual health care workers

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[7] The decision to use this term is explained in the next section.

[8] This search filter was developed by Flinders Filters for the Lowitja Institute and makes searching for Aboriginal health topics on pubmed simple and easy. With the Program co-leader, I commissioned this work. See Tieman et al. (2014) for further information.

- Papers of little or no relevance to the review questions, in spite of using relevant key words in the description. While this criterion seems highly subjective, it arises because of inadequacies in either the search strategy or the data bases that led to the initial inclusion of papers that perhaps only mentioned racism or discrimination in passing, rather than addressing the topic in any substantive way.

A total of 685 items were found, of which 610 were excluded. Seventy-five abstracts were read, and a further 27 papers were then excluded. Of the 48 papers remaining, a further 24 were excluded after being read. These 24 papers were supplemented with a further 23 peer reviewed articles and one grey literature report found through the advice of colleagues or by hand-searching of relevant journals and of reference lists in the papers (without the post-2009 restriction), making a total of 46 sources.

Defining terms and review questions

The focus in this chapter is on institutional and systemic racism (as distinct from internal and interpersonal forms), and strategies to address it. In the first paper of this chapter, we defined institutional racism in simple terms, as 'built-in racial discrimination', or 'the overt and subtle ways in which the operation of institutions and organisations has the effect of discriminating against minority populations' (Dwyer, Willis & Kelly 2014:547). We were seeking to emphasise that personal intention by individuals is not essential (though it can contribute) for this kind of racial discrimination to operate. Again to put it simply, institutional racism refers to racism at the level of organisations, while systemic racism refers to social structures. In health and health care, we are interested in both, and in health care institutions both apply as do internal and interpersonal racism.

Jones CP (2003:9) emphasises the systematic nature of racism:

> *First of all, racism is a system. It is not an individual character flaw, nor a personal moral failing, nor a psychiatric illness. It is a system (consisting of structures, policies, practices, and norms) that structures opportunity and assigns value based on phenotype, or the way people look.*

Jones J (1997:438, cited in Purdie, Dudgeon & Walker 2010:36) defines institutional racism as:

> *those established laws, customs, and practices which systematically reflect and produce racial inequalities.. If racist consequences accrue to institutional laws, customs, or practices, the institution is racist whether or not the individuals maintaining those practices have racist intentions.*

The American scholar David Wellman (1993:5-6, cited in Awofeso 2011:2) offers a definition that encompasses all the types or levels, and brings the purpose as well as the mechanisms of racism into focus:

> *The deliberate structuring of privilege by means of an objective, differential and unequal treatment of people, for the purpose of social advantage over scarce resources, resulting in an ideology of supremacy which justifies power of position by placing a negative meaning on perceived or actual biological or cultural differences.*

This definition is useful for describing racism against Australia's First Peoples. It highlights the material purpose (in Australia's case, the appropriation of wanted land and resources). It encompasses the terrible ideology that suggested that Aboriginal people were not quite human, the 'missing link' in evolution from apes to humans. This offensive idea was used to justify murder over many years, was still being discussed openly in my early life in rural Queensland, and carries on to this day in racial taunts, including those famously addressed to Adam Goodes on the football field (Riseman 2013) and continuing in 2015. It also highlights the negative stereotyping of Aboriginal and Torres Strait Islander people that is used to justify continuing exclusion and disrespect. This definition is also quite confronting for people who enjoy the social and economic advantages of White privilege.

Attempts to address institutional racism affecting the health and health care of Aboriginal and Torres Strait Islander people have focused on a set of positive alternative strategies, for which there are many competing terms and meanings, as summarised in Table 1.

Table 1: Strategies for addressing racism in health care: terms and definitions

Term	Definition
Cultural awareness	Aims to increase awareness of cultural, social and historical factors applying to Aboriginal and Torres Strait Islander peoples and (less commonly) to promote participants' self-reflection on their own culture and tendency to stereotype. NOTE: the failure to adequately address this last aim, and the tendency to focus on 'the other' rather than the self, is the basis of widespread critique of this approach and the term.
Transcultural care and cultural sensitivity	Emphasises self-awareness and acceptance of cultural difference, and knowledge of power relations, race and cultural identity. (UK origins)
Cultural safety	Aims to address the effects of colonialism by focusing on the cultural safety felt by the individual seeking health care. Focused on responsibility to protect cultural identity, through requiring the practitioner to question both their own cultural underpinnings and the imbalance of power relations within the health care interaction. Becoming more commonly used in Australia. (NZ origins – Papps and Ramsden 1996))
Cultural security	Australian term, intended to shift the focus to the system and organisation. Not broadly used.
Cultural competence	Originally focused on creating congruent behaviours, attitudes and practices in the individual, and recently more focused on organisational values, practices and policies. This term is criticised for its reductionist application in educational settings (Tervalon& Murray-Garcia 1998).

Source: Modified from Downing, Kowal & Paradies, 2011

I have chosen to use the term cultural competence, based on the original systemic framework (Cross et al. 1989) to signify the desired state of health care systems and organisations. This is not to imply that the organisation or its staff have acquired a working capacity in 'other' cultures. But rather to denote that the organisation has in place the necessary policies, procedures, programs and protocols to support, permit and require its staff to provide culturally safe care; and that it continues to engage in the relationships and internal processes needed to maintain and improve that capacity. That is, I am using the term competence not in its reduction to a set of quantifiable routines that can be checked off as achieved in the assessment of individual health care practitioners' standards of knowledge and practice.

Cultural safety and cultural competence frameworks share an analysis that is informed by the structures of racism and inequity that privilege Whites and their world view; and a focus on locating the experiences and concerns of (in this case) Aboriginal people centrally in strategies to improve health care (Browne & Fiske 2001). For my purposes, the desired state is the delivery of culturally (and clinically) safe care, which can be achieved in a culturally competent health service. That is, following the Australian Indigenous Doctors Association (2004), cultural safety is seen as a quality of the care experience of Aboriginal patients; and cultural competence is a characteristic of the system, organisation and staff that is required for the delivery of culturally safe care. My decision to use the term cultural competence is based on my assessment that it serves best for my purpose of focusing on the systemic and organisational factors that enable health care organisations to support cultural safety.

These concepts and meanings are not uncontested in the literature. For example, Johnstone and Kanitsaki (2007) offer a critique of the concept of cultural safety, and suggest that its emphasis on the subjectivity of patients – that is, that cultural safety is a characteristic to be assessed by the impact on patients and their experience of respect for their cultural integrity (as opposed to the knowledge and perspectives of health professionals) – is problematic. This line of criticism was not found in more recent papers. My experience of using the term cultural safety with clinical staff is that they readily grasp the idea that the care they provide needs to avoid harm to the patient's cultural identity and integrity, which parallels the idea of clinical safety.

Cultural safety means ensuring that the care experience respects and protects patients' integrity, within their cultural norms and values, and avoids harm to their cultural identity. It is a simple but profound idea, and while its origins lie firmly in scholarship by Indigenous thinkers in post-colonising settings, it could be applied to people of any culture including, for example, lesbian, gay, bisexual, trans- and/or intersex people. It does not require health care providers to have expert knowledge of the cultural practices and meanings that shape the patient's approach to health and health care (although some knowledge is helpful). It rather requires them to approach the care of the patient with recognition and respect for their worlds and world views, their priorities and life choices, that is, without assuming that the dominant culture is the norm or desirable; or that members of that culture are of superior worth. Tervalon and Murray-Garcia (1998) aptly characterise this approach as requiring ‘cultural humility’. Cultural safety is based on an understanding that the dynamics of individual encounters are connected to broader social and structural issues (Browne & Fiske 2001: 143), including the relationships of colonisation. Cultural safety also requires that the policies, protocols, practices, procedures and programs that shape the health care offered to patients are non-discriminatory, respectful, flexible and effective for all patients.

Cultural competence is a way of thinking about the capacity of organisations and teams to ensure that patients and staff are supported in this endeavour (Cross et al. 1989). Cultural competence and cultural safety are entirely consistent with the principle of equal treatment according to need, as we all need to be treated with respect and without assault on our identity or integrity as people. The meaning of competence in this context is not reduced to the mastery of a finite body of knowledge evidenced by performance of quantitative assessments, such as typically applies at the level of individual professional competence and is criticised by scholars such as Tervalon and Murray-Garcia (1998). Rather, it is intended to apply to the capability of the organisation or system as a whole to generate, implement and monitor the necessary policies, procedures, programs, relationships, environmental settings and human resource management to support and require the delivery of culturally safe care (Cross et al. 1989; Betancourt et al. 2007).

The implications are multifarious. For example, in health research, ‘Aboriginality’ is routinely listed as a risk factor. This is a helpful short-hand in some contexts, acknowledging the need for attention to Aboriginal people among those experiencing particular health problems. But it can also be used in ways that are disrespectful and misleading. Being Aboriginal does not of itself make one more prone to most diseases, conditions or injuries.

This literature review does not attempt to cover studies regarding the legal and policy questions addressed in the third of the papers above, which are reviewed in the paper. This review is focused on two questions relevant to the proposition being tested in this chapter:

1. What is the evidence regarding the incidence and characteristics of systemic racism towards Indigenous people in health care in Australia?
2. What evidence is there regarding the cultural competence framework as the basis for methods to reduce or remove institutional racism?

Evidence of systemic racism against Aboriginal people in Australian health care

The evidence that access and quality of care for Aboriginal people (compared to the rest of the Australian population) is compromised is strong and growing. Evidence of differentials in access to and quality of health care that is not explained by clinical or other relevant factors (including disease prevalence and geography) is a priori evidence of systemic or institutional racism (that is in this context, the policies and funding regimes, health care practices and prejudices that affect Aboriginal people differentially).

Untangling the evidence is not straightforward, as there are other important causes of poorer health outcomes for Aboriginal people that lie outside the health system (principally, exposure to the negative impact of social and cultural determinants of health). In an influential study of comparative burden of disease, Vos et al. (2009) showed that disparities are spread across all major disease groups, with cardiovascular diseases, injuries, diabetes, mental illness (including substance use disorders) and respiratory diseases contributing the highest excess burdens of illness. While acknowledging the complex causation of these differences, the authors suggest that the higher case fatality rates for most diseases are related to poorer access and poorer quality of care (including late presentation, problems in acute management and poor follow-up). These health policy/care factors also contribute to higher burden of illness for those who survive.

In Dwyer, Willis and Kelly (2014), we noted documented disparities in relation to screening, prevention of complications and potentially preventable hospitalisations (DoHA 2009), rates of intervention and waiting times for surgery (Australian Institute of Health and Welfare [AIHW] 2011), including access to kidney transplantation (Cass et al. 2004), as well as continuity of care (Lawrence et al. 2009) and supportive services such as cardiac rehabilitation (National

Health and Medical Research Council [NHMRC] 2005). We also noted the impact of past and present experiences of exclusion, shaming and stereotyping (Heart Foundation of Australian and Australian Health & Hospitals Association 2010; Purdie, Dudgeo& Walker 2010; Eckermann et al. 2006; Alford 2005; Rogers et al. 2005); and language and interpersonal communication difficulties (Purdie, Dudgeon & Walker 2010; Taylor & Guerin 2010; Cass et al. 2002).

Recent evidence generally confirms the widespread existence of differentials in access and quality of care, and the impact on health outcomes.

Evidence regarding cancer care

While the higher cancer mortality of Aboriginal patients is well known (e.g. 2.5 times more likely to die within 5 years of diagnosis in the Northern Territory (Condon et al. 2005)), the possible factors underlying this differential are many and complex. Boffa (2008) reviewed the evidence of barriers to cancer care, including late diagnosis, lower participation in screening, cost of specialist care and of travelling for care, and the author's practice-based knowledge of differentials in the treatments offered to Aboriginal patients resulting from assumptions about their treatment preference and likely compliance. A literature review of evidence in relation to barriers to optimal lung cancer care for Aboriginal people (Davidson et al. 2013), identified a complex combination of individual beliefs and behaviours, health care system issues and the impact of social determinants as contributing to poorer outcomes and reduced access to care. In relation to the health care system, they found that 'racism and discrimination continue to permeate the Australian healthcare system…with potentially disastrous implications for … health and well-being' (Davidson et al. 2013:74). They suggested a range of policy and systemic responses, including strategies to increase the cultural competence of mainstream providers.

Cardiovascular care

In relation to cardiac care, a Heart Foundation and Australian Healthcare and Hospitals Association (AHHA) report (2010) identified an inpatient death rate of twice the national average, and a 40% lower rate of intervention for Aboriginal patients. There is some evidence of improvement in a recent national report on cardiac health (AIHW 2015: vii-viii), although Aboriginal people still have higher death rates and lower rates of access to effective treatment. There was a 41% decrease in the cardiac death rate between 1998-2012; and increased interventions for those presenting with a severe heart attack (from 25% in 2004/05 to 46% in 2012/13 – still comparing poorly to the intervention rate for non-Indigenous Australians of 70%; and still showing strong regional variations). A qualitative study of Aboriginal cardiac patient journeys (Artuso et al. 2013) identified barriers to use of health services at both organisational and individual levels, including perceptions of interpersonal and institutional racism among patients, families and health care staff.

Kidney care

Differential access to kidney transplantation (Cass et al. 2004) is particularly important given the high incidence of kidney disease (8 times the national average (Preston-Thomas, Cass & O'Rourke 2007)), and the heavy burden of dialysis for patients. As part of a large qualitative study (Devitt et al. 2008), Anderson et al. (2012) addressed the views of renal physicians, who reported that they commonly identify Aboriginal patients as both non-compliant and high-risk candidates for kidney transplant. Although the definition and assessment of noncompliance were neither systematic, nor based on evidence about the value of compliance in predicting transplant outcomes, some physicians gave considerable weight to compliance and risk in their decision-making. The authors concluded that it is likely that reliance on assessment of compliance by some renal physicians will continue to disadvantage Aboriginal patients with kidney disease.

Mental health

The negative impact of experiences of racism in health care has been shown to cause high psychological distress, and to have more impact than experiences of racism in other settings (Kelaher, Ferdinan & Paradies 2014). This study also reported a lower incidence of experiences of racism in health care settings than in other settings, a finding that the authors suggest may be evidence of benefit from health care system attention to the needs and priorities of Aboriginal people.

Other indicators

Other indicators of differential access to care include longer waiting times for Aboriginal patients to be seen in hospital emergency departments (AIHW 2012:19), and for surgery (AIHW 2012:38-39; AIHW 2014:232). Longer waiting times are one factor that influences Aboriginal people to leave hospital without being treated, or against medical advice.

National data indicates that Aboriginal people were six times more likely to leave hospital without medical discharge (AIHW 2008); and a regional study in New South Wales describes higher rates of Aboriginal people leaving without treatment, or against medical advice, from rural hospital emergency departments (Wright 2007). Self-discharge from inpatient care is also higher for Aboriginal patients (Einsiedel et al. 2013), with communication failures prominent among the identified factors influencing this outcome. Most of the Aboriginal patients did not know the reason for their admission or their predicted length of stay. The involvement of Aboriginal Liaison Officers was associated with reduction in self-discharge. The authors conclude that improving cultural safety may be the key.

The important question of clinical cognitive errors in care arising from conscious or unconscious bias was not covered in this review, due to the exclusion of studies focused on interpersonal racism, but I note that there is long-standing evidence (Burgess et al. 2007) and increasing interest in the impact of this problem on patient care (see for example Leslie & Bellear 2013).

These kinds of differentials have also been documented in the USA (reviewed by Dovidio & Fiske 2012).

Although it was not the focus of this search, it is worth noting that systemic and interpersonal racism also affects Aboriginal people in the workforce. The experience of Aboriginal people in the health workforce was explored by Roche et al. (2013), in a large qualitative study, which found that the lack of culturally safe working environments was a common experience.

Our definition of institutional racism correctly focused on the impact rather than the intention of health care practices and policies. The evidence reviewed above reinforces our understanding that the existence of institutional racism with an impact on health care outcomes is beyond debate; and supports our findings (in Dwyer, Willis & Kelly 2014) that there is a gap between high level policies and the implementation of effective strategies to link those policies to practice (as also noted by Durey 2010). While in many ways the question of interest is what to do about it, it is unlikely that such efforts will be well founded without an explicit analysis and understanding of systemic racism and how it works.

In a comprehensive review of research on the impacts of racism on health in the USA, Feagin and Bennefield (2014) use critical race theory to argue the need for root and branch acknowledgement of the systemic purposes, methods and effects of racism in general and in health care settings, and the agency of largely White administrators, professionals and researchers in perpetuating racist practice (and for most, their own white privilege). These authors and others (e.g. Anderson 2002) are critical of the perspectives that focus on disparities (eg epidemiology and public health more generally) because they fail to take account of racism as a central cause of the observed differentials. Feagin and Bennefield (2014) suggest that ‘no lasting changes for all Americans will occur until systemic racism is more directly conceptualized, focused upon, and eradicated’ (p13).

The difficulty of implementing change based on critical race theory, or other analyses of systemic racism, is expressed by Metzl (2012) in an essay on ‘structural competency’ in which he articulates the ‘particular bind’ for American medicine produced by ‘the divergence between knowing a lot about the effects of structural violence and institutional racism and doing little to address them’ (p214).

Evidence on cultural competence as a framework for improvement

As the research team for the first two papers in this chapter discovered, it is one thing to recognise and understand the purpose, methods and impacts of systemic racism, but it is quite another to explicitly and directly confront it in efforts to reduce its impacts on health and mainstream health care in practice. While change strategies need to be based on an *analysis* of how systemic racism really works (and who benefits), the most effective *methods* for change are not likely to rely primarily on earnest discussions of Whiteness and privilege by clinical teams.

The strategy of focusing on where you want to get to, rather than where you're coming from, is a well-established practice in change management with a strong evidence base in management studies and organisational psychology. It does however carry the risk of papering over the power imbalances that underlie systemic racism (and other forms of discriminatory practice such as sexual harassment), and making invisible the vested interests that motivate resistance to the advocated change and/or misinterpretation and re-shaping of its meaning and intent (as documented in relation to cultural competence in the mental health service in the UK by Bhui, Ascoli and Nuamh (2012)).

The focus of the first paper in this chapter (Dwyer, Willis & Kelly 2014) is on precisely this problem. The paper documents the disconnect between high level policies that enshrine cultural respect (among other terms) on the one hand; and the implementation of practical measures to reduce discrimination, enhance respect for cultural identity and improve both access and the quality of care for Aboriginal patients on the other. We suggest that the principles and methods of cultural competence (CC) may provide the link, because of its focus at all levels of the system, but only if it is properly implemented in the many decision-making levels and processes that lie between the legislature and the practice of health care staff.

The literature is growing, but the evidence of impact is not yet strong. Studies of the effectiveness of this approach for Indigenous people in Australia, New Zealand, Canada and the USA were found to be of questionable quality in a recent systematic review (Clifford et al. 2015). The main benefits reported were improved patient satisfaction and access to care, and improved confidence for health professionals. The main intervention strategies reported were training, culturally specific health services and increasing the Indigenous health workforce.

A recent issues paper, prepared by the above group of authors and published by the Australian Institute of Health and Welfare's (AIHW) Closing the Gap Clearinghouse, affirms the more comprehensive nature of CC compared to cultural awareness, emphasising the need for a multi-level approach (Bainbridge et al. 2015). The formation of partnerships with local Aboriginal communities, as well as action to embed CC in governance, policies and programs, were found to be useful, and it was suggested that legislation or policy to entrench a requirement for attention to CC, as is the case in the USA and New Zealand, is also useful. These authors note the lack of national standards, or a coherent approach to teaching and training. Other papers reviewed below also tend to favour the related frameworks of cultural safety and CC over more traditional cultural awareness approaches, as the most likely basis for working on improvement in access and quality of care for Aboriginal patients.

The limitations of the cultural awareness approach

Downing, Koval and Paradies (2011:247) conducted a systematic review of the development of Indigenous cultural training as an initial response by policy makers to awareness of the 'cultural chasm' between health service providers and Indigenous peoples (citing Thomson 2005), and its negative impact on access to health care. They found that most Australian programs are based on the cultural awareness framework – ie training that aims to inform health care staff about Aboriginal cultures – and that this approach has largely shown disappointing results (Downing, Kowal & Paradies 2011). Durey (2010) conducted a narrative review of evaluations of the impact of cultural training, and found evidence of short-term improvement in practice, but a complete lack of long-term impact studies.

In a follow up to their systematic review (Downing, Koval & Paradies 2011) Downing and Koval (2011) suggest that a cultural safety framework, based on insights from post-colonial theory, may be more effective. If health workers are to be able to respect and protect against harm to cultural identity, they need to understand how it is created. Thus a cultural safety framework is based on an understanding of the ways in which 'colonial processes and structures shape and negatively impact' indigenous health (Downing & Koval 2011:10, citing Smye et al. 2006).

These and other authors (Williams & Mohammed 2013:1210,) point out that the apparent failure of cultural awareness training seems predictable because it tends to both ‘essentialise’ Aboriginality and make ‘Other’ Aboriginal people. The very act of giving health workers a sense of some knowledge of Aboriginal cultures keeps the focus on Aboriginality and away from the need for health workers to acknowledge their own cultural positions and the ways in which the mainstream system denigrates and discriminates against Aboriginal people. It also may encourage health workers to make assumptions about their Aboriginal patients as people who will conform with stereotypes, a practice that is not helpful to the quality of the health care relationship, or to diagnosis and treatment. Cultural awareness training may thus defeat its goal which is to enable the provision of care that treats Aboriginal patients as individuals, according to their needs, with respect and without prejudice.

The evidence supporting cultural competence

In a recent systematic review of 19 reviews, Truong, Paradies and Priest (2014) examined the evidence for cultural competency, which they defined to include interventions (principally training) aimed at health care staff, as well as those applied at the level of the organisation or system. They found some evidence of a link between the cultural competence of organisations and that of their staff (but this is a long way short of evidence of safer care). They found moderate evidence of improvement in provider knowledge/skill and health care access/usage, but weaker evidence for improvements in patient or client outcomes. They also found that few of the reported interventions included attention to racism and discrimination, and only some included attention to self-reflection and awareness of one’s professional and social culture. They suggest that reflexive anti-racism training is a promising alternative to cultural awareness, enabling reflection on the sources and impacts of racism while avoiding the more difficult topic of White guilt (see Koval, Franklin & Paradies 2013).

ACCHOs and some other Indigenous-specific teams and organisations play a critical role in providing culturally and clinically safe PHC to their patients and communities. They address the negative impact of continuing discrimination, and act as partners with mainstream health services to support efforts to improve mainstream care (Panaretto et al. 2014; Baba, Brolan & Hill 2014, Freeman et al. 2014; and three earlier studies briefly reviewed in Freeman et al. 2014).

While there is, as yet, little evidence of outcomes from organisational cultural competency approaches in the mainstream Australian health system, recent research reviewed below supports two important foundational ideas: the first is to base approaches on an explicit recognition of the ongoing impact of racism and colonisation; and the second is to use a comprehensive and sustained set of strategies in policy, practice, programs, training and reward systems for staff.

The value of a foundation in recognition of racism and colonisation

Research evidence and scholarship from Australia, Canada, the UK and the USA supports the need for approaches founded on recognition of the continuing impact of colonisation and/or racism in interventions.

Australian research

In a set of related papers, Durey and colleagues first articulate a detailed characterisation of the problem of institutional, interpersonal and internalised racism as perceived and reported by experienced non-Indigenous doctors (Durey & Thompson 2012) and as seen from an ethical perspective (Durey, Thompson & Wood 2011). Durey et al. (2012) then propose an approach to improvement, using the Australian Cultural Respect Framework (Australian Health Ministers' Advisory Council's Standing Committee on Aboriginal and Torres Strait Islander Health Working Party 2004). Their framework is consistent with cultural competence models, focusing on change at the levels of system, staff and patient-family-community, with the goal of improving the quality of care.

Rix et al. (2015, 2014, 2013) report on the perspectives of dialysis patients and renal nursing staff. They report a high level of recognition among both patients and staff that Aboriginal patients experience interpersonal and institutional racism, acknowledgement of the responsibility of the health service to address their needs, the need for service redesign to do so, and acceptance of the need for staff training in cultural competence.

In a qualitative study of Aboriginal perspectives on care for chronic illness, Aspin and colleagues (2012) report the difficulties of finding culturally safe care and the ongoing impact of exposure to racism; and the strength patients drew from community and family support, and regular ongoing access to PHC. The authors conclude that mainstream services would be improved by recognition of the wealth of their patients' cultural knowledge, and incorporation of this recognition into care and support programs. In a qualitative study on access to primary health care for Aboriginal patients with diabetes, Lau and colleagues found evidence supporting the need for a comprehensive approach to CC, based on recognition of the impact of history (dispossession and colonisation) and ongoing racism and discrimination (Lau et al. 2012).

Wilson et al. (2015) report on a qualitative study of the perspectives of health care practitioners about their practice in providing care for Aboriginal patients. They developed a framework for categorising the skill and readiness level of practitioners to work with Aboriginal patients in a culturally safe way (progressing from 'don't know how' to 'too scared' to 'too hard' to the final 'barrier breaker' – those learning to practice competently by 'breaking through' their own anxieties and developing skills and knowledge in practice). The authors suggest that this framework offers a practical and less confronting way to engage health care professionals in discussions that incorporate their own identity and values.

DiGiacomo and colleagues (2013) report experiences of racism, and difficulties accessing services (at all, as well as culturally competent services) in a study of the perspectives of carers and care providers for Aboriginal children with disability. Funston (2013) reports on a qualitative study of the outcomes of a 2-day 'yarn-up' focused on sexual assault service provision for Aboriginal children and young people in metropolitan Sydney, involving eighty invited managers and workers, both Aboriginal and non-Aboriginal. The findings confirm collective expert opinion of the importance of system and organisational level attention to cultural safety and competence, including recognition of racism and the 'invisible trauma' of colonisation (p. 3823). Participants recommended meaningful incorporation of Aboriginal worldviews, a strengths-based approach, support for Aboriginal and non-Aboriginal workers, and better access to services. The challenges arising from sexual assault for Aboriginal children and young people (some of whom are both victims and perpetrators), families and service providers are a particularly difficult example of the interactive effects of ongoing racism:

> *Aboriginal and Torres Strait Islander children and young people and their families are likely to face what has been described an as 'inescapable dilemma', to maintain silence about abuse or risk involving what is perceived as racist and inequitable child protection and criminal justice systems – systems which have the power to break families and communities apart, exacerbating existing grief, loss and disconnection from kin and culture. (p3827).*

The need for continuing work to improve services is reinforced by an audit of antenatal services for Aboriginal women in WA (Reibel & Walker 2010), which found that most services used by Aboriginal women had not achieved a model of service delivery consistent with the principles of cultural competence.

International studies

Studies from the UK and the USA support interventions based on explicit analyses of racism and colonisation. A UK transcultural psychiatry study traced the English experience of attempts to address inequities in mental health, and found a similar pattern to that observed in Australia and elsewhere (Bhui, Ascoli & Nuamh 2012). An initial policy focus on reducing inequalities (as opposed to focusing on cultural complexity) led to acceptance of the need for change. But this was followed by the emergence of resistance and dispute about the evidence, and the development of alternative interpretations that shifted focus away from issues of race equality. The authors suggest this is a defence against the pain of acknowledging systemic discrimination (enacted in an announcement by the Minister in 2005 that it was 'not helpful to refer to racism' (p192)). These authors acknowledge that mention of racism may trigger anxiety and fears of wrongdoing (p196), but reject the critique of the systemic racism paradigm because it lets individuals off the hook (p197-198). They call for clearer definition and a consistent set of standards for a multi-layered framework of cultural competence. Bradby (2010), in considering this same history and context, argues that institutional racism has not been correctly conceptualised, by which she means that the link between individual and organisational racism and health inequities is not made, or is not sufficiently clear. Bradby's perspective may be firmly grounded in the individualised medical model of illness, but this perspective is widespread in the workforce and will need to be addressed in programs aiming to improve organisational as well as staff CC.

The same reticence doesn't seem to apply in USA approaches. Havens and colleagues (2011) report on the implementation of a training program entitled Dismantling Racism. These authors argue that CC approaches are flawed in failing to focus on institutional racism, while antiracism training explicitly addresses the function of power in upholding institutional racism, and the underlying social conditions that work to maintain disparities and discrimination. The approach under study remains focused on staff training, but with other components as well. Shultz and Skorcz (2012) report on a program called the 'Undoing Racism Workshop', and emphasise the importance of a common language and framework for discussing racism. The Workshop was embedded within a much broader strategy that aimed to reduce infant mortality differentials in a poor district.

The evidence supporting a comprehensive approach

Much of the work reviewed above provides support for the comprehensive CC framework (Truong, Paradies &Priest 2014; Durey et al. 2012, Rix et al. 2015; Funston 2013; Bhui, Ascoli & Nuamh 2012; Shultz & Skorcs 2012; Lau et al. 2012; Wilson et al. 2015; McDermott 2012; Davidson et al. 2013). Two additional American papers report on the evidence for a comprehensive approach. In a broad review of evidence for interventions that seek to reduce racial differentials in access to the social determinants of health and in effectiveness of health care in the USA, Williams and Mohammed (2013) suggest that a comprehensive approach to cultural competence including organisational, structural and clinical cultural competence interventions has potential to improve health and care access.

Jones, Trivedi and Ayanian (2010) report on a set of five American organisational case studies of interventions aimed at improving care for racial and ethnic minority groups, with a focus on cardiovascular and diabetes care. They identified two important external success factors – external accountability and the alignment of quality and financial incentives – and four internal factors – organisational commitment, population health focus, use of data to inform solutions and a comprehensive approach to quality.

Evidence of mainstream responses to this evidence and policy shifts

It would be wrong to conclude this review without a discussion of the way the mainstream health system is responding to its increasing awareness of the problems and strategies discussed above. There is reason to believe that since the transfer of responsibility for Aboriginal health from the Aboriginal and Torres Strait Islander Commission (ATSIC) to the health portfolio in 1995, there has been slow and patchy but sustained growth in efforts within the mainstream health system to improve access and quality of care for Aboriginal people. This view is supported by the findings of Kelaher, Ferdinand and Paradies (2014) that experiences of racism are less common in health care than in other settings.

In an important example, a report on the national Better Cardiac Care measures (AIHW 2015) documents one of several targeted approaches to improve access and quality of mainstream care for Aboriginal and Torres Strait Islander people. While progress on ‘closing the gap’ remains slow in many areas (Australian Government 2015), there is some qualitative evidence of improvement (e.g. Willis et al. 2011).

There are other examples of good practice in the mainstream health system. The Hunter New England Health Service (Hunter New England Health Aboriginal and Torres Strait Islander Strategic Leadership Committee 2012) report on their sustained multi-strategic approach as a ‘long and complex undertaking’ (p67). They emphasise the need to address racism, and to establish effective partnerships with Aboriginal people and organisations.

There is also evidence of increasing attention by professional groups and organisations to the implications for practice. For example Davidson et al. (2012) report on a workshop discussion held at the second Indigenous Cardio Vascular health conference in Alice Springs in 2012 (an initiative of the Cardiac Society of Australia and New Zealand – see Jeremy and Cameron 2012 for details). They conclude:

> *Although the widespread challenges of improving Indigenous health outcomes were recognised, participants considered that addressing health disparities in the acute care sector was important and achievable. Although multiple barriers were identified, it was considered that these challenges were not insurmountable and certainly within the remit of the CSANZ to address and develop solutions. In addition to overarching initiatives such as lobbying and advocacy, targeted approaches such as increasing the Indigenous workforce, increasing the numbers and specialisation of AHWs, improving data systems and outcome monitoring, facilitating access to information and cultural competency training and leveraging the opportunities afforded by telehealth are important initiatives and improving health outcomes for Indigenous Australians. (Davidson et al. 2012:642).*

While it is distressing that attention to these problems has come so late, it is encouraging to see the practical focus of these initiatives.

Conclusion

The published work in this chapter addresses my third proposition: that the inadequacy of operational responses in the mainstream health system to the particular needs of Aboriginal patients (in spite of high level policy that requires such responses) constitutes systemic racism; and that the absence of a legislative base on which such responses could be reliably built in to the system reinforces the problem. The first part of this double-barrelled proposition is supported by the evidence presented in this chapter as follows:

Systemic racism and cultural competence

The evidence that the mainstream health care system delivers poorer access and less effective care, on average, to Aboriginal patients compared to the total Australian population is well established, and seems to be found in every aspect of care that is examined. On the principle that policies and programs should be judged on their effects rather than their intentions, this evidence is sufficient to establish that there is systemic racism. The interesting questions are both how these harms are allowed to continue and what should be done about it.

How is systemic racism allowed to continue?

> *Although the task of confronting institutionalized racism may seem overwhelming, it is not. The first step is to name racism in a society where many are in denial about its continued existence and impacts….The second step is to identify the mechanisms by which institutionalized racism operates…. The detailed understanding of these mechanisms will engender a sense of collective efficacy that can move people to action. The final step is to mobilize the political will for action….If we do not confront institutionalized racism, we abandon all hopes for success in our struggle for social justice and health equity. (Dr. Camara P Jones, Centers for Disease Control and Prevention 2003)*

In Dwyer, Willis and Kelly (2014), we examined the text of interviews with clinical and support staff in six metropolitan hospital units that care for significant numbers of Aboriginal patients from rural and remote areas of South Australia and the Northern Territory. We focused on their explanations for the way things are, and what happens when they try to do something about it. The emblematic quote in relation to why things are the way they are was spoken by a nurse:

> *….you treated them like any other Tom, Dick or Harry that came through the ward. We did our normal treatment, did what we had to do and when it came to discharge, yeah.*

> *. .you just did the normal protocol for everybody and that's been my experience for 20 years. (Dwyer, Willis & Kelly 2014:549)*

This way of thinking uses the principle of equal treatment wrongly, as a reason not to respond to members of a group whose care needs are demonstrably different, thus ignoring the critical second part of the equal treatment principle – 'according to need'. That is, equal treatment is not achieved through the provision of care regardless of the person's cultural, religious, sexual preference or other background (Taylor & Guerin 2010:173). This ward nurse went on to explain that he had learned that this way of thinking was not adequate when he became involved in a project that set out to improve the care for this group of patients, thus demonstrating in microcosm both the potential for change at the bedside, and importantly, the role of leadership and management in establishing the frameworks that guide practice.

We also heard from people who had tried to do something about it, including this doctor, who reflected on the disconnection between policy and practice:

> *Unless you're going to mean something rather than look good because…it's actually supposed to mean something and those sorts of ideas [for action to improve care] should be all flourishing around the hospital. But they don't and then you have to ask and so why don't they? Well talking the talk is – makes them feel fantastic, good Christians or whatever we're supposed to be feeling about ourselves, but actually doing that sort of thing is quite a different matter and that's where the barrier is. (Dwyer, Willis & Kelly 2014:548-9)*

We concluded that there was a failure to enact high level policy at the operational level, in the face of both evidence of health system contribution to the burden of illness and excess mortality that is carried by Aboriginal people, and widespread official handwringing about the need for change. Further, this failure is a different kind of evidence of the problem of systematic discrimination against Aboriginal people. It also offers an insight into an important barrier against efforts to improve health care for Aboriginal people: that is, a widespread sense that it is somehow wrong or illegitimate to make particular provisions to meet the particular needs of Aboriginal patients. We suggested that it is at the level of operational policies, programs and protocols, in hospitals and health services, that the failure to translate official high policy goals into practice needs to be addressed, and this will also require practical leadership by the Department of Health (in setting goals, offering incentives and resources, and collecting data relevant to the measurement of improvement).

In Kelly, Dwyer, Willis and Pekarsky (2014) we explored the important barrier of travel to the city, which discourages rural and remote Aboriginal patients from getting needed health care. There is also an impact on staff in primary health care and other services, for whom arranging and supporting travel is time-consuming work that is not recognised by the health care system.

Cultural competence as a systemic strategy for improving access and quality of care

In Dwyer, Willis and Kelly (2014) we suggested that cultural competence may provide a framework for action to address the systematic discrimination we had observed, because of two characteristics. Firstly, CC requires multiple strategies to enable change at every level of an organisation, which we saw as necessary given the multi-level nature of the barriers. Secondly, it takes a positive position on the capacity of the mainstream system to change – the framework carries the suggestion that the system can become competent to deliver culturally safe care – without denying the underlying racism that makes such action necessary.

While noting the different histories of the term CC in different countries, the evidence reviewed above supports the need for multi-level strategies, including but not limited to action to enhance the knowledge and skills of staff. It is too early to assess whether the CC approach is able to deliver meaningful and sustained change.

Would legislation for government stewardship help?

The second part of the proposition is focused on the question of enabling legislation. In Howse and Dwyer (2015), we document the dearth of enabling legislation for Aboriginal health, and argue that this situation flows logically from the legacy of the doctrine of *terra nullius*. We suggest that legislation is needed for what is a normal legislative purpose – to allocate enduring government responsibility, in this case for stewardship of a system capable of providing effective health care for Aboriginal people. We also suggest that the correct foundation for the enactment of such legislation would be the explicit undoing of the legacy of terra nullius through recognition in the Australian constitution of Aboriginal and Torres Strait Islander peoples as the First Peoples, owners and custodians of the land on which we all depend for life and nationhood.

As noted earlier Recognise Health, sponsored by the Lowitja Institute, has been willingly supported by more than 130 leading national organisations in all sectors of the mainstream and Aboriginal health system. Importantly, through the membership of many of these organisations, virtually the entire health workforce is represented, along with the organised health consumer movement. This response has reinforced my conviction that there is significant good will in the mainstream health system to address systemic racism, and in the Aboriginal health sector to engage in that effort. What is needed is a practical, business-like, system-wide approach, built on solid foundations. The former can potentially be provided by the cultural competency framework; the latter requires legislation at minimum, and optimally constitutional change.

At the launch of the Recognise Health coalition on 5th March 2015, legendary singer songwriter Archie Roach offered a personal perspective about why recognition matters:

> *What it is really about is how we see ourselves and how we feel about ourselves as people. Because for too long, since I was a kid, growing up, ending up on the street, I was told that I was lazy, no good, worthless, black. And when you're told this long enough, you start to believe it. And it destroys you inside, in your head, in your mind.*

> *So that is why it is so important that we are recognised within the constitution of this country as the first peoples….*
> (Archie Roach 2015).

The papers in this chapter are intended to establish both the current ambivalence in the mainstream health system's response to Aboriginal people and their health care needs; and the need for solid legal foundations for sustained government responsibility for effective action. Such foundations need to begin with a definitive answer to the remaining shadow of terra nullius, in the form of recognition of the role and history of Aboriginal Australia in our constitution; and then be encoded in health law.

Postscript

While writing this chapter, I attended the funeral of Mrs Mary Buckskin, formerly the CEO of the Aboriginal Health Council of South Australia, and a nurse by background, who was 57 when she died of cancer. Mary was the second oldest of eight children, and the seventh that her mother buried. Her surviving sister told the story of Mary's birth in a country town in Victoria. Mary's mother was initially turned away when she went to the hospital in labour, on the explicit basis that Aboriginal people were not admitted. Thankfully, her father was able to get the local football club leaders to intervene, and that is how Mary became the first Aboriginal baby born at that hospital. The burden of hardship, loss and grief borne by Mary's family, and many Aboriginal and Torres Strait Islander families, is hard to imagine.
[Note: This story is included with the permission of Mary's family.]

Chapter 4: Accountability and the mystery of reform

In this chapter the published work addresses the third of my propositions: that current Australian approaches to accountability, based on New Public Management (NPM) methods and founded in agency theory, are inappropriate to the Aboriginal Community Controlled Health Organisation (ACCHO) sector and an alternative is needed. As outlined at the end of Chapter 2, the accountability puzzle is the second of the two major concerns arising from the Overburden Project (Dwyer et al. 2009). When that study was completed, I and my colleagues had come to the conclusion that while we had explicated the fundamental mismatch between the business of Aboriginal health care and the machinery of NPM-inspired contracting, we had not focused enough on the problem of accountability.

Why accountability matters

This is a critical matter, because accountability regimes have come to be the place where government/ public sector concerns about the governance and capability of Aboriginal organisations are brought to bear. This is not unreasonable given that accountability is widely viewed as providing a solution to a range of governance problems (Koop 2014:567), but in this case, there is a real conundrum.

Governments fund the sector because of entrenched policy that supports doing so, and because of evidence of both clinical and cultural competence. Aboriginal governance, incorporating accountability to the community as well as to funders, is one of the foundations of this competence, but governments don’t trust Aboriginal governance, and their sense of risk drives them to two unhelpful responses. The first is to impose tight specifications in funding contracts, and burdensome accounting and reporting measures. The second is to limit the growth of the sector, restricting coverage of the population and holding some organisations at sub-optimal size. One of the ways of achieving this is to encourage new (mainstream) entrants to the field, or offer funding to existing mainstream providers rather than the sector (see for example Dwyer et al. 2015b:51). It seems that the perception of financial or political risk (for the government, the funder and/or the taxpayer) is allowed to outweigh the risks of not adequately funding primary health care (PHC) (continuing illness, injury and poor health outcomes experienced by Aboriginal people), even though addressing poor Indigenous health outcomes is a recognised health priority.

So these measures are costly, but they don't actually resolve the underlying concerns for public administration (or for ACCHOs) because accountability per se is not the problem. So far, there is no evidence that the measures have enhanced the confidence of governments, and sector development is stalled or halting. I suggest that something other than more accountability is needed.

It is also true that there are difficult tensions for some of those who take on ACCHO governance roles. The concepts of fiduciary duty, including the need to avoid conflicts of interest, are accepted and encoded in the regulatory framework, the constitutions of organisations, and the guidelines established by the sector (NACCHO, undated). According to Aboriginal governance expert Professor Mick Dodson, there is no fundamental mismatch between the principles of good corporate governance and good community governance (Dodson & Smith 2003:13-14).

ACCHO board members face the same fiduciary obligations as do all corporate board members to act in the interests of the organisation, not their own or their families' and friends'. The pressures are not fundamentally different, but for ACCHO board members serving in small communities, within a network of complex family and cultural obligations and relationships, the pressure may be more intense (Mawson et al. 2007). While there is considerable knowledge, skill and leadership capability within communities (Moran & Porter 2014), low levels of formal education can also make the technical aspects of governance challenging for some board members. As noted in Chapter 2, incidents of fraud, mismanagement and governance failure in the sector loom large in the minds of funders (eg Dwyer et al. 2015b:64, 46).

While the policy and program development standoff is unresolved and reform is needed, progress has nevertheless been made in the development of the sector and in its accountability arrangements. There are some good results for which both the sector and the funders deserve credit (Martin 2014; Haynes, Holloway & Thompson 2014; reviewed below, NACCHO undated).

The upshot of the situation described above is that the development and strengthening of the sector is held back, the narrative of failure continues (reinforcing the original government concerns), and the wicked problem of reliable access to PHC for Aboriginal and Torres Strait Islander communities and people remains unresolved. In this conundrum, an effective accountability regime has the potential to be part of breaking the cycle.

The current situation

Sector development and funding

As noted above, it is agreed and entrenched in policy, and supported by evidence (reviewed in Appendix D: Dwyer et al. 2015b:4-6), that ACCHOs are the preferred providers of PHC for a majority of Aboriginal people, and are more effective in some important ways than mainstream providers. It is also clear that there is not adequate coverage, particularly in remote and rural areas, for Aboriginal people to have reliable access to PHC provided by ACCHOs, or indeed in some of those areas, reliable access to *any* PHC. In its recent report on spatial distribution of PHC services in relation to the Aboriginal population, Australian Institute of Health and Welfare (AIHW) found 40 2nd level Statistical Areas[9] where Aboriginal people lack access to any Indigenous-specific PHC service[10] within one hour's drive and there is poor GP access. The report also notes that 61% of these SA2s have high rates of potentially preventable hospitalisation (AIHW 2015:19).

Given the relatively small size of the Aboriginal population (just less than 3% of the total Australian population), the amount of money required to extend coverage is well within the nation's means; and given both policy and evidence, the ACCHO sector should be the major recipient of that funding. This was generally the case from 1995, when funding responsibility was transferred from the Aboriginal and Torres Strait Islander Commission to the

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[9] These are Australian Bureau of Statistics collection areas with between 3000 and 25,000 people.

[10] This term also includes government-provided clinics and some private clinics that have a specific focus on Aboriginal health care.

Commonwealth Department of Health, until approximately 2012. Since then, growth in the sector seems to have stalled, while non-Indigenous health care organisations, often new entrants to Aboriginal health care, have gained a greater share of available funding (Alford 2014:10-11; Henderson 2015).

In the 2014/15 federal budget, cuts of more than $160M over four years were made to the Aboriginal health budget. The government also announced the establishment of the Indigenous Advancement Strategy, a program that both reduced the amount and changed the basis of funding for Aboriginal affairs generally (Gardiner-Garden 2014). Funding lines were consolidated (from 150 to five main programs) and open competitive tendering was introduced, a process that seems to have resulted in increased funding to non-Aboriginal organisations (Henderson 2015; Close the Gap Campaign Steering Committee[11] 2015:4-5).

While core funding for the ACCHO sector has not been withdrawn (and the funding period was restored to a three-year cycle, after one year's interruption), funding for some important services has been lost. There is also concern in the sector that additional funding for Aboriginal health under the government's Closing the Gap program[12] has been disproportionately allocated to mainstream health services. In response to these concerns, the (independent) Close the Gap Campaign Steering Committee has called for 'a new mechanism to determine the appropriate Aboriginal and Torres Strait Islander share of mainstream health programs on a basis that reflects both the population size and an index of need' (Close the Gap Campaign Steering Committee 2013:10).

Accountability and reporting requirements

Accountability and reporting requirements are high in all health care organisations, for some good reasons. While all the normal compliance requirements for organisations that employ staff and offer services to the public apply, there are two main sources of additional

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[11] The Close the Gap Campaign Steering Committee is a coalition of over 30 leading Indigenous and mainstream organisations, auspiced by the Australian Human Rights Commission and funded by members and by Oxfam. It launched the Close The Gap Campaign in 2007. 'Closing the Gap' is the national government policy and funding program.

[12] For a description of this program, see Australian Government Department of the Prime Minister and Cabinet (2015).

monitoring and reporting requirements for health care organisations. The first is the need for careful detailed records of the care of individual patients. The second is the pursuit of quality and safety, and the important role of data in documenting, managing and monitoring improvement efforts and results, both within the organisation and in aggregate in the field and the professions.

The need for this data is universally recognised and accepted. As documented in Dwyer et al. (2011, 2009), ACCHOs face additional requirements, because they are funded in more complex ways, and each funding program has its own requirements for reporting (many but not all of them tightly specified), and ACCHOs are funded through multiple programs and by many funders at both levels of government. Reports include financial reports (which may be required from one to four times each year for each program), activity reports (types of services provided and numbers of participants/patients), data on clinical indicators and special-purpose compliance reports (eg mandated risk assessments, above the requirements of legislation and regulation). A recent case study of a single Aboriginal Cooperative, providing health and other services in a regional centre with total funding of about $15M, documented 62 funding agreements, with 12 different funding organisations, generating a requirement for 428 reports (Silburn et al. 2015).

The work in this chapter seeks to establish how and why current accountability regimes are inappropriate and ineffective, and to offer some insights as to what might be done about it. The papers provide evidence that NPM-inspired contractual accountability approaches, focused on financial management and activity, are not sufficiently focused on addressing the concerns of funders or the priorities of communities; and are not well aligned to the accountability environment for ACCHOs. Further, the evidence indicates that both funders and providers of care are aware of this problem and of the need for alternative approaches.

The background and context to the research represented in the papers and attachment is first explained, followed by an explanation of the production of the papers themselves, including my contribution. A review of the empirical research on accountability in mainstream public administration and in the third sector is presented, including a small collection of Australian papers directly relevant to current practices in accountability between governments and the ACCHO sector. The implications of this body of knowledge for my work on accountability are addressed, along with an analysis of the contribution of the papers to my third proposition.

The research story

The papers in this chapter are collaborations of the Contracting at the Margins Research Group[13], arising from our joint decision to explore accountability. The work was grounded in an application for research funding in New Zealand that was unsuccessful; and in the FAR project ('Funding, Accountability and Results for Aboriginal health services') funded by the Lowitja Institute as a follow-on to the Overburden Project.

The Overburden Report was seen in the Cooperative Research Centre (CRC) as one of a number of successful outcomes from the 2005-2009 program. Partly as a result, I was invited to contribute to the application for a new round of funding for 2010-14. When the application was successful, I was appointed in 2010 to the role of Research Program Co-Leader for one of three programs, in my case focused on 'Enabling Policy and Systems'. The CRC was by this time being operated by the Lowitja Institute, a newly incorporated company, which took over from the unincorporated joint venture that had been the previous structure of the CRC.

The Institute adopted a model for program leadership based on a partnership that required at least one of two leaders to be of Aboriginal heritage; and at least one to have significant research experience. In the case of Program 3, the program leadership was a partnership initially with Mr Alwin Chong, then the Senior Research and Ethics Officer with the Aboriginal Health Council of SA; and subsequently with Dr Kim O'Donnell, a research associate in the Department of Health Care Management at Flinders. I took overall responsibility (working with the Program Manager) for the management of the Program's research work (commissioning, peer review, budget oversight, board reporting). It was expected that I would spend approximately half of a full-time workload on the role.

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[13] See Chapter 2 for an explanation of this group.

Having provided part of the basis for the successful application for another 5 years of CRC funding, the CRC was already committed to funding the FAR project, as it was known. This project sought to engage the ACCHO sector and Commonwealth and state/territory governments in the Northern Territory and Queensland in case studies of reforms in each jurisdiction that were then in the planning and development stages. In the NT, a framework agreement for the transfer of clinics in rural and remote Aboriginal communities from NT Health to regional ACCHOs had been negotiated (Northern Territory Aboriginal Health Forum [NTAHF] 2009), and implementation work was commencing. The process was conducted under the auspices of the Northern Territory Aboriginal Health Forum (NTAHF), a mature formal partnership group consisting at the time of NT Health, the Aboriginal Medical Services Alliance of the NT (AMSANT) and the Commonwealth Department of Health and Ageing (through the Office for Aboriginal and Torres Strait Islander Health (OATSIH)). In Queensland, a policy supporting ‘Transition to Community Control’, was under development (Queensland Health 2011; Queensland Aboriginal and Islander Health Council [QAIHC] 2011b), and planning towards transfer of primary health care services in Cape York to Apunipima Cape York Health Council had been underway since 2006.

I negotiated with the NTAHF partners and both Queensland Health (QH) and the Queensland Aboriginal and Islander Health Council (QAIHC) to gain their agreement to participate in the research project, which would observe and record the reform processes as they developed. I was successful in gaining formal endorsement by NTAHF, and in negotiating agreements with two regional ACCHOs (one in each jurisdiction) that enabled the conduct of three case studies: NTAHF, East Arnhem (NT), and Cape York (northern Queensland). The contract for this project was signed in August 2011, following a successful quality assurance workshop with the partners and other stakeholders and experts. Agreement with Queensland Health was not concluded, as the Queensland reform process ground to a halt prior to the 2012 election of a conservative government in Queensland, and effectively lapsed at that time (although it was not officially terminated, and there has been sporadic activity in subsequent years, which seems to have ceased in 2015).

The papers

The first paper below is the initial academic publication from the FAR project. It used three case studies (in Canada, New Zealand and the NT) to examine the proposition that rhetoric and action in the policy field indicate awareness of important problems with the application of NPM-inspired contracting and accountability approaches, and the emergence of alternatives. The second had its origins in a grant application in New Zealand (on which I was a proposed international adviser), which was seen at the time as building on the Overburden Project. It aimed to unpick the various accountability 'pulls' affecting community-based non-government organisations (NGOs), in a way that would be useful to the NGO sector in their strategic management.

PAPER SIX – Indigenous people's health care: new approaches to contracting and accountability at the public administration frontier

This paper (Dwyer et al. 2014) is a comparative case study of emergent reforms in the way that Indigenous health care is funded and regulated by government funders in three countries - Canada, New Zealand and Australia. The FAR project provided the basis for the Australian case study. The paper was initially presented at the annual conference of the International Society for Third Sector Research held in Siena Italy in July 2012.

Statement of my role

I led the process of detailed research design and the engagement of partners for the FAR project, which provided the basis for the Australian case study. Data collection commenced in 2012, and was completed by the end of 2013. The final report of the project (Appendix D) was published by the Lowitja Institute in 2015.

I wrote the first draft of the paper, designed the format for the case studies and wrote the Australian case. I prepared successive drafts for review by my co-authors, and took responsibility for the revision and final approval of the manuscript. Dr Amohia Boulton and Professor Josée Lavoie prepared the case studies of reforms in New Zealand and Canada respectively, based on their work and that of colleagues in those countries. Dr Tim

Tenbensel made a significant contribution to this paper in drafting its core proposition, following discussion by all authors, and reviewing drafts and suggesting improvements. Professor Jacqueline Cummings acted as a sounding board, reviewing drafts and suggesting improvements. All authors contributed to refining the draft and revision following review.

INDIGENOUS PEOPLES’ HEALTH CARE: New approaches to contracting and accountability at the public administration frontier

Judith Dwyer, Amohia Boulton, Josée G Lavoie, Tim Tenbensel and Jacqueline Cumming

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Abstract

This paper analyses reforms to contracting and accountability for Indigenous primary healthcare organizations in Canada, New Zealand and Australia. The reforms are presented as comparative case studies, the common reform features identified and their implications analysed.

The reforms share important characteristics. Each proceeds from implicit recognition that Indigenous organisations are ‘co-principals’ rather than simply agents in their relationship with government funders and regulators. There is a common tendency towards more relational forms of contracting; and tentative attempts to reconceptualize accountability. These ‘frontier’ cases have broad implications for social service contracting.

Keywords

Third sector organizations, Indigenous health services, public management, contracting, accountability, primary health care

INTRODUCTION

In the ‘settler societies’ of Australia, New Zealand and Canada, Indigenous peoples live shorter lives compared to the total population, and carry a higher burden of disease (Australian Bureau of Statistics 2011; Ministry of Health 2010; King, Smith and Gracey 2009). Official attempts to address Indigenous health inequalities have frequently been judged as failures by governments, Indigenous communities and researchers (e.g. Browne *et al.* 2011, Australian Indigenous Doctors’ Association 2010). At the same time, primary health care (PHC) initiatives that emerge from Indigenous communities themselves have been accommodated through government policy and funding programmes that enable care to be delivered by community-based third sector organizations (TSOs). These organizations also function as the base (of knowledge and resources) for communities to advocate for health rights and priorities.

Governments in these countries, applying New Public Management (NPM) practices to varying degrees, have imposed requirements for contracting, performance and accountability that have been shaped for other contexts (Lavoie 2005) and emphasize the imperatives of government funders (Christensen and Laegreid 2001; Boulton 2005).

In response, Indigenous TSOs, aiming to provide comprehensive PHC services to meet community needs, have little choice but to ‘patch together’ many precisely targeted funding programmes. Evidence indicates that the constraints of these funding programmes can undermine responsiveness to communities (Ospina Diaz *et al.* 2002; Christensen and Ebrahim 2006), align poorly with the imperatives of professional staff (Hwang and Powell 2009), create high transaction costs for TSO recipients (Tenbensel *et al.* 2013) and potentially threaten the sustainability of the Indigenous PHC sector (Lavoie *et al.* 2010).

In response to these concerns, new discourses and approaches to contracting and accountability have emerged in Canada, New Zealand and Australia over the past five years. While they are informed by public administration theory, particularly new public governance and public value (Osborne 2007; O’Flynn 2007), they confront governance and accountability challenges that have not yet been satisfactorily addressed in theoretical debates (Ryan 2011).

This paper analyses emerging reforms in each country, as comparative case studies in the development of alternative approaches to government-TSO relationships. Our goal is to contribute to efforts to address the policy and practice challenges that must be resolved if alternative methods of contracting and accountability are to be accepted.

THEORETICAL FOUNDATIONS

The relationships between Indigenous PHC organizations and governments in the three countries have been shaped by two radically different frameworks. The Indigenous PHC sectors arose from community activism in the 1970s – 1990s, in pursuit of the goals of better health and health care as well as self-determination (Anderson 2006; Lavoie 2004; Durie 1994). These initiatives echo (and sometimes precede) broader debates on the value of public engagement in PHC (World Health Organization 1978). Indigenous health movements arose because of experiences of exclusion from health care; and of poor quality care that failed to recognise the health impacts of colonisation and continuing social disadvantage, or the importance of Indigenous culture and identity (Durie 2001; Lavoie, O’Neill and Reading 2009). Around the world, Indigenous minorities continue to place a strong emphasis on health, often using the concept of health as a human right and a right of Indigenous peoples in particular (United Nations, 2007).

At around this time, governments in English-speaking industrialized countries began to adopt the practices known collectively as New Public Management in the pursuit of public sector reform (Hood 1991), including the use of contracts to govern service delivery and ensure a narrow concept of accountability. Thus in the health sector, the funder is seen to act on behalf of taxpayers, ensuring that services are effective and targeted to patient needs; and that providers make efficient use of taxpayer funds. This approach underlies the move towards explicit contracts for services, with the funder determining performance targets (cost, volume and quality), and the provider cast as an agent of government policy.

There are several problems with the NPM approach to contracting for health and other social programmes, including the problem of information asymmetry. That is, the funder is often unable to determine the best approach to services or the best use of resources (Sabel 2004). This is especially problematic when applied to the funding of TSOs serving marginalized populations, where the rationale for contracting services is based precisely on acknowledgement that the contracted TSOs know more about the needs of, and are closer to, the client groups (Sullivan 2011, Ch. 5). There are also significant problems with reconciling the NPM-inspired contracting goals of competition, and ease of withdrawal of funding to contracted providers, with the PHC goals of continuity of care and long-term treatment relationships (Palmer and Mills 2003).

Contracting is characterized on a continuum from classical (traditional form of contracting to purchase discrete and well-defined goods or services) to relational contracting (Williamson 2000). The term 'alliance contracting' is used in the private sector – 'an agreement between parties to work cooperatively to achieve agreed outcomes on the basis of sharing risks and rewards' without 'the adversarial relationships common in more traditional contracts' (Clifton *et al.* 2002). Attempts to implement quasi-classical contracting to purchase healthcare services have been consistently problematic, and shifts towards relational approaches first emerged in the 1990s (Goddard and Mannion 1998; Ashton 1998).

In health care, longer-term relational contracts aim to preserve the benefits of separating the roles of funder and provider, while offering relative security to support a robust health care system. The need for workable levels of trust between the parties to a relational contract runs counter to the agency thinking typical of NPM, although there is evidence that the risks arising from the need for trust in relational contracting for PHC can be minimized (Liu *et al.* 2007). However, a significant gap remains with regard to both theoretical foundations and effective methods for meaningful accountability in relational contracting frameworks.

Accountability in this context is generally defined as a power relationship where an accountability holder has the right to information, auditing and scrutiny of the actions of an accountability giver (Mulgan 2002, p. 3). The obligations on both parties (the exchange of money for information and compliance) align well with this sense of accountability. While the NPM conceives the accountability relationship as being one sided (accountability of the provider to the funder who represents the clients), recent research has recognized the complexity of accountability relationships for TSOs among others (Williams and Taylor 2013), and the difficulties of making NPM-style accountability requirements work effectively (Romzek and Johnston 2005). For many TSOs accountability is a complex interplay among the requirements of communities, funders and professionals (Tenbensel, Dwyer and Lavoie 2013); and the providers' accountability to the funder may not be seen as the most important accountability relationship (Boulton 2005, p. 263).

Tension about accountability measures arises partly from differences in the ways that funders and providers use activity and financial data – funders to meet their upwards reporting requirements; and TSOs for management and reporting to boards and communities as well as to funders. On the other hand, some standardization is useful to all for performance monitoring. While these problems have been substantially resolved for financial data, data about service delivery is both more complex and more contested. The ideal of 'collect once, use often' is seldom achieved in practice (Auditor General of Canada, 2002; Digiacomo *et al.* 2010.

But accountability tensions also have deeper sources (Williams and Taylor 2013). Sullivan (2009, p. 66) offers an alternative understanding in which accountability is 'the activity of rendering an account within a group and between groups so that the actors negotiate their identity, obligations and commitments in relation to each other, producing an environment of reciprocal accountabilities'. In this paper, we suggest that the problem of reconciling different interpretations of accountability, and developing methods that are workable and acceptable for funders, providers and communities, is a major hurdle for reformers, and a significant barrier to improvement in health care for Indigenous communities.

METHODS

We conducted a comparative case-study analysis of emergent reforms in Canada, New Zealand and Australia. The reforms are current attempts to address the funding and accountability relationship between government funders and Indigenous TSOs providing PHC and social services.

The case studies are designed to test the proposition that the reforms are based on recognition of shortcomings in the dominant (NPM-based) methods of contracting with TSOs. More specifically, we analyse the extent to which the reforms tend to move away from tight specification of deliverables towards more 'bundled' or integrated longer-term contracts; and the extent to which the dominant accountability regime is modified with measures that aim to recognise reciprocal responsibilities for common goals and desired outcomes.

The case studies are based on analysis of policy documents, relevant research and direct observation by the authors, who were involved in separate studies of each of the reforms. We describe the context and the reform policy instruments, and present an analysis of the implications for more integrated and longer-term contracts and for shifts in accountability and related reporting requirements.

EMERGING FUNDING AND ACCOUNTABILITY MODELS FOR FIRST NATIONS IN CANADA

In Canada, the federal government has assumed authority over 'Indian' (First Nations) affairs since 1867. The Indian Act 1876, while decried as an instrument of oppression (Gabriel *et al*, 2011), nevertheless created a point of contact between the state and First Nations. The Act required each Nation to elect a Chief and Councillors, who were then tasked to act as a government for the Nation. This imposed model has in some cases displaced traditional forms of governance. In other cases, both forms coexist (Imai 2012; Mackie 2012).

While the powers of the imposed form of governance were initially trivial, Canada has for more than a century legally recognized and engaged with a form of First Nations local governance. Since 1982, Section 35 of the Canadian Constitution recognizes Aboriginal and treaty rights, and has been widely interpreted as recognition of Aboriginal peoples' right to self-government (Lux 2009). This implies the transfer of responsibility for health and social programme planning, management and delivery to First Nations governments. Competitive contracting has no place in this framework.

Two federal departments, the First Nations and Inuit Health Branch of Health Canada (FNIHB) and Aboriginal Affairs and Northern Development Canada, have responded to First Nations aspirations for self-government with a range of funding and contracting options.

Thus, First Nations ('on-reserve') communities receive PHC in one of two governance models: from community-controlled health services which are accountable to community local government authorities; or from clinics operated by FNIHB. More complex and acute care, and PHC provided off-reserve, is funded by the province. For the general population, most health care is provided by public services funded by provincial universal health insurance, and in the case of hospitals, operated by the provincial government or regional health authority.

Policy instruments: Cumulative reform increases integration

Since 1982, multiple approaches to contracting have emerged. Communities have three main options: multi-department funding agreements (MDFA), block funding agreements (BFA) and flexible funding agreements (FFA), which bring varying degrees of flexibility. MDFAs are the most flexible, as they bring together multiple social programmes (health, education, child welfare, economic development, income assistance, infrastructure, housing and local governance) under a single relational agreement between the First Nations government and the federal government.

In contrast, BFAs and FFAs relate to health services only. BFAs are block-funded flexible agreements offered for periods up to 10 years, with opportunities to add new programmes as they emerge. In contrast, communities who sign a FFA must secure the federal government's permission before moving funding between budgetary lines (Health Canada (FNIHB) 2012a). These options have been relatively well received by First Nations, with 89 percent of the eligible 610 First Nation communities involved in one or other type of agreement as of 2008 (Health Canada (FNIHB) 2008b).

Integrated contracting, with exclusions

While these opportunities have been portrayed by governments and some scholars as an expression of self-government (Magallanes 1999; Chartrand 1999), many limitations have been noted (Lavoie, O'Neil and Reading 2009; Lavoie *et al*. 2005). These arrangements are only available to discrete First Nations and Quebec/Labrador Inuit communities, while services for Métis and Aboriginal people living in urban areas are provided by mainstream organizations, with few urban Aboriginal health clinics available. Some of these services are resourced through relational contracts, while others depend on a collection of classical contracts (Lavoie, Browne, & Wong, 2013). More research is needed to map funding and accountability pathways off-reserve.

On-reserves, both BFAs and FFAs exclude some programmes from the flexible framework (e.g. the Aboriginal Diabetes Initiative, the First Nations Home and Community Care programme and the recently implemented Maternal and Child Health programme) (Health Canada (FNIHB) 2008a)). Some of the excluded programmes have been introduced as a pilot phase. Once implemented nationally and shown to be worthwhile (Health Canada (FNIHB) 2012b), these programmes are then integrated into the flexible contractual framework.

Accountability

Some of the exclusions noted above arise from a reporting problem with national programmes. Although the First Nations and Inuit portion of these programmes is managed by a separate authority (FNIHB) standardized national reporting frameworks nevertheless apply to the funding. Thus, accountability requirements preclude the inclusion of these programmes in a flexible contractual arrangement.

Further, accountability frameworks under all models of contracts remain fragmented and onerous. Lavoie and colleagues (2005) documented that in 2003-04, 169 First Nation communities in British Columbia submitted an estimated 5,813 reports to the federal government to satisfy their accountability requirements for health services alone.

The challenges outlined above reflect the accountability processes set in place to ensure that all federal department programmes provide returns on investments (Phillips and Levasseur 2004). While accountability is key, the former Auditor of General of Canada has acknowledged that federal government processes may be ill-equipped to meet the needs of local PHC organizations: ‘there's not much point in First Nations exchanging data for dollars with the federal government when the information is of no real benefit to either party’ (cited in Yourk 2002).

The Canadian approach, which has focused on administrative arrangements between the federal government and a single community or group of communities, has effectively imposed accountability frameworks designed for very different kinds of procurement. As noted by the Auditor General of Canada

(2002), there are ‘several problems with the use of this funding mechanism for the provision of core government services’, including poor definition of services, lapses in funding related to delays in contract renewals, lack of accountability to First Nations members, and reporting overburden. Similar issues have been noted in contractual relationships between the federal government and the NGO sector more broadly (Phillips and Levasseur 2004).

For these reasons among others, new approaches to contracting and accountability for health are emerging. In British Columbia, the federal government has implemented a transfer of its budget and responsibilities for health funding and service delivery to a province-wide consortium of First Nations (First Nations Health Council, Government of Canada, and Government of British Columbia 2010). The newly created BC First Nations Health Authority (FNHA) now assumes what were previously federal responsibilities, including the funding of First Nations TSOs.

Although it remains unclear how this transfer will be structured, the FNHA will have some latitude in rethinking the administrative instruments it will use to then contract out services to individual First Nations community providers. This structural shift offers an opportunity for the FNHA to develop alternative approaches based on mutual accountability. However, while the agreement between the FNHA and the federal and provincial governments (Government of Canada, Government of British Columbia and First Nations Health Society 2011) uses this terminology, the accountability framework currently focuses solely on the FNHA’s responsibilities.

Key points

Canadian First Nations health organizations see their role both as advocates and as service providers. They are able to use data gathered through their contractual role, and other activities, to deliver evidence-informed critiques of policies. They thus play an important role in working to shift accountability from a top-down to a mutual process, where accountability is required of both parties. While it is clear that not all First Nations organizations are equally skilled in this art, it is also clear that developing such a skill is an integral part of the self-government project, and essential to the refinement of approaches to accountability and to contractual instruments.

NEW ZEALAND: TOWARDS WHĀNAU ORA AND INTEGRATED CONTRACTING

Background

In New Zealand, the Treaty of Waitangi establishes the relationship between the state and Māori, providing a constitutional basis for efforts to improve Māori health status (Durie 1994; Robson and Harris 2007). Starting in the 1980s, the principle of biculturalism required all organizations delivering health services to give effect to the principles of the Treaty of Waitangi in their operations (Durie 2001) and be responsive to Māori priorities in their policy and practice. By the mid-1990s, it was evident that ‘responsiveness to Māori’ had produced only token changes (Cunningham and Durie 1999, p. 240). Consequently Māori challenged the concept of ‘mainstreaming’ arguing that Māori themselves were better placed to manage and deliver their own programmes and act as guardians for their own people (Royal Commission on Social Policy 1988).

During the same period, extensive government reforms encapsulating a radical NPM programme reshaped the public sector (Boston et al. 1996). In health, fundamental restructuring allowed services to be outsourced through contracting with the third sector. These reforms enabled approximately 250 Māori- and iwi (tribe)-led TSOs to develop as service providers, with structure and governance arrangements that varied from community-based entities (with directors being both Māori and non-Māori members of the local community), to tribally-based services operating under the ownership of government-recognised Rūnangas, (tribal authorities) (Abel et al. 2005).

The reforms to the broad state sector produced a complex patchwork of contractual relationships between a variety of national government agencies (social service, health, education, justice) and non-government service providers. Many Māori providers held multiple small contracts with one or more funders (Lavoie 2005). Contractual accountability centred on measurable outputs that could, in theory, be controlled by the provider. The prevailing orthodoxy was that only Ministers could be held accountable for results (Boston et al 1996), and discouraged inter-agency co-operation because this would blur lines of accountability.

A change of government in 1999 led to a shift in thinking towards joined-up government and accountability for outcomes (Chapman and Duncan 2007). However, the government also decentralised funding of health services to 21 District Health Boards in 2001 (Gauld 2009). New primary care structures known as Primary Health Organisations (PHOs) were introduced to improve access to PHC services and coordination among providers (Barnett and Barnett 2004) and ensure community participation in priority setting (Abel et al. 2005).

The introduction of PHOs and subsequent policy shifts changed the structure and organization of Māori health providers. Those with a sufficiently large enrolled patient population transformed directly into standalone PHOs, while smaller providers became part of larger mainstream PHO organizations. Māori providers now range from being part of mainstream PHOs, to small, single entity organizations serving discrete communities of people, and large Māori-led organizations collectively delivering PHC and social services to hundreds of thousands of New Zealanders through an array of contracts.

Policy Instrument: The Whānau Ora model of health and social service delivery

The concept of whānau ora (family health) emerged as the primary goal of He Korowai Oranga, the Māori Health Strategy in 2002 (Ministry of Health 2002). Defined as ‘Māori families supported to achieve their maximum health and well-being’ whānau ora is an inclusive, culturally anchored approach, based on a

Māori worldview of health which holds that changes in the well-being of an individual can be brought about by focusing on the family collective or whānau, and vice versa (Families Commission 2009).

The Whānau Ora approach introduced in 2010 (Taskforce on Whānau Centred Initiatives, 2010), obliges services to work collaboratively across traditional sector boundaries; to place whānau needs at the centre of all care plans; and ultimately to improve whānau (family) well-being (Boulton, Tamehana and Brannelly 2013).

The government's Whānau Ora approach thus requires the development of new governance and contracting arrangements, to ensure community, service providers and funders meet their respective responsibilities and obligations. These approaches must be flexible enough to achieve measurable whānau ora (wellbeing) outcomes yet robust enough to work across disparate sectors of government which largely continue to operate separate budgets and portfolios.

Twenty Māori health and social service providers were selected in 2010/11 to lead the Whānau Ora model in their communities. A budget appropriation was made in 2010 for $134.3 million over four years, with participating providers retaining existing funding and contracts (with many being reconfigured). Initial efforts at 'joined-up' service provision, with several government agencies providing integrated pools of funding to enable Māori TSOs to meet the health and social care needs of families (whānau), are underway.

Contracting reforms

Integrated contracts (single agreements for funding provided by several government departments) that focus on shared outcomes are recognised as essential for the achievement of whānau ora outcomes. In part, the Whānau Ora approach is a response to public sector interest in integrated contracting that emerged first in the Ministry of Social Development in 2007 (Pomeroy 2007; Ryan 2011), and is now the focus of government attempts to streamline contracting with non-government service providers (Ministry of Business, Innovation and Employment 2013). Some Māori health sector organisations are also developing integrated contracting initiatives outside the Whānau Ora umbrella. However, these developments are in their early stages, and results are yet to be seen. Importantly, the funding environment is more complex than ever with no rationalization of public sector funding agencies.

Accountability

While the focus on measurable outcomes for families and communities is a strength of recent developments, there is a risk that more rigorous use of outcome-based performance indicators in the implementation of Whānau Ora may effectively set performance benchmarks for Māori TSOs that are inequitably high when compared to those for mainstream health services.

The expectation of outcome reporting represents a significant shift in thinking about performance and accountability; one made even more challenging by the recognition that whānau ora outcomes may be iwi (tribe), hapū (sub-tribe), or even community specific. Considerable investment has also been made in evaluating the new model. An intensive programme of action-research activity is gathering evidence of service reconfiguration; whānau-centred service delivery; greater inter-agency collaboration; and the achievement of improvements in whānau well-being.

Key points

The Whānau Ora approach to health and social service delivery is in many ways more consistent with the approach of Māori healthcare providers, which have always worked across the somewhat artificial boundaries that construct and define 'social', 'health', 'education' and other human services (Boulton 2005, 2007; Crengle 1997). This is regarded as a necessity for services that have emerged from a cultural understanding of the well-being of the whole whānau (family); and take a holistic approach (Boulton 2007).

The intended shift to accountability for outcomes rather than outputs is also promising, if risky, and may provide the basis for rebalancing accountability to funders with accountability to community. However, concepts of whānau ora are likely to differ across organizations, regions, funders and providers, and even between providers and whānau themselves (Boulton, Tamehana and Brannelly 2013). Flexibility is needed in the design, operation, contracting and evaluation of the services, which are necessarily locality-specific. Care must be taken, for example, that moves to establish national outcomes do not undermine the community-driven approach that underpins Whānau Ora.

PATHWAYS TO COMMUNITY CONTROL IN AUSTRALIA'S NORTHERN TERRITORY

Unlike the situation in comparator countries, in Australia there is no legal basis in treaties or constitutional recognition on which to build national legislative responsibility for Indigenous health (Howse 2011), although formal recognition of the original inhabitants has been included in some jurisdictional constitutions.

The third sector in Aboriginal and Torres Strait Islander PHC in Australia was initiated in the 1970s, and now constitutes a significant part of the Australian health system, providing PHC services to between one third and one half of the Aboriginal population (NHHRC 2009, p. 87; NACCHO 2009, pp. 2-3) in rural, remote and urban settings. There are approximately 150 Aboriginal Community Controlled Health Services (ACCHSs) in Australia (Martini *et al.* 2011).

ACCHSs aim both to provide health care and to advocate for and represent their communities in health policy and access to resources. Their relationships with government are characterized by heightened political sensitivity, at least partly as a result of this combined role of service provider and representative organization (Sullivan 2009).

The combined role has been formally accepted by all national and jurisdictional governments, which have committed to a policy framework that endorses comprehensive PHC provided by organizations that ‘maximize community ownership and control’ (NATSIHC 2003, p. 1). However, these policy positions are not consistently supported in public administration or policy debate (Anderson 2006; Sullivan 2011, ch. 5).

Since the 1980s, Australian governments have embraced the contractual methods of NPM vigorously (O’Flynn 2007), and the current arrangements for funding are fragmented and complex, with excessive administrative and reporting requirements (Australian National Audit Office 2012; Department of Finance and Deregulation 2010).

The relative roles of the national and jurisdictional (State/Territory) governments in health policy and healthcare delivery are overlapping and accountabilities are contested (NHHRC 2009). This includes responsibility for Aboriginal health, with both levels of government providing direct funding for Aboriginal-specific healthcare providers. The sector is funded and held accountable through a complex array of short-to-medium term funding contracts, a situation that contrasts with the mainstream health system, where essential basic care is either provided directly by government or funded through long-term fee-for-service arrangements. Mainstream TSOs are also subject to the burden of complex contractual environments, and this situation is the subject of increasing concern and policy attention (Productivity Commission 2010; McGregor-Lowndes and Ryan 2009).

The cost and efficiency problems caused by the complex contractual environment for Aboriginal services are well documented (Eagar and Gordon 2008; Dwyer *et al.* 2011). The current arrangements also work against the goal of delivering comprehensive PHC that is responsive to community needs (Dwyer *et al*. 2011). Problems with the governance of Aboriginal PHC community providers receive public attention from time to time (e.g. Office of Registrar of Indigenous Corporations 2012), and reinforce a lack of trust among government funding bodies, overshadowing the good practice of the majority of service providers. The need to strengthen local governance has been acknowledged by the sector, while the need to reform the funding and accountability relationship so that it supports the development of a robust PHC system for Aboriginal people is recognized by all parties (Department of Finance and Deregulation 2010; Dwyer *et al.* 2011). Reform efforts have been initiated by several jurisdictions. This case study focuses on the Northern Territory (NT), the jurisdiction with the highest proportion of Indigenous people in its population (30% compared to the national average of 2.6% (MacRae *et al.* 2012).

Policy instrument: the regionalization project

The NT Aboriginal Health Forum (NTAHF), a tri-partite body (with representatives of both levels of government and the community-controlled sector) has been working to improve health services and the funding relationship for more than 15 years. In 2009, the NTAHF, adopted *Pathways to Community Control* (NTAHF 2009), a plan for the development of a comprehensive regional PHC system for Aboriginal communities. The goal is to provide reliable access to an agreed platform of PHC services (Tilton and Thomas 2011), with regional governance in the hands of Aboriginal communities – to the extent that they decide to take it on, and are able to demonstrate capability according to agreed standards (Department of Health and Families 2010).

Community control of PHC services is already a reality in some communities; whereas others are served by NT government clinics. Five stages of community control are articulated, and it is expected that communities will make decisions about where to locate along a continuum, with 'advisory only' community bodies and continuing NT government PHC delivery at one end, and full regional community governance and PHC delivery at the other (NTAHF 2009). Of a total of 16 regions, 5 are already under community governance and delivery (including 3 urban areas); and 6 others with some community controlled service delivery are at various stages of regional planning and/or development.

Contracting reform?

There is an intention, as yet enacted only for two PHC providers, to 'bundle' government funding into a single contract. It is intended that the negotiated establishment of a regional board taking responsibility for the delivery of PHC to the Aboriginal people of the region would result in longer-term certainty in funding levels and simplification of reporting requirements (NTAHF 2009). The allocation of funds at regional level implies greater flexibility in decisions about local service delivery and resourcing within the region. In the two rural regions currently operating in this model, governance arrangements have been tailored to ensure local constituencies have a voice (e.g. Katherine West Health Board 2003).

Accountability

While a shift in accountability arrangements towards a more relational approach is an explicit intention, it is not yet possible to detect any general change in practice.

Neither is it possible to discern progress on recognition of ACCHS accountability to their communities in formal accountability arrangements. However, the overall approach contrasts with previous tendencies (on both sides) for Aboriginal community governance to be cast as a form of separatism, and thus for providers to be seen as being isolated from the mainstream health system and from government and its resources. This is evidenced in the collaborative development of the regionalization project itself, its specification of core PHC services and the negotiated standards for assessing the readiness of a regional organisation to take responsibility for PHC governance and delivery.

Key points

Progress has been slower than expected, and there are tensions over the timing, cost and processes of development (Allen and Clarke 2011). The additional funding for implementation is tightly controlled; the capacity of the Forum to lead the project has been questioned; and media coverage of problems in the governance of some existing community-controlled health services have given weight to concerns about capacity. However, the long-term policy commitment to this direction remains; and progress, albeit slow, continues. It is too early to report on outcomes.

These reforms suggest a shift from the principal: agent contracting approach in two ways. Firstly, the provision for jointly-negotiated progress towards community governance and delivery on the basis of agreed standards (and transfer of some service delivery) represents a significant step towards a genuine partnership approach between communities and governments. It also brings the potential for patient care provided by both the community controlled sector and the mainstream health system to be better integrated.

Secondly, while compromises are required from communities that seek to take on the governance and delivery of PHC services, in this reform process the principle of community governance is entrenched in overall health system design in a practical sense, rather than simply being honoured in the rhetoric of high policy principles.

SYNTHESIS: EMERGING TRENDS AND THE NEED FOR A NEW THEORY AND PRACTICE OF ACCOUNTABILITY

The approaches adopted in Canada, New Zealand and Australia each have distinctive features, but share some important characteristics. They all represent attempts to resolve or reconcile the competing imperatives of Indigenous community-based providers of comprehensive PHC with those of government funders. In British Columbia, existing authority to govern healthcare in discrete Indigenous communities is being transferred to the provincially-based First Nations Health Authority, in the hope of side-stepping limitations of the federal government’s systems. In New Zealand, the need for family-centred health and community care supported by integrated funding, has provided the impetus for reform. And in Australia’s Northern Territory, reforms aimed at establishing a regionalised system of PHC delivery are expected to result in a shift towards relational approaches to contracting and accountability.

In spite of these differences, there are three major common themes in these emerging approaches: two that represent significant challenges to entrenched NPM practices; and one important barrier against the development of new approaches.

First, these case studies provide empirical observation of an incremental departure from ‘principal:agent’ logic in contracting. Each proceeds from recognition of Indigenous communities and organizations as long term partners rather than simply agents in the relationship with government funders and regulators. The priority given to Indigenous concepts of health and family (especially in the New Zealand case); recognition of the continuing sovereignty of the Indigenous polity (especially in the Canadian case); and acceptance of the role of community-based TSOs as both PHC providers and representatives of their communities (especially in the Australian case) all represent important departures from the 'principal-agent' concept of the relationship between funders and providers. That is, in accepting that Indigenous communities and organizations have a substantive and independent role in defining the parameters of health policies and programmes, governments are effectively recognising them as advocates and policy-makers in health and health care, rather than simply the contract-takers that is their ideal role in the NPM framework. We suggest that this is more correctly seen as a 'principal-principal' relationship; and that it represents an approach to shared governance as envisaged in new public governance theory (Osborne 2007).

The second common theme is the tendency to move towards more relational forms of contracting. 'Integrated contracting' in New Zealand, 'flexible funding' in Canada and 'bundling' in Australia are all steps towards longer-term more integrated funding contracts. This is most clear in the Canadian situation, with explicit pooling and integration of funds already in place. The intended pooling of separate funding lines in New Zealand has the creation of 'wrap around services' (that cross portfolio boundaries) as its goal, and taken together with the emphasis on evaluation, offers the potential for the development of workable levels of trust among funders and providers on the basis of shared goals. Movement towards community control in the Northern Territory on the basis of a shared policy on regionalization, an agreed delineation of essential PHC services and standards of community capacity also provides the basis for an approach to the contractual relationship based on shared goals and functional trust.

However, the case studies also indicate that reform of accountability regimes is more difficult. The sense that accountability is an 'accounting' matter (and fundamentally about the exchange of money for information and compliance) is deeply entrenched, and we found less evidence of practical reform in this regard. While other accountability pulls (to community and other stakeholders) are recognized, they do not (yet) compete as the focus of effort and consequences. Neither is there any place in NPM-style contracting for recognition of the Indigenous communities, in many cases the owners of provider organizations, as accountability holders in relation to government.

We suggest that competing views of the standing of funders and providers in relation to communities are an important source of accountability tensions in all three countries. NPM approaches are based on the idea that the purchaser is acting on behalf of citizens as 'customers', to ensure that providers meet their needs well. The Indigenous health movements, and the Indigenous TSOs they created, are explicitly acting as the representatives of communities, and the TSOs enact this role in structures and practices of direct accountability to their communities as ‘owners’. Resolving these competing claims to the role of protecting the interests of citizens/communities may not be possible – neither party can be absolved of this responsibility. However, we suggest that work to clarify the distinctions between these claims, and to accommodate both in accountability arrangements that apportion rather than duplicate measures accordingly, may be an important next step.

We also suggest that the trust between funders and providers that is required in relational contracting and lubricates accountability relationships is particularly fraught in the inter-cultural/inter-racial setting of Indigenous health care, reflecting the historical tension between Indigenous communities and settler populations (Havemann, 1999). This reality tends to heighten the importance, as well as the difficulty, of finding alternatives to principal:agent approaches to accountability.

The need for accountability is universally accepted by all the actors in these case studies, but reform is elusive. The concept of reciprocal accountability described by Sullivan (2009) may provide the basis for redesigning accountability regimes in ways that recognize the complex accountabilities held by each party. The reforms reported here suggest the possible foundations for an alternative approach to state-TSO relationships. However, we conclude that a fundamental re-thinking of accountability regimes is a critical missing element.

We suggest that Indigenous PHC is a case in which the inadequacy and contradictions of NPM-based approaches to funding and accountability are heightened, as is the potential for meaningful alternative methods to contribute to better performance. If this is correct, then the experience of Indigenous PHC TSOs has implications for broader state-TSO relationships and both further theory development and a new programme for action are required.

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PAPER SEVEN – How not to kill the golden goose

This paper (Tenbensel, Dwyer & Lavoie 2014) is another output of members of the Contracting at the Margins Research Group. The original idea was presented by Dr Tenbensel at a meeting, and was used as the basis for a grant application in New Zealand in 2012. Although the research that was intended to test the theoretical framework presented in this paper did not proceed, the writing of the paper was important in the development of my thinking about the central problem of accountability in the complex world of Indigenous primary health care.

The paper uses the concept of different accountability 'pulls' in tension with each other, as a way of thinking about and analysing the multiple accountability relationships faced by NGOs that contract with governments for service delivery. This paper was our attempt to develop a practically useful framework for organisations analysing their own accountability environments, and for funders who sought to enhance the utility of their accountability regimes, given the limited extent to which competing theories about accountability had produced useful advice (Knutsen & Brower 2010).

Statement of my role

I contributed to successive drafts, and to the developing framework, in particular by a critique of a significant aspect of its design, which supported a reduction in the number of 'poles' of accountability included in the model, thus (in my view) improving its claim to conceptual parsimony.

How not to kill the golden goose: Reconceptualizing accountability environments of community-based third sector organizations

Tim Tenbensel, Judith Dwyer and Josée Lavoie

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Abstract

For third sector organizations (TSOs) that deliver publicly-funded health and community services, accountability practices are predominantly shaped by the imperatives of government funders. However, the ensuing public management accountability regimes can undermine TSO responsiveness to communities, align poorly with imperatives of professional staff, create high transaction costs and threaten TSO sustainability. Public management literature lacks an adequate framework for conceptualizing TSO accountability. We outline a conceptual framework – the triskele – for analysing accountability tensions experienced by TSOs that could assist funders and other stakeholders with the difficult task of designing more workable and meaningful accountability regimes for all stakeholders.

Keywords

Third-sector organizations, accountability, contracting, health services, public management

INTRODUCTION

Third sector organizations (TSOs) have become an increasingly prevalent part of the public management organizational landscape. TSOs involved in publicly-funded services frequently face formidable challenges in balancing multiple accountabilities to a diverse range of stakeholders and constituencies (Alexander et al., 2010; Christensen and Ebrahim, 2006). These include government funding and regulatory agencies, the communities from which TSOs arise, practitioners and their professional and occupational associations, board members, volunteers and sector peak bodies.

Existing accountability arrangements impact on the sustainability of TSOs and the third sector in general. Managing diverse accountabilities can be challenging, and possibly debilitating for TSOs. Some authors suggest that the increasingly stringent and complex accountability requirements placed on third sector organizations by governments may have the effect of 'killing the golden goose' (Smith and Smyth, 2010), as the mission of TSOs atrophies and TSOs morph into quasi-governmental providers.

While accountability tensions are commonly identified in the literature, we argue that this issue remains under-theorized. Consequently, relevant participants, including the community-based TSOs, funders and other key stakeholders lack an adequate conceptual model for understanding and diagnosing accountability tensions. The absence of an adequate conceptual framework has helped to perpetuate accountability regimes that are blind to the complexity of the accountability landscapes in which TSOs operate. In this article, we present a framework for thinking about these problems that all key participants could use in designing and negotiating workable accountability. We begin by outlining the 'golden goose' problem. Second, we draw from TSO literature to outline a three-point conceptualization of accountability tensions. This model describes three types of accountability pull – 'upwards' to funders, 'downwards' to communities and 'sideways to practitioners. Third, we expand on this model of accountability to develop a more comprehensive framework (the 'triskele') that takes into account and additional and important manifestation of 'overstretched' TSO accountability. Finally, we show how this integrated model could be used by public managers to help reduce avoidable TSO accountability tensions and perhaps even to create accountability environments that are more workable for all stakeholders.

TSOs AS THE GOLDEN GOOSE

TSOs feature prominently in the delivery of publicly funded services. This has been shaped by a number of diverse but related developments and a long history. Publicly funded TSOs are a symbol of the responsiveness of the state to diversity. Rex (1991) noted that the British state keenly supported the development of minority ethnic voluntary organizations soon after the start of the large-scale migration in the 1960s and 1970s. Such organizations were regarded as efficient, cheap and often popular means of meeting the 'additionality', located in cultural or linguistic difference, which could not be met by the state or established voluntary sectors. The provision of separate services was a considerably cheaper and a higher profile option; the authority could be seen to be taking action at little cost and with little disruption to mainstream services (Ahmad and Bradby, 2007). Governments of all ideological persuasions have advocated and presided over increased TSO involvement in policy implementation and service delivery since the 1980s (Kendall and Deakin, 2010; Taylor and Bassi, 1998). Within the disciplines of public policy and management, the growth in TSO involvement in service provision is often attributed to the proliferation of new public management (NPM) and its advocacy of 'contracting out' (Christensen and Lægreid, 2001; Lane, 2000). Analysts argue that the downsizing or dismantling of the welfare state that was an important goal underlying NPM approaches has brought new challenges for governments in the delivery of services (such as education and health) that should enable citizens to survive and thrive in market economies, increasing concern about the failure of government to deliver in these areas, and an impetus to further reduce or remove the direct role of government (Sabel, 2004). More recently, the shift in emphasis to what Stephen Osborne (2010) calls 'new public governance' has also added impetus to the role of TSOs in the delivery of publicly-funded services.

As summarised by Smith and Smyth (2010):

> (t)he attraction of contracting with third-sector organizations – the "golden goose" – reflects many factors: pressure to contain costs, new attention to civil society organizations and their potential to build social capital and community, and the influence of New Public Management, which seeks to improve the efficiency and effectiveness of public services through contracting, privatization and decentralization. (2010: 270)

Public managers have the job of operationalizing and implementing government programmes and priorities. The golden goose of TSOs, in many situations, comes to be seen as the state's only or best hope in tackling 'wicked problems' such as reducing health inequalities. In contexts in which governments commit to such policy objectives and see TSOs as key players helping to achieve them, public managers are one set of key players in constructing and modifying mechanisms of accountability. Communities are another set of key players and can also be the source of troublesome accountability tensions.

As Smith and Smyth suggest, however, the major trends in the development of regimes of accountability to funders, while expanding the scope of TSO activity, have not made life easy for TSOs. Contracting, as a technology for public management, has become a versatile and ubiquitous mechanism for making accountability to funders manifest. In theory, contracts can be highly flexible in that contracting parties, provided that they agree, can include anything in a contract. Much contracting theory assumes that contracting parties are equal partners who are free to walk away if the terms of the contract are not agreeable. However, for most TSOs there is a substantial imbalance of power, as their viability largely depends on the availability and extent of government funding. In any case, such an imbalance of power is integral to models of contracting inspired by agency theory. Agency contracts presume that the agent is subordinate to the principal. The principal (the funder) should be inherently sceptical of the agent's performance. Thus, the TSO, as the agent, is required to 'prove' that it is performing as required.

The key question here is what do funders consider to be value for money and/or appropriate use of resources. Historically, in public administration, there have been many different ways of answering this question. The trajectory of answers has tended to start with 'input accountability' (organizations used funding to pay staff, buy materials and rent office space), through process accountability (they met procedural requirements such as timeliness of service), through output accountability (there are services they provided that we can count), through to outcome accountability (they had a tangible impact on the community/clientele).

For most publicly funded social services, the bulk of contractual requirements are expressed in terms of outputs and/or processes. While outcome-based contracts are, in theory at least, regarded as preferable, output and process accountability remain the norm because outputs and processes are things that the provider is more unambiguously able to control (whether they are meaningful or not).

Many potential drawbacks of this characterization of contractual accountability between funders and providers have been discussed in public management literature. For example, the proposition that funders are seeking 'best buys' in a competitive market of service providers is not realistic in relation to primary health care in rural settings, where service providers are hard to find, and the funder's freedom to exercise the sanction of contract withdrawal or non-renewal is compromised by the necessity of long-term and continuous care provision (Loevinsohn and Harding, 2005; Palmer *et al.,* 2006; World Health Organization, 2008).

Undoubtedly many funding agencies and their staff are becoming increasingly aware of this problem (e.g. Productivity Commission, 2010). There is widespread recognition that quantitative measurement of outputs and processes, while intuitively appealing as providing 'objective' and readily available indicators, can be highly problematic and may provide funders and providers with very little meaningful information (Radin, 2006, Ryan, 2011). Alternatively, relational or alliance contracting approaches have emerged in situations where it is not possible to fully specify the services or outputs required, where service providers must respond to the needs of clients across a broad spectrum, where continuity of long-term relationships between providers and clients are desirable, and where there is not a functioning competitive market of providers for funders to contract with (Palmer and Mills, 2003, 2005; Perrot, 2006).

In these situations, relational contracting offers an alternative model that emphasizes shared goals and longer timeframes and requires a level of negotiated trust between funders and providers rather than scepticism (Lambright, 2009; Van Slyke, 2007). This trust is limited and instrumental, and may well be breached, but in relational contracting, it is the foundation of working relationships, backed up with appropriate accountability measures (both short- and longer-term).

Nevertheless, public funders are unlikely to let go of activity-based performance requirements in contracts, and it could be argued to do so would not be compatible with the requirements of public accountability and transparency. Funders and providers often built up trust-based relationships in order to build a more nuanced picture of how well a provider was doing, but they did not and could not abandon the routines of performance contracting. The phenomenon of relational contracting behaviour co-existing with formal agency contracts has also been observed across a wide range of settings (Allen, 2002; Dwyer *et al*., 2009; Lavoie *et al.,* 2010; Palmer and Mills, 2003; Rensford 2010).

In this environment, those working for funding agencies are faced with a thorny paradox. The routines associated with contractual performance monitoring require funders to define the outputs, processes and/or outcomes they seek to fund and to monitor for accountability purposes. But public sector funding agencies contract out to TSOs precisely because they do not know how services should be delivered to particular marginalized groups, or what constitutes effective service delivery.

This creates some unsettling dynamics because TSOs are accountable to stakeholders other than funders. Indeed, they often have very well-developed notions of how they are accountable to the communities they serve and the practitioners who work for TSOs. A prominent theme in third sector organizational literature is that the viability of TSOs may be fundamentally threatened due to the accountability demands placed on them by public funders, particularly through performance-based contracting. As Smith and Smyth conclude, '(i)nadvertently, current policies and practices may be "killing the golden goose" by undermining effective performance and sustainability and community and civic engagement in third-sector organization' (2010: 297).

Smith and Smyth argue that over time the benefits of contracting for TSOs may be outweighed by increased difficulties in maintaining organizational mission. Similarly, Christensen and Ebrahim suggest that 'a central challenge for nonprofits and funders alike lies in creating a culture of accountability that is built on mission and purpose rather than external scrutiny' (2006: 208). This mission, the expression of an organization's commitment to a particular community, is not readily acknowledged or taken into account by government funders (Ebrahim, 2003). A conventional agency theory response, however, is that such considerations are well and truly 'out of bounds' for public managers. After all, only the principal's requirements and expectations have normative legitimacy, and it is presumed that any agent will be predisposed to shirk or cheat. As a consequence, the principal-agent model treats any difference in motivation that stems from these organizations' missions as problematic by definition.

While this issue of tension between the imperatives of funders and broader mission of TSOs is crucially important, the accountability landscapes of TSOs are shaped by a broader range of factors. Public management practices are not the only threat to the health of the golden goose. TSOs may also be challenged or even threatened by the demands from their communities or from staff. We argue that these demands and pressures need to be considered as parts of a dynamic, inter-connected system rather than in isolation. What is needed, we argue, is a framework for analysis that moves on from the principal-agent stand-off; accepts the broader world of other accountabilities; and makes the whole range of accountabilities and their measures visible in some way could enable the funders to focus on a smaller and more useful or compatible set of accountability requirements.

MAPPING TSO ACCOUNTABILITY ENVIRONMENTS

Unpacking accountability

Accountability is a notoriously slippery and multi-faceted concept. Some authors prefer a relatively narrow meaning (Mulgan, 2000), arguing that the term should be limited to considerations of governmental accountability. However, accountability is generally used in literature on non-government organizations as an 'umbrella' concept that covers a multitude of different understandings. This article adopts the following broad definition suggested by Christensen and Ebrahim (2006: 196): '…accountability refers to being answerable to stakeholders for the actions of the organization, whether by internal or external initiation'.

Accordingly, different types of accountability entail different ways of answering the question 'how do we know if a third sector organization is meeting the needs of its stakeholders?' The literature on accountability generally distinguishes between two features – namely, accountability to whom, and accountability for what. TSOs may be accountable to a diverse range of constituencies, including their membership, the population they serve, the government agencies and other organizations that fund or donate money and resources to them, regulatory and accreditation agencies, the communities in which they are located, other organizations with which they form collaborative relationships, the staff they employ and the volunteers who donate their time. The sorts of things that TSOs may be accountable for include paying for particular inputs (e.g staff), producing particular outputs or outcomes, compliance with laws and regulations, meeting specified sets of organizational or professional standards, acting in accordance with the mission of the organization, having an impact on policy, adapting to ever changing community needs, and upholding the organization's public reputation (Candler and Dumont, 2010). Any or all of these dimensions of accountability may be relevant to particular TSOs. But only some of these accountabilities are likely to be operationalized through specific, codified mechanisms and routines.

Given the broad range of stakeholders TSOs are accountable to, and the variety of things that they might be accountable for, there is potentially a vast number of specific, discrete accountabilities that could be identified for any single organization. Broadly speaking, this inductive approach is consistent with 'stakeholder theory' which suggests that organizations scan their environment for all relevant stakeholders, and conceptualize performance in terms of addressing the different requirements of multiple stakeholders (Donaldson and Preston, 1995; LeRoux, 2009; Steurer, 2006). Candler and Dumont (2010: 263) follow this logic in identifying nine types of stakeholders and ten areas of activity that TSOs could be held accountable for. When these are conceived as two separate dimensions and cross-tabulated, this produces a matrix of ninety cells. The matrix is useful because it draws attention to less visible components such as compliance with regulations (for example in radiation safety, biological hazards, blood products, mandatory accreditation and mandatory police record checking) which taken together can add up to a great deal of activity.

While this matrix identifies empirical possibilities, Candler and Dumont also comment that many cells will be empty for most organizations (2010: 273). Clearly, a ninety cell matrix is not so useful for the task of theorizing accountability, although it does provide a very useful coding framework for empirical research. We suggest that public managers in funding agencies would be better served by a more parsimonious conceptual framework that boiled down the multiple measures of accountability to a few important categories and made clear the relationships among them.

One way of getting to a more parsimonious framework for diagnosing accountability tensions is to look at the extent to which the 'to whom' and 'for what' dimensions of accountability are actually independent of each other. Perhaps these two aspects are tightly coupled. For example, TSOs are likely to be accountable to government funding agencies for the ways in which financial resources are used, for quantified service outputs, and for assuring compliance with the law and relevant standards, whereas they tend to be accountable to their members for acting in accordance with their mission and providing responsive care.

The three-pole framework of TSO accountability

The centrality and 'pull' of accountability to funders for the use of (usually public) funds is a prominent theme of TSO literature. (O'Dwyer and Unerman, 2008: 803-804) describe this as hierarchical accountability which 'is narrowly functional, short-term in orientation and favours accountability to those stakeholders who control access to key resources'. Knutsen and Brower (2010) describe it as 'instrumental' accountability which constitutes the 'instrumental, resource-seeking, and practical dimension of the organization' (2010:590). What this accountability is for, of course, is the use of these resources. Knutsen and Brower identify expressive accountability which is 'value-oriented and resource-consuming'. The expressive type of accountability is oriented to the community, which may manifest in concrete or abstract ways. Ospina *et al*. identify a 'downwards pull' to community, which they describe as 'members, clients, community leaders and other organizations'. This is accountability *for* 'priority and mission setting; provision of services, programs and information….adherence to mission; educating the identity-based community' (Cribb, 2006; Ospina *et al*., 2002).

This accountability pull is particularly pressing for those TSOs that have stronger links to their communities. The communities in question are those that define themselves in terms of locality and/or ethnicity or other group characteristics and that have a tangible organizational identity and presence in the form, inter alia, of their TSOs. Examples include indigenous organizations and others that form specifically to address the needs of under-served and marginalized groups such as single parents or residents of disadvantaged neighbourhoods. Because TSOs with strong links to their communities are likely to experience strong 'pulls' from their communities, as well as sharing with those communities the lack of status and credibility that is part of marginalization, these organizations are also likely to face an even more complex balancing act when compared to other TSOs with weaker or indirect links to community. In this respect, the term 'community' is more encompassing than the term 'service users'. Service users may well be drawn from the community in questions, but accountability to service users is only one aspect of accountability to communities.

Many authors also identify ‘sideways’ or ‘lateral’ accountability as an accountability pull that is distinct from upwards and downwards accountability (Brown and Moore, 2001; Christensen and Ebrahim, 2006; Ospina *et al.,* 2002). Christensen & Ebrahim define lateral accountability as accountability ‘to one another and themselves, as the staff, volunteers, community board members, and the community agencies with whom they work’ (2006: 198). This can take a number of forms. The common denominator of all these forms is that of lateral accountability to practitioners. Organizations may be directly or indirectly accountable to the standards of practice of occupational and professional groups (Kim and Lee, 2010). Sociological literature on TSOs has identified tensions that emerge when organizations develop and grow beyond the initial energy of founding members. Often, this occurs as a natural outcome of success-driven growth. In particular, professionalization of organizational staff has been identified as a major potential source of internal tension, particularly when professional and occupational norms regarding service delivery diverge from community expectations (Hwang and Powell, 2009). For example, in the health sector, medical and other health professions usually form an important part of the TSO workforce, and TSOs therefore need to be cognizant of the demands and requirements of professional groupings. TSOs may have very limited capacity to shape clinical and service roles as these are constrained by traditional scopes of clinical practice and demarcations between them, defined by professional bodies.

Another form of lateral, or ‘peer’ accountability can be manifest in network relations between provider organizations. TSOs may be part of networks of providers in a particular service area, or they may be part of networks that attempt to bring different sorts of providers together in order to tackle joined-up, ‘wicked’ problems. Formal or informal provider networks entail some level of responsibility or answerability to other organizational members of the network. At the most ‘integrated’ end of the spectrum of network co-ordination, practitioners may eventually identify with the aims, goals, and needs of the overall network rather than with their particular organization (Keast *et al.,* 2007)

Having identified the three key poles of accountability, we can now give more detailed descriptions of the possible tensions between the poles.

Tensions between funder and community accountability

The tension between accountability to funders and accountability to community is likely to be most marked when government agencies demand rigorous accounting for resources used and quantifiable outputs in terms that are not aligned with the financial accounting and activity monitoring needs of the organizations themselves (for management purposes) or those required for reporting to community boards and other community forums. In this situation, community organizations will regard the funders' requirements at best as unwanted distractions and at worst as seriously diluting organizational resources and energy that could be used to advance the organizational mission.

This problem has many causes. Government agencies that fund TSOs generally seek to collect data in a standardised way from all providers, in order to meet requirements of the funders' accountability to central government agencies and for public reporting.

In many cases, this limits what can be counted and also defines how it is to be counted. Other reasons for this problem include the logistics of agency contracting (specification of requirements in advance and in isolation from potential providers), the prevailing managerial culture of the agency or the heightened political sensitivity that often applies when funding is provided to marginalized groups and organizations (Dwyer *et al*., 2011).

This creates tension when communities seek more flexible, less bureaucratic forms of service delivery that do not make seemingly arbitrary distinctions between closely related needs and services. The transaction costs of hierarchical accountability may be increased because TSOs take action to avoid the potential negative impact of fragmented funding on models of care (such as comprehensive primary health care) that require an integrated, responsive approach to the presenting needs of the person, family or community (Dwyer *et al*., 2011; World Health Organisation, 2008). Rather than sacrificing integrated approaches, providers devote additional resources to 'retrofitting' the services actually provided to the funders' categorization. Precision in activity reporting is lost, and potentially, these requirements may impede TSOs from responding to emergent needs of the community – the weight of compliance activity may impede the agility of the TSO (Lavoie *et al*., 2010).

Tension between practitioner and community accountability

Practitioner accountability, the third 'accountability pole', results in two theoretically important sources of accountability tension. First, tension between accountability to peer practitioners and organizations and accountability to communities may manifest in a variety of ways. There is a potential discrepancy between practitioner norms and responsiveness to clients and communities. Even though professionals are socialized into an ethic of service, professional standards and practice can come into conflict with community expectations. In fact, the very concept of 'service provision' may be inappropriate to some communities (O'Brien and Sullivan, 2005). Accountability to one's peers in practice is based upon explicit and implicit codes of practice and ethics. Tension between community and peer accountability may be particularly important where there are social and demographic differences between staff and community (Hwang and Powell, 2009). The tension between community and practitioner poles may also be manifest between community-based organizational boards and the professional staff of the organization. Another potential source of tension is apparent when professional and inter-professional routines and requirements such as referral practices and respect for patient confidentiality create obstacles, from the point of view of service users and communities (Kronstal, 2009).

There are other kinds of tensions between professional and community accountabilities. TSOs may be constrained from offering the sorts of services communities seek because of professional staff accountability to conform to occupationally-defined scopes of practice. Managers may work together across organizations to pool resources and collaborate closely, perhaps to lobby the government, develop a service delivery model or share corporate services (such as payroll and information technology). These activities may generate accountability obligations that community members regard as diluting accountability to them (for example, the capacity of the board to decide independently on the forms of financial or HR reporting they require). Similarly, expansion of the range of services through participation in a network offering training positions may bring accountability for the provision of defined categories of technical experience for junior professional staff. This may conflict with community preferences for more joined-up, seamless services.

Tension between funder and practitioner accountabilities

Finally, funder and practitioner accountabilities may be in tension when perceived obligations to the organization's staff are affected by the encroachment of regimes of instrumental accountability. These accountability tensions may have similar origins and play out along similar lines to managerial/professional tensions in larger public sector organizations (Brandsen, 2009). This is more likely in larger TSOs that have a greater differentiation of the workforce. According to Hwang and Powell (2009), such tensions between managers (who have the most direct responsibilities to funders) and practitioners are most likely when organizations are staffed by more traditional professions such as medicine, while nursing occupies an intermediate space. Many TSOs are smaller organizations, with less internal differentiation. However, the tension between accountability to funders and to staff can be apparent in other forms that are even more pertinent. Meeting compliance requirements may limit TSO capacity to meet specified contractual requirements within budget. Funder and practitioner accountabilities may also be in tension when scopes of practice of professional groups conflict with contractual accountability to funders. For example, a TSO may be challenged in recruiting nurse-practitioners (nurses with advanced training and authority to prescribe medicine) because of budgetary constraints, even though this may be the only feasible way to meet contractual requirement to provide primary care nursing services. Finally, when TSOs are part of inter-organizational networks of TSOs, their obligations and accountabilities to such networks may be in conflict with their accountability to funders (Choudhury and Ahmed, 2002).

Connections with public management frameworks

The above account of competing 'accountability pulls' has important resonances with the wider literature on varieties of social co-ordination which has been very influential in understandings of public management tensions over the past 20 years. In this literature, hierarchies, markets and networks are identified as theoretical 'ideal types' of social co-ordination (Thompson, 2003; Thompson *et al*., 1991). Each type of coordination, in turn, entails a distinct understanding of accountability. This framework has proved very useful for diagnosing and making sense of organizational tensions (Entwistle *et al*., 2007; Tenbensel *et al*., 2011).

However, some adaptations are necessary to link the TSO literature on organizational accountability and public management concepts. For most TSOs, there is little to distinguish hierarchical and market accountability requirements, as these tend to be fused in public sector regimes shaped by new public management (Considine, 2001). Accountability to funders typically involves a combination of hierarchical and market elements. That is, while technically the method of holding to account is based on parties contracting with each other and thus mutually accountable only for meeting the terms of the contract, in practice funders require responsiveness to changing circumstances and forms of financial control that are more consistent with hierarchical relationships. For example, some funding agencies in Australia require that contracting organisations not only deliver the specified services at the agreed price but also demonstrate that the funding has all been used for that purpose. For the sake of parsimony and consistency, then, the categories of market and hierarchy are fused into a single 'funder' accountability category that is consistent with 'upwards' accountability in the TSO literature.

The other important difference is that in much of the 'hierarchies, markets, networks' literature, there is no equivalent of 'downwards' accountability to communities. For most authors using this framework, the term 'network' conflates or fuses lateral relationships between organizations providing services and relationships between citizens, communities, service recipients and organizations that provide publicly funded services. Accordingly, some authors (Newman, 2001; Pierre, 2000; Tenbensel, 2005) have argued that the inclusion of 'community' as a separate mode of co-ordination is necessary in public management. This is particularly pertinent to service sectors such as health, social services and education in which practitioner expertise-based accountability supports and promotes quite different routines than those associated with community-based accountability.

THE 'TRISKELE' FRAMEWORK OF TSO ACCOUNTABILITY TENSIONS

This framework, drawn from TSO literature, identifies the three key accountability poles relevant to TSOs. However, not all accountability tensions faced by TSOs are attributable to differing expectations emanating from different accountability poles. Accountability tension can also be exacerbated when there are multiple, differing accountability requirements emanating from within a single pole. For example, a TSO may have multiple contracts with a single funder or contracts with multiple funders (Ebrahim, 2003). Each different contract requires reporting against different outputs, processes and/or outcomes, and different ways of compiling and reporting the performance information.

Recently, research into indigenous health service contracting in Australia highlighted this type of problem (Dwyer et al., 2009). Indigenous health providers are attractive to many different government funders, and/or to many different parts of a single funding agency. This often leads to unintended consequences as the TSO becomes 'over-burdened' by contractual accountability requirements simply by virtue of having to manage a plethora of specific contracts, each negotiated separately without funders considering the fit with other contracts (Dwyer et al., 2011; Lavoie et al., 2010). Fragmentation of accountability requirements within a particular locus of accountability also ratchets up overall accountability tensions.

The conventional accountability triangle, therefore, needs to be supplemented to take account of this increasingly common dynamic. The conceptual framework we propose can be depicted in the form of the ancient Celtic symbol of the *triskele* – a motif consisting of a triangle of interlocking spirals (see Figure 1).

The three vertices each represent a distinct type of accountability. Imagine that the three accountability points of the triskele are connected by strands of rope (see Figure 1). The rope signifies both the 'boundary relationships' between the TSO and its key constituencies (communities, funders, practitioners), and the organisational resources and energy required to attend to these accountability requirements. The rope strands are capable of absorbing a certain amount of tension, but have a breaking point which organisations seek to avoid. The TSO and the services it provides sits within the inner triangle of the triskele, subject to pulls from each pole. Tensions between poles are those tensions that organisations experience between manifestations of upwards accountability to funders, sideways accountability to peers and downwards accountability to communities. These tensions may be exacerbated when differences between the accountability expectations associated with two of the poles increase (see Figure 2). A strong pull in one direction may have the unintended consequence of distorting or disabling the organisation's response to other accountability pulls.

Tensions within accountability points are depicted by increasing the layers of the spiral around a particular point. Here, the rope is stretched further (or substantially more rope is required) in order to cover off accountability to funders. In Figure 3, which illustrates the 'overburden' problem described above, we can see that a greater proportion of the rope is required to attend to accountability to funders than is the case in Figure 1.

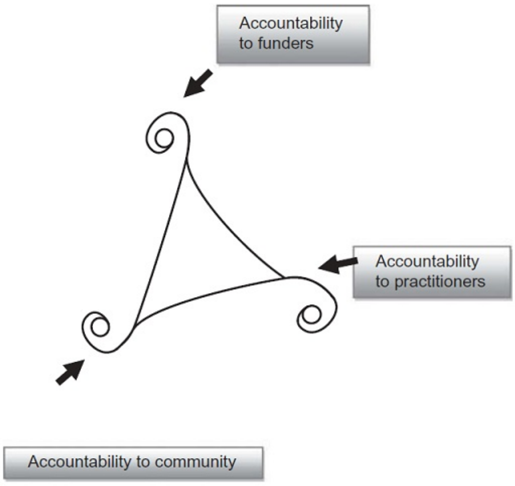

Figure 1: The TSO accountability 'triskele'

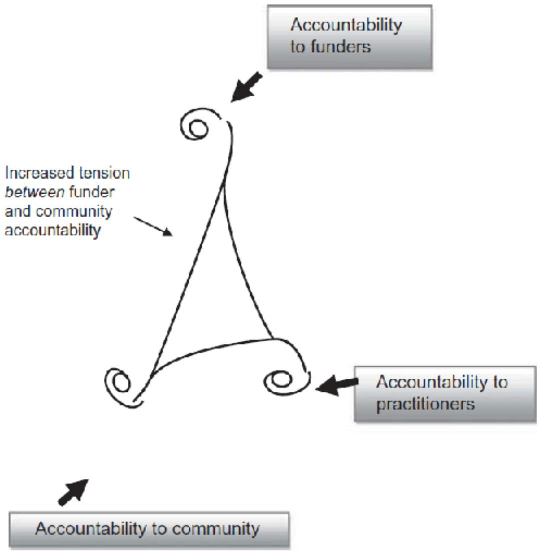

Figure 2: Increased tension *between* accountability poles

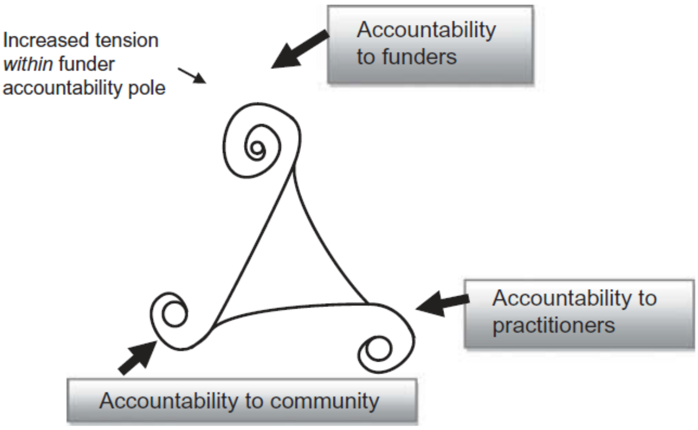

Figure 3: Increased tension *within* accountability poles (the overburden problem)

TSOs may also experience accountability tensions when their community constituency is internally divided. Internal community power struggles may be played out within the TSO, or between different formal and/or informal manifestations of the community. Examples of this would include tensions between accountabilities to organisational board members and service users (potentially quite different manifesta- tions of community); between the community leaders and the community managers of the TSOs; or between families competing to secure employment or advocating for access to a larger portion of services provided by the TSO).

There may also be significant tensions within and/or between networks of practitioners employed by TSOs. For example, inter-professional disputes over regulated scopes of practice that play out in larger mainstream health care organisations can just as easily affect TSOs (Hwang and Powell, 2009). TSOs may also experience competing accountability obligations to different inter-organisational networks and partnerships they are part of. By incorporating the concepts of 'between-pole' and 'within-pole' tensions, the triskele model provides a way of visually depicting the specific nature of accountability conflicts that are pertinent to any particular TSO.

Using the triskele framework to inform public management practice

The triskele framework provides a useful advance in the conceptualisation of TSO accountability for researchers in this area. However, it also has the potential to provide practical benefits in that it could be used by public sector funding agencies, in conjunction with TSOs, to develop a workable map of the accountability landscape of TSOs. In doing so, public managers may perceive ways in which accountability requirements of different stakeholders overlap and conflict, and potential strategies to reduce the tension and/or overload. They could thus assist in the process of keeping the overall level of accountability tension to a tolerable level for the organisation, and reducing the possibility that the 'golden goose' is killed as a consequence of intolerably conflicting accountability requirements.

With this in mind, we suggest that the triskele model provides a rather different starting point for public managers involved in negotiating accountability requirements with TSOs. These are the opportunities that arise, for example when re-negotiating a funding agreement, or when entering into new agreements. This work is generally undertaken by middle management who are, in turn, accountable to senior management. These mid-level public managers have an important role as 'boundary-riders' between the worlds of public sector accountability and third sector organisation service to communities.

The first, and the most basic, application of the framework can be characterized as 'first do no harm'. Public managers can use the triskele framework to help ensure that new, or renegotiated, accountability requirements do not inadvertently increase overall accountability tension for a TSO. This would require a capacity to understand (or at least a curiosity about) the overall accountability landscape of the TSO. At the very least, public managers should endeavour to find out how well or badly their account- ability requirements fit with other requirements from the same funder. It may not be possible for individual public managers to sort out or simplify the knot of multiple accountabilities to funders. However, they may be in a position to identify potentially conflicting accountabilities to the same organisation (or the same part of the same organisation), and to initiate conversations between different parts of a single funding entity, or even between different funding organisations. Using the triskele to help identify the 'overburden' problem depicted in Figure 3 may help stimulate the design of 'integrated contracting' in which funders initially attempt to align their multiple accountability requirements.

Secondly, the framework can be used to generate 'best-fit', contextually specific solutions to different types of 'between-pole' accountability stretching. Where possible, public managers should be encouraged to play an active role in facilitating environments in which TSO accountability requirements between the points of the triskele are better aligned. This is more than relational contracting (although relational contracting is likely to play an important part of it). The best space for this is currently around negotiation of accountability for outcomes. All three points of the triskele speak the language of outcomes, even though they may each have their own dialect. This common platform of outcome accountability can be used by public managers to stimulate productive dialogue about which outcomes, and which measures and thresh- olds, are more meaningful to various stakeholders.

We should point out here that a relational and more consensual approach to design of accountability requirements does not necessarily mean that funders are 'locked in' to problematic long-term relationships with TSO providers. In fact, if accountability requirements are better aligned (and valid), they are both more likely to elicit enhanced TSO attention to performance and to enable emerging problems to be identified (by accountability holders). Thus funders may have stronger grounds for intervening in, or even exiting these relationships because 'poor performance' would mean that the provider is unable to deliver what the *community* wants.

A third implication of the triskele is that public managers should attempt to build into their thinking and their consideration the 'collateral' impact of changes to accountabilities to practitioner bodies, over which they may also have some influence. Use of the triskele framework provides a way of considering these changes as part of an interconnected system.

Fourthly, the triskele could serve as a foundation for facilitated conversations about accountability between representatives of TSO providers, funders, communities, practitioners and other stakeholders. For example, funders could sit with TSO sector representatives or individual organisations and map all the relevant accountabilities; then figure out which accountabilities belong primarily or overwhelming where. The triskele framework and the rope metaphor can provide a succinct visual image of the accountability landscape to be used for such purposes. For example, for a particular, one of the 'between-pole' tensions (for example, between community and practitioner) may be the most stretching at a particular time, while the others are less problematic. A second TSO may be facing the overburden problem *and* divergence between accountability to funders and community, and its profile would be quite different. A third TSO may be particularly affected by tensions between conflicting practitioner requirements, and associated tensions between the funder and practitioner expectations. Each of these situations could be depicted by different versions of the triskele image. This visual representation could be used to prompt stakeholders to explore and discuss the parts of the triskele that are less familiar to them in order to help generate a fuller picture of accountability demands. If used to stimulate discussion, different stakeholders may well 'draw' the triskele differently, and these differences in perception could provide the basis of further conversations about why these perceptions differ.

Finally, this integrated framework can be used to help TSOs and their stakeholders assess new or prospective developments that are likely to impact the organisation's accountability environment. Examples of such developments include changes to high- level government policy, changes to public sector performance reporting regimes, new requirements of professional accreditation, or changed governance arrangements of the TSO. As well as these external perturbations, the framework enables TSOs to assess holistically the impact of any innovations in accountability requirements. This would be the point at which, for example, a possible solution to the 'overburden' problem such as integrated contracting (Pomeroy, 2007) could be assessed in terms of its implications for the TSO's accountability to practitioners. That is, would integrated contracting, in which funding for different health and social services was pooled, have implications for staff and their professional accountability? Where new initiatives are proposed to reduce tension between practitioner and community expectations of TSOs (such as client-led design of service delivery), how would these affect existing accountabilities to funders? The implication is that careful diagnosis of the nature of accountability stretch is necessary, and that particular reformulations of accountability that may be in vogue at a particular time may or may not be appropriate to the context of particular TSOs.

CONCLUSION

We have developed the triskele conceptual model of accountability tensions for third- sector organisations that has the potential to be used creatively by public managers and a wide range of stakeholders relevant to third sector provision. This framework represents an important advance in that it considers accountability to practitioners as an element of accountability landscapes that is of equal importance to the more commonly recognized loci of TSO accountability (funder and community). The distinction between accountability tension between points, and within points is also an important advance. Our model aims to fulfil two important functions – firstly to provide a general diagrammatic picture of accountability landscapes that is able to capture the multi-faceted nature of TSO accountability (the triskele), and secondly as a means of conveying information about specific accountability landscapes by providing for different manifestations of accountability tensions. In this way, we envisage that this conceptual model can make an important contribution to theoretical and practical discussions about the redesign of TSO accountability.

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Impact

Dwyer et al. (2014) was one of the top 3 most accessed articles in the Journal in 2014, and was given open access status as a result (accessed 21 October 2015 at: http://www.tandfonline.com/toc/rpxm20/16/8). It is too early to assess the academic impact of this paper, which has only two citations (Google Scholar 21 October 2015). Tenbensel, Dwyer and Lavoie (2014) has six citations (Google Scholar 21 October 2015).

The international journal in which both of these papers were published has an impact factor in 2014 of 1.027 (Thomson Reuters 2015 Journal Citation Reports) with a ranking of 16/46 (Public Administration).

Literature review: accountability methods and effectiveness

The published papers above review selected evidence, with a focus on accountability for the NGO sector, and particularly for Indigenous health organisations. The literature review reported in this chapter is focused on empirical research on accountability methods, relevant to relationships between government agencies and service providers particularly the NGO sector, but also other providers of health and social services, and a small collection of recent papers addressing current accountability regimes for ACCHOs.

Definitions of accountability

The empirical mainstream public administration and third sector research found in my search is highly varied, but not as extensive as I expected. Recent work is tending to move on from the 'increasingly sterile polarised debate' between old public administration and new public management (Tenbensel 2005:268), towards a focus on networked governance and multiple modes of accountability. However, NPM thinking, methods and institutional arrangements continue in practice, and are seen as likely to continue (Shaw 2013; Tenbensel 2005; Salamon 2000). The concepts and terms require explanation in this specialised field rich with contending theories.

In Western thought, accountability is a relatively new concept (in spite of the old origins of the word, traceable back to the 11th century English 'doomsday book'), and its meaning has been strongly contested. Mulgan's well known definition emphasises the core elements of 'hard' accountability – an obligation to report to an external person or body, which holds authority both to require an account (of performance and/or compliance with the requirements of the role or purpose), and if necessary to impose sanctions (Mulgan 2000). This definition has been further developed, but is fairly broadly accepted. Boven's (2007) definition is nicely operational:

> *Accountability is a relationship between an actor and a forum, in which the actor has an obligation to explain and to justify his or her conduct, the forum can pose questions and pass judgement, and the actor may face consequences (p. 450).*

Several typologies have been published (Williams & Taylor 2013; Pestoff 2011; Romzek & Johnston 2005; Dubnick & Frederickson 2010), which are largely variations on Day and Klein's five types of accountability (1987:26, cited in Bovens 2007): political (or democratic), legal, administrative, professional and social. There are also different (and sometimes confusing) ways of thinking about and distinguishing between the goals and methods of accountability (reviewed in Williams & Taylor 2013). These frameworks are considered in their own right in Chapter 5.

The alternative definition of accountability, which seems to be losing currency in the mainstream public administration literature, is broader and is accused of having a tendency to conflate accountability with a sense of responsibility, as in the original debate between Friedrich and Finer in the early 1940s that established the modern meaning of the term (Mulgan 2000:557). That is, for some authors, accountability includes an internal or shared sense of social or moral obligation, without the elements of a reporting relationship to an external authority or the possibility of sanctions (see Cribb 2006:38-45 for a review of this thinking). However, the concept of 'voluntary accountability' (Koop 2014; Karsten 2015) – organisations establishing and publishing measures to allow stakeholders to monitor their work – and some related terms are of interest for my purposes.

These conceptualisations are distinct from (though overlapping and often conflated with) the mutual obligations of the parties to a contract to fulfil its terms, generally enforceable through litigation. In law, a contract is an agreement freely entered into by independent parties that involves exchange (typically of goods and/or services for money), rather than an authority relationship per se. However, the obligations of contracted service providers to report performance and compliance (supported by the growing technical capacity to use data to monitor performance) are central to accountability in contracting with the third sector. The contractual accountability of an agent to a principal remains an important current method in the governance of public services under any paradigm, and this meaning of accountability is also important for my purposes and in the research literature.

Bovens (2007) noted that accountability is something that started as an instrument for ensuring effectiveness and efficiency of public governance and has become an icon, an end in itself, and a concept in need of rescue 'from its advocates and friends' (Bovens 2007:449, citing Dubnick 2002). Bovens (2007:448) and others describe it as a 'golden concept', universally accepted as a good thing (Saltman 2012); and there is a tendency for it to be conflated with other 'good things', as illustrated by Dubnick and Frederickson (2010:i150):

> *…the … program shows that hollowed-out or third-party agencies and programs are less well managed, and presumably, therefore, less accountable…*

The related concept of governance

Accountability needs to be considered in relation to governance, the meaning of which is also complex. Dodson and Smith (2003:1) define it as:

> *the processes, structures and institutions (formal and informal) through which a group, community or society makes decisions, distributes and exercises authority and power, determines strategic goals, organises corporate, group and individual behaviour, develops rules and assigns responsibility.*

The common meaning (for example corporate governance as the system of control and authority for a corporation) is not quite what current public administration writers usually mean (Heinrich et al. 2010 is an exception). Governance is used in a particular way, within the discourse of 'networked governance' and 'New Public Governance' (Osborne 2007) which are suggested to constitute a new paradigm supplanting NPM.

In this construction, governance is used to denote the arrangements for managing and controlling government programs (and policy development) in an era when services, programs and even policies are produced by interdependent actors in networks[14], of which the public sector is a participant and leader or coordinator. The relevant characteristics of the era are defined as outsourcing and public-private-NGO partnerships, or 'hollowed out government', or 'the contract state', or 'third party government'.

'Networked governance' or New Public Governance (Osborne 2007) is thus defined in contradistinction to what are seen as its two predecessors. The first is the idealised era of old public administration (in which the public sector is characterised as both regulating and producing public services – i.e. plain 'government' rather than 'governance'). It is worth noting that this characterisation was never correct in relation to health and social services, or several other fields (Salamon 2000; Tuohy 2003). The second era is the subsequent NPM push for government both to exit some of the field (e.g. running telcos and power networks) and to manage the irreducible remainder through contracts or contract-like arrangements (e.g. Hood 1991).

One of the important links between governance and accountability for my purposes is the increasing interest in accountability as an antidote to the network governance 'problem of many hands' (Thompson 2005) or diffusion of authority and responsibility.

This brief overview of relevant terms and concepts needs to include a reference to the concept of new public value (NPV) or public value management (PVM), which is also seen as a successor to NPM. From the point of view of the public sector, the NPM paradigm had

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[14] The term 'network' is also a technical one, and shouldn't be seen as implying a cozy club of influence or access (although that may happen). It signifies here the fact that the problems governments need to solve, or the needs they set out to meet, cannot be met by either the public sector, or any other body, acting alone. The fact that this is not an entirely new phenomenon needs to be noted.

reinforced the hierarchical accountability of public sector agencies to the political level, with stronger delineation of the direction-setting role of parliaments, ministers and other political office holders (Christensen & Laegreid 2001: 96-101). Current public administration models seek to reframe the role of government agencies and public servants now that the idea that policy and execution can be effectively separated is losing favour. Public Value Management (e.g. Stoker 2006) is a framing of the public sector management style seen as most effective for the era of networked governance, with the achievement of public value as its core goal, building on the work of Moore (Moore 1995, 2013) and others. While it is sometimes described by its champions (including Stoker 2006 and O'Flynn 2007) as a 'new paradigm', others argue that it is 'less a new paradigm than it is a repackaging of ideas and principles' derived from public administration and governance (Shaw 2013). These contentions serve as a reminder that the new is almost always built on the foundations if not the full architecture of the old, and 'new' approaches to accountability and governance are likely to retain characteristics of both public administration foundations and NPM institutional arrangements, inter alia.

Literature search strategy

As described in Chapter 1 (under the heading *Literature review methods*), a methodical (but not 'systematic') literature search was conducted, supplemented with hand searching. The aim of this review was to address two questions, the first of which is the focus in this chapter: *What is the recent evidence on contractual accountability regimes relevant to the relationship between health and community sector NGOs and their funders, and the need for alternatives?*

The second question (*What conceptual frameworks, relevant to PHC and the relationship between government funders and the ACCHO sector, might support a new approach to accountability relationships between the ACCHO sector and government agencies?)* is the focus in Chapter 5.

In short, the empirical research literature, along with a small collection of directly relevant Australian papers, is used in this chapter to address the first question, and the theoretical and framework-development literature is used in Chapter 5. One search was conducted for both purposes.

The search terms were: *public sector OR third sector OR NGO OR not-for-profit AND governance AND accountability.* Various additional subject terms were used to suit the requirements and utility of the data bases. The data bases searched were ATSIS Health, Australian Policy Online, CINAHL, Expanded Academic ASAP International, Oxford Journals, Proquest Health Management, PubMed, SAGE, Closing the Gap Clearinghouse (AIHW), SCOPUS and Web of Science.

The exclusion criteria were:

- Papers published before 2009
- Papers focused on accountability within government or public service only, without reference to contracted service delivery
- Papers of little or no relevance to the review questions, in spite of using relevant key words in the description. While this criterion seems highly subjective, it arises because of inadequacies in either the search strategy or the data bases that led to the initial inclusion of papers that perhaps only mentioned accountability in passing, rather than addressing the topic in any substantive way.

A total of 455 articles were found, of which 356 were excluded. Ninety-nine abstracts were read, and a further 64 papers were then excluded. Of the 35 papers remaining, a further 25 were excluded after being read, and one was found to be more relevant to the contracting topic and is included in the literature review in Chapter 2. These 9 papers were supplemented with a further 23 peer reviewed articles, four books, two book chapters and four commissioned research papers on institutional or government websites found through the advice of colleagues or by hand-searching of relevant journals and of reference lists in the papers (without the post-2009 restriction), making a total of 42 sources.

For this chapter, an additional exclusion criterion was applied, to exclude papers that do not report original empirical research or are not methodical reviews of empirical research. One inclusion criterion was used: papers that address current accountability regimes for the ACCHO sector. The twenty-one papers reviewed for this chapter generated evidence in relation to current practice in Australia, the question of performance and its measurement in contracted service delivery, the challenge of multiple accountability relationships and goal displacement, the question of voluntary and community accountability, and the question of alignment between governance and accountability measures for NGOs.

Evidence regarding current Australian practice

A small set of publications addressing the challenges of accountability in Australian Aboriginal health were found (Haynes, Holloway & Thompson 2014; Martin 2014; Moran & Porter 2014; Moran, Porter & Curth-Bibb 2014). They generally confirm the findings of *The Overburden Report*, while reporting some progress on the efficiency and usefulness of accountability reporting regimes, and on the related question of fragmentation of funding. They also address the challenge of unbalanced accountability 'pulls' as between government funders and local communities.

While several international authors note the problem of the cost of producing data for accountability (Dubnick & Frederickson 2010; Millar 2013), it is a universal theme in this small set. Haynes, Holloway and Thompson (2014) surveyed 21 ACCHOs in Australia about the reporting requirements of their government funders, with a focus on the Commonwealth Department of Health. This commissioned research took the findings of *The Overburden Report* as the basis for assessing the impact of the Department's efforts to improve efficiency and reduce duplication of reporting. Most respondents reported improvements in the requirements and the format; and identified benefits for the ACCHO sector of having the data. Those with good relations appreciated a quarterly review process with the local grant officer, and valued the feedback they received. Concerns about reporting were not different in type from those found in *The Overburden Report*. For some respondents, lack of feedback on some data reporting was a particular concern, as was the representation of their work through the National Key Performance Indicator (KPI) collection. The ACCHOs sought more comparative feedback, and responses to positive results. The problem of multiple requirements from multiple funders was not seen to have improved.

Martin (2014) reports on a review commissioned by the Commonwealth Department of Health, to assess improvements in the efficiency of ACCHO reporting regimes over a decade.

Significant progress was found, while problems of duplication of information in different forms for different government funders remain. The introduction of online reporting, and the use of the national PHC data set, known as the National KPIs (Council of Australian Governments 2008), are significant achievements. Overall, the report describes the funding relationship between ACCHOs and the Department of Health as having long-term, relational characteristics, and there is progress on moving activity reporting towards measures that focus more on health and health care outcomes. However, effort continues to be expended on input and process measures.

Moran and Porter (2014) and Moran, Porter and Curth-Bibb (2014) report on a review conducted for the Australian Institute of Health and Welfare's Closing the Gap Clearing House on potential methods of improving governance performance in remote Aboriginal communities through innovation in public financing methods. Drawing on relevant international comparisons, they explain the ways in which current financing methods for remote Aboriginal communities work against the development of effective political accountability of local leaders to communities, because of the countervailing power of administrative accountability to higher (and geographically remote) authorities. Thus the base of leaders' authority tends to be located outside the community, and accountability to communities is impaired. They suggest that this contributes to community disengagement, in spite of 'considerable political capabilities' within local government electorates. They recommend a move to devolved financing arrangements, with more decision-making autonomy for local authorities and organisations, to bring those capabilities into play, and 'then address deficits in administrative and technical performance' (Moran & Porter 2014:115). They conclude thus:

> *The current grant guidelines managed by the Department of Finance should explicitly include guidelines for devolution to Indigenous governance, with stable rules and rewards for performance, to counter spending departments defaulting to administrative deconcentration with its fragmenting of systems and escalating controls. Financing frameworks are needed that can wrap an accountability framework around the political aspirations and capabilities of Indigenous local governments and organisations, rather than hoping they will somehow 'rise above the*

> *odds' and 'earn autonomy' in the face of the external dictates of multitudinous grants and programs (Moran & Porter 2014:124).*

This paper makes an important contribution regarding the conflict between accountability to communities and to governments affecting leaders and organisations. This finding concurs with those of Hug and Jager (2014) – see below.

These papers provide evidence of improvements in government contracting (particularly by the national Department of Health)[15] but the continuation of funding and reporting complexity. The analysis of the accountability and development problem in the way Australian governments fund Aboriginal communities and organisations, and the resultant conflict for organisations and leaders between accountability to governments and accountability to communities is particularly helpful for my purposes.

Contracted service delivery and accountability for performance

In the international literature a set of seven studies (four conducted in the USA), summarised below, investigated the question of performance of contracted service delivery. Romzek and Johnston (2005) conducted case studies of accountability in contracting for 5 social service programs in Kansas. They found that clarity of contract responsibilities, suitability of performance measures, ease of production of performance data, contractor autonomy, retention of risk by government, minimal requirements for complex new technologies, and alignment of accountability design with the strategies and tasks enhanced the effectiveness of accountability. They conclude that while public managers were skilled in specifying contracts (including clarity in reporting relationships and suitability of KPIs), they were less able to design effective strategies for collecting timely performance data. They also found that contract and accountability management were less effective when contracts were designed for interdependent or competitive networks of providers (as opposed to

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[15] More recent changes in the machinery of government have split Aboriginal health funding and accountability between Health and Prime Minister and Cabinet Departments. Concurrent changes in the structure of funding programs (consolidation into the 'Indigenous Advancement Strategy') and an increase in the share of funding going to non-Aboriginal organisations are likely to have reversed at least some of those gains.

single providers), and when risk was shifted to contractors. While contracts contained penalties for poor performance, they were rarely invoked, partly because for some programs, there were few if any alternative providers. Their findings tend to undermine the argument in favour of competitive markets for social services contracting.

O'Connell (2005) reports a different result in a study of reform in health/welfare transport systems in Kentucky, which shifted to a capitation and broker model, where the state, brokers, providers and riders were all 'actors' in the accountability environment. O'Connell used routine data from 15 regions, a provider survey and a survey of riders to assess performance (on cost and quality). The new system was found to reduce mileage and cost per rider and increase trip-grouping (ie multiple riders), at the cost of a slight decline in timeliness. Collusion between riders and providers (to include non-funded purposes and lengthen rides) was reduced.

These results indicate the limitations of agency-theory inspired approaches to accountability (ie between the funder and provider) in complex environments with many stakeholders. The authors suggest that accountability emerges from the interplay of many actors in an 'accountability environment' (Kearns 1996, cited in O'Connell 2005), some of whom are not in contractual relationships.

Romzek and Johnston's (2005) finding in relation to the low value of reliance on market forces is supported by Heinrich (2010) who conducted an evaluation of third-party provision of after-school tutoring for public school students in under-performing schools in Milwaukee. She reports that while this national program has been much studied, good evidence of improvement in learning as a result of the program has not emerged. The study found no observable correlation between market share, cost and effectiveness of providers. The authors conclude that the idea that poor families and their children, and/or their schools acting on their behalf, will constitute an effective 'market' for tutoring services is not supported by the evidence.

Two papers explicitly compared direct public sector delivery with contracted service delivery in local government in Wales (Andrews & Entwhistle 2010), and in five 'hollowed out' government agencies in the USA (Dubnick & Frederickson 2010), against various measures of performance and accountability. Andrews and Entwhistle (2010) conducted a quantitative examination of the relationship between public service performance (measured by indicators of standards, costs and responsiveness) and partnerships with either other public, private or third sector organisations, in 46 local government services, using statutory performance data and a survey of managers. They found that public-public partnerships were the only type to deliver improvements in effectiveness, efficiency and equity. Public-private partnerships were less effective, less equitable, and had no impact on efficiency. Public-NGO partnerships made no difference on any measure. The authors suggest that local government departments 'pick their partners for different goals' (p693); choosing other public sector organisations for complex cross-cutting problems, private providers for more routine service delivery, and NGOs for their capacity to engage with excluded groups.

Dubnick and Frederickson (2010) found some evidence that direct government delivery is both more accountable and more effective, as measured by statutory performance data (noting the limitations of the instrument). They conclude that accountability via hierarchy is the most effective, closely followed by accountability based on relational approaches to contracting or grant management (P.i151).

Dubnick and Frederickson (2010) also discuss the effectiveness of performance measurement. They note that formal contracted data requirements have not translated into reliable and consistent performance measurement data, and suggest that 'real accountability…may have less to do with formal systems of performance measurement…and more to do with grant and contract management and oversight at the operational level', along with executive and legislative branch politics (p.i155). This finding tends to support our conclusions (Dwyer et al. 2011) and those of other authors (e.g. Loevinsohn et al. 2009; Dickinson et al. 2013; Allen et al. 2012) that while the formal accountability arrangements are based on the transactional, principal: agent model, those who must make them work tend to rely on more relational approaches.

In the USA, where even more than in Australia the federal government conducts most of its health and social service delivery through third parties (Salamon 2000:1615), there is another weakness in federal performance regimes, and this is the tendency to ‘superimpose managerial logic and managerial process on inherently political process embedded in the separation of powers’ (Dubnick & Frederickson, 2010:i143). That is, political processes may hand on conflicting goals to implementers, a problem which is essentially a policy challenge rather than one of performance by contractors, as originally explored by Pressman and Wildavsky (1973). This is an area where more tightly coupled networks or relational contracting may be more effective than transactional contracting (Dubnick & Frederickson 2010:i156), as these forms allow for problems of goal incongruence to be managed and monitored more actively.

Romzek and Johnston’s (2005) disappointing findings in relation to the reliable collection of performance data are matched by the findings of Saliterer and Korac (2013), regarding its use. They surveyed local government officials in Austria, and found that while there is use of the data for the external reporting obligations of the local government authorities themselves, it is not often used for managing the performance of the contracted providers. This would appear to undermine the NPM nostrum that contracting out of public services leads axiomatically to a focus on results. Barnett and colleagues (2009:123) also report disappointing progress in the New Zealand health system on performance reporting and monitoring, for either quality or efficiency, and the tendency for Ministry officials to use informal mechanisms of small rewards (such as early payment) or punishments (such as imposing increased levels of monitoring) rather than those mandated in the funding agreements.

These papers reinforce the problematic nature of the value of ‘market forces’ in contracting for health and social services, where both results and costs can be difficult to assess in the relevant time frame; the limitations of accountability methods that rely on the collection and use of performance data; and the tendency for those requirements to paper over or simply hand on conflicting policy goals.

The problems of many hands and many eyes: multiple accountability relationships

The move from control by hierarchy (the classic conception of the bureaucratic state, and of 'the firm') to control by market (the NPM mode of 'the contract state') and subsequently or in parallel to control by networks (called 'the governance model' by some, including Tuohy (2003)) creates the problem of many hands (Bovens 2007): exactly who is accountable? Networks cannot, almost by definition, be seen as a simple side-by-side or top-to-bottom collection of bilateral accountability sets that come together to work (for service delivery and/or policy development) in some sort of mechanical way. Thus simply 'buying' services, or 'contracting out' or even 'commissioning' is not an adequate description of what government and public agencies are doing; and thus while contractual approaches to accountability may be necessary, they are not sufficient (e.g. Romzek & Johnston 2005; Tuohy 2003).

A small set of papers addresses the matching problem of many eyes, that is, the challenges of multiple accountability relationships, where organisations are accountable to multiple stakeholders and/or funders. Public and third sector organisations are alike in facing the problem of being accountable to many different forums or authorities[16], all of which apply their own unique set of criteria (Bovens 2007:455; Tuohy 2003; Bovens, Schillemans & T'Hart 2008; Koppell 2005).

Koppell (2005) suggests a typology of five dimensions of accountability: transparency, liability (are there consequences for performance?) controllability (did the organisation do what the controllers want?), responsibility (did they follow the rules?) and responsiveness (did they fulfil the substantive demand/need?). He conducted an often-cited case study of the Internet USA Corporation for Assigned Names and Numbers (ICANN), which found it was impossible for ICANN to be accountable in all five dimensions, because they conflicted. ICANN faced unclear lines of accountability (it was not clear who or what ought to control ICANN) and unclear responsibility due to ambiguities in its founding documents. Responsiveness was not possible because of deeply divided constituencies; and liability and

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[16] It is worth noting that private and public corporations face a similar problem in responding to the interests of their many stakeholders, as originally theorised by Freeman (1984).

transparency were also challenging because of lack of clarity about which standards to judge its performance by (private or public), given its commercial activities.

Complex accountability relationships for NGOs are the focus of two papers. Hug and Jager (2014) examine multiple accountability relationships for a large European Economic Development NGO, in regard to donors who fund it; recipients (small to medium enterprises (SMEs) in developing or transitioning countries); and beneficiaries (the poor). They conducted exploratory case studies of three major projects, which they use to generate rather than prove hypotheses about the relationship between accountability pulls and effectiveness. However, they make an interesting conclusion, contrasting 'resource-based accountability' and 'impact-based accountability' and find that accountability really only works upwards – from the local SMEs that deliver the interventions, to the international NGO that funds them, and ultimately to the donor – at the expense of great risk of poor performance and irrelevance from the point of view of poverty reduction. They make the point that identity-based non-profits (with owners or powerful stakeholders who directly represent the interests of clients or beneficiaries) are in a different position, supporting the important findings of Ospina, Diaz & O'Sullivan (2002) summarised below.

Ospina, Diaz and O'Sullivan (2002) explored the accountability relationships of four successful Latino organisations in the USA, as examples of 'identity-based not for profits'. This paper has been significant in reinforcing the concept of upward and downward accountability pulls. The authors found that the organisation-community link was the core relationship in the organisations' accountability environments, and they use various methods to achieve 'negotiated accountability'. While only some of the organisations have 'hard' accountability to their communities or members, all were driven by community/member priorities and concerns. Mulgan (2000) might argue that (at least for some such organisations) there is no direct accountability relationship, but Koop (2014) might say there is 'voluntary accountability' (see below).

These papers provide evidence in relation to a major challenge for accountability in the ACCHO context, that is, the interaction between three tensions in the accountability environment. The first is the problem of multiple stakeholders each holding a part of the accountability environment and often pulling in different, and perhaps directly conflicting, directions. The second is the tendency for the major providers of resources to dominate the accountability environment, regardless of the impact on achievement of the avowed primary purpose. The third is the significance of ‘downwards’ accountability to communities, particularly for identity-based NGOs.

These tensions highlight a fundamental problem in the accountability relationships between government funders and the ACCHO sector – governments fund ACCHOs because they are closer to, more acceptable to and more effective for their community ‘owners’; but impose accountability regimes that risk compromising those very characteristics. They do so by ‘pulling’ accountability effort towards the funder, almost inevitably reducing the time and effort available for ensuring accountability to community. I will return to this central problem in Chapter 5.

Voluntary and community accountability?

While ‘voluntary accountability’ could be seen as a contradiction in terms in public administration (Mulgan 2000), it is of continuing interest particularly but not only for the NGO sector. Voluntary accountability is defined by Koop (2014: 1) as ‘the degree to which an actor is, without being required to, committed to offering information on, and explanation of, his or her own conduct to another actor, and may be sanctioned for this conduct’. That is, while the agency chooses to report, their voluntary reporting may bring to light issues on which they can be sanctioned, thus elevating this concept from the realms of an internal or moral sense of responsibility.

Koop (2014) measured the engagement of 103 Dutch public agencies in up to 10 voluntary activities that meet this definition of accountability. The author doesn’t accept the instrumental argument prima facie (ie that this activity is motivated purely to avoid the possible consequences of not being transparent with stakeholders, such as the replacement of self-regulation with increased legislated accountability regimes), but rather tests it against an alternative explanation: a ‘logic of appropriateness’ (i.e. that it is natural or rightful). The study found that more voluntary accounting is given by agencies that deal with more politically salient issues (i.e. where the activities are more highly visible politically), those that receive public funds and those with more staff.

Karsten (2015) followed Koop (2014), presenting a set of case studies exploring the accountability motivations of mayors and aldermen (political executives) in 12 cases of decision-making about the placement of facilities for the homeless, in the Netherlands and Belgium (Flanders). The author found that both appropriateness and external threat were sources of motivation, but so was a strategic motive – to strengthen power or avoid negative reactions.

Molyneux et al. (2012) conducted a literature review on the use of community accountability methods as an approach to strengthening public accountability in peripheral health facilities in low and middle-income countries. The methods identified from 21 papers were committees and groups (19), public report cards (1) and patient rights' charters (1).The results were mixed. In relation to committees, the authors found that three factors affect outcomes: selection, composition and general functioning of the committee or group; relations with health workers and health management systems; and the broader context, ie government and socio-cultural norms and practices. In relation to report cards, they reported clear indicators of positive impact, attributed by the study authors to the fact that report cards overcome two problems – lack of relevant information and failure to agree on what the community expects of the health care providers. Patient's rights charters were not of much use, and were perhaps too much a western concept for the setting of the study.

Both voluntary accountability and community accountability are important methods in the ACCHO context, and these papers provide both support for their validity, and caution about the availability of the right conditions for their application.

Matching governance and accountability for NGOs

A single paper focused primarily on the delineation of alignment between governance styles and accountability methods for NGOs. Millar (2013) examined this alignment in a comparison of European Union (EU) and Canadian approaches to contracting with NGO's for international development projects. The networked governance model of the EU (which is more deliberative and ‘networked’, involving non-state actors and a broader range of stakeholders in policy development and decision-making) relies more on public reporting and deliberation as accountability methods. A more contractual form of governance in Canada relies on fiscal auditing, and performance reporting and management, for accountability. The author concludes that the EU approach probably provides policy makers with more opportunities for policy learning, but would not be acceptable in Canada due to the ‘action logic’ of the national government.

Millar (2013) contrasts the ‘administrative accountability’ in Canada with the ‘social accountability’ of the EU networks. She argues that the long chain of command in the decentralized Canadian governance system (with multiple non-state agents) makes monitoring difficult as well as more onerous, and goal conflict more likely. EU methods, on the other hand, deal better with goal conflict, but have problems of compliance with rendering account. Incentives to comply are derived from reputational risk as well as the coercive powers of the state. The author points out the implication that networks only work ‘in the shadow of hierarchy’; and that strong institutional supports for collaborative decision-making are vital for accountability in networked governance systems (p257).

The Canadian case is more relevant to Australia, and there are strong parallels with the accountability relationships between ACCHOs and governments. The focus on outputs by government staff who need to report results upwards, the defaulting of performance measures to the level of inputs and processes (with quality coming a poor second), and high transaction costs are common elements. Disagreement with the substance of NGO contributions to public policy debates, or other reasons for perceiving that they add little value, is another likely common factor in Canadian and Australian governments’ reluctance to shift towards engaging with NGOs in networked governance arrangements that enhance their legitimacy, as Millar points out (p265).

Summary

Overall, the literature reviewed above makes several important contributions that support my published papers, and suggests likely directions for future development of more appropriate accountability arrangements in the context of Aboriginal health care.

First, progress by some Australian government funders in improving the efficiency of reporting regimes is welcome, but continuing complexity and fragmentation in the multiple funding and accountability relationships for ACCHOs remains problematic. The uncertain value of reliance on market forces is not surprising in the complex business of health and social care, but it is significant in undermining one of the principal rationales for NPM-based approaches to contracting and accountability. The problematic nature of both collecting and using performance data for accountability purposes is also relevant, although the countervailing importance of at least some of this data to inform quality improvement and national policy for health care means that this difficulty cannot be avoided.

The ‘problem of many eyes’ is central to the challenge of designing better accountability methods in the ACCHO context. In particular, accountability to communities is something that ACCHOs and government necessarily share, and is critically important. The potential value of both voluntary accountability and community accountability methods is also relevant, as is the caution the papers have provided.

Finally from my perspective, the Canadian and EU comparison case highlights the similarities between Canada and Australia, and the challenges this country would face in attempting to rely more on the deliberative EU approach. The focus on the need for alignment between overall governance of Aboriginal PHC and the accountability relationships among those involved, is also of value.

Conclusion

The published work in this chapter addresses my third proposition: that current Australian NPM-based approaches to accountability, founded in agency theory, are inappropriate to the ACCHO sector and an alternative is needed. This proposition is supported by the evidence presented in this chapter as follows:

1. The weight of evidence in current literature that quasi-classical contractual accountability approaches are not adequate to the complex challenge of governance in what is effectively a network of actors engaged in the endeavour to improve access and quality of PHC for

Aboriginal people (including governments, communities, the ACCHO sector, and mainstream health care providers). In current thinking, contractual accountability remains necessary, but the intention is that contracts are in themselves more relational, and the governance of the contractual relationship is more flexible and inclusive.

2. The demonstrated recognition by governments that the principal/agent assumptions underlying existing accountability regimes are not effective, given government's own efforts to find alternatives (Dwyer et al. 2014).

3. The distorting effect of onerous accountability regimes imposed by government funders on ACCHO/NGO capacity to fulfil their accountability obligations to communities.

I have argued that current accountability regimes carry high transaction costs, and the reporting requirements have not succeeded in resolving the underlying concerns of government officials, while noting that some of the information generated is valuable for the ACCHOs and government agencies, as well as for health policy development and program evaluation. This is why government agencies have been willing to engage in attempts to reform their roles in the PHC system for Aboriginal people and communities, towards more genuine engagement in collaborative approaches, relational contracting and perhaps, a different approach to accountability.

In recent years there has been considerable progress on the collection of good clinical and care data about Aboriginal and Torres Strait Islander health care (Martin 2014), and the National KPIs for Aboriginal PHC are providing valuable information about effectiveness of care (AIHW 2014) (see Thompson et al. 2013; Dwyer et al. 2015b:4-6; Holman 2014 for a review of this evidence). This progress has been achieved slowly, but the collections now seem well established and accepted. More remains to be done, especially in the less clinical aspects of PHC.

Financial reporting is more straightforward, and more standardised, and compliance with requirements is regarded as high. However, government funders remain concerned about corporate governance failures in Aboriginal organisations, including ACCHOs, and these concerns have some credibility due to high profile cases (Dwyer et al. 2015b:64). As discussed in Chapter 3, systemic racism plays a part in the tendency to see Aboriginal organisation failures as representative of some essential vulnerability in Aboriginal organisations generally, or as evidence that there is a conflict between good corporate governance and Aboriginal cultures; while mainstream organisation failures are more likely to be seen as individual cases that may shed light on needed improvements in the practice and regulation of corporate governance.

The perception by governments of the ACCHO sector as being ‘high risk’ is one of the underlying factors in the trend for Australian governments to allocate more of the total budget for Aboriginal health and other services to mainstream rather than Aboriginal organisations (Henderson 2015), along with the stated purpose of supporting improvement in both the availability and quality of services provided by mainstream health organisations for Aboriginal people. It must at the same time be said that political support for the ACCHO sector is seen as being more solid than it is for any other portfolio area in Aboriginal affairs, as evidenced by the recent decision to return to three-year funding allocations for ACCHOs after a temporary pull back to annual funding (Ley & Nash 2015).

My published papers presented in this chapter have articulated the problem with NPM-inspired approaches to accountability; and why their application to the Indigenous health sector is in many ways not appropriate; and they have established one way of thinking about the multiple accountability ‘pulls’ experienced by community-based NGOs in health. In the next chapter, I seek to articulate the foundations for a novel alternative approach to accountability that has the potential to work for both sides of the funding relationship.

Chapter 5: Conclusion – Reciprocal accountability as the basis for resetting the relationship

> *Of the three core cultural values …. the most significant of these I believe is that of reciprocity, or ngapartji… This is not only a word but a working philosophy that incorporates the essence of the tjukurpa[17] into its intent and implementation in various social/cultural situations. It essentially means, 'you do something for me, in return I do something for you'; which is the core concept governing relationships and exchange… John Binda Reid (Reid & Taylor 2011).*

In this final chapter I seek to synthesise the findings of the collection of published work to address my final proposition: that a framework of reciprocal accountability could provide the basis for resetting the relationship between Aboriginal communities, the sector and government funders. Two published papers are presented, establishing some parameters of the sector development that is needed to realise the long-established community and policy goal of equitable access to primary health care (PHC) for Aboriginal and Torres Strait Islander people, one of which is resolution of the problem of accountability. An original framing of the structural tension in accountability relationships for Aboriginal Community Controlled Health Organisations (ACCHOs) is explained and is used to propose a novel approach to accountability regimes that is intended to provide the basis for resetting the ACCHO-funder relationship. The implications of that approach are outlined in the form of possible methods that could be tested modified and used by participants in the funding relationship. The implications for future research are briefly considered, and the thesis concludes.

The papers

The development of the 'Funding, accountability and results for Aboriginal health services ' (FAR) project has been outlined in Chapter 4. The first paper is the summary version of the main report of the FAR project, with the full report included as Appendix D.

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[17] 'the lore and law of how to live and conduct ourselves as Aboriginal people' (Reid and Taylor, 2011:5).

Thanks to sponsorship by Professor Alex Brown, the leader of the Aboriginal health stream in the South Australian Health and Medical Research Institute, Professor Josée Lavoie was awarded the Australian Primary Health Care Research Institute's International Visiting Fellowship (2013), during which she led (and I often contributed to) several seminars and policy roundtables with government and sector decision-makers on the Canadian experience of transferring former government PHC services to community control by First Nations. Based on these discussions, Professor Lavoie and I developed a comparative analysis of the challenges and methods for transferring PHC services to community control in Canada and Australia. The second paper arose from that analysis.

PAPER EIGHT – The road is made by walking: Towards a better primary health care system for Australia's First Peoples

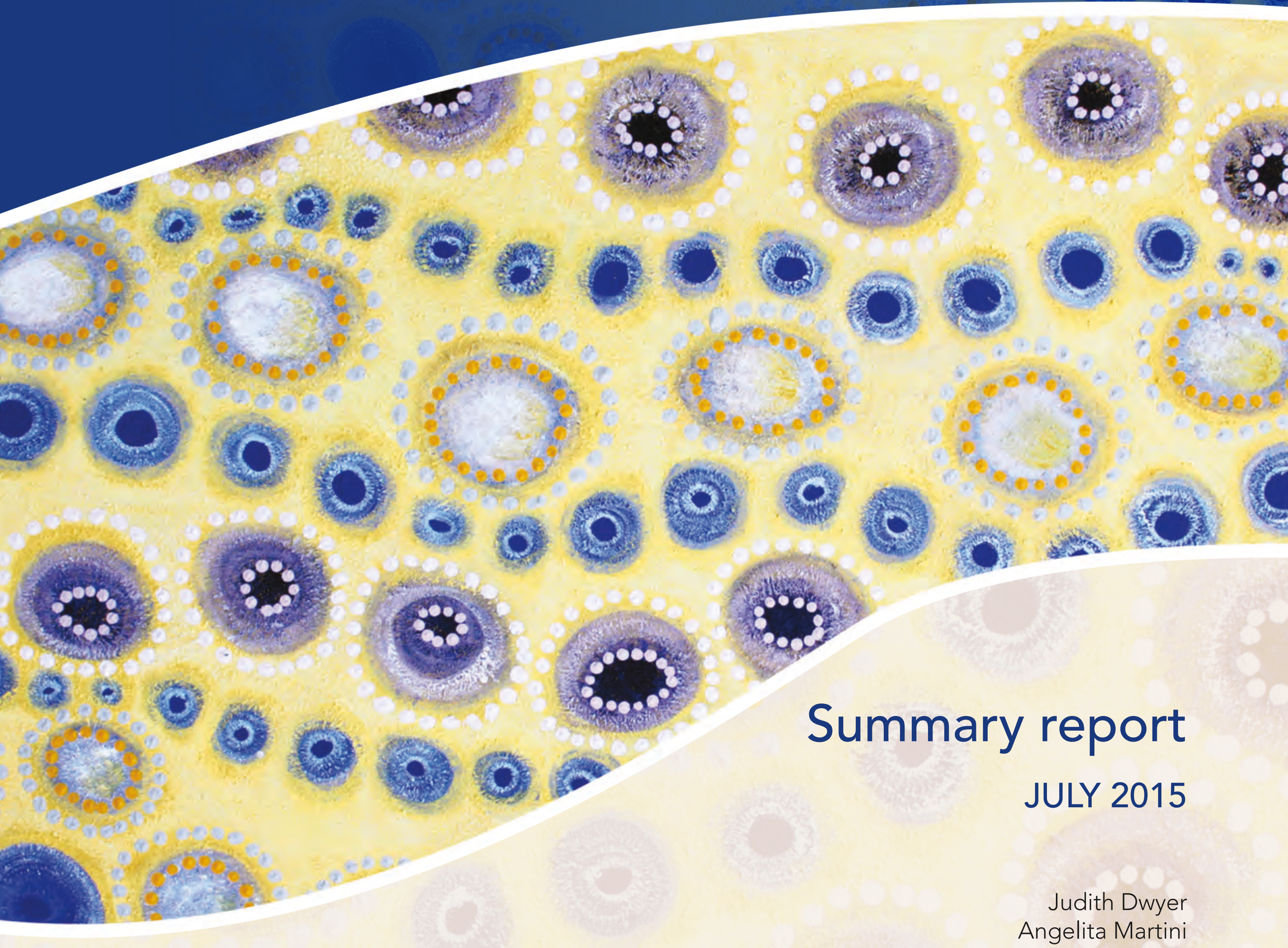
This report (Dwyer et al. 2015a) is the summary version of the main report from the FAR project, prepared for industry and community audiences. It addresses two main questions about the intended reforms in the Northern Territory and Cape York Queensland. First, what does the experience tell us about how to implement health policy and health system reforms effectively? Second, what changes are needed in the PHC system to achieve the policy goal of equitable access to PHC for Aboriginal people? The paper derives a set of essential elements of reform to enable future policy changes to be implemented effectively; and provides evidence that concerns about governance and accountability were a brake on progress.

Statement of my role

I was the leader and originator of this project, prepared the research design in consultation with national and international advisers and research partners, and led the project throughout. I prepared the first and subsequent drafts of the report, based on qualitative data collected and analysed by co-authors, responded to interactive peer review, and worked with team members (co-authors) and with professional editors at the Lowitja Institute, led by Ms Cristina Lochert, to finalise the report.

The Road Is Made by Walking:

Towards a better primary health care system for Australia's First Peoples

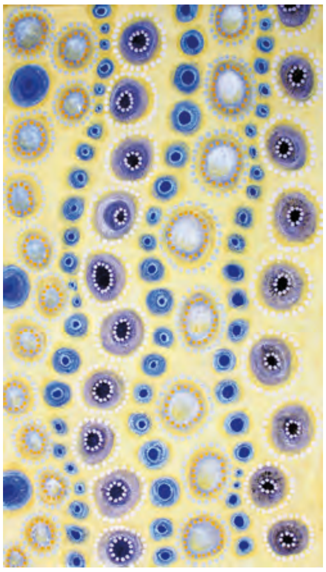


Summary report

JULY 2015

Judith Dwyer
Angelita Martini
Cath Brown
Edward Tilton
Jeannie Devitt
Paula Myott
Brita Pekarsky

ARTWORK



About the artist

Karen Kulyuru was born in 1969 and raised in Ernabella (Pukatja) on the Anangu Pitjantjatjara/ Yankunytjatjara Lands. Karen first learned to paint by watching her mother, and comes from a family of batik silk artists. She started painting at Ernabella Arts and Crafts many years ago. Karen lives in Adelaide with her family and children and regularly attends professional development workshops at Better World Arts. Her paintings have been exhibited extensively across Australia.

About the artwork

Tjukula (Rockholes) 2012
Acrylic and sand on canvas
61 x 107 cm
Better World Arts catalogue KKU0073

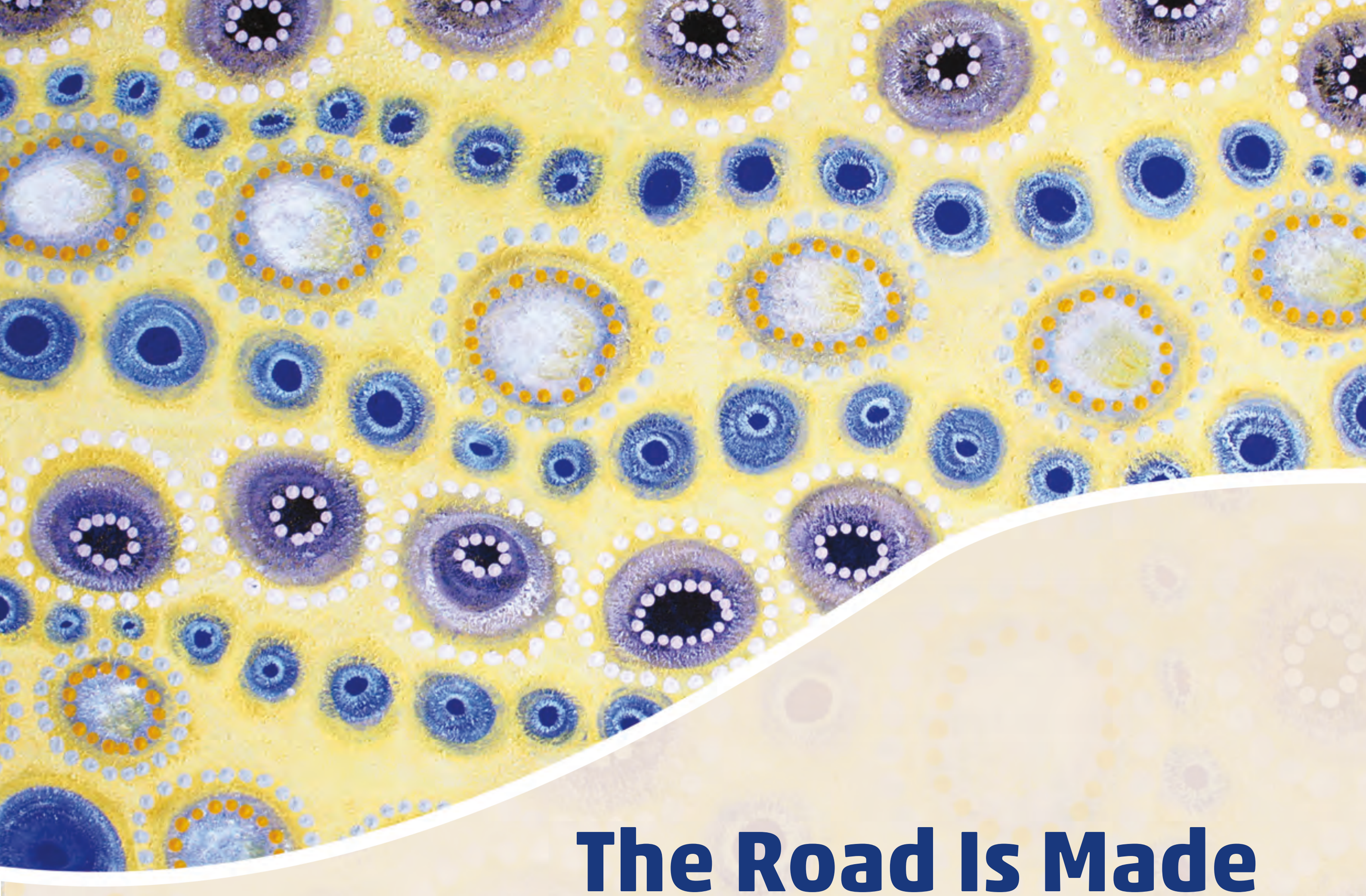
This painting was produced during the 'Manta' (earth) workshops. Karen describes her painting as Walka. Walka is any meaningful mark or pattern and may be an image on a cave wall, on rock or on sand and has cultural and ritual significance. It is used on the body during inma or ceremony. This painting is reminiscent of the designs that are created on batik. Karen's work is heavily influenced by the beautiful batik designs she painted alongside her mother Angkuna and sister Unurupa from the 1970s onwards in the Ernabella craft room.

Batik designs evolved from a mixture of traditional imagery, Indonesian influences, as well as the early Walka drawings painted at the Ernabella mission school in the 1940s and 50s. Karen's mother Angkuna was prolific in her craft making and produced beautiful lengths of fabric, many of which are in public and private collections. Karen painted batik for many years and this influence is still visible in her highly decorative, detailed paintings today.

Important traditional symbols are still placed within these works, including tjukula (rockholes represented by concentric circles), creek beds and bush foods for harvesting. This painting depicts rockholes (tjukula), and sandhills surrounding them. Karen is influenced by the beautiful colours and shapes of the landscape. She uses both desert tones and brighter hues in her works and often illustrates aspects of nature from the desert country where she grew up, to the flora here in Adelaide, where she has lived for many years.

REPORT TITLE

The title is taken from Antonio Machado's poem 'We make the road by walking' in *Selected Poems of Antonio Machado*, Louisiana State University Press, Baton Rouge, LA, 1978.



The Road Is Made by Walking:

Towards a better primary health care system for Australia's First Peoples

Summary report

JULY 2015

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the Lowitja Institute
Australia's National Institute for Aboriginal and Torres Strait Islander Health Research

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Contents

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We are grateful to the international and national advisors on the research team who supported the thinking and analysis in this work in many ways—Dr Amohia Boulton, Professor Jacqueline Cumming, Dr Josée Lavoie, Dr Patrick Sullivan and Dr Tim Tenbensel—and particularly Dr Kim O'Donnell, whose doctorate in public health helped to inform this work. We wish to acknowledge the following individuals who tirelessly responded to our requests for their time, wisdom, documents and advice: Ms Wendy Ah Chin, Dr Andrew Bell, Dr John Boffa, Mr Cleveland Fagan, Dr Jackie Mein, Mr Eddie Mulholland, Mr Paul Stephenson, Ms Caroline Taunton, Ms Jill Thomas and Dr Mark Wenitong.

We are also indebted to Associate Professor Janelle Stirling and Dr Judith Gomersall for their thoughtful and constructive peer review of this report in draft form.

The study team gratefully acknowledges the funding of this study by the Lowitja Institute CRC and the support of Flinders University.

About this report

This publication is one of five that report on the work of the **Funding, Accountability and Results (FAR)** project, all published by the Lowitja Institute in 2015.

FAR is a study of reforms in primary health care for Aboriginal and Torres Strait Islander communities in the Northern Territory (between 2009 and 2014) and Cape York, Queensland (between 2006 and 2014). The study background, its aims and methods, case studies, findings and conclusions, and the suggested essential elements of reform are reported in the project report and the summary report.

Two brief histories of the project research partner organisations and a case study have also been prepared in order to contribute to the record of development of the broader Aboriginal community controlled health sector in Australia, to give context to the larger research study, and for our partners' own use.

Project report:

The Road Is Made by Walking: Towards a better primary health care system for Australia's First Peoples – Report
Judith Dwyer, Angelita Martini, Cath Brown, Edward Tilton, Jeannie Devitt, Paula Myott and Brita Pekarsky
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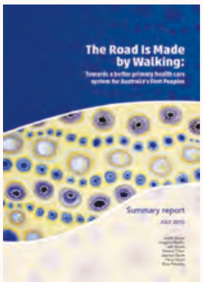

Project summary report:

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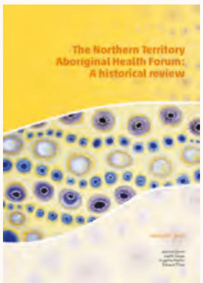

The Northern Territory Aboriginal Health Forum: A historical review
Jeannie Devitt, Judith Dwyer, Angelita Martini and Edward Tilton
ISBN 978-1-921889-46-2

Miwatj and East Arnhem: Case study
Paula Myott, Angelita Martini and Judith Dwyer
ISBN 978-1-921889-47-9

Towards a History of Apunipima Cape York Health Council, 1994–2006
Edward Tilton, Angelita Martini, Cath Brown and Kristy Strout
ISBN 978-1-921889-45-5

Abbreviations

ACCHO	Aboriginal Community Controlled Health Organisation
AMSANT	Aboriginal Medical Services Alliance Northern Territory
ATSIC	Aboriginal and Torres Strait Islander Commission
FAR	Funding, Accountablity and Results
FRP	Final Regionalisation Proposal
NGO	non-government organisation
NTAHF	Northern Territory Aboriginal Health Forum
NTH	Northern Territory Department of Health
PHC	primary health care

Terminology

In keeping with usage in the Aboriginal community controlled health sector, the term 'Aboriginal' is sometimes used in contexts that may also apply to Torres Strait Islander people. The term 'mainstream' is used to mean non-Indigenous institutions and organisations.

The names of all government departments and several other organisations have changed during the study. For simplicity, we use the names that were current in December 2014.

Introduction

The research reported here is a study of reforms in primary health care (PHC) for Aboriginal and Torres Strait Islander communities in the Northern Territory (between 2009 and 2014) and Cape York, Queensland (between 2006 and 2014). In both places, the intention of the reforms was twofold: to establish a regional system of PHC provision with reliable access to care for all Aboriginal and Torres Strait Islander communities in the regions, and to increase community control of health care by transferring some or most of the responsibility for providing PHC from government health authorities to regional Aboriginal Community Controlled Health Organisations (ACCHOs). These were bold plans with long histories of development in both jurisdictions.

The study aimed to contribute two kinds of knowledge. The first concerns the question of how to implement health policy and health system reforms effectively. The second concerns the substance of the reforms needed to achieve the policy goal. That is, we aimed to learn about what needs to be changed, as well as how to implement the changes.

Background

The provision of PHC to Aboriginal and Torres Strait Islander people is undertaken by the ACCHO sector and the mainstream health system (mainly in general practice). Access is patchy, resulting from the history of development of services and the policy directions and practices of federal and state/territory governments and the mainstream health system. The ACCHO sector in Australia delivers essential health care for communities and individuals, and its role has been endorsed in policy agreements among all Australian governments for many years. The available evidence indicates that ACCHO services are effective. ACCHOs are funded through a complex array of short- to medium-term contracts, a situation that is recognised as problematic. Health policy aims to ensure better access for Aboriginal and Torres Strait Islander people to PHC, but unresolved issues of stewardship and governance, funding and regulation remain.

The study was informed by a theoretical model of the problems. It suggests that the current regimes of funding and accountability and the planned reforms are shaped by the interaction of two different ways of thinking about the goals and methods for improving Aboriginal and Torres Strait Islander health and health care. The first is based on Aboriginal and Torres Strait Islander concepts and principles for health and self-determination and the second is based on public management methods generally known as New Public Management. These ideas (and the tensions between them) provide a framework for understanding how the reforms progress, or fail to progress, and the implications for future policy and practice.

Study aims and methods

The study was conducted from September 2011 to December 2014 and aimed to understand the reforms while they proceeded on their own timelines and agendas. Specifically, we sought to answer these research questions:

1. How effective are the methods used to plan and implement the reforms; what are the critical factors that enable or impede implementation; and what are the gaps and why?
2. What are the implications of the reform experience for policy and practice in the funding and accountability arrangements for Aboriginal community controlled health services and their government funders?

We aimed to provide a coherent description of reforms in PHC for Aboriginal communities in the Northern Territory and Cape York, Queensland, and an analysis of what helped and what got in the way of progress, and what might be done differently in the future. The research was structured as a set of three case studies, one at the level of an Australian jurisdiction (the Northern Territory) and two at the level of regions (East Arnhem in the Northern Territory and Cape York in Queensland). We documented the experiences of each case and analysed the common themes and their implications for future reform work.

The case studies focused on two reforms:

- the regionalisation program outlined in *Pathways to Community Control* (NTAHF 2009) (Case studies 1 and 2): the goal of the Pathways regionalisation program, which was led by the Northern Territory Aboriginal Health Forum (NTAHF) between 2009 and 2014, was to enhance access for Aboriginal people throughout the Northern Territory to culturally safe comprehensive PHC, based on regional organisation and community governance of care delivery
- the Transition to Community Control project in Cape York (Case study 3): the goal of this project was to integrate the management and delivery of PHC to Aboriginal communities in Cape York by transferring responsibility for PHC services delivered by Queensland Health to Apunipima Cape York Health Council.

The study was developed in accordance with the Lowitja Institute's Facilitated Development Approach. We negotiated endorsement of the study with our research partners and received ethical approval from four ethics committees. We conducted 69 interviews with 55 people involved in the reforms and analysed 242 public and internal documents dealing with the reform processes and structures, financial information and policy considerations. We also engaged in less formal discussions with our research partners as the study progressed, and our notes of those discussions also informed our analysis.

The case studies

The process of reform in the Northern Territory and Cape York has been difficult and complex, and progress has been slow. However, the work continues and although the reform efforts analysed in this report have been frustrating, many valuable lessons can be learned from the experience.

Case study 1: Pathways and regionalisation in the Northern Territory

Case study 1 documents the work of the Northern Territory Aboriginal Health Forum to establish a regional community controlled PHC system, as articulated in *Pathways to Community Control* (NTAHF 2009) and subsequent documents. The goal of the Pathways regionalisation program was to enhance access for Aboriginal people throughout the Northern Territory to culturally safe comprehensive PHC, based on regional organisation and community governance of care delivery.

Background and study goals

The NTAHF is a formal partnership of the Aboriginal Medical Services Alliance Northern Territory (AMSANT), the Northern Territory Department of Health (NTH) and the Australian Government Department of Health (henceforth the Department of Health) and was established in 1998. Since its inception, the NTAHF has worked consistently on the development of the PHC system for Aboriginal and Torres Strait Islander communities in the Northern Territory, with some notable successes (for details see *The NTAHF and Regionalisation: An Historical Overview* (Devitt et al. 2015), a related paper published as part of this study).

The notion of regionally based PHC services is a longstanding part of the NTAHF's agenda of PHC reform. The partners had an agreed definition and a shared vision for regionalisation 'through system reform and the development of Aboriginal community controlled primary health care services which provide safe, high quality care and facilitate access to specialist, secondary and tertiary care' (NTAHF 2010:10). The Pathways regionalisation program was funded by the Department of Health and governed by the NTAHF. Regions were resourced to develop formal proposals for regionalisation.

Summary of progress

In 2010 and 2011 significant elements of the planned reforms were detailed and resourced. Both the Barkly Regional Committee (in 2010) and East Arnhem (in 2012) submitted formal proposals for regional community controlled health services, but neither was formally endorsed to proceed. In 2014–15 regionalisation lost its funding and work ceased. At the time of writing, the partners were working towards recommencing the reforms.

Findings

1. Establishing PHC regions and regional governance was more complex and took longer than planned. There were difficulties both in the central planning and resourcing, and in the process of local communities negotiating agreements to regionalise PHC. The full implications of establishing regions as governance units that function as part of the Northern Territory health system and hold funds for PHC in the region were not fully appreciated.
2. The level of authorisation and commitment required to sustain the reforms over time, and in spite of external changes and difficulties, was not negotiated and secured at the outset. The NTAHF, as a deliberative and collaborative forum, had insufficient authority to drive implementation. The exercise of shared authority and responsibility by the NTAHF partners was always a challenge.
3. Time and resources were inadequate. There were significant gaps in the skills and resources available to the program, and several important elements (such as the design of funds pooling arrangements) were not progressed.
4. Progress was affected by the challenge of working across cultures. Concerns about the capacities of Aboriginal communities and their leaders were not openly discussed and managed. Turbulence in the health system disrupted some longstanding relationships and exacerbated the problem of trust among the partners.

Case study 2: Towards regionalisation in East Arnhem

This case study documents the engagement of the Miwatj Health Aboriginal Corporation (Miwatj) and the communities and leaders of East Arnhem Region in the planning and implementation of the Pathways regionalisation program led by the NTAHF between 2009 and 2014.

Background

East Arnhem has a population of about 10,000 people spread over 33,000 square kilometres, with 10 major remote communities (five of them on islands), many homelands and outstations, and two towns. East Arnhem is culturally rich and linguistically diverse with three major language groupings, and is served by four PHC providers. Miwatj (established 1992) approached the Pathways regionalisation program as a way of pursuing its existing goal of 'one health board to represent all Aboriginal people in the region' (Miwatj 2014). Miwatj is governed by a regionally representative elected board, which includes senior community leaders (Miwatj 2014). It operates from four sites and is funded by the federal and Northern Territory governments through 17 main contracts. Miwatj works closely with two community organisations that support homeland communities.

East Arnhem regionalisation proposal

The East Arnhem Steering Committee—made up of 14 community representatives, five government representatives and two representatives from AMSANT (the peak body for ACCHOs in the Northern Territory)—commenced work in 2008 and submitted its Final Regionalisation Proposal (FRP) in June 2012. Regional advisory functions were established and a large community consultation process involving 400 community members (Christie et al. 2011) was conducted.

Structures and processes for regional governance were a source of tension throughout the project. Government representatives favoured the development of an overarching regional board, while community leaders decided to adapt the Miwatj Board. The Miwatj constitution was amended to achieve broad representation across the region, including representation of Laynhapuy Homelands Association and Marthakal Homelands Association (which provide services in remote homelands). An 'alliance agreement' to enable coordination of planning, organisation and delivery of care with both homelands associations and NTH services was designed and negotiated, and it provided for an incremental approach to PHC integration.

The proposal was considered by the NTAHF but no definitive response was given. Requests for further development work were made by the Department of Health, but differences on the question of a single ACCHO board for all services in the region and the role of the Miwatj Board were unresolved. No further developments in relation to the FRP occurred during the period of this case study, although Miwatj has continued work on the development of a regional PHC service, including the successful transition of the Yirrkala clinic in 2012, and ongoing work on transition of a second NTH clinic. Advocacy with the NTH and government ministers has continued.

Findings

This case study documents some practical progress, but not success, in implementing the intended reforms. The major findings are:

1. Regionalisation was an existing goal for Miwatj and community leaders, who saw it as both a pathway to better health care and as an expression of self-determination.
2. Problems with acceptance by government of community leaders' decisions were seen by those involved as showing a lack of respect and a failure to understand community structures and processes.
3. Withdrawal of high-level government commitment to community control, and a shift to a focus on 'participation', was seen as an expression of lack of trust in Aboriginal capacity. The impact of several high-profile governance failures or problems in Aboriginal organisations influenced the thinking of politicians and public servants.

Case study 3: Transition to Community Control in Cape York

This case study explains work towards the transition of PHC for Aboriginal communities in Cape York from Queensland Health to Apunipima Cape York Health Council (Apunipima), following the signing of a multi-party Deed of Commitment in 2006.

Background

Apunipima was established in 1994 with strong support from the Cape York Land Council and the Aboriginal and Torres Strait Islander Commission (ATSIC) Regional Council, and also from government. In 2005 the Cape York Institute recommended that Apunipima take on the delivery of PHC services for Aboriginal communities in Cape York, using existing Queensland Health and new national funding. The tripartite Cape York Regional Health Forum endorsed a plan based on this proposal in 2006, and all parties (Commonwealth and state governments and Apunipima) signed a Deed of Commitment in August 2006, with a target date for full implementation by June 2011.

Early progress followed by loss of momentum

In 2006 a Transition Planning Unit was established within Apunipima, funded jointly by the Department of Health and Queensland Health, and an extensive round of engagement with local communities was undertaken to seek endorsement. In accordance with the recommendations of the Cape York Institute proposal, Apunipima reduced the size of its board and included members from government health departments and private enterprise (ACYHC 2007:99).

During this time (2006–07) the legitimacy of the Deed of Commitment and Apunipima's capability were questioned by government agencies. During 2007 and 2008 Apunipima completed several major pieces of work aimed at furthering implementation, including a roadmap for the transition to community control (ACYHC 2007). A report released in 2008 (Eagar & Gordon) recommended funds-pooling for Cape York, combining existing Queensland Health funding with an amount from the Department of Health (approximately $20 million), to achieve equity in funding per capita. In 2008 Apunipima commenced its first permanent PHC services and in 2009 the Mossman Gorge health service was the first, and to date only, clinic to transition completely.

By 2010 regional planning for transition seemed to have stalled. Ironically, progress on a state-wide transition policy for Queensland, pursued by the state ACCHO peak body (the Queensland Aboriginal and Islander Health Council) since 2006 (QAIHC 2011), seems to have had the effect of delaying progress in Cape York. Work on this initiative continued for several years, but the draft transition policy was not endorsed before major restructuring in Queensland Health and a change of government in Queensland in 2012.

By 2014 Apunipima had achieved significant growth to become a major provider and partner in the delivery of PHC to the Aboriginal communities of Cape York. However, the commitment to full community control of Cape York PHC services had not been realised. In all communities other than Mossman Gorge, a hybrid PHC system operates, with attendant problems in service coordination and pressure on working relationships.

Findings

Significant progress has been made, but several problems prevented the full implementation of the Deed of Commitment. The major problems were:

1. Lack of an authorised collaborative tripartite regional body (i.e. both governments and Apunipima), which left the project without a focus for planning and decision making. An unstable political and health system environment in Queensland, and major concurrent national changes, exacerbated problems with authorisation and implementation.
2. Resources to enable implementation were available only in the first few years. This affected Apunipima's capacity to maintain engagement among the dispersed communities of Cape York.
3. Hostility to community control among local Queensland Health staff and some of the concerns about the practicalities of transition for staff were seen as evidence of systemic racism.
4. The inherent difficulties of managing and governing a health organisation across a large diverse region made good corporate governance a challenge. Government concerns about Apunipima's governance added to this problem. Split roles in PHC, with both Queensland Health and Apunipima providing aspects of care in each community, resulted in problems of coordination and working relationships.
5. There was a lack of consideration of the underlying inadequacy of resources for PHC in the region, in spite of available evidence.
6. Funding complexity was not addressed and the reporting burden grew with increased funding.

Overall findings and conclusions

Although each case study is unique, strong common themes are apparent both in the implementation problems encountered and in the implications for the future development of the PHC system.

Achievements

Although the policy goals were not achieved, significant progress was made towards the development of a regional PHC system. Community engagement work was undertaken, the rationale for regionalisation of services was consolidated and some health services were transferred to community control. At the jurisdiction level in the Northern Territory, several important technical and policy issues were addressed, including the definition of core PHC services and a framework for the development of regionalisation proposals. Approaches to assessing the readiness of community organisations to undertake regional governance were developed in both jurisdictions (although this matter remains controversial).

Barriers in the implementation methods

The planned reforms were beset by the following implementation barriers and difficulties.

Authorisation, auspice and control

There were problems in the authorisation of the reforms in both the Northern Territory and Cape York, with high-level commitments not being matched with secure structures and processes for sharing power and control in order to manage the reforms. The auspice body in the Northern Territory, NTAHF, lacked the executive authority to enable timely binding decisions about the reforms. In Cape York, structures to auspice and authorise the reforms were unstable or missing.

For governments, the level of organisational and policy change during the period (including changes in elected governments nationally and in the Northern Territory and Queensland, departmental restructures and shifts of individual senior decision makers) had an impact on both their commitment to, and interpretations of, the reforms.

The responsibilities the reforms placed on Aboriginal participants to represent the community, and the associated cultural obligations they took on, were a challenge that was often underestimated by funding agencies. There was also a perception by participants that government did not acknowledge the cultural legitimacy of ACCHOs and their role in shaping the dialogue about community control of the health sector. Although a continuing partnership between governments and the Aboriginal community controlled health sector was an essential requirement, there was a mutual perception of failure to maintain commitments and a sense of significant pressure on established relationships and mutual trust.

Our first conclusion is that future reform efforts will require more secure authorisation and auspicing to succeed in this complex cross-agency and cross-cultural endeavour.

Inadequate resources: money, time and capacity

One reason for difficulties in the reforms we studied was that the work had been under-estimated—in complexity, the timelines, and the skill and resource requirements. In each case study, the need for adequate resourcing of the change process itself was insufficiently recognised and provided for.

The complex changes involved in the planned reforms required a range of specialised knowledge and skills—clinical, financial, planning, governance and policy. Although such expertise may have existed, it was not reliably available. There was also a mutual perception of failure to maintain commitment to agreed timelines and processes.

Our second conclusion is that future reform efforts will require more attention to realistic time and resource allocations (both human and material) and the negotiation of explicit commitments.

Working across cultures, in partnership

Working across cultures and in partnerships is difficult but is inescapable in the reform program. The working relationships we studied were often robust and effective, but were also characterised by a mutual lack of trust. This can be attributed to the separate interests of funders and providers, and to the intercultural nature of the relationship and the pervasive and perverse impacts of systemic racism (that is, the ways in which discriminatory effects are built into care systems, with or without intention on the part of those working within them). Although racism was not overtly expressed, it was considered by many participants to be an important underlying influence. Finding good ways to work across cultures remains a significant outstanding challenge, in spite of the fact that there is much skill and experience among some of the people involved.

Many of the strengths, as well as the challenges, are shaped by traditional and contemporary Aboriginal and Torres Strait Islander cultures. These aspects are seen by participants to have been misunderstood and their significance underestimated in the reforms.

The challenge of working across community and government sectors is also a significant one. Given the different priorities, meanings, timelines, goals and interests that the partners hold, this work is also cross-cultural. Both kinds of intercultural challenges can only be addressed if they are openly acknowledged, explored and made part of the work program.

Our third conclusion is that future reform programs need to be founded on a solid explicit basis for working across cultures that acknowledges and mitigates the impacts of systemic racism, and recognises the impacts of the different contexts in which community and government representatives work.

Implications for future development

Our second research question considers what the experience of the reforms tells us about the requirements for the future—the funding and accountability relationships, and the governance and stewardship arrangements that are needed for an effective PHC system for Aboriginal and Torres Strait Islander communities.

This study accepted long-established national policy commitments to the development of the ACCHO sector and did not set out to investigate the merits of this policy direction. However, nothing emerging in this study suggests that the policy direction should be changed. The goal of improving access to essential health care for Aboriginal and Torres Strait Islander people and communities remains critical. Continuation, in some form, of the work described in this study is needed. What then are the implications of our results for the future development of the PHC system for Aboriginal and Torres Strait Islander communities?

Regionalisation and the implications for governance and stewardship

The development of a regional system of PHC for Aboriginal and Torres Strait Islander communities has implications for the design of the health system as a whole, both at jurisdiction and regional level. Major aspects include the ways that care is structured and coordinated across a region, the allocation of pooled or bundled funding to regions and thence to providers, and the collection and analysis of data to guide regional planning and assess results.

There has been a tendency in Australian health policy debates for regionalisation to be seen as a straightforward restructuring of existing health care arrangements. In contrast, experience in New South Wales with regional structures and funding for public hospitals and health services in the last decades of the twentieth century is a good local example of the benefits of a more systemic approach. NSW Health gave serious attention to regional governance, regional funding allocation, equity in funding on a population basis, fairness for provider agencies within a region, the development of networks of care, and the role of the central health department in a regionalised system.

Importantly, attention is required both to the governance of regions at jurisdictional level and to the structures and methods by which ACCHOs and the mainstream system articulate with each other within each region and at jurisdiction level. This is not a simple matter of defining regional boundaries and asking those within them to work collaboratively.

Stewardship, or the careful and responsible management of the system for Aboriginal and Torres Strait Islander health, is something that all organisations can contribute to but that can only be achieved by governments. The reforms in both jurisdictions clearly offered an opportunity and a need for better systematic integration of ACCHOs in the jurisdictions' public health systems, but this opportunity was not realised.

Regionalisation has mixed implications for communities. For some, it brings an opportunity to participate in developing a major community controlled service on the basis of transfer of government services. For others, it brings a requirement to relinquish local control in favour of regional development. The requirement for full amalgamation of local ACCHOs into a single regional ACCHO as a *precondition* of transfer is a significant barrier to the staged development of service integration. More flexible system design would enable suitable regional/community alternatives to be accommodated in central/government plans.

It appears that regionalisation was seen in government as a way to honour the policy intention to support the development of the ACCHO sector while also addressing some concerns about the governance of ACCHOs. However, while governance concerns clearly influenced government agencies, the matter appears not to have been aired or negotiated in relevant forums.

Our fourth conclusion is that future reforms in the PHC system for Aboriginal communities should continue to use a regional approach, under Aboriginal community control, and should develop coherent regional systems for funding and governance, and for coordinating PHC services among all providers across the region.

Funding, contracting and accountability

Government funders ruled out addressing the question of the overall adequacy of funding levels for PHC for Aboriginal people as part of the reforms despite the strong implication that an adequate funding base is not only required but can also be expected to result in improved health status indicators.

Both governments and the ACCHO sector support the goal of equitable allocation of funding on a population basis. The allocation of funding for a regional population (weighted for risk and cost factors) is not straightforward, but is a tested method for achieving more equitable access to care. In the case of under-served (often rural and remote) regions, additional funding, not simply reallocation, is needed. Regional allocations then require distribution to service providers, and this is also a complex task that requires a mandated structure and process that is transparent and fair to providers, communities and citizens.

Our fifth conclusion is that increased funding is needed to support adequate access to culturally safe PHC across and within regions, and that levels should be based on the size of the regional populations (weighted for risk and cost factors) and distributed to providers within regions with fairness and transparency.

The pooling or bundling of funds was a clear explicit intention of the reforms in the Northern Territory (NTAHF 2009:27) and in Cape York (CYRHF 2006:9). However, we found no evidence of substantial work within government on the methods for achieving this change, which would require high-level approvals and significant technical workup.

We found a similar pattern of inactivity in relation to the systematic sharing of needed base-line information, such as the funding of clinics to be transferred, their service data and the extent of coverage of the area population. In the Northern Territory, modelling of the funding for infrastructure and services that would be required to provide the identified 'core' PHC services was not undertaken. In Cape York the funding implications (for equitable health care provision) were identified (Eagar & Gordon 2008) but not addressed.

A lack of attention to the question of reform in the accountability regime (i.e. the number and nature of reports required etc.) is notable. The East Arnhem and Apunipima case studies both show an increase in funding from the 2009–10 financial year and a rapid rise in reporting requirements, particularly from the Australian Government.

Our sixth conclusion is that enduring reform in the funding and accountability relationship between government and the ACCHO sector should be based on long-term contracts for bundled or pooled funds to support comprehensive PHC, and a modified accountability regime more suitable to the functioning of PHC, and to the shared responsibilities of providers and governments.

What needs to be done?

Based on our conclusions, future work to develop a regional system of community controlled PHC for Aboriginal and Torres Strait Islander communities needs to address six essential elements of substantive change (summarised in Table 1), almost all of which were explicitly or implicitly included in the reforms we studied.

Table 1: Elements of substantive change

Element	Explanation	Status
REGIONAL COMMUNITY CONTROL Establish regional PHC system, based on ACCHO sector and community governance	The establishment of a regional system of PHC would enable progress towards reliable access to the range of essential PHC services, including referrals to specialised care across the country, and ensure cultural safety. Models of regionalisation must allow for adaptation by regions and support coordination of care among all relevant regional providers. Strong community governance is essential.	Included
ENGAGEMENT Operating as part of the larger health system, engaged with other providers and with funders	Clarity of roles and coordination between mainstream and ACCHO providers would improve coordination of care for patients and access to specialised care. Engagement between funding agencies and ACCHOs in addressing issues of mutual concern is needed to improve working relationships, address systemic racism and enhance reciprocal accountability.	Included
POOLED FUNDING Funded through long-term pooled or bundled funding contracts	Reform in contracting (towards fewer longer-term contracts) is needed to support comprehensive PHC, to enable equity in funding, to enhance efficiency for both funders and providers, and to provide a more suitable basis for meaningful accountability.	Included, but not developed
GOVERNANCE AND STEWARDSHIP Community governance at regional level; stewardship by government	Attention to governance in the ACCHO sector focused on the challenges of regionalising governance; governments take stewardship responsibility for long-term development of a robust PHC system; all parties need to take a business-like approach to identifying and resolving their concerns in these areas.	Included implicitly; some aspects undeveloped
ACCOUNTABILITY Accountable to communities and mutually accountable with funders	ACCHOs need to be accountable to communities for effective care, access and responsiveness, and reciprocally accountable with funders to meet contractual obligations to each other. Governments need to be accountable for equity in funding and access to care, and the mainstream health system for ensuring equitable access to culturally competent care.	Included implicitly, but not addressed
FUNDING LEVEL Funded to achieve equitable coverage for Aboriginal and Torres Strait Islander people, according to need	Increased funding for regional Aboriginal and Torres Strait Islander PHC is needed to close recognised equity gaps, according to need and rural/remote costs. In absolute terms, the funding gap is not large, but some reallocation to regional PHC, and increases over time, are required.	Explicitly excluded

Although the three case studies gave attention to governance, and implicitly required more attention to stewardship by governments, these matters remained problematic. The reforms also implicitly entailed some changes in the model of accountability between the ACCHOs and their government funders, and between ACCHOs and the communities they serve. Although ongoing additional funding (i.e. to fund equitable access to PHC for Aboriginal and Torres Strait Islander communities) was explicitly excluded, this need has been identified in several economic analyses. We suggest that the funding requirement is substantial but achievable.

Implementing the six essential elements of substantive change would require commitment and accommodation from governments, Aboriginal and Torres Strait Islander communities and the ACCHO sector. In order to commit to increased investment in community-governed PHC:

- governments require assurance of performance in delivery of high-quality care
- governments need to accept that the current methods of funding and contracting are not suitable to ensure performance in this context, and need to work with the sector to develop longer term and less complex and fragmented approaches.

In addition:

- the ACCHO sector requires long-term assurance of funding and acceptance of its role in the health system
- the sector and government need to accept the implications of a negotiated understanding of regionalisation and reformed engagement with each other
- all parties need to work together in an enduring structure for partnership and to develop a workable approach to reciprocal accountability.

These are not simple matters, and long-term commitment is required, along with strong leadership.

The development of a regionalised system of PHC for Aboriginal and Torres Strait Islander communities, under community governance, offers a pathway towards better health care and better health. We conclude that the goal of equitable access to PHC through a regionalised network of ACCHOs working with the mainstream health system is achievable, and that action to achieve it should commence—or recommence—as soon as possible.

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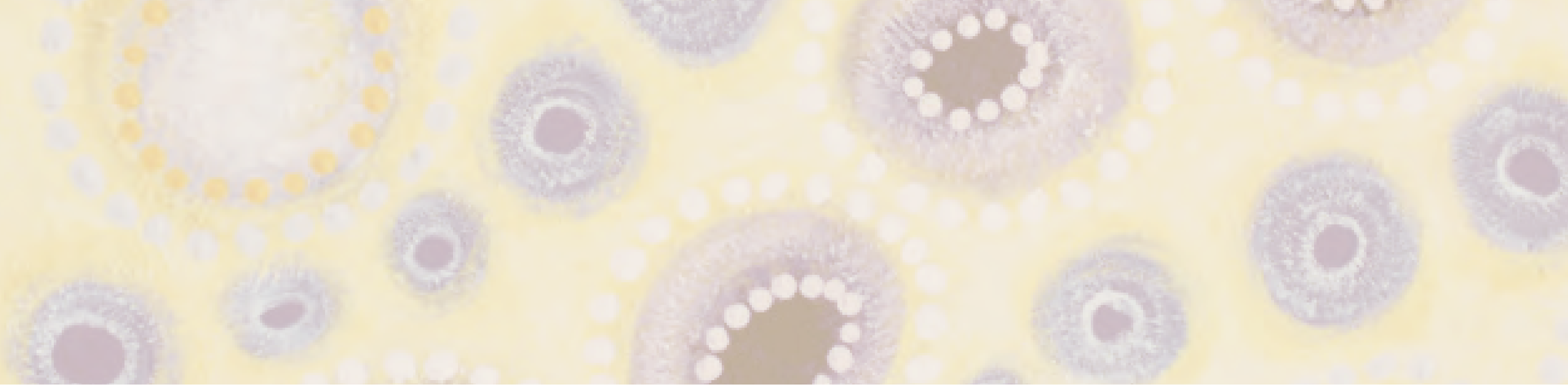
Author biographies

Professor Judith Dwyer is Director of Research in the Department of Health Care Management at the Flinders University School of Medicine, and a former CEO of Southern Health Care Network in Melbourne, and of Flinders Medical Centre in Adelaide. She teaches in the Flinders' Master of Health Administration, and conducts research focused on health system governance and design, with a particular focus on Aboriginal health services. She served as a Research Program Leader for the Lowitja Institute from 2009–2014. Judith is the lead author of the popular text *Project Management in Health and Community Services*, 2nd edition.

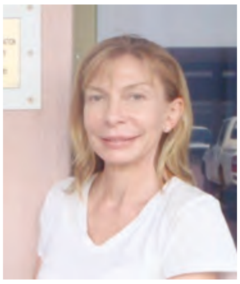
Dr Angelita Martini is a Senior Lecturer in the Centre for Health Service Research in the School of Population Health at the University of Western Australia. Her current research is focused on the health needs of vulnerable Western Australians, and models of care in cancer services. She has extensive experience in research coordination, tertiary education and curriculum development roles in medicine, nursing, Aboriginal studies and public health. Angelita has held management positions in the private and public sectors, both nationally and internationally, in health, education and correctional services.

Ms Cath Brown is a Noonuccal woman from Minjerribah [North Stradbroke Island] off Brisbane. In 2007 she took up a Research Officer position at James Cook University, within the School of Indigenous Australian Studies Empowerment Research Program, to become involved in the delivery of the Family Wellbeing Program. Cath facilitated the empowerment program with Aboriginal and Torres Strait Islander individuals, groups and organisations predominantly in North Queensland. She has completed a Graduate Diploma in Indigenous Health Promotion, graduated Master of Public Health [Health Promotion] and has begun a research Masters looking at Aboriginal health advocacy.

Mr Edward Tilton has more than 20 years of experience in the Aboriginal and Torres Strait Islander health field, with particular expertise in primary health care planning, community development, policy development and consultative processes. He has worked for the Aboriginal community controlled health sector at a local, jurisdictional and national level, as well as for the Northern Territory Government. He currently provides consultancy services to a wide range of Aboriginal community controlled services, government departments, and research agencies across the country, specialising in the complex and culturally diverse environments of northern and central Australia.



Dr Jeannie Devitt is an anthropologist with more than 30 years of experience working with Aboriginal people in the Northern Territory particularly in remote areas. Jeannie has worked primarily for Aboriginal community controlled organisations including the Northern and Central Land Councils, Indigenous Health Services, Indigenous Community Councils and Legal Services as an employee and as a consultant. She was a Senior Research Fellow with the Cooperative Research Centre for Aboriginal Health from the late 1990s, and has undertaken nationally funded Aboriginal health research projects, as well as research commissioned by the Australian Government in relation to kidney disease within Indigenous communities. She is currently employed by the Menzies School of Health Research in Darwin.



Ms Paula Myott is a public health professional with 20 years of experience working in the Aboriginal health and international development fields, and expertise in program design and management. She was employed by Miwatj Health as Director of Regional Health Reform during this project. Paula has worked in government and in non-government organisations (NGOs) and has executive level management experience. Her roles have included establishing frameworks for stakeholder engagement and management in complex contexts and leading organisational change processes. Paula has worked with all levels of government as a NGO stakeholder on the research:policy:implementation cycle, and is currently working on a PhD with Flinders University focused on accountability between governments and ACCHOs.

Dr Brita Pekarsky has worked as a health economist since 1991 in the areas of pharmaceutical regulation and primary health care. Her involvement with Aboriginal and Torres Strait Islander health started in 1997 when she worked on the evaluation of the Aboriginal Coordinated Care Trials. Brita's research focus is on how we can improve the health of the community by improving the way in which primary care services in the Aboriginal health sector are financed. She is a private consultant economist and also has an appointment at Wardliparingga, the Aboriginal Health Unit at the South Australian Health and Medical Research Institute.

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PAPER NINE – Implementing Indigenous community control in health care: Lessons from Canada

This paper (Lavoie & Dwyer 2015) encapsulates some of the results of the ongoing comparative analyses of policy and practice in Indigenous health care in Canada and Australia conducted among Professor Lavoie, myself and other members of the Contracting at the Margins Research Group.

Statement of my role

Professor Lavoie prepared the first draft, and led the development and revision of this paper. I contributed much of the analysis of the Australian context, policy settings and barriers to progress, and contributed to the ‘knitting’ of the Canadian and Australian perspectives. This paper was a true collaboration, initiated by Professor Lavoie, drawing on our years of working together on these issues.

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Implementing Indigenous community control in health care: lessons from Canada

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Abstract

Objective. Over past decades, Australian and Canadian Indigenous primary healthcare policies have focused on supporting community controlled Indigenous health organisations. After more than 20 years of sustained effort, over 89% of eligible communities in Canada are currently engaged in the planning, management and provision of community controlled health services. In Australia, policy commitment to community control has also been in place for more than 25 years, but implementation has been complicated by unrealistic timelines, underdeveloped change management processes, inflexible funding agreements and distrust. This paper discusses the lessons from the Canadian experience to inform the continuing efforts to achieve the implementation of community control in Australia.

Methods. We reviewed Canadian policy and evaluation grey literature documents, and assessed lessons and recommendations for relevance to the Australian context.

Results. Our analysis yielded three broad lessons. First, implementing community control takes time. It took Canada 20 years to achieve 89% implementation. To succeed, Australia will need to make a firm long term commitment to this objective. Second, implementing community control is complex. Communities require adequate resources to support change management. And third, accountability frameworks must be tailored to the Indigenous primary health care context to be meaningful.

Conclusions. We conclude that although the Canadian experience is based on a different context, the processes and tools created to implement community control in Canada can help inform the Australian context.

What is known about the topic? Although Australia has promoted Indigenous control over primary healthcare (PHC) services, implementation remains incomplete. Enduring barriers to the transfer of PHC services to community control have not been addressed in the largely sporadic attention to this challenge to date, despite significant recent efforts in some jurisdictions.

What does this paper add? The Canadian experience indicates that transferring PHC from government to community ownership requires sustained commitment, adequate resourcing of the change process and the development of a meaningful accountability framework tailored to the sector.

What are the implications for practitioners? Policy makers in Australia will need to attend to reform in contractual arrangements (towards pooled or bundled funding), adopt a long-term vision for transfer and find ways to harmonise the roles of federal and state governments. The arrangements achieved in some communities in the Australian Coordinated Care Trials (and still in place) provide a model.

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Introduction

Internationally, primary healthcare (PHC)[1] renewal continues to be identified as a key pathway to achieving health equity, meeting the needs of underserved and poorly served populations, and for improving the efficiency of healthcare systems.[2–4] PHC services generally include four key components: (1) primary care provided by general practitioners (GPs) and, more recently, by nurse practitioners; (2) primary prevention activities (health promotion) designed to prevent the onset of illness; (3) secondary prevention interventions focused on assisting in the management of chronic illness to avoid or delay the development of complications; and (4) tertiary prevention interventions designed to assist in the management of complications, to ensure that optimal autonomy is retained. Advocacy and referrals are integral components.[1] Comprehensive PHC, the goal of Indigenous providers of health care (and some others), also emphasises the need to attend to and be informed by the social determinants of health that affect the health and life chances of the people, and their access to good health care. In this paper, the focus is on the provision of comprehensive PHC by Indigenous community-based organisations.

Evidence shows that when PHC is not accessible (geographically, economically or culturally), responsive or effective, people delay seeking help, rely on emergency care and lose the benefits of continuity of care.[2,5] In many countries, histories of colonialism have resulted in power differentials that negatively affect PHC access and responsiveness to Indigenous people's needs. For the past 25 years, both Canada and Australia have endorsed community control of Indigenous health services, but implementation has followed different pathways. Canada has focused on transferring pre-existing PHC services previously delivered by the federal government to the established First Nations local government authorities 'on reserves' (i.e. for discrete First Nations communities). In the Canadian context, community control over these services has been constrained by a disconnect between resourcing and needs, as well as some contractual inflexibilities, which, at times, undermine responsiveness.[6,7] Australia has established a multiplicity of Commonwealth, state and territory funding programs for community-controlled PHC[8] in response to community activism in the 1970s. The Aboriginal Community Controlled Health Organisation (ACCHO) sector has grown substantially over the past 40 years, largely through the funding of community-initiated submissions. In the Australian context, community-controlled PHC has been constrained by an over-reliance on short-term specific-purpose funding and inflexible contractual obligations.[9] More recently, some jurisdictions have been promoting the transfer of PHC services delivered in Aboriginal communities from the state or territory health authority to an Aboriginal community-based governance structure. However, the process in both countries has been bumpy and complex.

Policies in favour of Indigenous community control clearly face implementation challenges in both countries. The aim of the present paper is to contribute to continuing efforts to achieve implementation, with a particular focus on how the Canadian experience could inform Australian implementation approaches.

Methods

Canadian challenges and strategies were reviewed, with reference to policy and evaluation documents (grey literature) that emerged over time. The Canadian strategies were then assessed for relevance to the Australian context, recognising the common complexities of implementing community control across communities with diverse needs, capacities and experience, the challenges of formulating a meaningful accountability framework and the need for adaptation of administrative arrangements to support the delivery of responsive PHC.

Results and Discussion

In Canada, provincial governments have constitutional responsibility for the planning and delivery of healthcare services. The federal government started to assume responsibility for the delivery of health services on-reserve in the 1920s,[10] on humanitarian grounds (so federal policy states) or based on Treaty obligations (according to First Nations; for a more detailed discussion, see Boyer[11]). By the mid-1960s, most of the 610 First Nation reserve communities had access to some level of public health and PHC services delivered by federally employed nurses and interpreters. Community Health Representatives (CHRs; the Canadian equivalent of Aboriginal Health Workers) were added to the team in the mid-1970s, along with Addiction Prevention Workers (APWs). The role of the CHRs was to assist nurses with prevention and treatment activities. CHRs and APWs were employed by the community, with funding from the federal government. This was the beginning of community control.

CHRs and APWs were employed in nearly all First Nation communities; only very small communities were not provided with this opportunity. CHRs and APWs were hired by Chief and Council, the governance structure originally created by the Indian Act in 1876.[12] The Chief and Council governance structure is the equivalent of local government, and continues to be the point of contact for consultation, negotiations and, in some cases, joint decision making with other levels of government (municipal, regional, provincial or federal). Chief and Council can also, if the community wishes, exercise some control over community-based schools, health services, child protection, economic development, community infrastructure and other federally funded programs.[13]

In 1985, a change was made to the Canadian Constitution (Section 35) recognising the right of First Nations, Inuit and Métis' to self-government. Greater opportunities for community control emerged as a result. Funding options include multidepartment funding agreements (MDFA), block funding agreements (BFA) and flexible funding agreements (FFA). Flexibility depends on the model chosen by the community. MDFAs are the most flexible because they bring together multiple social programs, such as health, education, child welfare, economic development, income assistance, infrastructure, housing and local governance, under a single relational agreement. In contrast, BFAs and FFAs relate to health services only. BFAs are block-funded flexible agreements signed for 3–5 years. A new version of this option is being offered, allowing communities to sign for up to 10 years, with opportunities to add new programs as they emerge. In contrast, communities that sign an FFA must instead secure the federal government's permission before moving funding between budgetary lines.[14] These options have been relatively well received by First Nations, with 89% of the eligible 610 First Nation communities involved in one or other type of agreement as of 2008.[15] Communities who are not interested or ready to engage in this process (because of a perceived lack of capacity or other priorities) continue to receive their community-based PHC from federal government employees.

Pre-existing services delivered by the First Nations and Inuit Health Branch of Health Canada (FNIHB; the Canadian equivalent of the Office of Aboriginal and Torres Strait Islander Health (OATSIH)) are being transferred to community control. Communities wanting to manage on-reserve health services simply express this interest to the federal government. Unless the community has a history of management challenges with other programs, the federal government extends bridge funding for 12 months for the community to undertake a community needs assessment and develop a community health plan.[16] Funding for community health services is based on historical expenditures in that community, and this is for the most part non-negotiable.[6] Once the community health plan has been approved by the federal government, community control can be implemented. Communities can choose to sign an agreement alone or as part of a multicommunity consortium. Communities of less than 500 members are precluded from signing a BFA unless they affiliate themselves with other communities because of sustainability issues. Communities receive separate funding to undertake an evaluation of their services every 5 years. Recent work has demonstrated that First Nation-controlled services are able to deliver on health outcomes.[17]

The accountability struggle

Canada has struggled with issues of accountability. When community control was initially implemented, agreements included onerous reporting requirements. Local FNIHB program managers adopted pragmatic strategies to ease that burden by overlooking missing reports of little utility.[7] In 1997, the Auditor General of Canada chastised FNIHB for not following up on missing reports.[18] From then on, punitive measures (withholding of funding) were put in place to ensure that all reporting requirements were met.[19] In 2004, the Auditor General of Canada revisited First Nations' reporting requirements, suggesting that, in fact, these were unduly onerous, dictated by government funders rather than based on consultations, of low use for community organisations, incremental because new programs added reports without considering the overall reporting burden, failed to inform on performance and were largely unused to report to Parliament.[20]

The Auditor General of Canada further pointed out that 'there's not much point in First Nations exchanging data for dollars with the federal government when the information is of no real benefit to either party'.[21] Lavoie *et al.*[7] documented that in 2003–04, First Nations in the province of British Columbia (169 communities) produced an estimated 5813 reports to meet their accountability requirements for health services alone. They further noted that many reports were never read because FNIHB lacked the human resources to do so. First Nations and FNIHB confirmed having little use for the information collected.

A key barrier to consolidating a meaningful reporting framework has been the accountability requirements of Treasury Board of Canada Secretariat (hereafter Treasury Board), which oversees accountability for all federal programs, grants and contribution agreements. In 2006, an independent Blue Ribbon Panel appointed by the Treasury Board reviewed all grants and contributions ($27 billion CND in annual spending), including those discussed herein. They concluded that:

(1) There is a need for fundamental change in the way the federal government understands, designs, manages and accounts for its grant and contribution programs.
(2) Not only is it possible to simplify administration while strengthening accountability, but it is absolutely necessary to do the first in order to ensure the latter.
(3) Making changes in an area of government as vast and multifaceted as grants and contributions will require sustained leadership at the political and public service levels.[22]

To operationalise these, the Blue Ribbon Panel recommended the following.

(1) Increased respect for recipients of grants and contribution agreements, and the reframing of this relationship as a partnership.
(2) A marked simplification of the reporting and accountability regimen to reflect the circumstances and capacities of recipients and the real information needs of the federal government.
(3) Encouraging innovation, stating that 'the goal of grants and contribution programs is not to eliminate errors but to achieve results, and that requires a sensible regime of risk management and performance reporting'.[22]
(4) Organising information collected so that it can serve program managers and recipients alike.

The panel noted that mechanisms other than grants or contributions are needed for the funding of essential services such as health, education and social assistance in First Nation communities because grants and contribution agreements lead to costly and unnecessary reporting burden.

The report of the Blue Ribbon Panel led to the revisions in the contribution agreements used by FNIHB discussed above. FNIHB was also tasked to consolidate reporting requirements and reduce the burden. A first iteration was produced in 2008.[23,24] Another revision is underway, in consultation with First Nations provincial organisations (peak bodies for communities), to further reduce onerous requirements and include key outcome indicators developed by FNIHB.[25]

Lessons for Australia?

The Canadian context is very different from the Australian one. Importantly, there are no equivalents to the treaties and the Royal Proclamation of 1763 that recognised continuing Indigenous rights in Canada. Aboriginal and Torres Strait Islander peoples are not recognised in the Australian Constitution and government responsibility for Indigenous health is not defined in health law.[26] Thus, there is no enduring basis for accountability by governments for improvements in Aboriginal health care, including for transferring PHC provision to community-controlled healthcare providers, despite continuing policy commitments.[26,27] Further, despite earlier policy commitments to self-determination,[28] the policy discourse has largely shifted away from Indigenous rights and towards a focus on 'closing the gap' in social, economic and health status indicators between Indigenous and non-Indigenous Australians.[29]

Second, First Nations are taking on pre-existing services, previously delivered by the federal government in discrete communities, whereas this is not usually the case in Australia, where community-controlled services have more often been created *de novo*. When taking on community control, the responsibility for the management and delivery of services is transferred to a pre-existing governance structure that has been regulated by a federal act of parliament since 1876. In contrast, Australian community-controlled health services are non-government organisations owned by the local community and incorporated under various national or state laws.

Finally, BFAs and FFAs are transfers from a single level of government. MDFAs, when associated with land claim agreements, can be tripartite agreements between the federal department in charge of First Nation health, the Ministry in charge of First Nation education, economic development, income assistance, governance etc. and the First Nation. For example, the Nisga'a Agreement, the James Bay and Northern Quebec Agreement, and the Labrador Inuit Association Agreement are legislated tripartite agreements that include provisions for self-administration of health services.[30] Accountability provisions for MDFA agreements sit outside the usual grant and contribution agreement frameworks, and provide First Nations who are signatories with budgetary line flexibility across healthcare, income assistance, economic developments and other spheres of government funding. These agreements can facilitate cross-sectoral innovations focused on determinants of health. There is no equivalent in Australia (Table 1).

Given these important differences, what then can be learned from such a different context?

Lesson 1: implementing community control takes time

As shown in Fig. 1, implementing community control in Canada to the 89% level took 20 years (1989–2008),[15] despite the fact that community control was being implemented in communities with considerable engagement with the community-based healthcare services and a governance structure that had been in place since 1876. In Australia, efforts to transfer services to community control are generally conducted under tight timelines,[31] which are generally not achieved, leaving a sense of failure and opportunities for allocating blame.[32]

Table 1. Comparison of contexts and processes for implementing community control in Canada and Australia

	Canada	Australia
Pre-existing health services are being transferred	Yes	Local services often created *de novo*; some transfers from state governments
Transfer is to a pre-existing Indigenous governance structure that manages other programs as well	Yes	No; some health services established by existing community organisations
Single government (federal) to single government (First Nation) transfer	Self-government agreements can be tripartite; others are single government transfers	No; transfer requires tripartite agreements

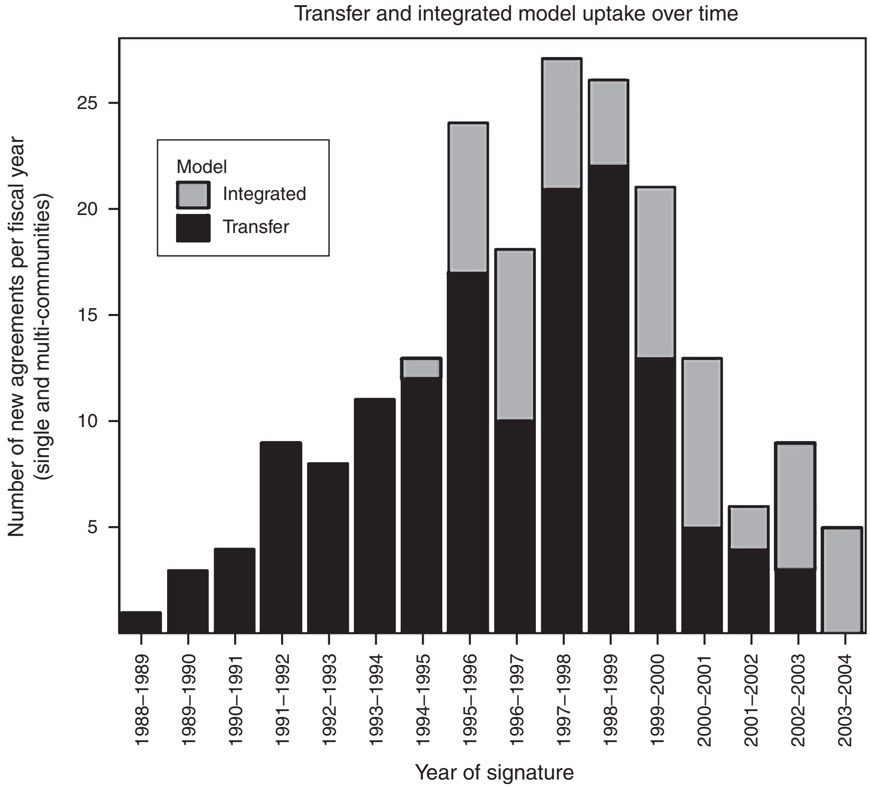

Fig. 1. Community control uptake in Canada over time: Transfer and integrated models.

Lesson 2: supporting change management with resources

As discussed above, the federal government initially funds First Nations for 12 months to develop a community health plan that reflects community-identified priorities. Every 5 years, the same organisations receive funding to undertake an evaluation of their services, which is used to adjust the community health plan before renewal. Research suggests that this change management cycle is key to ensuring continuous improvement.[7]

Lesson 3: tackling the thorny issue of accountability

Canada is slowly developing tailored mechanisms designed to fund First Nation health organisations. Accountability frameworks based on meaningful indicators are attached to the funding mechanisms. Although the work is far from complete, tailored administrative instruments are more likely to yield meaningful information that can be used by federal and First Nation program managers to ensure that services deliver on their objectives.

This work needs to happen in Australia as well, but there are significant barriers. The problems of low levels of trust across cultures, and the continuing effects of histories of dispossession and conflict are important factors. However, they are common to both countries. We suggest that there are three major barriers that differentially affect approaches to the implementation of community control in Australia.

Current contractual arrangements are ill-equipped to deliver PHC outcomes The first barrier stems from the fact that Australia embraced the contractual approaches of new public management (NPM) more thoroughly than Canada,[33] which means that moving to an approach that meets the needs of PHC is more difficult. Evidence shows that over-reliance on NPM-informed contractual agreements is unhelpful to local governance in rural and remote Indigenous communities.[34] In funding PHC, this approach, with its focus on tendering predefined specific health interventions, has also been found to be a poor fit[9,35] because PHC requires continuity of care and long-term trust-based relationships between healthcare providers and clients. A model for such a funding arrangement exists in the agreement still in place for Katherine West Health Board in the Northern Territory (a funds-pooling arrangement originally established as part of the Coordinated Care Trials[36]).

Implementing sustainable and effective community control in Australia will take time, and success requires a long-term vision and resources for change In many rural and remote Australian Aboriginal communities, where the jurisdictional health authority provides basic primary care, transfer to community control will require careful community processes of development and agreement making in order to establish a structure and plan for local or regional ownership and delivery of PHC. This needs to be supported in policy and guidelines, resourced and factored into timelines. So far, and in the context of the legacy of dispossession and community dislocation, Australian governments have underestimated the amount of work and time required.[32] Political commitment that endures beyond election cycles is also needed.

Accountability on both sides The more complex mix of funding and regulatory roles between levels of government in Australia means that no government holds enduring responsibility for Aboriginal and Torres Strait Islander health, and thus no government holds clear accountability for improvement.[26] Although constitutional reform may be required to fully address this issue, other solutions include: (1) the allocation of responsibility for PHC to the federal government, as recommended by the National Health and Hospital Reform Commission;[37] or (2) federal and state agreements enacted in matching legislation, clarifying roles and responsibilities and harmonising contractual and accountability requirements.[26]

Recognition that administrative simplification is necessary in order to strengthen accountability, as articulated in the Blue Ribbon Panel report to the Canadian Treasury Board,[22] could provide the basis for the reform of approaches to funding contracts in Australia. The development of a national system of meaningful indicators of health care effectiveness in PHC for Aboriginal people[38] is an important step in that direction.

Accountability by ACCHOs to their communities is structured into the sector by community ownership, but enactment and reporting of that accountability (for quality and access, good governance and responsiveness to community priorities) is less visible. The sector is actively working on methods to address this requirement (see http://www.naccho.org.au/promote-health/governance-initiative/, accessed 4 September 2015).

Conclusions

Current efforts to facilitate the development of the community-controlled sector in Australia stand to make a unique contribution to closing the gap in Aboriginal and Torres Strait Islander health. Canada has been engaged in a similar process for over 20 years, and the available evidence indicates that the gap can be narrowed with effective community-controlled PHC.[17]

The Canadian context is different, and we do not believe Canadian solutions will fit the Australian context exactly. Still, Canada's experience can inform the implementation of community control in Australia.

Competing interests

None declared.

Acknowledgements

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Impact

It is too early to assess the impact of either of these papers, or the companion documents to *The Road is Made by Walking* (5 in all). They were launched at the National Library in Canberra on 19th November 2015, and our intentions are that they will provide the basis for further academic and popular or industry press publications. Most importantly, the papers are intended to inform future reform efforts, through the work of Aboriginal health advocates and policy makers. At the time of writing, discussions with a national Aboriginal health leadership group and an approach to Commonwealth policy workers were planned.

I was invited to provide advice to the NT Aboriginal Health Forum as the project drew to a close in 2014, when the Forum was considering how it might re-group and move forward on the planned reforms. I hope my contribution assisted the Forum members.

I hope that the second paper (Lavoie & Dwyer 2015) will provide a useful point of comparison in the future design of transfer policies and implementation projects.

The continuing role of the ACCHO sector

The first of these published papers (Dwyer et al. 2015a) draws on the reform experiences of the Northern Territory and Cape York Queensland to articulate the basis of a practical, viable pathway to ensuring equitable PHC coverage for the Aboriginal population. The six 'essential elements' of change (Dwyer et al. 2015a:10) outline a regional community-controlled PHC delivery system, with equitable levels of pooled or bundled funding for service delivery; supported and held accountable in an environment of coherent stewardship by government and effective regional ownership and governance by and on behalf of communities. There are several advantages to this model:

1. It would provide for the first time a framework for equitable population-based funding of essential or 'core' PHC, by establishing a regional structure to receive funding to serve a regional population, and allocate it (in accordance with negotiated policies and guidelines) to service providers.

2. With contracting reform, and with funding programs more secure (through legislation or other means), it could address the current paradoxical situation where, compared to PHC for other Australians, PHC for Aboriginal people is more heavily reliant on contingent/insecure funding sources that can be removed, reduced or changed without reference to Parliament[18].
3. It could allow for varying forms of regional ACCHO structures, shaped by local circumstances, history, community preferences and relationships, and the availability of other health services in the regional system of which the ACCHO sector is a key part. Varying forms of community control could be developed, as decided by communities and negotiated with government on transparent agreed criteria, as was envisaged in *Pathways to Community Control* (NTAHF 2009).
4. It could enable the extension of locally responsive care for small remote communities (through transfer of government-delivered services and new developments), building on the strength of existing ACCHOs, and based on existing successful models.
5. Finally, it could provide the basis for a simplified accountability regime, in which government funders take responsibility for harmonising their requirements and the sector takes responsibility for governance standards, codes of practice and development, and for early support and intervention for ACCHOs in difficulty. A framework of reciprocal accountability between ACCHOs and their funders would support these arrangements, and could be used to strengthen the accountability of both governments and ACCHOs to communities for good stewardship of the system, and thus for good health care.

The report suggests that this model is the logical expression of existing government policy goals. It is also consistent with the thinking of the ACCHO sector, as expressed both in policy positions and in action. Developments in the sector that are consistent with this model include the regional structure of the Queensland Aboriginal and Islander Health Council (QAIHC 2011a:29), the governance and financing models for Katherine West and Sunrise Health Services in the Northern Territory (Bailie, Menzies School of Health Research Local

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[18] I am grateful to my colleague Dr Brita Pekarsky for conversations in which she initiated this way of analysing the current financing situation.

Evaluation Team & Katherine West Health Board 2000), the role of regional support services like the Kimberley Aboriginal Medical Services Council (http://www.kamsc.org.au/) in Western Australia, and the existence of several successful 'hub and spoke' models within the sector, in both rural and urban environments.

Health care is inevitably delivered by a network of care providers, as no one organisation can meet all of most people's health care needs. In both rural and urban environments, the PHC networks are inevitably regional in nature, whether formally constructed (such as through the Institute for Urban Indigenous Health in Brisbane (Institute for Urban Indigenous Health [IUIH] 2011) and through Primary Health Networks in the mainstream system (Department of Health 2015)) or informally developed among health staff, groups and organisations. This is consistent with the weight of evidence about care integration (Leutz 2005), and in rural and remote areas is essential for many practical reasons, not simply the distances both staff and patients must travel. It is also supported by the findings of a study of Aboriginal engagement in regional health forums in two jurisdictions under the Aboriginal Health National Partnership Agreements, which documented an association between Aboriginal engagement in regional forums and improved uptake of health assessments (Kelaher et al. 2014). The regional nature of health care systems, and their reliance on provider networks, is an important feature in relation to accountability; and places PHC in the sphere of network governance, as illustrated by the reliance on regional clinical networks in the Northern Territory reform case study reported in Dwyer et al. (2015b – Appendix D).

The second paper contributes some important parallels with Canada in relation to the need for contracting reform, the time required for effective implementation of PHC transfers to community control, and the critical importance of accountability reform. In particular, the Canadian experience reinforces the view (in relation to government contracts in general) that 'not only is it possible to simplify administration while strengthening accountability, but it is absolutely necessary to do the first in order to ensure the latter' (Lankin & Clark 2006, cited in Lavoie & Dwyer 2015, quoting an Expert Panel appointed by the Treasury Board of Canada).

A threshold question: why not just use the mainstream system?

Before considering necessary reforms, there is a (usually unspoken) threshold question to be addressed: why maintain a separate PHC delivery system, would it not be better to focus solely on the mainstream system becoming effective and available to all?

This question arises in relation to many specialised services for 'vulnerable' populations, and the answer is often contingent on reduction in the level of vulnerability, adequate capability in the mainstream system and effective methods of assessment and transfer (Lewis et al. 2013). Setting aside for the moment consideration of the self-determination framework, these general conditions have not (yet) been met for the Aboriginal population. Health care outcomes confirm continuing 'vulnerability'. The mainstream PHC system based on general practice is, for some, not available at all, and often not capable. Indeed, it can be argued that the size of the Aboriginal population makes it unlikely that general capability will be achievable in a reasonable time frame – there is simply not enough demand in the average general practice patient group (Britt, Miller & Valenti 2001). Finally, the expressed preference of a large part of the Aboriginal and Islander population for community-controlled PHC, and the heightened sensitivity of the politics of Aboriginal health care, militate against the likelihood of effective assessment and transfer.

The experience of separate women's health services is relevant. These services arose from social movements in the late 19th and the 20th centuries, and were a response to the dissatisfaction of women with the care they could or couldn't get in the mainstream system (Dwyer 1992; Liamputtong & Dwyer 2003). In Australia, they grew and survived as independent organisations for roughly thirty years, but in the last decade have largely been absorbed into the mainstream in two ways. Firstly, the mainstream has changed in response to the feminist critique; secondly, a range of specialised services operate within mainstream organisational structures (for example, the women's health services of the SA public health sector). And still, a small number of independent NGOs remain (including importantly the family planning associations in each state and territory and, for example, the Jean Hailes Foundation – see https://jeanhailes.org.au/ and Women's Health Victoria – see whv.org.au/).

Refugee health, workers' health, migrant health and baby and child health services are other relevant examples of health care developed by and for population groups that were not well served in the mainstream; and they have had varied and challenging histories as independent organisations. While any special measures to address the needs of vulnerable groups are likely to lose official support and status in the era of neo-liberalism (Davis 2014), the weight of continuing need for their service delivery separate from the mainstream system is also a factor.

These comparisons suggest that the independent ACCHO sector will always face challenges; and that continuing survival and growth will depend on many factors. But the ACCHO sector can be seen to differ from services for other groups defined by 'vulnerability' because it is an expression of self-determination by the First Peoples, and because of the strong official endorsement of its role, as discussed throughout this thesis. At the same time, government ambivalence about the role of the sector manifests in failure to either enable it to develop the capacity required for equitable coverage, or to institute an alternative approach systematically. The lack of any real legislated government responsibility for Aboriginal health enables this ambivalent stasis to continue (Howse & Dwyer 2015).

Sector development or ambivalent stasis?

The rest of this chapter is based on the conclusion that the sector will continue to play a vital role in PHC for Aboriginal and Torres Strait Islander peoples, particularly but not only in rural and remote areas; and that it is past time for government policy and practice to move beyond ambivalent stasis to a systematic development approach, as outlined above.

The case studies in Dwyer et al. (2015b – Appendix D) demonstrate the ambivalence of governments in relation to the implementation of a new way forward. Progressive policy positions are negotiated, but implementation is highly fraught with risk-averse decisions and a lack of open communication about barriers and difficulties. Thus, the wicked problem remains – for governments, ACCHOs are officially endorsed in policy and rhetoric as the more effective providers of PHC for Aboriginal communities, partly because they are close to their communities, and for the majority preferred by them (Taylor et al. 2012:44). And yet, there is deep reluctance in government about taking effective action to develop a reliable PHC system for Aboriginal people based on the ACCHO sector. Concerns about governance are the (sometimes unspoken) risk to government; and the accountability regimes that are used to manage that risk themselves tend to reduce accountability to the communities (perhaps thus undermining the very relationship which is the underlying reason for engaging with the ACCHO sector) (Moran & Porter 2014).

If lack of confidence in ACCHO governance is the barrier, what is the solution?

Insecure funding and onerous accountability measures for the sector are designed, inter alia, to address funders' lack of confidence in ACCHO governance, but they are not effective for this purpose. No amount of reporting and monitoring will produce good governance. At best it provides funders with a warning that there are problems (or assurance of their absence) and ACCHOs with a set of measures that both increase the chances of staying on track, and a method that brings problems to the attention of the board. The kind of accountability measures that government can impose and enforce with sanctions are effective to identify causes for concern after the fact, when financial reports are missing, or late, or contain worrying information; or there are untoward changes in activity reports; or poor annual risk assessment reports; or community criticism and complaints. The constraints of compliance and audit requirements can also be useful for leaders and managers (Dwyer, Shannon & Godwin 2007:40) and act as a deterrent to abuses of power. However, they are not reliably effective to prevent governance problems, or allow early intervention, or even to identify the causes of problems. Governance is always done by those in the room, not the regulators.

The main cause of poor performance that is of concern to governments is governance/financial failure or incompetence. Analysis of the risk assessment frameworks mandated by governments (for example, the Office for Aboriginal and Torres Strait Islander Health (OATSIH) Risk Assessment Profile Tool (Department of Health 2014)) makes it clear that other causes of poor performance are not of concern, although they are often more important for access and quality of care (eg workforce supply and quality). Government is concerned that its funding of ACCHOs brings high levels of risk of waste and fraud, which in turn brings reputational risk for the government[19] and potential consequences for the responsible public servants. These concerns arise because a) there is in fact an incidence of waste and fraud (as there is in every setting); and b) there is a general lack of trust and confidence in Aboriginal governance and financial management in Australian society. This risk to government can be seen to outweigh the more substantive risk of continuing poor access to PHC for some Aboriginal people (Lavoie & Dwyer 2015).

It is worth noting another paradox here: the insecure funding that is used at least partly because of the concern about waste and fraud can make organisations more vulnerable to both. For example, stop/start programs and their associated staffing challenges, in environments where recruitment and retention can be difficult in the best of circumstances, make waste more likely. Similarly, the very complexity of funding and reporting can provide extra opportunities for deceitful dealing.

On the other hand, accountability to community is not as robust as it could be for two main reasons. First, the main structure for accountability to community (the board) is also the governance structure for the organisation. When the performance of the board itself (including its management of the CEO) is the problem, it is difficult (but by no means impossible) for other community members to hold the board accountable. Second, the available accountability measures are designed to provide risk management for the funders, rather than to enable the community to assess performance in ways that are meaningful from the community perspective.

In the context of Aboriginal health, current accountability regimes count dollars and commodified activities, activities that are defined centrally according to government funding program logic. These methods are not adequate to the complex reality of PHC needs, goals and services. However, from the perspective of central government officers, there is utility in reducing complexity to countable units and using the numbers to compare

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[19] The strength of this concern supports Patrick Sullivan's observation that Aboriginal policy is written for mainstream audiences (Sullivan 2015, 2009).

outputs among providers and trends over time. Comparative data is also useful for providers of care.

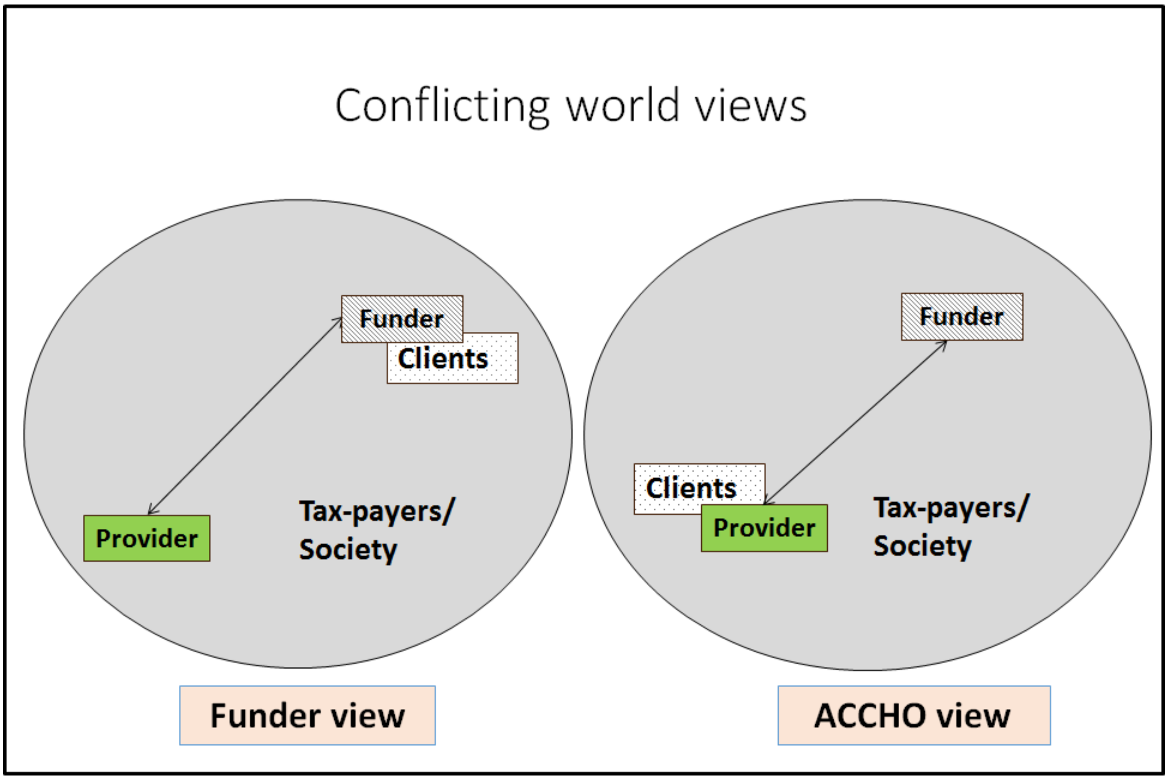
In summary, current accountability regimes have not resolved the problem of distrust and lack of confidence by government and government officers, nor do they support robust community accountability, and they are not capable of ensuring good governance. How then is this impasse to be resolved? I argue that while the kind of data (about the use of funds and the services provided) that is exchanged for money in the funding contracts can be useful for several purposes, what is needed is a resetting of the relationship to resolve or better manage government's lack of confidence, institute more suitable methods for ensuring and supporting good governance, and enable the sector to develop as a critical component of the Australian health care system. A reciprocal approach to accountability provides the most likely basis for such a resetting.

Tension in the accountability relationship, and strengthening accountability to community

Consideration of the conceptual conflict between the foundational ideas of New Public Management (NPM) based contracting and the self-determination framework of the ACCHO sector provides a useful insight into the accountability problem.

As explained in Chapters 2 and 4, human service contracting with the private and non-government organisation (NGO) sector has largely been based on the idea that the government funding body is the principal, acting on behalf of the citizens/residents, purchasing services for them from providers of care who act as agents of government policy in a relationship governed by contract. On the other hand, the ACCHO sector is founded on the twin goals of self-determination and better health – a 'by us, for us' movement. The sector is thus held to be the health representative of their communities, speaking and acting on their behalf, by virtue of the fact that the organisations are developed, owned, governed and operated by the community. So, both government funders and ACCHOs hold a role and responsibility that enables (and requires) them to represent the interests of the communities being served. In Dwyer et al. (2014), we described this as a relationship of co-principals, rather than of a principal and an agent. The tension in these world views can be diagrammatically represented thus:

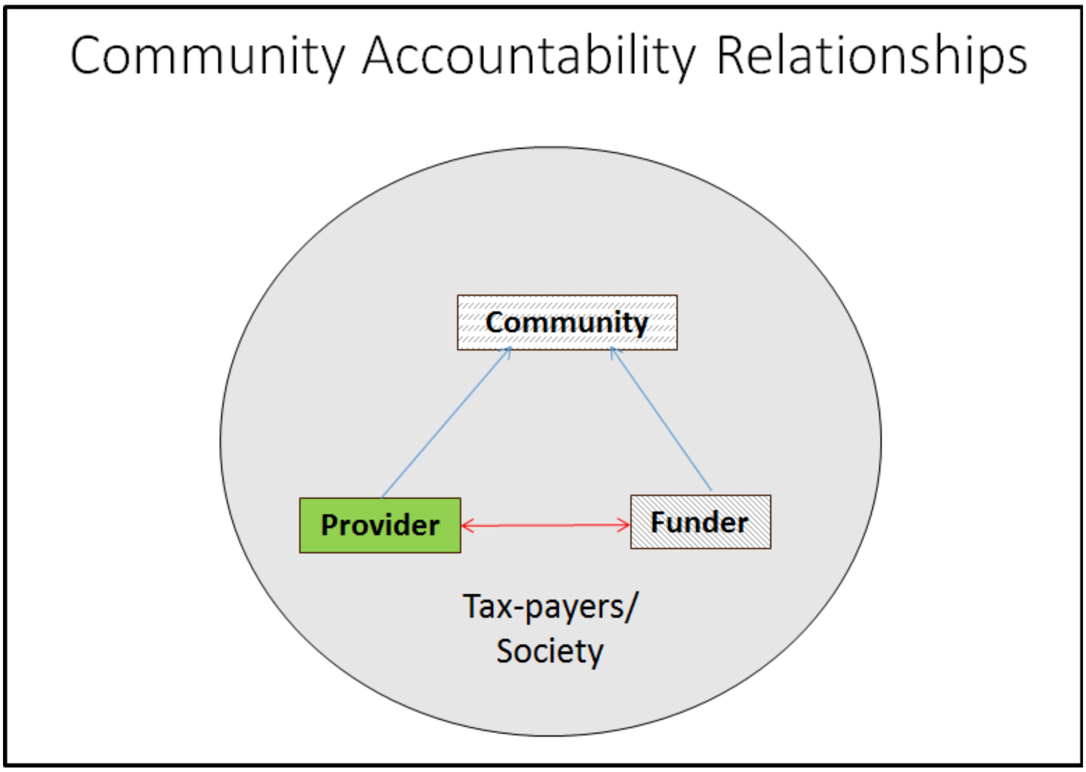
Figure 2: who represents the clients/community?



Each side of the funding relationship claims moral authority to hold the other accountable on the basis of their role in representing the interests of the clients/communities, and both are correct. For ACCHOs, it is an essential part of their purpose that they will act as advocates for the health interests of their communities, and speak on their behalf, as well as acting as service providers. Governments on the other hand hold some of the authority to determine and respond to the health care needs of communities, and to fund providers accordingly on terms they set, in contractual instruments (in the case of Aboriginal health programs) or legislated regulations (such as the Medicare Benefits Schedule).

Thus, there is a contest of frameworks and roles, which is one of the sources of tension in the working relationships between funders and the ACCHO sector. The underlying reality of this situation is inevitable, given that both sides do hold real responsibilities. It also occurs in other sectors, for example between public hospitals and their government owners and funders. But this way of seeing the situation suggests a potential alternative way of constructing the relationship between communities, ACCHOs and governments, represented in Figure 2, that is, by positioning communities as accountability holders rather than as passive (and contested) beneficiaries in the relationship between funders and providers.

Figure 3: Making accountability to community visible



This diagram suggests that it is the community to which both governments and ACCHOs have a responsibility. This depiction is consistent with the analysis of Moran and Porter (2014) of the corrosive impact on remote Aboriginal community leadership and accountability when the centrally determined accountability 'pull' of funders dominates in the obligations leaders must fulfil, and stymies the development of genuine political leadership, accountable to its constituency.

The situation in Canadian First Nations communities ('on reserve' communities with local self-governance) is a relevant case in which relationships are approximately as shown in

Figure 2. To simplify a complex reality, typically funding for health care is allocated by government to the (First Nation) local government, which owns and operates the health service on behalf of the community; and holds the health service accountable through hierarchical corporate reporting and control methods, involving both staff and board/Council channels. In Canada, the overwhelming majority of PHC for First Nations communities is funded this way, with contracts that are much more relational and long-term (Lavoie & Dwyer 2015). A change in the Canadian constitution in 1985 (recognising the right of First Nations, Inuit and Meti people to self-government) is seen as providing a basis for increased community control (Lavoie & Dwyer 2015).

In Australia, while various community structures and processes for reciprocal accountability continue, Aboriginal communities do not have the equivalent local government structures in most cases, and there is not an independent local/regional incorporated body to represent the interests of communities, a situation that is likely to continue. Thus the way of making accountability of providers to the community more visible (and more reliably robust) is unlikely to be through the combined operation of both local government corporate accountability and traditional community structures as in Canada.

It is possible under Australian corporate structures to separate the representation of community interests from responsibility for corporate governance in different ways – the local Health Action Teams established by Apunipima provide one example (Dwyer et al. 2015b:49). However, whether more robust structural arrangements of this nature would be generally workable or acceptable in the sector and in communities is unknown.

Sources of accountability to community

Both ACCHOs and governments have existing accountability obligations to communities. In the case of ACCHOs, there are obligations to provide effective care in the interests of clients and the community, as a result of both professional responsibilities to clients and corporate responsibilities to owners. In the case of governments, there is general responsibility to ensure that equitable access to essential PHC is available to all citizens, including Indigenous citizens, under various acts of parliaments at both levels. In addition, there is a particular

Australian government health responsibility as a signatory[20] to the UN Declaration of the Rights of Indigenous Peoples (UNDRIP). UNDRIP includes particular consideration of health and health care:

> *Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right. (United Nations 2007: Article 24, section 2).*

There is another potential basis for an accountability obligation of government to Aboriginal peoples, but it is not yet established in Australian law. It is arguable, and indeed may seem self-evident, that in forcibly transferring control of Aboriginal lands to the Crown, and asserting sovereignty over Aboriginal peoples, Australian governments acquired a trustee or fiduciary position in relation to the interests, including in health and wellbeing, of Aboriginal peoples, and thus an obligation to act for their benefit. To date, no specific fiduciary[21] obligation of the Crown to Aboriginal people, either arising from the fact and consequences of colonisation (Behrendt 2002) or in relation to health, has been established in law, as it has in Canada (by virtue of founding documents, treaties and encoding in the modern Canadian constitution (Boyer 2003)). This absence has its foundations in the doctrine of terra nullius, and survives despite limited recognition of native title.

Towards a reciprocal accountability framework

The concept of reciprocal accountability challenges the common hierarchical meaning of the term in public administration – where one party has authority over the other. But it is in keeping with the contractual meaning, where each party is accountable to the other for meeting the terms of the contract. I use the term to cover the situation where each side of

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[20] After initially voting against the Declaration in 2007, along with Canada, the USA and New Zealand, Australia signed in 2009.

[21] ‘Fiduciary’ derives from the Latin for trust, and fiduciary duty is an obligation to act in the interests of a person or group. A trustee has a fiduciary duty to the person/s for whom assets etc are held in trust; a guardian or parent of a child has a fiduciary duty to act in the interests of the child, the board of an organisation has a fiduciary duty to the owners or shareholders of the organisation.

the accountability relationship has the capacity to hold the other to account, for related but not identical responsibilities.

For the purposes of establishing the basis for resetting the relationship, I suggest that there are enough reasons to justify governments entering into specific arrangements with the Aboriginal community and the ACCHO sector to enact their stewardship responsibilities for Aboriginal health more effectively. The inequity in health outcomes for Aboriginal people is the most fundamental. The government's general responsibility for equitable access to health care, combined with the special responsibility to Aboriginal peoples imposed by UNDRIP, are important in themselves, and the latter only strengthens the basis for arguing that there is an implied fiduciary relationship between the government and Aboriginal people. That relationship brings rights to Aboriginal people, to have a particular voice in governance and stewardship arrangements. It also brings obligations on government to use effective arrangements for the implementation of agreed policy goals, even if they require some suspension of the 'business as usual' rules that are now so widely known not to work.

Given that the fiduciary duty of ACCHOs is explicit, in common and corporate law, the relationship between government and ACCHOs (as funders and providers and as co-principals) can then be seen to encompass two sources of reciprocal accountability: the normal reciprocal accountability under the terms of a contract (ie the obligation on the parties to fulfil the terms), and a common (though different) duty to act in the interests of Aboriginal clients/communities to achieve the agreed goals of health and health care improvement.

Existing frameworks for NGO and networked accountability relationships

The complex nature of NGO accountability relationships is addressed in several frameworks found in the academic literature, which have been comprehensively reviewed by Williams and Taylor (2013). These authors derive a 'holistic accountability framework' that has three main elements: accountability goals (based on Koppell 2005); stakeholders (including 'upward', 'downward' and 'lateral' accountability holders); and mechanisms (the reporting/auditing methods that may be used at different levels and for different purposes).

The framework is intended to enable the iterative construction of accountability approaches/mechanisms with stakeholders in particular contexts; and to make the relationships explicit for both NGO leaders and accountability holders. The Williams and Taylor (2013) framework, and all of those reviewed in their paper, take as given a hierarchical principal/agent relationship between NGO's and government. While they provide useful models for analysing the accountability environment, they do not contemplate reciprocal accountability in the sense that I seek to explore.

However, the limitations of the hierarchical approach to contract accountability for managing accountability relationships in networks, and the concept of accountability as an interactive set of reporting relationships among actors in a network, have been established in the literature reviewed in Chapter 4. Tuohy, in describing the governance of health systems in particular, suggests that the diffusion of responsibility is the major accountability challenge:

> *Because of the very difficulty of locating responsibility, accountability mechanisms in the governance model rather focus on the generation of information that will then be used by participants in the network in their negotiations with each other and by the broader publics to ensure that their interests are being represented (Tuohy 2003:204-5).*

In particular, the new public governance framework (Osborne 2007) focuses on accountability within networks of actors engaged in the delivery of services, accountability that is necessarily shared and thus has elements of reciprocity (Dubnick & Frederickson 2010. Contractual accountability is not absent, but contracts are in themselves more relational; and the more flexible and interactive governance of the network and its contractual relationships is critical both for assurance of effective service delivery and for learning about program design. And there is comfort for responsible governments - as Millar (2013:86) points out in relation to the social accountability approach of the European Union, networks function 'in the shadow of hierarchy', with governments always retaining the residual power of the purse no matter how the rights and responsibilities of the parties may be defined in ways that constrain their decision-making.

It is hard to imagine this ideal arrangement in the difficult environment of government relations with Aboriginal communities and organisations, conducted over great distances, but it is remarkably close to the way managers of Aboriginal health services express their preferred way of enacting accountability (Dwyer et al. 2011:40). It is also more suitable for the regional networks typical of health systems.

It seems to me to be more in keeping with Aboriginal concepts of reciprocity, and more consistent with the sociological view articulated by Patrick Sullivan, defining reciprocal accountability in the Aboriginal Australian context in terms of negotiated relationships: 'accountability is the activity of rendering an account within a group and between groups so that the actors negotiate their identity, obligations and commitments in relation to each other, producing an environment of reciprocal accountabilities' (Sullivan 2009:66).

Defining the purposes of the reciprocal accountability framework

The question then is how the relationship between government, Aboriginal communities and ACCHOs might move towards the kind of approach envisaged in new public governance, and more closely aligned to Aboriginal concepts of reciprocity. Some consideration of how accountability arrangements themselves can be assessed is necessary. There is a tendency to regard accountability as a general good thing, which may be related to its reputational value (Busuioc & Lodge 2015:1). However, accountability is not the equivalent of responsiveness, or service excellence, or good financial management or even transparency (Williams & Taylor 2013; Bovens 2007), although it usually does seek to monitor and reward achievement (or sanction short-falls) in these sorts of characteristics or goals.

Bovens (2007), in considering the problems of governance in the European Union, addressed the confusion about methods and goals of democratic accountability. He discerned three main purposes of accountability in the literature: to monitor and control government conduct; to prevent the development of concentrations of power (and the risk of abuse, cronyism etc); and to enhance learning capacity and effectiveness. He then describes three fundamental perspectives on the basis of which accountability arrangements themselves might be evaluated. They are:

- *Democratic:* Does the arrangement enable legitimate democratic bodies to monitor and evaluate executive behaviour, and to induce executive actors to modify?
- *Constitutional:* Does the arrangement curtail the abuse of executive power and privilege?
- *Learning:* Does the arrangement stimulate public executives and bodies to focus on achieving desirable societal outcomes?

Adapting these evaluative perspectives to the governance and accountabilities of government, Aboriginal community and PHC provider relationships, there are three main ways to assess accountability arrangements, as follows:

Table 2: Accountability between Aboriginal communities, governments and ACCHOs

Perspective	**Government**	**NGO**
Democratic - Accountability to community, control on executive action	Does the arrangement enable communities to monitor and evaluate government decisions and actions?	Does the arrangement enable communities to monitor and evaluate corporate behaviour of NGOs and modify it in accordance with priorities?
Constitutional – Accountability as restraint on concentration and abuse of power	Does the arrangement enable the concentration or abuse of executive power to be curtailed?	Does the arrangement curtail the abuse of corporate power and resources?
Learning – Accountability provides feedback-based inducements to improve effectiveness and efficiency	Does the arrangement stimulate government and the public sector to improve policies and programs to achieve desirable health outcomes?	Does the arrangement stimulate NGOs to focus on quality and accessibility of care and good use of resources?

Following this logic, I suggest that within a framework of reciprocal accountability, arrangements should be designed to address three main purposes:

1. To enable Aboriginal people and communities to monitor a) the extent to which the shared work of government funders and PHC providers meets the needs of communities and is responsive to their priorities, and b) the quality and accessibility of care; and c) to have the means for the results of that monitoring to be heard and acted on.
2. To provide governments with a) assurance that providers are focused on the effectiveness of their care and b) are not abusing their corporate powers and resources; and c) the means to ensure that failings are remediated.
3. To provide PHC providers with assurance a) of effective government stewardship of the PHC system and b) that government funding and management practices are efficient, fair and reasonable; and c) the means to report on failings.

The development and negotiation of accountability mechanisms that could address these purposes would require a resetting of the relationships between the Aboriginal community, the ACCHO sector and government funders. The challenges for each purpose and possible methods of achieving it are outlined below. Please note that in suggesting possible new arrangements, I acknowledge that these ideas have largely not been tested with the parties to the relationship. My purpose here is simply to test the prima facie applicability of the ideas above to the circumstances of Aboriginal health care by asking whether suitable and potentially feasible methods and arrangements can be derived.

Please also note that what follows assumes that the regional approach to PHC system development and governance is accepted by federal and jurisdictional government health authorities. This would imply the need to systematically incorporate the reality of regional network governance of the PHC system into their own structures and practices, and into the requirements they place on both their own and external funded agencies. Acknowledgement, support, communication with and as appropriate membership of those regional network bodies by health authorities could assist in both the regional coordination of the work of all relevant PHC providers including ACCHOs, and the practical governance of contracted services.

Accountability to communities – a National Aboriginal Health Council?

It has been argued above that Aboriginal communities have a particular claim to hold governments accountable, based on both the provisions of the UN Declaration of the Rights of Indigenous Peoples and on the concept of an implicit fiduciary relationship arising from the circumstances of colonisation, even though this fiduciary relationship is not established in Australian law. The question here is how might this accountability obligation be enacted? The answer is not obvious, given the general absence of formal representative bodies for the Aboriginal population, through which such a right and responsibility could be enacted[22].

One solution would be the establishment of a national body to represent the interests of Aboriginal communities in relation to health and health care. Relevant precedents exist, including the Aboriginal and Torres Strait Islander Commission (ATSIC), with its articulated national and regional structures. The National Congress of Australia's First Peoples could take on the mandate to auspice a body to fulfil this role.

In a mainstream equivalent, the Health Performance Council, established under the South Australian Health Care Act, is also relevant. The Council has responsibility to monitor and report to the SA Parliament on the performance of the SA public health system. Members of the Council are independent of the SA Department of Health, and are appointed by the Minister on the basis of a combination of expertise and capacity to serve the interests of the people of South Australia (*Health Care Act 2008 (SA): Part 3*).

The development of a model suitable for the current purpose would need to be based on a genuine engagement of Aboriginal communities and governments; and it may be very

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[22] This absence has its origins partly in the fact that Aboriginal Australia has always been made up of hundreds of independent nations or groups. But it can also be traced back to the policies and practices of colonisation, the doctrine of terra nullius, and the resultant absence of formal settlement of the relationships among Aboriginal Australians and settlers which could serve as the basis for the development of legal and institutional arrangements.

different from the examples cited above. It would be important that the responsible body was constituted to represent Aboriginal people, and not primarily the ACCHO sector. It would also be important for this body to have regional as well as national expression, in the light of both the realities of the health care system discussed above, and the expressed preference of many Aboriginal people to be represented primarily at the level of their traditional clan or nation groups. But a national body seems essential if it is to have the capacity to monitor the performance of government and have its voice heard.

The national body could have its primary relationship with government through the Australian Health Ministers’ Council, and could have a mandate that encompassed both the performance of the mainstream health system as a whole, and the effectiveness of government programs that fund and regulate the PHC system for Aboriginal people. Formal multi-year agreements regarding the performance of the mainstream health system in achieving equitable health care access and quality for Aboriginal patients could be negotiated, reported, monitored and assessed by the national body, which could provide its assessment to national and jurisdictional parliaments. Monitoring of the effectiveness of government programs that fund and regulate the PHC system for Aboriginal people, and the development of priorities for improving it, could also be the subject of formal agreements for reporting, monitoring and assessment.

A simple example of the kind of substantive health care improvements that could be the subject of a national agreement is a variation to procedures for informed consent for treatment, which is problematic for some Aboriginal patients, particularly when they need to travel for care (Kelly et al. 2011:23-24). A procedure in keeping with cultural decision-making methods for these patients could be developed and implemented, probably involving negotiation of consent prior to travel, thereby making care safer and more accessible for the patients, and resolving a difficulty for hospitals and their professional staff. Such a change is possible now, but the will to negotiate change in the complex existing regimes with multiple empowered stakeholders is not evident.

Accountability of ACCHOs to their communities

The accountability of ACCHOs to their communities is established both in statutes and in community understandings, and is usually strong, being founded on ownership by those members of the community who take up membership of the ACCHO, and governance by community representative boards, as well as other methods for community engagement. (The same cannot be said for other providers of PHC to Aboriginal communities, but formulating and enacting an equivalent obligation is possible, and there are examples of good practice). Efforts to strengthen community accountability of ACCHOs are usually pursued through governance improvement and methods for more active community engagement. However, a national body established to represent Aboriginal communities in relation to health and health care could also be given oversight of accountability by PHC providers including ACCHOs to their local and regional communities, through its regional chapters.

Reciprocal accountability arrangements between government funders and ACCHOs

As discussed in Chapters 2 and 4, funders and providers will always remain accountable to honouring the terms of the contracts they negotiate; but the contracts need to change from the short-term programmatic (or 'body part') structures of most current contracts, to fewer, more flexible and longer-term contracts, backed up with better collaborative arrangements to govern the contractual relationship. These arrangements would be strengthened with the establishment of a statutory basis for enduring government responsibility for Aboriginal health care, as discussed in Chapter 3.

The move to longer-term, more entrenched and flexible funding would bring greater assurance for the ACCHO sector. Governments would require a matching assurance, through arrangements that address their concerns about governance and accountability. Based on the research presented in this thesis, and my own experience both in working with the ACCHO sector and as a senior executive and contributor to health system policy development, I suggest three important changes that could provide the basis for resetting the relationship, strengthening the ACCHO sector and building towards equitable access to PHC for Aboriginal people across the country.

1. Structure and approach to the funder/provider relationship: building trust and confidence

While relationships remain politically sensitive, and systemic racism continues, there is also an array of structures and processes for the relationship that contribute to its survival and success. Tripartite partnership agreement bodies at regional level, for example, have been shown to contribute (Kelaher et al. 2014). The important role of the Northern Territory Aboriginal Health Forum in sector and PHC system development is another example (Dwyer et al. 2015a).

The impact of systemic racism, and the documented low levels of trust between Aboriginal people and non-Indigenous Australians (Reconciliation Australia 2012), on the working relationship can only be changed with conscious effort, and successful partnering over time. I suggest that this situation calls for more use of face-to-face and narrative methods of enacting the working relationship (between contract managers and funded ACCHOs, and at state and national levels), including its accountability dimensions. Normal financial, activity and quality reporting by both ACCHOs and government would need to continue, and this information would be also be required for the purposes of the proposed National Aboriginal Health Council.

2. Early engagement when governance is an issue

A second change that has been under discussion for some time is for the sector itself (through the jurisdictional National Aboriginal Community Controlled Organisation (NACCHO) affiliates) to take an active role in early engagement with ACCHOs that are showing signs of trouble. Most affiliates do this, informally or otherwise, and all currently take a role in supporting governance development (promoting the national standards, supporting training, accreditation and so on). Such an arrangement was included in a report on governance improvement prepared for the then Minister for Aboriginal Health, the Hon.

Warren Snowdon, by a working group of which I was a member. The final draft report[23] includes discussion of the role of governance support programs established in each jurisdictional affiliate. Their nominated functions were to provide expert guidance on high level governance issues including strategic planning and community engagement processes, and to support member ACCHOs in the recruitment of senior staff. The functions also included supporting and advising member ACCHOs during periods of structural or contractual change, when an ACCHO is identified by the affiliate or by OATSIH as being at risk or in crisis, and assisting with internal conflict (National Governance Enhancement Working Group, 2013:8).

3. Information governance

Federal and jurisdictional governments could take responsibility for harmonising their information requirements, in relation to financial and activity data. Harmonisation of clinical and quality data is well underway.

All parties involved in PHC need good data on which to base efforts to improve Aboriginal and Torres Strait Islander peoples' health and significant progress has been made in recent years. The resulting reporting frameworks have different ownership by distinct and sometimes overlapping institutional structures that report trends on Indigenous health and related social outcomes. While this can involve duplication, it can also meet a variety of accountability and information needs in a way not possible with a single system. Important examples are the Aboriginal and Torres Strait Islander Health Performance Framework (Australian Health Ministers Advisory Council [AHMAC] 2015), the Productivity Commission's report on Overcoming Indigenous Disadvantage (Steering Committee for the Review of Government Service Provision [SCRGSP] 2011), and the annual Closing the Gap Prime Minister's Report (Australian Government 2015).

There is a well-developed data infrastructure for Indigenous health service provision, and the data quality agenda is increasingly linked to performance measurement systems. This

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[23] Unfortunately, the Working Group's Final Report was submitted to the Minister shortly before the 2013 federal election was called, and it has not been published nor to my knowledge taken up by the Department of Health. I hold a final draft dated May 2013.

system has been criticised by the ACCHO sector for failing to provide an institutional environment in which there is both perceived independence from all actors and the correct drivers of accountability (ie towards good performance by all, rather than merely compliance). Existing systems are perceived to be owned and managed by government, and to contribute little to the accountability of government itself. These problems could be addressed.

Conclusion

Whether the methods of resetting the relationship between government funders, the ACCHO sector and Aboriginal communities suggested above are workable will be assessed by others. I hope the framework in Table 2 above is helpful to those who must consider the suitability of any arrangements for achieving the legitimate purposes of accountability in this context. However, as I reach the end of the marathon of thesis-writing, the question for me is whether my propositions have been upheld. I believe they have, and I am left with three questions that could be addressed in future research and policy development.

Is New Public Management in its dying days?

The published work in this thesis has provided evidence of the lack of fit between NPM inspired methods of funding and regulating, and the good governance and delivery of comprehensive PHC for Aboriginal communities. Recent research on the methods generally labelled as NPM is equivocal, and there is a view that the practice of NPM has neither achieved the hopes of proponents nor justified the fears of critics (Hood & Dixon 2015). The hubris of the attempt to treat even the most complex human services as if they were simply bundles of discrete consumables that could be designed, priced, distributed, paid for and assessed on market principles has become clear; as has the falsity of the neoliberal idea that citizens are just consumers and public services just consumer goods.

On the other hand it also seems clear that while new public administration approaches are emerging in both theory and practice, they are not so much replacing NPM as building on its institutional arrangements with more subtle and appropriate approaches to the governance and contracting of the delivery of services to the public (Heinrich et al. 2010; Christensen 2012; Shaw 2013; Tenbensel 2005). These approaches, under various labels of New Public Governance and Public Value, do not envisage a return to the predominance of direct provision of services by government (a situation that has never really held in Australian health care in any case). Rather, they seek to find ways of working with the 'new' non-government actors in public service delivery that are more collaborative, more focused on the shared search for public value, and better equipped to enable ongoing improvement in the effectiveness and efficiency of service delivery.

In the context of Aboriginal PHC, it seems that the importance of NPM has been as the driver of an approach to relationships between mainstream governments and Aboriginal NGOs that has had negative (and foreseeable) consequences. NPM has inspired the forlorn project of commodifying PHC (based on vertical targeted programs, or what some in the sector call 'body part funding'). It also has a wicked interaction (perhaps an elective affinity (McKinnon 2010)) with unresolved foundational issues for Australia and systemic racism. In a relationship where mutual trust is known to be low, NPM has brought an approach to funding and regulation that enshrines lack of trust, and an expectation that difficulties in the relationship will continue.

The work in this thesis also supports the idea that NPM methods have been honoured selectively in Australian public administration and particularly in the health system. The paddling duck analogy seems to apply in reverse – much activity above the water line, but less change below. In spite of the formal provisions of the contracts, some politicians, public servants and ACCHO leaders continue to have good working relationships, to extend to each other the flexibility that trust allows, to act on the basis of shared assumptions that time-limited funding will in fact continue, and to blur the lines between formally discrete funding programs. There is grounds for hope that a better approach to the relationship between funders and ACCHOs is possible under the right conditions.

Can the barriers of systemic racism be removed or reduced enough to enable good quality and access to PHC for Aboriginal people?

Racism towards Aboriginal people is deep and broad in Australian society, with devastating health and other impacts on Aboriginal people and communities, and long-standing foundations that the nation is yet to address. Care for Aboriginal people in the mainstream health system is compromised by the impacts of systemic racism, but there is also some evidence that the situation is better than it was. Given this reality, the health system faces serious barriers that have to be overturned if the principle of equity is to be honoured in practice. I suggest that the key to improving the effectiveness of health care will be to find the leadership and will to put operational policies, programs and protocols in place, thereby giving staff both permission and guidance; and that significant change in the delivery of care will follow. Intervention research on innovations to achieve this is needed.

Is reciprocal accountability a practical approach, and could it be acceptable?

Governments will not accept additional funding and accountability burdens without some pressing necessity. ACCHOs have little choice, as their funding is conditional on their compliance. Is there a pressing necessity? I suggest that there is:

1. The gap in health status remains, and there are good reasons to believe that providing equitable access to PHC is one of several potential strategies to improve the rate of progress. Progress on the social and cultural determinants of health is critical, but PHC is also important.
2. Governments have a long-standing commitment to supporting the ACCHO sector, and the political cost of withdrawing from that commitment would be high. On the other hand, the current stasis is not sustainable, so making progress is the more likely solution.
3. Resetting the relationship to enable governments to have greater assurance of good governance by the sector would provide a more secure basis for progress, and the framework of reciprocal accountability offers this advantage. There may be other ways to achieve it, but I suggest that any method will require a ‘new deal’ and that the deal will need to include more secure and better funding in return for a focus on stronger governance by the sector.

Both theory development and implementation studies are needed. The challenges of researching the implementation work of governments will be significant.

Final word

The research represented in this thesis has been focused at the intersection of public administration and Aboriginal primary health care. With colleagues from both sides of the funding and regulatory relationship, I have sought to examine the policies and actions, the successes and failures of both. It has often been a sensitive endeavour with both rich rewards and maddening frustrations for the researchers and the researched.

In Chapter 1 of this thesis, I suggested that meaningful approaches to accountability were the missing piece of the puzzle I set out to solve, and an obstacle that gets in the way of effective implementation of available methods to improve access to good PHC for Aboriginal people. I then suggested:

> *What is needed are methods and measures that are more focused on health gain, and less on 'counting widgets'; that are conducive to the long-term development of a robust system, rather than simply responding to short-term reporting requirements; and that better fit the nature of the relationship between Aboriginal community-based providers and government funders, and work for both sides.*

I believe that the work in this thesis has analysed the barriers and identified the principles on which the way forward can be developed. I hope it proves to be of use.

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Aboriginal health care and public administration: Could a framework of reciprocal accountability reset the relationship?

VOLUME 2: Appendices

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A thesis submitted in fulfilment of the requirements for the degree of Ph D by published work

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Appendices

Appendix A: National strategies

Dwyer J, Silburn K & Wilson G 2004, *National strategies for improving Indigenous health and health care*, Office of Aboriginal and Torres Strait Islander Health, Canberra.

Appendix B: The overburden report

Dwyer J, O'Donnell K, Lavoie J, Marlina U & Sullivan P 2009, *The Overburden Report: Contracting for Indigenous Health Services*, Cooperative Research Centre for Aboriginal Health, Darwin. Available at: http://www.lowitja.org.au/crcah/list-crcah-publications

Appendix C: Managing two worlds together

Dwyer J, Kelly J, Willis E, Mackean T, Battersby M, Pekarsky B & Glover J 2011, *Managing Two Worlds Together: City hospital care for country Aboriginal patients; Study 2 – Staff perspectives on care for country Aboriginal patients*, Lowitja Institute, Melbourne. Available at: http://flinders.edu.au/medicine/sites/health-care-management/research/mtwt/

Appendix D: The road is made by walking

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Appendix A: National strategies

Dwyer J, Silburn K & Wilson G 2004, *National strategies for improving Indigenous health and health care*, Office of Aboriginal and Torres Strait Islander Health, Canberra.

Aboriginal and Torres Strait Islander Primary Health Care Review: **Consultant Report No 1**

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In 2003, a series of papers was commissioned to provide information, analysis and advice to Government as part of a Review of the Australian Government's Aboriginal and Torres Strait Islander Primary Health Care Program. The Review examined issues relating to funding for comprehensive primary health care for Aboriginal and Torres Strait Islander people and the impact of activity in this area. The commissioned material complemented information obtained from previous reviews and evaluations as well as that obtained from program data.

An Interdepartmental Committee (IDC) oversaw the Review process. Members of the IDC were from the Australian Government Departments of the Treasury; Prime Minister and Cabinet; Finance and Administration; Immigration and Multicultural and Indigenous Affairs; Health and Ageing (Chair); and Aboriginal and Torres Strait Islander Services.

This is Volume 1 of the published Review papers. It is the major external assessment undertaken for the Review and it draws on the findings of all commissioned papers as well as material from a range of other sources.

The papers in this series are:

Volume 1. National Strategies for Improving Indigenous Health and Health Care by Judith Dwyer, Kate Silburn and Gai Wilson, La Trobe University.

Volume 2. Investment Analysis of the Aboriginal and Torres Strait Islander Primary Health Care Program in the Northern Territory by Carol Beaver, Centre for Chronic Disease, University of Queensland and Yuejen Zhao, Health Gains Planning Unit, Department of Health and Community Services, Northern Territory.

Volume 3. Costings Models for Aboriginal and Torres Strait Islander Health Services by Econtech Pty Ltd.

Volume 4. Capacity Development in Aboriginal and Torres Strait Islander Health Service Delivery – Case Studies by Cindy Shannon and Helen Longbottom, School of Population Health, University of Queensland.

Volume 5. Cancer, Health Services & Indigenous Australians by John Condon, Cooperative Research Centre for Aboriginal and Tropical Health.

Volume 6. Maternal and Child Health Care Services: Actions in the Primary Health Care Setting to Improve the Health of Aboriginal and Torres Strait Islander Women of Childbearing Age, Infants and Young Children by Sandra Eades, Menzies School of Health Research.

Volume 7. Substance Misuse and Primary Health Care among Indigenous Australians by Dennis Gray, National Drug Research Institute, Curtin University of Technology; Sherry Saggers, Centre for Social Research, Edith Cowan University; David Atkinson, Rural Clinical School, University of Western Australia and Phillipa Strempel, National Drug Research Institute, Curtin University of Technology.

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Contents

Figures

Tables

Acronyms and abbreviations

ABS	Australian Bureau of Statistics
ACCHS	Aboriginal Community Controlled Health Service
AHMAC	Australian Health Ministers' Advisory Council
AHW	Aboriginal Health Worker
AIDA	Australian Indigenous Doctors' Association
AIHW	Australian Institute of Health and Welfare
AMA	Australian Medical Association
APY Lands	Aṉangu Pitjantjatjara Lands
ARIA	accessibility/remoteness index of Australia
ATSIC	Aboriginal and Torres Strait Islander Commission
ATSIHPF	Aboriginal and Torres Strait Islander Health Performance Framework
ATSIHWIU	Aboriginal and Torres Strait Islander Health and Welfare Information Unit
CARPA	Central Australian Rural Practitioners Association
CATSIN	Congress of Aboriginal and Torres Strait Islander Nurses
CCT	Coordinated Care Trial
COAG	Council of Australian Governments
COPD	chronic obstructive pulmonary disease
CPHC	Comprehensive Primary Health Care
CSHTA	Community Health Services Training Australia
DALYs	disability adjusted life years
DASR	Drug and Alcohol Services Report
DEWR	Department of Employment and Workplace Relations
DRG	diagnosis related group
EPC	enhanced primary care
FTE	full-time equivalent
GP	general practitioner
GPPAC	General Practice Partnership Advisory Council
GST	goods and services tax
HACC	Home and Community Care
HBG	health benefit group
HIC	Health Insurance Commission
HR	human resources
HRG	health resource group

IDC	Inter-departmental Committee
IT	information technology
MBS	Medical Benefits Scheme
MOU	memorandum of understanding
NACCHO	National Aboriginal Community Controlled Health Organisation
NAGATSIHID	National Advisory Group on Aboriginal and Torres Strait Islander Health Information and Data
NAHS	National Aboriginal Health Strategy
NATSIEHP	Review of the Implementation of the National Aboriginal and Torres Strait Islander Eye Health Program
NATSIHC	National Aboriginal and Torres Strait Islander Health Council
NHC	Nganampa Health Council
NHIMG	National Health Information Management Group
NHMRC	National Health and Medical Research Council
NIHIP	National Indigenous Health Information Plan
NPHP	National Public Health Partnership
NSFATSIH	National Strategic Framework for Aboriginal and Torres Strait Islander Health
NTP	Ngunytju Tjitji Pirni
OATSIH	Office for Aboriginal and Torres Strait Islander Health
PBS	Pharmaceutical Benefits Scheme
PHC	Primary health care
PHCAP	Primary Health Care Access Program
PHCSs	Australian Government funded Aboriginal and Torres Strait Islander primary health care services
SAR	Service activity report
SCATSIH	Standing Committee on Aboriginal and Torres Strait Islander Health
SCRGSP	Steering Committee for the Review of Government Service Provision
STI	Sexually transmitted infection

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Summary

The severity and human cost of poor health among Indigenous Australians is well recognised, and the challenge of overcoming Indigenous Australians' health disadvantage is daunting. However, over the last eight years, a good foundation for effective action to improve Aboriginal and Torres Strait Islander health has been built. Although results are not yet seen in widespread improvement in 'headline' indicators of health outcomes, there is evidence of intermediate improvements in health status in some communities, increasing capacity in the primary health care system and greater engagement by the mainstream health system.

Indigenous Australians do not yet enjoy equitable access to effective health care, and continued effort to build a comprehensive primary health care system that can meet their needs is required. While it will take some years of development to achieve equitable access to primary health care for Indigenous Australians, there is sufficient evidence of its effectiveness to warrant the investment required. Significant real improvements in health outcomes, measurable through indicators of health status, can be expected.

However, health is not determined by health care alone. Much could also be gained if current initiatives to strengthen community capacity and coordinate investments in Indigenous communities are successful in addressing some of the social determinants of ill-health; and if Indigenous communities and governments are successful in fostering an environment that enables communities, families and individuals to engage more actively in sharing responsibility for their own health.

This paper was commissioned following the Australian Government's request to the Minister for Health and Ageing to review the Aboriginal and Torres Strait Islander Primary Health Care Program. The Primary Health Care Review (the Review), undertaken through an Inter-departmental Committee (IDC), reported to the Australian Government through the Minister for Health and Ageing in the 2004–05 budget context[1]. Our task was to provide an assessment of the level and impact of current funding and health care provision for Indigenous Australians; a strategy for improving the effectiveness of health care for Indigenous people; and advice regarding outcome indicators against which the effectiveness of Australian Government investment in Indigenous health care could be monitored. Government policy, as articulated in the *National Strategic Framework for Aboriginal and Torres Strait Islander Health* (NATSIHC 2003) and in the Government's response to the Commonwealth Grants Commission report on funding (Commonwealth of Australia 2002), is taken as the guiding framework for this paper.

The context in which this paper was developed did not allow open consultation with Indigenous health care organisations or Indigenous communities. Our assessment is based on available literature from government, Indigenous and research arenas, and draws heavily on the many reviews conducted over recent years. The evidence has been analysed against available standards and norms, and the framework of government policy goals, with a focus on access to care and effectiveness of the service system.

The paper contains proposals for expansion in the program of primary health care for Indigenous Australians which are intended to be developed in a way that is consistent with the *National Strategic Framework for Aboriginal and Torres Strait Islander Health*. These proposals, and others, will require development, testing and refinement, in partnership between Indigenous organisations and communities and government, when funding allows expansion to occur.

This extended summary is intended to present the main ideas and proposals in a form that can be read as a stand-alone document, in order to make the substance of the report accessible to a broader readership.

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[1] This paper was written before the decision to abolish ATSIC was announced. The implications of this change for some aspects of health care planning and forums have not been addressed.

Our approach to the task

Our approach is based on program logic, a model for evaluating programs in complex environments that tracks the causal connections between inputs, throughputs, impacts and outcomes. We have assembled the available evidence, with the generous assistance of the Australian Department of Health and Ageing and the advice of independent experts, and used comparators from mainstream Australia and the indigenous populations of comparable countries, to assess each element of the Australian Indigenous health 'program'. Our focus is on the primary health care services funded by the Australian Government, both Indigenous-specific and mainstream, within the context of the whole complex and interdependent Australian health care system.

In this paper, we start from a consideration of the questions facing decision makers (on what basis can decisions about investment in Indigenous health be made and in what ways can health care delivery address the problem?) and then examine current access to health care and the evidence regarding its effectiveness. Next we consider the current limiting factors in the capacity of the health system and how they might be resolved. We then address the question of measurable improvements in the impacts and outcomes for Indigenous Australians' health that could be expected if Indigenous people have adequate access to good health care; and finally consider the levels of investment required to enable these outcomes.

The challenge of improving Indigenous health

The Australian Government has expressed its determination to address Indigenous Australians' health disadvantage both alone (Commonwealth of Australia 2002, p. 25) and in concert with state and territory governments (NATSIHC 2003). Commitment to addressing Indigenous disadvantage more broadly has been affirmed through a range of policy and leadership initiatives, including most recently the Council of Australian Governments (COAG) Shared Responsibility initiative and the report *Overcoming Indigenous Disadvantage: key indicators 2003* (SCRGSP 2003). The need for strategies to address *health* disadvantage is consistently acknowledged as a core component of the broader agenda.

The challenge now is to determine the most effective strategies for achieving measurable progress in Indigenous health. The context is one of long-standing health problems, combined with long lead times required to demonstrate improvements, particularly in 'headline' indicators such as reduction in mortality rates. In this context, government policy has established two key criteria against which any proposed policy or funding change can be assessed: the potential to improve health outcomes and the potential to improve equity of access to effective health care services (Commonwealth of Australia 2002).

The role of health care

While the causes of illness and injury for any community lie in broad environmental, economic, social and biological factors, nevertheless an effective health care system is essential to preserve life and health. It does so through diagnosis and treatment; through early intervention to minimise the impact of illness and injury; through identifying and managing risks to health (e.g. the spread of infectious disease); and through supporting the capacity of individuals, families and communities to take responsibility for their own health. No amount of investment in housing, education, employment, infrastructure or other potentially health-promoting public policy can replace the functions of health care; but the effectiveness of health care can be greatly enhanced by the positive impacts of healthy public policy.

The role of comprehensive primary health care

Ready access to local primary health care (PHC) is universally recognised as the foundation of a functioning health system. Primary health care provides an immediate response to acute illness and injury; it protects good health through screening, early intervention, population health programs (such as antenatal care and immunisation) and programs to promote social and emotional wellbeing and prevent substance abuse.

Critically for the Indigenous population, primary health care identifies and treats chronic diseases (including diabetes, cardiovascular and renal disease) and their risk factors. Primary health care also acts as a pathway to specialist and tertiary care, and enables local (or regional) identification and response to health hazards; transfer of knowledge and skills for healthy living; and identification and advocacy for the health needs of the community.

The Australian health system as a whole is built on a base of primary health care, which works well for most Australians. But there is strong evidence that it has not worked well for Aboriginal and Torres Strait Islander people, and problems with access to primary health care provided the momentum for the development of the Indigenous-specific health sector (in the form of Aboriginal Community Controlled Health Services) beginning in 1971.

While lack of access to a responsive health system, particularly primary health care, is not the only cause of Indigenous health disadvantage, there is good evidence that primary health care can make a significant contribution to redressing it (Commonwealth Grants Commission 2001, p. 116).

Current access to primary health care is inadequate

Access to primary health care is essential to improve health status, but the current level of primary health care provision to Indigenous Australians is inadequate to meet that need. The delivery system for Indigenous primary health care is and will remain a complex inter-dependent network of services, Indigenous-specific and mainstream, generalist and specialised, across all ages and all aspects of health need. The challenge is to improve access for Indigenous Australians to effective care across this broad system. This section assesses current adequacy of access, and argues that the current strategy of both developing the Indigenous-specific sector and enhancing mainstream accessibility must continue.

Indigenous Australians use services funded through the Medical Benefits Scheme (MBS) and the Pharmaceutical Benefits Scheme (PBS) at less than half the rate of non-Indigenous Australians (even with no adjustment for the relatively higher burden of disease). In 1998–99, for every $1 of MBS-funded services used by non-Indigenous Australians, 41c was used by Indigenous Australians, and through PBS, the equivalent measure is 33c (OATSIH 2003a, p. 33; AIHW 2001). Access to services funded through the Office for Aboriginal and Torres Strait Islander Health (OATSIH) partly redresses this imbalance, but *total* Australian Government spending on primary health care services for Indigenous Australians was only about 70% of that for other Australians (AIHW 2001, pp. 4, 25–26).

These comparisons based on cost are not by themselves a good measure for equity of access, because they are not adjusted for need, or the higher cost of delivery to small remote and rural communities. The level of utilisation of health services by Australians rises sharply with their level of illness. People with one significant medical condition use 4 times the average MBS and PBS services; with five conditions, it is up to 12 times. Given the poorer health of Indigenous Australians, equitable access to health care would result in much higher than average use.

Indigenous Australians' access to primary health care is a problem in all areas of Australia, but varies with location. Aboriginal and Torres Strait Islander Australians do not access mainstream services, even in cities where they are readily available, to the level that would be expected given their health status. The government's approach to improving access is based on two complementary strategies: increasing the capacity of the Indigenous-specific sector, and enhancing the accessibility of the mainstream primary health care system, through adjustments to MBS and PBS and other measures. Both of these strategies are essential, because Indigenous Australians (like all Australians) need good access to a complex network of primary health care services with good linkages. Both Indigenous-specific and mainstream services are needed by Indigenous communities.

Indigenous-specific services will continue to play an essential role in addressing Indigenous health disadvantage, for four key reasons. Firstly, Indigenous Australians need different services because their health needs are different. In particular, the greater prevalence of chronic diseases in the Indigenous population means that a complex ongoing set of interventions is required which can only be provided by a skilled multi-disciplinary workforce, able to sustain effective long-term treating relationships and links with other providers. General practice services funded through the MBS are not able to meet these needs fully (Keys Young 1997), while Indigenous-specific agencies are designed to provide the basic health infrastructure required for effective service delivery.

Secondly, for several reasons including historical and cultural ones, mainstream health services are not generally capable of meeting the needs of Indigenous Australians and this makes it hard for Indigenous people to use them. This lack of capacity is more pronounced in some areas where traditional cultures and languages are still practised. Work to change the responsiveness of mainstream services should continue, but effective primary health care is needed now. Many Indigenous Australians will go without primary health care (Keys Young 1997, p. 61) if a service that specifically welcomes them and responds appropriately to their needs is not available.

Thirdly, the Indigenous population constitutes such a small proportion of the total primary health care ‘market’ in many areas of Australia (even if they used mainstream general practitioners (GPs) and other services proportionately) that their power in the market to stimulate mainstream health services to be responsive to their needs is severely limited. Their high levels of poverty exacerbate this problem. GPs are responsive to their markets, and a strategy that relied on GPs making independent decisions to substantially change their services to meet the needs of 2% of the market would be unlikely to produce significant results, and neither would many of them have the skills and experience to do so. However, there are some outstanding exceptions among GPs and mainstream community health agencies, and the work of these individuals and groups makes a valuable contribution, as do GPs who work part-time in local Indigenous-specific clinics.

Finally, the role of Indigenous-specific services is not simply one of *substitution* for mainstream services. They also provide a base for training of both Indigenous and non-Indigenous health professionals, and for research and development of new approaches to Indigenous health (either alone or in partnership with mainstream agencies and researchers). This aspect is particularly important in urban services, because of their proximity to medical schools etc. and to the headquarters of mainstream specialist providers (e.g. the leadership of child and adolescent mental health services tends to be based in capital cities). Indigenous-specific services in all areas provide the referral pathway to specialist and tertiary services, and support the providers in their responses to Indigenous patients. They are also the appropriate base for community development approaches to improving health.

For these reasons, an effective primary health care system for Indigenous Australians requires Indigenous-specific services. This applies in urban as well as rural and remote areas. While a much higher proportion of Australian Government health care spending for Indigenous people in remote regions is through OATSIH funding (over 90% of primary health care spending in remote areas was through OATSIH in 1998–99) more than half of all spending for urban and rural people was also through OATSIH (between 50% and 60%), in spite of the much greater availability of mainstream services.

However, the mainstream primary health care system, both Australian Government and state/territory funded, also makes an essential contribution which could be further strengthened. Efforts to enhance the accessibility of MBS and PBS services since the landmark Keys Young Report (1997) have made it easier for Indigenous Australians to obtain Medicare cards, use GPs and receive prescribed medicines. They have also assisted Indigenous-specific agencies through enabling MBS funding for their GP services. This work should continue, and the current proposal to set up an MBS item for an Aboriginal and Torres Strait Islander Adult Health Check is a relevant example.

Impact and outcomes of the current system of health care

We have argued that access to good primary health care is essential to enhancing Indigenous health status, and that current access is inadequate. While recent increases in funding have improved access, significant focused effort within the health system only commenced eight years ago (in 1995–96), and has developed gradually over that time. While continuing poor health status is not unexpected in these circumstances, there is evidence that the impact of existing services is positive. Because of poor access, evidence of impact can only be assessed in relation to those communities that are reasonably well served by effective primary health care. This evidence is by definition local, and the impact tends to be swamped in national and state/territory-level data.

There is reliable evidence of real achievements by Indigenous-specific services in some key areas (see summary in the Appendix). A few examples are highlighted in Table A below.

Table A: Examples of impacts and outcomes of Indigenous-specific health services

Communicable diseases control through vaccination
• *Increased childhood immunisation rates* – to 91% of children in the Tiwi Islands and 100% in Wilcannia (KPMG 2000).
• Indigenous people who attend an Indigenous-specific medical service are more likely to be appropriately vaccinated for *Pneumococcal disease* than Indigenous persons who attend a GP (76% versus 32% respectively) (Department of Health and Ageing 2003b).
Treatment of communicable diseases
• By 1997–98, the *prevalence of gonorrhoea* in the Anangu community served by Nganampa Health Council was reduced by 46% and *chlamydia* by 20%. Prevalence has since remained stable at 5% and 6% respectively. Approximately 70% of the adult population served by Nganampa Health Council participate in an annual STI screen (Miller *et al*. 2001; Torzillo 2003; Department of Health and Aged Care 2001b).
Cancer screening
• The Northern Territory Well Women's Program, which operates in a region with a high proportion of Indigenous women and has a long history of engagement with women and local Aboriginal Health Services, has achieved a high rate of *cervix screening* (61%) in the Alice Springs Remote area, which is comparable to the rate for Australian women generally (62%) (Condon 2004).
Reduced complications of chronic disease
• In 1999 a trial to improve diabetes care in the Torres Strait resulted in an 18% fall in hospital admission rates and a reduction of 41% in the number of people admitted to hospital for diabetes-related conditions. On follow-up in 2002 there was a continuing reduction in hospital admissions for diabetes complications (from 25% in 1999 to 20% in 2002). The proportion of people with good glycaemic control increased from 18% to 25%, and the proportion of people with well-controlled hypertension increased from 40% to 64% (McDermott *et al*. 2001; McDermott *et al*. 2003).
• A mental health project at the Geraldton Regional Aboriginal Medical Service *reduced psychiatric admissions* of Aboriginal and Torres Strait Islander people to Geraldton Regional Hospital by 58% (Laugharne *et al*. 2002).
Improved maternal and child health outcomes
• Since 2000 the Townsville Aboriginal and Islander Health Service's Mums and Babies Project increased the numbers of women presenting for antenatal care (from 40 to over 500 visits per month in 1 year). The number of antenatal visits made by each woman has doubled, with the number having less than four visits falling from 65% to 25%. *Pre-natal deaths*/1000 reduced from 56.8 prior to the program to 18 in 2000; the number of babies with *birth weights less than 2500 grams* has dropped significantly; and the number of *premature births* has also decreased (Shannon & Longbottom 2004; Eades 2004; Atkinson 2001).
• Since 1990 an *antenatal program* at Daruk Aboriginal Community Controlled Medical Service, Western Sydney has achieved increased awareness amongst Aboriginal women of the importance of antenatal care. Thirty-six per cent of Indigenous women presented within the first trimester, compared with 21% at Nepean and 26% at Blacktown Hospitals' antenatal clinics; and women attended more antenatal visits (an average of 10 at Daruk compared to six at Nepean and nine at Blacktown) (Eades 2004).

There are many other examples of mainstream and Indigenous-specific services actively improving access to services for Indigenous Australians with high need. For example, the Inala Health Centre General Practice in Queensland, working with the local Indigenous community, increased services from a low of 12 Indigenous attendances in 1995–96 to 3894 in 2000–01. The Centre has an Indigenous doctor and used several strategies to improve access, including employment of another Indigenous staff member, display of posters and other visual signs of welcome, cultural awareness training for all staff, dissemination of information about the services to Indigenous communities and promotion of collaboration between service providers (Department of Health and Aged Care 2001b).

Evidence regarding the broad impact of mainstream health care is incomplete, due to inadequate data regarding Indigenous status in the most populous states. State and national collections appear to show evidence of improvement in some indicators.

- Aboriginal and Torres Strait Islander infant mortality has declined from over 80 deaths per 1000 live births in the 1970s to 26 deaths per 1000 live births in 1981 (ABS 2000c, p. 76), with continuing gradual improvement. In 2000–02 the Indigenous infant mortality rate in the Northern Territory was 18.1 per 1000 live births (compared to 11.2 for the total population) and in NSW, which had the lowest rate, it was 9.5 per 1000 live births (compared to 5 deaths/1000 live births) (ABS 2003, p. 96).
- Indigenous life expectancy increased by 1.6 years for males and 0.9 years for females over the ten years from 1989–1999 (as measured by median age at death). Non-Indigenous life expectancy increased by 2.7 and 2.8 years, so the gap continued to grow (ABS 2000c).
- Age-specific death rates have declined for all age groups except 15–24 and 45–54 years (based on WA, NT and SA data) (ABS 2000c, p. 75).

A less direct measure of impact is offered by calculating the effect on Indigenous health and health care of withdrawing OATSIH funding for primary health care services. For nine preventable diseases (which account for about 27% of current health spending for this population), the withdrawal of OATSIH-funded services in the Northern Territory was estimated to cause a loss of healthy life (using Disability Adjusted Life Years or DALYs) of 2.6, 6.1 and 12.6 years per person in 5, 10 and 20 years time respectively (Beaver & Zhao 2004). Savings in the OATSIH program would be offset by increased costs to other parts of the system, largely hospital costs, resulting in a ratio of costs to savings of 5 times over 5 years, 7 times over 10 years and 11 times over 20 years. The applicability of this modelling nationally is untested, and it cannot be generalised to other diseases. However, the overall findings are supported by the known impact of effective primary health care for chronic conditions in populations globally. Further, the modelling is robust to realistic variances in key assumptions, and can be accepted as a valid indicator of the direction (if not the precise measure) of the real positive impact of health care provision.

The available evidence of health impact in Indigenous populations, and the known effective interventions of primary health care, indicate that the impact of effective primary health care is seen in:

- reduced prevalence and incidence of *communicable diseases* that are susceptible to immunisation programs;
- reduced complications of *chronic disease* through effective chronic disease management programs;
- improved *maternal and child health* outcomes (such as birth weight) through the implementation of culturally appropriate antenatal and early childhood programs; and
- reduction in *social and environmental risks* through effective local public health advocacy, such as changes to liquor licensing regulations.

The available evidence of intermediate health outcomes achieved by effective Indigenous-specific health services gives grounds for governments to increase their investment in improving access to comprehensive primary health care. Further, there is no reason to believe that health interventions that are of proven effectiveness for the general population cannot be effective in Indigenous populations, provided that the delivery system that brings these interventions is effectively tailored to the needs of Indigenous communities.

Capacity of the health system

While funding levels are a critical brake on access, the current capacity of the delivery system is also not adequate to respond to health needs. Significant growth in funding would need to be complemented with vigorous attention to some major limiting factors, and further development of the service system including:

- care delivery models;
- structure of the delivery system;
- workforce development;
- governance development;
- data for decision making;
- effective leadership;
- coordination by governments; and
- greater engagement by the mainstream health system.

These issues are of vital importance—four that go directly to the major questions for government are addressed below.

Care delivery models

The existing OATSIH definition of comprehensive primary health care (CPHC) provides a sound basis on which to build further specification of the basic platform of services, and of service system models. The four key elements are:

- competent clinical care—treatment of acute illness and injury, emergency care and management of chronic conditions (including mental illness);
- population health programs—antenatal services, immunisation, screening programs for early detection of disease, and specific health promotion programs (e.g. physical activity, nutrition, oral health, prevention of substance misuse);
- pathway for access to secondary and tertiary care—referral, support for referred patients, development and maintenance of linkages with a range of health services (such as medical specialists and referral hospitals) and related community services (aged care, disability); and
- client/community assistance and advocacy—identification of factors contributing to illness or risk; working with individuals and communities to develop strategies to reduce risk or harm, including for health risk factors and health determinants which lie outside the direct ambit of the health system. (NATSIHC 2003; Shannon & Longbottom 2004).

If the goal of comprehensive primary health care for Indigenous Australians is to be achieved, a necessary next step is to develop better specification of the basic platform of services and capabilities that must be achieved at various levels (e.g. for given population sizes and travel distances).

Detailed specification of services is a task that is beyond the scope of this paper, and should be tackled by a multi-disciplinary group with strong clinical and community input. However, Table B below gives a draft list of the key elements.

Table B: Elements of comprehensive primary health care

Health services
Clinical services—with access to emergency care 7 days/24 hours (local or remote)
Antenatal care
Immunisation
Care of 0–5 yr olds, and support for effective parenting
Sexually transmitted infection (STI) services
Primary medical care
Screening where there is an appropriate method and good evidence of outcomes
Access to specialist care and referral to secondary and tertiary services
Secondary prevention of chronic disease
Care coordination for people with complex and chronic conditions
Mental health services and programs to enhance social and emotional wellbeing
Specific vertical programs (nutrition, substance abuse)
Support
Standard treatment protocols for common conditions, based on evidence
Data collection, evaluation, monitoring
Ongoing staff development—including health worker training
Intersectoral collaboration (focused on known opportunities for health gain)
Programs to enhance the capacity of Indigenous families and individuals to take responsibility for their own health
Standards
Competent and expert care
Well lead and managed (sound policies and procedures, practice guidelines and manuals)
High quality
Universal access

Source: Based on personal communication with Dr Paul Torzillo (2 September 2003)

The delivery system

Specification of a platform of services that should be available to all Indigenous Australians is an important step, and can be used to guide the development of the system that can deliver these elements. It is important to clarify that all Australians need access to a wide range of primary health care services, and no one agency or type of service can provide the full range. Key elements include GPs, pharmacies, laboratories and radiology services; and allied health, maternal and child health, women's health, men's health, aged care, and community health programs, domiciliary care, transport, and mental health. The list could go on. The point is that a service system, with effective links between services, rather than any single program is required.

The precise mix of agencies and service delivery methods required to achieve access to these services will be highly variable, and local planning and capacity development remain essential. However, it is possible to specify key characteristics of the required delivery system.

Firstly, we have argued above that such a system is made up of a combination of Indigenous-specific and mainstream services, and even further enhancements in MBS and PBS will not change this reality, although they could deliver meaningful improvements.

Secondly, effective comprehensive primary health care requires a combination of 'horizontal' and 'vertical' systems and programs. The horizontal element is made up of local/regional primary health care agencies and GPs, adequately resourced to deliver and coordinate the required platform of services in an integrated package of care for their communities, complemented by specialist services (such as the Royal Flying Doctor Service and pathology laboratories). The vertical element is made up of targeted national- or state/territory-level programs (e.g. Eye Health, Cervix Cancer Screening), which are designed to address specific health issues and achieve specific targets.

It follows that a strategy of funding 'best buys' won't work unless there is a strong network of local and regional service providers in place to deliver them. The modelling carried out by Beaver and Zhao (2004) assessed the best buys for reducing the burden of illness from nine preventable chronic conditions. They found that clinical primary health care for newly diagnosed and existing patients was the most effective intervention for saving health care resources (primarily through better management of the progression and complications of chronic disease, and resulting reduced demand on more expensive components of the delivery system).

These findings illustrate the potential for enhancing the cost-effectiveness of intervention through evidence-based planning and care delivery. They also indicate that delivery of the most effective interventions requires a platform of comprehensive primary health care. Best buys are part of effective primary health care, not a substitute for it.

Thirdly, there is a minimum size below which health care agencies cannot be effective. For Indigenous-specific agencies, there are good reasons to move towards a regional model, based on achieving critical mass. Arrangements for existing small agencies, and to enable local responses to local problems, will be needed. This element of the service system is further addressed under governance below.

Specification of the basic platform of services that constitute CPHC, and the establishment of an agreed regional model for the Indigenous-specific service system, with adequate resourcing, have the potential to deliver several benefits. These measures can provide a guide for decision making in relation to funding and support, can support progress towards the goal of equity of access to care, assist the development of good practice in clinical care and the use of effective interventions, and enable stronger governance and management.

Governance and structure of Indigenous health organisations

There are many examples of good governance and management practice in the field of Indigenous health, and there are also areas where improvement is required. The Australian Government funds a range of Indigenous health agencies, most of which are Aboriginal Community Controlled Health Services (ACCHSs). They are represented nationally by the National Aboriginal Community Controlled Health Organisation (NACCHO).

In 2000–01, 129 Indigenous-specific primary health care organisations were funded by the Commonwealth and they provided 1.3 million episodes of care. A significant proportion of funded primary health care services (43% or 56 services) receive less than $500 000 per year with only 17 services receiving over $2 million per year. The ACCHSs receive funding from multiple sources and programs, each requiring different reporting formats.

Service capacity often reflects historic arrangements and agencies are not currently funded equitably on the basis of community need. It should be noted that the Government has considered and rejected the option of reallocating existing funding for Indigenous health organisations more evenly (Commonwealth of Australia 2002, p. 25) in light of the Commonwealth Grants Commission (CGC) finding that there was no evidence of funding in excess of needs in any location (CGC 2001, p. 144).

We propose two policy principles for action to enhance the effectiveness of Indigenous organisations. Firstly, future funding should be provided at levels that enable agencies to achieve critical mass for good governance and effective service delivery. In many areas, a regional approach to governance structures, with local arrangements for service delivery, is the most practical method of achieving this goal given small, dispersed populations. Alignment of regional boundaries, and the size of regions, should be based on the design requirements for effective health care delivery. Arrangements to accommodate existing small agencies will be required.

Secondly, the principle of Indigenous governance of Indigenous-specific services should remain strong, and the forms and types of organisations that are accommodated by this principle should continue to develop, in accordance with Indigenous community needs. At the same time, other forms of engagement for specific services and purposes (such as partnership arrangements and Indigenous services and committees within mainstream agencies) need to be actively pursued.

National system development for Indigenous health

Effective delivery of health care also requires good stewardship and governance at the national system level. Since 1995–96 the Australian Government (both alone and in concert with states and territories) has progressively implemented strategic reforms aimed at enhancing the health care system for Indigenous Australians at the national level. Highlights of system-level developments are summarised in Table C below.

The location of responsibility for Indigenous health within the Australian Department of Health and Ageing is virtually universally supported within the health sector, including Indigenous health organisations. The reasons for this support include the greatly enhanced ability to bring public health and medical expertise to bear, the emerging evidence of effectiveness, the leverage applied to the mainstream health system to enhance its response to Indigenous health disadvantage, and the record of achievement over the last eight years in allocating increased funding from within the health budget to Indigenous health. Responsibility for Indigenous health should remain with the mainstream health portfolio.

Table C: System-level development

National leadership and planning
• Framework Agreements are in place in all jurisdictions, and health forums are established.
• Regional planning is completed in all jurisdictions and plans are being used to inform service enhancement priorities.
• The National Strategic Framework for Aboriginal and Torres Strait Islander Health, which sets out a 10-year plan, was endorsed by all governments in July 2003.
Increased investment in service delivery (1995–96 to 1998–99 unless otherwise specified)
• Australian Government funding has grown from $1059 per Indigenous person to $1433 (annual growth of 10.6%) and state/territory funding increased from $1144 to $1470 (annual growth of 8.7%) (AIHW 2001).
• The number of episodes of care provided by Australian Government funded Aboriginal and Torres Strait Islander primary health care services (PHCSs) increased by 39% (SAR 1998–99 to 2000–01).
• The number of Medicare-funded GP services provided in Aboriginal Community Controlled Health Services (ACCHSs) and state/territory-funded clinics increased by an estimated 142% (from 0.25 GP services per Indigenous person to 0.56) (Deeble *et al*. 1998; AIHW 2001)
• The number of private GP services provided to Indigenous people increased by an estimated 54% (from 1.63 GP services per Indigenous person to 2.36) (Department of Health and Ageing data 2003, unpublished).[2]
• The number of PBS items dispensed per Indigenous person increased from an estimated 1.43 to 2.11, with an estimated total cost increase of 100% (i.e. from $9.8m to $20.4m) (Department of Health and Ageing data 2003, unpublished).
• Between 2000–01 and 2002–03, access to PBS in remote areas was improved through Section 100 arrangements from a total of $6.6m to $16.6M (Department of Health and Ageing data 2003, unpublished).
• Between 1998 and 2001, the proportion of PHCSs providing preventive programs increased from 54% to 74% providing men's health programs, 69% to 88% providing women's health programs, 74% to 80% providing child growth monitoring and 61% to 73% providing well person's health checks (SAR 1998–99 to 2000–01).
Workforce and data development
• The number of doctors working in PHCSs has increased significantly with available data suggesting that it has doubled in the period since 1997–98 to a total of 201 in 2001–02. (SAR 1997–98 and 2001–02)[3].
• There are now 44 Indigenous general practitioners (50% more than in 1996) and 921 Indigenous registered nurses (33% more) in Australia (ABS 2001 Census); and 178 Indigenous students graduated from tertiary health professional courses in 2002.
• Since 1998, computerised patient information and recall systems have been implemented in 57% of ACCHSs (SAR 2000–01).

Impact of adequate investment in effective health care

Ultimately the Government's goal is to eliminate the life-expectancy gap between Indigenous and non-Indigenous Australians. However, government also recognises that focusing on this indicator of health is not a practical strategy (SCRGSP 2003). The current Aboriginal and Torres Strait Islander Health Performance

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[2] It should be noted that there are caveats on both MBS and PBS data (AIHW 2001). Direct comparisons of 1995–96 data with 1998–99 data are additionally difficult due to changes in both methodology and data availability.

[3] This is an estimate based on 1997–98 and 2001–02 SAR data. The data from the two periods are not directly comparable (due to lack of recording of full-time equivalent numbers in the earlier year) but any error is likely to understate the real gain.

Framework (ATSIHPF) project, under the auspices of the Australian Health Ministers' Advisory Council's (AHMAC) Standing Committee on Aboriginal and Torres Strait Islander Health (SCATSIH), is working to develop an evidence-based framework for monitoring progress in health, consistent with the whole-of-government approach endorsed by COAG in the report *Overcoming Indigenous Disadvantage: key indicators 2003* (SCRGSP 2003).

One of the distinguishing features of the COAG and AHMAC approaches is the explicit tracing of links from strategic action to headline indicators. The Aboriginal and Torres Strait Islander Health Performance Framework will be the chief vehicle for assessing the effectiveness of implementation of the *National Strategic Framework for Aboriginal and Torres Strait Islander Health*, which has been endorsed by all governments. It will use program logic to trace the impacts and outcomes of health system interventions, and will use indicators for monitoring each major element of the 'program' of Indigenous health care. The table below outlines the highest priority indicators agreed by SCATSIH in 2002, as an interim measure pending the development of the Aboriginal and Torres Strait Islander Health Performance Framework.

Table D: Priority indicators from the current National Performance Indicators for Aboriginal and Torres Strait Islander Health

Outcomes
Life expectancy at birth
Infant mortality rate
Low birth weight babies
Child hearing loss
Vaccine-preventable disease rates
Overweight and obesity
Sexually transmitted infection rates
Age-specific death rates and ratios
Impacts
Pap smear rates
Childhood immunisation
Smoking prevalence
Alcohol consumption
Inputs and processes
Government expenditure
Indigenous workforce
Access to health care
Management of key conditions

This is an appropriate list of indicators, and the existing evidence of local impacts and outcomes shows emerging improvements in many of the items. The list will be refined as part of the finalisation of the Performance Framework.

Designing the right indicators is a technical challenge, as they must be valid signposts for better health and sensitive to improvements on the ground. The second step is to select a workable number of them (as SCATSIH has done). Good data collection and analysis are also essential, and finally, none of this will serve its purpose without consistent focus and monitoring over time.

The Aboriginal and Torres Strait Islander Health Performance Framework project should deliver valid answers to the question of impacts and outcomes in a reasonable timeframe. The work by the Australian Institute of Health and Welfare (AIHW), the Australian Bureau of Statistics (ABS), OATSIH, state/territory health authorities and health care providers over recent years to improve data collection, including the identification of Indigenous status, provides a strong foundation, but further effort is required.

We conclude that the elements of an effective performance monitoring system are in place or in progress, as a result of focused effort over several years, and results should be forthcoming within a reasonable time frame.

Required types and levels of investment

We have argued that significant additional funding is required to meet the Government's policy goals of equitable access to effective health care and improved health outcomes. In this section, we address the questions of funding levels, methods and timeframes.

Funding levels

Recent expert analyses of *total* spending and Indigenous health care needs relative to non-Indigenous Australians (see below) show clearly that less than half of the required funding is currently available. Within this total level of spending, there is also a mismatch of type of investment, with low spending on primary health care offset by higher use of hospital care (at approximately twice the rate of non-Indigenous Australians), which is neither good for health nor an efficient use of health resources.

In regard to primary health care, current spending is also less than half the level that is required. MBS and PBS spending has increased in recent years in response to changes designed to make medical and pharmaceutical services more accessible to Indigenous Australians, but is still less than half of equivalent spending on non-Indigenous Australians, without adjustment for need or remoteness. This is partly compensated for by grant funding through OATSIH, but the total level is still inequitable in comparison to non-Indigenous Australians, and inadequate to maximise health impacts and outcomes.

Adjustments for need and remoteness add significantly to total funding requirements. Given the poorer health of Indigenous Australians, equitable access to health care would result in higher than average use. The additional cost of delivering services in remote areas, and other characteristics such as high proportions of patients who primarily speak languages other than English and lack literacy skills, mean that higher unit costs of care are also incurred.

There is no simple answer to the question of how much funding will deliver the needed level of access to effective care. The economic modelling that has been done in recent years (Econtech 2004; Commonwealth Grants Commission 2001; Mooney *et al.* 1998; McDermott & Beaver 1996; Beaver *et al.* 1996; McDermott 1995) has variously allowed for burden of illness, remoteness, costs of treating people for whom English is not their first language, and the costs of infrastructure. Estimates range from 2.2 to 7.3 times the average per capita resources required by the non-Indigenous population.

OATSIH has analysed the modelling work, noting that some of the studies use data from specific populations, such as Indigenous people living in the Northern Territory. When figures are adjusted to take into account the Indigenous population on a national basis, and including allowance for remoteness and burden of illness, they fall between 3 and 6 times the national average per capita expenditure (OATSIH 2003e). The Commonwealth Grants Commission concluded that 'at least 2 times' average per capita expenditure was required given adjustment for poorer health status and greater reliance on the public system; and that this number would need to be multiplied by a factor of up to 2 to allow for the impact of greater costs in remote areas.

Econtech (2004), in a paper commissioned for the Review, estimates the required level of total health funding on a population needs basis (i.e. adjusting for the poorer health status of Indigenous Australians) at approximately 2.21 times the spending on non-Indigenous health care. There was no adjustment made for the additional costs of remoteness, or for culturally appropriate services.

The OATSIH analysis (OATSIH 2003e) concluded that lower resource requirement estimates emerge from modelling of the costs of a minimum level of health services. The higher estimates relate to the cost of providing additional services, to address health inequities and to provide culturally appropriate programs.

We conclude that total health spending on Indigenous populations would need to be increased to a level between 3 and 6 times the national average per capita expenditure to achieve equitable access to effective care. It is beyond the scope of this paper to estimate the budget implications of applying this modelling to OATSIH and other funding programs.

Funding methods

The complex nature of the primary health care system, and the involvement of both national and state/territory governments, inevitably mean that funding programs will also be complex and require significant planning and coordination effort.

The Primary Health Care Access Program (PHCAP) provides a framework for ensuring needs-based planning and allocation of funding; for collaboration between mainstream and Indigenous providers; and for managing the partnering relationships among key stakeholders, including governments, which are a necessary part of this endeavour. The evidence of impact presented earlier indicates that PHCAP-funded sites are delivering improved health impacts. While PHCAP is far from perfect, the forums and agreements it has created are in place, the policy intentions are broadly understood, and the major partners remain committed to the program. Any replacement is likely to suffer from the same complexities and long lead times. We conclude that investment in PHCAP should be continued, and that it should be used as one major method of increasing the funding for primary health care for Indigenous Australians.

Funding for ongoing primary care services needs to be made more certain, so that agencies can consolidate their focus on quality and effectiveness. Although complexity of funding sources makes this task difficult, OATSIH and other funding agencies could work with the sector to achieve it.

Timeframes

Health gain from additional resources is not a straight-line ‘dose response’ relationship. In a situation where there is inadequate primary health care, too small an increase may not enable the system to reach the level of effectiveness where health gains begin to be seen. However, the sort of increase required cannot be taken up quickly and a staged program of increased funding is required. Funding for service delivery should increase at a pace determined by the capacity of the delivery system to deploy it effectively. Investment in system infrastructure (including workforce development, better information systems and data collection, resources to support good governance, leadership development and infrastructure for quality improvement) should be front-loaded into the funding roll-out, to ensure that sound capacity is developed in a timely way.

We propose that a staged increase in funding of comprehensive primary health care for Indigenous Australians be properly scaled, based on the PHCAP framework, using a variety of funding formulae appropriate to local organisations and conditions. Administrative arrangements should provide greater certainty for primary health care providers and should hold providers accountable for outputs and impacts.

Conclusion

The weight of the evidence we have considered in the course of preparing this paper has convinced us that the groundwork has been done and there is a clear pathway for government to fulfill its commitment to address Aboriginal and Torres Strait Islander Australians health disadvantage.

Summary of conclusions

- Government commitment to overcoming Indigenous disadvantage requires that policy and funding decisions be based on two criteria: the potential to provide equitable access to effective health care; and the potential for improvement in Indigenous health.
- Good progress has been made in recent years in the development of the service delivery system and system infrastructure, both mainstream and Indigenous-specific.
- Current access to and investment in Indigenous primary health care is too low, but the existing level is producing some positive health impacts and outcomes.
- Investment in comprehensive primary health care should be increased to a level between 3 and 6 times the national average per capita expenditure.
- Funding should be allocated through both Indigenous-specific and mainstream funding programs, and to both Indigenous-specific and mainstream providers.
- The principle of community control of planning, management and delivery of Indigenous primary health care services should be maintained, in accordance with the National Strategic Framework. Community participation in partnerships and other forms of collaboration with mainstream health care agencies is also needed.
- The Primary Health Care Access Program should continue to be used as the major vehicle for additional funding and for the development of effective partnerships and plans.
- Urban Indigenous-specific agencies should continue to be supported, in light of the needs of urban Indigenous Australians, and in recognition of the roles these agencies play in developing the capacity of the mainstream health system.
- Indigenous health care should continue to be funded and administered as part of the health portfolio.
- Outcomes and impacts of increased funding should be monitored through the National Performance Framework currently under development. Sustained monitoring of a small number of valid indicators, focused on those conditions and targets that are sensitive to improvements in primary health care, and supported by robust data collection and analysis, are needed.

1 Introduction

This paper has been commissioned by the Department of Health and Ageing (on behalf of the Interdepartmental Committee [IDC]) as part of the Primary Health Care Review (the Review). The Review arose from the Government's request to the Minister for Health and Ageing to review the Aboriginal and Torres Strait Islander primary health care program and report in the 2004–05 budget context. The Review was undertaken through an Interdepartmental Committee comprising members from the Departments of Health and Ageing, Treasury, Finance and Administration, Prime Minister and Cabinet, Immigration and Multicultural and Indigenous Affairs, and Aboriginal and Torres Strait Islander Services.

1.1 Purpose and scope

The objectives of this paper are to:

- assess the impact of Australian Government funding for comprehensive primary health care for Aboriginal and Torres Strait Islander Australians (both mainstream and Indigenous-specific) in various locations including urban, rural and remote areas;
- provide advice on the strategy and relevant timeframes required to achieve appropriate levels of comprehensive and effective health care for Aboriginal and Torres Strait Islander Australians; and
- provide information and advice on the likely short-, medium- and longer-term health impacts that could be expected to result from increased investment in this area.

1.2 Approach to the task

Our approach is based on program logic, that is, a model for evaluation of programs in complex environments that tracks the causal connections between inputs, throughputs, impacts and outcomes. Thus we examine the levels of funding, the way funding is applied, and the service delivery that results, in terms of their effectiveness to produce the desired outcome, which in this case is to eliminate or minimise Indigenous health disadvantage.

We have assembled the available evidence, with the generous assistance of the Office for Aboriginal and Torres Strait Islander Health (OATSIH) and the advice of independent experts, and used comparators from mainstream Australia and the indigenous populations of comparable countries, to assess each element of the Australian Indigenous health 'program'.

The next part of this paper explores the nature of the challenge the country faces in the effort to improve the health of Indigenous Australians and key aspects of the policy context. This section establishes the context and the fundamental policy goals, which are the foundations for the application of program logic—that is, they establish the goals and standards against which the effectiveness of the program is then assessed.

Part 3 *(Effectiveness of current programs)* examines current levels of access to primary health care services and the impacts and outcomes of the current service system.

Part 4 *(Strategies for narrowing the gap)* examines the current capacity of the health system and proposes strategies for improving access and outcomes.

Part 5 *(Measuring improvement and required investment)* addresses the difficult challenge of designing and monitoring reliable indicators to provide valid information about progress in access to health care and in health outcomes. The required level of investment to achieve measurable results is assessed in this section.

We have attempted throughout to enable the reader to appreciate the current situation, weigh the available evidence and assess strategies on the basis of their potential to deliver measurable improvements in the health of Indigenous Australians. The paper has been kept as concise as possible, consistent with meeting these requirements. For ease of reference, the focus of each part is explained in italics at the beginning, and the import of each section is summarised in italics at the end. Case studies are used to illustrate with practical examples some of the approaches and models we assessed, and some successful strategies already underway.

On terminology

We have used the terms ‘Indigenous-specific services’ and ‘Indigenous primary health care agencies’ when we need to encompass both Aboriginal Community Controlled Health Services and other agencies (such as those owned and managed by state or territory governments) established with the primary goal of providing health care to Indigenous people. Aboriginal Community Controlled Health Services are defined as ‘primary health care services initiated and managed by local Aboriginal communities to deliver holistic and culturally appropriate care to people within their community’ (NACCHO 2003, p. 2). Other terms are defined as they arise; and the glossary provides a check list of the abbreviations used in this paper.

2 Context: Indigenous policy, Indigenous health and health care

This part gives an overview of Indigenous health disadvantage, and examines the rationale for focusing on health care, and particularly primary health care, in strategies that aim to improve Indigenous health outcomes. It also outlines the policy framework adopted for this paper.

2.1 Indigenous health disadvantage

The significant health disadvantage of Indigenous Australians has been well documented and is seen in virtually all accepted indicators of health status. Indigenous Australians have much higher death rates than non-Indigenous Australians in all age groups (ABS & AIHW 2003, p. 179) and the infant mortality rate is over two and a half times the national average (ABS 2000c, p. 75). Men of Aboriginal and Torres Strait Islander descent die, on average, 21 years earlier than their non-Indigenous counterparts, and for women the difference is 19 years (ABS & AIHW 2003, p. 182). This gap could potentially be greater if life expectancy was divided into years of good health and years of disability (WHO 2000). However, the exclusion of NSW and Victorian data (accounting for about one-third of the total Indigenous Australian population) from both the numerator and denominator in the calculation of these headline rates means that the precise gap is not known and could be slightly smaller than estimated.

The gap applies to both rural/remote and urban Indigenous populations, although patterns of disease and access to services are different. The AIHW notes that there is an increase in mortality rates in the general population with remoteness of location, and this gradient may also apply to the Indigenous population. While this has not been conclusively established, there is evidence that Indigenous Australians living in remote Australia have higher levels of some conditions such as end stage renal disease, than those living in urban areas (Cass *et al.* 2001).

The history of concerted effort in policy development, funding programs and service delivery to improve the health of Indigenous Australians is a relatively short one (arguably commencing only in 1995–96), if assessed against experience in comparable countries (USA, Canada and New Zealand) (Ring & Firman 1998; AMA 2003). Available information indicates that of the indigenous populations of these countries, Indigenous Australians suffer the highest burden of illness and early death. By the end of the 1990s, the USA, Canada and New Zealand had decreased the gap between their indigenous and non-indigenous populations to between five and seven years while Australia's gap remained significantly greater at 21 years for males and 19 years for females (WHO 2000; AMA 2003; ABS & AIHW 2003; Ajwani *et al.* 2003). While differences in methods of identifying Indigenous status and other data problems mean that these figures must be treated with caution, the size of the difference in the longevity gap is too large to be explained by data problems or statistical artefacts. It should be noted that there has been a recent reversal (i.e. widening of the longevity gap) in New Zealand, which coincides with significant economic and structural changes in New Zealand during 1980–1999 (Durie 2003; Ajwani *et al.* 2003).

While there are significant gaps in the available data, there is no doubt that the health disadvantage of Indigenous Australians in all locations is significant when measured against mainstream Australia and when compared to the situation of Indigenous peoples in comparable countries. Specific national initiatives to address Indigenous health disadvantage have commenced relatively recently compared to the USA, Canada and New Zealand, and have not yet delivered equitable access to health care. Overcoming Indigenous health disadvantage (in rural, remote and urban locations) is a major national challenge.

2.2 Social, economic and cultural factors underlie the health problem

Health is determined by environmental, social, economic and biological factors, and health care alone is not the answer to any community's health problems. Indigenous people's health in particular is affected by the history of colonisation, and the ensuing economic and educational disadvantage, cultural dislocation, social exclusion, remoteness and other factors specific to their situations.

Both Indigenous and other commentators refer to a failure of public policy to address the broader social, economic and cultural determinants of poor health outcomes for Indigenous Australians (Ring & Brown 2002; Pearson 2000; Langton 2002; Altman & Hunter 2003). The deep and widespread problems of poverty, breakdown in family relationships and family violence, youth alienation, and abuse of alcohol and drugs have complex causation. There is a sense of uncertainty as to how underlying causal factors can be addressed and vigorous debate from different ideological perspectives. Uncertainty about policy directions is also reflected in the complexity of arrangements for institutional leadership and coordination among the various levels of government.

While the analysis of Indigenous leaders such as Dr Noel Pearson and Professor Marcia Langton remains controversial, new approaches to preventing abuses, regaining community cohesion and enhancing economic productivity are emerging. They share a shift in focus from receipt of assistance ('sit down money') to active community and individual engagement and self-determination (Pearson 2000; Langton 2002). Recent initiatives from within the Indigenous community are focused on addressing the underlying causes of disadvantage as well as the effects. Examples include the Youth Employment and Training Initiative in Mackay Queensland, the Tangentyere Night Patrol in the Northern Territory and the Atunypa Wiru Minyma Uwankaraku: Good Protection for all Women Project in the Northern Territory (Queensland Government 2003).

This is not to suggest that transformational change will come quickly, given the inter-generational nature of the damage that has been suffered by Indigenous Australians, both since white settlement and in the last 30 years. However, there is a sense that Indigenous leaders and communities are seeking to build community capacity from the inside, in active partnerships with government, business and the non-government sector. The willingness of mainstream Australia to support new initiatives (e.g. the Indigenous Enterprise Partnership, a partnership between Cape York communities and companies such as Westpac, and the establishment of the Rio Tinto Aboriginal Foundation) is also an optimistic sign.

This paper does not seek to address the broad field of Indigenous affairs, nor to comprehensively address the major social and environmental determinants that contribute to illness, injury and disability. Rather, we seek to outline the policy context, and acknowledge the complexities and uncertainties that face government, Indigenous peoples and all those who wish to contribute to reducing disadvantage.

Some important policy decisions have been made. But there is not yet a strong sense of progress towards an envisioned future in which Indigenous Australians enjoy prosperity and health to a level comparable to other Australians, while retaining and building strong Indigenous identities, cultures and communities. Progress on broad social, economic and cultural determinants of health status is essential (but not sufficient) if Indigenous health disadvantage is to be addressed.

2.3 Is a focus on health care necessary?

The health system does not hold the key to the prevention of illness and injury arising from social and economic causes, although it does have a contribution to make particularly at the community and regional level. However, an effective health care system is nevertheless essential for several reasons. Firstly, the current burden of illness in Indigenous communities requires proportionate allocation of health care resources to meet the resultant need for health care. Diagnosis and treatment of cancer, diabetes, heart disease, mental illness, communicable diseases and the full range of health problems, as well as maternity and infant care, can only be provided through an adequate health care system.

Secondly, screening, early diagnosis and secondary prevention in the management of chronic disease are essential to limit the future burden of illness requiring treatment. Thirdly, health knowledge and the advice of health professionals is required to enhance the capacity of individuals, families and communities to share responsibility for their own health. To do this requires knowledge about and resources for healthy lifestyles, local identification of emerging health hazards, and local action to 'make healthy choices easy' (through improving access to resources for health such as healthy food supply). While the education system, for example, can contribute in many ways, it is not reasonable to expect school teachers to be responsible or knowledgeable in these areas. By the same token, health workers cannot expect to change the broader determinants of health status. However, they can act at a local level to identify and assist communities to ameliorate the local impacts of causal factors, and thereby enable communities to advocate for change at the regional, state/territory or national level.

Evidence from other populations, including mainstream Australia, clearly demonstrates the impact of access to good health care in reduced burden of illness and longer life as well as reduced pain and suffering (WHO 2000). The mechanisms through which this gain is delivered (effective illness prevention, maternity care, screening, diagnosis, treatment, rehabilitation and palliation) are applicable to all people. The things that vary are the pattern of illness and injury; the relative impact of different environmental, social, cultural and biological factors; and thus the required focus of effort, mode of intervention and style of care delivery.

Given the relatively poor health of Indigenous Australians the provision of health services is particularly critical. However, they do not currently have equitable access to these services and this, along with the broader conditions of their lives, contributes to their health disadvantage. In rural and remote areas where a larger proportion of Indigenous Australians live (70% compared to less than 33% for all Australians) (ABS & AIHW 2003, p. 17), mainstream primary health care services (funded through MBS and PBS) are either not available, not adequate or not suitable for a variety of reasons (Keys Young 1997). Consequently, Indigenous people are more affected by the general difficulties in access to care that apply outside cities and major centres, as well as being uniquely disadvantaged as compared to rural and remote Australians generally.

Thirty per cent (30%) of the total Indigenous population resides in major cities representing one per cent (1%) of the population in these cities (ABS & AIHW 2003, p. 2). Urban Indigenous people typically experience less infectious diseases and have better access to hospital services for injuries than rural and remote Indigenous people. However, they are also disadvantaged in access to mainstream care (Department of Health and Aged Care 2001a) and, given their health status, are relative under-users of primary care and specialist services. Evidence for this includes the following.

- Total health care expenditure per capita (including public acute care and private hospitals, Australian Government contribution to residential aged care, medical services provided under MBS, PBS, and OATSIH-funded services) for Indigenous people in highly accessible areas (using the accessibility/remoteness index of Australia [ARIA] classification) is $1145, lower than that for non-Indigenous people in the same area ($1373) and lower than that for Indigenous people in remote areas ($2259) (AIHW 2001, p. 13).
- MBS and PBS expenditure on Indigenous Australians is lower than for non-Indigenous Australians in every ARIA category. The lowest per person expenditure on non-Indigenous Australians (which occurs in remote and very remote areas) is higher than that for the highest expenditure category for Indigenous Australians (in highly accessible areas) (AIHW 2001).
- In 1997, between 15% and 20% of Aboriginal and Torres Strait Islander people using urban health services did not have access to a current Medicare number (Keys Young 1997, p. 15). This problem is likely to have been reduced (although not eliminated) in recent years, through successful initiatives to increase Medicare enrolment.

Health care alone is not the answer to any community's health problems, but no community can sustain good health outcomes without an effective health care system. Indigenous Australians do not enjoy equitable access to health care, in particular primary health care, and this contributes to their poorer health status.

Evidence for this position arises from global evidence of the effectiveness of health interventions, as well as from the demonstrated impacts of improved Indigenous access to health care where it has been achieved (see section 3.7 below).

2.4 Is primary health care important?

The design of the Australian health system is intended to ensure access to the appropriate level of care at the right time, in the interests of both better health outcomes and lower costs. For most Australians, rapid access to local primary health care ensures that diagnosis and intervention are initiated as early as possible, and that access to specialist and hospital care is controlled by primary care gatekeepers. The general principle is to respond to health need at the primary level or the level closest to primary care that is appropriate. This design principle is endorsed by a wealth of evidence from around the world (WHO 1978; WHO 2003).

Health care delivery systems: complexity and collaboration

The health care delivery system in all developed countries is a complex network of generalist and specialised agencies and providers, with a structure determined partly by effective design to meet changing needs and partly by the impact of history and professional and other sectional interests.

In most areas, for both mainstream and Indigenous populations, multiple providers contribute to the delivery of health care, linking with each other and coordinating care where possible. Collaboration and coordination at the local level are necessary to reduce gaps and duplication, and to ensure continuity of care for individuals. There are many methods by which links between providers are established and maintained (from GP referral networks with community health services and hospitals through to cooperative health planning arrangements at regional and state/territory level).

For Indigenous health care, coordination between providers and collaboration between the primary health service and Indigenous communities present particular challenges. A key provider, such as an Aboriginal Community-Controlled Health Service (ACCHS), may take on the role of facilitating community involvement and coordination between providers. Alternatively, an organisation such as a health advisory board may be established for this purpose, and to drive reform to better meet the diverse needs of local Aboriginal and Torres Strait Islander people (Department of Health and Aged Care 2001b p. 28).

The best arrangements to meet the needs of different communities will vary, but will almost inevitably require collaboration between service providers, and between Indigenous and mainstream agencies.

When access to primary health care is compromised, one major impact is that people present for care later and sicker. Diagnosis and intervention are delayed, disease processes are more advanced, and resultant mortality, morbidity and disability are increased. Much of the current reform effort in the mainstream health system is aimed at moving care out of hospitals and into the primary care sphere for conditions (known as ambulatory care sensitive conditions) where this approach is appropriate (e.g. see Swerissen 2002; Department of Human Services Victoria 2002). The contrast is stark for the Indigenous community: it has been estimated that, adjusting for age, the rates of hospital admission of Indigenous Australians are between 2 and 11 times higher than for non-Indigenous Australians for these conditions (Stamp *et al.* 1998).

Comprehensive primary health care is more than primary medical care. It brings additional elements of health protection, health promotion and identification of emerging and local needs, as well as a strong multi-disciplinary approach that aims to optimise both the productivity of skilled health staff and the breadth of coverage of health care needs. The mix of services required under the banner of comprehensive primary health care will vary in accordance with several factors, including the availability of other providers.

For Indigenous communities in remote and some rural areas, primary health services provided largely by an Indigenous-specific organisation (backed up with appropriate arrangements for access to specialist and tertiary care) are generally the most efficient models that can be provided locally.

Comprehensive primary health care

The *National Strategic Framework for Aboriginal and Torres Strait Islander Health* (NATSIHC 2003, p. 17) identifies that comprehensive primary health care includes at least the following elements.

- *Clinical services* (for management of chronic and communicable disease, acute care and emergency care).
- *Illness prevention services* (including population health programs such as immunisation, screening programs and environmental health programs).
- *Specific programs for health gain* (e.g. antenatal care, nutrition, physical activity, social and emotional wellbeing, oral health and substance misuse).
- *Access to secondary and tertiary health services* and related community services (such as aged and disability services).
- Client/community *assistance and advocacy*.

For Indigenous Australians in cities and major regional centres, primary health care services that are focused on the particular needs of the Indigenous community play a valuable role as part of the health system, but do not necessarily provide universal care for all Indigenous residents and generally do not need to cover the same breadth of health care needs. These communities have more choice in their use of services. However, just as agencies such as Family Planning and those specialising in industrial injury provide a key resource for both their patients and other care providers, Indigenous primary health care agencies play a vital role in the health system. This role has five components:

- acting as informed advocates for the health needs of the local Indigenous community;
- ensuring access to primary health care for many urban Indigenous people who would otherwise not access such care;
- specialist resource to the mainstream and as a lever for action to improve the responsiveness of the mainstream health system;
- education and training for Indigenous and non-Indigenous health professionals in the delivery of primary health care to Aboriginal and Torres Strait Islander people; and
- resource support for some Indigenous-specific rural and remote services.

Finally, a focus on primary health care is important because of the growing role of the primary health care sector (both mainstream and Indigenous) in the prevention and management of chronic illness. Chronic conditions (as opposed to infectious disease) are now the major burden of illness for most of the world's people, and are a growing problem for Aboriginal and Torres Strait Islander people, accounting for much of the gap in life expectancy (Beaver & Zhao 2004, p. 5). Effective clinical management of conditions such as diabetes, heart disease, kidney disease, cancer and mental illness is the key to reducing their consequences and costs. This requires both specialist knowledge and ongoing, community-based delivery of the package of care people with these conditions need, with a strong focus on preventing the development of complications. Early identification of those at risk or in the early stages, and intervention to reduce the risk or retard the development of chronic illness is critical. Primary prevention (through diet, exercise, lifestyle generally and attention to environmental and social factors) can also assist in containing and ultimately reducing the impact of these conditions. As Beaver and Zhao point out, the growing epidemic of chronic disease requires realignment of the service delivery system from its current focus on acute care to a chronic care model, with a stronger focus on comprehensive primary care (Beaver & Zhao 2004, p. 5).

The coordinated care trials and other initiatives have demonstrated the importance of a well-organised primary sector in minimising the burden of illness among people living with chronic conditions such as diabetes, heart disease, kidney failure and some cancers (KPMG 2001). For example, in the Tiwi Islands the introduction of a Renal Disease Project under the auspice of the Tiwi Health Board resulted in improved service provision and an estimated reduction in progression to end-stage renal disease of 50% (Department of Health and Aged Care 2001b).

This role is likely to grow in importance, and while the evidence of benefits to patients is stronger than the evidence of cost savings in the acute sector, both aspects are important. Collaboration between primary care staff and specialist staff in hospitals is particularly important in relation to this group of patients.

A focus on the provision of comprehensive primary health care for Indigenous communities is appropriate within the overall design of the Australian health system. Mainstream delivery mechanisms need to be complemented with Indigenous-specific primary health care services. The roles of Indigenous primary health care services in rural and remote areas are different from their roles in cities and major regional centres.

2.5 Policy context

This section notes the broad development of a supportive policy framework for coordinated action and identifies the Government policy that was used to guide the considerations and recommendations in this paper. Finally, this section explains our working definition of Indigenous disadvantage and health disparities for the purposes of this paper.

The Australian Government has expressed its determination to address Indigenous health disadvantage both alone (Commonwealth of Australia 2002, p. 25) and in concert with state and territory governments (NATSIHC 2003).

Commitment to addressing Indigenous disadvantage more broadly has been demonstrated through a range of policy and leadership initiatives, including most recently the COAG Shared Responsibility initiative and the report *Overcoming Indigenous Disadvantage: key indicators 2003* (SCRGSP 2003). The need for strategies to address *health* disadvantage is consistently acknowledged as a core component of the broader agenda.

The challenge now is to determine the most effective strategies for achieving measurable progress in Indigenous health. The context is one of longstanding health problems, combined with long lead times required to demonstrate improvements, particularly in ‘headline’ indicators such as reduction in mortality rates. In this context, government policy has established two key criteria against which any proposed policy or funding change can be assessed: the potential to improve health outcomes and the potential to improve equity of access to effective health care services (Commonwealth of Australia 2002).

Since the 1970s, many policy documents have been written about Indigenous health and government responsibilities and action. While there is sometimes a sense of ‘too much talk, too little action’, significant progress has been made, and several important decisions are of benefit in the current context. The transfer of responsibility for Indigenous health from the Aboriginal and Torres Strait Islander Commission (ATSIC) to the then Commonwealth Department of Health and Aged Care in 1995–96 was an important landmark, as it bought much needed health expertise into the area and, for the first time, made the Australian health department take responsibility for Indigenous health. It also provided the opportunity for an enhanced leadership and stewardship role at a national level both within the health sector and across government. While this change was controversial, it was welcomed by the Aboriginal Community Controlled Health Sector, including NACCHO, and the Australian Medical Association (AMA) at the time (Anderson & Sanders 1996) and it seems the question is now settled.

The *National Aboriginal Health Strategy of 1989* (NAHSWP 1989) is an important foundation document on which current policy and program directions have been based. The recent endorsement of the *National Strategic Framework for Aboriginal and Torres Strait Islander Health* (NATSIHC 2003) continues this work. The developing policy direction and focus has established a valuable base for coordinated national action, manifested in the Aboriginal and Torres Strait Islander Health Framework Agreements (Framework Agreements) (between the Australian Government, the relevant states/territories, ATSIC and NACCHO state affiliates) and the COAG-sponsored Shared Responsibility Agreements for whole-of-government coordination in Indigenous affairs (between the Australian Government, the states/territories and selected regional councils).

The recent release by the Productivity Commission of the report, *Overcoming Indigenous Disadvantage: key indicators 2003* (SCRGSP 2003), which is endorsed by COAG, also demonstrates 'a new resolve, at the highest political level, not only to tackle the root causes of Indigenous disadvantage, but also to monitor the outcomes in a systematic way that crosses jurisdictional and portfolio boundaries' (SCRGSP 2003, p. v).

For present purposes, two current policy statements have been adopted as the policy framework that guides this report.

2.5.1 Australian Government policy

The Government response (Commonwealth of Australia 2002) to the Commonwealth Grants Commission *Report on Indigenous Funding 2001* (CGC 2001) includes a concise statement of ten principles to be used in redressing Indigenous disadvantage. These principles provide a clear and useful guide for the purposes of this paper. In summary, they are:

1. Services should be flexible and based on *partnerships and shared responsibilities* with Indigenous people.
2. Programs and services should be funded and implemented in a *secure, long-term context*.
3. Access should be based on *equity with all Australians* and a focus on measurable outcomes.
4. *Mainstream programs and services* have the same responsibility to assist Indigenous as all other Australians.
5. *Resources* needed to address disadvantage faced by Indigenous clients can be greater than for other groups, especially in rural and remote locations.
6. *Additional Indigenous services* are required where mainstream services are unable to meet need.
7. *Capacity to achieve outcomes* is an important criterion in determining whether mainstream or Indigenous-specific programs and services should be used.
8. *Coordination* is needed within and between governments.
9. *Improving community capacity* is key to achieving sustainable outcomes for Indigenous communities.
10. *Data collection* systems need continuous improvement (Commonwealth of Australia 2002, pp. 21-22).

2.5.2 National Strategic Framework for Aboriginal and Torres Strait Islander Health

The National Strategic Framework for Aboriginal and Torres Strait Islander Health (NSFATSIH) (NATSIHC 2003) builds on the 1989 National Aboriginal Health Strategy that was never fully implemented (ATSIC 1994). It is a guide for government action over the next ten years to ensure a coordinated, collaborative and multi-sectoral approach to improving health outcomes. Significantly, the National Strategic Framework for Aboriginal and Torres Strait Islander Health was endorsed by Federal Cabinet in February 2003, following consultation, negotiation and agreement with key Indigenous health stakeholder organisations, and signed by the Australian Health Ministers' Conference (AHMC) in July 2003. The National Strategic Framework for Aboriginal and Torres Strait Islander Health has been endorsed by all governments (Australian Government as well as all states and territories) thereby providing a multilateral, bipartisan and whole-of-government commitment to its implementation. Strengthening comprehensive primary health care is one key priority.

The Framework acknowledges a shared responsibility with and represents a significant partnership between different levels and sectors of government and Indigenous organisations. The challenge remains to translate the key strategies into concrete steps with clear responsibilities for the Commonwealth, state and territory governments; to provide resources; and to maintain commitment to its implementation. Processes are underway for these purposes, including the development of a health performance framework to monitor improvements in health status.

State and territory governments are currently responsible for developing National Strategic Framework for Aboriginal and Torres Strait Islander Health Implementation Plans at the jurisdictional level, and the Australian Government is preparing a national level implementation plan across the fourteen relevant Commonwealth Government agencies. Implementation plans are intended to identify practical strategies to be implemented within each jurisdiction, as well as performance information to be used to monitor NSFATSIH performance through the proposed Aboriginal and Torres Strait Islander Health Performance Framework.

The National Strategic Framework for Aboriginal and Torres Strait Islander Health establishes an agreed Commonwealth, state/territory and Indigenous health stakeholders approach that can serve as a base for concerted action. It stresses a whole-of-government and whole-of-health-system responsibility, and the need for sustained effort. In order to make further progress, more concrete strategies and additional resources are required across governments and across the range of mainstream and Indigenous-specific programs. The policy settings are in place, the challenge now is one of implementation. Successful implementation will require sustained investment and sustained effort by all parties.

2.6 Defining disadvantage and health equity

The National Strategic Framework for Aboriginal and Torres Strait Islander Health provides a clear statement of the policy goal:

> 'To ensure that Aboriginal and Torres Strait Islander peoples enjoy a healthy life equal to that of the general population that is enriched by a strong living culture, dignity and justice.' (NATSIHC 2003, p. 7)

Equality of health outcomes is not generally seen as a realistic goal, given the impact of factors as diverse as individual genetics and climate on the longevity and wellbeing of human beings, and the term equity is more frequently used. Put simply '... equality is concerned with sameness; equity with fairness. Policies are unlikely to be able to make people the same, but they can ensure fair treatment.' (Baum 2002, p. 228)

Equity of access to health care is an important related policy goal, enshrined in Australian legislation and health policy (including the *Health Insurance Act 1973*, and the *Australian Health Care Agreements,* *1998–2003*), and encapsulated in the third principle of the Government's response (Commonwealth of Australia 2002) to the CGC report.

The key principle is that access to health care should be proportionate to need rather than ability to pay. The provision of care according to burden of illness, and according to the availability of effective treatments (i.e. capacity to benefit), are both supported by this principle. The decisions of governments and health care providers about how to spend the health dollar can be analysed in terms of the relative weightings given (in practice) to these two criteria.

It is one of the objectives of the Aboriginal and Torres Strait Islander Health Performance Framework that any measurement of health equity and health outcomes should be set in a program logic framework (i.e. tracing linkages from inputs through to outcomes). The Aboriginal and Torres Strait Islander Health Performance Framework and the NSFATSIH take a whole-of-government approach and will apply that approach to the processes, outputs and outcomes on which health systems and related sectors can have an impact.

The overarching COAG policy goal is to overcome Indigenous disadvantage. The concept of health equity may be useful for present purposes. Equity as a policy goal is defined in terms of equitable investment, equitable access to health services and equitable health outcomes as between non-Indigenous and Indigenous Australians, and between different Indigenous population subgroups. The goal of the National Strategic Framework for Aboriginal and Torres Strait Islander Health, consistent with these concepts, is to achieve equity in the context of a developing health system, through attention to all the key elements of program logic from inputs through to outcomes.

3 Effectiveness of current funding and programs

Access to primary health care is essential to improve health status, but the current level of primary health care provision to Indigenous Australians is inadequate to meet that need. The delivery system for Indigenous primary health care is and will remain a complex inter-dependent network of services, Indigenous-specific and mainstream, generalist and specialised, across all ages and all aspects of health need. The challenge is to improve access for Indigenous Australians to effective care across this broad system. This part first assesses current adequacy of access, and argues that the dual strategy of both developing the Indigenous-specific sector and enhancing mainstream accessibility should continue. We then present a summary of available evidence of the impacts and outcomes of existing care delivery, before turning to the related issue of good data for decision making.

3.1 Framework for assessment: program logic model

The program logic approach tracks a theoretical causal pathway where desired *outcomes* such as improved health status and wellbeing are premised on the generation of certain *impacts*, such as changes in modifiable risk and protective factors operating in individuals and environments. These impacts are premised on changes in *processes and/or structures* such as improved capacity and higher quality or better coordination of services and programs. In turn, the implementation of new processes and structures requires a range of *inputs or activities* such as supporting policy directions, workforce development and funding. These chains of inputs and effects take place in a wider social and political context that mediates the effectiveness of all elements. However, if empirical evidence of change can be seen for each of the points along the continuum, then it can be reasonably predicted that the outcomes are at least in part attributable to the program (Gabriel 2000, p. 347).

Our assessment of the system is focused on access and effectiveness, but other aspects are also addressed (service system design, quality and data). We have not conducted any primary research or formal consultations. We have used available literature from government, Indigenous and research arenas (including a number of major pieces of research work commissioned for this Review). OATSIH staff have assisted by providing copies of the many published reviews and assessments in various areas of Indigenous health care and access to some internal documents on a confidential basis. We have referred to the research literature and official data collections wherever possible. The evidence thus assembled has been analysed against available standards and norms, and the logic of the program model to enable us to form conclusions about the adequacy and effectiveness of the health system elements. There are many limitations, arising from lack of reliable data and research evidence, as well as lack of consultation and the short timeframe for meeting the requirements of the Review. We have attempted to identify those limitations as they arise. We have taken a pragmatic approach to the need to reach conclusions on imperfect evidence, while attempting to ensure that this process is transparent to the reader.

We have used the program logic framework in our analysis, which is designed to track linkages between inputs (such as funding, workforce, policy), structures and processes, outputs and ultimately outcomes.

3.2 Comparison to available international benchmarks

Canada, the USA and New Zealand are the most relevant comparator countries, with commonalities in both mainstream and indigenous populations and systems. Each of these countries began providing comprehensive primary health care services to their indigenous populations much earlier than Australia, sustained higher levels of funding over a longer period of time and have significantly reduced the difference in life expectancy between their indigenous and non-indigenous populations.

A number of factors have been identified as contributing to the disparity between Australia and the USA, Canada and New Zealand in health outcomes for indigenous peoples. Access to clinical primary health care is a major factor. International studies have demonstrated that in developed countries the level of primary care services is directly correlated with better health outcomes. This is especially so for low birth weight and infant mortality (Starfield 1996; Starfield 2000). While Australia is ranked as having a middle-level development of primary health care systems, access to this system for Indigenous Australians requires improvement (Ring & Firman 1998). In the USA services to indigenous people have included clinical care, prevention, education, community leadership and involvement. Collaboration with other sectors such as the environment and housing have also been evident. These services have been more comprehensive than those provided to the non-indigenous population and have frequently been delivered by an indigenous-specific service system (Kunitz & Brady 1995; Kunitz 1996).

A long-term commitment by governments to funding and supporting health services, including indigenous-specific services, is a key element in achieving improved health outcomes. Canada initiated selective health care services for indigenous people as early as the 1800s. The US Federal Government also began funding primary health services in the early 19th century, and established the Indian Health Service in the 1950s. By the 1990s an annual amount of $2.2 billion was provided (Kunitz 1996). Improvements in health status have been demonstrated, although some caution must be used when referring to this data as it only includes enrolled Native Americans. Infant mortality, deaths from infectious diseases and alcohol consumption declined dramatically, and the rate of deaths from chronic disease has been limited (Kunitz 1996).

A more direct comparison can be made in relation to diabetes. The 1994–96 American Indian/Alaskan Native age adjusted death rate for diabetes was 3.5 times the US all-races rate for 1995 (Indian Health Service, n.d. p. 138). In Australia in 1999–2001, diabetes accounted for 10.6 times as many deaths as expected for Indigenous males and 17.6 times as many deaths for Indigenous females based on the total Australian male and female rates (ABS & AIHW 2003, p. 136).

New Zealand also has a long history of targeting the health of the indigenous population, commencing in the 1900s. In 1990–94, the average Australian Indigenous mortality rate (for all causes) was 1.9 times the Maori rate, 2.4 times the American indigenous rate and 3.2 times the rate for the total Australian population (Ring & Firman 1998). While data problems give rise to a need for caution, the Australian Bureau of Statistics (ABS) concluded that data problems could not entirely explain the differences (ABS 2000b, pp. 44-45).

Active engagement by communities in their health services has also been identified as a positive factor in contributing to improved health outcomes. Strong leadership by Maori and Native American peoples has contributed to the development of primary care services since the middle of the 1950s (Pool 1991). In contrast, Australian governments only commenced funding Indigenous-specific primary health care services in the 1970s in response to community initiatives (Anderson & Sanders 1996).

The implementation of proactive workforce strategies by governments, and educational institutions giving priority to the training of Indigenous people, have also been significant in comparator countries, with the first Maori doctor, for example, graduating in 1899, whilst the first Australian Indigenous doctor graduated in the 1980s, almost 100 years later (McLean 1991; ABS & AIHW 1997).

Canada, New Zealand and the United States have made significant progress in improving health outcomes for their indigenous populations. Lessons for Australia include the need for a strategic approach that is resourced, implemented and sustained; a well-funded comprehensive primary health care system that maximises access for Indigenous peoples and incorporates strong community ownership by them; the need to develop a competent workforce; and ensuring that the health sector can collaborate with other sectors such as the environment or housing portfolios of government. Australia has only recently developed an approach that addresses some of these lessons, and the challenge of full implementation and sustained effort remains.

3.3 Current access to primary health care

Indigenous Australians use services funded through the Medical Benefits Scheme (MBS) and the Pharmaceutical Benefits Scheme (PBS) at less than half the rate of non-Indigenous Australians (with no adjustment for the relatively higher burden of disease). In 1998–99, for every $1 of MBS-funded services used by non-Indigenous Australians, 41c was used by Indigenous Australians, and through PBS, the equivalent measure is 33c (OATSIH 2003a, p. 33; AIHW 2001). Access to services funded through OATSIH partly redresses this imbalance, but *total* Australian Government spending on primary health care services for Indigenous Australians was only about 70% of that for other Australians (AIHW 2001, pp. 4, 25-26).

Terms and concepts: Mainstream funding programs and mainstream providers

'Mainstream' is a term adopted by the Indigenous community to describe non-Indigenous Australia, and now widely used in this field. It is a useful term because it is shorter than 'non-Indigenous' and less sensitive than 'white'.

In the field of primary health care, mainstream *funding programs* are those which pay for services delivered to all Australians, principally MBS and PBS. Mainstream *providers* on the other hand are those not working in Indigenous-specific health care agencies. Thus Indigenous providers may be paid for through mainstream funding programs (as when doctors in an ACCHS bill Medicare). Similarly, mainstream providers may be paid for through Indigenous-specific funding (as when an ACCHS contracts with a hospital to provide specialist care in an Indigenous clinic).

It is recognised that the mainstream mode of delivery of MBS- and PBS-funded services is not effective for Indigenous Australians, particularly in rural and remote Australia where market conditions do not support the availability of sufficient numbers of health care providers. Other contributing factors include the difficulty some Indigenous people experience with maintaining effective Medicare enrolment, proving their identity and making co-payments, as well as cultural and social factors that inhibit use of mainstream services by Indigenous people (Keys Young 1997). The significance of these other factors is evidenced by the lower use of MBS- and PBS-funded services by urban Indigenous people (see Table 1). MBS services used by urban Indigenous people (per capita) cost the government 43% of the level used by urban non-Indigenous people, and the same ratio for PBS services is 36%. The amounts of MBS and PBS expenditure for both Indigenous and non-Indigenous rural and remote people are lower than the equivalent urban population; but Indigenous status is a stronger predictor of low usage than remoteness.

Table 1: MBS/PBS expenditure per capita, Indigenous and non-Indigenous 1998–99

					Ratio (Indigenous /non-Indigenous)		
Area of expenditure (per capita)		Urban	Rural	Remote	Urban	Rural	Remote
Medicare	Indigenous	157	151	84			
	non-Indigenous	367	285	197	0.43	0.53	0.43
PBS	Indigenous	55	56	23			
	non-Indigenous	152	116	89	0.36	0.48	0.25
OATSIH	Indigenous	212	183	386			
	non-Indigenous						
Total	**Indigenous**	**424**	**391**	**492**			
	non-Indigenous	**519**	**401**	**286**			

Source: AIHW 2001.

There is some evidence that other mainstream Australian Government-funded programs are also less effective in delivering services to Indigenous Australians. Use of Aged Care Assessment Teams (which determine access to Residential Aged Care and some Home and Community Care services) in 2000–01 was 45 assessments per 1000 Aboriginal and Torres Strait Islander people over 50 years of age, compared to 112 per 1000 non-Indigenous Australians over 70 years of age[4]. The number of aged care assessments for Indigenous Australians decreased between 1998–99 and 2000–01 and at this time it was lower than when national reporting began in 1995–96 (Lincoln Gerontology Centre 2002, p. 29). In 2001–02, 0.6% of people in residential aged care facilities reported being of Aboriginal and/or Torres Strait Islander descent (AIHW 2003b).

In 2002–03, approximately 2.5% of Home and Community Care (HACC) clients across Australia and 43% of those from the Northern Territory reported being of Aboriginal or Torres Strait Islander descent (Department of Health and Ageing 2003c, p.7). While this overall level of access is approximately equivalent to the proportion of Indigenous people in the community, when the burden of illness is taken into account, the levels of use of HACC services could be expected to be higher. In addition, access to these services is not consistent across regions. For example, in a needs assessment conducted recently in Victoria, it was found that of 960 Aboriginal and Torres Strait Islanders in the Western Metropolitan Region of Melbourne classified as being in the target group, only 19 were receiving HACC services (the regional total target population was 9406 clients) (Frizzell 2003).

The Aboriginal and Torres Strait Islander Aged Care Strategy was introduced in 1994 to enable the development of flexible models of residential and home-based care that could change as communities changed. By 2002, 63 services were receiving funding under this strategy for 300 residential places and 111 aged care packages (AIHW 2003c).

For Aboriginal and Torres Strait Islander Australians, the proportion of health expenditure on private sector services such as private hospitals, private dentists and allied health professionals was very low at 5% in 1998–99 compared with about 26% for other Australians (AIHW 2001). In part this reflects the lower socioeconomic status of Indigenous Australians and their greater reliance on government-funded services.

3.3.1 Adjusting for need

These comparisons based on cost are not by themselves a good measure for equity of access, because they are not adjusted for need, or the higher cost of delivery to small remote and rural communities. The under-utilisation of Australian Government-funded programs is more stark when the relative burden of illness and injury among Indigenous Australians is considered. Because of higher need for health services, Indigenous Australians would be expected to use health services at a significantly higher average rate than the rate applying to all Australians.

The level of utilisation of health services by Australians rises sharply with the level of illness. A study linking MBS, PBS and hospital data (Department of Health and Aged Care 2000) demonstrated that average health service costs for a person with one condition were $2300 per person per year, $5400 for people with two conditions, and $14 300 for five conditions. The mainstream Coordinated Care Trials, which generally targeted people with complex, ongoing medical conditions, also provide relevant experience. For example, the North Eastern Victoria Trial population (prior to the trial) used MBS and PBS at five times the national average, and the rate for the NSW Linked Care Trial was 6.6 times (Monash University & KPMG 2000). Given

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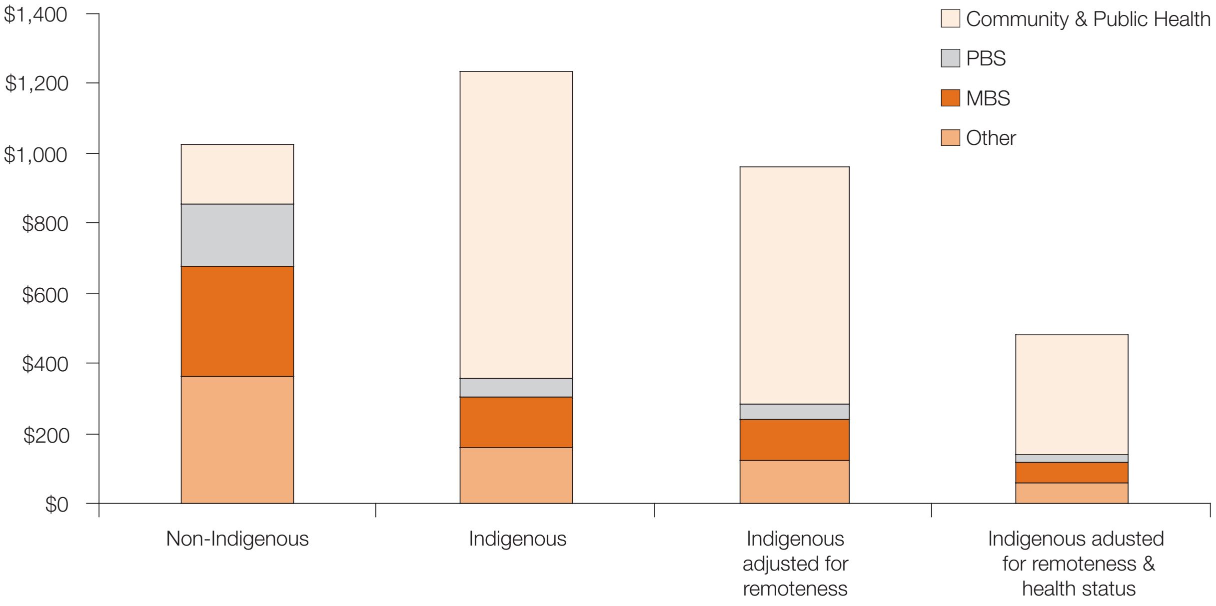
[4] Because a greater number of Indigenous people become ill at a younger age and have shorter life expectancy the age boundaries used for planning in aged care are 50+ for Indigenous people and 70+ for non-Indigenous people (Lincoln Gerontology Centre 2002, pp. 15, 29).

the poorer health of Indigenous Australians and the proportion living with more than one chronic disease, equitable access to health care would result in higher than average utilisation with estimates of per capita resources required by the Indigenous population ranging from 1.9 to 7.3 times the average required by the non-Indigenous population (OATSIH 2003e).

Actual per capita expenditure on primary health care in 1998–99 for Indigenous Australians is compared to expenditure for non-Indigenous Australians in Figure 1 below, which graphically illustrates the gap when remoteness and burden of illness are taken into account. The index for remoteness used in the calculation of this graph is 2 (only applied to the population in remote areas) and for burden of illness is 2.

If access to services were equitable, it could be expected that Indigenous Australians' *use* of Australian Government-funded health programs would be at least twice that of non-Indigenous Australians, and the cost would be between 2 and 7 times the average for all Australians, according to residence in remote versus rural or urban areas. The Commonwealth Grants Commission considered the various estimates presented and concluded that 'per person expenditure benchmarks that range from double the national average in highly accessible areas to just over four times the national average in very remote areas would not be unreasonable' (Commonwealth Grants Commission 2001, p. 127). The required level of expenditure is more comprehensively addressed in section 5.2.

Figure 1: Total primary health care expenditure 1998–99 (per capita)



Source: OATSIH (2003b) based on AIHW 2001.

Note: Other includes patient transport, dental, non-PBS medical and appliances

3.3.2 Recent initiatives to address the mainstream access gap

Recognition of a significant gap between expected need for mainstream programs and actual spending on Indigenous Australians (Deeble *et al.* 1998; Keys Young 1997) led the Australian Government and states/territories to agree in principle to increase funding in line with need, documented in the Agreements on Aboriginal and Torres Strait Islander Health (Framework Agreements) developed in the mid-1990s (Burns *et al.* 2002).

The Keys Young Report (1997) on use of MBS and PBS by Indigenous Australians identified some areas where changes could be made to improve these programs. It also concluded that without significant structural modifications MBS and PBS could not be made wholly appropriate mechanisms for financing health services for Indigenous Australians. Progress on improving Indigenous access through mainstream funding programs is addressed below.

Improving access to the Medical Benefits Scheme

Significant work has been undertaken to achieve needed changes in the MBS. To improve access to Medicare and the quality of related data, the Health Insurance Commission (HIC) and its partners have:

- implemented an active campaign to improve enrolment in Medicare through simplified enrolment procedures and agreements with state/territory authorities, ACCHSs and directly with communities;
- examined barriers to billing in ACCHSs and developed streamlined arrangements which are currently being trialled in a large remote Aboriginal and Torres Strait Islander primary health service;
- introduced (in November 2002) a voluntary Indigenous identifier on the MBS database to assist with obtaining accurate data on MBS use (OATSIH 2003d); and
- in recognition of the need for longer consultations and other differences in the style of work for GPs within Indigenous-specific services, enabled doctors employed in ACCHSs and some remote Aboriginal and Torres Strait Islander Health Services managed by State Governments (Queensland, and Northern Territory) to charge Medicare for their services, creating an additional revenue stream for the service. This arrangement (under section 19(2) of the *Health Insurance Act 1973*) has allowed some agencies to employ local GPs to provide sessions.

In the period since the introduction of this arrangement the number of doctors employed in ACCHSs increased significantly, doubling from approximately 97 doctors in 1997–98 to 201 doctors in 2001-02 (DHA 2003d). At the same time there have been very significant increases in services provided through this mechanism (increasing from 95 000 in 1995–96 to 415 167 in 2001–02) (OATSIH 2003d). This has been the greatest contributor to increased access to MBS over the past few years.

In addition, the HIC has introduced new MBS items for health assessments available to all Australians, with different eligibility criteria for Indigenous Australians in recognition of their poorer health status (principally a lowering of the age criterion from 65 to 55 years). However, uptake of these health assessments has been low, with 4269 Indigenous people accessing them between November 1999 and August 2003. Even the lower age limit on these items excludes many Indigenous people who would benefit from health assessments, given the high burden of chronic disease amongst those aged from 15 to 54. Work to address this limitation is well advanced.

The HIC has also introduced Enhanced Primary Care (EPC) items for care planning and case conferencing services, for which Aboriginal and Torres Strait Islander people of any age with a chronic condition and complex care needs are eligible. However, there is currently no data on use of these services by Indigenous people.

Other initiatives to improve access to MBS include the training of new GPs in undergraduate programs and registrar placements. Most universities now include Indigenous health as a core part of medical practitioner training and a significant proportion of Aboriginal and Torres Strait Islander health services have become accredited GP registrar training sites since the late 1990s (OATSIH 2003d).

Local health system development, involving local GPs and communities working together to improve access of GP services, has been effective in some areas. The leading example is Inala Health Service in Queensland where the number of Indigenous patients was increased by 203% between 1995 and 2000 (Department of Health and Aged Care 2001b). However, this kind of action is not yet widespread enough to influence national statistics. Access to specialists, imaging and pathology services is a further problem (Cunningham 2002) that flows on from lower use of primary health care, and is yet to be addressed.

Improving access to the Pharmaceutical Benefits Scheme (PBS)

Work to improve access to pharmaceuticals through the PBS has been focused on access in remote areas. Special supply arrangements were introduced in 1998, under the provisions of s.100 of the *National Health Act 1953*, which enable supply of prescribed medications free of charge (to all patients, Indigenous or not) by eligible remote area Aboriginal and Torres Strait Islander Health Services.

The increase in the number of participating services and expenditure on pharmaceuticals through s.100 is shown in Table 2.

Table 2: PBS Section 100 – Expenditure and number of participating services

Financial year	1999–00	2000–01	2001–02	2002–03
Australian Government expenditure*	$3.8m	$6.0m	$12.1m	$15.1m
Participating services	105	105	151	153

(* excludes GST)

Source: OATSIH 2003d.

This initiative has had a significant impact. Using 2001 population numbers it appears that for remote area Indigenous Australians access to pharmaceuticals through this mechanism alone equates to around $134 per capita—a very significant increase on previous access levels estimated at $23 per capita in 1998–99. Access in urban and rural areas (which are not eligible for the s.100 arrangement) is not likely to have changed significantly from 1998–99 levels of $55 and $56 respectively (OATSIH 2003d). Extension of the s.100 arrangements, with appropriate adjustments for urban settings, would improve this situation.

Population health programs

The Australian Government has also introduced a range of population health programs specifically targeted to Indigenous Australians. This is important because while some mainstream population programs (such as cervical screening) are particularly relevant to Aboriginal and Torres Strait Islander peoples' health, they are often not used because they are not tailored to meet the needs of this group. For example, the National Childhood Pneumococcal Vaccination Program (which provides access to free pneumococcal vaccine for children considered at highest risk from invasive pneumococcal disease) has an emphasis on Indigenous children given that their rates of pneumococcal disease are up to 15 times higher than those of non-Indigenous children living in urban areas. Between 2001–02 and 2003–04 $19.25 million has been committed to this program. However, there has been varied uptake, with higher coverage in areas where there are high proportions of Indigenous Australians. There is evidence to suggest that Indigenous Australians who attend an Indigenous-specific medical service are more likely to be appropriately vaccinated than Indigenous people who attend a GP (76% versus 32% respectively) (OATSIH 2003d).

Population screening programs have also been made more relevant:

- While cancer is the third most common cause of death for both Indigenous and non-Indigenous Australians, causing 16% and 29% of deaths respectively in 2001, the survival rates for most cancers are lower for Indigenous than other Australians, indicating that preventive strategies and clinical care are not as effective as they should be for this group. Initiatives to address this problem include the Aboriginal and Torres Strait Islander Women's Forum, which has contributed to the *Principles and Practice, Standards and Guidelines for Providers of Cervical Screening Services for Indigenous Women*, a resource that will assist agencies involved in cervical cancer prevention and control to ensure that their services are appropriate and accessible to Aboriginal and Torres Strait Islander women.

- The Aboriginal and Torres Strait Islander Bowel Cancer Screening Pilot Site Working Group provides a consultative mechanism for achieving optimal Aboriginal and Torres Strait Islander participation in the pilot and possible national bowel cancer screening program. The Working Group is investigating barriers to participation in bowel cancer screening with a view to developing a strategic plan to address them in the event of a national roll-out.
- Although the provision of breast screening programs is improving, national data shows that uptake levels among Indigenous women remain low. In 2001 the National Advisory Committee to BreastScreen Australia endorsed a strategy for increasing the participation of Aboriginal and Torres Strait Islander women in breast cancer screening. An evaluation of the impact and outcomes of the strategy is planned for 2004 (OATSIH 2003d).

Increasing awareness of Indigenous health disadvantage in mainstream public health and health promotion programs seems to have led to improvements in coverage of Indigenous health concerns. For example, the National Public Health Partnership, an inter-governmental initiative to plan and coordinate public health activities and to provide a more strategic and systematic approach to addressing health priorities, included recognition that Aboriginal and Torres Strait Islander issues should be given priority in all areas of the work program (National Public Health Partnership 2002, p. 2). This has resulted in the development of initiatives such as Eat Well Australia with strategies to include Indigenous communities in mainstream programs and targeted Indigenous initiatives where additional work is required (in this case, the National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan) (National Public Health Partnership 2001).

3.3.3 Access through OATSIH funding programs

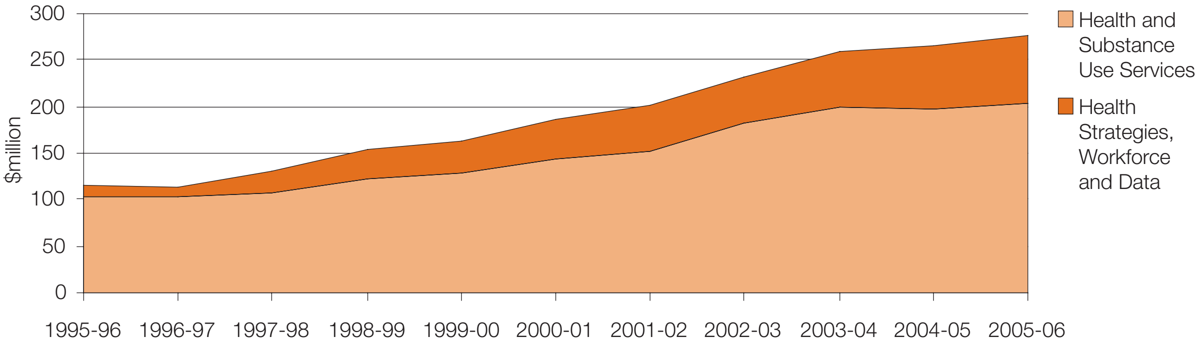
Australian Government funding through the Office for Aboriginal and Torres Strait Islander Health (OATSIH) is intended to facilitate health system improvements and to fund Indigenous-specific services. Since the mid-1990s there has been consistent growth in OATSIH funding programs from new policy initiatives. These include:

- additional funding in 1995–96 for workforce, mental health, hearing, data improvement, planning and service support initiatives;
- additional funding for primary health care services each year; and
- resources for social and emotional wellbeing programs in 1998–99, as well as specific funding to combat infectious diseases in Aboriginal and Torres Strait Islander communities.

Figure 2 below shows how this funding has been distributed between the various areas of action.

Recurrent Australian Government funding for Indigenous-specific primary health care services in 1998–99 was estimated at $187.5 million, or more than double the $91 million of MBS and PBS funding that flowed to Indigenous Australians in that year (AIHW 2001). System capacity to deliver care has improved in line with increased funding since the mid 1990s as shown in Figure 3.

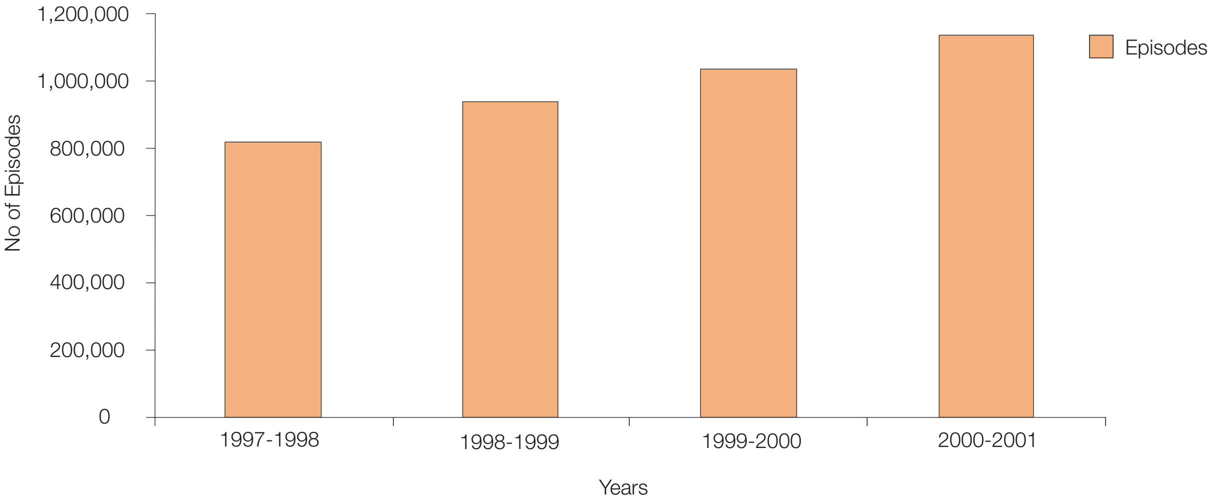
Figure 2: Indigenous health expenditure—actual and budgeted 1995–96 to 2005–06



Source: Department of Health and Aged Care (2001a, vol. 2, p. 15).

Figure 3: Total episodes of care for PHCS services 1997–2001[5]

Total episodes of health care reported in Service Activity Reporting



Source: OATSIH & NACCHO 2003, p. 27.

Indigenous-specific agencies are unevenly distributed across the states and territories, and there are large variations in staff size and operating budget. This reflects the largely historical and opportunistic nature of the decisions to fund each of the individual services (Shannon & Longbottom 2004). Ease of access to Indigenous-specific services is thus variable across the country, with some areas relatively well supplied, and others either lacking ready access to an Indigenous-specific agency or having access to a small agency which is not able to meet many aspects of need.

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[5] Figure 3 refers to the increase in the number of episodes of health care between the years 1997–98 and 2000–02 for those 90 PHCSs that reported for each of these years and including the intervening years. (OATSIH & NACCHO 2003, p. 27).

Some aged care programs under the *Aged Care Act 1997* include Aboriginal and Torres Strait Islander-specific initiatives. There are 30 Aboriginal and Torres Strait Islander-specific residential aged care services run directly by Aboriginal and Torres Strait Islander community-based organisations or that target the local Aboriginal and Torres Strait Islander community. There has been a significant increase in the number of places under this strategy from 27 places in 1996 to 480 in 2003.

Despite these advances it is evident that access is inadequate to meet the high levels of health care need. For several reasons access to primary care through MBS and PBS is not fully effective for Indigenous Australians, and significant under-funding and under-utilisation of primary care services is the result. This issue was identified several years ago, and changes to mainstream and Indigenous-specific funding programs, have resulted in improved access. However, the level of spending is not sufficient to achieve equitable access to primary health care when compared to levels of spending for non-Indigenous Australians, particularly in light of the burden of illness and injury among Indigenous Australians, and their geographic locations. Increased investment is needed if the health system is to manage the current burden of illness as well as achieve improvement in health outcomes. Consideration of the size of that investment, and its components, needs to be based on the potential impact on health outcomes as well as the goal of equity of access. We return to this question in Part 5.

3.4 Access to state/territory-funded services

Because of the split responsibilities between state/territory governments and the Australian Government for the delivery of health care, it is essential to examine briefly the funding and use of programs under both jurisdictions to obtain a complete picture.

Expenditure for Indigenous Australians through programs administered by state and territory governments, mostly admissions to public hospitals, accounted for around 70% of total Indigenous expenditure, almost twice the rate for non-Indigenous Australians (36.5%) (AIHW 2001). State/territory contributions to primary health care for Indigenous people are highly variable (see section 5.3 for further consideration of this issue).

Data on Indigenous use of mainstream state/territory-funded services is poor, due to failure to collect data on Indigenous status consistently (ABS & AIHW 2002). In 1999–2000 only the Northern Territory and South Australia reported having acceptable data on Indigenous status and morbidity in hospital statistics (ABS & AIHW 2002).

Nationally, it is not possible to draw reliable conclusions about adequacy of access to hospital services from the available data on admissions of Indigenous people (which would be expected to be higher than the non-Indigenous population given their greater burden of disease). However, in 2000–01, after adjusting for age, Indigenous Australians were admitted to hospital approximately twice as frequently as the general population (ABS & AIHW 2003, p. 77). This level of hospitalisation is of concern whether it reflects the greater burden of disease or the lower access to primary care, and represents a significant cost to both Indigenous Australians and the health system.

A recent study of hospitalisation patterns of Australia's Indigenous population found that in general Aboriginal and Torres Strait Islander patients also have longer stays in hospital than non-Indigenous patients. Although longer stay in hospital can be the result of numerous factors, for the Indigenous population it is likely to be in part a result of inadequate primary health care (Ishak 2001).

The split in responsibility for health between the Australian Government and states/territories means that there would also be a split in the flow of any future cost savings accrued in the acute sector that might result from more effective primary health care. It is essential that concerns about cost- and benefit-shifting are managed in a constructive way between the Australian Government and the states and territories.

Condon (2004) notes the improvements that are possible through improved collaboration between primary care and specialist agencies. He cites the evaluation of the Specialist Outreach Program which commenced in 1997 in the Top End of the Northern Territory. Through this program, the number of gynaecology consultations provided for women living in remote Indigenous communities in the Top End increased from less than 200 in 1996 (when only hospital outpatient services were available) to approximately 1000 in 1999, 90% of which occurred in community health centres in remote communities. Forty-seven per cent of gynaecology consultations provided by the specialist outreach service included colposcopy for follow-up of Pap Test abnormalities or other cervical symptoms (Gruen *et al*. 2001).

A general picture of under-use of mainstream services in urban areas is evidenced by the repeated experience of dramatic increases in uptake of services in mainstream agencies when they take action to make their services accessible and welcoming to Indigenous people. For example, there was an 85% increase in the number of Aboriginal and Torres Strait Islander people using the Darebin Community Health Service, located in the inner northern suburbs of Melbourne, after the health service employed an Aboriginal community development worker, built collaborative working relationships with Indigenous organisations at the local level, improved the cultural knowledge of non-Indigenous staff, and improved the cultural appropriateness of service models (Firebrace *et al*. 2001). Similarly in the acute sector, Flinders Medical Centre initiated action to enhance its services to Aboriginal and Torres Strait Islander people in 1996, including establishing Karpa Ngarratendi (Aboriginal health team), ensuring appropriate signage and an Aboriginal and Torres Strait Islander space, and working with the local Kaurna Heritage Committee on sites of significance on the Flinders Medical Centre campus. In the five years from 1996–97 to 2001–02, attendance by Aboriginal and Torres Strait Islander people increased tenfold, from 178 to 1752 (including increased transfers from the Northern Territory) (C Morgan pers. comm. 29 August 2003).

The overall picture of Indigenous use of health care that emerges is one of higher spending on hospital care (delivered through states and territories, jointly funded) and lower access to primary care, particularly through the Australian Government's mainstream funding mechanisms. This pattern of use is not the most effective for any population.

3.5 Structure of the primary health care delivery system

This section addresses the dual strategy of using both mainstream and Indigenous-specific agencies to deliver health care for Indigenous people, and the capacity of this mixed system to extend coverage to all Indigenous Australians.

3.5.1 Complementary Indigenous-specific and mainstream services

Access to primary health care is a problem in all areas, but varies with location. Indigenous people do not access mainstream services, even when they are readily available, to the level that would be expected given their health status. The Government's approach to improving access is based on two complementary strategies: increasing the capacity of the Indigenous-specific sector, and enhancing the accessibility of the mainstream primary health care system, through adjustments to MBS and PBS and other measures. Both of these strategies are essential, because Indigenous Australians (and all Australians) need good access to a complex network of primary health care services with good linkages. Both mainstream and Indigenous-specific services are needed by Indigenous communities.

Indigenous-specific services will continue to play an essential role in addressing Indigenous health disadvantage, for four key reasons. Firstly, Indigenous Australians need different services because their health needs are different. In particular, the greater prevalence of chronic diseases in the Indigenous population means that a complex, ongoing set of interventions is required which can only be provided by a skilled multi-disciplinary workforce, able to sustain effective long-term treating relationships and links with other providers. GP services funded through the MBS are not able to meet these needs fully (Keys Young 1997), while Indigenous-specific agencies are designed to provide the basic health infrastructure required for effective service delivery.

Secondly, for several reasons including historical and cultural ones, mainstream health services are generally not structured or organised to address the specific spectrum of indigenous health disadvantage. The lack of capacity is more pronounced in some areas where traditional culture and languages are still practised. Work should continue to change the responsiveness of mainstream services, but effective primary health care is needed now. Many Indigenous people will go without primary health care (Keys Young 1997, p. 61) if a service that specifically welcomes them and responds appropriately to their needs is not available.

Thirdly, the Indigenous population constitutes such a small proportion of the total primary health care ‘market’ in many areas of Australia (even if they used mainstream GPs and other services proportionately) that their power in the market to stimulate mainstream health services to be responsive to their needs is severely limited. Their high levels of poverty exacerbate this problem. GPs are responsive to their markets, and a strategy that relied on GPs making independent decisions to substantially change their services to meet the needs of 2% of the market is unlikely to produce significant results, and neither would many of them have the skills and experience to do so. However, there are some outstanding exceptions among GPs, and mainstream community health agencies, and the work of these individuals and groups makes a valuable contribution, as do GPs who work part-time in local Indigenous-specific clinics.

Finally, the role of Indigenous-specific services is not simply one of *substitution* for mainstream services. They also provide a base for training for both Indigenous and non-Indigenous health professionals, and for research and development of new approaches to Indigenous health (either alone or in partnership with mainstream agencies and researchers). This aspect is particularly important in urban agencies, because of their proximity to medical schools etc. and to the headquarters of mainstream specialist providers (e.g. the leadership of child and adolescent mental health services tends to be based in capital cities). Indigenous-specific services in all areas provide the referral pathway to specialist and tertiary services, and support the providers in their responses to Indigenous patients. They are also the appropriate base for community development approaches to improving health.

For these reasons, it is not feasible to build an effective primary health care system for Indigenous Australians without Indigenous-specific services. This applies in urban as well as rural and remote areas. While a much higher proportion of health care spending for Indigenous people in remote regions is through OATSIH funding (over 90% of primary health care spending in remote areas was through OATSIH in 1998–99) more than half of all spending for urban and rural people was also through OATSIH (between 50% and 60%), in spite of the much greater availability of mainstream services.

However, the mainstream primary health care system, both Australian Government and state/territory-funded, also makes an essential contribution which could be further strengthened. As noted above, efforts to enhance the accessibility of MBS and PBS services since the landmark Keys Young Report (1997) have made it easier for Indigenous Australians to obtain Medicare cards, use GPs and receive prescribed medicines. They have also assisted Indigenous-specific agencies through enabling MBS funding for their GP services. This work should continue, and the current proposal to set up an MBS item for an Aboriginal and Torres Strait Islander Adult Health Check is a relevant example.

3.5.2 Capacity to extend coverage

All communities should have secure established methods by which access to needed care is guaranteed. For rural and remote communities, linkages, transport, communication and partnerships among providers can address deficits. But they will only be effective if they are well planned, widely understood, adequately resourced and accountable, and mutually agreed by the range of providers which are necessarily involved (OATSIH 2003b).

The impact of the current incomplete coverage is that some programs are unavailable to large sections of the Indigenous population. For example, well person's health checks have the potential to detect both risk factors and unidentified illness within communities (e.g. diabetes). These would be more widely detected if access to comprehensive primary health care was more widely available. However, a renal screening program carried out in a South Australian Indigenous community found that more than 25% of all adults screened (n=42/149) had previously undiagnosed persistent microalbuminuria (a marker for renal disease). Hypertension was found in more than 40% of participants and 58% of those had been undiagnosed prior to screening (Shephard *et al.* 2003).

Limited capacity within the primary health care system is also highlighted by the recent report on the *Review of the Implementation of the National Aboriginal and Torres Strait Islander Eye Health Program* (NATSIEHP) (Centre for Remote Health 2003). The authors found that the National Aboriginal and Torres Strait Islander Eye Health Program is not well integrated with existing primary health care services, partly due to the limited capacity of the primary health care system to support it. While some aspects of the program can run independently, the poor level of integration means that key components of eye health care are not incorporated into regular primary health care practice, such as well person's checks (including diabetes screening) and chronic disease care, including retinopathy screening for diabetics.

The authors also found minimal benefit to the Eye Health program from mainstream programs or services, and they call for enhanced linkages between the NATSIEHP and other mainstream programs at a national, state and regional level.

The existing network of Indigenous-specific and mainstream agencies serving rural and remote Indigenous communities needs to be extended so that coverage is complete. The population size of communities will largely determine the range of services that can be provided locally, not only because of high cost but also for technical and workforce reasons. The evidence we have reviewed for this paper indicates that comprehensive coverage is achievable given adequate resources, careful staging of growth and attention to workforce strategies. Further, the policy framework within which such expansion can occur, as articulated in the *National Strategic Framework*, is established. Implementation is now required.

Extending coverage to provide secure access to comprehensive primary health care is an essential step in developing the capacity of the system to respond to need, and this will continue to depend on a mix of both Indigenous-specific and mainstream health care providers and funding programs. For remote communities, Indigenous-specific services are major providers, alone and in collaboration with others for some aspects of primary care and for effective access to secondary and tertiary services. In urban communities, Indigenous-specific agencies play an essential role in ensuring access to needed care, but it is a different one.

3.6 Quality of current services

Quality of health care is a broad concept currently defined as 'the extent to which a health care product or service produces the desired outcome' (Australian Council for Safety and Quality in Health Care 2003). It cannot be separated from issues such as access which are addressed elsewhere in this paper. In relation to mainstream services, we have taken the quality goal to be ensuring that Indigenous Australians receive the same quality of care as non-Indigenous Australians, and care that is appropriate to their needs.

Systematic evidence regarding the quality of care provided to Indigenous Australians in mainstream agencies is not available. However, there are a number of reports that document the kinds of issues faced by Indigenous Australians when using services and that impact profoundly on the quality of care provided to them. These include the history of the organisation's role, attitudes of service providers, lack of cultural knowledge (including in the planning and design of facilities and services), physical environment, poor communication and lack of information (Clarke *et al.* n.d.; Devitt & McMasters 1998). The relative under-use of diagnostic services is also an indicator of a potential quality problem (Cunningham 2002).

Indigenous patients require competent, informed and responsive care from health care providers who are able to deal appropriately with what can be a challenging patient group (presenting with atypical patterns of disease and complex pathology). Racism, or cultural stereotyping, can impede the communication that is necessary for good history-taking, accurate diagnosis, effective treatment and adequate follow-up.

Patients also need confidence and a level of trust for the treating relationship to be successful. The recent history of interactions between hospitals and Indigenous people cannot be ignored. For example, until the 1960s, public hospitals provided segregated accommodation for Aboriginal and Torres Strait Islander people (Saggers & Gray 1991) and participated in the removal of children (Human Rights and Equal Opportunity Commission 1997). Racism and cultural stereotyping impede the development of trust and respect, and Indigenous people are subjected to experiences of shaming in the course of their care (Department of Human Services (SA) 2003). Shame is described as 'a powerful emotion resulting from the loss of the extended self' that 'profoundly affects Aboriginal and Torres Strait Islander health and health care outcomes' (Morgan *et al.* 1997, p. 598).

In relation to mainstream primary care, anecdotal evidence indicates variable quality, and grounds for concern that problems of communication and 'compliance' impact negatively on clinical outcomes (Keys Young 1997). Keys Young (1997, p. 50) documented that even in situations where Indigenous people could get access to medication, poor communication and lack of supports to take it correctly meant that they were often not able to do so. For example, a family without a refrigerator will not be able to store some medications properly; instructions to take medications with meals can result in medicines not being taken properly if meals are not regular; and limited literacy means that written information on labels can be useless. One method of addressing these issues, available as a result of changes to PBS access under s. 100, is to provide medication at the point of consultation, when health workers can explain appropriate use in the relevant conditions.

While formal mechanisms such as cultural awareness training may have a long-term impact, they are only one element required to create change. There are other more immediately effective approaches to improving the quality of mainstream care for Indigenous Australians.

- A focus on the goal of effective clinical care, and an analysis of what is needed to achieve it, is more likely to lead to practice change among clinical staff.
- The development of strong working relationships between mainstream clinical staff and staff of Aboriginal Health Services and/or hospital-employed Aboriginal Liaison Officers lays the basis for effective collaboration and sharing of expertise.

Leadership in mainstream agencies to encourage and support clinical staff to provide quality care for Indigenous Australians is an essential prerequisite for improved quality.

Information regarding the quality of services in Indigenous-specific agencies is not systematically available, and anecdotal evidence indicates that it is variable, as it is in mainstream agencies. While many organisations undertake regular monitoring of quality indicators, this practice does not seem to be universal.

One notable difference between the mainstream and Indigenous system (not surprising given its smaller size and shorter history) is the relative lack of infrastructure for quality. Mainstream quality agencies such as the Quality Improvement Council (for community-based health services) and the Australian Council for Healthcare Standards (for hospitals and others) have developed some resources to support quality in health care delivery to Indigenous people, but this is not adequate to serve the needs of Indigenous-specific agencies. The apparent general lack of benchmarking capacity and data is an indicator of the early stage of development of quality infrastructure for the Indigenous sector.

Existing quality monitoring in the Indigenous-specific sector seems patchy, and the development of infrastructure for quality needs attention. Apart from access problems, the main barriers to quality of care for Indigenous Australians using mainstream health care services seem to arise from lack of familiarity in some clinical staff with the atypical patterns of disease and complex pathology experienced by many Indigenous patients, and cultural and other barriers to effective clinical relationships between mainstream staff and Indigenous clients. Methods are available to address these issues, and leadership is required to ensure that action is taken.

3.7 Impact and outcomes for Indigenous health

In this section, we examine the available evidence of the impacts and outcomes of health care for Indigenous Australians. We focus on Indigenous-specific services, but also address mainstream health impacts. An illustration of the application of program logic to the inputs, process and structures, impacts and outcomes of one major ACCHS (Nganampa Health Council) is provided.

While recent increases in funding have improved access, significant focused effort within the health system only commenced eight years ago (in 1995–96), and has developed gradually over that time. Continuing poor health status is not unexpected in these circumstances, but there is evidence that the impact of existing services is positive. Because of poor access, evidence of impact and outcomes can only be assessed in relation to those communities that are reasonably well served by effective primary health care. This evidence is, by definition, local and the impact tends to be swamped in national and state/territory-level data.

Evidence regarding the impact of health care and health outcomes for any population is far from complete. In approaching this question, there are some important limitations which must be acknowledged.

1. The complexity of health and health care means that simple indicators of broad health outcome can never give a valid reliable measure of the effectiveness of the health care system or the return on investment in health care. Health outcome measures reflect more than health system activities; they are an indication of whole-of-government and non-government activity.
2. The focus in measuring impact of health care is properly confined to those areas where it can make a difference.
3. Indicators are more reliable and available in relation to specific illnesses, causes, markers and pathways. These indicators are useful for judging the impact of specific interventions over time.

While health outcomes (longevity, wellbeing, functional capacity) are the ultimate goal of health care, intermediate outcome indicators are the most useful for assessing the contribution of primary health care to health improvement, because they are sensitive to primary health care interventions. The long lead times between implementation of primary health care interventions and health outcomes precludes direct assessment of health improvements in the short to medium term (OATSIH 2003f).

The gap in health outcomes for Indigenous Australians remains critical, but the picture on the ground gives some cause for optimism. Since the mid-1990s, there has been increased investment in Indigenous health, through a mixture of Indigenous-specific and mainstream initiatives. The result is increased availability and quality of primary health care services for Aboriginal and Torres Strait Islander people in some regions; and some improvements in access for Indigenous people to mainstream services. Increased numbers of Indigenous people in the health workforce, increased Indigenous health knowledge and information, and the development of a strategic research capacity (Shannon *et al.* 2002) have also resulted.

3.7.1 Impacts and outcomes of Indigenous-specific services

Shannon *et al.* (2002), in their analysis of successful Indigenous-specific health projects, also found that progress is patchy. In areas where funds had been invested in capacity building and service provision, there was evidence of improved accessibility, better service provision and improved quality of care. There was also evidence of an increasing focus on the development and adoption of strategies with measurable impact, including maternal and child health services, substance use programs, a range of disease-specific initiatives, and injury prevention and control strategies.

There is reliable evidence of real achievements by Indigenous-specific services in some key areas (outlined in the Appendix). Some examples are given in the listings below.

Communicable diseases control through vaccination

- *Increased childhood immunisation rates*—to 91% of children in the Tiwi Islands and 100% in Wilcannia (KPMG 2000).
- *Increased adult immunisation and reduced incidence of pneumococcal disease* in far north Queensland. Almost all (96%) of the estimated Indigenous population over 50 received the influenza vaccine for the first time in the first five years of the program, and 73% received the pneumococcal vaccine. The annual incidence of vaccine preventable invasive pneumococcal disease decreased from 120 cases/100 000 Indigenous adults in 1993 to 13/100 000 in 1999, rising to 44/100 000 in 2000 (Hanna *et al.* 2001).
- The Northern Territory *Haemophilus influenzae type b (Hib) Vaccination Program* resulted in 75% of children under five being adequately immunised, with 8.3% being partially immunised by the end of 1996. The incidence of invasive Hib disease in children under five decreased from 141/100 000 in the pre-vaccination era to 19/100 000 following vaccination (Department of Health and Aged Care 2001b; Markey 1998; Markey *et al.* 2001).
- Indigenous people who attend an Indigenous-specific medical service are more likely to be appropriately vaccinated than Indigenous people who attend a general practitioner (76% versus 32% respectively) (OATSIH 2003d).

Treatment of communicable diseases

- By 1997–98, the *prevalence of gonorrhoea* in the A<u>n</u>angu community served by Nganampa Health Council was reduced by 46% and *chlamydia* by 20%. Prevalence has since remained stable at 5% and

6% respectively. Approximately 70% of the adult population served by Nganampa Health Council participate in an annual STI screen. Between 1985 and 2000, *syphilis* rates in those between 12 and 45 years reduced from approximately 20% in 1984 to 0.5%–1% and have remained at this level (Miller *et al.* 2001; Torzillo 2003; Department of Health and Aged Care 2001b).

- Ngaanyatjarra Health Service in Western Australia has achieved a fall in *gonorrhoea* rates from 14.1% in 2001 to 12% in 2002 (Ngaanyatjarra Health Service, cited in OATSIH 2003g).
- Reductions in prevalence of *scabies* from 36% to 2% within nine months through Healthy Skin Programs in three communities in the Northern Territory (Dowden 1999; Scarlett 2001; Connors 2001).

Cancer screening

- Wurli Wurlinjang Aboriginal Community Controlled Health Service in Katherine has reduced the percentage of women who have never had a *Pap smear* from 44% to 28% (Department of Health and Aged Care 2001b; Todd 1999).
- Northern Territory Health Department increased *screening for cervical cancer* at Yuendumu to 78% of eligible women, from 51% prior to the screening program (and from 2% in 1987) (Department of Health and Aged Care 2001b; Gilles *et al.* 1995).
- The Northern Territory Well Women's Program which operates in a region with a high proportion of Indigenous women and has a long history of engagement with women and local Aboriginal Community Controlled Health Services, has achieved a high rate of *cervix screening* (61%) in the Alice Springs Remote area, which is comparable to the rate for Australian women generally (62%) (Condon 2004).

Reduced complications of chronic disease

- A community-directed program for primary and secondary *prevention of obesity, diabetes and cardiovascular disease* in the Looma community (Kimberley region of WA) resulted in participation in diet and/or exercise strategies by 49 high risk individuals; protection from increase in plasma glucose and triglycerides in these people at high risk (over 2 years); improvements in diet and level of physical activity amongst the community generally; and reduction in fasting insulin amongst the general community (Rowley *et al.* 2000).
- The Tiwi Islands *Renal Disease Project*, funded by the National Health and Medical Research Council (NHMRC) in consultation with the Tiwi Health Council in 1995, used antihypertensive medication for all people identified as suitable for treatment, achieving 70% compliance with treatment, reduction in blood pressure and reduced progression to death and end stage renal disease by 62% over the three-year period of the project. Estimated savings on dialysis were between $700 000 and $3.1 million over three years (Hoy *et al.* 1999; Hoy *et al.* 2000).
- In 1999 a randomised trial to *improve diabetes care* in the Torres Strait, where communities have the highest rates of diabetes in Australia, resulted in an 18% fall in hospital admission rates in some communities and a reduction of 41% in the number of people admitted to hospital for diabetes-related conditions in communities with recall and reminder systems. On follow up in 2002 there was a continuing reduction in hospital admissions for diabetes complications (from 25% in 1999 to 20% in 2002). The proportion of people with good glycaemic control increased from 18% to 25%, there was increased use of insulin (7% to 16%), and the proportion of people with well-controlled hypertension increased from 40% to 64% (McDermott *et al.* 2003).

- The Yarrabah Family Life Promotion Program (established in response to three suicide epidemics beginning in the mid 1980s) has *reduced the incidence of self harm*. In the three quarters ending in June 1996 there were 45–50 incidents of self-harm per quarter for males and 20–25 for females. This rate fell to 10–20 incidents for both men and women in late 1996 and to fewer than 5 in 1998. There were no deaths from suicide in 1997 and 1998, compared to three in the mid-1980s, nine in the early 1990s and eight in the mid-1990s (Mitchell 2000; Hunter *et al.* 1999).
- A mental health project at the Geraldton Regional Aboriginal Medical Service *reduced psychiatric admissions* of Aboriginal people to Geraldton Regional Hospital by 58% (Laugharne *et al.* 2002).

Improved maternal and child health outcomes

- Since 2000 the Townsville Aboriginal and Islander Health Service, Mums and Babies Project increased the numbers of women presenting for *antenatal care* (from 40 episodes of care per month in February 2000 to over 500 per month by January 2001, a level sustained in 2002–03). The number of antenatal visits made by each woman has doubled, with the number having less than four visits falling from 65% to 25%; 93% of those attending had at least one ultrasound. Pre-natal deaths/1000 reduced from 56.8 prior to the program to 18 in 2000; the number of babies with birth weights less than 2500 grams has dropped significantly; and the number of premature births has also decreased (Shannon & Longbottom 2004; Eades 2004; Atkinson 2001).
- By 1998–99 approximately 90% of women attending Nganampa Health Council had their *first antenatal visit* earlier than 20 weeks, approximately 90% had more than five antenatal visits and almost 100% of women were having an ultrasound. Between 1984 and 1996 perinatal mortality rates decreased from 45.2/1000 to 8.6/1000 (the national average for non-Indigenous babies is 6.7/1000), the proportion of babies with low birth weight decreased from 14.2% to 8.1% (the national average is 6.2%), and the mean birth weight increased from 3080 grams to 3183 grams (national mean is 3365 grams) (Eades 2004; Sloman *et al.* 1999).
- An *antenatal program* operating at Daruk Aboriginal Community Controlled Medical Service, Western Sydney since 1990 has achieved increased awareness among Aboriginal and Torres Strait Islander women of the importance of antenatal care. Thirty-six per cent of Indigenous women presented within the first trimester, compared with 21% at Nepean and 26% at Blacktown Hospitals' antenatal clinics; and women attended more antenatal visits (an average of ten at Daruk compared to six at Nepean and nine at Blacktown) (Eades 2004).
- The Strong Women, Strong Babies, Strong Culture Program piloted in the Top End of the Northern Territory achieved an increase in the proportion of women who attended for *antenatal care* in the first trimester of pregnancy from 16.7% to 24.4%; and increased the diagnosis and treatment of genital infections during the study period. Following the trial, only 0.9% of women in pilot communities required treatment for genital infections compared to 37.4% in non-intervention communities. There was an increase in average birth weight in intervention communities of 171 grams (compared to an increase of 92 grams in non-intervention communities); reduction in the prevalence of low birth weight by 8.4% in pilot communities and 1.5% in non-intervention communities; a reduction in the proportion of preterm babies of 1.5% in pilot communities compared to an increase of 1% in non-intervention communities; and reduction in the proportion of babies born with low birth weight (from 20% to 11%) (Mackerras 2001).

- Congress Alukura, a branch of the Central Australian Aboriginal Congress, sees 98% of Indigenous women who receive *antenatal care* in Alice Springs. The proportion of women starting antenatal care in the first three months of pregnancy has increased from 21% to 33%; and more women are having pap smears. The average birth weight of babies born to these women increased from 3168 grams to 3271 grams (narrowing the gap with non-Indigenous babies to 50 grams) (Mackerras 1998).
- Ngunytju Tjitji Pirni Aboriginal Corporation (NTP) operating from Kalgoorlie in Western Australia is a child and maternal health service that has achieved an increase in *antenatal screening* from 14 women between January and June 2002 to 75 women in the same period in 2003; an increase in the number of people receiving health education from 83 in 2002 to 644 in 2003; and an increase in infant and child checks from 57 in 2002, to 599 in 2003. Outcomes include a marked improvement in infant health with a reduction in the number of low birth weight babies (Ngunytju Tjitji Pirni Aboriginal Corporation, cited in OATSIH 2003g).

Reduction in social and environmental risks

- The health service in Halls Creek in Western Australia worked with the community to *reduce alcohol consumption*. Over time emergency evacuations due to alcohol-related injury decreased and there was a reduction in domestic violence (Department of Health and Aged Care 2001b; Douglas 1998).
- The communities living on the lands around Curtin Springs in the Northern Territory took action to *reduce alcohol consumption* through negotiating conditions restricting alcohol sales with the Curtin Springs Roadhouse. The local health service played a critical advocacy role. This initiative resulted in significant reductions in the amount of alcohol purchased (as measured by a 79% decrease in purchases by the roadhouse between 1997 and 1998). Outcomes include reductions in violence and alcohol-related health problems, with the number of people presenting at the Amata Clinic with alcohol-related trauma decreasing from 41 in 1996 to 14 in 1997 (Department of Health and Aged Care 2001b; D'Abbs *et al.* 1999; Gray *et al.* 2004).
- The Woorabinda Aboriginal Council in collaboration with the local hospital developed a number of intervention strategies to *reduce injury*, including restricting the trading hours of the Woorabinda public house. Over two years the intentional injuries in the community declined significantly (Department of Health and Aged Care 2001b).

There are many other examples of mainstream and Indigenous-specific agencies actively improving access to services by Indigenous people with high need. For example, the Inala Health Centre General Practice in Queensland, working with the local Indigenous community, increased services from a low of 12 Indigenous attendances in 1995–96 to 3894 in 2000–01. The Centre has an Indigenous doctor and used several strategies including employment of another Indigenous staff member, display of posters and other visual signs of welcome, cultural awareness training for all staff, dissemination of information about the services to Indigenous communities and promotion of collaboration between service providers (Hayman 2001).

A less direct measure of impact is offered by calculating the effect on Indigenous health and health care of withdrawing OATSIH funding for primary health care services. For nine preventable diseases (which account for about 27% of current health spending for this population), the withdrawal of OATSIH funding in the Northern Territory was estimated to cause a loss of healthy life (using Disability Adjusted Life Years or DALYs) of 2.6, 6.1 and 12.6 years per person in five, ten and 20 years time respectively (Beaver & Zhao

2004). Savings in the OATSIH program would be offset by increased costs to other parts of the system, largely hospital costs, resulting in a ratio of costs to savings of 5 times over five years, 7 times over ten years and 11 times over 20 years. The applicability of this modelling nationally is untested, and it cannot be generalised to other diseases. However, the overall findings are supported by the known impact of effective primary health care for chronic conditions in populations globally. Further, the modelling is robust to realistic variances in key assumptions, and can be accepted as a valid indicator of the direction (if not the precise measure) of the real positive impact of health care provision.

3.7.2 Impact and outcomes of mainstream health care

Evidence regarding the broad impact of mainstream health care is incomplete, due to inadequate data regarding Indigenous status in the most populous states. State/territory and national collections appear to show evidence of improvement in some key indicators.

- Indigenous infant mortality has declined from over 80 deaths per 1000 live births in the 1970s to 26 deaths per 1000 live births in 1981 (ABS 2000c, p. 76), with continuing gradual improvement. In 2000–02 the Indigenous infant mortality rate in the Northern Territory was 18.1 per 1000 live births (compared to 11.2 for the total population) and in NSW, which had the lowest rate, it was 9.5 per 1000 live births (compared to 5 deaths/1000 live births) (ABS 2003, p. 96).
- Indigenous life expectancy increased by 1.6 years for males and 0.9 years for females over the ten years from 1989 to 1999 (as measured by median age at death). Non-Indigenous life expectancy increased by 2.7 and 2.8 years, so the gap continued to grow (ABS 2000c).
- Age-specific death rates appear to have declined for all age groups except 15–24 and 45–54 years (based on Western Australian, Northern Territory and South Australian data) (ABS 2000c, p. 75). While the quality of some of the data on which these assessments have been made is variable, Northern Territory data is of consistently high quality. A recent comprehensive analysis of the Northern Territory data on mortality trends in the Indigenous population over 4 years of age shows a significant and steady decline in all-cause age standardised mortality between 1967 and 2000: 30% for females and 19% for males (Condon *et al.* unpublished).

3.7.3 Impact of effective primary health care: case study using program logic

This case study illustrates some of the health outcomes and impacts achieved by Nganampa Health Council. Figure 4 below, developed in consultation with Dr Paul Torzillo, is structured using program logic, so that it also provides an illustration of the links between inputs, structures and processes, impacts and outcomes.

The Nganampa Health Council is an ACCHS, formed in December 1983, providing comprehensive primary health care to people living on the Anangu Pitjantjatjara Lands (APY Lands) in the north west of South Australia, a population of 2833. There are seven major and many smaller communities on the lands. Nganampa is governed by a board of management elected from the local Aboriginal community and many of its managers and staff are Aboriginal. Nganampa has a clear mission statement and organisational structure, well-defined roles and responsibilities, and good human resource management practices to underpin service delivery. Management and practice has also been informed by richly contextualised local knowledge, regular reviews, evaluations and research (Shannon & Longbottom 2004).

Common health problems of children include respiratory illness, ear disease, gastroenteritis, skin infections, malnutrition and growth failure, adolescent illness, STIs and petrol sniffing-related illness. In addition, serious infections such as meningitis and trachoma occur more frequently in Indigenous children than non-Indigenous children. Common adult problems include Syndrome X disorders (obesity, diabetes, vascular disease, renal failure and hypertension) as well as trauma and STIs in young adults. Some people on the APY Lands also have diseases such as tuberculosis and rheumatic fever, and again, while these are not common, they are more common in this population than the non-Indigenous population (Torzillo 2003).

The health service has developed over a 20-year period, slowly building management and service capacity and adding to its funding base. It now provides a range of primary health care services in a number of sites and initiates action and projects in sectors other than health (Nganampa Health Council 2000). Nganampa has prioritised the provision of high quality clinical care and has responded to local needs, such as immunisation, sexual health screening (Miller & Torzillo 1998), and chronic disease management.

Nganampa's innovations in STI screening and treatment are an example of the practical demonstration of a new more effective approach which contributed to new policy directions. Nganampa has also improved the coordination of primary, secondary and tertiary care through more streamlined referrals and contributed to a more efficient use of those services. For example, Nganampa has achieved a consistent reduction in the levels of emergency evacuations to hospitals for acute conditions (Department of Health and Aged Care 2001b).

The Nganampa Health Council has also maximised the integration of different vertical programs by focusing on ongoing patient-centred care. In addition Nganampa has been effective in harnessing funds from a range of sources in order to provide an integrated service. Their aged care and disability facility sourced funds from various governments and departments in order to provide treatment, housing, meals and personal maintenance services (Shannon & Longbottom 2004).

Nganampa has also addressed the health of the Anangu people by improving their environment. The *Housing for Health* initiative identified shortfalls in health hardware such as washing facilities, waste disposal, and food storage and preparation resources. Alternative designs for necessary infrastructure were generated in consultation with local people and built. This initiative demonstrated that a competent primary health care service is well-placed to define the requirements for intersectoral action for health.

Nganampa currently receives funds equivalent to approximately four times average MBS spending per capita. However, due to its remoteness, there are still budget shortfalls each year due to the costs associated with patient assisted-transport and employment of nurses (Busutil 2003).

Figure 4 below is a simplified map and not all of the arrows linking processes/structures with impacts and outcomes have been drawn. For example, monitoring the health of the population and having effective recall and reminder systems (impact) will link to most of the outcome boxes. Similarly, Anangu Health Worker education and good staff orientation will enhance the capacity of the organisation to produce all the elements identified under the impacts heading.

3.7.4 Summary of impact of effective primary health care

The available evidence of health impact in Indigenous populations and the known effective interventions of primary health care, indicate that the impact of effective primary health care is seen in:

- reduced prevalence and incidence of *communicable diseases* that are susceptible to immunisation programs;
- reduced complications of *chronic disease* through effective chronic disease management programs;
- improved *maternal and child health* outcomes (such as birth weight) through the implementation of culturally appropriate antenatal and early childhood programs; and
- reduction in *social and environmental risks* through effective local public health advocacy, such as changes to liquor licensing regulations.

The available evidence of intermediate health outcomes achieved by effective Indigenous-specific health services gives grounds for governments to invest in further improving access to comprehensive primary health care. Evidence regarding the impact of mainstream services is poor, due to lack of data regarding Indigenous status. However, there is no reason to believe that health interventions that are of proven effectiveness for the general population cannot be effective in Indigenous populations, provided that the delivery system that brings these interventions is effectively tailored to the needs of Indigenous communities.

Figure 4: Nganampa Health Council ‘Program’: impacts and outcomes

Inputs

Funding: In 2001–02 approx $9m (access to Medicare funding difficult)

Physical infrastructure: Administrative centre at Umuwa and 6 major clinics and 3 health worker stations

Governance: Governed by the Anangu Health Committee which meets every 4–6 weeks

Management:
An Anangu Director
A Health Services Director Manager
A part-time Medical Director
Each clinic has an Anangu Health Mayatja (Manager)
A finance manager, program accountant and book-keepers are based in Alice Springs

Clinical, administrative, public and environmental health staff

Processes/structures

Data system including: Population register to provide basis for activity, outcome reporting and program planning; chronic disease register; and paper-based system to record daily collection of health statistics

Acute clinical care (and use of standard treatment protocols across all clinics)

Prevention programs (immunisation, sexual health screening and chronic disease management)

Programs such as aged and disability care, women’s health, children’s health, dental health

Hospital liaison

Extensive staff orientation

Anangu health worker education

Impacts

Health of the population is monitored: a recall and reminder system is being put in place but this is not well established yet as the service does not have a reliable computerised recall mechanism for most of these chronic conditions

Increased proportion of people listed on the chronic disease register (from 16% of population in 1998 to 48% of population in 2002)

Improved access to competent, evidence-based care

Increased proportion of children immunised from around 60% in the 1980s to more than 90% in 2003

Increased numbers of people being screened every year for 3 STDs (approx 70% people between 12 and 40 years)

School age checks performed – 80% of target group tested and referred to treatment as required.

Increased number of women screened for cervical abnormalities (approx 73%)

Increase in number of women attending antenatal care as per guidelines

120 people registered with HACC program, 179 people spent 2298 days in respite care

Outcomes

Should result in reduction in morbidity and mortality associated with chronic disease in the longer term

Reduced emergency evacuations (from 294 in 1997–98 to194 in 2001–02)

Should lead to reduced incidence of vaccine preventable communicable diseases

Reduction in number of people with and prevalence rates of STDs. Gonorrhoea decreased from 14.3% to 5.4%; Chlamydia from 9% to 3.9%, Syphilis from 20% to 0.7%.

Should lead to increased child health, including eye and ear health

Perinatal deaths decreased from 45.2/1000 to 8.6/1000

Reduced mortality from treatment of cervical abnormalities is a longer term outcome

Low birth weight babies reduced from 14% in early 1980s to 6% in 2003 (and mean birth weight is now the same as the national average)

3.8 Cost-effectiveness

The Review required an assessment of the cost-effectiveness of current services, and two consultancies were let to address this issue, one with a focus on estimating resource requirements (Econtech 2004) and the other with a focus on estimating the cost-effectiveness of different levels of investment in various types of interventions (Beaver & Zhao 2004). Beaver and Zhao provide an analysis of the cost-effectiveness of current OATSIH funding for the Northern Territory population.

Both are useful papers, but neither provide a comprehensive assessment of the cost-effectiveness of the range of current services, in the sense of relating current spending in various components of the service delivery system to health impacts or outcomes and comparing their value for money. The complexity and interdependence of the main elements of the health system make it virtually impossible to provide a meaningful answer to such a broad question, and we have not attempted to do so. This section focuses instead on the cost-effectiveness of services funded by OATSIH.

The Beaver and Zhao (2004) paper uses a sophisticated system for matching resources (Health Resource Groups or HRGs) and benefits (Health Benefit Groups or HBGs) based on a framework developed in the UK, which can be thought of as roughly analogous to Diagnosis Related Groups (DRGs) for hospital care. They focused on nine preventable diseases (hypertension, diabetes, renal disease, ischaemic heart disease, chronic obstructive pulmonary disease (COPD), respiratory infections, diarrhoea, malnutrition and skin infections) which account for about 27% of current health spending for the Northern Territory Indigenous population. The analysis uses known health impacts of interventions at various levels of the health system (health promotion, prevention, clinical primary health care (new cases), clinical primary health care (existing cases) and hospitalisation, and calculates health benefits using DALYs and the actual costs of delivering these types of interventions.

They analysed the effectiveness of the current level of Australian Government investment in primary care by calculating the impact on the Northern Territory Indigenous population of withdrawing OATSIH grant funding for these nine diseases. They found that withdrawal would result in reduced grant costs of $23 million over five years, $59 million over ten years and $104 million over 20 years (using a 5% discount rate). The impact would be delayed diagnosis and treatment, more severe chronic conditions and more hospitalisations. As discussed above in section 3.7.1, the loss of healthy life would be equivalent to a loss of 2.6, 6.1 and 12.6 years per person in five, ten and 20 years time respectively. The increase in costs for the Territory government, and MBS and PBS, would exceed $136 million over five years, $470 million over ten years and $1261 million in 20 years (Beaver & Zhao 2004, pp. 32-33). That is, the ratio of costs to savings from not funding Indigenous services in relation to these nine preventable conditions is 4.9 times over five years, 7 times over ten years and 11.1 times over 20 years. The authors note the limitations of the modelling, including limitations of the expenditure and cost data, and other information required to inform scenario assumptions, as well as the short timeframes in which the work was completed (2003, p. 2).

Based on modelling in the Northern Territory (Beaver & Zhao 2004), OATSIH funding for Indigenous-specific services is highly cost-effective, resulting in net health system savings of between 5 and 11 times the cost over 5 to 20 years, and additional years of healthy life of between 2.6 and 12.6 over the same periods.

3.9 Lack of good data undermines decision making

Good data is required for management, needs-based planning (at local, regional, state/territory and national levels), the development of evidence-based practice, and for monitoring and reporting on changes over time. Planning and resource allocation models are only as useful as the data that are available to support them.

3.9.1 Current data problems

Currently there are a number of problems with data collection on Indigenous health and health care, both at the population level and at the service delivery level, and these constrain effective policy development, planning and program evaluation. These issues include:

- poor identification of people of Aboriginal and Torres Strait Islander descent;
- little focus on Indigenous Australians in mainstream data collections;
- variability in quality and consistency of data collected across jurisdictions; and
- inadequate recording of successful and attainable evidence-based approaches (NATSIHC 2003).

In addition, changes in the numbers of people identified as being of Aboriginal and or Torres Strait Islander descent in national data collections have made it difficult to track changes to the health of Indigenous Australians. It appears that the remarkable 'denominator shift' that occurred between the 1991 and 1996 census may have resulted from a combination of an increased number of people prepared to identify as Indigenous, changes in census editing procedures and changes in the proportion of couples in which one partner is Indigenous who identify their children as Indigenous. It appears that changes between the 1996 and 2001 censuses are based more on real population growth than further changes in the propensity to identify as Indigenous (ABS & AIHW 2003).

The absence of reliable data from the larger states (New South Wales and Victoria) in most population-based data collections is a major problem. While Indigenous people make up a small proportion of the total population in these jurisdictions (2.1% and 0.6% respectively), the Indigenous people of NSW and Victoria form 29.4% and 6.1% respectively of the total Indigenous population (ABS & AIHW 2003). Further, because they are more urbanised than the Indigenous populations in other areas, the absence of data on their morbidity and mortality is a significant limitation on current knowledge and on ability to track and analyse change. Efforts are underway to improve the situation in all states and territories, but continued effort and political commitment are required.

The failure of mainstream health care providers to collect data on Indigenous status from their patients is another important problem. Recent research has demonstrated effective strategies for doing so (Pulver *et al.* 2003; Young 2001).

3.9.2 Service-level data for Indigenous-specific services

Since 1998–99 Australian Government-funded Aboriginal and Torres Strait Islander primary health care services have reported data on their service activity, including activity not funded by the Australian Government, through service activity reporting (SAR). Aboriginal and Torres Strait Islander substance-use services now also contribute to a specialised Drug and Alcohol Service Report (DASR). These data collections provide the most comprehensive source of information on the activities of Australian Government-funded Indigenous health services. Limitations to the data include the use of broad indicators and the reliance in some cases on estimates of episodes of care and service population figures (which have not been independently audited). The collection provides information on service activity per annum, funding levels and workforce composition. The agencies have achieved a 97% response rate over the last three years of collection of SAR. Neither the SAR nor DASR are designed to provide client level information nor to assess the performance of individual agencies.

3.9.3 National data collections

In 1995, the Commonwealth funded the Aboriginal and Torres Strait Islander Health and Welfare Information Unit (ATSIHWIU) to improve data and statistics about the health and welfare of Australia's Indigenous peoples. This Unit was run by the ABS's Centre for Aboriginal and Torres Strait Islander Statistics until June

2002 when the ABS decided not to renew the contract. A review of the ATSIHWIU in late 2002 identified that it had been successful in improving data and recommended that the work continue. OATSIH is continuing targeted work to improve the quality and availability of Aboriginal and Torres Strait Islander health and welfare statistics through arrangements with the ABS and AIHW. This work includes:

- continued production of the biennial report on the *Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples;*
- assessing the available Indigenous mortality data to determine whether the data quality supports time trend analyses; and
- an examination of Indigenous identification processes in key administrative data sets with a view to improving the quality of Indigenous data in these collections.

The 'National Indigenous Health Information Plan …This time, let's make it happen' (NIHIP) was adopted by AHMAC in 1997 and the National Health Information Management Group (NHIMG) was charged with implementing the plan. Key objectives of the plan include:

- addressing the ethics, ownership and use of data about Indigenous Australians;
- developing a strong Indigenous workforce to facilitate improvements in the coverage and quality of Indigenous health information;
- improving the capacity of major health and related data collections to separately identify Indigenous persons; and
- fostering a long-term commitment to major special purpose collections to obtain essential information unable to be obtained from administrative data sources.

In 2001 the National Advisory Group on Aboriginal and Torres Strait Islander Health Information and Data (NAGATSIHID) was established to advise the NHIMG and is now responsible for continuing implementation of the NIHIP. This includes working on improving Indigenous identification in a range of administrative datasets (birth registrations, death registrations, hospital separations, cancer registries, general practice data collections, community mental health services data, and alcohol and other drug treatment services data); advising relevant agencies on information and data collection priorities; and providing advice to SCATSIH on National Performance Indicators (ABS & AIHW 2003).

Implementation of the NIHIP is specified as a key action area of the *National Strategic Framework for Aboriginal and Torres Strait Islander Health* (NATSIHC 2003). In addition, the NSFATSIH has outlined a comprehensive range of strategies for data availability and quality, data development, information management at the primary health care level, and research and knowledge transfer.

3.9.4 Improvements in data and information

Significant data problems remain, but progress has been made.

- Since 1997, four biennial reports on the health and welfare of Australia's Aboriginal and Torres Strait Islander peoples have been produced by the AIHW and the ABS and the fifth is due in 2005.
- The 2001 National Health Survey included a supplementary Indigenous sample and provided estimates of Indigenous health indicators. National Indigenous Health Surveys will be undertaken every six years from 2004–05.
- Improved quality of Indigenous data from the Census of Population and Housing and for annual Indigenous population estimates and projections (ABS & AIHW 2003).
- A voluntary Indigenous identifier is now included in Medicare registrations (ABS & AIHW 2003, p. 9).
- The Communicable Diseases Network of Australia is currently working on making surveillance for STIs nationally consistent (OATSIH 2003a, p. 24).

- A framework for reporting on the performance of mainstream services in meeting the needs of Indigenous Australians for inclusion in the yearly *Report on Government Services* has been developed.
- The inclusion of a question about Indigenous identification in the Alcohol and Other Drug Treatment Services National Minimum Data Set and provision of advice from the AIHW to agencies about how to improve data quality.
- Progress in improving the coverage of Indigenous births has meant that ABS was able to publish information about births registered as Indigenous in 1999 for all states and the Northern Territory (ABS & AIHW 2003).
- The proportions of Indigenous Australians identified as such in the death registration systems have been increasing steadily, albeit slowly, over recent years (ABS 2000c; ABS & AIHW 2003).
- The AIHW continues to work with state and territory authorities to improve the coverage and quality of Indigenous data in collections of hospital separations, cancer registrations, community mental health services, alcohol and other drug treatment services, community services and disability services.
- The Department is also funding a project (auspiced by NAGATSIHID) to improve Indigenous identification in communicable diseases reporting.
- The National Housing Data Agreement achieved publishable data across all COAG jurisdictions in 2003.
- The Expenditure Report prepared by AIHW every three years.

Significant progress has been made in recent years towards improving national, state/territory and service-level data on the health and health care of Indigenous Australians. It is vital that this work continues, and is adequately resourced, as it provides the basis on which monitoring of effectiveness and decisions about how best to improve health and health care can be made.

Case study: Western Australian Aboriginal Child Health Survey

'The first fully representative community survey of Aboriginal child health and wellbeing has been underway throughout Western Australia since April 2000. The project is being conducted under the auspices of the Kulunga Research Network by researchers from the Telethon Institute for Child Health Research. Funding for the project has come from a mixture of Australian Government and state government and private organisations. The ABS has been a major partner providing consultancy services as well as outposted staff and support for survey development and field work.

By the end of 2001, over 130 screeners and interviewers (60% of whom were Aboriginal Australians) enumerated a selection of 786 census districts from across Western Australia, listing 166 287 dwellings and randomly sampling 2386 families with Aboriginal children under the age of 18 years. A total of 1999 (83.8%) of these families consented to participate. Intensive interviews gathered information on 5289 children with separate interviews on 1073 young people aged 12–17, and additional interviews with 3153 carers of these children. School data was also collected for a high proportion of the children. During 2002, intensive data screening, cleaning, editing and validation took place. In addition, record linkage work was undertaken to further enhance the scope of the data; 92% of carers gave consent for their survey data to be administratively linked to hospital records, and 96% of carers gave consent for the data on their children to be linked to both hospital and birth records. Where consent was given, 96% of children and 93% of carers were successfully linked to the administrative health records maintained on the WA Health Services Research Linked Database.

Survey results will be communicated to participating Aboriginal communities in a culturally appropriate form with the assistance of the project's Aboriginal Steering Committee and the Kulunga Research Network. Starting in late 2003 and continuing through 2004, the findings will be published in several formats. A monograph will provide an epidemiological framework not previously available as a planning resource to define the burden and impact of common child disorders at the population and regional levels. This information will assist policy makers, service planners and purchasers in health, education, family and children's and justice agencies in estimating service needs and the potential advantages of alternative policies and programs. Additionally, a major community-based dissemination strategy is planned to communicate survey findings to Aboriginal communities throughout Western Australia. This aims to provide information relevant to community-level decision-making needs.'

(Source: Telethon Institute for Child Health Research, 2003, p. 235)

4 Strategies for narrowing the gap

The Review required advice on the strategy and relevant timeframes required to achieve appropriate levels of comprehensive and effective health care for Aboriginal and Torres Strait Islander people. This part commences with a consideration of the requirements for an adequate well-managed service delivery system on the ground, and then addresses the broader issues of national leadership, supportive policy, workforce capacity, information and healthy public policy.

The experience of the last 30 years (since the initiation of Aboriginal Community Controlled Health Services), and particularly the period since the mid-1990s, means that decisions about how to improve health care for Indigenous Australians can now be made with a degree of confidence. There are some important limiting factors that mean a developmental approach is required, and expenditure growth should be carefully scaled to enable capacity to develop. It is also essential, while taking a national perspective, to ensure that regional and local variations in health problems, health system capacity, cost structures, workforce supply and community capacity are recognised. All strategies will need to be tailored to local and regional conditions, within the framework of national goals and policies.

4.1 Care delivery models

This section defines comprehensive primary health care, explains some of the necessary conditions for effective CPHC and proposes the development of a delivery system model for Indigenous-specific services funded by OATSIH (with variations for location and other factors). This section is focused primarily on Indigenous-specific agencies, but the role of mainstream agencies in Indigenous health care delivery is also addressed.

4.1.1 Definition and scope of comprehensive primary health care

The established OATSIH definition of comprehensive primary health care (CPHC) is sound and consistent with the WHO definition described in the Alma-Ata declaration (WHO 1978). Its taxonomy of four key elements specifies a platform of services:

- clinical care—treatment of acute illness and injury, emergency care and management of chronic conditions (including mental illness);
- population health programs—antenatal services, immunisation, screening programs for early detection of disease, and specific health promotion programs (e.g. physical activity, nutrition, oral health, prevention of substance misuse);
- facilitation of access to secondary and tertiary care—referral, support for referred patients, development and maintenance of links with a range of health services (such as medical specialists and referral hospitals) and related community services (aged care, disability); and
- client/community assistance and advocacy—identification of factors contributing to illness or risk, working with individuals and communities to develop strategies to reduce risk or harm, including for health risk factors and health determinants that lie outside the direct ambit of the health system (OATSIH 2003c; NATSIHC 2003; Shannon & Longbottom 2004).

If the goal of comprehensive primary health care for Indigenous Australians is to be achieved, a necessary next step is to develop better specification of the basic platform of services and capabilities that must be achieved at various levels (e.g. for given population sizes and travel distances).

Detailed specification of services is a task that is beyond the scope of this paper, and should be tackled by a multi-disciplinary group with strong clinical and community input. However, the following is a draft list of the key elements.

Table 3: Elements of comprehensive primary health care

Health services
Clinical services – with access to emergency care 7 days/24 hours (local or remote)
Antenatal care
Immunisation
Care of 0–5 yr olds, and support for effective parenting
STI services
Primary medical care
Screening where there is an appropriate method and good evidence of outcomes
Access to specialist care and referral to secondary and tertiary services
Secondary prevention of chronic disease
Care coordination for people with complex and chronic conditions
Mental health services and programs to enhance social and emotional wellbeing
Specific vertical programs (nutrition, substance abuse)
Support
Standard treatment protocols for common conditions, based on evidence
Data collection, evaluation, monitoring
Ongoing staff development, including health worker training
Intersectoral collaboration (focused on known opportunities for health gain)
Programs to enhance the capacity of Indigenous families and individuals to take responsibility for their own health
Standards
Competent and expert care
Well-led and managed (sound policies and procedures, practice guidelines and manuals)
High quality
Universal access

Source: Based on personal communication with Dr Paul Torzillo (2 September 2003)

4.1.2 Chronic disease care: a ‘best buy’ requiring a base of CPHC

The modelling carried out by Beaver and Zhao (2004) assessed the ‘best buys’ for reducing the burden of illness for nine preventable chronic conditions. They found that Clinical Primary Health Care (new cases) and Clinical Primary Health Care (existing cases) were the most effective interventions for the purposes of saving health care resources. Health promotion was the third priority for eight of the nine diseases (malnutrition is the exception). Prevention was more effective than hospital care in terms of saving resources (Beaver & Zhao 2004, p. 21).Health promotion and prevention become more effective in saving resources in the longer-term (20 years), but are still less cost-saving than clinical primary health care (Beaver & Zhao 2004, p. 21).

These findings illustrate the potential for enhancing the cost-effectiveness of intervention through evidence-based planning and care delivery. However, effective delivery of these most effective interventions requires a platform of comprehensive primary health care. Good clinical care for new and existing cases can only be reliably provided from a base of competent general primary health care, readily accessible to patients and responsive to their broad health concerns. 'Best buys' are part of effective primary health care, not a substitute for it.

The existing OATSIH definition of comprehensive primary health care is a sound basis on which to build further specification of the basic platform of services, and service system models, which are needed to improve access to health care and health outcomes for Indigenous Australians. It is possible to identify some services that provide a clear and strong return on investment, but (with some minor exceptions) they can only be effectively provided from a base of comprehensive primary health care.

4.2 The primary health care delivery system

Effective primary health care is a seemingly non-controversial goal in most health systems, but is nevertheless difficult to achieve. Perhaps one of the reasons for this is that the primary health care system is at the bottom of the pyramid, characterised by small-scale provider organisations (or small groups of practitioners), providing services that lack the glamour of tertiary care and operating far from the centres of power. Strong policy support from the centre needs to be informed by an understanding of some of the dilemmas primary care providers face. This section attempts to outline some of the conditions required for effective primary health care, and the key elements of the service system.

4.2.1 Requirements for effective primary health care

Reference to the mainstream Australian system for models of comprehensive primary health care is not particularly helpful, because the mainstream system is itself plagued by discontinuities, jurisdictional boundary problems, and great tension between the goal of integrating care for patients on the one hand and the goal of targeting services through tight specification of eligibility and service types on the other. In this respect, Indigenous programs are less conflicted and contested by competing interests and there is perhaps more freedom to develop a coherent system. The major tensions that the system must balance are explained below.

Achieving both integration of care and effective targeting

There is much rhetoric about the need for integrated care, and a significant body of experience in finding methods for delivering it ('horizontal programs'). But there is also evidence to support the pursuit of specific health goals and the use of targeted programs to achieve health gain in relation to specific health problems ('vertical programs'). These potentially conflicting goals or methods are both important, and need to be managed together.

As in all organised human endeavour, there is a need in health care to enable specialisation (i.e. break the system up into manageable components of care and manageable organisational arrangements) on the one hand, and then to find ways of coordinating the pieces to make a coherent whole on the other (Mintzberg 1991). In the case of Indigenous primary health care (and this is also true in the mainstream), the most effective approach is for primary health care organisations or practitioners to fulfill the integrating function, presenting a 'seamless' point of entry to the whole system and acting as the anchor point for individuals, coordinating access to care and working with clients to ensure that the inputs of all the other players are managed coherently.

If this anchor point and integrating function are working, vertical programs, delivered either by the primary health care service itself or in close collaboration, can be tightly specified and targeted; and population-level key performance indicators can be collected and monitored, with a minimum of discontinuity for the patient. Secondary prevention for chronic illness can be achieved with both specialised skill and generalised management of care for the individual. Finally, the needs of the seriously ill can be met in a coordinated way.

For this approach to managing both integration and targeting to work, some prerequisites must be in place.

- The implications of new, targeted programs for primary health care providers (increased workload; new data collection and information technology [IT] needs; facility and equipment requirements; need to develop new partnerships) must be recognised in the development of policy and funding programs (e.g. Centre for Remote Health 2003).
- The work of establishing effective links with primary care providers must be included in the remit of targeted programs that sit outside core primary health care activities (e.g. breast cancer screening), and both the process of development and the resourcing levels must take this into account.

Community governance/localism and national/state/territory programs

The second significant tension that must be managed is the potential conflict between the desire of local communities and agencies to determine local priorities and the policy goals of national or state/territory programs that seek to improve outcomes at population level.

Both of these goals are vital: inability to respond to local issues can be a serious barrier to implementing local solutions for health gain, and can compromise effective local management of resources and services. On the other hand, it is equally vital that the primary health care system has the capacity to support the delivery of national programs in areas where there is strong evidence of both significant need and the effectiveness of an intervention or program method.

These potentially conflicting goals can be reconciled. For example, the Northern Territory Preventable Chronic Disease Strategy has been implemented in both mainstream and Indigenous health care organisations, with considerable success (Weeramanthri *et al*, 2003). Focused on five diseases, the Strategy has succeeded in achieving interim outcomes. Preliminary analysis against a baseline of 21 indicators shows a trend in:

- improvement of birth weights;
- sustained high levels of immunisation;
- a slowing in the rate of growth of renal dialysis treatments;
- a decline in the number of diabetic amputations in the Top End;
- some improvements to the food supply;
- a relatively stable per capita alcohol consumption; and
- a continuing decline in adult smoking prevalence, though slower than in the rest of the country and still with very high levels in the Indigenous community (Territory Health Service 2001).

A careful process of development and negotiation of this program is seen as essential to its success.

For this sort of success to be generalised, the following are required.

- Effective use of planning and negotiation forums (such as the Partnership Forums - see section 4.4.1) to enable participation by all parties in the development of national/regional priorities, to identify potential conflicts between local and national priorities, and establish arrangements to enable local variation.
- Agreed methods of framing requirements and negotiating local implementation so that programs can be targeted to real local priorities, local agencies can plan for engagement and if necessary be resourced to deliver their component, and so that there is joint ownership of program outcomes.

For comprehensive primary health care to be effectively implemented, the decision-making and management processes of the delivery system (at all levels) must be designed to support the primary care level. This in turn requires that the inevitable tensions between integrated care and targeted programs, and between local and national priority-setting, be acknowledged, recognised as legitimate challenges for all parties, and carefully managed through robust, durable and mutually respectful negotiation processes.

4.2.2 Service system models

Good system design in this field must recognise and accommodate diversity while ensuring that universal access to a common platform of services is available. While there will be variation in levels of funding, capacity and volumes of services delivered across the Indigenous-specific sector, it would be useful to establish standards and benchmarks against which service development could be planned and progress towards the goal of universal access could be monitored. While the following discussion is focused on Indigenous-specific agencies as the cornerstone of the model, we would emphasise that achieving CPHC requires a network of services, Indigenous and mainstream. Differences between remote, rural and urban models are noted as they arise.

The Primary Health Care Access Program (PHCAP) program has established benchmarks for relative funding effort and absolute levels of funding for primary health care on the basis of population size, remoteness and current capacity to utilise Medicare. We propose that a flexible service system model also be developed, based on a regional approach. A core platform of primary health care services to be provided at regional and local levels for given population sizes would be specified, and could be used as a template to guide funding decisions and service development.

The historical development and local autonomy of ACCHSs must be respected, while at the same time recognising that sustainability and effective health care delivery arrangements are essential. The success of any new approach will depend on strategies that focus on health care delivery and the goal of health gain, rather than on re-organising existing organisations to fit a model. While the forms and structures of existing organisations may need to change over time (particularly where small size is a strong limiting factor on effectiveness), this should be achieved as part of a program of growth and development in health care delivery, by negotiation and in stages. The regional template should not specify a requirement for a single regional board of governance. Rather it should allow for a mix of organisational arrangements, including the following:

- Local ACCHSs linked at regional level through consultation and negotiation forums, and shared support services (finance, human resources [HR], IT, data collection, clinical and management protocols).
- Regional ACCHSs with local clinics and programs (e.g. Nganampa Health Council SA, Katherine West NT, Central Australian Aboriginal Congress NT).
- A regional primary health care network including Indigenous-specific and mainstream organisations, that work together on health programs for Indigenous people to ensure that the necessary services are available in the region.
- Arrangements whereby community-based agencies contract with government or private sector agencies for care delivery, and act as purchasers rather than managers of service delivery.

The service system model should enable funding for necessary support services at regional and local level. A regional network of local ACCHSs could establish and jointly manage a regional support capacity, to provide shared services such as financial reporting, human resource and industrial relations expertise, staff development, information systems support, data processing, and supply management, where they are not achievable at local level. Clinical support services could also be provided by this mechanism, including diagnostic services, evaluation of care and analysis of evidence both of effective methods and local and regional progress against indicators and targets.

The service system model would need to be flexible enough to support cross-portfolio sharing or pooling of resources, such as a single facility housing all health, community and education agencies in small communities.

It is also important that regional boundaries are determined on the basis of the needs of health care delivery, recognising mainstream health regions where appropriate. Consistency with local government and Aboriginal and Torres Strait Islander Commission (ATSIC) boundaries is also strongly desirable.

In building a stronger and more capable comprehensive primary health care system, it will be essential to take a developmental approach, with an agreed growth path. In some under-serviced areas, it will not be practical to develop an Indigenous-specific agency, or at least, not immediately. For these cases, the service system model could also specify good practice in providing Indigenous services from within mainstream organisations, such as is currently happening in Central Australia under PHCAP. The National Strategic Framework for Aboriginal and Torres Strait Islander Health requires that these services should be provided in partnerships among Indigenous-specific and mainstream agencies, in ways that maximise community decision making, influence and control (NATSIHC 2003).

It may be helpful to describe stages of development, with a cluster of characteristics of each level (e.g. from Stage 1 where there is no Indigenous-specific service through to Stage 4 where there is a good Indigenous primary care service with effective links into other services, strong regional structures, etc.).

The establishment of an agreed model for the Indigenous-specific service system, combined with specification of the basic platform of services that constitute CPHC, has the potential to deliver several benefits. These measures will provide a guide for decision making in relation to funding and support, support progress towards the goal of equity of access to care, assist the development of best practice in clinical care and the use of effective interventions, and support stronger governance and management.

4.2.3 Care coordination for people with chronic conditions

The significant burden of chronic disease in Indigenous communities means that care coordination is of central importance, and arrangements that are known to be supportive of care coordination should be designed into the primary health care system.

There are three important system design elements. Firstly, the role of the primary care provider as the coordinator of the patient's care must be endorsed. Secondly, funding methods that enable the primary care provider to perform this function (possibly including some element of capitation) are needed. Thirdly,capacity to link medical records would facilitate the effective transfer of needed information between care providers. Each of these elements raises issues of privacy and choice, which need to be resolved with Indigenous communities and individuals.

The development of the Oacis system in South Australia (which currently provides an integrated medical record for patients with kidney disease across metropolitan Adelaide) provides a model for a clinically appropriate, well-designed use of record linkage to improve care (HealthConnect Program Office 2003). Privacy issues have been addressed, and technical requirements are understood. While such a system may seem a long way in the future particularly for remote services, these agencies have proven their willingness and capacity to use sophisticated solutions to the problems of distance and isolation, with many ACCHSs routinely using population registers. For example, Nganampa has established a population register that includes information on daily clinical contacts as well as specialised medical databases. This is used to plan and implement strategic health interventions, and provide activity reports to staff, communities and funding bodies. Nganampa has also established a chronic disease register to improve the management of clients with a chronic illness (Shannon & Longbottom 2004). It seems that there is support for this kind of system among some communities who understand the privacy issues involved, and see them as acceptable in the context of potential health gain (e.g. for antenatal care and immunisation programs).

Given the importance of complex chronic illness in the Indigenous population, systems and processes that enable strong coordination of care are needed. They will require collaborative development and informed agreement by communities, with particular sensitivity to any concerns about privacy and autonomy. There are some early signs of informed and considered acceptance among Indigenous communities.

4.2.4 Indigenous-specific agencies in urban areas

The extent to which Indigenous-specific agencies are best placed to deliver all elements of comprehensive primary health care will vary with location, including remoteness but also local conditions (such as distance from and relationships with other agencies). Other factors include the relative roles of private general practice and the full range of public and private sector care providers, and their readiness to provide appropriate care.

The basic definition of CPHC describes services that should be available to urban Indigenous Australians, whose poor health status indicates poor access to existing health care agencies. But there are more options for Indigenous people in relation to access to care; and for Indigenous-specific agencies in relation to working collaboratively with others, and these should be taken up where they can deliver health benefit.

While concern to allocate the maximum possible amount of funding to remote and rural people is recognised, this should not mean continuing disadvantage for urban Indigenous people. They should be able to use an Indigenous-specific primary health care service if they need to do so. A need based on reluctance to use mainstream services (for whatever reason) is a valid need in circumstances where such reluctance will result in lack of access to health care. The challenge to enhance the acceptability of mainstream services lies primarily with the mainstream, and secondarily, with the ACCHSs (whose roles include advocacy and advice to the mainstream).

The application of service system models and the basic platform of CPHC will be different in urban areas. The same access principles should apply. The challenge to make mainstream services more acceptable and accessible to Indigenous Australians lies primarily with the mainstream (see section 4.3).

4.2.5 Services for non-Indigenous Australians in remote areas

Expansion of the network of primary health care in remote areas could provide an opportunity to resolve the question of access to Indigenous-specific services for non-Indigenous people in areas where the ACCHS is the only local service. This issue is generally satisfactorily resolved in practice, and codifying the arrangement in policy would strengthen the basis for good practice. The funding method could be based on either MBS/PBS or a component of per capita funding, or a combination of the two.

4.2.6 Mainstream service delivery

This discussion of the primary health care system has focused largely on Indigenous-specific agencies, because this is the sector that has Indigenous health as its primary goal, and which can be designed and adapted to respond as closely as possible to Indigenous health care needs. However, the mainstream system also plays a vital role. On any given day, at least as many Indigenous Australians attend private GPs as ACCHSs across Australia, and Indigenous people rely on the mainstream secondary and tertiary systems.

There is growing awareness at all levels in the mainstream health system of the fact that Indigenous health care is everyone's responsibility, but that awareness and willingness is yet to be converted to active engagement throughout the mainstream system. There is some tendency to regard Indigenous health care as the responsibility of the ACCHS sector, and in the secondary and tertiary sectors, as a primary health care issue.

Acceptance of responsibility throughout the system needs to be embedded into the full range of policy and governance instruments, from Health Service Agreements to statements of objectives in Articles of Association or incorporation, and the strategic plans of agencies. Continuing national, professional, management and peak body leadership is needed.

The role of mainstream services is to provide easy access to quality care for Indigenous patients. This requires policy commitment; understanding of the health care needs of Indigenous patients, and the particular barriers to access that they encounter; the engagement of clinicians in ensuring that clinical practice is appropriate; and the supportive role of Aboriginal Liaison Officers and local ACCHSs.

It also requires debunking of the myth that Indigenous-specific funding is more than adequate to meet needs. This myth underlies an attitude or belief in some mainstream providers that the health care funding pie has been definitively cut on racial lines, and that mainstream resources are really for the care of non-Indigenous people.

For the providers of health care, better ascertaining and recording of Indigenous status is an immediate practical issue, often needed for effective care delivery as well as for better understanding and reporting of Indigenous health status and health care use in the long term.

The Divisions of General Practice have an important role to play in enhancing the capacity of general practice in Australia to provide effective primary health care for Indigenous Australians. The recent review of the role of Divisions of General Practice (Department of Health and Ageing 2003a) notes the variable relationships between them and ACCHSs, and the variable level of engagement in relevant activities by the divisions (Department of Health and Ageing 2003a, pp. 45-47). The report acknowledges the fact that for some Divisions of General Practice, the absolute numbers and the proportions of potential Indigenous patients who might use general practice care in the area are very low, but notes that 'it is essential that all Divisions undertake activities that improve the health of Indigenous Australians' (Department of Health and Ageing 2003a, p. 46). In four relevant recommendations, it urges that the Australian Government fund a consortium to identify models of best practice for Divisions of General Practice and ACCHSs in working together; that a common performance indicator be introduced by the Australian Government to measure effective engagement between the two sectors; and that guidelines for culturally safe practice in general practice be developed.

The Government has supported the Commonwealth Grants Commission's view that appropriate strategies to address lack of responsiveness by mainstream agencies include involving Indigenous Australians in the design and delivery of mainstream services; and improving the relationship between mainstream and Indigenous-specific programs (Commonwealth of Australia 2002, p. 15).

The mainstream health system's commitment to enhancing Indigenous health and health care needs to be strengthened, and embedded in policy, service agreements, strategic plans, objectives, performance agreements and other instruments. A strategy and resources are needed to support this work, and to support mainstream clinicians in their endeavours to enhance the effectiveness of the care they provide to Indigenous patients.

4.3 Governance and structure of Indigenous health organisations

There appears to be significant variation in the organisational effectiveness of Indigenous health services. Some are relatively well-funded, well-staffed, well-governed and managed, able to provide a comprehensive range of primary health care services, and supported by useful data about their communities, client base and service outputs. In three significant field studies (Department of Health and Aged Care 2001b; Shannon *et al*. 2002; Shannon & Longbottom 2004) the critical success factors for comprehensive primary health care and the Indigenous-specific health service sector have been examined. The factors identified are generally consistent with the principles of good health care management and practice applying in the mainstream:

- adequate secure resourcing;
- reasonable access for the population to be served;
- interventions based on good evidence of efficacy;
- effective collaboration by the range of providers needed for comprehensive care;
- capacity for innovation based on evidence;
- priority-setting that reflects community perceptions of needs; and
- acceptability to the community.

The differences lie in the particular styles of comprehensive primary health care (with a greater range of services being provided by single agencies serving Indigenous communities, as compared to agencies of similar size in the mainstream); and in the way that the principle of community engagement is expressed.

There are some outstanding examples of success. Detailed case studies of Nganampa Health Council SA and Townsville Aboriginal and Islander Health Service QLD (Shannon & Longbottom 2004) reveal that, with the current level of investment and current system influences, these services have been able to develop into effective primary health care services.

> 'Their development has taken a long time and sustained effort over many years. They have demonstrated that they have good systems in place to manage their resources on a daily basis and have strategic approaches to manage longer term issues. Both services have intermediate outcomes that should, in time, lead to improvements in health outcomes' (Shannon & Longbottom 2004, p. 121).

The authors include a cautionary note about the potential for health gains to be undermined by the impact of social and economic disadvantage in these communities.

The Australian Government funds a range of Indigenous health agencies, mostly to provide primary health care services, and many also receive state/territory funding. The majority of these agencies are ACCHSs which are defined by the National Aboriginal Community Controlled Health Organisation, the peak body for ACCHSs, as

> '… primary health care services initiated and managed by local Aboriginal communities to deliver holistic and culturally appropriate care to people within their community. Their board members are elected from the local Aboriginal community.' (NACCHO 2003, p. 2)

NACCHO is strongly committed to this model of community control (for reasons including the history of the sector's development in an environment of mainstream neglect). The services provided by these agencies include:

- the diagnosis, treatment and management of illness and disease;
- population health programs such as screening and immunisation; liaison with secondary and tertiary health services; and
- advocacy and support roles.

In 2000–01, 129 Indigenous-specific primary health care organisations were funded by the Australian Government and they provided 1.3 million episodes of care, as well as undertaking related activities such as training (Department of Health and Ageing data 2003d).

A significant proportion of Australian Government-funded primary health care services (43% or 56 services) receive less than $500 000 per year with only 17 services receiving over $2 million per annum and able to offer a broad range of primary health care services. This funding is often from multiple sources each requiring different and specific reporting formats. The higher burden of disease experienced by Indigenous people impacts on staff workloads and coupled with relatively low funding levels, generally limits the capacity of these services to provide early detection and prevention programs. However, there are a number of high capacity agencies that are providing a good base of clinical care, and early detection and prevention programs, which are having an impact. The roles agencies play vary by location, with ACCHSs providing virtually all primary health care in some remote areas, often including 24-hour emergency care. State/territory-funded Indigenous-specific and mainstream services provide such care in other remote areas (e.g. some parts of the Northern Territory, and in Cape York).

Service capacity often reflects historic arrangements, and agencies are not currently funded fully on the basis of community need. It should be noted that the Government has considered and rejected the option of reallocating existing funding for Indigenous health services more evenly (Commonwealth of Australia 2002, p. 25) in light of the Commonwealth Grants Commission finding that there was no evidence of funding in excess of needs in any location (Commonwealth Grants Commission 2001, p. 144).

4.3.1 Effective Governance in Indigenous agencies

There are many examples of good governance practice in the field of Indigenous health, and there are also areas where improvement is required.

The extent of effective governance and leadership in ACCHSs around the country, and the development of appropriate governance styles and conventions, needs to be acknowledged. Most services meet accountability requirements, and over time, board members and staff have developed impressive skills and expertise in managing ‘interculturally’ (i.e. between traditional informal Indigenous ways, obligations and relationships, and the formal legal structures of incorporated organisations). For example, the Katherine West Health Board, which was established in 1997 to manage a coordinated care trial, has extended its role to become a community-controlled service provider, delivering a range of services (and purchasing others) in one of the most remote communities in Australia. Initially, Territory Health Services provided technical support to the Board so that members gained the skills and expertise to govern a service with complex arrangements. The Board now has the capacity to assess and plan for the whole of the region’s health needs and has made a significant improvement in the provision of health services for its service population (Department of Health and Aged Care 2001b; KPMG 2001).

The contributions made by clinicians and managers with the drive and technical competence needed to build successful organisations, especially those who have sustained their commitment over many years, have been vital but largely unrecognised. Shannon *et al.* (2002, p. 64) found that leadership (by Indigenous and non-Indigenous people) was a key factor in the success of the projects they examined: ‘Strong and sustained leadership by a skilled individual was key to a number of projects but was not acknowledged despite the evidence' (Shannon *et al.* 2002).

However, the incidence of governance problems in ACCHSs is of concern with 24 of 184 (13%) community-managed organisations delivering health and substance use services experiencing difficulty in July 2003 (OATSIH unpublished 2003h). Causes of these problems include the following.

1. *Small size* of organisations, that must nevertheless shoulder the full burden of corporate accountability, often without access to critical resources and skills such as accountancy services, HR expertise, adequate IT and timely legal advice, and without an adequate asset base, or secure ongoing funding.
2. Arising from the above, weakness or poor development of guidelines, *policies and procedures* that might otherwise strengthen and protect ongoing management functions, particularly for small organisations or organisations that have grown rapidly without implementing a robust management system.
3. The intensity of demand for the time, energy and influence of key leaders in communities, with *leadership skills* being stretched too thin in communities that are under high levels of stress.
4. The shortage of *Indigenous health and management professionals* with management skills and experience; and difficulties of recruiting and retaining skilled staff (Indigenous or not), exacerbated by lack of security of tenure for staff employed on 'soft' funding.
5. The challenge of creating and sustaining effective corporate governance in the 'intercultural' space occupied by Indigenous organisations (Martin 2003), and the difficulties of *managing the tensions* between formal governance structures and methods and the informal structures and relationships within communities, including strong family groupings.
6. The complexities of administering different *reporting requirements* from different funding sources, and the burden of constant submission writing for renewal/expansion of funding sources with the need to 'invent innovation' to meet funding guidelines.
7. Difficulties in developing and maintaining *effective linkages* with other agencies whose contributions to care are necessary.

This list is similar to one that might be produced in relation to service failure in mainstream health services, particularly in smaller organisations and rural areas.

Community control as a governance model

The principle of community control is one of the key features of Indigenous-specific agencies and one of the cornerstones of the development of these services (Shannon *et al.* 2002). It is based on the political goal of self-determination (Griew *et al.* 2003; Anderson 1994), and the practical goals of improving community capacity and tailoring services to meet needs in ways that will be accepted by Indigenous people. It essentially requires that ownership and governance of the health agency are vested in the local Indigenous community, generally through the mechanism of a local Indigenous board of governance and an Indigenous CEO. This arrangement aims to enable the local community to decide on its priorities, policies, management structure, staffing and service profile, within funding guidelines.

Community control emerged with the founding of the first Aboriginal Medical Service in Redfern NSW in 1971, and has been closely held and valued within the sector and more broadly by

Indigenous communities. It was accepted as a fundamental part of the National Aboriginal Health Strategy (NAHSWP 1989) and is endorsed in the National Strategic Framework for Aboriginal and Torres Strait Islander Health (NATSIHC 2003). The principle of community control has similarities to the traditional and still common governance structures of some public hospitals, community health centres and other mainstream health agencies (including the substantial non-government sector).

While the concept of 'cultural appropriateness' is generally endorsed in relevant government policies, government agencies and policy analysts also express concern that good corporate governance may be compromised in Indigenous organisations precisely because of adaptations of generally accepted governance principles. Areas of concern include weaknesses in the separation between board and management roles; and in the application of conventions for avoidance of conflict of interest, for example through strong demarcation between the roles and interests of recipients and providers of services (Martin 2003). We note that these issues also give rise to governance problems in mainstream agencies.

Shannon *et al.* (2002), in their assessment of achievements, developed a typology of forms and methods of community control and community participation. They describe a broad continuum of engagement with Aboriginal and Torres Strait Islander communities, with five levels—community-controlled, community-initiated, community-grounded, community-adopted and community-oriented projects (Shannon *et al.* 2002, p. 12).

The key issue from a health system perspective is quality health care supported by good governance and effective management.

The Commonwealth Grants Commission has endorsed the importance of 'working partnership arrangements and effective community control of services' (Commonwealth Grants Commission 2001, p. 133) and the Government has endorsed the importance of community engagement in its response to the Commonwealth Grants Commission report (Commonwealth of Australia 2002). This policy position is supported by the findings of Shannon *et al.* (2002), which reiterate the widespread though hard won general support in Aboriginal and Torres Strait Islander health policy for the participation of Aboriginal and Torres Strait Islander people and organisations in primary health care. The successful projects they reviewed demonstrated

> '…the value of diversity at a local level within a national framework that provided consistency in policy direction. The success of a range of models of community participation reflected the importance of engagement of the community, rather than the necessity of one prescriptive model' (Shannon *et al.* 2002, p. 66).

They also stress the need for diversity, to 'reflect the diversity inherent in Aboriginal and Torres Strait Islander communities', shaped within the broad strategic directions that might ensure equity in access to care.

We propose two policy principles and a number of practical areas for action to enhance the effectiveness of governance in Indigenous organisations. Firstly, future funding should be provided at levels that enable agencies to achieve critical mass for good governance and effective service delivery. A regional approach to governance structures, with local arrangements for service delivery, is the most practical method of achieving this goal given small, dispersed populations. Alignment of regional boundaries, and the size of regions, should be based on the design requirements for effective health care delivery. Arrangements to accommodate existing small agencies will be required.

Secondly, the principle of Indigenous governance of Indigenous-specific services should remain strong, and the forms and types of organisations that are accommodated by this principle should continue to develop, in accordance with Indigenous community needs and the needs of ACCHSs. At the same time, the validity of other forms of engagement for specific services and purposes (such as partnership arrangements and Indigenous services and committees within mainstream agencies) should be recognised.

Practical strategies to enhance governance capacity are also required. The key requirements (in place or underway in some areas) include the following.

- Access to key areas of ***technical management know-how*** and capacity, either in-house or through other means, including accounting and financial management, information systems, human resource management and industrial relations, and legal and other support for compliance with applicable standards and regulations.
- ***Development of governance, leadership and management skills*** through effective learning programs and methods, and identification of the essential skills and experience required of board members. Resources are required to enable trialling and evaluation of a range of approaches to support emerging and current Indigenous leaders in health care (including both formal teaching and alternative approaches such as mentoring, coaching and learning sets).
- Support for the development, testing and evaluation of ***policies and procedures*** to guide boards, managers and staff in the fulfilment of governance and management requirements.
- ***Alignment of funding programs, accountability and reporting requirements*** to enhance security of funding, reduce the burden of reporting and submission-writing, and encourage focus on meaningful indicators of throughput and impact of service delivery.
- ***Infrastructure for quality improvement*** activities, including clinical protocols (see Couzos & Murray (2003) and the CARPA manual [CARPA 1997]), good IT and data systems, benchmarking, and a user-friendly evidence base.

Case study: factors supporting effective governance

Nganampa Health Council (NHC) has worked hard to achieve good governance. NHC was established in 1983 and took over management of the health service from the South Australian government in 1985. The administrative centre for the health service is at Umuwa and there are six major clinics and three health worker stations. NHC receives approximately $9 million dollars per year from a range of sources.

The governing body (the Council) has 20 members, including the Director (who is an A<u>n</u>angu person), A<u>n</u>angu Health mayatjas (managers), an elected representative from three health worker stations, three elected representatives of the Women's Council, four elected general representatives from the A<u>n</u>angu Pitjantjatjara Lands, two elected A<u>n</u>angu Health Worker representatives and the Chairman of A<u>n</u>angu Pitjantjatjara.

The Council meets every four to six weeks. The NHC committee is provided with technical, clinical and financial advice. The Health Services Director presents options and potential consequences in decision making and problem solving, the Medical Director provides advice on medical and clinical matters and the finance manager provides financial planning advice. A principle of 'twinning' has been established, by which Anangu and non-Anangu managers work together in complementary roles. NHC also has processes to obtain input from other staff (including having representatives on the NHC and through getting reports from staff at meetings).

The NHC has overseen the development of very effective models of primary health care (see section 3.7) that are demonstrated by measurable impacts and improved health outcomes over time.

Source: Shannon & Longbottom 2004

While the principle of community control is well established and clearly supported in public policy, achieving good governance is a continuing challenge for Indigenous-specific agencies, as it is in the mainstream. We propose the development of a robust framework for the Indigenous-specific service system, including the specification of a basic platform of services, combined with action in accordance with the principles and strategies outlined above, to support continuing development of good governance.

4.3.2 Governance in the mainstream

Attention to Indigenous health at the governance level of mainstream health care organisations (public and private hospitals, regional health services, divisions of general practice, community health, mental health, disability services and many others) is patchy. Indigenous community representatives, and Indigenous health professionals can make a significant contribution in this area, and some States (notably South Australia and New South Wales) have incorporated Aboriginal Health Advisory Committees into the governance arrangements for mainstream health agencies. However, there is no consistent approach to engaging Indigenous people in mainstream health care planning and management.

There are some outstanding examples of initiatives taken by health care agencies to ensure better access for Indigenous people, and to enhance the relevance and effectiveness of their services. For example, in recognition of a failure to engage with Aboriginal and Torres Strait Islander communities in a strategic planning process, the Parks Community Health Service in South Australia undertook work to build relationships with local Aboriginal and Torres Strait Islander people that, over time, resulted in the establishment of an Aboriginal Health Committee. This committee developed strategies that would be effective and acceptable to the local community and was successful in securing funding for a team of Aboriginal Health Workers.

The Aboriginal Health Team has developed joint services and programs with other Aboriginal and community organisations. This work has also involved examining how mainstream agencies can validate different cultures in their policies, practices and processes. A key impact is an increase in the number of Aboriginal and Torres Strait Islander people using mainstream services at the Parks Community Health Centre (Tesoriero 1995). Such efforts seem to depend on a combination of motivation by clinical and management leaders in the organisation, a critical mass of demand or use, and the availability of resources.

There is also evidence that research bodies, both government (NHMRC and others) and non-government (such as the national foundations for various illnesses or organs), are instituting policies and procedures to ensure that the research agenda is relevant to Indigenous Australians, and that research on health care delivery and health system design addresses their concerns and supports the development of tailored interventions to meet their needs.

The learned colleges of the health professions, peak bodies such as the AMA and the organisations that support general practice (including the divisions and their peak bodies) are also increasingly attending to their responsibilities for Indigenous health. However, practice on the ground by divisions, as evidenced by vigorous participation in partnerships and initiatives with Indigenous health organisations, remains very variable (Commonwealth of Australia 2003, p. 47).

Attention to the needs of Indigenous communities by mainstream health care providers and other mainstream agencies is patchy, and the governance levels of these organisations bear responsibility for ensuring that Indigenous Australians enjoy equitable access to needed services. Measures to formalise and consolidate that responsibility are required.

4.3.3 Capacity of government agencies

Martin (2003) suggests that it is not only Indigenous capacity that needs to be built, but that capacity of government and its agencies is often a major limiting factor in addressing disadvantage. Policies, procedures, funding program 'rules' and the conduct of relationships are seen as insufficiently responsive to the challenges of health care delivery and to the realities of Indigenous communities.

Government departments and their officers as well as Indigenous organisations, communities and their representatives need the skills for strategic engagement in relationships for planning, funding and accountability. The middle-level officers of government departments, who function as the major interface with health care providers, need content knowledge and management skills. Health care provider organisations express frustration about rapid staff turnover, asymmetric timelines (i.e. a perception that deadlines only apply to the less powerful) and the length of the chain-of-command in government departments. At the same time, providers acknowledge the support they receive from Department of Health and Ageing and state/territory department staff, and the commitment of many staff to improving Indigenous health.

While there is much good practice and constructive engagement, we would suggest that the effectiveness of public administration of Indigenous health could be improved through careful examination of current strengths and weaknesses (e.g. through organised constructive feedback on performance) and use of the results to revise operating procedures, program guidelines and staff training programs.

4.4 National system development for Indigenous health

Since the *National Aboriginal Health Strategy* (NAHSWP 1989), and the transfer of responsibility for Indigenous health to the Australian Government health portfolio in 1994–95, a slow but steady development of supportive policy platforms and national implementation plans is evident. The evaluation of the NAHS (ATSIC 1994), and its conclusion that implementation of the 1989 strategy had substantially failed, led to recognition that achieving coordinated action was a very difficult challenge, one which required concerted and sustained effort.

4.4.1 National leadership and coordination

Since 1995–96 the Australian Government (both alone and in concert with states and territories) has progressively implemented strategic reforms aimed at enhancing the health care system for Indigenous Australians at the national level. The *National Strategic Framework for Aboriginal and Torres Strait Islander Health* (NATSIHC 2003) provides a consistent strategic direction, and was endorsed by all Australian governments in 2003. National coordination is now addressed through NATSIHC and SCATSIH; and the Framework Agreements reinforce the strategic direction in each state/territory jurisdiction. Information and data improvement are being addressed through the NSFATSIH, SCATSIH, NAGATSIHID, the ABS and the AIHW; and the *Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework* (SCATSIH 2002) provides guidance for all relevant parties. With the exception of AIHW and the ABS, all of these initiatives or bodies, and many more, are less than seven years old.

The picture at the state/territory level is complementary, with the development of new forums, advisory bodies and methods of engagement with the Indigenous community. The Framework Agreements negotiated during the latter half of the 1990s established commitment from all jurisdictions to:

- develop national and state/territory level forums;
- introduce regional planning;
- increase allocation of health sector resources to reflect the level of need; and
- place a priority on improvement in data collection and evaluation (Anderson *et al*. 2002).

Continuing national leadership is essential to maximising the performance of the health system for Indigenous health. The leading and coordinating role of the Australian Government is clearly accepted, but the roles of states and territories in funding and coordinating major parts of the health system mean that coordination between the levels of government is a critical challenge. Elaborate arrangements to achieve coordination between levels of government and with Indigenous organisations and community representatives will continue to be needed, and will continue to require financial and human resources to maintain. Creativity is required to ensure that coordination is achieved where it adds value, and that the 'policy disconnect' noted by Indigenous organisations is avoided.

Many of the necessary elements of national coordination for Indigenous health have been consolidated over the last ten years.

- The *National Aboriginal and Torres Strait Islander Health Council* was established by the Minister in 1996 and restructured in March 1999 following a review of its operation. The Council has played a key role in linking the development of national Aboriginal and Torres Strait Islander health policy and strategy with local and regional developments. It is charged with bringing together the Framework Agreement partners as well as a range of other people with expertise to provide national policy advice.
- *State and Territory Health Forums* were established in each state and territory under the Framework Agreements to decide on key issues in regional planning, to contribute to policy development and to evaluate the implementation of the Framework Agreements. The Forums include representatives from the Australian Government, state and territory governments and the Torres Strait, ATSIC (the Torres Strait Regional Authority in the Torres Strait) and the Aboriginal and Torres Strait Islander community-controlled health sector. The Forums have achieved varying levels of success to date.
- The *Standing Committee on Aboriginal and Torres Strait Islander Health* (SCATSIH) provides advice to the Australian Health Ministers' Advisory Council on matters of Indigenous health.
- The *National Public Health Partnership* is a mainstream inter-governmental working arrangement to plan and coordinate public health activities, provide a more strategic and systematic approach to addressing health priorities and provide a vehicle to assess and implement major initiatives, new directions and best practice in population health. It has adopted a policy requirement that attention to Indigenous health be included in all mainstream public health initiatives (National Public Health Partnership 2002, p. 2).
- The *Joint Advisory Group on General Practice and Population Health*, which is made up of four nominees of the National Public Health Partnership (NPHP), and four nominees of the General Practice Partnership Advisory Council (GPPAC), also includes a nominee of NACCHO to improve the link with Indigenous community-based primary health care services (OATSIH 2003b).

NACCHO and its state/territory affiliates provide leadership in the field and act as advocates for the interests of their members.

These policy and strategy platforms demonstrate political and institutional will and promote coordination in action on Indigenous health. As Shannon & Longbottom (2004) found from case studies, one of the clear contributors to success in Indigenous health care delivery was political commitment, and the location of projects within a supportive policy framework. For example, Queensland Health's Indigenous Workforce Management Strategy—sponsored by the Director-General—provided the necessary authority and policy commitment to make Indigenous recruitment an acceptable performance indicator at district level, and to ensure workforce change. The Western Australian Aboriginal Identification Project (Young 2001) is another example of the influence of national strategies, in this case in response to recommendations of the Aboriginal and Torres Strait Islander Health Information Plan as endorsed by the Australian Health Ministers' Advisory Council.

Impact of supportive policy on effective care: Katherine West

The Katherine West Coordinated Care Trial (CCT) demonstrates the benefit of a supportive policy environment. Katherine West used the opportunity afforded by the CCT to explore new funding and structural options, with a resulting improvement in health services. Having established its policy 'niche', the Katherine West CCT has been influential in the development of arrangements for PHCAP, which potentially allow models of coordinated care to be extended and modified, bringing additional primary care resources and a new approach to funding. Shannon & Longbottom (2004) concluded that the continued development of a policy framework for Aboriginal and Torres Strait Islander health was an imperative. The building of broad consensus in policy direction, and a commitment to coordination and integration is crucial to effective progress, and the experience of the Katherine West CCT is an exemplar of this effect.

While national coordination and negotiation arrangements are vital, continuing leadership and commitment are required to ensure that they are focused on achieving results on the ground, and that their work bears fruit. The current arrangements are necessarily complex, but we would recommend that these structures remain in place to guide and support the development of additional capacity and enhanced effectiveness in the provision of Indigenous health care and healthy public policy.

4.4.2 Existing portfolio allocation should be maintained

The location of responsibility for health within the Australian Government Department of Health and Ageing is virtually universally supported within the health sector, including by Indigenous health organisations. The reasons for this support include the greatly enhanced ability to bring public health and medical expertise to bear, the emerging evidence of effectiveness, and the record of achievement over the last eight years in the allocation of increased funding from within the health budget to Indigenous health. The benefits of location within the health portfolio also include an enhanced ability to benchmark spending and strategies in Indigenous health with mainstream standards and approaches; and greater engagement of the mainstream health system, state/territory health authorities, training institutions and learned professional colleges than would otherwise be the case. Responsibility for Indigenous health should remain with the mainstream health portfolio.

A long-term strategic policy framework with appropriate resource commitments is seen as essential to support and sustain further achievements in Aboriginal and Torres Strait Islander health and to enable further capacity building, enhanced sustainability of programs and improved health outcomes. The location of responsibility for health within the Australian Government Department of Health and Ageing is virtually universally supported within the health sector, including by Indigenous health organisations.

4.5 Workforce development

A competent workforce of adequate size is critical if both mainstream and Indigenous-specific health services are to be effective. Currently, the capacity of the workforce is a key limiting factor in the provision of health services to Indigenous Australians, in rural, remote and urban areas.

The workforce required to provide comprehensive primary health care to Indigenous Australians includes a diverse mix of health care providers (general practitioners, Aboriginal health workers, nurses, allied health, mental health and public health personnel) and a range of skilled professionals to manage and administer complex services (including health service managers, accountants, human resources personnel, data managers and IT providers).

4.5.1 Current workforce issues

To deliver effective services, whether through Aboriginal community-controlled health services or through mainstream agencies, the workforce needs to be highly skilled (both clinically and in the provision of culturally appropriate services), and available. There are currently a number of limitations with respect to both skill and availability of the workforce that need urgent and sustained attention. These include the low capacity of mainstream agencies to provide culturally appropriate and evidence-based care to Indigenous people who often have co-morbidities and complex care needs (Department of Health and Aged Care 2001a); the limited number of appropriately skilled personnel in rural and remote areas; and the limited number of Indigenous health care professionals. In 2001 only 0.9% of health care providers were Indigenous (3742 people)[6], and of these, 853 (23%) were employed as Aboriginal Health Workers (AIHW 2003a, p. 18). Excluding this category, the proportion is a tiny 0.7%—this number would need to be increased almost four-fold to reflect Indigenous representation in the population as a whole (2.4%).

The following table provides an overview of the percentage of Indigenous people participating in selected categories of the health workforce in 2001.

Table 4: Indigenous and total health workforce 2001 in selected categories

Worker category	Total number	Total Indigenous	%
Medical staff (including general practitioners, specialists, medical administrators, trainees)	46 804	151	0.3
Nurses (including registered and enrolled nurses and nursing assistants)	244 419	1 916	0.8
AHW (Indigenous health worker)	915	853	93.2
Dentists and dental workers	25 052	155	0.6
Pharmacists	12 046	10	0.1
Allied health professionals	38 645	133	0.3
Complementary therapies	6 926	24	0.3
Environmental health officer	3 302	114	3.5

Source: AIHW 2003a, p. 85-86

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[6] Health care providers include medical, medical imaging, dental, nursing, pharmacy, allied health, complementary therapies and other personnel.

There are fewer total health and community services workers in remote areas than in major cities (1498 health workers per 100 000 population in very remote Australia compared to 3005 in major cities; and 796 community services workers per 100 000 population in very remote Australia compared to 1008 in major cities) and high rates of staff turnover in these areas (AIHW 2003a, p. xiv). Rapidly growing areas on the outskirts of major cities also experience low relative numbers of health and community service workers.

However, some progress has been made in recent years, as evidenced in the 2001 census results:

- 44 general practitioners identified as Indigenous, 50% more than in 1996;
- 61 Indigenous medical administrators in 2001, almost three times the number in 1996; and
- 921 registered nurses identified as Indigenous, 33% more than in 1996 (694).

4.5.2 Current initiatives

It is imperative to address workforce issues if the capacity of both mainstream and Aboriginal community-controlled health services is to be increased. A coordinated effort by Australian Government and state/territory governments is required to address the training, supply, recruitment and retention of appropriately skilled health professionals, health service managers and health policy officers to work in both mainstream and Indigenous services (Standing Committee on Aboriginal and Torres Strait Islander Health 2002).

All Australian governments endorsed the Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework in 2002, which provides a consistent approach to Indigenous primary health care workforce development. This work is progressed through the AHMAC Aboriginal and Torres Strait Islander Health Workforce Working Group. The key objectives of the health workforce strategy are:

- increasing the numbers of Indigenous people working in all health professions;
- improving the clarity of roles, regulations, recognition, training and support provided to Aboriginal and Torres Strait Islander Health Workers;
- addressing the development needs of other professionals, both health care providers and managers, contributing to Aboriginal and Torres Strait Islander health;
- improving the training, recruitment and retention of both Indigenous and non-Indigenous staff working in Aboriginal and Torres Strait Islander primary health services; and
- making governments accountable for achieving these objectives and supporting Indigenous people to drive the process.

Health professionals

In 2002, 35 Indigenous students commenced a course in general medicine, compared to 22 in 2001 (DEST data). The membership of the Australian Indigenous Doctors' Association (AIDA) in 2003 included 55 Indigenous medical practitioners and 70 Indigenous medical students.

Several initiatives which aim to improve workforce capacity are underway. The Puggy Hunter Memorial Scholarships Scheme, which provides scholarships to Indigenous students in health careers, was established in 2002. AIDA and the Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN) continue to increase their capacity and provide a higher level of assistance and support to their members, especially medical and nursing students.

The Indigenous Nursing Education Working Group (established by OATSIH in 2000) has formulated recommendations to increase the participation of Aboriginal and Torres Strait Islander people in the nursing workforce and to increase the competence of the nursing workforce to deliver culturally appropriate care to Indigenous Australians (Indigenous Nursing Education Working Group 2002). Recommendations address recruitment and retention of Indigenous nurses, curriculum development and implementation, advanced nursing practice and post graduate education, articulation between Aboriginal Health Worker courses and university study, establishment of partnerships between Aboriginal and Torres Strait Islander communities and universities, and monitoring and accountability. The working group is pursuing the implementation of its recommendations with universities, nursing registration boards and others, with a focus on developing a consistent approach to the education of nurses about Aboriginal and Torres Strait Islander health and culture.

It is generally recognised that as a group ACCHSs experience ongoing shortages in their workforce. A recruitment and retention package for health professionals employed by ACCHSs is required, including individual retention payments (similar to the Rural and Remote GP Program) weighted towards remote and rural services, and recognising the additional difficulties of retaining staff in non-urban areas. Rural health workforce agencies assist ACCHSs, among others, in GP staff recruitment and retention, and this service could well be extended to other health professions.

OATSIH intends to provide a mechanism for strengthening salary supplementation for doctors, nurses and allied health workers employed by Australian Government-funded, Indigenous-specific agencies, especially in rural and remote areas. A key element in attracting medical staff to work in Indigenous primary health care is to ensure that service in Aboriginal and Torres Strait Islander communities contributes materially to a doctor's career. Currently, leaving the proximity of the major teaching hospitals in the larger cities can have a negative effect on the chance of a doctor being accepted for specialty training or advancement. OATSIH proposes to work with the colleges to ensure that service to Indigenous communities is recognised for these purposes.

Aboriginal Health Workers (AHWs) play a key role in facilitating access to the health system for Aboriginal and Torres Strait Islander people, and there is a need to enhance their skills, raise their professional status and establish the potential for their training to articulate to tertiary sector training and health careers. Community Health Services Training Australia (CSHTA), a national industry training advisory board, is developing revised AHW competencies, aimed at strengthening their role and capacity, with completion expected in 2005. Negotiations to establish AHW associations in each state and territory are taking place, with the first association already established in South Australia.

An implementation package is required to support the new national AHW competencies currently under development, drawing on the lessons learned from the under-utilisation of the 1996 AHW national competencies. This will require the development of standard learning resources, a comprehensive competence assessment strategy, support for ACCHSs for ongoing training and associated salary costs, articulation into the tertiary sector and support for community-controlled Registered Training Organisations. Consistency of application of national competencies across Australian Government and state/territory-funded primary health care agencies is also necessary.

Some important steps in ensuring that mainstream health professionals are trained in Aboriginal and Torres Strait Islander issues have been taken. The Committee of Deans of Australian Medical Schools has made an explicit commitment to increasing enrolments and retention of Indigenous students, and has completed a draft Indigenous studies curriculum, intended to be a standard component of all medical degrees. The Royal Australian College of General Practitioners and some GP divisions are also active in workforce training and development. The Australian Nursing Council also recently endorsed a recommendation that all state and territory nursing registration boards incorporate Indigenous studies in nursing curricula. A Masters of Applied Epidemiology (Indigenous Health) course is operating at the Australian National University (National Centre for Epidemiology and Population Health). OATSIH has funded nursing courses with a focus on Indigenous health at Deakin and Sydney universities. The Queensland General Practice Alliance has been funded to assist GPs in providing accessible services to Indigenous clients. There does not seem to be similar progress in some other important professions, including dentistry and allied health.

OATSIH intends to pursue a coordinated package of initiatives designed to increase the number of Aboriginal and Torres Strait Islander people working in the health professions. This includes improved retention and support services for Aboriginal and Torres Strait Islander students in tertiary health courses, student incentives, cadetships and scholarships, incentives for innovative course design, on-campus support mechanisms and support for professional associations. Professional associations are key vehicles in providing the close personal support that has been shown to be effective in improving Aboriginal and Torres Strait Islander graduation rates. OATSIH will continue to work closely with the Australian Indigenous Doctors' Association, the Congress of Aboriginal and Torres Strait Islander Nurses and the proposed national Aboriginal Health Worker association. OATSIH will also work with the GP Education and Training program to ensure that 10% of all GP registrar training places are identified as Indigenous health training places.

Given the significance of the undersupply of health professionals, it would make sense for governments to invest in further strategies to increase the participation of Indigenous young people in health professional education (Objective 1 in the Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework). This is clearly a long-term investment, and an inter-departmental responsibility, and should be sustained for at least 10 to 15 years. The strategies for Objective 2 (roles, regulation and recognition of Aboriginal Health Workers) and the other objectives in the Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework would provide a quicker return, and could be pursued more vigorously with a significant investment.

Management and other support staff

The need for professional development for management and other staff should also be addressed. Areas such as IT, planning, accounting, evaluation and general management are in need of attention.

A health management training course jointly funded by the New South Wales Government, the Department of Employment and Workplace Relations (DEWR) and OATSIH, managed by the Australian College of Health Service Executives and delivered by the University of New England, assists Indigenous managers and aspiring managers to undertake mainstream health management qualifications. It is proposed that this program will be developed nationally as a multi-site program of health management studies, with additional funding support to be sought from state and territory governments and DEWR. This initiative would focus on assisting Indigenous managers or aspiring managers with a track record in health or related sectors to attain recognised mainstream qualifications.

Good human resource practice is also important, and funding to enhance HR management skills (in areas of recruitment, retention, performance management, staff development, job design) for organisations providing health care to Indigenous people could also be allocated.

Management and leadership development for Indigenous managers and board members provides an important opportunity to improve governance and the retention and performance of staff. A small number of strategies should be trialled and evaluated, and the successful ones should be made available at regional, state/territory and national level. Indigenous organisations have a key role as settings for learning, and as the carriers of experience and technical knowledge.

The establishment of stronger regional networks or regional services may also assist in the management of workforce problems. Health professionals and managers are often attracted to diversity and development opportunities in their jobs, and the potential to work across a regional network may assist with staff recruitment and retention.

4.5.3 Good human resource management practice is also needed

While overall supply of health professionals and skilled support workers is a critical issue, it is also true that agencies can act to improve their ability to attract and retain good staff. Nganampa Health Council, for example, has acted consistently and over a long period of time to enhance its management of staff, provide needed on-the-job training (as well as being a registered provider of training), and provide a supportive working environment for staff (Shannon & Longbottom 2004). Nganampa still experiences staffing difficulties, but they would be more severe without good HR practice.

Good human resource practice improves recruitment and retention

An analysis of existing human resource management within a number of effective Indigenous primary health care services has suggested key requirements for effective recruitment and retention strategies (Shannon & Longbottom 2004; Department of Health and Aged Care 2001b). These include:

- the leadership and cultural knowledge of Indigenous management and staff;
- a clear philosophy and mission statement that recognises the value of skilled committed staff and is relevant to their work;
- a well-defined organisational structure with clear roles and responsibilities, and the necessary mix of staff and skills to support an organisation of its size;
- managerial and administrative expertise and a dedicated financial manager;
- a dedicated human resources manager;
- critical mass of staff and resources;
- annual reports produced every year, providing a comprehensive overview of the organisation’s work including financial statements;
- clear policies and procedures, reviewed and updated as required;
- an ongoing program of review and evaluation;
- regular clinical staff meetings (3–4 times per year) to review goals and strategies;
- a recruitment strategy that involves bringing short-listed applicants to visit communities and understand the environment in which they would be working;
- an intense orientation process that includes a focus on cultural issues, the local service delivery context and practical issues (e.g. four-wheel drive training course);
- probation arrangements and active performance management;
- terms and conditions for staff that reflect an understanding of the demands placed upon them and the personal and professional isolation that can be felt working in remote communities. For example, a one-week break every 12 weeks, in which staff are required to leave the remote setting; an open phone policy, which encourages staff to seek advice and de-brief on difficult issues;

- staff supported in their roles by skilled technical advisors and visiting specialists;
- staff supported by key local community people with specialised knowledge;
- a professional development program which staff are encouraged to undertake and which is related to service activities;
- secure recurrent funding for staff training programs;
- career advancement possibilities within the organisation;
- a high value placed upon the role of the Aboriginal Health Workers as a critical component of the primary health care system;
- a comprehensive accredited Aboriginal Health Worker training program;
- long-serving staff who carry corporate memory; and
- adequate salaries.

The availability of a skilled workforce is a major limiting factor on the capacity of the health system to provide effective health care to Indigenous Australians. The Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework (SCATSIH 2002) sets out specific objectives and methods of pursuing them, and provides a policy framework for addressing workforce shortages. Strong investment in workforce development will be important as part of an overall strategy to enhance Indigenous access to effective primary health care. Good human resource management practice also contributes to agencies' ability to attract and retain good staff.

4.6 Information and data

Good information and data is required to support planning, evidence-based practice, quality improvement and for monitoring and reporting on changes over time. To be most useful, this data should be accurate, consistent, tracked over time and freely available to all who want to use it, especially Indigenous communities and health services.

4.6.1 The National Strategic Framework for Aboriginal and Torres Strait Islander Health: goals and strategies

To support the collection, collation and publication of accurate comprehensive data, capacity building at the local, state/territory and national levels is required. Priorities have been specified in the National Strategic Framework for Aboriginal and Torres Strait Islander Health. In relation to improving data availability and quality the National Strategic Framework for Aboriginal and Torres Strait Islander Health makes the following recommendations:

- Continuing implementation of the National Aboriginal and Torres Strait Islander Health Information Plan;
- Developing consistent environmental health audit tools and environmental health indicators for Indigenous communities;
- Linking data collection activities at all levels of government between health services, housing agencies and other community and welfare programs to facilitate a cross-sectoral approach and support preventative and environmental health activities;

- Conducting representative surveys where there are important information gaps (such as oral health);
- Improving the quality, collection and management of health workforce data in both mainstream and Aboriginal community-controlled health services.

In relation to the development of data, information management and utilisation at the service level, the National Strategic Framework for Aboriginal and Torres Strait Islander Health specifies:

- development of minimum data sets useful for planning at local, regional and state/national levels;
- development of a framework that clarifies the nature and purpose of existing data and identifies and addresses gaps; and
- investment in information technology and staff skills to enable establishment of improved data systems in primary health care services, including computerised patient records for use as care planning tools, and improved resources for evaluation and analysis of health system data.

Further, the National Strategic Framework for Aboriginal and Torres Strait Islander Health recommends that to improve data quality and availability, continuing oversight of data issues by the National Advisory Group for Aboriginal and Torres Strait Islander Health Information and Health is needed. It is essential to make sure that Indigenous people are involved in developing data collections so that they are appropriate to their needs. It is also vital to ensure that:

- the ABS standard for Aboriginal and Torres Strait Islander identification is used in all data collections;
- training and support to health care staff for collecting data about Aboriginal and Torres Strait Islander status at all collection points is provided;
- the employment of Indigenous people by organisations involved in data collection, analysis and research is encouraged;
- the ABS survey and census collection program is maintained;
- mainstream data collections include adequate samples of Aboriginal and Torres Strait Islander peoples; and
- annual reporting of the Aboriginal and Torres Strait Islander National Performance Indicators is maintained.

These goals and activities need to be adequately resourced. Activity to address both the national- and agency-level information needs is underway, and is described below.

4.6.2 Information for clinical, management and accountability needs

The data required for national collections of health status, and for monitoring at the national level are often different from the data required for management, evaluation, and quality improvement at the agency level. This information is vital to the effectiveness of care and for accountability, and will also require resourcing.

A Service Development and Reporting Framework for OATSIH-funded services is being developed. This work is intended to make reporting easy for service providers, and to enable them to use the information they collect for continuous quality improvement and evaluation. Compliance with reporting will be built into accountability requirements under the single funding agreements.

It is critical that data collection for reporting is not over-burdensome for agencies (Sibthorpe *et al.* 2003, p. 2), can be incorporated into daily practice, and produces information that is meaningful for communicating with communities. This means that routine data collection is necessarily limited in scope. To complement routine datasets, it may be useful to establish nationally coordinated sentinel sites for comprehensive data collection on specific issues or activities. Establishing sentinel sites would also enable piloting of data collection methods and refinement of data. The Cooperative Research Centre in Aboriginal Health and other research groups have the needed capacity to support this work.

4.6.3 Information for health system performance measurement

Growing demands for health care, rising costs, limited resources and evidence of wide variations in health care practice have prompted interest across the world in the measurement and improvement of health system performance.

Indicators of long-term health outcome (such as increased life expectancy at birth) are too distant in time from the factors that impact on health to be useful for policy makers and others in their endeavours to measure the success of programs and interventions. Focusing only on the longer-term outcomes can create the perception that nothing is changing and engender a sense of hopelessness, when in fact there may be good evidence that gains are being achieved (SCRGSP 2003).

Performance indicators should enable measurement of health system functions and should provide answers to questions about relationships between different elements of the system (e.g. between health financing, and the level and distribution of health services) (Murray & Frenk 2000). Good data collection is clearly critical if performance indicators are to be meaningful.

Interim National Aboriginal and Torres Strait Islander Health Performance Indicators, which were intended to enable governments to report on progress towards improving Indigenous health, were endorsed by AHMAC in 1997. These indicators covered mortality and morbidity, access to and impact of health services, workforce development, health risk factors, intersectoral issues, community development, and quality of service provision and were reported on in 1998, 1999 and 2000 (ABS & AIHW 2003). A refined set of 56 indicators and a draft framework were developed by the Cooperative Research Centre for Aboriginal and Tropical Health in consultation with the AIHW, OATSIH, SCATSIH, NHIMG and NACCHO and endorsed in 2000 (ABS & AIHW 2003). These indicators pertain to government inputs, social equity, access to health services, risk markers and outcomes for people (Burns *et al*. 2002). However, data for reporting against indicators were either not available or of poor quality in many jurisdictions and all jurisdictions have agreed to continue reporting and to attempt to make improvements to enable complete coverage in the future (ABS & AIHW 2003). SCATSIH has prioritised 15 indicators (see Table 5) and is overseeing a scoping project to identify the improvements that are needed to enable reporting against them.

Table 5: Priority indicators from the current National Performance Indicators for Aboriginal and Torres Strait Islander Health

Outcomes
Life expectancy at birth
Infant mortality rate
Low birth weight babies
Child hearing loss
Vaccine-preventable disease rates
Overweight and obesity
Sexually transmitted infection rates
Age-specific death rates and ratios
Impacts
Pap smear rates
Childhood immunisation
Smoking prevalence
Alcohol consumption
Inputs and processes
Government expenditure
Indigenous workforce
Access to health care
Management of key conditions

In May 2003, SCATSIH agreed to oversee the development of a national Aboriginal and Torres Strait Islander Health Performance Framework (ATSIHPF) to support the implementation of the National Strategic Framework for Aboriginal and Torres Strait Islander Health, consistent with the mainstream National Health Performance Framework (Australian National Health Performance Committee 2001). This Framework includes three levels: health status and outcomes, determinants of health and health system performance. Equity is intended to be built into each level. The health system performance level has nine dimensions (effective, appropriate, efficient, responsive, accessible, safe, continuous, capable and sustainable). OATSIH is currently undertaking work to define each of the dimensions of health system performance from Aboriginal and Torres Strait Islander perspectives as well as to map existing indicators that may be useful.

Both the National Aboriginal and Torres Strait Islander Health Performance Framework and the Service Development and Reporting Framework should be supported. It is essential that indicators of primary health care performance are harmonised across the two frameworks, using common data definitions (where relevant) and ensuring that processes of collection, processing, collating and analysing data are synergistic.

Investment in improved data collection by primary health care providers is essential, but needs to be focused and streamlined. As much as possible, routine data collection in primary health care organisations should be a by-product of administrative and clinical processes. Routine comprehensive collection on some key indicators should be complemented by sentinel site surveys and research. The Aboriginal and Torres Strait Islander Health Performance Framework project is expected to deliver valid indicators of impacts and outcomes.

The work by AIHW, ABS, OATSIH, state/territory health authorities and health care providers over recent years to improve data collection, including the identification of Indigenous status, provides a strong foundation, but further effort is required. We conclude that the elements of an effective performance monitoring system are in place or in progress, as a result of focused effort over several years, and results should be forthcoming within a reasonable timeframe.

4.7 Working with other sectors: healthy public policy

Governments and health systems are often criticised for failing to work effectively with other sectors, and thereby failing to take advantage of opportunities to enhance the health impacts (or reduce the health risks and consequences) of policies and programs in other portfolios of government and in industry generally.

The goal of intersectoral collaboration is pursued vigorously in rhetoric, but is in fact a real struggle to achieve. There are many good reasons for this—health is not the goal of living, but a resource for living, and not every decision can be based on health considerations. Lack of attention to health goals by other portfolios is also an inevitable downside of the necessary structuring of the work of government into functional portfolio areas.

However, effective intersectoral collaboration can strongly enhance the effectiveness of health expenditure. Beaver and Zhao estimate that it might be possible to increase the benefits of primary health care by 35% when other sectors, and the community, are highly engaged (Beaver & Zhao 2004, p. 34). There is evidence of consistent effort by Indigenous organisations to take advantage of this potential leverage. For example, service activity reports show that approximately 80% of Australian Government-funded Aboriginal and Torres Strait Islander primary health care agencies have undertaken some school-based activity; approximately 75% have provided support for public housing issues (OATSIH & NACCHO, 2003); while 20% have organised store-based dietary interventions (Keys Young 1997). The Keys Young report notes that capacity to do this appears to be linked to funding—better-funded services are more likely to be proactive.

The critical factors for success seem to be a combination of:

- an important health issue at stake;
- a practical method, with a strong cost–benefit case, of enhancing health impact (or minimising health risk) within another system; and
- leadership at the key pivot point, which may be local, regional, state/territory or national.

The best approach to enhancing the effectiveness of intersectoral collaboration may be to establish the conditions that *enable* opportunities to be exploited, rather than attempting to set up machinery that *requires* reporting about collaboration (such as a mandatory health impact statement), which does not have a proud record of success. Very different approaches might be needed at local versus national level, and while uncertainty about effectiveness remains, experimentation should continue. The following conditions might enable opportunistic gains in this respect:

- Recognition of the legitimacy of primary health care providers working with key local services such as schools and councils, to identify health hazards that can be addressed locally;
- Strengthening of information systems through which local and regional patterns of health problems can be identified and analysed;
- Support for local and regional coordinating mechanisms, such as standing cross-portfolio forums, which build relationships and create opportunities for collaboration;
- Development of mechanisms to enable primary health care providers to generate quick responses to maintenance/environmental issues that directly impact on health, such as leaking sewage drains.

The current program of Shared Responsibility Agreements under the aegis of COAG (Office of Aboriginal and Torres Strait Islander Affairs 2003) are a potentially important move to enhance the capacity of government to work across portfolios and the Australian Government/state/territory divide, and with Indigenous communities. Careful evaluation of this initiative will provide valuable insight into the factors that drive success as well as those which impede it.

Analysis of models from Canada (for early childhood policy and services) (Budgell 2002), the UK ('joined-up government', again often focused on support for families with young children) and the USA could also offer useful insights (Eades 2004).

It is important that work on intersectoral collaboration be focused at 'the pointy end'—that is, be driven by substantive opportunities rather than simply general principles. As noted earlier, there is an ever present risk of wasting time and resources on enterprises with little chance of success.

It would be useful to select a small number of key intersectoral issues, in collaboration with Indigenous organisations, for follow-through. Examination of the non-health determinants of key Indigenous health problems indicates that the following issues may be high priority:

- Family and community violence and abuse
- Support for early childhood development and effective parenting
- Improving educational opportunities for disadvantaged children (both health and social disadvantage)
- Trauma and injury prevention
- Alcohol and substance use
- Environmental risk factors (local and regional).

The following principles should apply.

- Clinical and public health expertise should be made available for working with other sectors, as this is the 'value add' the health system can offer.
- ACCHSs and other primary care agencies/services should be recognised as a strong source of knowledge about local and cultural issues, and should be resourced to participate in intersectoral work. At the same time, the reality that they cannot alone be responsible for outcomes on issues outside their control must be recognised.
- Engagement with industry should be based on local issues and specific evidence for effective methods.
- ATSIC and ATSIS are important partners for interactions between Indigenous communities and other Indigenous programs.

We suggest that approaches to intersectoral collaboration should be pitched at two levels. Firstly, Indigenous primary health care organisations should be resourced to pursue local opportunities to address health risk factors and preventable illness through working with other sectors on practical programs with a health component, and the legitimacy of their roles as advocates should be recognised. Secondly, at the national level, a short list of key issues should be identified and proposed to government for endorsement as a required focus for cross-portfolio action by the relevant departments. We would strongly urge that this list include a focus on early childhood development and health, for two reasons: this area is critically important for the future of Indigenous communities; and there is good evidence regarding a range of cost-effective interventions (Eades 2004).

5 Measuring improvements and required investment

The fundamental question that this paper addresses is whether increased (that is more equitable) investment in comprehensive primary health care for Indigenous Australians will result in a measurable improvement in health and wellbeing; and if so, how best should that investment be deployed. Our assessment is that there is now sufficient knowledge about how to invest additional funding for health gain that a planned progressive increase in investment is warranted. This part addresses the impacts and outcomes that might be achieved, the required level of Australian Government investment, and the funding methods and programs required. A short conclusion completes the paper.

5.1 Measuring the impact of adequate investment

It will be important, as part of a program of increased investment in primary health care for Indigenous Australians, that a manageable number of sensitive indicators of health outcomes and impacts are chosen and consistently monitored over time. People can then focus on ensuring that data collection and data quality activities provide the information needed to support sound monitoring. However, indicators are just artefacts that stand as signposts towards the goal of equitable health outcomes and cannot be allowed to displace the goal itself (as those who have focused on surgical waiting lists in various states have inevitably learned).

The lead times between increased investment in effective programs and improved health outcomes as measured by life expectancy are long. If the goal is to ensure that investment in health care is effective, it is more useful to monitor intermediate indicators of outcome and impact, because these indicators are more sensitive and results can be assessed in a shorter timeframe.

Only sustained effort will bring results

‘Current Indigenous mortality rates are at a level last seen for all Australians back in the early 1950s. For overall life expectancy, the corresponding reference point is the early 1920s. Given these excessive time lags in the profile of mortality, even if the pace of mortality change that has occurred among the total Australian population were to now apply to the Indigenous population, it would still take another 40 years before the Indigenous infant mortality rate reached the current level observed for the total population. Moreover, unless program efforts aimed at improving health outcomes for Indigenous Australians are dramatically enhanced, with commensurate effects, it will take another seven decades before the expectation of life at birth among Indigenous Australians reaches the level currently recorded for the total population. Clearly, the timetable for Indigenous mortality improvement is long term, and this adds further weight to the opportunity cost argument that there is an imbalance between health expenditure on Indigenous Australians and their needs’ (Kinfu & Taylor 2002, p. v).

The release of *Overcoming Indigenous Disadvantage: key indicators 2003* by COAG has established a new framework for developing useful indicators. The chosen goals and indicators are rightly focused on enabling effective monitoring of progress towards equitable outcomes for Indigenous Australians. However, the COAG framework is not specific enough to measure health system performance, and the indicators require further development and interpretation to be useful at this level (SCRGSP 2003, p. XXII).

The Aboriginal and Torres Strait Islander Health Performance Framework being developed by SCATSIH will include measures that reflect program logic for the whole health system from inputs through to outcomes and will distinguish between short-, medium- and long-term measurement of health system activity.

The ATSIHPF recognises that headline indicators such as mortality and life expectancy are significantly influenced by factors outside the control of the health system. Therefore, while health system performance will be measured against factors that are attributable to the health system, other determinants of health will also be measured to enable monitoring of progress across the whole spectrum of factors that influence health outcomes.

Health outcomes will be measured in relation to prevalence of disease and functional impairment, life expectancy, wellbeing and mortality. Determinants of health such as socioeconomic and environmental status, community capacity, health behaviours (e.g. smoking and excess alcohol consumption) and individual factors (e.g. blood pressure, cholesterol levels) will also be included. The ATSIHPF will measure health system performance in relation to nine domains of health system activity and overarching principles of quality and equity. One of the objectives of the Aboriginal and Torres Strait Islander Health Performance Framework is to include performance measures that recognise that comprehensive primary health care systems and appropriate secondary and tertiary health care are being developed, but have not yet been achieved.

Long- and short-term targets for improved Indigenous health and improved access to health care should be established on the basis of the Aboriginal and Torres Strait Islander Health Performance Framework and the Service Development and Reporting Framework, both currently under development.

5.2 Required level of Australian Government investment

This section examines current funding levels and patterns of use, and the estimated levels of spending required to enable equitable access to comprehensive primary health care; and to maximise health gain.

5.2.1 Current funding levels and patterns

The current level of spending on Indigenous health care is inadequate to meet the health needs of the population. Recent expert analysis of *total* spending and Indigenous health-care needs relative to non-Indigenous Australians (see below) shows clearly that less than half of the required funding is currently available. Within this total level of spending, there is also a mismatch of type of investment, with low spending on primary health care offset by higher use of hospital care (at approximately twice the rate of non-Indigenous Australians), which is neither good for health nor an efficient use of health resources.

Total expenditure on health services for Aboriginal and Torres Strait Islander Australians is estimated at $1245 million in 1998–99. This was equivalent to $3065 per person, compared with the $2518 per person estimated to have been spent for non-Indigenous Australians. This equates to $1.22 being spent per Indigenous Australian for every $1 spent per non-Indigenous person (AIHW 2001).

There are three major distinctions in types of health expenditure that must be understood in this field—mainstream versus Indigenous-specific, Australian Government versus other (state/territory, non-government and private), and primary health care versus secondary and tertiary care. Mainstream funding programs are major source of *total* health expenditure on Indigenous Australians, but if only primary health care expenditure is considered, mainstream *Australian Government* primary health care programs (MBS and PBS) provide less than half of the total.

The vast majority of *total* expenditure on Aboriginal and Torres Strait Islander Australians in 1998–99 (90%) was through mainstream Australian Government and state/territory health services, with inpatient hospital care making up the largest single component (36.4%, compared to 21.8% for non-Indigenous Australians). Only about 13% of total health expenditure on Indigenous Australians arises from use of mainstream Australian Government funding programs (including MBS and PBS), compared to 37% for non-Indigenous Australians (AIHW 2001). See Table 6 below for further details.

Table 6: Estimated health expenditure per Indigenous and non-Indigenous person 1998–99

	Per person Indigenous ($)	Per person non-Indigenous ($)	Ratio Indigenous/ non-Indigenous
Through state/territory programs			
Admitted patient expenditure	1 115	548	2.04
Other through state/territory program expenditure	1 090	372	2.93
Total through state/territory programs	**2 205**	**920**	**2.40**
Through Australian Government programs			
Indigenous-specific programs	298	1	..
MBS/PBS	224	601	0.37
Other Australian Government programs	169	336	0.50
Total through Australian Government programs	**691**	**937**	**0.74**
Through local government programs	**20**	**11**	**1.78**
Services through private sector programs	**148**	**650**	**0.23**
Total recurrent expenditure	**3 065**	**2 518**	**1.22**

Source: AIHW (2001, p. 4)

Setting aside state/territory and private expenditure, the largest avenue of delivery of *Australian Government funding* is through Indigenous-specific programs (43%), at a level of around $300 per person (AIHW 2001).

MBS and PBS spending has increased in recent years in response to changes designed to make medical and pharmaceutical services more accessible to Indigenous Australians, but is still less than half the equivalent spending on non-Indigenous Australians, without adjustment for need or remoteness. This is partly compensated for by grant funding through OATSIH, but the total level is still inequitable in comparison to non-Indigenous Australians, and inadequate to maximise health impacts and outcomes.

Adjustments for need and remoteness add significantly to total costs. Given the poorer health of Indigenous Australians, equitable access to health care would result in higher than average use. The additional cost of delivering services in remote areas, and other characteristics such as high proportions of patients who primarily speak languages other than English and lack literacy skills, mean that higher unit costs of care are also incurred.

5.2.2 Estimating needed funding levels

There is no simple answer to the question of how much funding will deliver the required level of access to effective care. The economic modelling that has been done in recent years (Econtech 2004; Commonwealth Grants Commission 2001; Mooney *et al.* 1998; McDermott & Beaver 1996; Beaver *et al.* 1996; McDermott 1995) has variously allowed for burden of illness, remoteness, costs of treating people with little or no English, and the costs of infrastructure. Estimates range from 2.2 to 7.3 times the average per capita resources required by the non-Indigenous population. OATSIH has analysed the modelling work, noting that some of the studies use data from specific populations, such as Indigenous people living in the NT. When figures are adjusted to take into account the Indigenous population on a national basis, and including allowance for remoteness and burden of illness, they fall between 3 and 6 times the national average per capita expenditure (OATSIH 2003e). The Commonwealth Grants Commission concluded that 'at least 2 times' average per capita expenditure was required given adjustment for poorer health status and greater reliance on the public system; and that this number would need to be multiplied by a factor of up to 2 to allow for the impact of greater costs in remote areas.

Econtech (2004), in a paper commissioned for the Review, estimates the required level of total health funding on a population needs basis (i.e. adjusting for the poorer health status of Indigenous people) at approximately 2.21 times the spending on non-Indigenous health care. There was no adjustment made for the additional costs of remoteness or for culturally appropriate services.

The Econtech paper also estimates the cost of bringing funding for Indigenous-specific services to the level currently provided to a set of eight 'best practice' Indigenous health services (2 very remote, 1 remote, 2 rural and 3 urban). Agencies were selected for the Econtech modelling on the basis of location (i.e. a mix of urban, rural, remote) and mode of service delivery (i.e. a mix of hub and spoke model, town-based service with outreach services and stand-alone service). In all cases agencies selected were high capacity sites demonstrating current best practice in the delivery of effective health primary health care services for Indigenous Australians.

The costing study indicates that, to extend the *current* level of care provided by these agencies to all Indigenous Australians, an average funding level of $890 per person is required (ranging from $2789 per person in very remote to $399 in urban areas). This is compared to the 1998–99 average per capita level of OATSIH funding of $295 per capita. The total cost of this level of funding is $409 million. The authors note the limitations of this method, including the lack of allowance for unmet need, for variations in the availability of alternative services or for inadequate staffing in some key areas (including specialists and allied health professionals). If an allowance is made for the cost of achieving adequate staffing in remote areas, the costs rise to $944 per capita or $432 million. They also note that this is modelling for the provision of 'best practice' in one component of the care system, Indigenous-specific services, rather than for a comprehensive care system. That is, the figures do not include mainstream programs such as Medicare, which would need to be considered as part of an integrated system. The authors also assume no increase above the current 'best practice' levels in any location, that is, no allowance is made for unmet need in the areas served by the chosen agencies.

The OATSIH analysis (OATSIH 2003e) concluded that the lower resource estimates emerge from modelling of the costs of a minimum level of health services. The higher estimates relate to the cost of providing additional services, to address health inequities and to provide culturally appropriate programs.

Health gain from additional resources is not a straight-line 'dose response' relationship. In a situation where there is inadequate primary health care to enable effective interventions to be provided to those who need them in a comprehensive, coordinated way, there is an outcomes curve. Too much money will give rise to diminishing returns, too little may not enable the system to reach the tipping point where health gain begins to be seen. This view is supported by the modelling undertaken by Beaver and Zhao (2004), and the strongly positive saving:cost ratios from optimal investment for the nine conditions, particularly arising from Clinical PHC (new cases) and Clinical PHC (existing cases) (Beaver & Zhao 2004, p. 21).

We conclude that total health spending on Indigenous populations would need to be increased to a level between 3 and 6 times the current national average per capita expenditure to achieve equitable access to effective care. It is beyond the scope of this paper to estimate the budget implications of applying this modelling to OATSIH and other funding programs.

5.3 Funding methods, programs and timelines

This section addresses the Primary Health Care Access Program (PHCAP) as a funding framework to resource comprehensive primary health care, then turns to funding formulae. We discuss the need for certainty and longer-term funding cycles; the need for a phased development program; and the need for effective accountability mechanisms. Our proposals are summarised in the final section.

There has been much progress in recent years towards making existing funding programs more effective, including the gradual implementation of PHCAP; improvements in the accessibility of MBS and PBS (addressed in section 3.3); growing understanding of the costs of service delivery; and increased funding for infrastructure, training and other development needs through OATSIH. Much has been learnt about how additional investments might best be deployed.

5.3.1 PHCAP provides a framework and a method

The Primary Health Care Access Program is a program of health system reform being implemented in partnership between the Australian Government, each state or territory government, the ACCHS sector and ATSIC (OATSIH 2003c). PHCAP has three objectives:

- to increase the availability of primary health care services in areas where they are inadequate;
- to reform the local health system so that it meets the needs of Indigenous Australians; and
- to empower people to take better care of their own health.

A formal agreement will be established between the Australian Government and each state and territory, via a memorandum of understanding (MOU), committing them to jointly fund improved comprehensive primary health care to better meet the needs of Indigenous Australians. Each MOU will include a commitment to:

- a range of potential models for service delivery with a preference for community-controlled models;
- joint funding arrangements that include maintenance of existing effort and an increase in resources in line with the arrangements in the Framework Agreements;
- financial transparency;
- potential funds pooling and other joint service arrangements; and
- re-investment of savings made in the acute sector from increased investment in primary health care (OATSIH 2003c).

The process is careful and complex. Funds are only allocated through PHCAP in states/territories where joint regional plans specified under the Framework Agreements have been completed. Only a few sites in each state/territory are being developed under this arrangement and many of these sites have a cap of 2000 on the population size that can be covered (as there were not sufficient funds to extend the program to the whole population). This has caused considerable debate and meant that implementation processes were more complicated than they might have been. It is intended that different implementation arrangements will be made in each state/territory, but implementation must ensure a joint approach to the roll-out of PHCAP and include strategic planning in the relevant local area. Local-level planning will include:

- identification of needs, priorities and gaps in both mainstream and Indigenous services;
- how services can be improved and expanded to form an effective and integrated local area health system; and
- governance and fund-holding arrangements.

The maximum level of funding to be allocated by the Australian Government under PHCAP is determined with reference to benchmarks that take into account the poorer health of Indigenous Australians and the increased cost of providing services in remote areas. The mix of funds will vary with the capacity to use Medicare (OATSIH 2003b). The basic benchmark is 2 times the average per capita use of MBS with an additional loading for remoteness (up to 4 times per capita use of MBS). The funding, which is assessed against the benchmark, includes funds currently utilised through the MBS, funds currently allocated for primary health care services and other funding. A total of $78.8 million over four years was allocated in the 1999–2000 Australian Government budget, and a further $19.7 million/year to be allocated from 2003–04 was committed in the 2001–02 budget, taking the total recurrent base to $54.7 million per annum (OATSIH 2003c).

Local-level planning provides opportunities to fill service gaps, improve links in the system (to improve care coordination and reduce duplication) and provide arrangements for greater community involvement (OATSIH 2003c). The case study below demonstrates the use of PHCAP to bring mainstream and Indigenous-specific services into partnership, with a net increase in the resources available to the local Indigenous community.

PHCAP sites include the four former Aboriginal Coordinated Care Trial sites, five sites in South Australia, seven sites in the Northern Territory and five in Queensland. A recent appraisal of the implementation of PHCAP strongly supports the program, identifying that the conceptual foundation, operational framework, long-term commitment and use of planning processes as a way of engaging communities and service providers are excellent aspects of the program (Mandala Consulting 2003). However, there is some concern in the field that the Program is 'too bureaucratic' and the machinery for approving expenditure under PHCAP is unnecessarily complex; that the 'rules' seem changeable; and that significant delays are being experienced as a result. Recommendations for improvement include simplifying the program, allowing greater flexibility to respond to different operating circumstances and expediting progress (Mandala Consulting 2003).[7]

Case study: PHCAP and the mainstream in Northern Adelaide

The strategic planning process undertaken in the Northern Metropolitan Region of Adelaide achieved a whole-of-system approach by engaging Indigenous community members and bringing them together with both Indigenous-specific and mainstream service providers.

The key to the success of the working relationships was a common vision to create a united Aboriginal Health Team. The mechanism was an MOU between two community-controlled health services and a mainstream community health service, which identifies clear service improvement outcomes. The planning identified service gaps for Indigenous people and proposed integrated mainstream and Indigenous-specific strategies to close the gaps.

Major achievements of the planning process were greater collaboration and coordination of programs and services on the ground and a significant increase in the commitment of the mainstream agencies to Indigenous health.

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[7] The Department of Health and Ageing is currently reviewing PHCAP and seeking to simplify arrangements for PHCAP implementation.

For example, during the course of the planning process the State Government increased their annual recurrent financial contribution by $747 800 with a commitment to an additional $519 000 in one-off funds for specific initiatives such as capital works and program development.

Additional Australian Government funds made available through PHCAP (including access to MBS and PBS) are supporting increased access to GPs, nurses and Aboriginal Health Workers, child and youth services, men's health, nutrition and diabetes programs. In addition, both Governments have made substantial commitments to upgrade and refurbish clinic facilities at the two health sites, which provide a 'shop-front' for delivery of a range of jointly funded services.

The CPHC approach provides for multidisciplinary health assessments and referrals to relevant allied health professionals, specialists, clinics and social services such as food banks and financial counselling (which now provide outreach sessions to both sites). Other actions include the development of culturally appropriate protocols with the major hospital in the region, and arrangements for referrals to local GPs.

Institutional racism is also being addressed, through revision of relevant policies and procedures, input to student training and cultural awareness training to achieve behaviour change in mainstream workers. This strong reform approach includes strategies to improve services for Indigenous people in the major public hospital in the region, as well as mental health services, GPs and prisons (including exit planning).

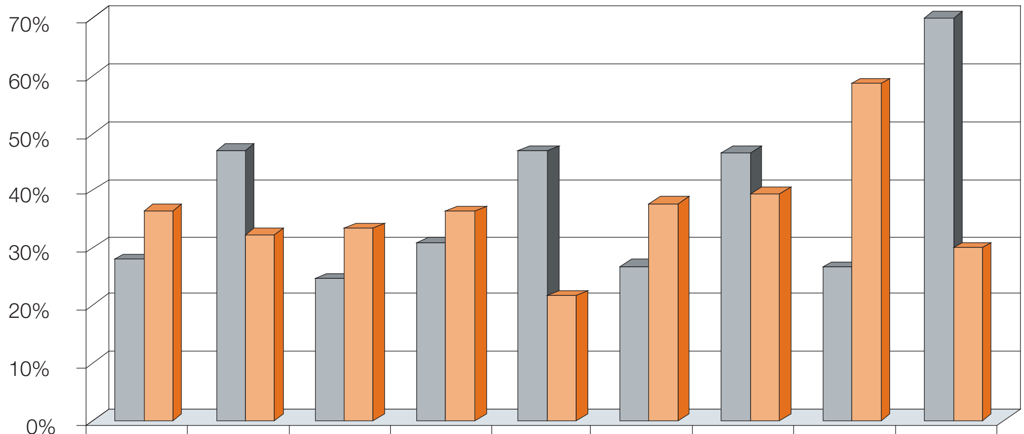
The planning process has given community members a greater understanding of the services in the region and an understanding of how PHCAP has the potential to improve them. A 'Leadership Group' has been formed to provide advice and oversee the planning, development and implementation of health and human services (both mainstream and Aboriginal-specific) for Aboriginal people in the region. This will ensure continuing involvement of the community in setting directions for the region and will maintain a coordinated approach to Aboriginal affairs by Aboriginal people for Aboriginal people in the region.

Case study provided by OATSIH 2003.

The National Strategic Framework for Aboriginal and Torres Strait Islander Health and the agreed regional health funding benchmarks established under PHCAP provide a useful basis on which to plan funding growth. The contributions made to primary health care funding by the Australian Government and state/territory governments vary in each jurisdiction. Figure 5 below compares these contributions with the PHCAP regional health funding benchmarks. These benchmarks are based on the 'basic' PHCAP model adjusted for regional cost variations. This gives an indication of the minimum level of resources required jointly between the Australian Government and state/territory governments to enable the development of effective primary health care services for Indigenous Australians.

In every jurisdiction, the Australian Government is providing well below the benchmark of what is provided for non-Indigenous Australians, largely because of under-utilisation of MBS and PBS programs. By contrast, in every state and territory with the exception of South Australia, the states and territories are funding at or above the benchmark. To assist in improving access to MBS funding, it would be helpful to allow primary health care providers to negotiate options including a choice between billing and partial cashing out the MBS aliquot for their populations.

Figure 5: Recurrent funding (1998–99) as a proportion of the PHCAP benchmark



	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Bench-mark
■ Commonwealth	28%	47%	25%	31%	47%	27%	46%	27%	70%
🟧 State	36%	32%	33%	36%	22%	38%	40%	59%	30%

Source: OATSIH (2003b, p. 7) using data from AIHW (2001)

Given the progress made under the PHCAP arrangements, and the investment in consultation, planning and negotiation forums, PHCAP offers the most practical and potentially most effective approach to a funding rollout. The key requirements to make this work include the following:

- increased investment, which will not only enable service development, but also give the parties to the enterprise a strong motivation to make it work;
- continuation of development of effective multi-party forums for planning and negotiation;
- continuation of the principle that funding increases are for additional services, not substitution; and
- engagement of mainstream providers as part of the system of care for Indigenous Australians.

Success for any partnership or alliance project, in the commercial world, in government and in the health care system, requires careful attention and considerable investment in relationship-building, including the development of trust and mutual understanding of business or policy imperatives and organisational cultures (Spekman & Isabella 2000). The PHCAP project faces all of these challenges, with the additional element of intercultural communication. No-one should be surprised that progress is initially slow, or that the road is rocky. The benefits are seen when mature alliance partners are able to work together to a level not previously possible and achieve mutually beneficial outcomes.

The ***Katherine West CCT*** has demonstrated the potential benefits of strategic use of increased resources. The pooling of an Australian Government allocation based on modelled per-capita PBS/MBS expenditure, and the Northern Territory Government's budget for the purchase of health services and administrative costs was backed up by an administrative contribution from OATSIH. The trial tested a potentially sustainable alternative method for funding primary health care that drew on Australian Government medical and pharmaceutical benefits, capitating and adjusting for relative need. While the method was debated, the testing of a new approach and commitment of increased funding has been successful in both health gain and good governance in a community control model (Shannon *et al*. 2002, pp. 55–56).

We recommend that the rollout of PHCAP continue and be accelerated using additional funding. PHCAP provides a framework for ensuring sound planning and allocation of funding, for collaboration between mainstream and Indigenous providers, and for managing the partnering relationships among key stakeholders, including governments, that are a necessary part of this endeavour. We considered the option of revising or rebadging the PHCAP program, because of the negative feelings in some areas about delays, and because of the inevitable wear and tear in partnership programs. We concluded that there is more to be gained by persisting, and not wasting the existing progress and learning.

5.3.2 Funding formulae and phasing

A range of funding approaches is required, both for different agencies and for different operations within agencies. A mixed model could involve tailored combinations of:

- a base grant for infrastructure (management, support services, training, IT, data collection and reporting) and for a base line service capacity (clinical management);
- capitation-based grant funding for a specified platform of primary health care services for the defined catchment population (which could in remote areas include non-Indigenous people);
- simple grant or fee-for-service arrangements (with low transaction costs) for services to additional patients (visitors, etc.);
- negotiated grants for specific additional services (i.e. for participation in 'vertical' programs, such as the Eye Health Program);
- capital and equipment funding, based on business plans.

Funds pooling is one method that has much to offer under the PHCAP umbrella, but it is not the only way to bring Australian Government and state/territory funding together, and should remain as one of a range of approaches. It may be particularly relevant in remote areas where there is only one provider, but joint funding of agencies may also be appropriate in other areas.

The need for improved funding is urgent, but the gap between current and needed levels (between 3 and 6 times the current OATSIH funding) is so large as to be unbreachable in the short term. A staged long-term program of growth in funding would be required to enable sustained growth in capacity, while also ensuring that the most effective interventions and service models are used. 'Front-loading' of investments in workforce development, governance capacity-building, data, information and other infrastructure for quality would enhance the effectiveness of funded service delivery and smooth the budgetary requirement.

5.3.3 Funding certainty

The literature review and over 100 case studies initially nominated for consideration by Shannon *et al*. (2002) (only 10 met their selection criteria for inclusion) demonstrated the 'stop–start' nature of past Aboriginal and Torres Strait Islander health policy and the short funding cycles that programs endured.

> ‘There has been a repeated search for innovation which results in a high turnover of projects and recycling of ideas, rather than utilising the not insignificant knowledge currently available and properly evaluating its effectiveness. The combination of rigorous evaluation, with realistic performance indicators, and extended cycles of funding would contribute to greater organisational stability and enable capacity building to occur.’ (Shannon *et al.* 2002, p. 66)

One of the clear requirements for improved performance in Indigenous primary health care is to move the balance of core and project-specific funding, so that higher proportions of total budgets are predictable. Reliance on ‘soft funding’ is a serious impediment to recruitment and retention of staff, and to strategic planning and development of services and organisations. Effective accountability must be assured, but ‘stop-start’ funding is not the best way (Shannon *et al.* 2002, p. 56).

The Australian Government (OATSIH) is aware of this problem, and much of its budget is allocated to service providers in a predictable way. However, OATSIH is not the only funder, and further progress towards reliable funding levels is needed.

Funding for ongoing primary care services needs to be made more certain, so that agencies can consolidate their focus on quality and effectiveness.

5.3.4 Accountability in a developmental framework

Accountability requirements should reward effectiveness, and enable the sharing of lessons learned. ACCHS organisations point out that their funding is more closely monitored than any other health sector. However, it is still important that funding and reporting requirements are designed so as to focus on the achievement of outputs rather than accurate accounting for inputs. It is equally important that the real costs of infrastructure and development are recognised, and that use of this portion of funding is monitored in appropriate terms (that is, in terms of capacity building rather than health service volume outputs) over an extended timeframe. The international development field may provide useful examples of methods for ensuring accountability while promoting sustainability and capacity-building.

The development of OATSIH within the Australian Department of Health and Ageing and its state and territory counterparts, and the evolution of community-controlled health organisations provide the basis for an increasingly comprehensive accountability framework for Indigenous health. However, Shannon *et al.* (2002) note that accountability regimes seem not to contribute to achievement in Aboriginal and Torres Strait Islander health practice, perhaps because responsibility for the projects they studied was diffused over a range of funders and other stakeholders. In most cases, financial accountability was to the funding agency, and requirements in this regard were clear. They also found increasing use of performance indicators to measure outcomes, and a growing focus on evidence-based approaches. However, staff were less likely to represent themselves as *strategically* accountable for their outcomes within a specific policy framework. Too many different accountability requirements in the pursuit of diverse policy and program objectives do not provide a good basis for coherent organisational strategy.

These findings and observations reflect dilemmas outlined earlier in this paper, that is, the challenge of balancing local agendas and community accountabilities with state/territory or national priorities, performance and accountability requirements. The diffusion noted by Shannon *et al.* (2002) is a significant challenge that needs to be managed collaboratively among the major stakeholders, including the funded agencies. The ongoing importance of the partnership forums and regional planning is highlighted by this dilemma. The need for sophisticated thinking about accountability measures is also brought into focus, and current work on the Aboriginal and Torres Strait Islander Health Performance Framework (outlined in section 4.6), will potentially provide one of the key technical requirements to enable accountability measures to be harmonised across jurisdictions and levels.

Shannon *et al.* (2002, p. 59) concluded that 'accountability, evaluation and funding reform were all possible, most usefully tied together in one package and necessarily related to processes of defining accountabilities to communities as well as funders'.

Reconciling community-level and system-level accountability

Programs in the Shannon *et al.* (2002) study with superior evaluation and accountability strategies had a more plausible story to tell about results. They showed that it was possible not only to reconcile accountability with community ownership but also that accountability constructed around very specific outcomes for community was the most powerful. Both the *Fixing Housing for Better Health* and the *Katherine West Coordinated Care Trial* were exemplars. They had strong lessons for both funders and service providers in Indigenous health (Shannon *et al.* 2002, p. 59).

Conclusion

The weight of the evidence we have considered in the course of preparing this paper has convinced us that the groundwork has been done and there is a clear pathway for government to fulfill its commitment to addressing Indigenous health disadvantage.

Summary of conclusions

- Government commitment to overcoming Indigenous disadvantage requires that policy and funding decisions be based on two criteria: the potential to provide equitable access to effective health care; and the potential for improvement in Indigenous health.
- Good progress has been made in recent years in the development of the service delivery system and system infrastructure, both mainstream and Indigenous-specific.
- Current access to and investment in Indigenous primary health care is too low, but the existing level is producing some positive health impacts and outcomes.
- Investment in comprehensive primary health care should be increased to a level between 3 and 6 times the national average per capita expenditure.
- Funding should be allocated through both Indigenous-specific and mainstream funding programs, and to both Indigenous-specific and mainstream providers.
- The principle of community control of planning, management and delivery of Indigenous primary health care services should be maintained, in accordance with the *National Strategic Framework*. Community participation in partnerships and other forms of collaboration with mainstream health care agencies is also needed.
- The Primary Health Care Access Program should continue to be used as the major vehicle for additional funding and for the development of effective partnerships and plans.
- Urban Indigenous-specific agencies should continue to be supported, in light of the needs of urban Indigenous people and in recognition of the roles these agencies play in developing the capacity of the mainstream health system.

- Indigenous health care should continue to be funded and administered as part of the health portfolio.
- The full potential of the mainstream health system to contribute to redressing Indigenous health disadvantage has not yet been realised, although there is increasing awareness of the need and commitment to contributing.
- Outcomes and impacts of increased funding should be monitored through the Aboriginal and Torres Strait Islander National Performance Framework currently under development. Sustained focus on a small number of valid indicators, focused on those conditions and targets that are sensitive to improvements in primary health care, and supported by robust data collection and analysis, are needed.

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Appendix: Outcomes, Impacts and Inputs for Indigenous health

The following tables give examples of achievements by Indigenous-specific agencies, both alone and in partnership with mainstream agencies. They have been chosen on the basis of availability of results (published or otherwise reported). They are typical of the types of outcomes primary health care services can deliver. The tables have been compiled with the assistance of staff of OATSIH.

Communicable disease control through vaccination

Vaccination is a highly effective public health measure that can produce rapid decreases in disease rates when effectively implemented. The introduction of Hib (*Haemophilus influenzae* Type b) vaccine is a good example, which all Australians should receive, according to the Australian Standard Vaccination Schedule (NHMRC 2003). Indigenous Australians also receive some vaccines that are aimed at preventing diseases that occur at higher rates in Aboriginal and Torres Strait Islander communities, including pneumococcal vaccines (different vaccines for adults and children) and in some areas Hepatitis A vaccine and BCG (for tuberculosis).

Outcomes	Impact/intermediate outcomes	Brief description of program inputs, processes/ structures	Program/reference
• Following the introduction of Hib vaccines there was a dramatic drop of >90% in notifications of invasive *Haemophilus influenzae* across Australia, in both Indigenous and non-Indigenous children. • In the Northern Territory the incidence of invasive Hib in Aboriginal children fell by 87% from 278 cases/100 000 child years (84 cases) in the pre-vaccination era to 37 cases/100 000 child years post vaccination. The number of cases of Hib in Indigenous children in Western Australia also dropped.	In the Northern Territory Hib immunisation coverage increased to 50% adequately immunised within one year of introduction of the vaccine, and to 75% within 3 years.	Conjugate vaccines for *Haemophilus influenzae* Type b (Hib) were introduced in Australia in 1993. Previously Hib was a major cause of infection (particularly meningitis) and death in Australian Aboriginal children, with some of the highest rates in the world reported in the Northern Territory.	Vaccination against *Haemophilus influenzae* type b (Hib). • McIntyre *et al*. 2002. • Markey *et al*. 2001. • Bower *et al*. 1998.

Outcomes	Impact/intermediate outcomes	Brief description of program inputs, processes/ structures	Program/reference
In North Queensland there has been a marked decline in invasive pneumococcal disease in Indigenous children from 21 cases in 2001 to 8 cases in 2002.	National data on immunisation coverage are not currently available, but there is evidence to suggest that Indigenous people who attend an Indigenous-specific medical service are more likely to be appropriately vaccinated than Indigenous persons who attend a general practitioner.	Provision of free conjugate pneumococcal vaccination to children at high risk from invasive pneumococcal disease (Indigenous children have up to 15 times the rate of this disease compared with non-Indigenous children living in urban areas).	National Childhood Pneumococcal Vaccination Program. • Hanna 2001 • Department of Health and Ageing 2003b. • Hanna *et al*. 2003. • Hanna, Hills and Murphy 2003.
In Far North Queensland the annual incidence of vaccine preventable invasive pneumococcal disease decreased from 111 cases/100 000 Indigenous adults in 1993–94 to 28/100 000 in 1999–2000.	In Far North Queensland 96% of the estimated Indigenous population over 50 received the influenza vaccine for the first time in the first five years of the program, and 73% the pneumococcal vaccine.	In Far North Queensland immunisation of Indigenous adults against influenza and pneumococcal disease commenced in 1996. The National Indigenous Pneumococcal and Influenza Immunisation Program was launched in 1999. Free influenza and pneumococcal vaccines were provided for all Indigenous adults over 50 and to those younger than 50 who had pre-existing conditions or alcohol-related problems but were in relatively good health.	Immunisation of Indigenous adults against influenza and pneumococcal disease. • Hanna *et al*. 2001.

Treatment of communicable diseases

Many communicable diseases cannot be prevented by vaccination, but are amenable to diagnosis and treatment in the primary health care setting. Early detection and treatment provides benefits in improved quality of life, prevention of later stage disease and prevention of complications, with associated cost savings. Examples of these are the treatment of sexually transmissible infections (STIs that are associated with infertility and increased risk of HIV transmission) and skin infections. Skin infections such as scabies put children at risk of developing skin sores (pyoderma), particularly those caused by Group A streptococci. Skin sores caused by Group A streptococci are associated with renal disease and possibly with rheumatic heart disease. Chronic infections in childhood are associated with failure to thrive, poorer long-term health and poor school performance.

Outcomes	Impact/intermediate outcomes	Brief description of program inputs, processes/ structures	Program/reference
Sustained reduction in the prevalence of STIs in the 12–40 age group: • Gonorrhoea prevalence fell from 61% in 1985 to 6% in 2002. • Chlamydia prevalence fell from 21% in 1985 to 5% in 2002. • Syphilis prevalence fell from 20% to <1%.	In 2001–02, 67% of 12–40 year olds participated in the annual STI screen.	Introduction of comprehensive STI and HIV control program in 1994 (which was built on in later years). The program includes: • separate clinics for men and women • annual screening of 12–40 year olds with follow-up treatment, partner notification and community education • improved systems for confidentiality • promotion of early presentation with symptoms • improving speed and accuracy of diagnosis and treatment • introduction of single dose therapy • reporting epidemiological data back to the community • services offered to people from the APY lands studying or in prison away from the lands • introduction of a Safe Ceremonies Strategy to promote safe practices during men's business.	Nganampa sexual health program, Anangu Pitjantjatjara (APY) Lands, SA. • Miller *et al.* 2001. • Shannon 2003. • Torzillo 2003. • Department of Health and Aged Care 2001b.
• The program has been extremely successful in reducing (from 35% to 12%) and maintaining a lower rate of community scabies for 15 months post intervention. • The prevalence of infected scabies fell from 11.5% to 0.5%. • Non-scabies pyoderma fell from 11 to 1.6%.	• More than 94% of children aged five years and under in the community were screened at each visit. • Repeat community treatment was not required because of sustained lower prevalence.	The Healthy Skin program was run in the Wadeye/Port Keats community in the Top End of the NT, commencing in June 2000. The program included: • educational programs • screening of children under 5 for scabies and pyoderma • children with infected scabies were given a single dose of intramuscular penicillin • a single community treatment day with scabicide (permethrin cream) • 2 community clean-up days • post treatment follow-up.	Factors supporting sustainability of a community-based scabies control program. • Wong *et al*. 2003.

Cancer screening

Cancer is the third highest cause of death in Aboriginal and Torres Strait Islander people (ABS and AIHW 2003). Indigenous people are particularly over-represented in deaths from oral cancers and cancers of female genital organs. Many of these cancers may be preventable: oral cancers are smoking-related; and cervical screening is a major preventive intervention against cervical cancer in women. Mortality from cervical cancer in Indigenous women is up to nine times higher than for non-Indigenous women (Condon 2004). Greater participation in cervical screening by Indigenous women will reduce this mortality rate. Many Indigenous women have not had adequate cervical screening due to poor health service access, cultural barriers and problems with screening quality due to concurrent infections.

Outcomes	Impact/intermediate outcomes	Brief description of program inputs, processes/ structures	Program/reference
	Achieved a high rate of cervix screening (61%) in the Alice Springs Remote area in 1997–99, which is comparable to the rate for Australian women generally (62%).	A program operating in a region with a high proportion of Indigenous women and with a long history of engagement with women and local Aboriginal Health Services. The NT Well Women's Program commenced in 1994, but Central Australia had a local Well Women's Program from 1988.	Northern Territory Well Women's Program. • Condon 2004. • Campbell & Kurnoth 2000.
	• Reduction in the percentage of women who have never had a Pap smear from 44% to 28% • Increased cervical screening rates for eligible women from 30% to 65% between 1992 and 1994.	Wurli Wurlinjang was established in 1992 and provides comprehensive primary health care services. The cervical screening program was established in 1993 and included establishing a Pap smear register and an intervention program (previously there had been no organised approach to cervical screening).	Cervical Screening Program, Wurli Wurlinjang Aboriginal Community Controlled Health Service, Katherine, NT. • Department of Health and Aged Care 2001b.
	Improved cervical cancer screening since Well Women's screening program established from 50% (1991) to 78% (1993).	Health services at Yuendumu are provided by Northern Territory Health. A well women's screening program, including cervical screening, was established in 1991. Women were recruited to the cervical screening program both opportunistically and by staff promoting the service when they visited camps and houses.	Yuendumu Cervical Screening Program, Northern Territory. • Gilles *et al*. 1995.
	• 79% of the Aboriginal female population of the Broome region were screened. • The program significantly increased the screening of Aboriginal women resident in remote communities from 26% to 42%. • 20% of women with past abnormal smears were screened within 4 months. • Smears taken by AHW staff were of high quality, none were technically unsatisfactory and over 90% had an endocervical component.	Broome Regional Aboriginal Medical Service (BRAMS) was established in 1978 and is part of the Kimberley Aboriginal Medical Services Council. In 1995 the service conducted a brief program to augment the Pap smear screening of Aboriginal women in the area. The program consisted of continuation of the existing opportunistic recall processes supplemented by three components: • development of an Aboriginal Health Worker-run Pap smear clinic • provision of Aboriginal outstation screening • active recruitment of targeted women. All components used *Health planner*, a computerised process tool to facilitate targeting and recall.	Augmentation of Pap smear screening of high risk Aboriginal Women, Broome Regional Aboriginal Medical Service. • Couzos *et al*. 1998.

Early detection and reducing complications of chronic diseases (including mental health)

Chronic diseases such as cardiovascular disease (particularly heart disease and stroke), diabetes and kidney disease are major causes of death and illness in Australian Indigenous communities. There are many common risk factors for these chronic diseases, including smoking, high blood pressure, family history, being overweight and having high cholesterol levels. This means that prevention activities targeted at these risk factors will have multiple benefits. Early detection and management of risk factors and chronic diseases reduces complications and slows progression of the disease, with associated cost savings from reduced secondary and tertiary care.

Indigenous men die from mental and behavioural disorders at four times the rate of other Australian men (ABS & AIHW 2003). Suicide rates in Indigenous men are 3–4 times higher than for other Australian men. The high rates of mental health problems are associated with high rates of alcohol and other substance use, disrupted social environments and high rates of violence in some Indigenous communities. Early detection and management of mental health problems can reduce rates of suicide and hospital admissions for psychiatric illness.

Outcomes	Impact/intermediate outcomes	Brief description of program inputs, processes/ structures	Program/reference
• In intervention sites, hospitalisations for diabetes-related conditions fell from 20% to 12%. In the comparison group hospitalisations fell from 22% to 20%. Between 1999 and 2002: • The proportion of diabetics with good glycaemic control increased from 18% to 25%. • The proportion of hypertensive diabetics with good blood pressure control increased from 40% to 64%. • Adult vaccination coverage for influenza increased from 55% to 68%, and for pneumonia from 63% to 74%.	• Health record review after one year of the trial identified significant improvements in diabetes care in communities across the Torres Strait, and especially in those communities with recall and reminder systems. Between 1999 and 2002: • Numbers of diabetics on registers increased from 555 in 1999 to 921 in 2002. • Except for regular HbA1c measures, all other care processes (regular checks of weight, blood pressure, urinary protein, serum creatinine, feet, eyes) improved significantly. • Primary care level clinical interventions (appropriate use reno-protective drugs, anti-hypertensives, insulin and recommended vaccinations) also improved.	In 1999, a one-year randomised cluster trial was conducted involving twenty-one remote Indigenous communities in far north-east Australia, (population about 9600). Locally managed recall and reminder systems were established in eight randomly selected clinics. Intervention sites also received staff training, regular phone calls, a newsletter and a mid-project workshop. All sites were supported by a specialist outreach service. After the trial, workshops were conducted to introduce recall and reminder systems into control communities. A follow-up audit was conducted in 2002.	Improving diabetes care in the primary health care setting in the Torres Strait. • McDermott *et al*. 2001. • McDermott *et al*. 2003.

Outcomes	Impact/intermediate outcomes	Brief description of program inputs, processes/ structures	Program/reference
- Reduction in blood pressure of those on medication. - Reduced progression to death and end stage renal disease by 62%.	- Health survey in 1995 showed a high prevalence of chronic disease risk factors including smoking, overweight, scabies, kidney infections. - In 1995 26% of the adult population enrolled in the program (46% were diabetic, 64% had hypertension and 67% had albuminuria) - 70% of those prescribed medication complied with treatment.	A research project to identify and treat those with risk factors and those with early stage renal disease was funded by the National Health and Medical Research Council in consultation with the Tiwi Health Council in 1995. This included use of antihypertensive medication for all people identified as suitable for treatment.	Tiwi Islands Renal Disease Project. - Hoy *et al*. 1999. - Hoy *et al*. 2000.
- There were 3 deaths from suicide in the mid 1980s, 9 in the early 1990s and 8 more in the mid 1990s. There were no suicides in 1997 and 1998. - In the three quarters ending in June 1996 there were 45–50 incidents of self-harm per quarter for males and 20–25 for females. This rate fell to 10–20 incidents for both men and women in late 1996 and to fewer than 5 in 1998.		The Yarrabah community has experienced three suicide epidemics beginning in the mid 1980s. In the early 1990s the Yarrabah Health Council, the community and visiting mental health professionals tried a number of strategies to prevent suicide, some of which they realised were not appropriate. However, over time, the community has developed a strong community-owned, community-level response to suicide prevention (the Yarrabah Family Life Promotion Program). This program has included training local people as Family Life Promotion Officers and linked closely with other community activities. Some of the other important elements of this program are: community ownership of the problem and the program; a social-historical understanding of health; a primary health care approach; a focus on community risk rather than individual risk; development of knowledge and skills; and time.	Yarrabah Community (far north Queensland) Family Life Promotion Program. - Department of Health and Aged Care 2001b. - Mitchell 2000. - Hunter *et al*. 1999.

Outcomes	Impact/intermediate outcomes	Brief description of program inputs, processes/ structures	Program/reference
• In the second year of the project, admissions of Aboriginal people to Geraldton Regional Hospital for psychiatric diagnoses declined by 58% with a reduction in bed days by 52%. • There was also a reduction in the number of Aboriginal people attending the hospital mental health outpatient clinic by 58%.	• At the end of 2 years, 61 Aboriginal people with mental health problems were 'on the file' of the Geraldton clinic, 22 were assessed and managed throughout the MidWest region and 52 were assessed and treated at Greenough Regional Prison. Most of these clients had not previously accessed mainstream mental health services. There were also significant numbers of non-Aboriginal people using the service.	The Maga Barndi mental health service was located at, and run through, the Aboriginal community-controlled Geraldton Regional Aboriginal Medical Service (GRAMS). It provided services to communities in Geraldton, the Midwest and Murchison areas in WA. The program included: delivery of clinical psychiatric services; staff training and forensic work. Service delivery included: regular clinical sessions at the GRAMS, six-weekly visits to provide clinical services and education to communities with highest identified need; telephone and clinical support on an as-needed basis to other communities; assessment of referred patients in their own homes; community-based follow-up; access to traditional modes of healing and psychiatric care; and assessment of the needs of local health professionals.	The Maga Barndi Mental Health Service, Western Australia. • Laugharne *et al*. 2002.

Improved child and maternal health outcomes

There has been a continuing gradual improvement in Aboriginal and Torres Strait Islander child survival in the last 20 years, but perinatal mortality for babies born to Indigenous mothers is still twice as high as for non-Indigenous mothers (ABS & AIHW 2003). Factors affecting poor pregnancy outcomes and early childhood survival include the age and health of the mother, access to antenatal care, duration of pregnancy (prematurity is a significant problem), illness during pregnancy, smoking in pregnancy and postnatal care. A number of health services and programs have been able to improve maternal and child health outcomes by addressing these contributory factors in a comprehensive way. Important common factors in successful mother and child programs include a family-focused, welcoming environment, continuity of care, integration with other services and outreach activities including home visiting.

Outcomes	Impact/intermediate outcomes	Brief description of program inputs, processes/ structures	Program/reference
• Reduced preterm birth rate (17% to 9.5%). • Reduced low birth weight (16% to 11.7%). • Reduction in perinatal deaths (58/1000 to 22/ 1000).	• In Feb 2000, 40 women per month attended the clinic, this increased to over 500 clients per month by January 2001. • 50% of women attending are presenting in the first trimester. • 93% of those attending had at least one ultrasound. • Doubling of the number of antenatal visits made per woman, with number having less than 4 visits falling from 65% to 25%. • Proportion of girls attending for antenatal care has increased from 15% to 20%. • Increase in number of women identified with STIs, all of which were treated. • Increase in number of immunisations from 362 per month in 2000 to 817 per month in 2002. • Care for sick children increased from 1095 episodes/month in 2000 to 3543/month in 2002. • In 2002 Women's business rose from 372 episodes/ month in 2000 to 1532/ month.	• Staff: program coordinator, 2 health workers, 2 female GPs, 1 child care worker and a driver. • Physical infrastructure: own building. Program features: • shared antenatal care with Townsville Hospital • all women seen by an Aboriginal Health worker and/or a midwife as well as a doctor • services provided to children including immunisations, growth monitoring, sight and hearing checks (and referrals to specialist services made as required) • workers from other agencies, such as CentreLink visit the service • The Tropical Public Health Unit supports additional programs that TAIHS is developing with the Mums and Babies project such as for breastfeeding and child nutrition • The Indigenous Health Unit of James Cook University assists with training of health workers • The Townsville Division of General Practice has assisted with new antenatal shared care booklets and posters.	Townsville Aboriginal and Islander Health Service, Mums and Babies Project. Commenced February 2000. • Atkinson 2001. • Department of Health and Aged Care 2001b. • Townsville Aboriginal and Islanders Health Services Limited 2002.

Outcomes	Impact/intermediate outcomes	Brief description of program inputs, processes/ structures	Program/reference
• Between 1984 and 1996 perinatal mortality rates decreased from 45.2/1000 to 8.6/ 1000. • Proportion of babies with low birth weight decreased from 14.2% to 8.1%. • Mean birth weight increased by 100 gm from 3080 gm to 3183 gm.	Steady increase over time of women receiving care (with targets met). By 1998/ 99 approximately 90% of women had their first prenatal visit earlier than 20 weeks, approximately 90% had more than 5 antenatal visits and almost 100% of women were having an ultrasound.	Strategy to improve antenatal care developed in response to identification of poor care as a key problem in the 1980s. The strategy includes: • care record system to be used in all clinics • antenatal care program with targets for each pregnancy. These are: first presentation before 20 weeks; more than 5 antenatal care visits; an ultrasound; an ultrasound performed at an appropriate time for estimating gestational age; have appropriate investigations performed and checked.	Antenatal care at Nganampa Health Council. • Department of Health and Aged Care 2001b.
	• Increased awareness amongst Aboriginal women of the importance of antenatal care. • Women present earlier in their pregnancy (36% of Indigenous women at Daruk present within the first trimester, compared with 21% at Nepean and 26% at Blacktown Hospitals' antenatal clinics). • Women attend for an average of 10 antenatal visits at Daruk compared to 6 at Nepean and nine at Blacktown. • Between late 1990 and late 1996 245 women utilised the Daruk program for 339 pregnancies (which is over 40% of the Indigenous women living in Western Sydney who gave birth in this period).	An antenatal program is part of the comprehensive primary health care provided by Daruk Aboriginal Medical Service. The program has established a good relationship with the Nepean Hospital Maternity Unit. The program is staffed by an Aboriginal health worker, a non-Aboriginal midwife and 2 female GPs. Program services include home visits, transport to clinics, ultrasound screening, support in labour and postnatal care.	Antenatal programs at Daruk Aboriginal Community Controlled Medical Service, Western Sydney. • Department of Health and Aged Care 2001b. • Daruk Aboriginal Medical Service and Western Sector Public Health Unit 1998.

Outcomes	Impact/intermediate outcomes	Brief description of program inputs, processes/ structures	Program/reference
• Increase in mean birth weight in intervention communities of 171 gm (compared to an increase of 92 gm in non-intervention communities). • Reduction in the proportion of babies born with low birth weight (from 20% to 11%). In non-intervention communities low birth weight fell from 17% to 16%. • Preterm births fell by 1.5%.	• Increase in the proportion of women who attended their first antenatal visit in the first trimester of pregnancy from 16.7% to 24.4%. • Increase in the diagnosis and treatment of genital infections during the study period. Following the trial, only 0.9% of women in pilot communities required treatment for genital infections compared to 37.4% in non-intervention communities.	This program was developed in conjunction with Aboriginal people in 3 communities in the Top End of the Northern Territory between 1992 and 1996. Intervention communities had high birth rate and high rate of low birth weight deliveries. The program involved community-based maternal education and support by respected community women (Strong Women Workers). Concurrent health service changes in pilot communities included improved access and improved testing and treatment for sexually transmissible infections. A comparison was done with NT Midwives collection to see how the intervention communities compared with other NT communities at the same time.	Strong Women, Strong Babies, Strong Culture Program, Northern Territory. • Mackerras 2001.
Between 1986 and 1995 the average birth weight of babies born to urban Alice Springs Aboriginal women increased by 100 gm from 3168 gm to 3271 gm (narrowing the gap with non-Indigenous babies to 50 gm).	• In the ten year period 1986–1995 there was an increase in the proportion of urban Alice Springs Aboriginal women starting antenatal care in the first three months of pregnancy, from 21% in 1986–1990 to 33% in 1991–95. • A large proportion of Aboriginal mothers used Alukura for antenatal care (In 1994, 98% of urban women and 18% of rural women).	• Congress Alukura in Alice Springs is the community-controlled Central Australian Aboriginal women's health and birthing centre and is a branch of the Central Australian Aboriginal Congress. Funding is provided by OATSIH, there are 14.5 staff positions and Congress Alukura is located in a specifically designed office and clinic 8 km from Alice Springs. • Services provided include: comprehensive antenatal and post natal care for mothers and babies; gynaecological services (including well women's checks, screening for STIs, contraceptive advice, infertility and menopause counselling and treatment); a visiting specialist obstetrician/gynaecologist; a limited bush mobile service; a visiting diabetic educator, healthy lifestyle and counselling service; a hospital and specialist liaison service; home visits and an education program.	Congress Alukura, commenced June 1989. • Ah Chee *et al*. 2001.

Outcomes	Impact/intermediate outcomes	Brief description of program inputs, processes/ structures	Program/reference
Since 2001 childhood anaemia has been reduced in the Darwin region from 51% to 19%. In some communities anaemia has been reduced to between 3–5%. Other regions of the NT have not shown the same reduction in prevalence of anaemia.	The interventions began in 2001, and there was steady decrease in anaemia prevalence in Darwin Rural communities from this time. Darwin Rural Services had support from child health nurse and public health physicians which was not available to the other two Top End Districts. East Arnhem communities have shown some reduction in anaemia prevalence, as has Alice Remote district, but the most significant reduction has occurred in Darwin Rural region.	A public health intervention in Darwin Rural communities (including Katherine) beginning in 2001, which included: • evidence-based literature review and guidelines • community discussion and collaboration • development of new protocols • clinical audits and feedback to health staff, managers and community members • education and training for health staff • effective use of recall systems • focus on best practise for managing childhood anaemia • development of local solutions by local staff and communities.	Primary health care intervention to reduce rates of childhood anaemia. Darwin Rural Services, DHCS. • Connors 2003.

Reduction in social and environmental risks

High rates of alcohol and substance use are risk factors for medical and mental health problems, and for increased rates of injury in communities. Alcohol and substance use in themselves are indicators of social and community disruption. In addition many Aboriginal and Torres Strait Islander communities have environmental factors which create increased risks of ill health and injury. These factors include overcrowded housing, inadequate rubbish removal, substandard water supplies and inadequate infrastructure to store, prepare and consume food. Primary health care services have been influential in bringing about changes in community alcohol consumption, and in reducing environmental health risks.

Outcomes	Impact/intermediate outcomes	Brief description of program inputs, processes/ structures	Program/reference
• Emergency evacuations due to injury decreased. • There was a reduction in alcohol and domestic violence presentations to hospital. • Criminal charges were static for the first 12 months of the intervention. During the following 12 months there was a fall of 18%.	• Alcohol consumption declined from 16.59 litres per capita in 1991–92 to 15.76 litres per capita in 1993–94.	In Halls Creek in Western Australia the community worked to reduce alcohol consumption, with the local health service playing an important advocacy role. The strategies employed included restricting trading hours, a school education program, an employment program, expansion of education opportunities and establishment of an arts centre.	Halls Creek community alcohol restriction program. • Douglas M 1998.
Reductions in violence and alcohol-related health problems. The number of people presenting at the Amata Clinic with alcohol-related trauma decreased from 41 in 1996 to 14 in 1997.	Significant reductions in the number of litres of alcohol purchased (between Jan–June 1997 the number of litres of alcohol purchased by the Roadhouse was 79% lower than the same time the previous year).	The communities living on the Lands around Curtin Springs in the Northern Territory took action to reduce alcohol consumption through negotiating conditions restricting alcohol sales with the Curtin Springs Roadhouse. The local health service played a critical advocacy role.	Curtin Springs, Northern Territory alcohol restriction program • D'Abbs et al, 1999.
• The incidence of injuries decreased from a mean of 96 /month prior to the intervention to 65 /month after the intervention. • The reduction in injury was across all age groups and injury types.		The Woorabinda Aboriginal Council provides a range of primary care services. Between 1997 and 1999 the Woorabinda Council in collaboration with the local hospital developed a number of intervention strategies to reduce injury, including restricting the trading hours of the Woorabinda public house.	Injury prevention project, Woorabinda, Queensland. • Shannon *et al*. 2001a. • Shannon *et al*. 2001b.

Increased access to primary and specialist health care, including mainstream services

Improving access to quality primary health care services (both Indigenous-specific and mainstream) and specialist services is an important factor in improving Aboriginal and Torres Strait Islander health. Factors affecting accessibility of services include not just physical location, but opening hours, staffing, types of health services provided, building infrastructure, community engagement, cultural appropriateness, transport arrangements and outreach activities. A number of services have demonstrated improved access for Indigenous clients by addressing these issues.

Outcomes	Impact/intermediate outcomes	Brief description of program inputs, processes/ structures	Program/reference
Major community gains in the areas of diabetes management, improved access to specialists and immunisation of adults and children.	Since 1995 the following has been achieved: • Health staff now include an Indigenous doctor, nurse and receptionist. • There was a dramatic increase in use of the service by Aboriginal people from 12 patient contacts in 1997–8 to 3894 patient contacts in 2000–01. • In the five-year period to 2000, Indigenous access had increased by 203%, whilst non-Indigenous access had increased 11.2% for the same period.	Inala has an Indigenous population of approximately 1000 people. The General Practice Health Centre (a mainstream general practice) worked with the local Indigenous community to improve access. Strategies included employment of Indigenous staff, purchase of culturally appropriate posters and artefacts, cultural awareness talks to all staff, disseminating information about the services to Indigenous communities and promoting collaboration between service providers.	The Inala Health Centre General Practice, Queensland. • Department of Health and Aged Care 2001b.
	Between 1997 and 1999: • When the service had been operating for 18 months, 90% of the Indigenous population of Point Pearce (234 people) had registered with the GP clinic with 739 attendances. • 100% of children and 50% of adults were immunised. • Almost 50% of the population had preventive health checks. • The nearest hospital in Maitland reported a decrease in Indigenous people being admitted.	The NYPCAHS established an Aboriginal Health Team and with Goreta Council established a small health centre at Point Pearce which is used by visiting service providers from NYPCAHS, other service providers and the Yorke Penisula GP Division who established an ante- and post-natal clinic. Preventive health check days for men, women and children are also run at the health service. GP services are available one day a week and the Aboriginal Health Team provides clinical services every day.	The Narungga Health Story, the Goreta Aboriginal Corporation (Aboriginal Council for Point Pearce) and the Northern Yorke Peninsula Community and Allied Health Service (NYPCAHS). • Department of Health and Aged Care 2001b.

Outcomes	Impact/intermediate outcomes	Brief description of program inputs, processes/structures	Program/reference
	• By 1999 – male patient access increased by 600%. • Access levels have been sustained. • Aboriginal leaders have confirmed that Yolngu men are now very interested in maintaining their good health. • Improved management of STIs. • Increase in identification and treatment of previously undiagnosed chronic disease	The service introduced a men's health program in 1996 to try to improve access to services for Aboriginal men. This includes a men's clinic that is separated from the main health service building. Employment of a male GP in 1998 expanded the range of men's services to include: STI management, contract tracing, health education and screening for chronic diseases. Employment of a male AHW was essential to the establishment and sustainability of the program.	Gapuwiyak Health Service in the Northern Territory. • Bryce 1999. • Department of Health and Aged Care 2001b.
	• The number of Koori clients accessing the DCH and identifying themselves as Aboriginal or Torres Strait Islander has increased by 85%. • Services accessed by Aboriginal people since the project began include medical, optometry, physiotherapy, podiatry, speech pathology, dietetics and counselling.	This work focused on developing collaborative working relationships at the local level between Aboriginal-specific or Aboriginal community-controlled organisations and mainstream services. The Service employed an Aboriginal community development worker in 1997, built collaborative working relationships with Aboriginal organisations at the local level, improved the cultural knowledge of non-Indigenous staff, and improved the cultural appropriateness of service models. The local GP division contributed funds to increase the hours worked by the Koori Access Worker to enable increased Koori/doctor relationships. An appropriate referral directory has been developed for GPs to use with Koori clients.	Darebin Community Health Service, Melbourne. • Firebrace *et al*. 2001.
	Between July 1999 & March 2000: • 59 clinic sessions were held. • 191 new patients were recorded with 423 visitations. • Of those accessing the service, 40% did not have a regular GP outside the service.	The Shoalhaven Division of General Practice in partnership with the South Coast Medical Services Aboriginal Corporation undertook a needs assessment to identify and respond to major health concerns of the Aboriginal community in 1999. This resulted in the establishment of a GP Aboriginal health clinic. The service includes provision of additional GP services outside the GP's surgery in a culturally appropriate setting. The service included a strong role for Aboriginal health workers in community education, population health, contacting and transporting women to clinical services, operating as a chaperone during Pap smear testing and sometimes doing pap smears.	General Practitioner Aboriginal Health Clinics Project, South Coast Medical Services Aboriginal Corporation. • Department of Health and Aged Care, 2001b.

Outcomes	Impact/intermediate outcomes	Brief description of program inputs, processes/ structures	Program/reference
	A range of improvements have occurred in services since the establishment of the KWHB in 1997. Since 1997 there has been: • A 22% decrease in total hospital admissions at the same time as there has been an increase in planned hospital admissions. • Increase in number of GPs, with resident GPs at three health centres. There has been a steady increase in the number of patients seen by KWHB: • 2000–01 – 22 140 • 2001–02 – 25 700 (14% increase) • 2002–03 – 29 959 – does not include Minyerri (14% increase).	The Katherine West Health Board was established in 1997 firstly as managers of the Coordinated Care Trial and now as a community-controlled health organisation with funds provided through PHCAP. Activities of the board have resulted in strong community control, development of management skills of board members, increase in staff numbers (which doubled in 2001/02), changes in the types of services delivered and the way they are delivered, and stronger service and workforce management capacity. Services are provided through 5 health centres and are also purchased from other providers such as Territory Health when required. Outstations and cattle stations are visited by a mobile primary care unit, population health services (such as women's health and drug and alcohol services) have been purchased, and specialist staff have been employed to expand environmental and nutritional programs. The KWHB is now able to assess and plan for the region's health needs, facilitated through health committees established in local communities.	Katherine West Health Board Aboriginal Corporation and Katherine West Coordinated Care Trial. • Shannon *et al*. 2002. • Mandala Consulting 2003. • Department of Health and Aged Care 2001b. • Katherine West Health Board Aboriginal Corporation 2003.
	• Congress shows improving levels of service capacity through its total episodes of care which have progressively increased between 1997 and 2001 by 21%, from 27 378 episodes of care in 1997–98 to 33 187 in 2000–01. • Improved collaborative planning for those with end-stage renal disease resulted in more people included on the transplant waiting list, increased accommodation options for people moving to Alice Springs from remote areas.	Service model includes: • comprehensive primary health care services delivered from Congress in Alice Springs • outreach services and transport service • collaboration with other services such as Alice Springs Hospital and Territory Health run services • visiting specialists, including in paediatrics, eye health, psychiatry, public dental and mental health Services provided: Sick care, home visiting, chronic disease clinics, screening programs, immunisation, hearing program, Alukura which delivers women's health care, Social and emotional health branch, substance misuse programs, educational programs, a male health program and community advocacy.	Aboriginal community-controlled comprehensive primary health care, Centre Australian Aboriginal Congress. • Bartlett & Boffa 2001. • Additional data from Service Activity Reports 1997–98 to 2000–01 provided by OATSIH.

Outcomes	Impact/intermediate outcomes	Brief description of program inputs, processes/ structures	Program/reference
	• Increase in number of Indigenous people from remote areas having access to medical specialists in their own communities (approx 3650 consultations and procedures occurred between 1997–99) • Reduction in average cost of consultations ($277 compared to $357 if patient had to go to Gove or Katherine and $450 at Royal Darwin Hospital. • Reduction in use of the Patient Assistance Transport Scheme resulting in direct savings and savings on senior nurse time. • Improved doctor patient communication and satisfaction with services. • Exposure and education of specialists to Indigenous health issues. • Education of primary health care staff in specialist areas.	The program was supported by the Royal Australasian College of Surgeons and the Royal Australian College of Obstetricians and Gynaecologists. Collaboration between primary care and specialist services and provision of specialist outreach services in community health centres in remote communities. Remote clinics provide a list of patients prior to the specialist's visit, transport to and from the airstrip, a consulting room, a driver to collect patients, practical support to assist the work, and a nurse or Aboriginal health worker to assist the specialist. Much of the follow-up care is provided by the primary health service. This program also contributes to education and skills transfer to primary health care service providers.	Specialist Outreach Program which commenced in the 1997 in the Top End of the Northern Territory. • Condon 2004. • Gruen *et al*. 2001. • Department of Health and Aged Care 2001b.

Appendix B: The overburden report

Dwyer J, O'Donnell K, Lavoie J, Marlina U & Sullivan P 2009, *The Overburden Report: Contracting for Indigenous Health Services*, Cooperative Research Centre for Aboriginal Health, Darwin. Available at: http://www.lowitja.org.au/crcah/list-crcah-publications

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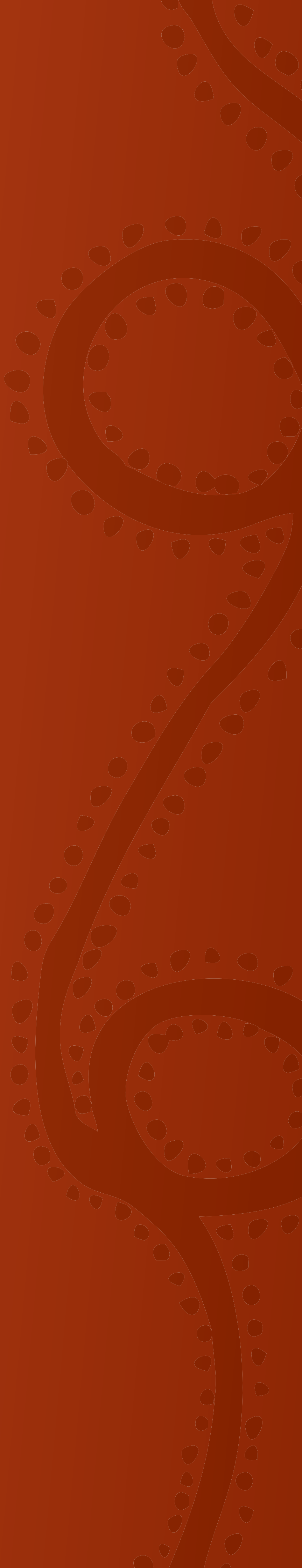

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Table of Contents

List of Tables

List of Figures

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The analysis in this report is focused on current problems and opportunities for improvement in funding and regulation. We hope that the body of the report also provides evidence of the good work, good communication and striving for improvement that goes on every day in Aboriginal Community Controlled Health Services and in the offices of government departments.

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Logo design

The logo represents the journey of the research team, travelling and talking with public servants and health service staff about the way primary health care is funded and regulated for Aboriginal and Torres Strait Islander peoples. The half circles represent people sitting; yarning up. The looping track represents the research journey backwards and forwards, checking information in the literature and cross-checking information with participants to ensure the facts are captured to tell the story *right way*.

Abbreviations

ACCHS	Aboriginal Community Controlled Health Service
CEO	Chief Executive Officer
CRCAH	Cooperative Research Centre for Aboriginal Health
DEEWR	Department of Education, Employment and Workplace Relations
DHF	Department of Health and Families
DHS	Department of Human Services
DoHA	Department of Health and Ageing
FaHCSIA	Department of Families, Housing, Community Services and Indigenous Affairs
HR	human resources
ICT	information and communication technology
MBS	Medical Benefits Schedule
NACCHO	National Aboriginal Community Controlled Health Organisation
NGO	non-government organisation
OATSIH	Office for Aboriginal and Torres Strait Islander Health
ORIC	Office of the Registrar of Indigenous Corporations
PBS	Pharmaceutical Benefits Scheme
PHC	primary health care
SAMSIS	Secure Aboriginal Medical Service Information System
SAR	Service Activity Reporting
SDRF	Service Development and Reporting Framework

Some Important Terms Defined

Aboriginal and Torres Strait Islander Community Controlled Health Services (ACCHSs): this term is used for agencies that are incorporated under the governance of a (predominantly) Aboriginal and/or Torres Strait Islander community Board, rather than being owned by government or non-Indigenous owners (referred to as non-government organisations or NGOs in this report). Many ACCHSs are members of peak bodies in each State and Territory—representative organisations that provide services to the member organisations (corporate support, strategic planning advice and assistance, help with funding negotiations, etc.) and advocate on behalf of members with governments and other parts of the health industry. Each State and Territory peak body is an affiliate of the national peak body—the National Aboriginal Community Controlled Health Organisation.

Funding and regulation: in this project, the terms *funding* and *regulation* are used to mean the finances that primary health care providers receive largely from governments, the conditions of funding, reporting requirements and accountability measures, and the way the providers and funders relate to each other.

Indigenous: we acknowledge the objections of some Aboriginal and Torres Strait Islander people and organisations to this term. It is used sparingly in this report where appropriate, for example, *non-Indigenous people*. It is also used where repetition of *Aboriginal and Torres Strait Islander* would make the text harder to read. This has enabled us to avoid the abbreviation *ATSI* to apply to people (we do use it to apply to organisations, such as *OATSIH*). The word *Indigenous* is capitalised in keeping with current practice, to indicate its specific use to apply to Australian Aboriginal and Torres Strait Islander peoples. It is not capitalised when used generically.

Mainstream: this is a term used in Australia to refer to non-Indigenous systems, institutions and practices.

Overburden: this term comes from the mining industry, where it is used to refer to the soil, rock and other materials that must be removed to get to the ore. We use it to mean the administrative work that has to be done by providers to acquire, manage, report on, and account for the funding they use to deliver services; and by funders to allocate, manage, monitor, acquit and report on the funding and the services and other activities it was used for. These are necessary functions, and can generate useful information for decision making, operational management, service quality and improvement, as well as for assessing outcomes and justifying further funding. But this is an overhead expense and effort, and should be kept to a minimum.

Primary health care (PHC): the *National Strategic Framework for Aboriginal and Torres Strait Islander Health* (NATSIHC 2003:17) identifies that PHC includes at least the following elements:

- clinical services (for management of chronic and communicable disease, acute care and emergency care)
- illness prevention services (including population health programs such as immunisation, screening programs and environmental health programs)
- specific programs for health gain (e.g. antenatal care, nutrition, physical activity, social and emotional wellbeing, oral health and substance misuse)
- access to secondary and tertiary health services and related community service (such as aged and disability services).

The concept of PHC is grounded in the Declaration of Alma-Ata, which resulted from the 1978 International Conference on Primary Health Care. There are several elements within the declaration that serve to constitute PHC:

> *It is the first level of contact of individuals, the family, and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process* (WHO 1978:VI).

The declaration further asserts that:

> *Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination* (WHO 1978:VI).

Executive Summary

In Australia, Aboriginal and Torres Strait Islander community health organisations play a significant role as providers of essential primary health care (PHC) in rural, remote and urban settings. Australian governments have developed policies and funding programs to support this growing health sector. But the current arrangements for funding are much criticised. Providers complain about fragmented funding programs, with too many reports required. Government staff also experience problems with administering these funds, with high workloads in processing and managing a multitude of programs and grants, and some lack of compliance by providers, particularly with activity reporting requirements.

This project aims to expand our understanding of these problems and find better ways of funding and regulating PHC for Aboriginal and Torres Strait Islander communities. Specifically, this report seeks to answer these questions:

- What are the major enablers and impediments to effective PHC delivery embedded in the current frameworks of funding and accountability for PHC services to Aboriginal and Torres Strait Islander people in Australian States and Territories?
- How could the effectiveness of funding and accountability arrangements be improved, drawing on insights from current Australian practice and international comparisons?

Contracting in health

Indigenous-specific health providers in Australia, Canada and New Zealand have emerged mainly as not-for-profit, community-governed PHC organisations. The relationship between the government and indigenous service providers is governed by contracts in all three countries.

Contracts are arrangements by which government funders specify the services they are *purchasing* for the community, and providers undertake to deliver them. These arrangements are specified in *service or funding agreements*, which are contracts between the funder (generally government) and the provider. Contracting creates some problems, but it is used by governments in many countries as a mechanism to enable community-based indigenous health services to be funded to provide improved access and responsiveness.

The theoretical framework for this study is based on contract theory, particularly the distinction between classical and relational contracts. Classical contracting is the traditional model for an exchange of goods or services for money. Relational contracting recognises the interdependence of contractor and supplier, and seeks to maximise the common interests of the parties in the enterprise. In the commercial sphere, this approach (known as alliance contracting) has become more common. The typical features are a long time frame, arrangements for sharing of profits and risk sharing.

The evidence from research indicates that the funding of Aboriginal and Torres Strait Islander Community Controlled Health Services (ACCHSs) in Australia is more suited to relational contracting. Relational contracting is preferred when the services are broad ranging (e.g. PHC) rather than narrow (e.g. contracting for specific immunisation or medical imaging services); when there is not a competitive market among providers; and when maintaining long-term relationships with providers for health services is important for continuity of care, workforce sustainability and system development.

Project methods

We collected and analysed three main kinds of data. They are:

1. Government funding program guidelines and policies in relation to PHC funding for ACCHSs and contract documents. These documents were analysed to produce 'a big picture' of the policy and program environment in each jurisdiction and to guide interviews and other project data collection and interpretation.

2. Interviews with senior staff from national and most State and Territory health authorities and a national sample of ACCHSs. Interviews were audio-recorded, transcribed and analysed to identify the main themes.

3. Financial reports of a sample of 21 ACCHSs for the financial year 2006–07. We collated this information to improve our understanding of the complex ways in which ACCHSs are funded.

Current government funding and regulation practice

The bulk of PHC funding to ACCHSs in Australia is provided by the Commonwealth Government, which funds virtually all ACCHSs from many different funding programs. Most State and Territory health authorities provide relatively smaller amounts of funding from several different program areas or divisions within the authority and from multiple funding programs (each with their own guidelines and activity reporting requirements).

The funding and regulatory practices of Australian governments are complex and fragmented, and bring a heavy burden of acquiring, managing, reporting and acquitting funding contracts to both sides of the funding relationship. These problems arise partly from a lack of consistency in the reporting requirements of national and State/Territory government funders, and are compounded, in the majority of health authorities, by internal structures that separate responsibility for policy and relationship development from responsibility for contract management. These arrangements complicate communication tasks and reduce the knowledge management capacity of the funder.

Health authority staff are aware of these problems and there is a widespread effort to address them. However, it seems that the implementation of intended reforms is slow and patchy, particularly where cooperation between two levels of government, or different government departments, is required.

ACCHS funding and income

We identified 145 ACCHSs across Australia that are engaged in providing comprehensive PHC for their communities, and we analysed detailed financial data from a representative sample of 21 agencies. More than half the ACCHSs in the sample reported income of between $1 million and $2 million, with an average of about $5 million. The number of separate funding grants received by ACCHSs in our sample ranged from six to 51, with an average of 22 per ACCHS.

About 80 per cent of *total funding* to sample agencies was provided by the Commonwealth, with 19 per cent coming from the States and Territories and the remaining 1 per cent from local and non-government sources. Almost two-thirds of grants were funded by the Commonwealth and 29 per cent by the States and Territories.

On average, Commonwealth grants were larger. Some program allocations were very small, with 2 per cent being for amounts of less than $1000, mostly for one-off purposes. A further 13 per cent were between $1000 and $2000. Nearly 60 per cent of programs allocated less than $100,000 to agencies in the sample. Allocations that exceeded $1 million were primarily core funding to operate comprehensive PHC services or nursing homes.

Just over half of the grants came from health-specific programs, and 30 per cent of grants were for broader community or social programs. 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, making up an average of about half of their total funding. The remaining 10 were funded from several specific-purpose programs.

The current funding regimes are almost entirely constructed as short- to medium-term contracts. But in practice the approach in health authorities and in ACCHSs is to treat much of this funding as ongoing. This pattern—the majority of program funding being ongoing in practice, but both sides having to contend with yearly funding applications—has also been documented in the Indigenous services field more broadly.

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 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.

Perspectives of funders and providers

There was general recognition that the current funding arrangements are too complex and inefficient for both sides, but also that definitive solutions are hard to find. The complex contractual environments in which ACCHSs work are not monitored or managed in any consistent way. They have emerged from a series of unlinked policy and program decisions, and simply grown over time.

Funders in most jurisdictions have moved to simplify and consolidate contracts, and to lengthen the standard funding term to three years. There are many barriers to this goal, including the nature of budget appropriations, and the need for cooperation among levels of government and different departments.

Both funders and providers consider themselves to be in long-term funding relationships, and tend to act in accordance with this belief. Relationships of trust between individuals are seen as important enablers of effective accountability, problem solving and decision making. Although classical contracts predominate, and bring a high reporting burden, the pattern of dispute resolution also indicates that the sector is regulated as a relational environment.

Heightened political sensitivity, and the related need to demonstrate strong accountability, tends to reinforce burdensome reporting requirements that seem to have limited utility.

Conclusion

Our examination of the current practices and policies of health authorities has identified characteristics of the funding relationship that are important barriers to good practice, as well as some enabling factors.

The complex contractual environment for ACCHSs and their funders is largely shaped by a classical approach to contracts, though often with a vocabulary and management environment that invokes relational contracts.

This tends to undermine the benefits of both forms. Those involved think and behave in ways that belie the intentions of classical contract provisions (such as avoiding expectations of ongoing funding); but the advantages of relational contract forms (such as reduced transaction costs) are not realised either.

Governments are committed to the development of a robust comprehensive PHC sector, but the classical contracting model is not adequate to support the achievement of this goal. We suggest that implementation of government policy commitments will require a different way of thinking about the relationship between government and the sector, with implications for both sides. We further suggest that the framework of relational (or alliance) contracting provides methods for improving both efficiency and effectiveness.

Accordingly, we suggest the following principles against which options for good practice in funding and regulation could be evaluated:

1. Long-term contracting for core PHC is the basis for the funder–provider relationship.

2. Core PHC funding allows flexibility for local priority setting, in accordance with agreed plans.

3. Data collection and monitoring are simplified and information is shared, based on sound performance and health outcome indicators.

4. Transaction costs are reduced and complexity is managed through a single main long-term contract and good contract management.

5. Risks for both sides are managed and capacity on both sides is enhanced.

No administrative arrangement is perfect, or perfectly implemented. Any approach will solve some problems, and create others. We suggest that relational contracting offers a sound alternative framework for redesigning the funding and accountability relationships for this critical sector of the Australian health system, thereby reducing administrative costs, improving performance and, ultimately, maximising the PHC contribution to closing the health gap between Indigenous and non-Indigenous Australians.

section 1:

Introduction

Health and health care are high priorities for indigenous peoples around the world, and this is reflected in the United Nations Declaration on the Rights of Indigenous Peoples (UN 2007:Articles 23 and 24). In recent decades, indigenous peoples in many countries have sought to secure more control over community-based health services, in the hope of improving access and responsiveness.

Governments have responded by developing contractual relationships with indigenous health organisations that now provide a spectrum of primary health care (PHC) services, ranging from health promotion and prevention to primary intervention and rehabilitation services. This shift echoes the Declaration of Alma-Ata and the Ottawa Charter's commitment to popular engagement in service planning and delivery (WHO 1978, 1986; WHO Department of Communicable Disease Prevention and Health Promotion 1997).

In Australia, Aboriginal and Torres Strait Islander community health organisations play a significant role as providers of essential PHC in rural, remote and urban settings. Australian governments have developed policies and funding programs to support this growing health sector. The guiding policy document is the *National Strategic Framework for Aboriginal and Torres Strait Islander Health*, signed by all Australian health ministers in 2003 (NATSIHC 2003). It affirms:

> *Within the health system, the crucial mechanism for improving Aboriginal and Torres Strait Islander health is the availability of comprehensive primary health care services. Effective and appropriate primary health care services must be available to all Aboriginal and Torres Strait Islander peoples. These services should maximise community ownership and control, be adequately funded, have a skilled and appropriate workforce and be seen as a key element of the broader health system* (NATSIHC 2003:1).

It goes on to outline the commitment of all Australian governments to nine principles, including community control of PHC services, local decision making about health care needs and priorities, and accountability of all parties. This policy intention has not yet been implemented effectively, despite much sustained effort and several implementation plans (Commonwealth of Australia 2007; Australian Government 2008).

PHC funding provided to Indigenous agencies is intended to improve the health of Aboriginal and Torres Strait Islander people by supporting good health care, while also meeting the need for accountability to communities and to governments. Another important enabling goal is to make it possible for PHC providers to recruit and retain skilled staff. But the current arrangements for funding are much criticised. Providers complain about fragmented funding programs, with too many reports required, and too many strings attached. Government staff also experience problems with administering these funds, with high workloads in processing and managing a multitude of programs and grants, and some lack of compliance by providers, particularly with activity reporting requirements.

This project aims to expand our understanding of these problems and find better ways of funding and regulating PHC for Aboriginal and Torres Strait Islander communities, from the point of view of Indigenous PHC provider organisations, as well as government agencies. Funded by the Cooperative Research Centre for Aboriginal Health (CRCAH), the project is a partnership between researchers at Flinders University (South Australia), the Australian Institute of Aboriginal and Torres Strait Islander Studies (Australian Capital Territory) and the University of Northern British Columbia (Canada). The idea for the project emerged from discussions with people in the Aboriginal and Islander PHC sector about their priorities for research, and was endorsed by the CRCAH Board. It has been supported by a national reference group, which includes representation of major stakeholders on both sides of the funding relationship and others with relevant expertise.

In this report we first outline the context and aims of the project. This is followed by a brief summary of current funding practice in indigenous health, nationally and internationally, and in the Australian mainstream health system, with a focus on the use of contracting for PHC. A summary of the methods we used for collecting and analysing data then follows. The results are given in three sections, covering funding arrangements in each State and Territory, as well as nationally; the sources and amounts of funding used by a sample of Aboriginal Community Controlled Health Services (ACCHSs); and the views and experiences of a sample of providers and funders. On the basis of this information, we outline the major current problems and a framework for better practice, incorporating the kind of changes that might reduce administrative overload while still meeting accountability requirements and improving the efficiency and effectiveness of PHC services.

Context and aims

The dominant model for delivery of Indigenous-specific PHC in Australia is through community-controlled organisations that incorporate principles of self-determination with PHC principles in their approaches to governance and management, priority setting and health care delivery. Efforts to implement funding programs and accountability arrangements based on national policy and these principles are characterised by conflicting goals among multiple parties and by implementation difficulties. These difficulties arise in a context of underlying contestation regarding claims for collective participation and control over health care resources by Aboriginal and Torres Strait Islander communities, in spite of official policy pronouncements that support those claims (Anderson 2006).

The sources of these difficulties also include the complexity of allocation and administration of funds in the form of contracts from multiple funding sources (typically national, State/Territory, and some local government and non-government organisations [NGOs], and, often, allocations from multiple funding programs within one department or organisation). The resulting contractual environment is characterised by ‘a multiplicity of fragmented, often proposal-driven, contracts with high administrative costs’ (Lavoie 2005:2). Lavoie concludes that Indigenous agencies that are funded by an Indigenous-specific government authority are better able to provide comprehensive services and are advantaged administratively and financially.

There have been several studies investigating the question of the appropriate level of funding for PHC services for Aboriginal and Torres Strait Islander people (Econtech 2004; Deeble *et al.* 1998; Beaver & Zhao 2004) and all have recommended significant increases to achieve equity of access with non-Indigenous Australians, including meeting the additional costs of remoteness and cultural appropriateness of care. This study does not address the question of adequate funding levels, but we recognise that inadequate funding is an important factor limiting the capacity of ACCHSs to achieve their health care goals. There has also been significant policy and program innovation to make mainstream funding programs more accessible to Aboriginal and Torres Strait Islander people and their health care providers, including the Coordinated Care Trials (DoHA 2001) and the Primary Health Care Access Program (Rosewarne & Boffa 2004), as well as changes to regulations governing access to subsidised medical services and medicines (Kelaher *et al.* 2004; Medicare Australia 2009).

On the ground, PHC providers aiming to provide high-quality, culturally appropriate services and programs continue to struggle with shifting funding lines, complex reporting requirements, competing policy priorities and sometimes difficult working relationships. In government departments, staff experience difficulties in assisting agencies to meet accountability requirements, and in negotiating tensions that affect PHC providers and arise from within, and external to, Aboriginal and Torres Strait Islander communities.

So far, however, the way that Indigenous-specific PHC services are funded and regulated across jurisdictions has not been systematically investigated. Likewise, the experience of government officers has not been documented. What is lacking is a comparative review that identifies the features of the different forms and shapes of the PHC funding system and relationships and analyses their strengths and weaknesses from the points of view of both the PHC providers and the funders.

Although we have drawn on research and experience in broader Aboriginal and Torres Strait Islander administration (including Morgan Disney and Associates 2006; Sullivan 2006, 2008, 2009), the issues are different for health, for several reasons. Importantly, the responsibility for funding Aboriginal and Torres Strait Islander health services was transferred from the Aboriginal and Torres Strait Islander Commission to the Commonwealth Department of Health in the mid-1990s. Subsequently, Indigenous-specific health programs and structures have not been folded into the whole-of-government mechanisms of the Office of Indigenous Policy Coordination and the Indigenous Coordination Centres (FaHCSIA 2009).

The purpose of this report is to broaden our understanding of the opportunities and constraints experienced by Indigenous PHC providers. Specifically, it seeks to answer these research questions:

- What are the major enablers and impediments to effective PHC delivery embedded in the current frameworks of funding and accountability for PHC services to Aboriginal and Torres Strait Islander people, in Australian States and Territories?

- How could the effectiveness of funding and accountability arrangements be improved, drawing on insights from current Australian practice and international comparisons?

section 2:

Analytical Framework—Contracting in Health

National policy for Aboriginal and Torres Strait Islander health care emphasises participation, community control, partnerships and comprehensiveness of PHC services (NATSIHC 2003). However, implementation is dominated by reliance on cumbersome coordination arrangements for planning and funding, and uncoordinated contracting with the ACCHS sector for service delivery.

Contracts in this context are arrangements by which government funders specify (broadly or in detail) the services or other activities they are *purchasing* on behalf of the community, and providers undertake to deliver those services or activities. These arrangements are generally specified in *service agreements* or *funding agreements*, which are contracts between the funder (generally, government) and the provider (in this case, the ACCHSs). In the mainstream health system, contracts and contract-like arrangements have been used in aspects of government funding for health care since the 1980s (e.g. output-based models like casemix for hospitals).

Although contracting in practice creates some problems, contracting is used by governments in many countries as a mechanism to enable community-based indigenous health services to be funded to provide improved access and responsiveness, particularly in Canada, New Zealand and Australia (Lavoie et al. in press).

In this section we first review relevant aspects of the funding and regulation of systems for PHC in Australia, Canada and New Zealand, and for the Australian mainstream system. We then present an analytical framework derived from comparative research that we have used to examine and assess current funding arrangements, and address the concept of accountability that underlies the requirement for reporting.

Indigenous health care: International comparisons

Although significant differences exist, Australia, Canada and New Zealand share much in terms of history, interests and debates. First, indigenous peoples in all three countries self-identify as such and are internationally recognised as indigenous by the United Nations' Working Group on Indigenous Populations because of their prior occupancy of their lands; the voluntary perpetuation of their cultural distinctiveness; their self-identification as indigenous; and their experience of subjugation, marginalisation, dispossession, exclusion and discrimination by the dominant society (UN Working Group on Indigenous Populations 1996). Second, each country shares a history of conquest by Britain and permanent settlement by a majority of people who shared similar values among themselves. Third, in each country, English common law prevails to varying extents, along with majority representative democratic government, and these approaches displaced traditional forms of governance, at least at the official level. Fourth, each country adopted some policies inspired by social Darwinism that were eventually displaced by post-assimilationist accommodations (Armitage 1995; Havemann 1999).

In all three countries, indigenous people seek greater control over community-based PHC services for their populations. Policies have emerged validating indigenous health services, and public funding has been allocated specifically to support these organisations. These policies have become understood as an endorsement of indigenous self-determination. The words vary, but the discourses are similar. Self-determination is to replace earlier policies of assimilation by promoting indigenous participation in policy development and in service delivery. Although Australian governments have recently moved away from the concept of self-determination (Anderson 2006), it remains as a fundamental underpinning in Aboriginal and Torres Strait Islander health policy in the form of endorsement for community control (NATSIHC 2003:2). Finally, indigenous people in these countries experience comparable economic situations (marginalised populations in prosperous industrialised countries—*fourth world in first world*).

In these countries indigenous people comprise a small part of the total population—2.5 per cent in Australia (ABS 2008a), 3.8 per cent in Canada (Statistics Canada 2008) and 14.6 per cent in New Zealand (Statistics New Zealand 2008). Indigenous people in all three countries utilise PHC services less often than non-indigenous people (Alford 2005). All countries have dual systems for PHC services: mainstream (non-indigenous) and indigenous-specific PHC service providers. Mainstream systems consist of PHC, which is primarily delivered by general practitioners or allied health practices (backed up by tertiary and secondary services). Indigenous people may access both types of PHC.

Indigenous-specific health providers in Australia, Canada and New Zealand have emerged mainly as not-for-profit community-governed PHC organisations. The relationship between the government and indigenous service providers is governed by contracts in all three countries.

Canada and Australia have federal and provincial/State jurisdictions, and both levels of government have responsibilities for indigenous health and health care. In Canada the federal government has responsibility for funding PHC services for First Nations people who live on reserves. PHC for all indigenous people who do not live on reserves (about 40 per cent of the population) is provided by the mainstream health system (along with a small number of urban indigenous-specific health organisations) and funded through many (mainly provincial government) authorities. This on–off reserve separation creates access problems, as people who do not live on reserves are not entitled to on-reserve services. The federal government transferred the responsibility for the management and delivery of on-reserve PHC services to communities, commencing in 1989. The funding arrangements for these 'transferred services' are based on a single long-term contract and competitive project or new initiative funding (Lavoie *et al.* 2005).

New Zealand has a unitary political system. New Zealand's health care system has been decentralised through the formation of 21 District Health Boards, each of which acts as the sole purchaser of public health services for its regional populations, as well as being the *owner of* most public health services (hospitals and other health care providers). Primary health organisations bring together all PHC providers for a defined population under the governance of community-based authorities. Maori providers are funded through multiple small contracts (Lavoie 2004).

In Australia the relative roles of Commonwealth (federal) and State/Territory governments in funding Indigenous-specific services, and other care for Aboriginal and Torres Strait Islander people, are overlapping and unclear. Both Commonwealth and State/Territory governments provide direct funding for Indigenous-specific health service providers in remote Aboriginal and Torres Strait Islander communities and in regional and urban settings, and also have overlapping roles in the mainstream health system.

Thus, although there are important differences in health systems, all three countries share a reliance on indigenous-specific PHC providers for a significant proportion of the total PHC used by indigenous people, and a contractual approach to funding. The basic structural features of funding in the three systems are shown in simplified form in Figure 1. Please note that the actual pathways of funding for any individual PHC organisation are much more complex in all three countries.

The policies and practices outlined above arose partly from concern about wide health disparities—*the gap*—between the health status of indigenous and non-indigenous people. In Canada and New Zealand indigenous health is worse than the mainstream populations (Anderson *et al.* 2006), but the gap is not as wide as in Australia. Table 1 illustrates health status comparisons.

Figure 1: PHC funding models

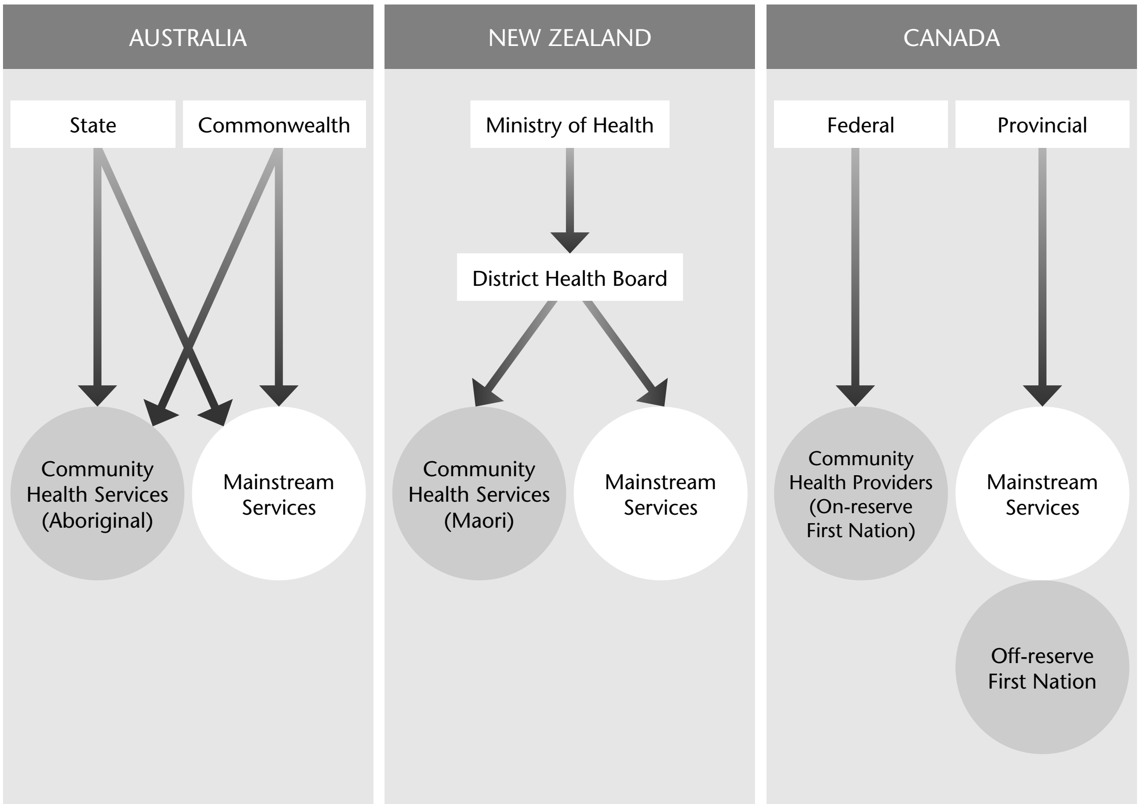


Table 1: Indigenous health status in Australia, New Zealand and Canada

Measure	**Australia**		**New Zealand**		**Canada**	
	Indigenous	**All**	**Maori**	**All**	**Aboriginal**	**All**
Male life expectancy	59*	77*	67.2**	74.3**	68.9#	76.3#
GAP (years)	–18		–7.1		–7.4	
Female life expectancy	65*	82*	73.2**	81.1**	76.6#	81.8#
GAP (years)	–17		–7.9		–5.2	
Infant mortality (deaths/1000 births)	14.3#	4.7#	8.9#	5.7#	6.4#	5.3#
GAP (extra deaths/1000 births)	9.6		3.2		1.1	
Low birth weight	13%#	6%#	8%#	6%#	5%#	6%#
GAP (low birth weight %)	7% higher		2% higher		1% lower	

Sources:
* AIHW 2008
**Statistics New Zealand 2008
#Oxfam Australia 2007

There may be many reasons for the greater health gap affecting Australian Indigenous people, of which access to PHC is one major factor (Robert Griew Consulting 2008; Dwyer, Silburn & Wilson 2004). Researchers have also suggested that the lack of a legislative or treaty basis on which to establish responsibility and rights between governments and Indigenous communities is important (Ring & Firman 1998). In Australia both Commonwealth and State/Territory governments can provide direct funding for Indigenous-specific health care, but neither are clearly responsible for this function. We suggest that these are important underlying factors that affect the funding and regulation of PHC services for Aboriginal and Torres Strait Islander people.

Funding and regulation of PHC in the mainstream Australian system

Governments fund approximately two-thirds of all health care costs in Australia, but only about one-third of total health expenditure is allocated to public sector providers (public hospitals and other community-based services, mostly owned and operated by State governments) (Foley 2008:4). The remainder is spent in the private for-profit or non-government sectors. The Commonwealth Government's share of direct funding goes almost entirely to the private and non-government sectors, partly through the Medical Benefits Schedule (MBS), which reimburses fee-for-service payments to doctors, diagnostic service providers and some other health professionals, and through the Pharmaceutical Benefits Scheme (PBS) to pharmacists for the supply of prescribed medicines. MBS and PBS are *uncapped* fee-for-service payment arrangements (that is, the annual cost to government is determined by the level of utilisation rather than by a budget cap). Subsidies for private health insurance premiums are another major uncapped cost. Local government plays an important role in many States and Territories, particularly in relation to environmental health. Local government is a small provider of funding to NGOs (Indigenous and mainstream) for health and community services.

The Commonwealth provides grant funding to a few non-Indigenous NGOs directly (such as the Royal Flying Doctor Service and Family Planning Australia). But grant funding accounts for a very small proportion of federal government direct funding. General practitioners and others funded through fee-for-service enjoy some benefits (access to an uncapped scheme where more patient visits translate into more funding and comparatively simple billing and reporting requirements), but they also experience high levels of administrative burden in the processes required for access to the schemes, and for some payment types (Parsons 2003).

One major criticism of the fee-for-service regime is that the reliance on market forces to ensure supply of health care providers does not work in rural and remote areas because the population is too small to support medical or pharmacy practices on the fee-for-service payments. The Commonwealth Government has in recent years introduced some measures that aim to improve the supply of doctors and other health professionals in rural and remote areas (Bartlett & Duncan 2000), but rural and remote Australia remains under-supplied (ABS 2008b).

Some aspects of PHC are provided directly by State/Territory governments, which also fund NGOs through grants or contracts. The pattern varies around the country, but the services funded through one or another of these methods include maternal and child health, mental health, public dental services, drug and alcohol services, community health centres, community rehabilitation and a range of other services to particular population groups.

Mainstream NGOS in some sectors funded by the Commonwealth and State/Territory governments also experience problems of fragmentation of funding and reporting (that is, they are funded by several sources for different aspects of one service) similar to those experienced in the ACCHS sector (Council of Social Services NSW 2008).

The arrangements for funding and regulation of PHC in Australia are generally seen as fragmented and unsatisfactory, and policy attention is turning increasingly to the use of alternative methods of ensuring access to care. The National Health and Hospitals Reform Commission (NHHRC 2008) has recommended sweeping changes that would reduce or remove overlapping government roles, and ‘defragment’ the primary health care sector by moving all responsibility for PHC to the Commonwealth Government. The National Primary Health Care Strategy also promises to address these problems (DoHA 2008a).

The ACCHS sector occupies a unique position as a predominantly grant-funded major provider of essential PHC to Aboriginal and Torres Strait Islander communities, providing approximately 1.5 million episodes of care to Aboriginal and Torres Strait Islander Australians in 2005–06 (DoHA & NACCHO 2008).

Study framework and approach

The methods used in this study are presented in detail in Appendix 1. In this section we give a brief overview of the theoretical framework and the approach we took. We set out to investigate the impact of funding programs as implemented in terms of administrative complexity, the burden of funding conditions, and of reporting and accountability requirements, and the effect on health care delivery and on the workforce (recruitment and retention).

Theoretical framework

The theoretical framework for this study is based on contract theory, particularly the distinction between classical and relational contracts (Macneil 1978). Classical contracting is the traditional model for an exchange of goods or services for money. Relational contracting recognises the interdependence of contractor and supplier, and seeks to maximise the common interests of the parties in the enterprise. In the commercial sphere, this approach has become more common with the move to outsourcing of certain aspects of businesses and is sometimes called *alliance contracting*. The typical features are a long time frame, arrangements for sharing of profits above predicted levels, and risk sharing for the unpredictable aspects of the shared business.

Classical contracts have a clear purpose and short duration. Before entering into the contractual relationship, both actors need to know exactly what will be exchanged, and contracts tend to be specific and detailed. Classical contracts concern discrete transactions and have limited flexibility, as the main concern is the exchange itself. Future interaction and asymmetry of information are not acknowledged in classical contracts. For example, the purchase of fuel from a petrol station involves a short transaction that is limited in scope, is measurable and has no foreseeable future. In contrast, relational contracting is based on mutual interest, flexibility and cooperation, as well as on trust among the actors. Relational contracting assumes that transactions are likely to reoccur, and recognises that the nature of the contracted services makes it difficult to specify and monitor outputs. Relational contracts are, therefore, less detailed in this regard (Palmer 2000).

Classical contracting is more formal and enforceable than relational contracting, due to more explicit specification of terms. Relational contracts more often rely upon self-enforcing mechanisms to guarantee the fulfilment of the contract, as each party wants to maintain its reputation and credibility, as well as good relationships (Perrot 2006).

Both contracting styles are applied in the health sector. Palmer and Mills (2003, 2005) found that contracting in health services is more relational and less formal in situations where there is a lack of competition, and thus there is a degree of mutual dependency between the provider and the purchaser. The purchaser needs the provider to deliver a wide range of health services (e.g. for rural populations, especially when there is no public provider). On the other hand, providers need secure incomes, as the market is limited in rural areas.

When the services to be provided under the contract are broad ranging, contracts are more likely to be relational than when, for example, a specific service such as diagnostic testing is being purchased. Insurance-type purchasers may use more classical contracts as compared to government purchasers. Insurers have defined members and may insure for services that can more easily be specified, and in markets that offer more competition among providers. Government purchasers are more focused on meeting their obligations to provide services for the population, and therefore are more likely to use relational contracts (Palmer & Mills 2003, 2005; Macinati 2008; Parker, Harding & Travis 2000). Experience in New Zealand indicates that maintaining long-term relationships with contracted providers for health services is seen as important, because frequent changing of providers disrupts or prevents the development of trust-based relationships of care, risks interruption of the continuity of service for consumers, and may be costly in terms of staff redundancy and possible legal action or adverse media coverage (WHO 2004). The differences between relational and classical contracting identified in the literature are represented diagrammatically below.

Another type of contractual partnering relationship is known as *alliance contracting*. Alliance contracting was first used in Australia in the 1990s for major infrastructure projects, and since then for many public–private partnering projects. Alliance contracting is based on the principle of risk sharing among participants and a *no fault, no blame approach*

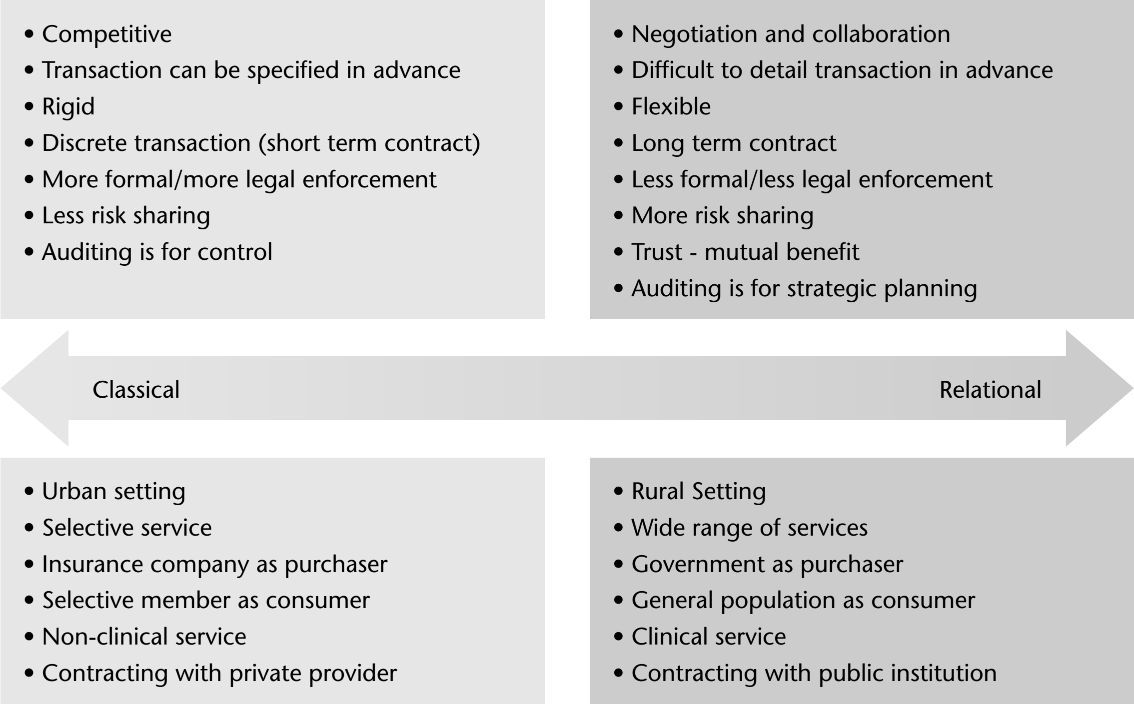


Figure 2: Contracting in health—classical versus relational

- Competitive
- Transaction can be specified in advance
- Rigid
- Discrete transaction (short term contract)
- More formal/more legal enforcement
- Less risk sharing
- Auditing is for control

- Negotiation and collaboration
- Difficult to detail transaction in advance
- Flexible
- Long term contract
- Less formal/less legal enforcement
- More risk sharing
- Trust - mutual benefit
- Auditing is for strategic planning

- Urban setting
- Selective service
- Insurance company as purchaser
- Selective member as consumer
- Non-clinical service
- Contracting with private provider

- Rural Setting
- Wide range of services
- Government as purchaser
- General population as consumer
- Clinical service
- Contracting with public institution

to problem solving in the relationship. There are three types of compensation models: cost-based (reimbursement based on provider's cost using an open book approach); a fee for normal corporate overhead and profit; and gainshare/painshare provisions (rewards for good performance and risks of poor performance are shared between participants). In alliance contracting the participants have incentives to focus on what is best for the project or service and on better risk management, and to ensure transaction cost reductions. However, alliance contracting requires more involvement from senior managers than traditional contracts, brings increased risk of decision-making deadlock and needs acceptance of risk by all participants (Department of Treasury and Finance Victoria 2006; Queensland Government Chief Procurement Office 2008).

Alliance contracting is seen as suitable for projects or services where there is uncertainty in the product, where the main focus of the buyer is improvement or breakthrough performance rather than just regular business, for large projects, and in situations where there is considerable risk (Turner & Simister 2001). Ruuska and Teigland (2008) found that alliance contracting works better in environments where there is a joint problem-solving task, where communication is continuous, and where alliance members have the capacity to resolve conflicts through discussion to each participant's satisfaction. This approach is essentially relational contracting, and Australian governments have considerable existing experience in its use (although largely not in the health sector).

Building on the work of Williamson (2000), Macneil (1985, 2000) and Lavoie *et al.* (2005, in press), we have adopted a framework that distinguishes between classical and relational contracts. The framework contrasts relational and classical contracts in terms of the nature of funding, the priority-setting process, monitoring, transaction costs and risks, and is summarised in Table 2.

Table 2: Contract characteristics

	Classical contractual environments	Relational contractual environments
Description	Organisations access funding for programs through a number of separate classical contracts to fund a complement of primary health care services	Funding agency engages with a provider in a long-term flexible contract to fund a core set of ongoing primary health care services
Nature of funding	Short-term, competitive, unstable from year to year	Long-term, non-competitive, population-based, stable
Priority setting	Funder allocates funding to meet nationally defined priorities	Promotes priority setting based on the pattern of needs experienced by patients and their relationship with the provider
	Funding agreements focus on individual interventions (e.g. immunisations) or single activities (e.g. workshops)	Promotes comprehensive primary health care and population approaches (e.g. prevention, health promotion, primary care treatment and rehabilitation services)
Monitoring	Explicit output requirements facilitate contract monitoring for single contracts	Contract monitoring more challenging for purchaser and costs may offset transaction cost savings
	Reporting requirements associated with multiple contracts are onerous	Reporting requirements can be lower
Transaction costs	High administrative costs associated with a single contract are compounded with multiple contracts	Relational contract carries lower transaction costs for both the funder and provider, may be partly offset by relationship-building and negotiation costs
Risk	Higher financial risk for the provider, who bears the responsibility to secure and acquit funding	Considerable management risk for purchaser in case of non-performance, and viability risk for the provider if the contract is not renewed

Source: Lavoie, Boulton & Dwyer (in press)

Contracting and accountability

Macneil's theory of relational contracts reframes the contract as 'relations in which exchanges occur' (Macneil 2000:878). What Macneil acknowledges is that contracts do not occur in a social and relational vacuum. Rather, contractual relationships are best understood as extensions of social relationships. In this context, the contract becomes a microcosm of the overall relationship between the funder and the provider, with the relationship generally articulated through contractual provisions for accountability. These requirements make accountability visible in public administration. But accountability is also about power and the discharging of responsibility *between* stakeholders, in this case the state and indigenous organisations. In the indigenous context, accountability is about social relations inscribed and informed by a legal framework, macro-policy statements, history and localised understanding.

Hughes Tuohy (2003) suggests that accountability requires three things: the identification of responsibility; the provision of information; and the availability of sanction. She discusses how through much of the twentieth century, the role of the state has been that of a 'principal' in a trust-based principal–agent relationship. Decisions over the provision of care by non-government

Table 3: Dimensions of accountability

	Classical contractual environments	Relational contractual environments
Political accountability	Related to the broader context of credibility and trust, and carries intangible indicators	Purchaser to government Provider to purchaser Provider to clients
Reciprocal accountability	Ensured through an appropriate dispute resolution process and third-party monitoring	Between purchaser and provider
Performance accountability	Monitoring of contracted output based on established standards where stated, and resulting impact on outcomes	Purchaser to government Provider to purchaser Provider to clients
Financial accountability	Appropriate and prudent use of public funding	Provider to purchaser

Source: adapted from Cumming & Scott 1998 and Hughes Tuohy 2003

providers, mainly physicians, were based on trust and the delegation of authority. The shift to contract-defined relationships associated with *New Public Management* has reshaped the role of the state from a trust-based delegation to that of contract monitoring first focused on deliverables (outputs) and, increasingly, on the reporting of a variety of performance indicators (results and outcomes) that can be audited to ensure quality in care provision. In the process, the state is increasingly defining how care should be provided.

Table 3 highlights four dimensions of accountability. The purchaser requires accountability for the use of public funding. The purchaser also requires performance accountability. An aggregation of providers' performance may be used to inform government on the performance of the overall system, assuming that the performance data available to, or produced by, providers are standardised and can be aggregated in a cost-effective manner. Clients are also interested in provider accountability. Measures of reciprocal accountability ensure that both parties can be held to the terms of the contract. Finally, political accountability is related to the broader context of credibility and trust, carries intangible indicators, and is more closely related to the culture, context, history and tensions influencing decision making in health care.

However, an important aspect of community-controlled organisations is missed in this formal analysis. The community organisations can represent and, in a sense, embody the clients. As Rowse (2005) points out, indigenous people require community-sector organisations to become visible as citizens. These organisations are not simply providers (the intermediary between clients and purchasers). As the representative voice of clients they, themselves, can demand accountability from the government that purchases the services. They have the right to this downwards accountability not only as the representative of citizens, but as the representative of a unique kind of citizen—indigenous people.

Reporting requirements are pragmatic extensions of accountability, generally defined in contracts. The link between accountability and reporting is poorly articulated in the literature. A study undertaken by the Auditor General of Canada (1996:Ch.13) investigated accountability practices from a First Nations perspective. This report considers accountability in the context of reciprocity, discusses the importance of transparency for both parties, and looks at obligations as a mechanism to foster better understanding and trust. The report highlights the distinction between performance and financial reporting to serve government needs and the same to serve community needs, noting that the format, if not the message, is necessarily different. It also suggests that responsibility in reporting should be aligned with capacity, but does not define the relationship between government needs for accountability and reporting requirements. The report was exploratory in nature and did not attempt to offer pragmatic solutions.

Current trends in accountability seem to require the elaboration of information systems that can inform on the performance of individual providers and, once performance indicators are aggregated, on the overall performance of the system. The realisation of this objective is, however, complex and costly (Light 2001). In Australia and internationally, there has been significant work in recent years towards the development of meaningful and theoretically informed performance indicators at the level of the health system (e.g. WHO 2000; Canadian Institute for Health Information & Statistics Canada 2000; National Health Performance Committee 2004), including for indigenous health (AHMAC 2006). There has been less attention to the development of indicators that are useful to *providers* of health care and can also be aggregated to generate information on the performance of the overall *system* (e.g. Sibthorpe 2004).

The slim but growing literature on quality in health care purchasing appears to support the development of provider-driven, and therefore provider-appropriate, standards of quality in service delivery (Buetow 2004; Crampton *et al.* 2004; Gross 2004; Ovretveit 2003). This is recommended as a cost-effective and appropriate answer to purchasers' concerns that also protects the need for services to remain responsive to local needs in service delivery.

Project methods

We received ethical approval for this project from the Flinders University Social and Behavioural Research Ethics Committee, and the Aboriginal Health Research Ethics Committee of South Australia.

We searched government websites for funding program guidelines and funding policies in relation to PHC funding for ACCHSs. Other documentation was collected from government websites, health authorities, and ACCHSs and their peak bodies. These include 2006–07 annual reports and financial statements, as well as some 2006–07 and 2007–10 Office for Aboriginal and Torres Strait Islander Health (OATSIH) and State/Territory contractual agreements. These documents were analysed to generate an overview of the policy and program environment in each jurisdiction and to guide interviews and other project data collection and interpretation.

We interviewed 20 senior officers responsible for Aboriginal and Torres Strait Islander health policy and funding in most States and Territories and the Commonwealth Government. We sought to construct both a description of the current funding and regulation of PHC providers from their perspective, and an understanding of the major areas of successes and challenges.

In order to gain an understanding of the experiences and perspectives of PHC providers, we also interviewed 23 Chief Executive Officers (CEOs) and finance staff of a sample of ACCHSs around the country. With the help of State/Territory peak bodies, we purposefully selected staff from a range of locations (urban, rural and remote), and from large and small, and new and established agencies.

We audio-recorded the interviews, and transcribed them. The interviews were then analysed to identify common ideas or themes—that is, the factual information and ideas and opinions in the text were extracted, grouped and analysed for their meanings.

Given the nature of the study, maintaining confidentiality for those we interviewed (particularly those in government departments) is difficult. We discussed this problem with all participants, and explained that we would take great care in our reporting of the interviews to avoid giving clues. All interviewees recognised and accepted the reality of this problem.

We used the financial reports of a sample of 21 ACCHSs to do a financial analysis of their government income in 2006–07. We collated this information to improve our understanding of the complex ways in which ACCHSs are funded, and to identify how the situation might be improved.

The results are presented in the following sections.

section 3:

Current Government Funding and Regulation Practice

In this section we summarise the funding practice and regulatory structures of State, Territory and Commonwealth health authorities in relation to ACCHSs.

Based on detailed analysis of a sample of ACCHSs (See Section 4), we estimate that the bulk (approximately 80 per cent) of PHC funding to ACCHSs is provided by the Commonwealth Government, including 63 per cent from the Department of Health and Ageing (DoHA) through OATSIH, which provides funding to virtually all ACCHSs in Australia. Within DoHA, OATSIH has operational responsibility for policy development, funding allocation, contract management and reporting for services for Indigenous health, including services provided by ACCHSs and mainstream providers of Indigenous-specific services. However, other divisions of DoHA (such as the Ageing and Aged Care Division) also provide funding to ACCHSs, along with other Commonwealth departments.

In contrast, most State and Territory health authorities provide relatively smaller amounts of funding to ACCHSs from several different program areas or divisions within the authority. Decisions about allocation of funding are generally made in program branches (e.g. community services, disability, mental health, ageing, acute care etc.), but funding is generally delivered through corporate finance or procurement divisions that are responsible for contractual arrangements with the non-government sector. ACCHSs also receive funding from other government departments, such as those responsible for justice and children.

Most State and Territory health authorities have multiple funding programs (each with their own program guidelines and specific activity reporting requirements), but unified financial guidelines. Service agreements or contracts are often constructed so that there is one agreement but several *schedules* (sections attached to the agreement that specify the amounts and purposes of different program grants, and the data about the funded services or activities that are required). During the year, if there is a change in the amount of funding to be provided, variations to the service agreement are issued, and they become part of the agreement.

In most States and Territories, tripartite regional forums (with representatives of OATSIH, the jurisdictional health authority and the Aboriginal and Torres Strait Islander health sector) are convened to plan and develop health services for the communities.

Table 4: Major funding categories

Length of funding commitment	
Ongoing	Funding that is assumed to continue unless a decision is made to cease (also referred to by funders and service providers as *recurrent*)
Medium term	Funding allocated for three to five years
Short term	Funding allocated for less than three years
Purpose	
Core operating	Funding for PHC delivery, administration, rent etc., including relevant salaries and goods and services
Health program	Funding for a specific health intervention or health promotion activity, sometimes defined as *body part* funding (e.g. ear health, cervix screening) and sometimes for other specified health programs (e.g. home support for people with chronic illness)
Project	One-off funding to buy equipment, meet a priority training need, for capital projects, or to trial new initiatives or meet urgent care needs

We were able to obtain some model or actual service agreement forms and associated funding guidelines from most State/Territory and Commonwealth health authorities. These were analysed to identify funding program lines, purpose and eligibility requirements, funding timeframes, allocation processes, reporting requirements, and auditing and dispute resolution procedures. These sources were checked in interviews with health authority and ACCHS staff, and augmented with information from government websites.

Funding categories

Because the funding arrangements are complex, it is necessary first to specify the major characteristics of funding types we observed. The categories of funding programs shown in Table 4 were derived from government websites and publications, as well as from commissioned reports, and were tested and refined in discussion with interviewees. They categorise funding according to two factors: length of funding commitment (ongoing, medium term or short term) and purpose of funding (core operating, health program and project).

The policies and practices vary among jurisdictions, and a brief summary of each (as at the time of writing, early 2009), is presented below.

Australian Capital Territory

Total population: 334,200; **Indigenous population:** 4000 (1.2 per cent)

There is one ACCHS in the Australian Capital Territory that receives funding from ACT Health in the form of a service funding agreement managed on behalf of ACT Health by the Aboriginal and Torres Strait Islander Health Unit. The ACCHS also receives grant funding from other branches of ACT Health and other ACT government departments. The Aboriginal and Torres Strait Islander Health Unit leads the funding negotiation process, is the point of contact for the ACCHS, and acts as a broker and collector of reports. Thus, the unit is responsible for collecting program reports on behalf of other areas within ACT Health that also provide funding to the ACCHS. The ACCHS is also directly funded by the Commonwealth through OATSIH. ACT Health began a three-year funding cycle in 2004.

Distinctive features of funding in the Australian Capital Territory are:

- one ACCHS
- three-year single funding contract since 2004
- consolidated distribution, liaison and reporting line for program funding (but not all grants) through the Aboriginal and Torres Strait Islander Health Unit.

New South Wales

Total population: 6,817,200; **Indigenous population:** 148,200 (2.2 per cent)

There are 53 ACCHSs operating in New South Wales that are funded by NSW Health. Several branches within the Department of Health provide funding to NGOs (primarily ACCHSs) to deliver PHC services to Aboriginal people. NSW Area Health Services (the regional bodies responsible for delivery of public health care in New South Wales) also provide some funding to ACCHSs.

Funding is coordinated through the relevant program branch, with financial administration through the Department of Health's Finance and Business Management Branch. New South Wales uses one- to three-year funding contracts, with three-year funding made available to ACCHSs that demonstrate high capacity and a low-risk approach to management.

The Centre for Aboriginal Health (within the Department of Health) and OATSIH have agreed that all funding provided by both agencies to ACCHSs will be encapsulated in one three-year Funding and Performance Agreement using the OATSIH Service Development and Reporting Framework (SDRF) as the basis (more information about the SDRF is given in the national government section below). This is seen as a way to decrease the administrative burden and additional cost incurred by both the ACCHSs and the department, as well as a way to directly involve the ACCHSs in planning for comprehensive service delivery, management, linkages and coordination, and community involvement. It is also intended to improve communication and interaction between branches within the department and with OATSIH, and to facilitate development and evaluation of key performance indicators across similarly funded programs (whether New South Wales or Commonwealth). Finally, the arrangement is intended to provide for detailed yearly planning within triennial funding periods, and improve timeliness of grant approval processes.

Distinctive features of funding in New South Wales are:

- one- to three-year funding agreements with schedules for separate grants and six-monthly financial and activity reporting
- a long-held plan to move to unified Commonwealth/State funding agreements.

Northern Territory

Total population: 210,700; **Indigenous population:** 66,600 (31.6 per cent)

There are 16 ACCHSs in the Northern Territory. The Northern Territory Department of Health and Families (DHF) provides funding to nine ACCHSs and directly provides clinical care to some Aboriginal communities. There have been some transfers of clinical services from DHF to ACCHSs, and vice versa.

Several separate divisions and program branches within DHF allocate funding for different services, and it is distributed by the Financial Services Branch. DHF has moved from one- to three-year single contracts with separate schedules for specific programs. Single contracts have replaced the previous practice of separate contracts for different program funding grants. Financial and activity reporting is required every six months.

Two ACCHSs, Katherine West Health Board and Sunrise Health Services, have negotiated three-year tripartite agreements between themselves and the Northern Territory and Commonwealth governments. Under Phase Three of the Northern Territory Intervention, the Northern Territory government is working with Aboriginal organisations and OATSIH (through the pre-existing Regional Planning Forums) and moving towards pooled funding to create regional ACCHSs as single providers for defined regions, similar to Katherine West and Sunrise.

The Northern Territory Aboriginal Health Forum, a collaboration between the Aboriginal Medical Services Association of the Northern Territory and its member organisations, DHF and OATSIH, has developed a jurisdiction-wide system for reporting key performance indicator data on Aboriginal health. Data delivery commenced on 1 July 2008.

Distinctive features of funding in the Northern Territory are:

- a move from one- to three-year funding agreements and six-monthly financial and activity reporting
- transfer of some clinical primary care services from DHF to ACCHSs and vice versa
- three-year tripartite funding agreements with Katherine West Health Board and Sunrise Health Services, and a move towards funding single regional ACCHSs with a view to extending pooled funding to other providers.

Queensland

Total population: 4,091,500; **Indigenous population:** 146,400 (3.6 per cent)

There are 25 ACCHSs in Queensland, many of which are funded by Queensland Health. Traditionally, Queensland Health has itself undertaken direct delivery of clinical primary care in rural and remote Aboriginal communities, with OATSIH funding small ACCHSs in those communities to deliver non-clinical services only. Larger ACCHSs in urban and regional centres are funded by OATSIH for comprehensive PHC services and may also attract funding from Queensland Health for particular programs.

Queensland Health funds the non-government sector, including ACCHSs, largely through its Health Services Purchasing and Logistics Branch, and is moving from one- to three-year funding contracts with separate performance schedules. Performance reporting (i.e. reporting against service targets) is required every six months, and financial and activity reporting is quarterly. ACCHSs also receive funding from other departments of the Queensland Government.

A long-term agreement has been signed between Queensland Health, OATSIH and Apunipima (the ACCHS for the Cape York region), which will enable the transfer of clinical services from Queensland Health to Apunipima over some 10 years.

Distinctive features of funding in Queensland are:

- direct delivery of Indigenous-specific clinical primary care by Queensland Health in rural and remote Aboriginal communities
- a move to three-year funding contracts with six-monthly performance reporting and quarterly financial and activity reporting
- funding by OATSIH of small ACCHSs in rural and remote communities for non-clinical care only
- experimentation in Cape York through a long-term transfer agreement between Apunipima ACCHS, OATSIH and Queensland Health.

South Australia

Total population: 1,568,200; **Indigenous population**: 26,000 (1.7 per cent)

There are 10 ACCHSs in South Australia funded by the Department of Health. The Aboriginal Health Division is responsible for policy and coordination, but no longer directly funds most services (the exceptions being the peak body, the Aboriginal Health Council of South Australia, and two specialised services). Remaining ACCHSs receive funding through mainstream regional health services, using procurement processes that apply to all NGOs funded by SA Health. Contracts are uniformly for one year, with an intention to move to three-year funding agreements. SA Health uses a single contract with several schedules.

Distinctive features of funding in South Australia are:

- one-year contracts with schedules and six-monthly financial and activity reporting
- the intention to move to three-year contracts.

Tasmania

Total population: 489,900; **Indigenous population:** 16,900 (3.5 per cent)

There is one ACCHS in Tasmania that provides regional clinics and is funded by OATSIH. The Tasmanian Department of Health and Human Services employs an Aboriginal Health Policy Officer.

A distinctive feature of funding in Tasmania is:

- the State government does not fund ACCHSs.

Victoria

Total population: 5,128,300; **Indigenous population:** 30,800 (0.6 per cent)

There are 34 Aboriginal community-controlled organisations funded by the Victorian Department of Human Services (DHS), approximately 20 of which provide a broad range of PHC. DHS has recognised the complexity of funding arrangements for ACCHSs and, following a comprehensive review, has recently made a commitment to reduce the number of separate funding lines and to simplify reporting arrangements (to align more closely with OATSIH reporting). Implementation is planned to occur progressively during 2009–10.

Within DHS there is a Koori Human Services Unit, which takes a policy and coordination role, but is not the provider of funding to ACCHSs. Funding is allocated by program divisions within the department, and then distributed through eight regions. The regions enter into service agreements with service providers. An officer in each region is charged with negotiating and maintaining an overview of the multiple funding lines provided to each NGO in his or her region. The department is also reviewing its internal arrangements of roles and responsibilities for Aboriginal affairs, with the intention of improving its way of working with Aboriginal organisations.

Contracts are for one or three years, with six-monthly financial reporting and quarterly activity reporting.

Distinctive features of funding in Victoria are:

- a mix of one- and three-year single funding agreements with schedules, and six-monthly financial reporting and quarterly activity reporting
- the role of regions in liaison with ACCHSs
- the DHS review and commitment to reducing the complexity of funding and reporting for ACCHSs, and improving its internal arrangements for working with Aboriginal organisations.

Western Australia

Total population: 2,059,000; **Indigenous population:** 77,900 (3.8 per cent)

There are approximately 20 ACCHSs located in diverse settings across Western Australia, with 16 funded by the Western Australian Department of Health through the Office of Aboriginal Health (OAH) from a range of seven funding programs. OAH has a specific PHC program budget and purchases services from the non-government sector. ACCHSs also receive funding from the Drug and Alcohol Office within the Department of Health and from the Department for Child Protection and the Department for Communities.

There is a mix of one- and three- to five-year funding contracts. WA Health intends to move to three- to five-year contracts depending on satisfactory reporting and compliance. Financial and activity reporting is six-monthly. There are two reporting templates currently in use, including one developed by OAH. OAH is working with OATSIH towards a single reporting framework, based on the OATSIH SDRF, although separate financial reports will continue to be required for acquittal purposes. Key performance indicators are being reviewed to make them more focused on outcomes.

Distinctive features of funding in Western Australia are:

- a mix of one- and three- to five-year funding agreements, with six-monthly financial and activity reporting
- OAH within the Department of Health manages funding to ACCHSs
- progress towards a single activity reporting framework for both WA Health and OATSIH based on the OATSIH SDRF.

Commonwealth Government

In contrast to the situation in most other jurisdictions, OATSIH carries responsibility for both funding and policy for Indigenous PHC. It provides direct funding for Aboriginal and Torres Strait Islander PHC and related purposes to 245 agencies, 80 per cent of which are Indigenous-specific, and 20 per cent of which are mainstream agencies providing Indigenous-specific services (OATSIH 2008).

The total number of ACCHSs (i.e. those whose mandate focuses on the provision of PHC) across the nation is approximately 150 (145 in 2008). Funding is also allocated to ACCHSs by other divisions of the Department of Health and Ageing and by other federal government departments.

OATSIH is progressively introducing a single, comprehensive three-year funding agreement (with separate schedules for discrete funding lines), subject to certain conditions, including annual submission of an SDRF plan and satisfactory performance against an annually applied Risk Assessment Framework.

The SDRF was developed in 2004 in consultation with the National Aboriginal Community Controlled Health Organisation (NACCHO) and its affiliates 'with the aim to standardise the non-financial reporting requirements of OATSIH funded organisations' (DoHA 2008b:ii). The framework is designed to assist ACCHSs to plan and report effectively on their utilisation of OATSIH funding, and 'to have greater input into how funding should be used to meet local community health service needs' (DoHA 2008b:ii). Activity, outcomes and progress with the agreed strategies are then reported twice a year against the targets in the SDRF. The SDRF covers service delivery, management, linkages and coordination, community involvement and future directions, but not capital works. Organisations may use the SDRF as a single plan for all activities and funding (including that received from other governments) at their discretion. As noted above, in the Northern Territory, New South Wales, Queensland, Victoria and Western Australia, there is movement towards streamlining State and Commonwealth activity reporting for providers through use of the SDRF.

OATSIH introduced the Service Activity Reporting (SAR) Framework in 1997–98 as a way to measure service provider output and to support accountability for funding. Since then, other reporting frameworks have been introduced, including SDRF, the Drug and Alcohol Services Report, the Urban Brokerage Services Report, the Bringing them Home and Council of Australian Governments Mental Health Counsellor Positions Reports, the Health@Home Plus Nurse Home Visits Report, and Healthy for Life Services Reports. OATSIH has signalled its intention to reduce the number of separate collections and improve the efficiency of this regime (OATSIH 2009).

In 2004–05 OATSIH developed a Resource Allocation Model in conjunction with the implementation of the Primary Health Care Access Program (Commonwealth of Australia 2007:41). The model was intended to enable allocation of funds based on Indigenous population and measures of poor access such as low use of mainstream funding through the MBS and PBS. It has been used to guide the allocation of new funds as they become available.

OATSIH has long recognised the concerns of the sector regarding the increasing administrative and reporting burden arising from multiple funding sources. A recent review aimed to streamline reporting, reduce duplication and ensure that data collected are relevant both to the funding body and to the providers (DoHA 2008b).

Distinctive features of national government funding are:

- the role of OATSIH as the main funder of ACCHSs, as well as the focus for policy and program development and funding within the health portfolio

- a single funding agreement with separate schedules for specific program grants and movement from annual to triennial funding

- the intention to move to funding based on regional Indigenous population levels and relative access to mainstream-funded services such as MBS and PBS.

Summary: Jurisdictional funding characteristics

Table 5 summarises the funding and reporting arrangements and pathways for distribution of funds to ACCHSs, as reported by health authorities in Australian jurisdictions.

Table 5: Jurisdiction health authority funding characteristics

Government	Funding contracts	Reporting	Allocation Pathway
Australian Capital Territory	Three years	Six-monthly financial & activity	The Aboriginal and Torres Strait Islander Health Unit distributes funding. The unit manages the majority of service agreements, and is the liaison and reporting line for most program funding.
New South Wales	One to three years	Six-monthly financial & activity	Several program branches coordinate funding, with financial administration through the Department's Finance and Business Management Branch. NSW Area Health Services also provide some funding to ACCHSs.
Northern Territory	One to three years OR Three-year tripartite	Six-monthly financial & activity	Several separate divisions and program branches within the Department allocate funding for different services, and it is distributed by the Financial Services Branch.
Queensland	One to three years	Quarterly financial & activity	Funding is allocated to ACCHSs largely through the Health Services Purchasing and Logistics Branch.
South Australia	One year	Six-monthly financial & activity	Funding through mainstream regional health services, using procurement processes that apply to all NGOs funded by SA Health.
Tasmania			No State-funded ACCHSs.
Victoria	One to three years	Six-monthly financial & quarterly activity	Funding through program divisions within the department, distribution through eight regions that enter into service agreements with the ACCHSs.
Western Australia	One year OR Three to five years	Six-monthly financial & activity	Funding, liaison and service agreement management is through the Office of Aboriginal Health, which has a specific PHC program budget.
Commonwealth Government (OATSIH)	One to three years	Six-monthly financial & activity OR Quarterly financial & activity	OATSIH is the main funder of ACCHSs with a consolidated focus for policy, funding and program development within the health portfolio.

Please note that this simplified summary illustrates the typical pattern from the jurisdictional perspective, and masks the complexity for ACCHSs that receive this funding in the form of many different grants, from several different government departments. The complexity for recipients is explored in Section 4.

Reporting and accountability requirements

This section highlights reporting requirements in three of the four dimensions of accountability outlined in Table 3. The dimension of political accountability is discussed in Section 5.

Financial accountability

As detailed above, the reporting requirements of different governments and different departments within one government vary. Typically, financial reporting is required every quarter or six-monthly, with audited financial statements annually. Some funding programs require *line* reporting and explanation of variances by line (i.e. information on expenditure on different types of goods and services and salary or wages costs); others require line reporting but no explanation of variances, implying budgetary line flexibility.

Performance accountability

Activity or performance reporting requirements are similarly mixed. Most funding programs specify reporting of quantitative data about services delivered and recipients and sometimes location. In addition to reporting of activity levels (*heads through the door*), some programs require reporting of clinical and related indicators of effectiveness or health impact (such as proportion of patients with diabetes whose sugar levels are well controlled, or proportion of expectant mothers who receive adequate antenatal care). On the other hand, capital and project grants tend to require narrative reports and/or progress indicators.

The SDRF is potentially a major step towards a nation-wide standardised accountability template, at least for forward planning and financial reporting. The SDRF seems to be useful as a tool for managers to improve planning and for managers and funders to review the process of service delivery, as well as to increase staff accountability. However the implementation of the SDRF has several limitations. Currently the SDRF is largely used only for programs funded by OATSIH and not for State/Territory or other Commonwealth programs. The development of plans and targets is a complex undertaking, and ACCHSs that are new to this way of working may struggle to articulate realistic plans and targets.

The sector is assisted with reporting and strategic planning by the State/Territory peak bodies, and through SAMSIS (Secure Aboriginal Medical Service Information System). SAMSIS is an initiative of the ACCHSs, funded by OATSIH. It is a repository and report generator that assists ACCHSs to process and report required service data. SAMSIS can generate reports based on aggregated data at regional, State or national level (SAMSIS n.d.).

Our review of the funding program guidelines and contract forms indicated several potential problems, and these were supported by comments from both funders and providers during interviews. Areas of potential or known challenges were:

- duplication of reporting on a single service or activity when it is funded from more than one source
- different data definitions used in reporting requirements of different governments or departments
- different information needs of the providers for purposes of management, decision making and quality improvement, on the one hand, and information needs of funders for accountability and higher level reporting, on the other
- the SAR system and the SDRF tend to duplicate data entry and reporting. The SAR is a basic *head count* of patients seen in clinics, and has provided useful data at the central level and for basic monitoring by ACCHSs.

Reciprocal accountability

The annual auditing requirements in most of the standard contract forms are in line with current government practice. In 2007–08 OATSIH introduced a Risk Assessment Framework, with a requirement for annual completion and sanctions for poor results. The risk assessments may also be conducted at other times, for example, where there has been a sudden and significant change in the Board and/or management, or where the organisation is being considered for a significant increase in funding from OATSIH (OATSIH 2007). The risk assessment is a standard OATSIH requirement of ACCHSs, and is undertaken in addition to their voluntary participation in Australian national accreditation processes.

The dispute handling provisions in the standard contract forms are similarly in line with generally accepted practice, requiring that both parties work constructively in a spirit of goodwill in the funding and delivery of services and initiate discussions with the other party to resolve concerns in the first instance. If a dispute arises that cannot be resolved, the agreements provide for the parties to take the issue to a higher level for resolution.

Reciprocal accountability for the fulfilment of each party's obligations to the other (one of the four dimensions of accountability) is principally enacted through audit and dispute resolution procedures. The current provisions appear to be one-sided, focusing primarily on the compliance of providers.

In conclusion

Our review of the funding and regulatory practices of Australian governments confirms the complexity and fragmentation of funding arrangements, and the perceived heavy burden of acquiring, managing, reporting and acquitting funding contracts for both sides of the funding relationship. These problems arise partly from a lack of consistency in the reporting requirements of national and State/Territory government funders. And they are compounded, in the majority of health authorities, by internal structures that separate responsibility for policy and relationship development from responsibility for contract management. Although these arrangements may have other advantages for the health authorities, we suggest that in relation to Indigenous health services they complicate communication tasks and reduce the knowledge management capacity of the funder (i.e. its ability to ensure that information about agencies and funding issues is shared and available to all who might need it).

There is also evidence of general awareness of these problems and a widespread effort to address them. However, it seems that the implementation of intended reforms is slow and patchy, particularly where cooperation between two levels of government, or different government departments, is required.

section 4:

ACCHS Funding and Income

In this section we report the results of a study of funding received by ACCHSs in 2006–07. This study was conducted to bridge an important knowledge gap, 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

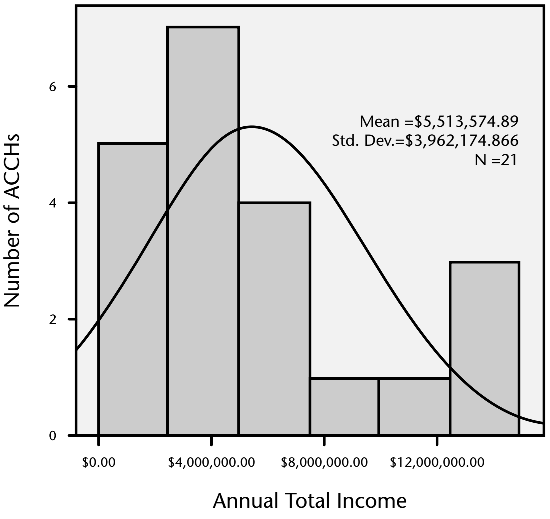
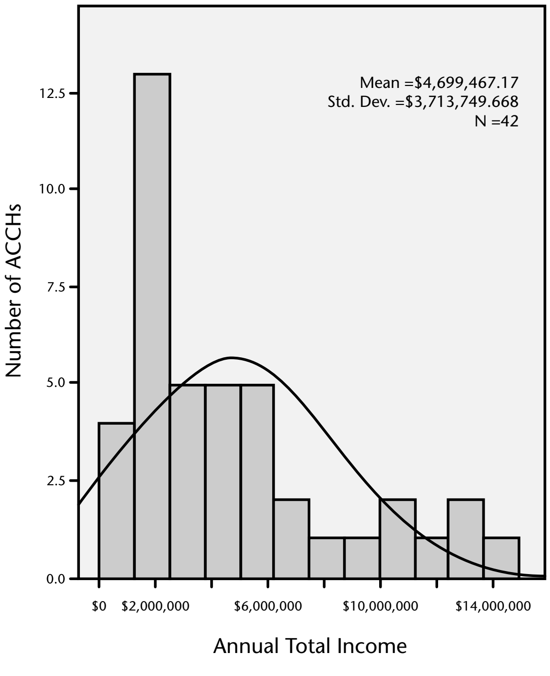


Figure 4: Total income of ACCHSs in ORIC reports



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

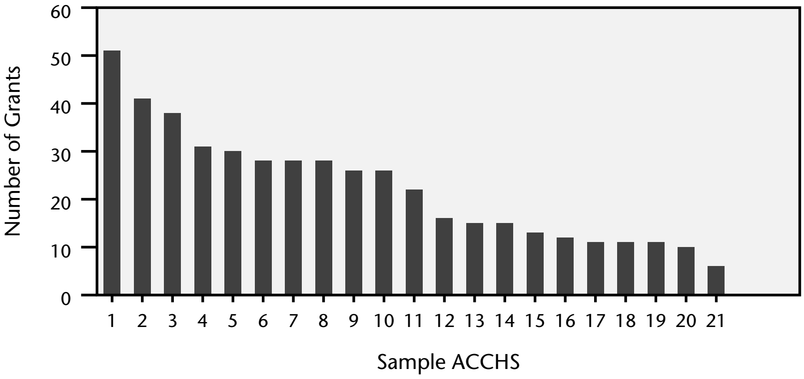
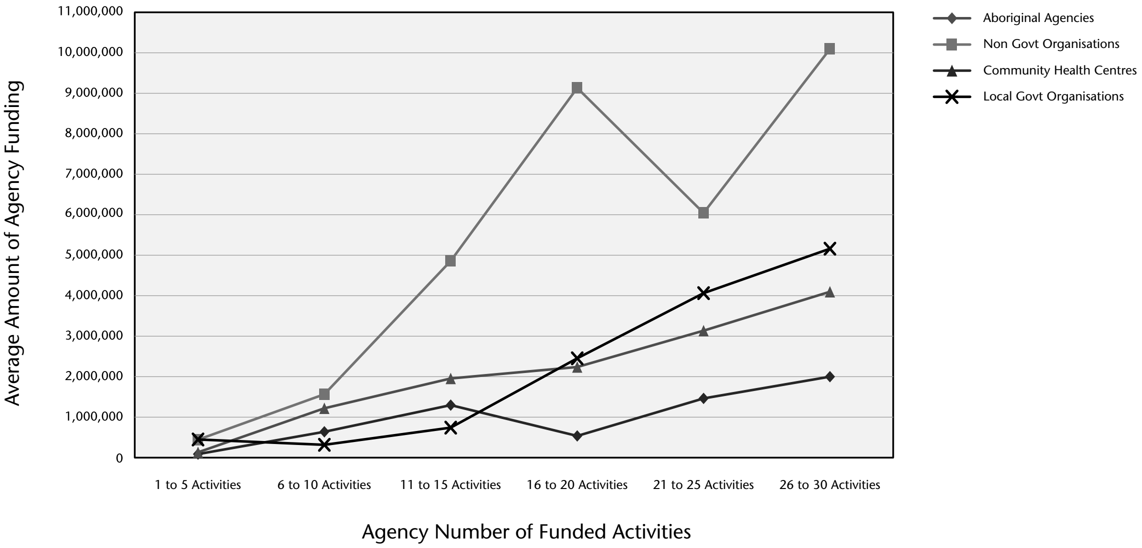


Figure 6: Activity funding to Aboriginal and other agencies (DHS Victoria)



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

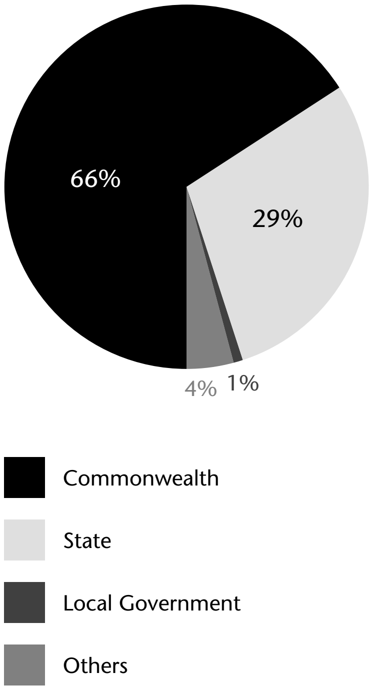
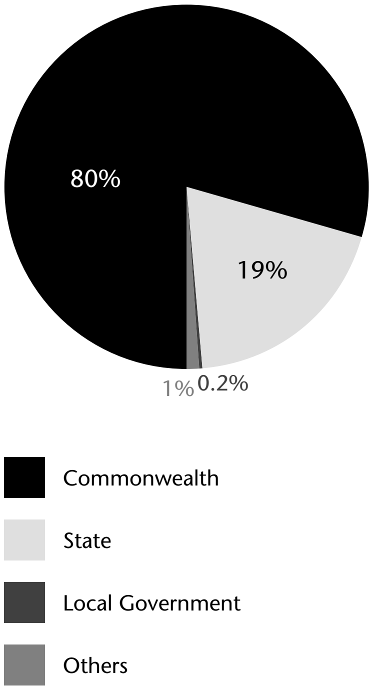


Figure 8: Percentage of funding amount by main sources



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. A detailed list is given in Appendix 2.

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

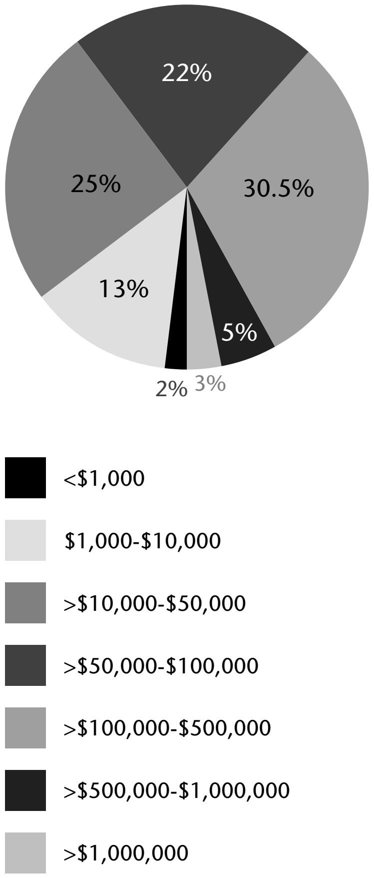
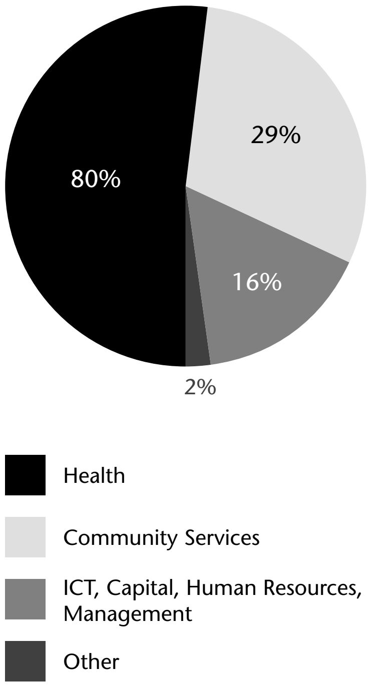


Figure 10: Grant categories



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

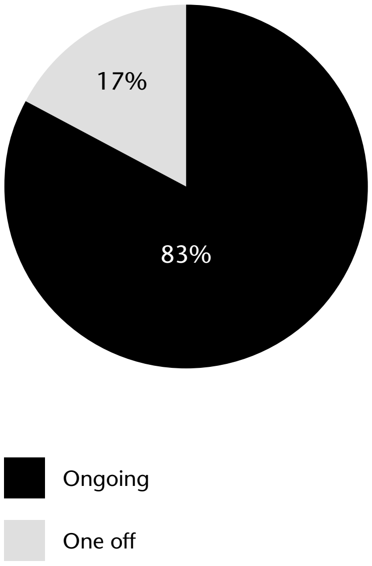


Table 7: Funding and allocation categories in the *Red Tape* report

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%

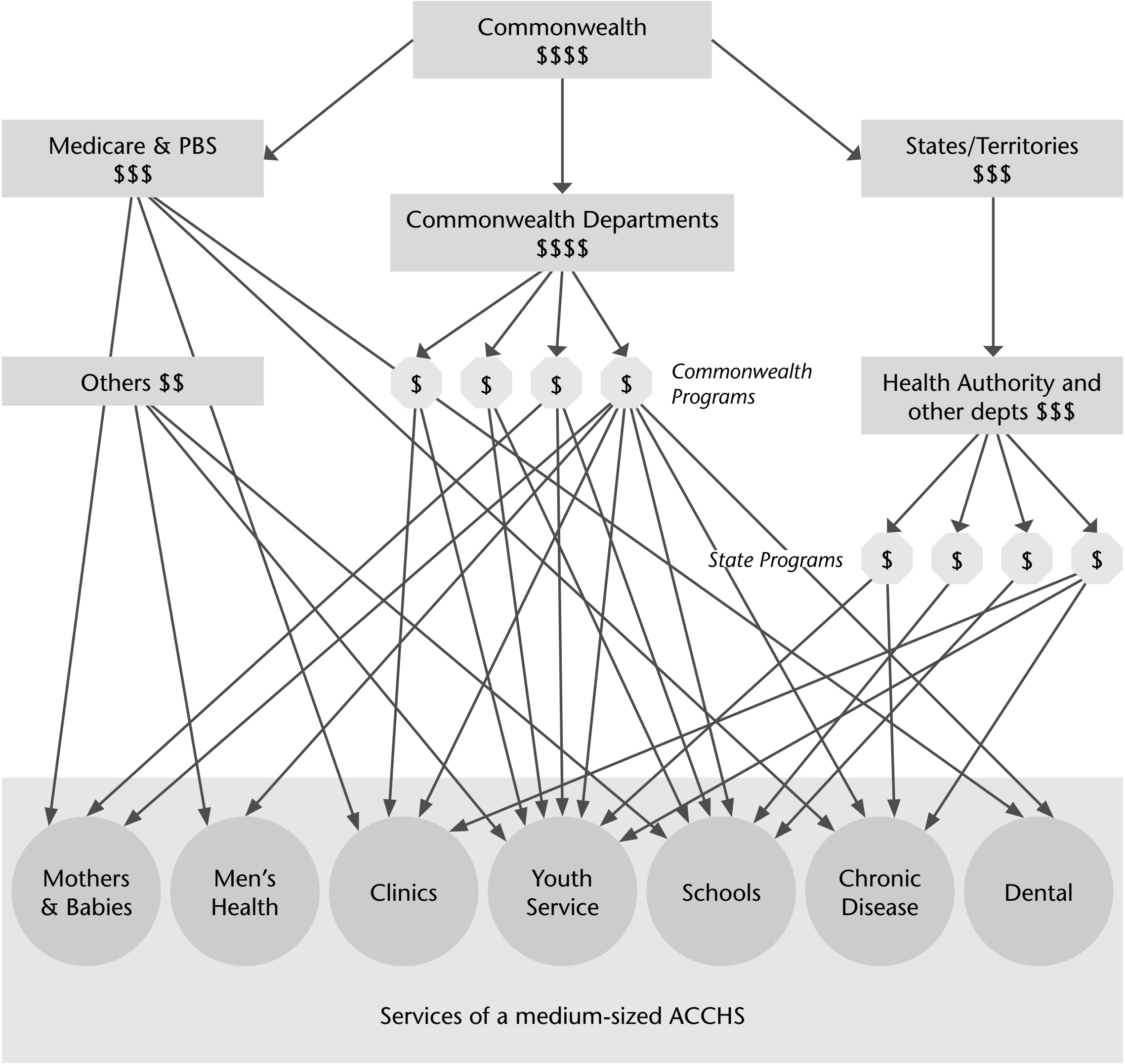
A Victorian study (Effective Change 2008:16) found a comparable level—a 74 per cent/26 per cent breakdown between ongoing and fixed-term funding. Although there are differences in the terms used in each of these sources, it seems that the majority of funding is effectively (but not contractually) ongoing, 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.

section 5:

Perspectives of Funders and Providers

In this section we report on the results of interviews with senior staff of ACCHSs and central health authorities of the national and most State/Territory governments. The analysis of the interview data is organised using headings based on our contracting framework, as shown in Table 2 above, and is informed by the accountability framework shown in Table 3. The interview questions are given at the end of Appendix 1.

Twenty senior staff from national and most State and Territory health authorities were interviewed between February and June 2008. One State chose to respond in writing, and one declined on the basis that the State does not directly fund ACCHSs. Responsibilities of those interviewed varied from PHC policy and strategic planning to management of funding contracts and broad Aboriginal health financial program management. Seven participants had primarily financial roles, and 13 had broader policy or mixed roles. Five staff identified as Aboriginal or Torres Strait Islander.

Between June 2008 and February 2009 we interviewed 23 CEOs and senior finance staff or managers of ACCHSs in most States and Territories. Most (70 per cent) of the CEOs interviewed were Aboriginal or Torres Strait Islander people, while less than half of the finance and management staff (40 per cent) were Aboriginal or Torres Strait Islanders. They worked in ACCHSs that span the full range of size, location and organisational *age*, but overall the agencies represented were somewhat less remote, larger and older.

Each interviewee was assigned a unique identifier. In reporting on our analysis in this section, we show the identifiers to indicate the sources of the data on which the analysis is based (the letter *H* indicates health authority staff and the letter *A* indicates ACCHS staff; *M* indicates a management role and *F* indicates a finance role). Quotes are attributed by identifying the sector and role of the speaker.

Nature of funding

Health authority staff and ACCHS staff confirmed that funding is complex to acquire and administer, and endorsed the need for simplification and flexibility (14HM, 8HF, 1HM, 6HF, 18HM). ACCHS staff reported that there are too many funding lines, too many service agreements and too much overlap (13AM, 8AM, 12AF):

> *There are lots of buckets of money from lots of different programs from the same funder that are addressing the same issues, but with a different name* (ACCHS CEO).

Both groups contrasted core PHC funding (funding that enables the operation of clinics, other PHC services, and related support, management and infrastructure services) with program or *body part* funding (funding that is directed to specific activities for specific conditions or health risks). Core funding for comprehensive PHC was seen to enable more independence and flexibility, allowing ACCHSs to continuously implement and adapt programs to meet local needs.

> *The actual cost of running and providing a service needs to be taken into consideration. [The agency] provides a lot of community activities, a lot of other things that we don't get funded for… We are transparent. We are accountable to all of our funding organisations. We do justify, but global funding that matches the actual costs of providing a service that we provide on a holistic basis would be the best outcome* (ACCHS CEO).

Interviewees spoke about the problem of using condition-specific health program funding to deliver services when core PHC services are not adequately funded:

> *unless you've got core primary health care money to deliver the basic minimal level of primary health care, you can't deliver a health service based on programmatic, organ-specific, disease-focused programs because that becomes selective primary health care and unless you've got core primary health care you're never going to be in a position to offer other relevant programs based on the community needs* (ACCHS CEO).

> *we make assumptions that everybody has access to a point of PHC… We make assumptions that everybody has equal right of access and they don't. We haven't gone in and argued a strategic approach to overcome this challenge* (Health Authority Manager).

Although some ACCHS staff reported that program grants can align well with agency activities, so that separate reporting on program grants can be useful internally as well as meeting external requirements (13AM, 2AF, 22AM), there was repeated comment on the problem of integrating funding programs that are focused on specific diseases or interventions with those that are for comprehensive PHC (8AM, 10AM, 20AM), and about the constraints against shifting resources to other areas that are underfunded but important to balance service delivery (2AF, 12AM, 9AM, 3AM).

Basis of funding allocation

Government finance officers were asked about the basis for determining funding levels, and confirmed that funding for ACCHSs was based on a combination of population (number of people served), historical (based on last year's allocation) and policy or political factors (e.g. in marginal seats in an election year, or when a related policy decision has an impact).

Some health authority staff stated that funding levels for many ACCHSs have not been reviewed for years.

> *there's the historical component. One of the challenges is that it's always been there so we don't challenge it and we don't say how can we improve it or what do we need to do to value add in terms of budget increase or better access to services or streamlining the way we do things. Budgets were acquired in a period of substantial growth and what has tended to happen is that Aboriginal health budget allocations have remained reasonably static, partly because we've not taken a strategic approach in developing a business case to argue for an increase in funding proportional to the health need of [Aboriginal and Torres Strait Islander] people. We've tended to take a project-*

> *focused approach. What we've not done, I don't think, in any of the jurisdictions, is sat down and asked what is the strategic budget we would need for the next five years and then build a strong business case* (Health Authority Manager).

ACCHS staff commented on the tendency for funding program grants not to include funding for essential components of service delivery, such as transportation (9AM, 7AM, 14AM, 2AM, 13AM) and human resources capacity building (3AM, 17AF, 8AM, 11AF), a problem that was also acknowledged by health authority staff (1HM, 16HF, 9HF). The need to allocate components of individual staff salaries to different program grants for the same or like purposes (e.g. different aspects of diabetes care) was noted to be both difficult conceptually (1HM, 2AF) and time consuming (3AM, 1HM, 4AF).

> *When we're dealing with health issues, [we need to determine] how much and what needs to be done to address the issues holistically and yet government provides a piecemeal funding approach* (ACCHS CEO).

Capital funding (e.g. for new buildings) is also complicated. Governments are understandably more reluctant to provide capital funding for assets that will not be owned by the government (9HF). But there is also the problem that lack of clarity about the responsibilities of each level of government means that capital investment decisions must often be made by both levels of government acting together. One health authority finance officer acknowledged a recent significant decrease (by more than 90 per cent) in the capital and maintenance budget, which occurred during the transfer of funding responsibility from one division to another within the health authority.

> *The state government [is] happy to put dollars into mainstream services because they're assets of the Minister. They're not willing to give infrastructure on Aboriginal land because assets would belong to the people* (Health Authority Finance Officer).

Funding is sustained but uncertain

Both health authority and ACCHS staff affirmed that they see their relationships as long term, even though most funding is allocated annually or for three years. However, uncertainty about the continuity of funding was reported to cause several problems, including periods of operating without knowledge of funding allocations, problems in meeting timelines for the spending of funds, and the effects of uncertainty on planning and operational decision making, on workforce sustainability and on the quality or volume of service provision.

Funders reported that most funding is expected to be ongoing in practice, and that they understand that staff members are often appointed on an ongoing basis (1HM, 2HM). They noted that administrative practices (e.g. arrangements to continue core funding at the beginning of a financial year before contracts were ready) were based on an assumption of continuation. They also acknowledged the problem of insecure funding:

> *There is a reasonable assumption that an ACCHS will receive continual funding but this is not contracted in a way that would make them feel secure* (Health Authority Manager).

Some ACCHS staff acknowledged a role for short-term funding as part of the total funding mix (10AM, 3AM, 1AM) but most reported that short-term funding is problematic because of the amounts involved (8AM, 15AM, 17AF), the difficulties of recruiting to short-term positions (8AM, 9AM, 2AM, 14AM), the burden of administration and reporting (18AM, 15AM, 3AM), the problem of discontinuing services in the face of community expectations (11AF, 8AM, 13AM, 17AF, 19AF), the difficulty of demonstrating outcomes from short-term interventions, and the problems for planning and strategic direction setting (11AF, 19AF, 1AM, 5AF). Some reported advantages of short-term funding were essentially related to inadequacies in longer term funding (such as its use to fill unfunded gaps in existing services) (8AM, 10AM, 1AM). Other advantages included additional resources to conduct short-term health promotion activities (18AM, 13AM, 10AM, 1AM), to conduct projects such as evaluations (18AM) or one-off events (16AM), and for developing new local programs (10AM).

Health authority staff generally agreed with the perspective of ACCHS staff, while noting that short-term funding provides greater flexibility for the funder (5HF, 9HF, 20HM). They also endorsed concern about the difficulty of demonstrating outcomes on the basis of short-term funding arrangements, the reputational risk of real or perceived failure, and the problem of 'good work falling by the wayside' (1HM, 13HM). They also commented on the lack of capacity for rigorous evaluation, or long-term planning, the problem of workforce sustainability, the additional reporting burden, and the tendency for short-term funding to require a focus on activity more than outcomes (13HM, 20HM). The shift by OATSIH and some State and Territory governments to three-year funding was noted as a positive step.

Machinery of government adds to the problems

Health authority finance officers affirmed that it was not possible for their departments to give an accurate account of the funding that ACCHSs receive from their own governments (whether Commonwealth or State/Territory), let alone the other level of government. This may reflect their management focus on specific contracts, but it means that overall monitoring of the adequacy or trends in funding to ACCHS, or indeed for Indigenous-specific services more broadly, is not possible. It also makes it difficult to assess the burden of administration these agencies must carry in the complex contractual environment in which they operate.

Different funding processes and formulae exist across divisions within some State and Territory health authorities. So, for example, indexation (annual adjustment for inflation) may be calculated differently within and between departments of the one government. These inconsistencies can constitute a barrier to more integrated funding or contracting arrangements, and tend to add to complexity for funding recipients:

> *It's a program line and we still fund Aboriginal organisations completely, irrespective of what other government programs are also funding them to do. This can get into a situation where Aboriginal organisations can struggle to cope. They're not doing so well in the programs they've already got. Other program areas aren't necessarily aware of this and overload them* (Health Authority Manager).

Finance staff in most jurisdictions said that new program funding is distributed by the Commonwealth Government to the State or Territory too often and too late, contributing to the problem of timely allocation to ACCHSs, and the pressure to recruit staff and spend quickly.

> *The Commonwealth rolls something out every week, it's challenging then for us to put things on the ground… It took a year to get the program funding to us for a three- to four-year program, we've already lost a year before we even get on the ground. We're a year behind in our reporting, a year behind in our achievements, hence we're a year behind in [managing] our under expenditure, or our potential to lose dollars. Because we're behind, the funding to our [ACCHSs] is behind* (Health Authority Finance Officer).

There were several comments from both sides on the problem of late allocation of funding, with ACCHSs continuing to operate on the assumption or promise of allocations. Cash-flow difficulties (5AF, 3AM, 16HF, 21AF), pressure to spend before the end of the contract period (16AM, 5AF) and impacts on operational decisions (9AM, 10AM) were reported, as was the negative impact on capacity to make and pursue longer term plans (8AM, 14AM, 12AM, 15AF, 10AM, 9HF).

> *All we want is funding certainty so that we can really start to give some long-term commitments to our programs on the ground* (ACCHS CEO).

The majority of senior officers with responsibility for Aboriginal and Torres Strait Islander health policy who were interviewed had very little direct responsibility for the allocation of funds, or the management of funding contracts, a role that tends to be undertaken either by specific program branches (e.g. acute care, community, disability, mental health etc.) or by centralised departmental contract management or business units in others. In some cases, this is a recent change from a previous structure in which funding, contract management and policy development were united in a branch or division focused on Aboriginal and Torres Strait Islander health. OATSIH is the main exception—it controls the funds, manages the contracts, is responsible for policy development, and acts as the purchaser of services from ACCHSs and mainstream providers. In the jurisdictions, the predominant separation of policy leadership from financial management (sometimes related to current government procurement procedures) may tend to exacerbate the complexity of accountability arrangements (through 'serving two masters').

The practice of requiring funds to be spent by the end of the financial year was seen as a problem by several ACCHS interviewees (9AM, 3AM, 6AF, 17AF). They noted that there are many reasons why funds may be unspent at the end of the year (including delays in funding allocation or in staff recruitment). Such funds may still be required in order to sustain the service in the subsequent year (6AF, 2AF) or to enable ACCHSs to balance unspent program funds and deficits (3AM, 9AM) or to respond to local priorities (13AM).

Impact on workforce

Funding levels are also seen to impact on the capacity of ACCHSs to recruit and retain staff. Health authority staff recognised that when support and administrative costs (e.g. for transport for an outreach worker) are not included in program funding, the result can be inequitable salary structures. In some jurisdictions, pay differentials result from ACCHSs having a different industrial award from that applying in mainstream health care organisations:

> *a different award means they pay at a lesser rate so we've got this incredible differential which in a sense is unfair because you have two people doing the same work but they're paid different salaries. I suppose it would equate to the argument where men would do the same job as women in the past and there was a gender salary differential, which is problematic* (Health Authority Manager).

About two-thirds of health authority staff said the administration associated with the provision of programs and reporting requirements is not factored into the funding allocated to ACCHSs. Once the ACCHS factors in a percentage (around 20 per cent) to cover administration, the funding is reduced somewhat and the ACCHS is unable to offer salaries commensurate with mainstream salaries.

> *we don't factor that in for ACCHSs. I think, somewhere, there has to be a debate by jurisdictions around the issues that if we fund programs in ACCHSs or in Aboriginal organisations, we need to build in the administration costs because if we don't do this, we tend to rob Peter to pay Paul, which means that we don't offer a salary that's commensurate with the salaries in the mainstream system. If I were to appoint, for example, Otitis Media Coordinators in [State], the salary rate that would be paid to a person in an [ACCHS] would be much less than a person paid within our jurisdictional positioning because at least we have a set of reference points in terms of State awards that apply for any employee working within the public sector* (Health Authority Manager).

The problem of salary differentials was highlighted by several ACCHS interviewees (13AM, 9AM, 16AM, 12AM). They also focused on the effect of short-term program funding on workforce insecurity (14AM, 17AF, 9AM) and the availability of in-service training (3AM):

> *We're training good Aboriginal people up in the health work, but obviously the departments and other health organisations are snapping them up and paying them substantially more money, so it's really a difficult journey for retention of staff as well* (ACCHS CEO).

Priority setting

Interviewees identified two main problems with the current use of priority funding programs for specific conditions or interventions. The first concerns the need for an adequate base of core PHC funding, so that targeted funding can be used as intended—to direct more resources to underserved areas, or areas of high opportunity for health gain. As noted above, if the PHC funding base is inadequate or absent, targeted funding tends to be 'patched together' and used to meet demand-driven core PHC needs.

> *If I can't find money in a dental bucket then I'm going to find money in a primary health care bucket or a maternal bucket, but it's all primary health care. So that's where I think shoe-horning yourself into specific areas—ears or eyes or kids or adults or renal or asthma or whatever it is—actually becomes more problematic. Little amounts of money, I think, is always hard as opposed to a generic bucket that is primary health care, which is what we do* (ACCHS Manager).

Almost all health authority staff recognised a national lack of coordinated strategic approaches to improving access to healthcare for Indigenous people. One suggested the need for a national access and equity policy (1HM).

Three-quarters of the health authority staff said that priorities are set centrally, and based, among other things, on nationally aggregated data that necessarily gloss over local and regional differences. These priorities are set to maximise government resources and to respond to Commonwealth directives more quickly. They noted the lack of a consistent approach within government that is inclusive of ACCHSs in setting these priorities.

The second set of problems relates to the inevitable tension between local and national priority setting. This was noted by several ACCHS interviewees, who commented on the problem of *top down* decisions without consultation on local priorities or without regard to the strategic approach of the organisation (8AM, 7AM, 1HM, 22AM). They noted a lack of consultation with service providers (11AF, 5AF, 12AM, 14AM) and that some of the centrally designed programs are not actually needed by the community (7AM, 8AM).

> *So we're never asked our opinion about where—in our community—what might be our priority and how might they fund those, which I suspect would be different all over Australia and so we have these national targets and programs that are developed out of Canberra but we don't know who they consult to get those ideas from* (ACCHS CEO).

> *I think from a government's perspective their priorities and how they allocate money differs from how we identify what our priorities are, because we do it from the community up; they do it from the politicians down* (ACCHS CEO).

ACCHS interviewees commented on their political, performance and financial accountability being both to government and to their communities. Conflicting funding and service priorities can leave ACCHSs caught in the middle (5AF, 8AM), engaged in ongoing consultation with communities to make sure that programs can run smoothly (15AF) and in parallel negotiations with funding authorities.

> *Part of the self-determination is to develop this local health clinic, made up of the local Aboriginal people and the senior people they elected by themselves, and generally that works. Occasionally clan priorities come into conflict with what's best for the organisation but nevertheless quite often the health committee will be told by the [State] government what goes and what does not go and yet their charter is to be self-determining and be involved in making their own decisions. So sometimes we have a problem with that* (ACCHS Finance Manager).

However, several ACCHS interviewees reported collaboration or discussion between the funding body and the ACCHS in deciding on programs and approaches (15AF, 10AM, 3AM).

Monitoring

The need for accountability results in the implementation of monitoring mechanisms. This was recognised as necessary by all participants. However, the nature and volume of the data required to satisfy reporting requirements, as well as the arrangements for their collection and reporting to funders, add considerable transaction costs for ACCHSs and funders. An ACCHS CEO referred to the sense of being regarded both as effective and subject to what the CEO regarded as excessive scrutiny:

> *Even with, like, our service getting rewarded, you know… we're the first organisation that OATSIH will look at for anybody to come in and have a look at how we're running our service and stuff… but you're constantly being surveyed, you're being audited…* (ACCHS Deputy CEO).

ACCHS staff commented on a lack of collaboration among State and Commonwealth funding authorities, and the lack of a standard reporting format (6AF, 18AM, 15AM). This is particularly burdensome for activity reporting (6AF, 16AM, 10AM, 12AM, 9AM, 20AM, 7AM). Line budgeting and the lack of standard templates are seen as major contributing factors (5AF, 17AF, 14AM, 9AM). The move to single funding agreements is welcomed, but does not necessarily reduce the burden of reporting, as separate schedules or numerous variations impede the promised simplicity of single agreements.

One finance officer related a situation where funding for a single service for one target group routinely requires eight reports. The ACCHS serves a local community that crosses over four sub-regions (in two separate regions) as defined by one non-health funder. It runs a service for one target group that reaches two sub-sets of people who are of interest to the department, and therefore the service is funded from two programs. Thus the ACCHS is required to produce eight reports every six months on the finances and activities of the service. The service is not very big (total funding is less than $200,000), and is coordinated by one person. The salary and goods and services costs incurred by this one person are routinely split eight ways. Staff in the funding department know that such precise accuracy is unlikely, and collaborate with the finance officer to agree on ways to avoid some of the absurdities of this situation. The finance officer reports that the routine financial reports are automated and, after setting up, the time taken is not great (except for variations) but the activity reporting is more difficult.

Some health authority staff also acknowledged the need (and indeed pressure) for government to change its reporting regime (10HM, 2HM), to streamline the reporting process and lessen the reporting burden, while also linking funding with meaningful health outcome data (6HF, 14HM, 7HF, 1HM). Health authority staff also acknowledged the problem of inconsistent requirements and timelines between State and Commonwealth government departments, and the failure to consistently adapt reporting requirements when funding amounts are low.

> *We actually don't give them a template to acquit the grants, so they make it up or they might just not do it* (Health Authority Manager).

Some ACCHS managers felt that the burden of reporting to State/Territory funding bodies is higher in proportion to the amount of funding (3AM, 17AF). Other concerns for ACCHS staff included ‘shifting goalposts’, where funding rules and guidelines were changed without notice or negotiation (13AM, 18AM, 11AF).

Some CEOs of ACCHSs felt that they were over monitored, with a focus on financial probity rather than performance or planning (6AF, 9AM, 20AM). Some regretted what they perceived as a reduction in the willingness of funding staff to undertake more positive forms of monitoring, such as site visits, perhaps due to the cost (20AM, 1AM). Some suggested that the level of monitoring, reporting and risk assessment required of ACCHSs is higher than those for mainstream agencies (8AM, 13AM, 9AM), and others that they feel ‘dictated to’ by health authority project officers (6AF, 11AF, 20AM).

> *I think they try to become, in effect, a de facto manager of the health service, rather than just funding it, buying the services, if you like, which is exactly what they should be doing* (ACCHS Finance Manager).

> *We’re the most over-reported and protected sector. You look at divisions of [general practice], you look at some of those mainstream health organisations and you look at the reporting arrangements that they have versus what Aboriginal organisations have. We have to report on every little thing* (ACCHS CEO).

> *Each program that we receive funding for all require different formatted data collection* (ACCHS Finance Officer).

Some health authority staff also felt that overall accountability requirements for ACCHSs were more stringent than those for mainstream agencies (10HM, 9HF, 1HM). Although underlining the need for communities to justify expenditure of public funds, they noted an excessive amount of justification through reporting, particularly when ‘you're talking small amounts of funding. There's got to be a balance’ (Health Authority Manager).

The majority of health authority finance staff agreed that ACCHSs (particularly rural and remote ones) struggle to keep up with government reporting compliance for a number of reasons, including lack of ICT and the staff to generate reports.

> *Remote locality of organisations getting the proper skilled-based people is a big issue* (Health Authority Finance Officer).

> *Some services don't have up-to-date technology, or don't know how to use the technology* (Health Authority Finance Officer).

> *Big [ACCHSs]… have the expertise and the money to provide reports. The small [ACCHSs] struggle with it. There’s a lack of skills to report at this level* (Health Authority Finance Officer).

Reporting is often not used well

Health authority staff in five jurisdictions reported that the data collected from most ACCHSs are more accurate and more up to date than data collected from mainstream services.

One ACCHS manager believed that the time and effort to collect data and generate reports was not justified by value for internal purposes (14AM). Another expressed frustration about barriers to sharing data:

> *There’s a lot of debate going on about privacy and confidentiality. Like we even had an issue with our auditors wanting to know how complete the project was and asking to see data—and they’ve got the medical people in the organisations saying, ‘oh, I can’t show you that, it’s all privacy and confidentiality’ and the like* (ACCHS Finance Manager).

But others valued the data for performance and quality management (8AM, 9AM), and commented on the value of the SDRF (15AF, 5AF) and the data generated from the ICT system *Communicare* (17AF, 10AM). However, there was widespread agreement that ACCHSs hardly ever get feedback from funding bodies on their performance reporting, except when there is something wrong or clarification of a report is needed (20AM, 6AF, 14AM, 10AM, 9AM, 1HM, 12AM, 18AM, 17AF, 19AF, 5AF, 10AM).

> *We send things to the department and the left hand doesn't know what the right hand is doing* (ACCHS Finance Manager).

Health authority staff noted the multiple purposes of data collections, including improving efficiency and healthcare delivery, identifying gaps in health care and monitoring the compliance of ACCHSs. Some expressed confidence that the data are well used:

> *We're required to report to federal government on all sorts of activities. The data will go to business and performance managers, it will go to a database to identify where the gaps are. It probably does go back to communities but they don't recognise it. It doesn't sit on a shelf as such. Stuff that works really well, we can roll out* (Health Authority Manager).

> *We do use the information, it's important for us to be able to acquit the money, and look at what is reported against, what they've spent, make sure they're using our money for the purpose that we ask them to and whether or not they're delivering adequately. This is important because we're responsible for public money. We need to be able to be accountable to our department and to the tax payer. If we get a ministerial brief or a question on notice, we've got that information on hand to say, yes, the money has been used appropriately* (Health Authority Manager).

Others expressed concern:

> *Data is passed on to the policy people. A lot of programs are really driven from Canberra and Head Office and they encompass everybody. Outcomes are decided centrally. We could do more, some of the stuff we collect doesn't get utilised as much as we'd like* (Health Authority Finance Officer).

Some participants on both sides commented on the need for better skills in analysing and assessing the importance of data about both financial and health care performance.

> *The measures need to be revisited to fit within the new Commonwealth agenda. Whatever data we collect demonstrates that [ACCHSs] value-add to the State's health care system and vice versa* (Health Authority Manager).

Funders also identified the lack of skills within their departments in assessing the reports.

> *There's also lack of skill level within our own agency of officers who assess reports to determine whether the report is satisfactory* (Health Authority Finance Officer).

Different data are needed

Health authority staff identified several areas where better data are needed, including the problem of identifying Aboriginality in mainstream services, and the lack of focus on Aboriginal and Torres Strait Islander people in mainstream data collections. More relevant to ACCHS activities, they noted the need for nationally consistent good quality data and more and more rigorous evaluation of the success of interventions:

> *The ACCHSs data is a lot more rigorous in terms of identifying Aboriginality and other identifiers. Legislation was passed last year to record Aboriginal identifier on the pap smear register. It's mandated on death certificates/death register. There is an Aboriginal identifier upon admission but some staff feel uncomfortable and don't ask the question, some people don't want to identify, some people identify sometimes and not other times* (Health Authority Manager).

> *The biggest issue is about Aboriginal identification. We've been looking at death recently and there's very little ability to collect Indigenous death* (Health Authority Manager).

> *The whole data collection needs to be improved so that, at the end of the day, we get more meaningful data so we can actually see what it is we're achieving, based on what it is we're funding. Another problem we encounter is communities are so transient, that we get possibly a misrepresentation of data* (Health Authority Manager).
>
> *A lot of the data we actually collect, is probably not that beneficial, it doesn't really tell us where the improvements have been made* (Health Authority Finance Manager).
>
> *Data is not one-way—it's two-way because when we combine our data with [ACCHS] data, then what you've got is a powerful piece of information that can be used within the national arena. Because in some cases what we don't do is use the data to show that we are doing things well and that we are closing gaps. We always tend to use data in a negative way and we've got to get out of the negatives and deficits. There is some extremely good stuff happening that is being driven by Aboriginal people or being driven in partnership with non-Indigenous people* (Health Authority Manager).

One-way accountability

One-way accountability is a term used by ACCHS interviewees to describe the lack of accountability of funding bodies to ACCHSs (18AM, 12AM). They also noted lack of reporting back to ACCHS unless they have failed to meet funding body expectations:

> *the accountability is put back on our organisations and NGOs and that, too, comes into play with the risk management, where funding bodies give us a risk management level but, at the same time, the accountability is not on them to provide that as well… We're accountable but who is keeping them accountable?* (ACCHS CEO).

Although the need for monitoring and reporting was recognised by all interviewees, there was concern about the usefulness, and the actual use, of much of the monitoring data. Further, there was a sense that ACCHSs are subjected to higher levels of scrutiny, possibly related to the relative lack of trust and credibility extended to them by funders and others. This finding suggests that monitoring mechanisms for ACCHSs are aligned more closely with public/political perceptions of the sector (and perhaps perceptions of Indigenous people themselves) than with overall performance of the sector and actual utility of the data. It further illustrates the problematic nature of maintaining accountability, for both funders and providers, in a situation of heightened political sensitivity and lower trust.

Transaction costs

Transaction costs in this context are the resources that are used in planning, negotiating, monitoring and accounting for the use of funding contracts, and they are incurred by both funders and providers. ACCHS interviewees referred to the time and energy required for several types of transaction costs: costs of acquiring funding, which tend to be proportionally higher for smaller grants; costs of preparing and submitting reports (outlined above); and the costs in financial accounting and administrative energy of managing multiple contracts. Several ACCHS staff commented on the workload involved in acquiring multiple grants for what is essentially PHC:

> *But there's still a lot of room for improving that because having to… deliver a comprehensive primary health care service you have to still go and find other monies. So that… increases your administrative load and also loading of staff, I suppose, in the organisation generally* (ACCHS CEO).

Health authority staff also acknowledged the resources consumed in designing, allocating, managing and analysing reports and acquitting grants, as outlined below.

Achievement of ACCHSs in acquiring funding

A small number of health authority staff said that there is a need for government to recognise and acknowledge the financial management skills of ACCHSs that use what little funding they have in the most effective way:

> *Many [ACCHSs] have built their service up by putting together all these little grants into what effectively was an operating budget. We need to recognise reality and say that these people have worked out how to use this totality of the money for best effect* (Health Authority Manager).

Several ACCHS staff indicated that their agencies had decided not to make submissions when small grants with substantive reporting requirements were offered because of the proportionally high costs of administration.

Health authority finance officers said that the reason for not giving an ongoing commitment to funding is to retain the ability to end funding of an agency if it is assessed as not meeting responsibilities.

> *Funding is not contracted long term in the service agreement because there's the government funder mentality that if the service provider responsibilities aren't being met, that the government can't get out of the contract* (Health Authority Finance Officer).

This is an important consideration for funders, and would need to be addressed in any funding reform (e.g. through hold-back provisions).

High volumes of monitoring and reporting

There was general agreement among health authority and ACCHS staff that the burden of reporting is too high, and that the level is linked to the nature of the funding programs and the reliance of ACCHSs on two levels of government. Current moves in several States towards streamlining data collection and reporting requirements are yet to be consistently implemented. Further, the tendency in recent years for governments to tighten reporting requirements for all recipients of funding has worked in the opposite direction.

> *By having short-term contractual agreements, the onus falls on the service provider. The reporting on activity data has increased, work has gone up and the process has become more formal with less room for negotiation* (ACCHS CEO).

> *It's a serious problem. It affects the efficiency and effectiveness of the programs offered by the recipient. In one ACCHS, the manager has to manage twenty-seven quarterly reports and financial statements and annual reports. When does she get time to run the organisation? It's been talked about but it's not been resolved* (Health Authority Manager).

Financial reporting was regarded as less problematic than activity reporting by many interviewees. However, there was some comment in relation to the costs for smaller and more remote services. Auditors are more costly in rural and remote areas and are not always available in the timelines required by government. One health authority manager (1AM) said that when this occurs, instead of withholding funding, funders should go to the ACCHS to find out why auditing reports are late and assist them.

Risk

Relationships

Interviewees on both sides of the relationship between ACCHSs and health authorities reported on good, as well as poor, relationships and experiences of lack of trust. About half of the ACCHS staff noted good relationships or communication with OATSIH (2AM, 10AM, 2AM, 10AM, 15AM, 1HM, 4AF, 18AM, 12AM, 9AM, 21AF), whereas just over a quarter said they enjoyed good working relationships with their State funding body (8AM, 10AM, 6AF, 12AM, 9AM, 8AM). Some health authority staff also acknowledged having very few problems with the ACCHSs they fund because of good working relationships between individual departments and ACCHS staff (18HM, 4HF). ACCHS staff endorsed the importance of individual relationships (8AM, 18AM, 20AM, 3AM) and mutual trust and understanding (15AM).

When ACCHS interviewees spoke about problems with health authority staff showing distrust or withholding information, or being reluctant to assist ACCHSs with problems on the ground (18AM, 11AF), they suggested that this arose when funding bodies saw ACCHSs as isolated or not being part of the whole health system (7AM, 6AF). ACCHS staff saw lack of knowledge about community organisations and communities by health authority project managers or finance managers (12AM, 5AF, 1AM) as a source of inflexibility, of difficulties in discussing problems and reluctance to approve proposals from the ACCHSs (1AM, 18AM, 11AF).

> *It would be great to have a different relationship with OATSIH or the Commonwealth Government where we were viewed as an integral part of the health system, that we are playing an important role in our region. If that was the view that was taken, we could have completely different funding arrangements that were based on an annual or three- or four-year budget, that there was a commitment to the region, that we would have flexibility to move money around without having to go back all the time for every minor thing* (ACCHS CEO).

A focus on compliance was sometimes resented by ACCHS staff, and multiple reporting requirements were seen to create tensions between funders and ACCHSs.

> *They almost feel a bit like the enemy at the moment. I find whenever you deal with them you're constantly struggling, constantly fighting. They're always asking for bits of paper and proof of things having been done and always holding up the funds because something hasn't arrived* (ACCHS Finance Manager).

Given the importance of person-to-person relationships, it is not surprising that interviewees recognised the need for functioning communication channels and some stability in the staff responsible for them.

ACCHS interviewees noted the need for having one long-term project officer in the funding body who understands the circumstances of each ACCHS and can act as a single entry and information point between ACCHS and the funding body (21AF, 5AF). However, they also noted that project officers often change (e.g. four project officers in 16 months) and there are gaps between appointments (1AM, 21AF, 19AF, 17AF). The problems arising from this instability were seen to include changing perspectives and understanding of issues (19AF), leading to duplication of effort and delayed implementation of programs (5AF, 9AM).

> *They come with different skill sets and different interpretations of what the requirements of the funding agreement are. In the seven months that I've been here we've gone through four project officers and I'm in the process of breaking in the fourth, training the fourth. They do tend to handover and get a briefing, I suppose, of where the organisation is at, but then their interpretation of that is different to the previous person* (ACCHS CEO).

Capacity problems

ACCHS staff generally need to build relationships and communication with many project officers from various funding sources (1HM). Some noted communication and coordination difficulties within funding bodies that impact on the timeliness of release of funds (3AM, 11AF), and that State and Commonwealth health authority staff tend to seek to shift the blame for problems to each other (13AM, 19AF). Several ACCHS staff also commented on the restricted decision-making capacity of health authority project officers:

> *And their decision-making ability is very, very restricted. It has to go to central office and it sort of gets lost in that—and the people that I've had to speak to in central office…* (ACCHS CEO).

Health authority and ACCHS staff said capacity varies in ACCHSs due to several factors: size and operating age of the ACCHS, geographic location, problems with access to telecommunications and ICT, leadership, lack of standard reporting templates, too many reports required, and difficulties recruiting and retaining staff particularly in rural and remote areas (where costs of food, transportation and housing are higher). One health authority program manager said that although they know the services are being delivered, ACCHSs need to articulate this in reports (11HM).

Lack of governance training and capacity for ACCHS board members was mentioned by several health authority and ACCHS staff. A senior ACCHS manager (8AM) said there is a need to allocate special administrative funding for the operation of Boards of Management. Others said ACCHSs were undervalued by mainstream services and that they were not seen as complementary but as competition for funding (13AM, 9AM). One CEO of an ACCHS said ACCHS capacity was affected by the number of deaths in Aboriginal communities and how important it is for staff to attend to 'sorry business'.

> *And I've found one of the greatest problems has been with the sorry business and I've really come to realise how remote we are, how they can't get to those places and how important it is for them to be there* (ACCHS CEO).

A CEO of an ACCHS said that one of the strengths is that the majority of the board members are Indigenous people. This was seen to be advantageous because they help to explain the business of the ACCHS to community members in their own language. Having regular staff meetings with the board also increases transparency and strengthens working relationships. One CEO provided an example of the capacity of the board to protect the service and pursue good practice in the face of pressures from the funder to jump into service delivery before the organisation was ready:

> *they put on the table and said 'we can give you a lot of money for alcohol and other drug service delivery; you've got to have it now and do the services now', and all of our Board sat around this table and said to [government] mob—and they're good people, really good people, trying to do the right thing—[the Board] said, 'no, what we want to do first is we want it step by step. We don't want to do what happened in previous programs, to blindly go and deliver services'. I mean, how does that work? 'First of all, we want to discuss it, we want to have basically a needs assessment, work out what we need to do.' And they said, 'oh, you can't really do that, it's service delivery. You've got problems. Alcohol's a problem', so in the end they [government] came back round to us and said, 'no, we'll do it your way'. So we've just completed our needs assessment now and we're now ready to develop our model* (ACCHS CEO).

Several ACCHS CEOs suggested that the practice of community control is compromised because some board members lack the writing and conceptual skills to respond to the accountability and reporting expectations of funders:

> *All of my Board [members] are flat out if they've gone to Grade 8 or 9 and yet they're being asked to run a multi-million dollar organisation… Never been CEOs, haven't been senior management, and yet we're saying, 'we want you to come in here and set the strategic directions for an organisation that has million dollar incomes' and it's really unfair* (ACCHS CEO).
>
> *Well, if we're going to manage [this organisation] we need to get a Board that is able to function as a proper Board and that's why I think the whole concept of community control is flawed, because the way you can get onto a Board is by the amount of people that you have at the [annual general meeting], not by having the expertise to actually contribute to the Board in terms of where that organisation's going* (ACCHS Finance Manager).

Two interviewees (7AM, 15AM) spoke about the important role of their boards in discussions about problems and progress, while two others (1HM, 8AM) commented on the need to build board capacity. Others noted that larger organisations enjoy a better negotiating position (2AM) and employ more staff to comply with reporting requirements (7AM, 10AM, 18AM).

The difficulties of running health care services in very remote areas were also discussed. Higher costs, transportation and housing problems (20AM, 8AM) in remote areas also influence the ACCHS capacity to recruit and retain staff (16AM). Health authority staff also commented on the difficulties of running smaller and more remote organisations, and misuse of funds through, for example, overuse of food and fuel vouchers (1HM).

Dispute resolution

Approaches to dispute resolution tend to support the view that staff on both sides operate on the assumption of a relational contract environment. Several health authority and ACCHS staff said disputes are settled quickly when there are good working relationships between management staff of both agencies. Having one point of contact between health departments and ACCHSs is seen as a positive step to strengthen communication and prevent or manage misunderstandings and disputes. Phone calls and face-to-face meetings convened early when issues arise were viewed as the best ways to resolve disputes, particularly by ACCHSs. Discussions with funding bodies were focused on matters like the need to simplify reports (2AM, 22AM) and the problems with late reporting (9AM), with collaboration (3AM, 9AM) and with the need to reallocate funds to ACCHS priority areas (12AM, 3AM), and problems with the timely release of allocated funding or retention of unspent funding at financial year end (3AM, 13AM, 2AF). Several interviewees from ACCHSs mentioned the need to bypass the normal communication chain to talk directly with the decision maker when disputes cannot be settled locally (8AM, 19AF).

On the other hand, there was some reference to the use of formal auditing or the threat of installing an administrator as a compliance measure, or in response to a community complaint. One CEO spoke of the need to:

> *engage in appropriate ways rather than to have the threat of an administrator coming in because you're $70,000 over on a budget* (ACCHS CEO).

Conclusion

Although there was general recognition that the current funding arrangements are too complex and are inefficient for both sides of the funding agreements, there was also recognition that definitive solutions are hard to find. Health authority staff, in particular, understood that some sources of the problem lie in the way funds are appropriated by parliaments, as one health authority manager explained:

> *It seems to be a significant barrier as to how governments appropriate and distribute funds, and measure outcomes. I think technically it's quite difficult to imagine how you can simplify it. As you go down the line, funding gets fragmented into different programs and then across the sectors as well* (Health Authority Manager).

Interviews with staff on both sides of the funding relationship have provided an insight into their perceptions of several important characteristics of current practice. The main points are summarised here.

- The complex contractual environment in which ACCHSs work is acknowledged by funders, but not monitored or managed in any consistent way. It has emerged from a series of unlinked policy and program decisions, and has simply grown over time.

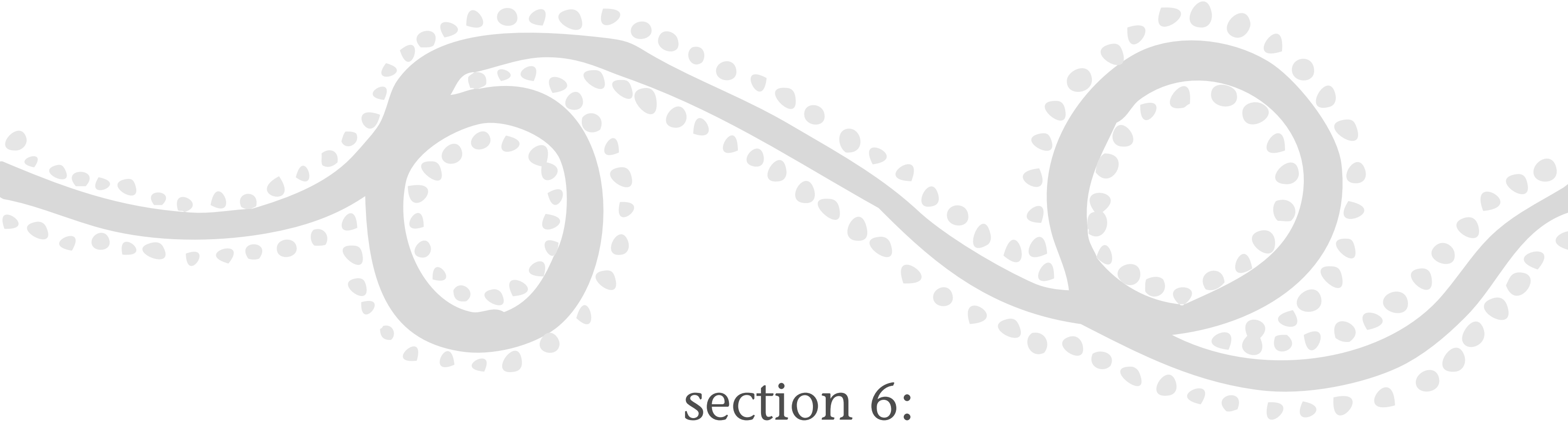
- Recognition of the administrative overburden has led funders in most jurisdictions to move to simplify and consolidate contracts, and to lengthen the standard funding term to three years. There are many barriers to this goal, including the nature of budget appropriations, and the need for cooperation among levels of government and different departments.

- Although recognising that virtually all funding is short or medium term, both funders and providers consider themselves to be in long-term funding relationships and tend to act in accordance with this belief.

- Relationships of trust between individuals are seen as important enablers of effective accountability, problem solving and decision making. The effectiveness and (in)stability of formal communication channels is a problem in this regard.

- Heightened political sensitivity, and the related need to demonstrate strong accountability, tends to reinforce burdensome reporting requirements that seem to have limited utility.

- Although classical contracts predominate, and bring a high reporting burden, the pattern of dispute resolution—which is reported as being largely trust based or relational in character—indicates that the sector is regulated as a relational environment. This finding is consistent with the evidence presented in Section 4.



section 6:

Discussion and Conclusion

This project aimed to identify the major enablers and impediments to effective PHC delivery embedded in current funding and regulation arrangements for PHC services for Aboriginal and Torres Strait Islander people, and to analyse the policy and practice implications for both funders and providers of PHC. We used a framework derived from contract theory and adapted for analysing contracting for PHC. Our examination of the current practices and policies of health authorities has identified characteristics of the funding relationship that are important barriers to good practice, as well as enabling factors. We discuss each of these main characteristics below, and then draw out the policy implications. Finally, we seek to integrate this material into a framework for better practice in funding and regulation that suggests the characteristics health policy makers, program managers and recipients of funding should aim to achieve.

Current funding and regulation: Barriers and enablers

Fragmented funding is a barrier to integrated PHC

Our review of the funding and regulatory practices of Australian governments confirms the complexity and fragmentation of funding, and the heavy burden of acquiring, managing, reporting and acquitting funding contracts for both providers and funders. As we noted at the beginning of this report, this problem affects Indigenous organisations across many portfolio areas (housing, land, education etc.) and is widely recognised.

ACCHSs operate in a complex contractual environment, where their services and operations are funded from a wide-ranging mix of core operating grants and program- or project-specific grants, virtually all formulated as short or medium term (maximum of three years). There is some evidence that the contractual arrangements for Aboriginal and Torres Strait Islander organisations are more complex than for mainstream organisations. This additional complexity arises at least partly because ACCHSs provide a broad range of essential PHC, rather than undertaking roles that are supplementary to mainstream public health care. It may also be related to the fact that they do so in an arena of heightened political sensitivity.

The effects of fragmentation are most severe for those without core funding. Even for those that do have core PHC funding grants, there are many add-ons requiring separate contracting provisions, and separate accounting and reporting. There is a mismatch between the application of tightly targeted funding guidelines and the broad responsive purpose and nature of PHC. ACCHSs argue that separate funding and reporting requirements applied to different aspects of the same service can intrude on the design and conduct of integrated services. Some staff on both sides of the funding relationship acknowledge a degree of artificiality in the allocation of costs as a result.

Unmanaged complexity and transaction costs impede efficiency

The complex contractual environment in which ACCHSs work is acknowledged by funders, but not monitored or managed in any consistent way across funders and programs. It has emerged from a series of policy and program decisions in both levels of government, and has simply grown.

The complexity of funding exposes funders and providers to additional administrative costs in acquiring, tracking, reporting on and acquitting multiple grants. 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, resources that are likely to be disproportionately high compared to mainstream agencies. However, financial reporting is seen as less onerous (and is better complied with) than activity reporting.

This situation is compounded by the disseminated nature of allocation and distribution pathways for funding to ACCHSs within many health authorities. The recognition by interviewees of the relatively more effective approach of OATSIH to the funding relationship highlights this problem.

Recognition of the administrative overburden has led funders in most jurisdictions to explore opportunities to simplify and consolidate contracts, and to lengthen the standard funding term to three years. Although important gains have been made, there are many barriers to this goal, including the nature of budget appropriations, and the need for cooperation among levels of government and different departments. There is a risk that the problems of reporting for one-year contracts may be simply transferred to the schedules attached to longer term contracts, with no overall improvement in efficiency. Implementation of intended reforms (such as use of standardised templates for reporting to both Commonwealth and State/Territory governments) is slow and patchy, particularly where cooperation between two levels of government, or different government departments, is required.

Long-term relationship behaviour enables trust and enhances capacity

Relationships of trust between individuals are seen as important enablers of effective accountability, problem solving and decision making. 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 brings for ACCHS, may be unnecessary given that most funding is effectively ongoing in practice.

The operating assumptions of both funders and providers highlight the paradox of short-term allocations. Staff on both sides tend to consider themselves to be in long-term funding relationships, and to act in accordance with this belief in some important ways. It should be noted that this belief is probably not widely shared in the broader bureaucracy and higher echelons (which have a larger role in determining the formal nature of funding contracts). Hence the paradox of explicit short- to medium-term funding agreements with behaviour on both sides that rests on an assumption of longer term funding relationships.

Although there was little direct discussion of the impact of race and racism, there is evidence of lack of trust on both sides. This feature of inter-cultural relationships between Indigenous and other Australians has been studied in the general community for Reconciliation Australia by Auspoll (2009), which found a significant amount of goodwill but a serious lack of trust. A similar pattern is likely to apply among funders and providers in the ACCHS sector.

We suggest that mistrust is also reinforced by the political sensitivity of Indigenous issues, which touch the raw nerve of foundational ideas of national identity (see, for example, Dixson 1999:43; Sullivan 2009b). Indigenous representative organisations are in a double-bind: the political sensitivity provides a way of getting attention for their members' needs, but it tends to lead to the kind of over-administration documented in this report. Similarly, government policy and program staff confront a heightened need to demonstrate value for money and the challenges of political sensitivity when they respond to non-compliance by ACCHSs with accountability measures.

Data for monitoring and performance management are compromised

> *Oversight for the health of the forest has been replaced by repeated exercises of counting trees. The problem is one of both volume and format* (First Nations and Inuit Health Branch employee, quoted in Lavoie *et al.* 2005:108).

Governments in Australia are increasingly concerned with ensuring value for money in the expenditure of public funds, and have sought to achieve this goal through tightly focused allocations and detailed requirements for reporting by recipients on what has been done with the money. Although the goals of ensuring value for money and its use as intended are sound, the impact of the measures enacted in pursuit of these goals is counterproductive. Performance accountability is compromised: the pursuit of efficiency by inappropriate means has led to inefficiencies that may compromise the performance of the sector as a whole.

Both funders and providers in this study strongly supported the need for good data and good analysis of service effectiveness. They also acknowledged that reporting on funded PHC services was too focused on 'counting heads through the door', to the detriment of capacity for monitoring and reporting health impact. As noted above, compliance with activity reporting is seen to be lower than with financial reporting. This may be partly due to the threat of sanctions being more vigorously applied to financial reporting problems, and may also reflect better standardisation and computerisation of financial reporting.

Progress is being made in data collection and reporting systems, with some consolidation of systems for data extraction and analysis. Data linkage in support of clinical care is also seen to be improving: for example, in the Northern Territory where Health Connect enables important patient information (such as medication usage) to be accessed in multiple clinics with patient consent.

However, current practice means that activity reporting required from ACCHSs is seen as demanding, and not helpful enough for internal performance monitoring. Although funders reported on the value of data for use in support of policy decisions and ongoing funding allocations, providers saw the data they send to health authorities as going into a black hole, with no useful feedback (such as comparisons with data from like services) or with feedback that is too delayed to be useful.

This is a complex problem, and progress is being made at the policy level towards measures of health service output and impact that are both valid and meaningful (AHMAC 2006; Sibthorpe 2004). Further, a recent OATSIH review of reporting requirements (OATSIH 2009) foreshadows a reduction in duplication, a focus on outputs and outcomes in relation to OATSIH-funded work, and more timely feedback.

However, our analysis suggests that the well-known problem of the reporting black hole is an almost inevitable result of the nature of the approach to funding. That is, reporting on tightly specified short-term funding for specific activities is likely to focus on those things that can be *counted* immediately (usually, the activities themselves) and specifically attributed to the relevant grant, to the detriment of a focus on indicators of intermediate or longer term outcomes, or broader measures of health and wellbeing.

National priority funding impedes responsiveness to local priorities

Governments seek to direct funding to national or jurisdictional health priorities, and to modes of care or interventions that are seen to be effective. On the other hand, local and regional providers of care for Aboriginal and Torres Strait Islander communities seek flexibility to respond to the pattern and priorities of need in their communities, and to take up local opportunities to make a difference. Tension between these goals is inevitable, and both are important. Staff in ACCHSs acknowledge that targeted priority funding is often *on target* locally; and both official policy statements and staff in health authorities acknowledge that locally determined priorities are important. Tension would be lessened, and efficiency enhanced, if targeted funding was not needed to replace or top up core PHC funding. More flexibility is also needed to enable government contract managers to respond to local needs (e.g. through negotiated variation in the application of targeted funds).

Tightly specified contractual arrangements do not provide the balance required in managing this tension. More flexibility and more accommodation for population-based approaches to health are needed.

Current practice: classical and relational contract paradox

The complex contractual environment for ACCHSs and their funders is largely shaped by a classical approach to contracts, though often with a vocabulary and management environment that invokes relational contracts. This situation is summarised in Table 8, highlighting the ways in which current practice incorporates elements of both classical and relational contracting. This tends to undermine the benefits of both forms. Those involved think and behave in ways that belie the intentions of classical contract provisions (such as avoiding expectations of ongoing funding); but the advantages of relational contract forms (such as reduced transaction costs) are not realised either. The same phenomenon has been reported elsewhere (Allen 2002; Palmer & Mills 2003).

Table 8: Current practice—classical and relational contracting paradox

	Classical contractual characteristics	Relational contractual characteristics
Nature of funding	Short-term contracts, sometimes competitive	*BUT, most funding is ongoing in practice, and decisions are based on that assumption* Long-term relationships among funders and providers are valued
Priority setting	National or jurisdictional priorities are funded short- to medium-term ACCHSs have little capacity to influence application to their communities	Some core funding for PHC (mostly from OATSIH) enables local priority setting, but may not support sufficient broad-based PHC
	Funding agreements focus on single interventions not PHC, and tend to emphasise individual care rather than population health	Core PHC funding enables population approaches
Monitoring	Short-term contracts focus on short-term outputs Multiple data collections are costly	There is progress towards good, standardised health and health care indicators, but implementation lags
	Data are not used as much or as well as needed	
Transaction costs	Unmanaged complexity drives transaction costs for both parties	*BUT, good communication and longer term relationships reduce some costs*
Risk	Complexity and number of contracts undermine compliance with accountability Providers risk default and withdrawal of funding Provider capacity is sometimes not adequate	*BUT, good communication and longer term relationships reduce some risks* *BUT, funder capacity to withdraw funding is compromised because funders depend on providers to deliver access to essential health care*

Towards a framework of good practice in funding and regulation

Current practice in funding and regulation is derived from a classical contracting model, which we argue is wrongly applied to the ACCHS sector. Although the classical contracting approach may be appropriate for some subcontracting of specific aspects of care by government, it is not adequate for the development of a robust comprehensive PHC sector. There are three important grounds for reform of the complex contractual environment in which ACCHSs operate:

1. Aboriginal and Torres Strait Islander communities experience poor health and poorer access to PHC. There is an urgent need to improve access to culturally safe, effective care as part of efforts to *close the gap*.
2. The sector occupies a unique position, endorsed in policy and practice, as a provider of essential PHC care, but current funding methods are not appropriate to this role.
3. The additional investment in PHC that is acknowledged as needed should be made in ways that offer better efficiency and effectiveness than the current arrangements.

As noted at the beginning of this report, governments are committed:

> *Within the health system, the crucial mechanism for improving Aboriginal and Torres Strait Islander health is the availability of comprehensive primary health care services. Effective and appropriate primary health care services must be available to all Aboriginal and Torres Strait Islander peoples. These services should maximise community ownership and control, be adequately funded, have a skilled and appropriate workforce and be seen as a key element of the broader health system* (NATSIHC 2003:1).

The National Strategic Framework goes on to outline the commitment of all Australian governments to nine principles, three of which are directly relevant to the question of better practice in funding and regulation:

> ***Community control of primary health care services:*** *supporting the Aboriginal community controlled health sector in recognition of its demonstrated effectiveness in providing appropriate and accessible health services to a range of Aboriginal communities and its role as a major provider within the comprehensive primary health care context. Supporting community decision-making, participation and control as a fundamental component of the health system that ensures health services for Aboriginal and Torres Strait Islander peoples are provided in a holistic and culturally sensitive way…*
>
> ***Localised decision making:*** *health authorities devolving decision making capacity to local Aboriginal and Torres Strait Islander communities to define their health needs and priorities and arrange for them to be met in a culturally appropriate way in collaboration with Aboriginal and Torres Strait Islander health and health related services and mainstream health services…*
>
> ***Accountability:*** *including accountability for services provided and for effective use of funds by both community-controlled and mainstream health services. Governments are accountable for effective resource application through long-term funding and meaningful planning and service development in genuine partnership with communities. Ultimately, government is responsible for ensuring that all Australians have access to appropriate and effective health care* (NATSIHC 2003:2–3).

We suggest that implementation of these commitments will require a different way of thinking about the relationship between government and the sector, with implications for both sides. We further suggest that the framework of relational (or *alliance*) contracting provides methods for improving both efficiency and effectiveness.

Accordingly, we suggest the following principles against which options for good practice in funding and regulation could be evaluated. Each is supported with some descriptive text outlining ways in which these principles could be addressed.

1. **Long-term contracting for core PHC is the basis for the funder–provider relationship. In such an arrangement, contracts of at least five years, with renewability, would be negotiated.** Expectations and required service levels would be specified through a negotiated agreement such as OATSIH's Service Development and Reporting Framework approach. Funders would appoint senior contract managers with contract management expertise and with delegations that enable them to make decisions in relation to the situations and needs of particular ACCHSs and communities. Annual negotiations would review and adjust service delivery levels and targets based on the SDRF and the uptake of additional funding.

   Other funding methods are complementary. Classical contracts (shorter term, specific interventions or purposes) would be used on the margins to complement long-term core PHC funding. Core PHC funding grants could also be complemented with fee-for-service or other output-based funding arrangements, such as MBS and PBS. Capital funding could be explicitly built in to funding formulae, and/or separately identified through an agency-specific accumulation fund and jointly managed.

2. **Core PHC funding allows flexibility for local priority setting, in accordance with agreed plans.** National priorities and, where feasible, non-health funding are integrated at national or State level and distribution is negotiated as part of annual plans. Resultant allocations are folded into the main contract. These priorities integrate into a defined and resourced basket of essential PHC services.

3. **Data collection and monitoring are simplified and information is shared, based on sound performance and health outcome indicators.** A single reporting framework and standard data dictionary provide parameters for policy and program managers in designing reporting requirements. Changes are designed nationally, and information is collected and analysed by an independent body (e.g. Australian Institute of Health and Welfare) with advice from funders and providers.

   Reciprocal accountability is enacted through improved access for ACCHSs and other providers to aggregated information about ACCHS performance, and the performance of the mainstream health system in responding to community health needs and priorities, and contributions to *closing the gap* (e.g. data on hospitalisation of Indigenous people for ambulatory care sensitive conditions).

4. **Transaction costs are reduced and complexity is managed through a single main long-term contract and good contract management.** Both contracts and compliance requirements are simplified and transaction costs for both sides reduced. Service reporting focuses on outputs and indicators of outcomes, not inputs. Contract management services could be offered to non-health funders by health contractors to enable inclusion of non-health funding in the single main contract.

5. **Risks for both sides are managed.** Risk for the provider is reduced through stability and flexibility of core PHC funding, and clearer communication and reporting lines. Risks for the funder are managed through contractual provisions regarding non-compliance, backed up with normal risk management and quality assurance methods. Provider capacity is also enhanced through adequate levels of core funding and adaptation of governance models to size and complexity (consistent with the principle of community control).

Implications for government structures and policies

There are many policy prescriptions for improving funding and regulation practice. The National Health and Hospitals Reform Commission (NHHRC 2008) has proposed a National Aboriginal and Torres Strait Islander Health Authority, which would take overall responsibility for funding PHC for Indigenous people and would operate as a large purchasing authority, along the lines of current arrangements in the Department of Veterans' Affairs for health care for entitled veterans. This is consistent with the Commission's recommendation that the Commonwealth take over responsibility for all PHC.

However, there are also great risks in any such change, particularly when political accountability is heightened. ACCHSs have been effective in maximising their sources of income, and centralisation of funding responsibility could remove this opportunity. The sector may well be concerned about opening up the funding currently provided to them by OATSIH to competition from mainstream providers.

Our purpose in this paper has been to study the effectiveness of current arrangements, and to formulate our findings as a set of principles or criteria that could be applied to assess potential improvements. The development of practical ways of implementing funding and regulation measures based on these criteria is itself a complex task, with both technical and policy problems to be solved.

No administrative arrangement is perfect, or perfectly implemented. Any approach will solve some problems, and create or exacerbate others. We do not suggest that relational contracting is a cure-all, but rather that it offers a sound alternative framework for redesigning the funding and accountability relationship for this critical sector of the Australian health system, thereby reducing administrative costs, improving performance and, ultimately, maximising the PHC contribution to closing the health gap between Indigenous and non-Indigenous Australians.

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Appendix 1:
Study Methods

In this appendix we give a more extended account of the methods we used in the study.

Scope

Our scope of interest was defined as funding and accountability mechanisms that are applied by federal and State/Territory governments to fund Indigenous-specific PHC service providers; and impacts and related issues for those providers and the funders (including relationships between them). Thus, we sought to examine the funding programs, and their associated conditions (services to be delivered, reporting, auditing, dispute resolution etc.) from which funding is provided by governments to ACCHSs. The program may be Indigenous-specific or mainstream. The providers of interest are, therefore, those that are primarily engaged in delivering PHC to Aboriginal and/or Torres Strait Islander people, and who are substantially governed by a board chosen from among the populations they serve. We excluded Aboriginal organisations that have a broader social or community role and provide a single health service (e.g. a visiting mental health nurse) or a narrow range of health services (e.g. drug and alcohol services only). This exclusion was based on our interest in the complex contractual environments for ACCHSs that seek to provide comprehensive PHC for their communities.

Desk-review of policy documents

We searched government websites for funding program guidelines and funding policies in relation to PHC funding for ACCHSs. This continues to be a work in progress, as these documents are difficult to access. The information relating to specific program funding, including some contractual agreements, was obtained during interviews with funding authority staff and the ACCHS management staff.

Other documentation was collected from government websites, health authorities, and ACCHSs and their peak bodies. These include 2006–07 annual reports and financial statements, as well as some 2006–07 and 2007–10 OATSIH and State/Territory contractual agreements.

These documents were analysed to generate an overview of the policy and program environment in each jurisdiction and to guide interviews and other project data collection and interpretation. Draft descriptions of arrangements in each jurisdiction were prepared and checked with health authority staff who had participated in interviews (see below).

Interviews with senior health authority staff

A purposive sample of senior Aboriginal health policy and finance staff was identified from websites and local knowledge. We contacted the chief executives and the senior Aboriginal and Torres Strait Islander health policy officer in each State and Territory and in the Australian Department of Health and Ageing seeking interviews with a senior officer and with an officer responsible for funding arrangements for the sector. The purpose of the interviews was qualitative: to construct both a description of the current funding and regulation of PHC providers from their perspective, and an understanding of the major areas of successes and problems. Semi-structured interviews lasting approximately one to one-and-a-half hours were conducted with 20 consenting officers. (The interview outlines are at the end of this appendix.) These interviews were audio-recorded, transcribed and analysed as described below.

Interviews with ACCHS staff

In order to gain an understanding of the experience and perspectives of PHC providers, we sought to interview a purposive sample of senior staff of ACCHSs. We contacted State and Territory NACCHO affiliates (that is, the peak body for PHC providers) requesting their nomination of PHC providers that we might approach for interviews. We also requested that the nominated agencies include a range of locations (urban, rural and remote), size and complexity, and age.

We contacted the CEOs of each nominated agency, and sought an opportunity to conduct an interview with the CEO and with the senior finance officer. Interviews with 23 ACCHS staff were conducted. They were semi-structured, and took one to one-and-a-half hours. (The interview outlines are at the end of this appendix.) These interviews were audio-recorded, transcribed and analysed as described below.

Data analysis

Transcriptions of the interviews were entered into tables for grouping and analysis. The tables were analysed to identify common ideas or themes—that is, the factual information, ideas and opinions in the text were extracted, grouped and analysed using the method of thematic analysis (Liamputtong & Ezzy 2005:257–85).

Two members of the project team (Kim O'Donnell and Judith Dwyer for the health authority staff, and Kim O'Donnell and Uning Marlina for the ACCHS staff) conducted preliminary coding, generating categories from the data and grouping the themes into categories after two to three interviews. These were then discussed with other members, refined on the basis of discussion and consensus, and further developed as the interviewing and analysis proceeded. New themes were added as the material accumulated and new groupings emerged.

Each interviewee was assigned a unique identifier. In reporting on our analysis in Section 5, we show the identifiers we assigned to each interviewee to indicate the sources of the data on which the analysis is based. Quotes are attributed by identifying the sector and role of the speaker.

The numbers interviewed on each side of the funding relationship are roughly equal, which is not reflective of the relative numbers in the two workforce segments (senior staff in ACCHSs and senior staff in Aboriginal health policy in health authorities). This weighting was chosen because our interest was in the relationship and transactions between the funders and providers of PHC for Indigenous Australians.

Confidentiality

Given the nature of the purposive sampling in this study, maintaining confidentiality for those we interviewed (particularly those in government health authorities) was difficult. We discussed this problem with all participants, and explained that while informed readers may make assumptions about who was interviewed, we would take great care in our reporting of interview data to avoid giving clues to the identity of interviewees, and to avoid enabling readers to attribute particular views or comments to individual interviewees. All interviewees recognised and accepted the reality of this problem.

Construction of funding database

The acquisition of information about funding programs proved to be more difficult than we had anticipated. Funding guidelines for each program are often not publicly available; staff in health authorities tend to have limited knowledge of activities outside their immediate areas of responsibility; many different sections of government health authorities are involved and there seems not to be a central repository of information specific to Aboriginal and Torres Strait Islander health care providers; and many other departments at each level of government are providers of funding, particularly portfolios responsible for families and community services, legal services, aged and disability care, and children’s services.

We therefore turned to analysing the information published by PHC providers in their audited financial statements and annual reports. Using information from NACCHO and its affiliates’ websites (the Aboriginal Health Council of Western Australia, the Aboriginal Medical Services Association of the Northern Territory, the Queensland Aboriginal and Islander Health Council, the Aboriginal Health Council South Australia, the Victorian Aboriginal Community Controlled Health Organisation, and the Aboriginal Health and Medical Research Council), as well as OATSIH and ORIC, we developed a list of ACCHSs that provide (comprehensive) PHC services in Australia. This study was conducted to bridge an important knowledge gap, as we were unable to identify an available source of consolidated information about the funding received by ACCHSs.

Where there was doubt about the role of the agency (i.e. is it in the business of providing PHC as defined?), we reviewed websites and other documents (such as annual reports that were available). As noted above, we excluded organisations that were not primarily focused on health care, even though they were providing single aspects of PHC (e.g. a mental health nursing service, a youth service, or a drug and alcohol service) as part of a broader community role.

A database was designed to enable the enumeration and analysis of discrete funding lines by funder, by jurisdiction, by PHC provider, and by amount and period of funding. Data were collected from provider agencies that agreed to participate, from annual reports where they were publicly available, and from financial and other returns filed with ORIC by PHC providers and available on the ORIC website.

Development of a *good practice* framework

Based on contracting and accountability theory—and on our analysis of current practice and trends, of the perspectives of funders and providers, and the findings of other relevant studies—we developed an analysis of the major problems and strengths of current contracting practice. We then used this analysis to construct a framework that articulates criteria which define the requirements for good practice in funding and regulation, in the light of current Australian practice—that is, it is focused on the opportunities for improvement.

Interview outline: Health authority questions

1. Please describe your role in relation to the funding and regulation of PHC services for Aboriginal and/or Torres Strait Islander people?
2. Within the Department of Health (or other title)—what is the pathway for allocation and distribution of funding for ATSI (Aboriginal and Torres Strait Islander) PHC services? Are there problems about coordination and communication in relation to funding and reporting?
3. Could you give us an overview of the ATSI PHC providers that receive funding from the State or Territory government in your State/Territory?
4. Could you explain the roles of the various areas of the Department in funding and regulating Aboriginal health services?
5. As you know, we're interested in understanding the details of all the funding programs through which funds are provided to ATSI PHC providers, including reporting and acquitting processes, timing etc., in 2007/08. We're interested in both Aboriginal-specific and mainstream funding programs; and Aboriginal-specific health care providers. We're using 3 broad categories at this stage—ongoing core funding; health program funding (e.g. funding from a 3-year program on eye health); and project funding (e.g. funding to trial or demonstrate a model or approach to health care). Do you think this is the right set of categories?
6. What are the advantages and disadvantages of short-term funding (1–3 years) from your point of view? What about longer term funding (5–10)?
7. If the Department wanted to move to more long-term funding, what would be the main barriers to making that change?
8. What do you think about the reporting requirements in this funding, and how the recipients cope with it?
9. What about the basis for allocation to ATSI PHC services—does the Department use population-based methods, historical, submission-based? Is the balance right? How would you like to see it changed? What are the barriers that would get in the way?
10. PHC providers often complain about the problem of priorities being set centrally and funding being targeted to those priorities, rather than their having the flexibility to decide what services should be provided locally. How well do you think that the arrangements and incentives for priority-setting work at the moment? What changes would you like to see? What are the barriers against change?
11. Is your office aware of concerns among funding recipients about the complexity of funding programs and reporting requirements? How serious do you think the problem is and why? What are the most significant barriers to change in this regard? How does/would the Department capture this information? Have any changes been made in response?
12. Do recipients of funding experience problems in complying with reporting/ and or auditing requirements? Why?
13. Thinking about the reporting data collected from ATSI PHC services by your department—what is it used for? Are there data that aren't used, or aren't used well? Are there things you'd like to collect but can't? Are the data passed on to other authorities or bodies?
14. If you had the power, what practical changes would you like to make to improve the effectiveness of funding and accountability processes?

Interview outline: ACCHS CEO/ Finance Officer questions

1. Please describe your role in your organisation, and in particular in relation to funding and accountability requirements?

2. As you know, we're interested in establishing the current state of play in funding and regulation for your service. What would you say are the best aspects of the funding you receive from all government sources? What are the problems that you experience?

3. Your last annual report lists these sources of funding [show table]. Is this list up to date and complete? Can you identify which are ongoing in practice and which are one-off or term limited?

4. How would you characterise the relationships you have with funding bodies—what are the good aspects? What are the bad aspects? Do you think there are common interests?

5. Can you describe the ways in which short-term funding is an advantage to your organisation? And what are the disadvantages?

6. In your experience, are the data collected for external accountability purposes also useful for your internal management or review purposes, or is it more the case that you double up collection and reporting?

7. In your experience are data about the same services required in different formats for different reporting requirements? Can you give specific examples?

8. Do you get useful reports back from your funding bodies based on the data your agency and others like it submit? Please describe.

9. Do you experience difficulties reconciling your reporting obligations to funders with your accountabilities to the community and to the board? And alternatively, are they sometimes a helpful reference point?

10. Some of the funding programs your agency receives are for the prevention, early diagnosis or treatment of particular diseases. What are the advantages of this vertical approach to funding PHC? What are the disadvantages? In your experience does this way of funding cause particular administrative or operational problems? Please explain the specifics. [Probe—need to 'fudge' funding purpose or guidelines in order to meet local needs, or just to take comprehensive PHC approach?]

11. If you had the power, what are the most important changes you would want to make in the way funding is administered?

12. Could we have a copy of your '06–07 annual report? Is this available in soft copy? Some ACCHO annual reports have a list of the programs funded, the amount of funding and the source of funding. Does your annual report have this list? If not, could we gain access to such a list?

Appendix 2:

Funding Programs Reported by Sample ACCHSs

Health program funding to 21 sample ACCHSs in 2006–07

Program name	Program description	Main source of funding
Aboriginal Health Promotion and Chronic Care	Support for community health services and ACCHSs to work collaboratively to improve health outcomes for Aboriginal people with, or at risk of, chronic disease	State health authorities
Adult continuing care	Assessment, treatment and continuing care and case management for adults with a mental illness	State health authority
After-hours clinic	To enable clinic hours to be extended	DoHA
Aged care and respite house	Provide low and high residential care, as well as aged care packages in the community	DoHA
Best Start	Improve health, education and development for Aboriginal children from birth to five years	State department of child protection
Bringing Them Home	Support for individuals and families, and related services to communities, affected by the forced removal of children	DoHA
Building Healthy Communities	To support people with chronic diseases	DoHA
Child and maternal health	Support, information and advice regarding parenting, child health and development, child behaviour, maternal health and wellbeing, child safety, immunisation, breastfeeding, nutrition and family planning. Parent groups and an opportunity to meet other parents in the local area	DoHA State health authority

Child health	Immunisation, school-aged screening, child growth monitoring in the under-fives and nutrition. Includes health promotion, disease prevention, surveillance and screening. Focus on improving child health through early detection, early intervention and follow-up treatment or referral to tertiary services	DoHA
Chronic diseases	Provide treatment, prevention and early detection of chronic illnesses such as asthma, cancer, cardiovascular disease, diabetes mellitus, musculoskeletal conditions and stroke	DoHA
Dental	School dental care, emergency and adult dental care, dental health promotion for people with diabetes and chronic illnesses, people with missing teeth, and young adults	State health authority
Disabilities support	Direct help for those with disabilities	State health authority
Dog Health	To improve the health of animals in remote Indigenous communities by controlling disease and parasites, which could be passed on to people, particularly children, who come into close contact with the animals	DoHA FaHCSIA
Eye Health Program	To improve the eye health of Indigenous people	DoHA
Falls prevention	To prevent older people from falling	DoHA
Health promotion and education	To deliver health promotion or education for various health issues	DoHA State health authority
Healthy for life	Maternal and child health, prevention and care for people with a chronic condition	DoHA
Hearing Health	To improve the ear health and hearing of Indigenous people	DoHA
Home and Community Care	Support for daily living meal preparation and delivery, laundry, personal assistance, cleaning and transportation	DoHA State health authority
Home-based outreach support	Support to people with mental illnesses in their home, as well as for homeless people	State health authority
Male health	Male sexual health, health education and health checks	State health authority
Maternity care enhancement	Support for women in postnatal period	State health authority
Medical specialist outreach	To improve access for people living in rural and remote Australia to medical specialist services	NGO
Mobile clinic	Mobile imaging with relay to specialists in capital city	State health authority
Nutrition	To improve healthy eating habit	State health authority
Patient Assistance Transport Scheme	Financial support for country patients and approved escorts to cover some travel and accommodation costs (for travel over 100 kilometres) to receive specialist medical treatment not locally available	State health authorities

Petrol Sniffing Prevention	Reduce incidence and impact of petrol sniffing in a defined area of remote Australia by providing Opel fuel, monitoring of treatment and respite	DoHA
Physiotherapist	Physiotherapy services	State health authority
Podiatry	To provide podiatry service	State health authority
Primary Health Care Access Program	Expansion of comprehensive primary health care including clinical care, illness prevention and early intervention activities	DoHA
Public and Environmental Health	Public health intervention, focused on housing and health *hardware*, and other social determinants of health	State health authority
Self-management	Improve health and wellbeing of those with a chronic illness by encouraging active management, better communication with families and general practitioners	DoHA
Sexual Health and Blood Borne Virus Strategy	Prevention of spread of HIV, other sexually transmitted infections and blood-borne viruses in communities by maintaining data on testing, treatment and contact tracing of sexually transmitted infections (including chlamydia, gonorrhoea, syphilis, HIV and trichomonas)	DoHA
Social and Emotional Wellbeing	To improve the wellbeing of Aboriginal and Torres Strait Islander communities using a broad definition, including but not limited to mental health	DoHA
Substance or alcohol abuse/ misuse	Prevention, emergency/detoxification, and treatment for individuals and families at risk of or affected by substance abuse	DoHA State health authority
Suicide prevention	Addressing suicide prevention across the community and strengthening population health approaches to reducing risk of suicide	DoHA
Uwankara Palyanku Kanyintjaku	Public health intervention focused on housing and health *hardware* and other social determinants of health	State health authority
Women's health	Education, support, screening, clinical care and follow-up for young women's health education, reproductive health, cervical and breast screening, staff support and ongoing education	DoHA State health authorities

Community and social program funding to sample ACCHSs

Program name	Program description	Main source of funding
Carer crisis support	Support carers, families and friends of people with mental illness with information, financial assistance or general support	State health authority
Child abuse	Prevention and early detection of child abuse	FaHCSIA
Child care	Provide childcare services	FaHCSIA State health authority
Community benefit	One-off project funding for work to improve wellbeing, quality of life, community participation and life management skills of disadvantaged individuals and communities; and to develop and strengthen communities across metropolitan, rural and remote regions	State health authority
Community Development Employment Projects	Employment in community initiatives to develop participants' work and employment skills	DEEWR
Community engagement	Engaging families and community to address various problems from education, health, family violence or social interaction problems	State community services department
Emergency Relief Program	Assists people in immediate financial crisis	FaHCSIA
HOPE–SRA	Address the complex interface between antisocial behaviour and education	FaHCSIA
In-home support	Assist Aboriginal families to improve parenting capacity and health, development, learning and wellbeing of Aboriginal children aged zero to three years	State health authority
Indigenous Family Violence	To prevent and reduce Indigenous family violence and child abuse through safe houses, night patrols, counselling services, support workers, perpetrator programs and education programs	FaHCSIA State health authority
Indigenous parenting program	Strengthen parenting skills and support the development, learning and wellbeing of Indigenous children	FaHCSIA
Kinship	To provide support for family members who look after children	State health authority
Link Up Program	Tracing, locating and reuniting Aboriginal and Torres Strait Islander people forcibly removed from their families and communities	DoHA
National Aborigines and Islanders Day Observance Committee	Supports celebration of Indigenous culture	FaHCSIA

Night patrol	Safety through transport home or to refuges and safe houses for people at risk of offending or victimisation	FaHCSIA Attorney General’s Department
Our Journey to Respect	Intergenerational violence prevention program targeting young Aboriginal males 14–18 years	State health authority
Safe House	Temporary accommodation for women and children who are victims of family abuse	FaHCSIA
Sport and recreation	To provide assistance to develop sport and recreation activities in the community	Department of Sport and Recreation
Whiz Kidz	Support kids to be active and do more physical activity	FaHCSIA
Youth art performance	Performing arts opportunities for Indigenous children, young people and their communities	FaHCSIA State arts department
Youth leadership program	To train Indigenous youth to be inspiring and effective leaders who will make positive differences to the lives of Indigenous people	FaHCSIA

Management, HR and ICT funding to sample ACCHSs

Program name	Program description	Main source of funding
Fringe Benefit Tax	A tax payable by employers for benefits paid to an employee or the employee's associate in place of salary or wages. Examples of benefits include a car, car parking, low interest loan and payments of private expenses	DoHA
Health worker training	Certificates II, III, IV in Aboriginal and Torres Strait Islander Primary Health Care, Certificate IV Community Care and Aboriginal and Torres Strait Islander Primary Health Care (Practice), or administrative and information technology training to help people to get jobs, as well as training for general practitioners, nurses and other health professionals	DoHA DEEWR
Managed health network	Secure network that connects general practitioners, specialists, hospitals, age cared facilities and allied health providers through a series of services and applications such as shared electronic health records, secure communication and tele-health	DoHA
Patient Information Recall System	This provides database, a patient's medical record inside clinics and to offsite medical officers at the time of the consult, electronic pathology results and other correspondence, electronically lodged Medicare claims	DoHA
Project Ferret	IT system to support chronic disease prevention and management programs	State department of health
Quality Improvement Initiatives	To support the implementation of quality improvement initiatives in the ACCHS	DoHA
Service Development Reporting Framework	To support the implementation of SDRF program	DoHA

Judith Dwyer is Professor and Head of Health Care Management in the Flinders University School of Medicine, where she teaches in a Master of Health Administration and conducts research on health systems and services. She is a former Chief Executive of Southern Health Care Network in Melbourne and Flinders Medical Centre in Adelaide, and was the inaugural President of Women's Hospitals Australasia. She grew up in rural Queensland, and has a long-standing interest in health care for Aboriginal and Torres Strait Islander people.

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Josée Lavoie is Associate Professor with the Health Sciences Programs at the University of Northern British Columbia and is affiliated with the Manitoba First Nations Centre for Aboriginal Health Research (MFN-CAHR). Josée's interests focus on the policies and financing mechanisms set in place in Canada, Australia, New Zealand and Colombia to support the continued development of indigenous primary health services and improve access to primary health care services. Josée has worked with indigenous controlled primary health care services since 1989, and continues to work closely with indigenous health organisations at the local, regional, national and international levels.

Uning Marlina is a Service Coordinator in Disability SA. In 2002, she completed a medical degree at Gadjah Mada University, Yogyakarta, Indonesia and worked at a Puskesmas, or Primary Health Care centre, that operates in a similar way to Aboriginal Community Controlled Health Services. Uning's interest is contracting in health service delivery to improve health outcomes for indigenous peoples. In 2006, she completed a Masters degree in Health Service Management at Flinders University.

Patrick Sullivan is an anthropologist who has studied the engagement of Aboriginal people with the Australian public sector since his introduction to the Kimberley region, Western Australia, in 1983. Much of his professional life has been spent working with independent Aboriginal organisations. He is the author of numerous scholarly articles, as well as practical reports, and the book *All Free Man Now: Culture, Community and Politics in NW Australia* (Aboriginal Studies Press, Canberra, 1996).

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Appendix C: Managing two worlds together

Dwyer J, Kelly J, Willis E, Mackean T, Battersby M, Pekarsky B & Glover J 2011, *Managing Two Worlds Together: City hospital care for country Aboriginal patients; Study 2 – Staff perspectives on care for country Aboriginal patients*, Lowitja Institute, Melbourne. Available at: http://flinders.edu.au/medicine/sites/health-care-management/research/mtwt/

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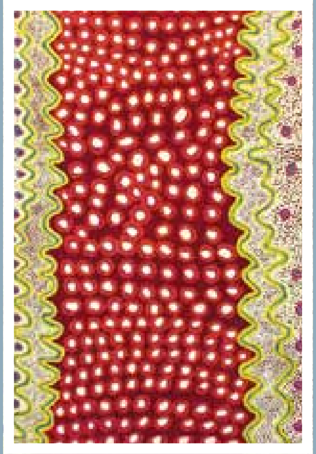
Managing Two Worlds Together:

City Hospital Care for Country Aboriginal People — **Project Report**



Cover Artwork:

Kuntjanu – Mingkiri Tjuta Tjukurpa (Marsupial Mouse Dreaming)

by Rama Sampson painting (no.74), courtesy Better World Art

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Additional copies of the *Managing Two Worlds Together: City Hospital Care for Country Aboriginal People—Project Report* and *Community Summary*, along with downloadable pdfs of all six reports emanating from this project, can be obtained from:

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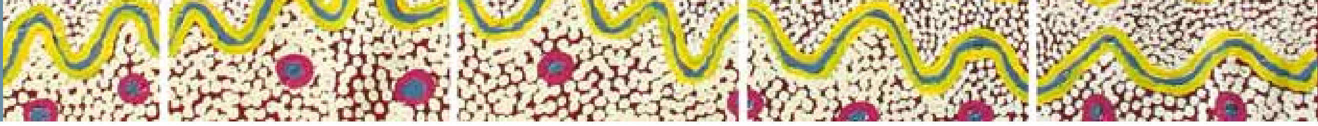
Table of Contents



Figures and Tables

The Managing Two Worlds Together Project

The Managing Two Worlds Together project aims to add to existing knowledge of what works well and what needs improvement in the system of care for Aboriginal patients from rural and remote areas of South Australia (and parts of the Northern Territory). It explores their complex patient journeys and what happens when they come to Adelaide for hospital care

The relationship between patients and health care providers is the foundation of care and requires communication across cultures, geography and life experiences. As a staff member in one rural Aboriginal Community Controlled Health Service put it: 'It's like managing two worlds together, it doesn't always work'.

Stage 1 of the project focuses on the problems. Four studies were conducted and are reported in six documents:

- *Managing Two Worlds Together: City Hospital Care for Country Aboriginal People Project Report* (**this report**—available on the website and as a printed document)
- *Managing Two Worlds Together: City Hospital Care for Country Aboriginal People Community Summary* (available on the website and as a printed document)
- *Managing Two Worlds Together: Study 1—Report on Admissions and Costs* (available on the website)
- *Managing Two Worlds Together: Study 2—Staff Perspectives on Care for Country Aboriginal Patients* (available on the website)
- *Managing Two Worlds Together: Study 3—The Experiences of Patients and Their Carers* (available on the website)
- *Managing Two Worlds Together: Study 4—Complex Country Aboriginal Patient Journeys* (available on the website).

Stage 2 will focus on solutions and will consist of a small set of action research projects. During 2012 the research team will work with partner organisations in this study to develop and/or document the implementation of strategies to improve the health care journeys for country Aboriginal patients, based on existing good practice and on the findings of Stage 1.

Full details about the project are available at the Managing Two Worlds Together website, which is hosted by Flinders University at: <www.flinders.edu.au/medicine/sites/health-care-management/research/MTWT/>.

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The research team is also grateful to our industry partners, and to members of the Project Management Group, which has functioned as a true sounding board for our emerging ideas and as a dynamic source of advice about the 'two worlds' we have explored.

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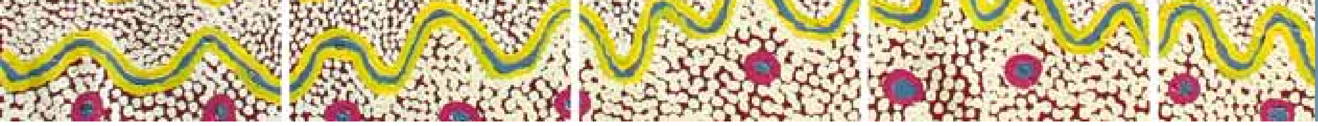
Abbreviations and Terms

AHLO	Aboriginal Hospital Liaison Officer
ECG	electrocardiogram
GP	general practitioner
PATS	Patient Assistance Transport Scheme
Country	In describing where people live, we use the terms *country* and *rural* to include all non-metropolitan areas. We use the more specific terms *regional, remote* and *very remote* in accordance with Australian Bureau of Statistics Accessibility/Remoteness Index for Australia (ARIA) definitions to indicate remoteness in terms of access along the road network. *Country* is used by Aboriginal people with a larger meaning of belonging and as a spiritual, as well as a geographic, home. The context of usage is a guide to interpretation of meaning.
Mainstream	We use *mainstream* to refer to non-Aboriginal systems, institutions and practices.



Summary

Project goal, scope and methods

The goal of this project is to improve knowledge of what works well and what needs improvement in the health care system for Aboriginal patients from rural and remote areas of South Australia (and parts of the Northern Territory). It explores their complex patient journeys and what happens when they come to Adelaide for hospital care.

The project is based on four separate studies:

- *Study 1—Report on Admissions and Costs* analyses the patterns of admission and length of stay of country Aboriginal patients in city public hospitals
- *Study 2—Staff Perspectives on Care for Country Aboriginal Patients* reports the views of staff who provide care for country Aboriginal patients in city and country hospitals and health services
- *Study 3—The Experiences of Patients and Their Carers* is a first-hand report of rural Aboriginal patients and their carers
- *Study 4—Complex Country Aboriginal Patient Journeys* maps four journey case studies, and analyses gaps and breakpoints in those care journeys.

Patterns of admission

Country Aboriginal patients are admitted to hospital more often than their urban and non-Aboriginal counterparts, and they often need to stay longer (hence their care is more expensive). But there is also evidence of 'missing patients'—that is, in spite of serious health problems, some country Aboriginal patients delay seeking care, or do not get access to care in city hospitals.

Patient journeys and staff experiences

Patients and their carers spoke of many good experiences, in particular of good quality care, and of the understanding and respectful way that many staff responded to their diverse needs and priorities. They also valued the times when transport, accommodation services and the many other back-up elements of their journeys worked well, enabling reasonable access to the care they needed. The problems they spoke of occurred when these elements were not in place, or failed to connect properly, and the consequences were often serious—for their health, for them personally and for their families, and financially (for patients, families and the health system). The system of care seems highly vulnerable to breaks and gaps when tested by the circumstances of this group of patients, often in spite of the best efforts of patients, carers and staff to make it work.

The views and experiences of staff reinforced the sense of a system that functions at the edge of its capacity in seeking to meet the needs of country Aboriginal patients, so that relatively small problems (like late planes or the lack of timely interpreting services) have consequences that reverberate in cost, in lost opportunity and in poorer health. The staff interviews highlight a paradox: although some clinical units have developed very specific practical responses to patient care needs, at the health system or organisational level (and in the thinking of some staff) there seems to be a failure to acknowledge that such responses need to be reliably available. Where the system works well, responses to the complexity of the patient journey are built in.

Policy and program environment

We examined the policy and program environment in which staff and patients engage in care, and found strong, high-level policies—such as the *Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004–2009* (AHMAC 2004)—but a lack of systematic funding and programs to implement them. There are many time-limited specific initiatives (such as those funded through the Closing the Gap program), but a lack of measures to embed the results in the system of care.

Findings

1. This project found many examples of good practice, based on careful attention, creative responses to the needs and circumstances of country Aboriginal patients, and strong relationships among Aboriginal patients and their health care professionals. But these 'best practice' strategies and protocols are not systematically implemented.

2. This project confirms the high burden of illness experienced by country Aboriginal patients. Barriers to access mean that they are more likely to receive needed care later in the course of an illness, or not at all, as evidenced in our analysis of admissions data and in the views and experiences of patients and staff.

3. Identification and recording of Aboriginality in clinical and administrative data collections is not adequate, and the lack of reliable information impedes both understanding of health care needs and capacity to monitor improvements. Continuing attention to this problem by SA Health and all health services is needed.

4. Patients' journeys are made harder by rigidities and gaps in the system of care, and in needed support systems. The patients (and their families/carers) undergo complex geographical and health care journeys, and this complexity is predictable due to the interaction of important underlying factors. All of these factors affect other groups of patients as well, but this group is likely to experience all or most of them. It is the interaction among the factors that makes access to good health care a complex challenge for this group of patients (and those who provide their care). The factors are summarised in Table 1.

5. The challenges of building good communication, trust and rapport in direct care interactions are significant for both staff and patients, and there are serious consequences of failure. Patients sometimes feel that their cultural values and needs are not respected, and staff sometimes struggle to communicate across differences in cultures, worldviews and experiences.

6. Coordination among care providers across geographical and sector boundaries is not reliable. When it is achieved, the benefits are real for patients, staff and organisations.

7. However, even with better coordination, support services (for travel, accommodation, coordination of physical and care journeys, interpreting and personal/family/cultural support for patients) are not adequate to need, and for some services cost is a barrier.

8. It seems that hospital systems that work reasonably well for city patients are not flexible enough for those who must travel for care. When the multiplier effect of all the barriers that impede the patient journey for country Aboriginal people is taken into account, it is clear that complexity is predictable for this group, and any attempt to improve care needs to be based on an assumption of complexity in the patient journey (as distinct from clinical complexity). Not all Aboriginal patients from the country will require tailored responses to complexity, but complexity should usually be expected.

9. Although there are many high-level statements of policy and principle to guide health care providers in caring for Aboriginal patients, there is a lack of operational policy and programs in the system of care that might support health care providers to build in reliable responses to complex patient journeys.

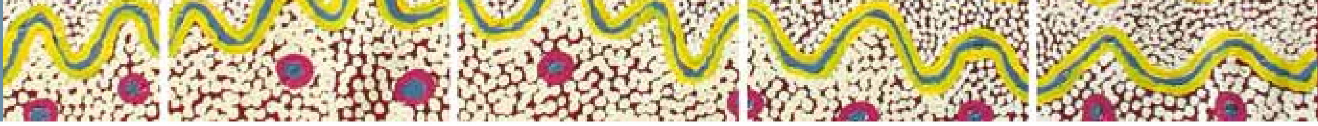
Table 1: Five factors that affect access and quality of care

Issue	Explanation
City/country	Some of the problems facing country Aboriginal patients and their health care providers are common to all country patients.
High burden of illness	People with chronic or complex conditions are affected more by systemic health care problems, especially across hospital/non-hospital sectors, although any patient may experience care problems.
Language	Some communication challenges that patients and staff encounter are common to all population groups for whom English is not a first language.
Financial resources	It is harder for all people who have little or no extra money to meet the costs of transport, treatment, being admitted for health care, and time off work or away from home and family.
Aboriginal/non-Aboriginal	There are ways in which Aboriginal people experience unique disadvantage in their interactions with the mainstream health system (and other social systems); and mainstream worldviews and beliefs about health and health care are often different from those held by Aboriginal people.

Conclusions

The following measures are likely to result in improvements in both the integrity of the patient journey and the effective use of health care resources.

1. Approaches to improving care for this group of patients need to be based on recognition that complexity in the overall patient journey is to be expected. Responses to manage complexity should be routinely available, and ruled out only when assessment shows they are not needed. This *complexity principle* could be used as the basis for the development of operational policies, programs and protocols to enable reliable access to good care for this group of patients.
2. Clinical units that regularly admit country Aboriginal patients need a dedicated coordinator role, with a focus on better pre- and post-admission preparation and follow-up. Such roles have been demonstrated to be effective elsewhere, including in relation to remote Aboriginal patients (Lawrence *et al*. 2009) and in clinical units in this project. Other clinical units need access to a coordinating resource person, a role that could be filled by Aboriginal Patient Pathway Officers or Aboriginal Hospital Liaison Officers (AHLOs), provided that a designated clinical staff member is reliably available to ensure proper communication and engagement within the clinical unit.
3. Assuming that coordinating capacity is available, access and quality would be improved if the following specific measures and services were available to patients, carers/escorts and staff:
   - adequate transport and accommodation arrangements (building on the work of Country Health SA and the Community Passenger Transport network) supported by improved access to financial help with costs, including up-front Patient Assistance Transport Scheme (PATS) payments (CHSA 2011; Department of Health 2010)



   - ready availability of interpreter services, and systematic implementation of the policies that require their appropriate use
   - use of pre-admission consent procedures and attention to ensuring informed consent (which may involve family and others, as well as the patient)
   - access to specialist outpatient care in regional centres, with visiting specialists working more actively with each other and with primary care providers, and backed up by use of e-health and other information technology
   - better systems to coordinate outpatient consultations wherever they occur, aimed at preventing waste and unnecessary travel.

4. The vital contribution to care made by AHLOs (and Aboriginal Patient Pathway Officers) would be further enhanced if their roles were better defined, understood and supported by both city and country staff and organisations. These workers are relied on too much to solve immediate problems in the patient journey (which should be predicted and planned for by the whole health care team) and could make a stronger contribution to ensuring quality and safety for Aboriginal patients.
5. Support from escorts and/or family and community members is important for patients. Practical methods of incorporating family members and escorts into health care, and defining their roles properly, are needed.
6. Attention to cultural priorities and spiritual needs should include systematic arrangements for access to *Ngangkaris*, as well as making the hospital environment more friendly (through visual cues and attention to gender concerns, coldness and food preferences).
7. Non-Aboriginal staff can and do develop skills and knowledge that help them to be effective communicators and carers across cultural and language groups. This capacity seems to require, first of all, recognition that one is ‘working in the intercultural space’ and appreciation that each of us holds cultural values and assumptions. The evidence is mounting that existing approaches to cultural awareness training are not effective. The concept and approach of cultural safety—with its focus on the essential link between culture and clinical quality and safety—may be more effective.

Next steps

This report summarises the results of Stage 1 of the project. In Stage 2 we aim to work with industry partners and stakeholders to develop further (and, where possible, test) the methods suggested in the conclusions. Success will depend on engagement by health care providers, on clinical and system leadership, and on enabling policy, programs and procedures. Health staff and units have expressed interest in being involved in work in each of the practice areas listed above. If this approach succeeds, the outcomes will be improvements in the quality of care, the integrity of the patient journey and the effective use of health care resources.

Why this Project?

The health system in South Australia is responsible for providing good care to all citizens. It is required, by legislation and policy (SA Health 2007), to respond to the particular needs and circumstances of Aboriginal people. The South Australian *Health Care Act 2008* places this obligation on the Department of Health and its health services, as the second of nine principles (Part 1:5b of the Health Care Act) states:

> Aboriginal people and Torres Strait Islanders should be recognised as having a special heritage and the health system should, in interacting with Aboriginal people and Torres Strait Islanders, support values that respect their historical and contemporary cultures.

The Department of Health has endorsed the *Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004–2009* (AHMAC 2004), which specifies high-level principles to guide the health system. The framework acknowledges that the health system 'does not provide the same level and quality of care to treat illness' for Aboriginal people, and that there is a need for greater focus on improving the performance and accountability of mainstream health services (AHMAC 2004:5). The Council of Australian Governments has reinforced the need for attention to this problem in the *National Partnership Agreement on Closing the Gap In Indigenous Health Outcomes*, which identifies 'Fixing the gaps and improving the patient journey' as one of six priority areas to be funded (COAG 2008:7).

This project was commissioned by the Department of Health to investigate the experiences of rural and remote Aboriginal patients who travel to Adelaide for hospital care, and the health system's capability to respond to their needs. If health care providers knew with confidence what to do to improve care for country Aboriginal patients, they would be more likely to act effectively to do so. Such actionable knowledge needs to encompass both an understanding of the causes of enduring problems, as well as a set of methods or strategies to address the 'symptoms' as they manifest in so many specific ways in different clinical areas and different settings. The project aims to assist hospitals and other health services to improve their care for this patient group, based on evidence about the nature of the problems these patients experience, why these problems occur and how they might be overcome.

What is the problem?

Until 1995 responsibility for Aboriginal and Torres Strait Islander health was shared between the health portfolio, the Department of Aboriginal Affairs and the Aboriginal and Torres Strait Islander Commission. The transfer of responsibility to the health portfolio in 1995 resulted in increased funding and removed some ambiguity about the role of the health system. The mainstream health system has slowly responded (Anderson *et al*. 2002), with increasing attention, to the burden of illness that Aboriginal people experience (NATSIHC 2003) and the need for effective health care.

Evidence of problems in health care

But change is patchy. Although there is evidence of increased access to primary health care in Aboriginal Community Controlled Health Services and mainstream general practice, screening rates and prevention of complications for Aboriginal patients are still lower than for the general population (AIHW 2011:95–8). Aboriginal people do not have equitable access to necessary primary health care services for several reasons and this is reflected in high numbers of potentially preventable hospitalisations (DoHA 2009; AIHW 2011:95–8). Although emergency department visits and hospitalisation rates for Aboriginal people are relatively higher, procedure rates are lower. Waiting times for surgery are longer than for non-Aboriginal patients, and nearly double for some cardiac and cataract surgery (AIHW 2011:100).

Aboriginal people are often sicker or clinically more complex at an earlier age and have some different care needs related to their life circumstances and positions in society. Experiences of shaming, misunderstanding and stereotyping make engagement with the health system less effective than it can and should be (NHFA & AHHA 2010; Purdie, Dudgeon & Walker 2010).

Aboriginal patients sometimes receive care that is ineffective, insensitive or inappropriate (Eckermann *et al*. 2006). Language and interpersonal communication breakdown across the cultural divide lead to difficulty in assessing symptoms, reaching an accurate diagnosis and providing effective care (Kowanko *et al*. 2003; Taylor & Guerin 2010; Purdie, Dudgeon & Walker 2010).

There is also evidence that access for Aboriginal patients and families, including rural and remote people, is compromised by barriers to care that affect them differentially (AIHW 2011). These include resources for travel and accommodation, availability of supportive or rehabilitation care, such as cardiac rehabilitation (NHMRC 2005; Cass *et al*. 2002), and continuity of care across different health and support services (Lawrence *et al*. 2009). The poorer health status of carers, the need for escorts and difficulties in fully understanding medical information for some patients, carers and interpreters (Stamp *et al*. 2006) further impede access and quality of care.

Schools of thought on these problems

Some studies of access and quality problems have concluded that the reasons for the disparities are not clearly understood (e.g. Fisher & Weeramanthri 2002), while other authors highlight the importance of recognising and addressing institutional racism (e.g. Henry, Houston & Mooney 2004). There are three important schools of thought about the underlying reasons why Aboriginal people and other marginalised groups experience differential access and quality of care, even in public health systems (like Australia's) that aim to provide universal access to quality care.

Marginalisation

There is evidence that patients from marginalised groups in society inherently mistrust mainstream health services and carers, based on previous experiences of poor communication, judgment, stereotyping, victim blaming and refusal of service (Alford 2005; Rogers *et al*. 2005). Socio-political issues impact directly on care delivery for these groups, making health care places personally unsafe or unresponsive for some. A lack of choice of service providers, or of staff from their own population group, deepens marginalised people's discomfort (Stamp *et al*. 2006).

Mainstream services often lack the flexibility, understanding or capacity to meet individual needs, and disconnections between health and support services add further complications (Harris *et al*. 2009; Taylor & Guerin 2010). In the primary health care setting, Aboriginal Community Controlled Health Services and/or choice of general practitioners (GPs) are available for many. But all Australian hospitals are mainstream institutions based on strong Western medical models of care, and choice of provider is not normally available. Non-inclusion of family and carers in health care planning, and poor consideration of a patient's own priorities, lead to limited health outcomes (Lowell *et al*. 2001) and unsafe care. Although many public health systems have responded to these problems with cultural awareness training for their staff, these programs have not delivered the anticipated benefits (Westwood & Westwood 2010), and other approaches are being sought and tried (AIDA & RACP 2004; Nygen 2008; Dudgeon & Walker 2011).

Racism is a factor in marginalisation. Racism is normally defined as the belief that members of particular racial groups share characteristics that are different from (better or worse than) those of other races, and the prejudice, discrimination or differential treatment based on that belief (United Nations 1969). In Australian health care, racism can be seen in assumptions that all Aboriginal people share certain characteristics, in impaired communication, and in failure to understand or respect the roles, beliefs, priorities and cultures of Aboriginal people—and in differential treatment based on those assumptions and patterns of behaviour (Paradies, Harris & Anderson 2008).

Post-colonial theory

Post-colonial theoretical frameworks provide critical cultural perspectives that question the thinking behind cultural policies and the extent to which they address historical and ongoing impacts of colonisation, disadvantage, marginalisation and 'othering' (Browne & Varcoe 2006; Sherwood & Edwards 2006; Taylor 2010). Closer examination of unequal power relations inherent in health care encounters, particularly when members of the dominant group provide health care, enable new understandings about how systems and even deeply committed individuals can unknowingly and unwittingly contribute to racial inequality. Questions are raised about how some behaviours get defined as normal and others as cultural, and about what creates an unspoken norm that marginalises people (Browne & Varcoe 2006). A reconsideration of culture as both dynamic and negotiated, with enduring elements, recognises Aboriginal people's individual relationships to, and expression of, culture, and that people may enact their cultures differently depending on the situation or context (Lynam *et al*. 2007).

Systems theory

Systems theory offers insights into the problems of gaps and breakpoints in health care, and the difficulties for specialised agencies in seeking to meet the broad health needs of people with complex health problems. Complexity theory (e.g. Plsek & Greenhalgh 2001) is particularly relevant here. Staff and managers in hospitals report that although small improvement projects are often successful, it is hard to sustain changes designed to improve care. The recent Improving the Culture of Hospitals project (Willis *et al*. 2010) and work on cardiac care reported by Lawrence *et al*. (2009) have documented successful changes and indicate the requirements for sustaining them. They conclude that good methods (based on a quality assurance approach that recognises the knowledge of Aboriginal staff and supports them to take on this role) are crucial but not enough, and that sustainable change requires attention at all levels—from respectful ways of working with Aboriginal communities to system policy and leadership.

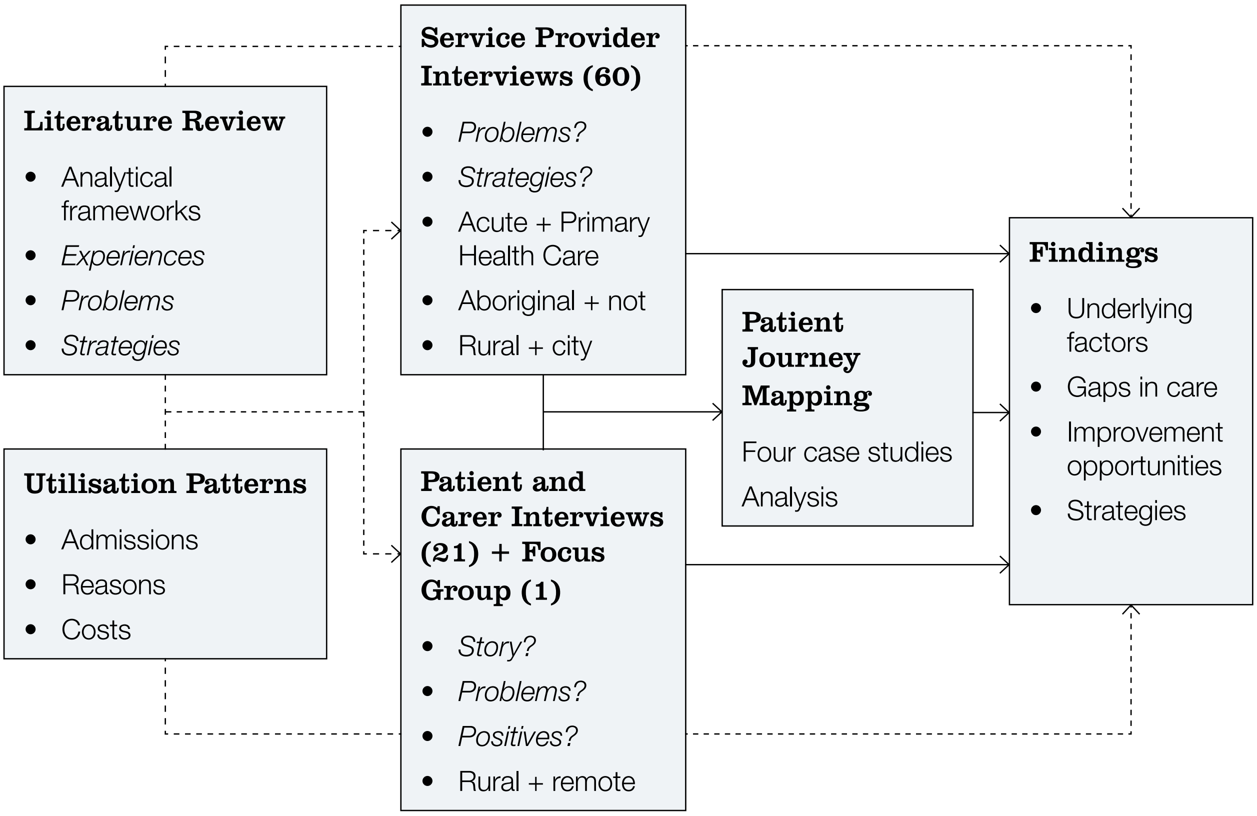
In short, the poor health status of Aboriginal and Torres Strait Islander people has been well described, and there is some evidence about the underlying reasons for the differences. There is also some understanding of the problems Aboriginal people experience in getting access to health care, and why. But there is a comparative lack of knowledge about the factors in the health care system itself that enable the known problems to continue, or of the feasible means of changing them to remove or reduce those problems. This project seeks to contribute to addressing this gap in knowledge.

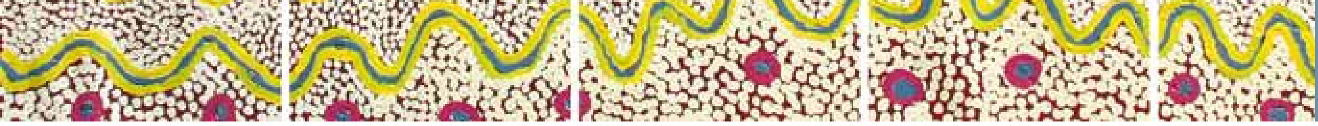
Our Approach: Project Design and Methods

The problem we set out to study is a complicated one, with many different aspects. We therefore structured the project as several linked studies using a mix of methods.

The Aboriginal Health Council of South Australia and the four major public health services at the time—Country Health SA; Central Northern Adelaide Health Service; Southern Adelaide Health Service; and Child, Youth and Women's Health Service—agreed to participate in this project. A Project Management Group was established, with a majority of Aboriginal members, which included representatives from the health services and other stakeholders. We sought and received ethical approval from six ethics committees. The structure of the overall project is represented in Figure 1.

Figure 1: Project structure





We conducted several literature searches, the results of which are reported in the relevant sections of our reports. We examined the overall pattern of admissions of Aboriginal patients from rural and remote areas, and used this information to identify the major health problems involved. We then focused on those health problems in approaching clinical units and country health services for the staff and patient interviews.

The three qualitative studies are based on first-hand views and reported experiences of rural Aboriginal patients and their carers, and of staff who provided care for them in city and country hospitals and health services. Staff in clinical units in Adelaide public hospitals that provide care for significant numbers of rural and remote Aboriginal patients, and staff in the country and city agencies that refer patients, were asked open questions about the problems they and their patients encounter, and the strategies they use to deal with them. Patients and carers were asked about what happened when they came to Adelaide for hospital care, and about their care before and after their admissions. Based on this information, we developed a framework to analyse the sources of the difficulties experienced by patients and staff and to identify the main problems and gaps.

With the agreement of patients and carers, we chose four stories as case studies and collected other information (from health care staff involved in their care) in order to identify factors that made the patient journey more complex and those that were avoidable.

Finally, we brought together the results of all four studies to formulate our main findings and conclusions. A longer explanation of the methodology of each study is available on the project website.

Throughout the project, members of the team (primarily Dr Janet Kelly) have kept in contact with individuals and groups in the health system who are working on relevant aspects of health care, and have been learning about their work and informing them about ours. This activity, along with the involvement of the Project Management Group members, also aims to develop the working relationships that will be needed in Stage 2 of this project. Stage 2 will aim to test and/or develop some of the strategies that are suggested by our findings in Stage 1, some of which are already in development, being trialled or have been implemented.

Aboriginal Patient Admissions to City Hospitals

We analysed two years of data on admissions of Aboriginal people from country South Australia to public hospitals (2006/07 and 2007/08). Data were provided by SA Health from the Integrated South Australian Activity Collection (ISAAC). The analysis of adult admissions focused on eight health problems that are the most common reasons for admission to city hospitals (278 of 2714 admissions), while the analysis for Aboriginal children included 363 admissions for the four most common health problems (72% of all admissions).

The main findings from this analysis are presented below. A more detailed report (*Managing Two Worlds Together: Study 1— Report on Admissions and Costs*) is available on the project website.

Data quality problems

Indigenous status is often not recorded, or not recorded accurately, by hospitals and this makes the data much less reliable. Further, the number of admissions for the conditions we focused on was quite small, which makes some analysis unreliable and reduces our ability to determine when differences between Aboriginal and non-Aboriginal people are statistically significant (i.e. when they are highly unlikely to be due to chance variations). Staff in hospitals sometimes find it difficult to ask questions about Aboriginality, and hospitals are working to address this problem.

Adult admissions

High reliance on country hospitals

Aboriginal South Australian adults (not just those living in the country) are much more likely (6.6 times higher rate) than non-Aboriginal people to be admitted to *country* hospitals for the eight conditions, and are also more likely (1.9 times higher rate) to be admitted to *city* hospitals. The relatively high reliance on country hospitals compared to the pattern for non-Aboriginal people indicates barriers to access to city hospitals (as well as problems with identification of Aboriginal status, which are likely to lead to under-counting of Aboriginal admissions, particularly in city hospitals).

Admissions to city hospitals

There were 2714 admissions of Aboriginal adults from country areas to city hospitals in the period. One-tenth (10.1%) of these admissions were for one of the eight selected health problems examined in this study (circulatory disease, digestive disease, endocrine disease, genitourinary disease, injury, kidney disease, mental health and respiratory disease). These disease groups accounted for the same proportion of non-Aboriginal admissions (10.0%).

The rate of admissions for Aboriginal adults was substantially higher (65%) than for the non-Aboriginal population. The Hills Mallee Southern SA Health region had a significantly higher than average admission rate for Aboriginal people, and the South East region had a significantly lower rate.

Admissions for particular health problems

There were 70 admissions of Aboriginal people for mental health conditions, a rate almost five times that of the non-Aboriginal population. Notably, no admissions were recorded for Aboriginal people aged 60 years and over. Rates in the Northern and Far Western region were lower than those for non-Aboriginal people.

The rate of admissions for respiratory disease (46 admissions) was twice as high for Aboriginal as non-Aboriginal people, with substantially higher rates at older ages, more than five times those in the non-Aboriginal population. People from the Eyre region had a rate of admission more than twice the average of the overall Aboriginal admission rate.

Aboriginal people from the Hills Mallee Southern region, and those from the Inner Regional remoteness category, had significantly higher admission rates for circulatory disease than non-Aboriginal people from those regions.

Cost of admissions

The *average cost per admission* was significantly higher for Aboriginal people than non-Aboriginal people overall (27% higher for the combined disease/condition groups) and for admissions for circulatory disease (54% higher).

Average length of stay

The average length of stay per admission was longer in the Aboriginal than non-Aboriginal population, both overall (23% longer) and for admissions for circulatory disease (32% longer). The actual number of days was 5.96 days compared with 4.84 days for all condition/disease groups combined, and 5.47 compared with 4.13 days for circulatory disease.

Admissions of Aboriginal children (less than 16 years old)

There were 505 admissions of Aboriginal children aged less than 16 years from country areas to city hospitals in 2006/07 and 2007/08. Almost three-quarters (71.8%) of these admissions were for one of the four selected health problems examined in this study (acute upper respiratory infections; low birth weight/short gestation; injury, poisoning and other external causes; and intestinal infectious diseases). However, these disease groups accounted for a much lower proportion of non-Aboriginal admissions (38.7%).

Admission rates of Aboriginal children for these health problems were 67 per cent higher than for non-Aboriginal children. But admission rates for Aboriginal children for all health problems were lower than the admission rates for non-Aboriginal children (90%). This finding suggests that either Aboriginal children do not need as many admissions for other health problems, or that they are missing out on many admissions. Again, poor identification of patients as Aboriginal is also likely to be an issue.

High admission rates for younger children

Of all admissions for these health problems, 81 per cent of Aboriginal children were aged 0 to 4 years, compared with 53.9 per cent of non-Aboriginal children.

Admissions from different regions

Admission rates varied by region, with Aboriginal children in Eyre having a 57 per cent higher rate compared with the overall Aboriginal rate. Aboriginal children in the South East and Hills Mallee Southern regions had lower rates (65% and 37%, respectively).

Admissions for particular health problems

Of admissions for the selected conditions, those due to injury, poisoning and other external causes comprised the greatest proportion of all admissions for both Aboriginal (51.5%) and non-Aboriginal children (54.0%). However, admission rates for these conditions were 59 per cent higher for Aboriginal children than for non-Aboriginal children, with a much larger differential in the 0 to 4 year age group.

The largest difference in admission rates between Aboriginal and non-Aboriginal children was for acute upper respiratory infections, with the rate for Aboriginal children just over twice that for non-Aboriginal children (mostly of children aged 0 to 4 years in both groups). Aboriginal children in the Eyre and Wakefield regions had the most elevated admission rates (more than eight times and more than six times respectively).

Admissions related to low birth weight/short gestation were 79 per cent higher for Aboriginal than non-Aboriginal children.

Admissions for intestinal infectious diseases were 50 per cent higher in Aboriginal than non-Aboriginal children. Admission rates were highest for Aboriginal children from the Eyre SA Health region (almost twice the level expected for this population, and more than seven times that for non-Aboriginal children in the region). Rates for Aboriginal children in very remote areas were more than 50 per cent higher than those for non-Aboriginal children.

Length of stay

On average, country Aboriginal children admitted for the four health problems stayed in hospital 49 per cent longer than non-Aboriginal children (6.7 days compared with 4.5 days). The greatest difference in average length of stay was for intestinal infectious diseases (more than two-and-a-half times), and the difference was 50 per cent for acute upper respiratory infection.

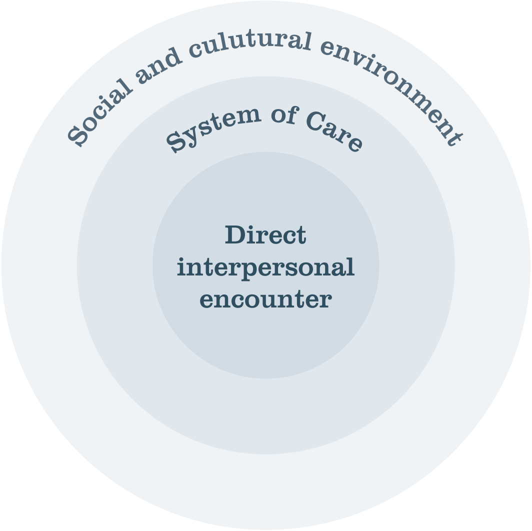
Patient and Staff Experiences

We interviewed 60 staff—about half from metropolitan hospital clinical units and about half from country health services. We asked the staff open questions about their experiences of providing care for country Aboriginal patients (description, barriers and enabling factors). We then interviewed 21 patients and carers, and conducted a focus group with eight Elder women, and asked them to tell the stories of their experiences.

The main findings are presented below: more detailed reports (*Managing Two Worlds Together: Study 2—Staff Perspectives on Care for Country Aboriginal Patients* and *Managing Two Worlds Together: Study 3—The Experiences of Patients and Their Carers*) are available on the project website.

There was a remarkable level of consistency in the main themes discussed by staff and by patients/carers, and some important differences. We analysed the two sets of interviews separately (using the software program NVivo and inductive analysis), and then compared them. Interviewees talked about issues in three domains: the direct patient–staff encounter, the care system (access and quality of care), and the social and cultural environment in which care happens. This simple structure is represented in Figure 2.

Figure 2: Three domains of factors affecting health care delivery



Patients and their carers spoke of many good experiences, in particular of good quality care, and of the understanding and respectful ways that many staff responded to their needs and cultural values. They also valued the times when transport, accommodation services and the many other back-up elements of their journeys worked well, enabling reasonable access to the care they needed. The problems they spoke of occurred when these elements were not in place, or failed to connect properly, and the consequences were often serious—for their health, for them personally and for their families, and financially (for patients, families and the health system). The system of care seems highly vulnerable to breaks and gaps when tested by the circumstances of this group of patients, often in spite of the best efforts of patients, families, carers and staff to make it work.

Staff interviews indicated widespread recognition and energetic attention to the challenges of caring for country Aboriginal patients, as well as some lack of response and empathy. The views and experiences of staff reinforced the sense of a system that functions at the edge of its capacity in seeking to meet the needs of country Aboriginal patients, so that relatively small problems (like late planes or the lack of timely interpreting services) have consequences that reverberate in costs, in lost opportunities and in poorer health. The staff interviews highlighted a paradox: although some clinical units have developed very specific practical responses to patient care needs, at the health system and organisational level (and in the thinking of some staff) there seems to be a failure to acknowledge that such responses need to be reliably available.

The main themes in the interviews with patients/carers and with staff are summarised below in relation to each of the three domains. Codes in brackets at the end of quotes indicate the speaker.

Patients and/or carers are labelled:

- **P** (patient)
- **C** (carer)
- **PC** (patient carer) or
- **FG** (focus group)

Staff are labelled:

- **M** (metropolitan location)
- **R** (rural)
- **H** (hospital)
- **G** (general practice)
- **A** (Aboriginal Community Controlled Health Service)
- **C** (community health service) or
- **S** (support or other service, such as aged care, accommodation).

The direct clinical interaction domain

The relationship between patients and their health care providers is the foundation of care. Most participants discussed both positive experiences and the particular challenges they face when that relationship requires communication across cultures, geography and life experiences. This central challenge was summed up by one rural staff member using the concept that gave us the title for this project: 'It's like managing two worlds together, it doesn't always work' (RA2).

Patient/staff interactions

The majority of patients and carers spoke of experiencing positive interactions with most staff, but negative experiences with a minority of staff members. This difference was initially explained by patients and carers as differences in personality and approach, but they also reflected on deeper issues of basic communication skills, respect and cultural safety. Some patients and carers had only positive experiences, while others reported being shamed, disrespected or frightened:

> I had no problems while I was in there. The staff were really good. We got looked after really good, perfectly (C2).
>
> Some might be racist or some might be good; you get things like that (P5).
>
> The big doctor came around with his group and told me to close my mouth as I didn't need to breathe through it. Easy for him to say. He said that to me in front of all the other students (PC24).

Most staff recognised the need for skill and knowledge in intercultural communication, while some seemed not to recognise that this challenge was relevant to their clinical care role. Staff commentary focused on the importance of building trust and rapport, the challenge of communicating clinical information across cultures, and the consequences of communication failure:

> people just tend to sort of—I don't know, keep to themselves… so you really need to communicate, really have to stress that communication, go in there and… make sure you see them every day (MH6).
>
> Sometimes doctors and nurses don't explain things so that Aboriginal people can understand them… You have to tell it to people straight, in ways they understand (RC1).
>
> Do they really understand in the first place, these tablets you have to keep taking forever… The ramification… if they have a stent it's reocclusion, reinfarction, possibly death… depending on their diagnosis… it has huge negative consequences (MH16).
>
> I just have to say that I really don't… communicate very well with the women, and that is just a fact of life (M23).

Cultural safety

Patients and carers were asked how they felt staff responded to their needs as Aboriginal people. Again, their experiences were mixed:

> Our experience has been very positive. We didn't encounter anything negative based on being Aboriginal. You have your radar on when you go somewhere new, and there was nothing to detect (PC23).

> Every time I called the nurse, like it takes a bit long time and I notice that every time the other lady, the white woman, do the button they really come quick (P5).

Staff spoke of their discomfort in intercultural relationships, and the need for knowledge and skills:

> I think you can get stuck on blame to the point where it becomes quite destructive and people… they're too scared to ask questions any more… too scared to do anything really because it's deemed as racist (MS1).

> I wonder whether it's also experience… Some of the staff I'm talking about are actually young, and not necessarily—haven't had those experiences, so sometimes there is overt racism. Sometimes it's ignorance (MS10).

Strategies

Some patients and carers felt that their own knowledge and abilities were important in helping them to negotiate care, and others appreciated the practical and cultural support they received from AHLOs:

> I thought I was treated better than somebody else, only because I asked questions and… when they asked me anything I was able to answer them back (P9).

> Aboriginal staff work in there, they come and spend most time with us, talking to us or if we need anything give them a buzz. Makes us a bit comfortable, someone there talking to us instead of waiting for the nurses all the time (P5).

Staff focused on the importance of knowledge and relationships:

> Yeah, I think having a bit of a knowledge of the things that are challenging… or a bit of an insight, is helpful… there is capacity to moderate what you do a bit, we can be a little bit flexible and that can be helpful (MH11).

> I think it's just really about being enquiring and polite, just as you would with anyone else, and not presume… (MH7).

Some staff expressed recognition of the importance of cultural safety, but others did not seem to recognise a particular need:

> You know it's not a one-way street—it's a two-way journey and it's about the health sector being willing to meet Aboriginal people halfway (MH3).

> … supporting them to be listened to and to be heard and just checking, constantly, that somebody's okay with that and not just being polite and just saying 'yes'… that confusion about what people's responses actually mean [is] I think one of the most dangerous things (MS1).

> I haven't asked them, and I really don't know if I'd want to (MH9).

In short, patient experiences were largely positive, but shaming, discrimination and communication failures were serious problems where they occurred. The difficulties of establishing trust and good communication across cultures, among people with very different life experiences and worldviews, and the importance of making it work if clinical care is to be safe and effective, were discussed by most staff. These results highlight the complexity of the challenge, as well as the importance of the skills and competence of staff, and some of the ways in which they succeed, struggle or fail. Recognition of the fact of 'working in the intercultural space' seems to be a necessary foundation for giving attention to the skills and methods that work. Staff who felt some level of confidence in this endeavour emphasised the importance of respect, engagement and some knowledge of their patients' home environments, and of their use of language and health concepts. Cultural awareness training did not emerge as a major enabler, a result that is consistent with other recent findings (Willis *et al*. 2010; Westwood & Westwood 2010) and with the critique of cultural awareness (RACGP 2010).

The care system domain

Access to care

Statistical analyses of the admission rates of Aboriginal and Torres Strait Islander people by the Public Health Information Development Unit (PHIDU 2010) note an apparent paradox: on average Aboriginal people are admitted to hospital more often than other Australians, and yet there are indications that some groups of Aboriginal people are not getting to hospital as often (or as soon) as would be expected given their health status (AIHW 2011; Shahid *et al*. 2011). Evidence from this project regarding the much greater reliance by Aboriginal people on country hospitals reinforces concern about access to city hospitals.

Transport, accommodation and cost are major barriers

Access to affordable transport and accommodation was the most significant concern for patients and carers travelling to the city for care, and staff interviews mirrored these concerns:

> I wouldn't like to see anybody else go through what I've been through with this sort of transport and worry of getting him there. At times he said, 'oh, don't worry about it, I'm not going to appointments. I can't get down, not going' (C6).

> Sometimes the people from the communities in the Territory may have to be away from community for three days to get here and… people have been exhausted, falling asleep. Assumptions have been made about their health status but in fact they've just been travelling… (MS10).

Support services assist to varying degrees, but strict rules and administrative requirements create barriers. The majority of patients stayed with family or friends, with others seeking affordable options in Aboriginal hostels and Cancer Council accommodation. Many people on pensions or low wages, and those experiencing chronic conditions, struggled financially to purchase medications and make trips to Adelaide for health care:

> The thing is you've got to come up with the money for the travel first and then apply for the funding afterwards and that doesn't help much, especially when you're only on a pension and we've got rent to pay, we've got bills to pay, we've got kids to look after. Putting petrol in the car, which is $75… (P1).

The role and health of carers and escorts

Carers and escorts were supported by hospital staff to varying degrees, with some becoming part of the care team and/or strong patient advocates. Support was appreciated:

> The staff were very supportive. My grandson is four years old and they brought out a bed so I could be with him. The nursing staff arranged for me to have meals when the trolley came around, help yourself they said, order what you like. I could go and get a cuppa from the kitchen (C2).

Staff recognised the vital role of carers, but also the limitations arising from the carers' own health status, their unpreparedness in many ways for the demands of the role, limited funding to support them, and the lack of formal recognition of carers as part of the health care team:

> [Patients who have escorts or carers] have less muscle tension and therefore less pain… Sometimes with… surgery there is some post-op delirium and having an escort helps to settle that so you want somebody they can identify with (MH15).

> We have had escorts that have been sent down with quite severe illnesses… they have spent more time in hospital than the patient (MH19).

Interpreting services are not adequate, with implications for informed consent

Interpreters were offered to some patients, but not to others, and patients' abilities to understand complex medical concepts were often overestimated. Uncertain capacity for informed consent, and lack of access to interpreters to assist with consent procedures, is a significant problem for patients and staff. Patients with a good command of English, access to written information and the ability to keep asking staff questions were best informed.

> I was quite happy with all the information that I received (P12)
>
> There's a couple of times when he had to have things done to him, we weren't told what or why that was done (C6).
>
> Now what an x-ray on my chest has got to do with my back… He didn't explain it to me, nothing was explained to me. My wife asked why did I have to get an x-ray on my chest, he didn't answer (P3).

Care delayed or foregone

Several staff in this study expressed concern about patients with certain conditions, and those who were older and living in more remote areas, not getting treatment when they should.

> We're seeing people here who actually haven't accessed the system so their cancers are very, very advanced. We've seen [Aboriginal people] who have got… major carcinoma that's disfiguring, just distorting their body shape… so they've obviously been in pain for a long time and that suggests to me that… they're reluctant or reticent or unable to access systems for whatever reason (MS10).

Some successful strategies to address these problems were also highlighted, including the Corporate Shuttle Service (which transports outpatients between accommodation and hospitals) as an important gap-filler. But for some patients the combined effects of access barriers led to their decisions to delay seeking, or not to use, city-based health care.

Coordination and quality of care

Both metropolitan and rural staff recognised the important problem of coordination between health services—city and country, primary health care and tertiary, and Aboriginal and mainstream—for the care of country Aboriginal patients.

City staff lack needed information about patients

Problems for patients moving between hospital and community-based care predominated in concerns about coordination and continuity of care. Lack of information about referred patients and lack of knowledge of other settings and their constraints are a problem for staff:

> One of the things that we face is lack of information… So we know they have come for an angiogram but we don't have any other history… So all of that is an instant barrier (MH16).
>
> We do find that admission information usually is poor for everybody across the board… usually you're starting from scratch and you have nothing to start with… you don't really know what they're about or who's at home, what their living conditions are like, any support services, you don't have anything (MH6).
>
> Improving communication would be helpful and getting people to—for us to understand what's going on up there and for them to understand what we need down here, what our limitations are (MH8).

Lack of coordination is expensive in human and financial terms

Patients and carers highlighted the difficulty of coordinating transport and hospital appointments and the apparent lack of understanding of most city services and staff of the need to accommodate this:

> People in the city understand that you come from the country, but they don't understand exactly what that means, that you might need to catch a bus at a certain time to get back home or else have to stay another night. Sometimes you have to really push to get appointments on the same day. They say, oh, why (PC24)?

Within each setting, staff make unreliable assumptions about the roles of other care providers. Coordination among health care providers was effective in some areas, and patchy or non-existent in others. In some cases patients experienced unacceptable delays due to poor communication and lost results. The need for better use of technology, and for someone to be responsible for coordinating the overall patient journey, is clear:

> There's no sort of preparation or there's no arrangements for Aboriginal people, we just send them down. It's purely a clinical-based decision. There's no consideration of the sort of social, family or cultural aspects of the transfer, which, to me, always seems like it's missing in some ways (RH6).

> it would also be good if we could access the electronic data manager… because we could look at all the blood results… the radiology results and even discharge summary… it would save a lot of mucking around and would benefit the patients a lot too. Sometimes patients end up getting tests repeated because you don't know what was done because the patient wasn't quite able to tell you (MH11).

> One woman with a broken arm travelled 500 kilometres for an x-ray and then returned home while waiting for an appointment. After some weeks, a… worker rang on her behalf and found that the x-ray had gotten lost. This required a local GP appointment and another x-ray and another round trip of 1000 kilometres. After another long delay the… worker rang again. After nine months the woman saw the specialist who said that her arm has now healed and she doesn't require surgery. However, her arm has healed with a large lump along her forearm and her functional ability has greatly reduced (FG1).

The hospital environment is sometimes cold and lonely, but good care is appreciated

Some patients found hospitals cold and lonely, with little personal or cultural support for gender and spiritual needs. Others just appreciated getting well and the environment did not matter:

> Yeah, wanting another blanket and they're too frightened to ask for it (P3).

> We had to use the one toilet and bath between us. I didn't like the idea of going… to the toilet and there's a man in there. It would be better if it was all women, have a women's ward or whatever. I walked in once and a man was on the toilet seat (P9).

> I sort of just go along as per normal. No, I didn't have any special needs (P12).

> They know me now and I have no worries about going down. This is the first time I have felt good for a while. The doctors and nurses there, they changed my life this year. I like it down there. The staff there say, 'Mrs [X], don't say you are back again', joking and welcoming me in again. Hospital is a good place to be (P4).

Discharge or transfer of care?

Some patients and carers experienced well-coordinated, collaborative and supported discharge and follow-up processes by city hospitals; others had disjointed experiences, with little consideration for home conditions or follow-up care. Local primary health care services, particularly the Aboriginal health service and/or GPs, played a major role in coordination and ensuring follow-up through a more holistic approach to case managing patients' health care journeys.

> Yes, with my daughter, it is good. The doctor and specialist send all the information to the GP at the Aboriginal health service. The intern checked the GP's name and contact details before I left the other day. They also said I or she can ring them at any time to ask questions (PC23).

> The Adelaide doctor sent a letter to my GP saying that I had my operation done but nothing else. There is a huge gap, not much follow-up. I have been left to my own devices a lot. I will have to go back and see the surgeon [In Adelaide] again and ask him what my options are (P7).

One staff member suggested that transfer of care might be a better approach:

> If you focus on discharge that's where people fall through the nets and you get the bad outcomes. You need to be able to transfer, you need to have identified people following on so that not only the patient, but the family, everyone knows exactly what's happening and it's going to—I mean, you'll still get people falling through the nets but it's going to minimise that (MH3).

The distinction between transfer of care (which applies only between hospitals/inpatient settings) and discharge from care (when patients are returning home or to residential care) may be a useful focus for thinking about this problem and seeking to address it. There are three important differences: agreement to transfer is negotiated in advance; information accompanies rather than follows the patient; and costs are borne by the transferring agency. A shift to transfer has many potential benefits—e.g. it could address the problem of inadequate access to medicines during the discharge period and the risk of serious health consequences—but would also bring additional costs for transferring agencies.

Social and cultural environment domain

The concerns of patients and carers were different from those of staff in this domain. Patients and carers focused closely on the importance of family support, and on the personal and family impacts of injury and disease. Staff spoke more of the challenges of responding to Aboriginal cultural ways and concerns in the health care setting. But both groups spoke about the impacts of racism and the realities of post-colonial Australia.

The importance of family

Patients and carers stressed the importance of having family nearby, or in contact via telephone. Family members provided patients and carers with much-needed physical, economic, social, spiritual and emotional support. Country family members travelled long distances to maintain contact. Some carers discussed extensive periods of time caring for family members:

> My nieces in Adelaide came to visit. Family makes a lot of difference. If I was on my own I would be thinking, thinking. But when family and friends come and visit it is alright (P4).
>
> I was giving him his insulin and patches for pain, the nurses taught me how to do it. I used to give him his insulin every morning, give him his shower, bath, I did all that. It was just another—like a routine for me. I feel lost now because I miss all that, really (C6).

Staff also spoke about the problems for patients of leaving the safety of their own country, and the burdens of long stays in the city:

> Just being such a long way from their family, their culture, their community (MH10).
>
> Anything that needs treatment, needs an operation, needs long-term, looking at two weeks to months or whatever, it takes a lot out of them financially, emotionally, no stability, health, family thing, all that stuff (RA6).

Responding to cultural concerns

A major concern raised by staff was the impact on Aboriginal patients of being in an environment of different cultural norms and expectations about gender:

> [Some of our wards] are mixed gender which is a huge issue. We try to avoid it but… last week we got an admission [of an Aboriginal woman] and she was put in a bay with three men. Of course, she was just freaking out and terrified the whole time. So as soon as the sun came up we moved her into a bay with women and she was okay (MH16).
>
> If there's, say, a female patient who has issues with male nurses then generally we wouldn't allocate a male nurse to look after them and certainly wouldn't have a male nurse treating that person without a female nurse present. With the men it's a bit more difficult because obviously nurses are… highly female (MH15).

They also noted the problems some Aboriginal people experience in adhering to Western medical clinical regimes:

> Aboriginal people have a very different idea… of what causes someone to not be well and the way that they've treated things in the past is very different as well. They get the *Ngangkari* that comes, does what they have to do and they get better straight away… you've started them on medication which it's going to be 14 days before there's any effect, that doesn't quite fit in with the way that they work, so you can understand that perhaps if there's not that understanding of the way that whitefella medicine works, they might not be willing to pursue it (MH3).

Staff spoke of some flexibility to respond to cultural requirements, but also noted the difficulties of reconciling cultural ways with Western ethics of care:

> We've had cleansing in this service a few years ago where they did a whole—throughout the cardiac area, including medical as well as surgical and it was last year or the year before they did the whole hospital (MH15).

> A lot of family will not—it's funny because in the mainstream world all this paperwork is sort of done when you're on your admission process to residential care. You talk to any Aboriginal person about end of life stuff and they just back off and go, 'no, no'. They don't do death well at all (RA2).

Death and dying

Patients and staff spoke extensively about patients' fear of dying in hospital, and the challenges when a patient dies away from home:

> She died in Adelaide and I had to bring her home then. I was looking after everybody else and calming them down and whatever else and the day they buried her I went crazy, I think it all just came out then (PC21).

> When my son died, they come over and asked us to turn the machine off and everything and—but they were good. They give me a room, they let all my mob stay in one big room and they were good to talk to (PC21).

> If someone dies down there alone it is terrible. You have to get the body back up here and everyone is really upset… It is generally better to have sick people up here—for cancer or something (RC1).

Going home to die was a frequent concern (and caused some stress between staff):

> I then started to discuss those issues with the doctor and the doctor wasn't happy, he said, 'no, there's no way we can let her go home. We still need to do further investigation'… Eventually he took me aside and he said, 'look, you take her home; you sign all the paperwork', and it was quite intense (RA2).

Aboriginal workers as cultural brokers

Staff commented on the difficult and broad roles of Aboriginal workers in the system, including the stressful nature of acting as a patient advocate and of being left with the burden of engagement with Aboriginal patients when clinical staff withdraw:

> I actually went to the [hospital] myself, on my own time, and sat with her for the weekend and observed what they were actually doing for her, what benefit it was having for her health and her psychological and physical and spiritual wellbeing, and acted as an advocate for her to the nurses. So I was sort of spending maybe ten or twelve hours on the Saturday and the Sunday (RA2).

> We have two AHLOs and one Aboriginal health nurse and they are just overrun, too busy to do anything except accommodation, flights, bookings, help get money from the bank or showing them around or organising food, accommodation. They try to look after the carers as well that come down, they have to find them accommodation and all that sort of stuff, as well. So they are limited in their resources and they don't really supply not many male patients with much true support really (MH16).

Post-colonial realities and systemic racism

Some patients and carers discussed how racism and colonisation impact on their approach to health care:

> There's a lot of things that went on with Aboriginal people. A lot of times they just guess because you are an Aboriginal person… if you've got hepatitis or something like that they put it down as being an alcoholic… (PC22).

A number of metropolitan staff expressed concern and frustration at the lower utilisation or engagement with mainstream services by Aboriginal people, but also recognised that failure to acknowledge and respond to the different needs of Aboriginal patients did not work:

> Even when I say from my experience on the wards, what I did there, it was like you treated them like any other Tom, Dick or Harry that came through the ward. We did our normal treatment, did what we had to do and when it came to discharge, yeah… you just did the normal protocol for everybody and that's been my experience for 20 years… it's only been in, like, the last year with [a chronic disease project], okay, maybe things have to change a little bit, so I guess I recognised that it wasn't working (MH9).

It is not just a difference in culture that makes it difficult for Aboriginal people. Cultural and historical factors are intertwined, so that a violation of a cultural norm risks reinforcing misunderstandings that exacerbate racism and contribute to Aboriginal people experiencing hospitals and the attendant health care as culturally unsafe for them (Polascheck 1998; Ramsden 2002).

Despite these barriers, staff reported the willingness of many Aboriginal patients and their families to comply with hospital regimes, or to adapt their practices to Western or biomedical processes. Similarly, we were alerted to examples of hospital staff attempting to adapt routines and procedures to Aboriginal preferences. Two clear ways forward were identified: first, strengthen the role of the Aboriginal Health Workers, AHLOs and Aboriginal Patient Pathway Officers as key personnel in building bridges between the two worlds; and, second, a strategy can be found in the concept and approach of cultural safety. This approach to cross-cultural health care provides space for staff at all levels in the health system to explore not just cultural differences, but also those practices that reinforce cultural dominance and racism.

Case Study: A Complex Patient Journey

As Aboriginal country patients negotiate their care journeys, complexities arise, and the health system's response to these complexities is a major determinant of those journeys and their outcomes. Although clinical complexity is often present and already assumed, complexity of the country Aboriginal patient journey and the care system is often overlooked, particularly in city settings. This leads to patients, their families, communities and local country health services (as well as hospitals) bearing avoidable costs of complexity.

A detailed report (*Managing Two Worlds Together: Study 4—Complex Country Aboriginal Patient Journeys*), including information about the methods we used to map several patient and carer journeys, and the results, is available on the project website.

The following case study illustrates the complexities.

Flying blind: the patient's story

An older woman, an Elder in her community and a resident in an aged care facility, had been blind for some years. Encouraged by staff to find out if her vision could be restored, she attended a local Aboriginal health service GP in 2009 and was given a referral to see a specialist in a major regional town. After a six-month wait she travelled for six hours by road to her appointment, travelling with a carer and a driver. On arrival, she was informed that the referral was out of date, and she would not be seen until she had a new referral. She returned home for another GP visit and another referral. Finally, she saw the specialist, who said that her eye condition was beyond his ability and he referred her to an Adelaide specialist.

After much encouragement and support by aged care staff, the woman flew to Adelaide for assessment, with a companion and the aged care manager who interpreted for her. It was determined that one eye could be operated on. They returned home to wait for a surgery date. Two surgery dates were made and then cancelled in late 2010, leading to excitement and then disappointment for the woman. In January 2011, after repeated calls to the city without a positive response, the aged care registered nurse rang the local Member of Parliament and explained the situation. By that afternoon, a surgery booking was made for five weeks time.

The surgery date was set with pre-admission checks in the same week. Based on earlier experiences of problems with transport, interpretation and consent in the city hospital, the aged care staff were cautious. The patient would not be able to fly after eye surgery, so the aged care bus, with a carer and driver, was arranged. The trip took 12 hours and everyone arrived exhausted. There were three pre-admission clinic appointments the next day, which took all day. The aged care manager, anticipating that there may be difficulties, arranged for an interpreter already known to the patient to attend, but the experience was still unsettling for the patient and carers.

At one stage a repeat electrocardiogram (ECG) was ordered because the copy of the ECG sent did not have a legible date. The patient refused to have the ECG because she believed there was nothing wrong with her heart, spiritually or physically. In view of her refusal, the hospital rang the aged care facility and asked if the date was visible on the original. It was, and a copy of the ECG was faxed with the date clearly showing. The next day the woman returned for x-rays and then went back to the motel to rest. Another carer, who was more familiar to the patient, spoke her language and knew the hospital, was called to assist the next day for surgery preparation and post-operative care.

Pre-operatively, the patient did not understand why she should take her underwear off for eye surgery and was unhappy at wearing a gown. At one stage there were four men (orderlies and nurses) around her, trying to lift her onto the trolley. She couldn't see them, but she could hear them and feel them getting closer. The only thing she knew about white men was that they were not to be trusted. She became more agitated and began to yell at them, to keep them away. The hospital staff were unable to work with her, as they saw her as uncooperative and violent, and they advised that they would cancel the surgery.

The carer intervened and said that if they would just give the two of them time and space the patient would get ready and get herself on the trolley with the carer's assistance. The woman was reassured and got changed and onto the trolley slowly and carefully. The carer covered the woman and pulled back the curtains and called the hospital staff back in—they seemed surprised at how well the two had worked together. The carer said that an anaesthetist, who had watched what was happening, came up quietly and asked the carer if everything was alright. They discussed together the need for something more than local anaesthetic and the carer assisted while a drip was put in, and promised to meet the patient in recovery.

After six hours, the patient awoke in recovery with bandaged eyes and called for the carer, who came to her bedside immediately. The carer said that she was asked by the recovery staff if she was alright being with the woman. She said, 'yes, of course', and then saw written on the case notes, 'warning—violent patient'. The patient was transferred to a ward and the carer stayed and assisted with her care until the patient fell asleep. The carer then slept in the chair until about 3 a.m., when hospital staff brought in a fold-out bed.

During discharge the next day, the city ophthalmologist requested the patient return in a week for an eye check. Ignoring the woman's refusal and the carer's explanations of the impossibility of this arrangement, he asked the nurse to make the appointment. The patient returned home with no intention or real possibility of returning in a week's time. Fortunately, an outreach ophthalmologist happened to be visiting the remote town the following week and the local Aboriginal health service arranged for him to see this patient.

Health system response: built in or reactive?

The additional costs of complexity of the country Aboriginal patient journey are often met by patients, their families and carers, and local health services. Local Aboriginal services are not funded to send staff members as escorts, and occasionally PATS reimbursements do not occur due to confusion and communication difficulties. In this case, the saving in attending the visiting ophthalmologist locally with a staff member, rather than returning to Adelaide, was estimated to be at least $5000. Investing in improved protocols such as timely and coordinated referrals, pre-admission consent procedures and interpreter services would further improve the efficiency of existing investments in the health system.

This case study illustrates that hospital and support service arrangements which work reasonably well for city patients are not responsive or flexible enough to respond to the complexities encountered by country Aboriginal patients. When country Aboriginal people need city hospital care, their patient journeys are highly likely to be complex, due to the impact of the five underlying factors, combined with the well-known complexities of the health system. Although *clinical* complexity is often present and already assumed, complexity of the *Aboriginal country patient journey* and the *care system* is often overlooked. This means that patients may miss out on needed care, experience poorer quality of care or face unnecessary additional stress. Patients, their families, communities, hospitals and local country health services bear the (sometimes preventable) human and financial costs of complexity in unpredictable or unmanaged ways.

This is a difficult problem that requires both the availability of highly specific interventions and support services that can be tailored to needs, and a general method of identifying needs and planning and coordinating responses. We suggest, below, that the *complexity principle* provides the basis for general responsive capability and that a set of specific interventions and services provide the methods (noting that most of these need to be adapted for each clinical unit or stream). Finally, the question of how to fund improvements is addressed.

The complexity principle

Although not all country Aboriginal patient journeys require tailored responses to complexity, complexity should usually be expected. The results of this project indicate that complexities are currently managed in one of two ways:

- in a planned and responsive approach, in which complexity is predicted and responses are ready
- by managing problems and crises as they occur, and otherwise using 'business as usual' principles.

The first option is based on prediction and preparation for patient journey complexity, specifically the possibility that some patient journeys will be very complex and the certainty that, on average, country Aboriginal patient journeys to city hospitals will be more complex than other patient journeys. The outcomes (for the health system, other organisations and patients) of the planned approach to patient journey complexity tend to be better, as we observed in the results of interviews with staff. In that study, we identified three clinical units in which complexity was expected and responded to. In each, a significant number of country Aboriginal patients were cared for, and each had a specific coordinator role that was part of the clinical team. The people in these roles were responsible for working with hospital, primary health care and support services to plan for and bring together the needed responses to the complex care journeys these patients experience.

Coordination of these complex journeys is an ongoing prerequisite for good care, but not all Aboriginal patients who are admitted to city hospitals require special arrangements. What is needed is the capacity to tailor responses according to the predictable complexities. In clinical units that treat significant numbers of country Aboriginal patients, this capacity relies on a dedicated coordinator role (full- or part-time). For clinical units that admit a small number of country Aboriginal patients, coordinating capacity could reside in the hospital-based AHLO and/or Aboriginal Patient Pathway Officer team—provided that an identified member of the clinical unit team takes responsibility for communication and liaison with those workers.

Interventions and support services

Analysis of this and other case studies identified eight important interventions in the system of care and support that could have made a difference:

- access to specialist care in regional centres and arrangements in outpatient services to accommodate people who travel long distances to attend (coordinated scheduling of appointments, flexibility for unavoidable late arrivals)
- use of e-health technologies to reduce travel requirements and delays in diagnosis and care
- use of pre-admission consent procedures
- better access to interpreting services
- improved intercultural skills and knowledge among hospital staff, supported with better access to AHLOs
- better support for travel requirements, building on existing work in South Australia and learning from other jurisdictions
- better accommodation options in the city
- use of the concept (and procedures) of transfer of care rather than discharge when patients move between hospital and community care.

These priorities are consistent with those that emerged from the interviews with staff and the larger group of patients and carers.

Cost and budget implications

All Adelaide public hospitals currently have at least two strategies to manage the complexities of country Aboriginal patient care:

- additional payments to hospitals for Aboriginal patient admissions (30% case mix loading, which compensates for longer length of stay and higher cost)
- AHLOs in hospitals and access to Aboriginal Patient Pathway Officers.

The complexity of some patient journeys can be managed by these two tools alone, but for other patients these two elements are not sufficient. The case mix loading for Aboriginal patients provides for higher inpatient care costs. An equivalent budget mechanism to enable overall coordination of care, including access to necessary transport and accommodation services, may be the only effective way to improve patient journeys and could also reduce some of the costs that arise as a result of lack of coordination and adequate support services. Such a risk-bearing arrangement for outlier patients should be funded from a central pool and be available to all relevant service providers.

Main Findings: Making Sense of it All

The combined results of the four studies that make up this project provide the basis for the following main findings.

1. This project found many examples of good practice, based on careful attention, creative responses to the needs and circumstances of country Aboriginal patients, and strong relationships among Aboriginal patients and their health care professionals. But these 'best practice' strategies and protocols are not systematically implemented.
2. This project confirms the high burden of illness experienced by country Aboriginal patients. Barriers to access mean that they are more likely to receive needed care later in the course of an illness, or not at all, as evidenced in our analysis of admissions data, and in the views and experiences of patients and staff.
3. Identification and recording of Aboriginality in clinical and administrative data collections is not adequate, and the lack of reliable information impedes both an understanding of health care needs and the capacity to monitor improvements. Continuing attention to this problem by SA Health and all health services is needed.
4. Patients' journeys are made harder by rigidities and gaps in the system of care, and in needed support systems. The patients (and their families/carers) undergo complex geographical and health care journeys, and this complexity is predictable due to the interaction of important underlying factors. All of these factors affect other groups of patients as well, but this group is likely to experience all or most of them. It is the interaction among the factors that makes access to good health care a complex challenge for this group of patients (and those who provide their care). The factors are summarised in Table 1 (this table can also be found on page 3).
5. The challenges of building good communication, trust and rapport in direct care interactions are significant for both staff and patients, and there are serious consequences of failure. Patients sometimes feel that their cultural values and needs are not respected, and staff sometimes struggle to communicate across differences in cultures, worldviews and experiences.
6. Coordination among care providers across geographical and sector boundaries is not reliable. When it is achieved, the benefits are real for patients, staff and organisations.
7. However, even with better coordination, support services (for travel, accommodation, coordination of physical and care journeys, interpreting and personal/family/cultural support for patients) are not adequate to need, and for some services cost is a barrier.
8. It seems that hospital systems that work reasonably well for city patients are not flexible enough for those who must travel for care. When the multiplier effect of all the barriers that impede the patient journey for country Aboriginal people are taken into account, it is clear that complexity is predictable for this group, and any attempt to improve care needs to be based on an assumption of complexity in the patient journey (as distinct from clinical complexity). Not all Aboriginal patients from the country will require tailored responses to complexity, but complexity should usually be expected.
9. Although there are many high-level statements of policy and principle to guide health care providers in caring for Aboriginal patients, there is a lack of operational policy and programs in the system of care that might support health care providers to build in reliable responses to complex patient journeys.

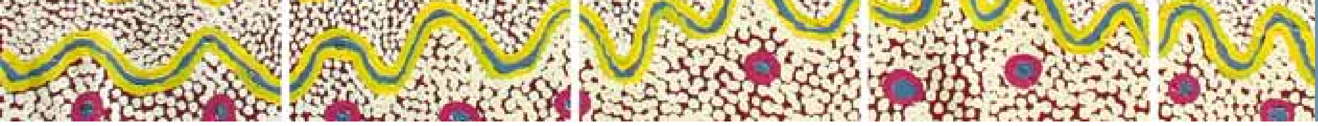
Table 1: Five factors that affect access and quality of care

Issue	Explanation
City/country	Some of the problems facing country Aboriginal patients and their health care providers are common to all country patients.
High burden of illness	People with chronic or complex conditions are affected more by systemic health care problems, especially across hospital/non-hospital sectors, although any patient may experience care problems.
Language	Some communication challenges that patients and staff encounter are common to all population groups for whom English is not a first language.
Financial resources	It is harder for all people who have little or no extra money to meet the costs of transport, treatment, being admitted for health care, and time off work or away from home and family.
Aboriginal/non-Aboriginal	There are ways in which Aboriginal people experience unique disadvantage in their interactions with the mainstream health system (and other social systems); and mainstream worldviews and beliefs about health and health care are often different from those held by Aboriginal people.

Conclusions and Next Steps

Based on the findings of this study, we conclude that the following measures or actions, if implemented by the health care system, are likely to result in improvements both to the integrity of the country Aboriginal patient journey and in the effective use of health care resources (and would have benefits for other country patients and for urban Aboriginal patients).

1. Approaches to improving care for this group of patients need to be based on recognition that complexity in the overall patient journey is to be expected. Responses to manage complexity should be routinely available, and ruled out only when assessment shows they are not needed. This *complexity principle* could be used as the basis for the development of operational policies, programs and protocols to enable reliable access to good care for this group of patients.
2. Clinical units that regularly admit country Aboriginal patients need a dedicated coordinator role, with a focus on better pre- and post-admission preparation and follow-up. Such roles have been demonstrated to be effective elsewhere, including in relation to remote Aboriginal patients (Lawrence *et al*. 2009) and in clinical units in this project. Other clinical units need access to a coordinating resource person, a role that could be filled by Aboriginal Patient Pathway Officers or AHLOs, provided that a designated clinical staff member is reliably available to ensure proper communication and engagement within the clinical unit.
3. Assuming that coordinating capacity is available, access and quality would be improved if the following specific measures and services were available to patients, carers/escorts and staff:
    - adequate transport and accommodation arrangements (building on the work of Country Health SA and the Community Passenger Transport network) supported by improved access to financial help with the costs, including up-front PATS payments (CHSA 2011; Department of Health 2010)
    - ready availability of interpreter services, and systematic implementation of the policies that require their appropriate use
    - use of pre-admission consent procedures and attention to ensuring informed consent (which may involve family and others, as well as the patient)
    - access to specialist outpatient care in regional centres, with visiting specialists working more actively with each other and with primary care providers, and backed up by use of e-health and other information technology
    - better systems to coordinate outpatient consultations wherever they occur, aimed at preventing waste and unnecessary travel.
4. The vital contribution to care made by AHLOs (and Aboriginal Patient Pathway Officers) would be further enhanced if their roles were better defined, understood and supported by both city and country staff and organisations. These workers are relied on too much to solve immediate problems in the patient journey, which should be predicted and planned for by the whole health care team, and could make a stronger contribution to ensuring quality and safety for Aboriginal patients.
5. Support from escorts and/or family and community members is important for patients. Practical methods of incorporating family members and escorts into health care, and defining their roles properly, are needed.
6. Attention to cultural priorities and spiritual needs should include systematic arrangements for access to *Ngangkaris*, as well as making the hospital environment more



friendly (through visual cues, and attention to gender concerns, coldness and food preferences).

7. Non-Aboriginal staff can and do develop skills and knowledge that help them to be effective communicators and carers across cultural and language groups. This capacity seems to require, first of all, recognition that one is ‘working in the intercultural space’ and appreciation that each of us holds cultural values and assumptions. Evidence is mounting that existing approaches to cultural awareness training are not effective. The concept and approach of cultural safety, with its focus on the essential link between culture and clinical quality and safety, may be more effective.

Next steps

This report summarises the results of Stage 1 of the project. The research team will engage in discussion with our partners in this project, with the Department of Health and with South Australia’s clinical networks to seek responses to the findings of this stage of the project and to shape the next stage. In Stage 2 we aim to work with industry partners and stakeholders to develop further and, where possible, test the methods suggested in the conclusions. Success will depend on engagement by health care providers, on clinical and system leadership, and on enabling policy, programs and procedures. Health staff and units have expressed interest in being involved in the work in each of the practice areas listed above. If this approach succeeds, the outcomes will be improvements in the quality of care, the integrity of the patient journey and the effective use of health care resources.

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Associate Professor Eileen Willis is Chair of the Board of Education at Flinders University School of Medicine. She has a research interest in the area of Aboriginal use and perceptions of water supply, which includes examination of access to hospitals, evaluation of the Aboriginal Health Worker (AHW) program in the Northern Territory, and the development of asthma teaching materials for AHWs in remote regions. Dr Willis was the foundation editor of the international journal, *Health Sociology Review*, and currently serves on the editorial board.

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Associate Professor John Glover is Director of PHIDU (Public Health Information Development Unit) at the University of Adelaide. His interest is in collecting, compiling and presenting data to describe and monitor social inequality and health inequality in Australia. John is best known for the social health atlases of South Australia and Australia, which form the core of PHIDU's online database.

Brita Pekarsky

Ms Brita Pekarsky has been working as a health economist in the private sector and universities since 1992. She is a member of the KPMG national evaluation team for the Indigenous Chronic Disease Package. Her research interests include financing health care, pharmaceutical economics and strategies to fund research into health care where there is a social incentive but no commercial incentive for research and innovation. She is currently working at BakerIDI.

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Professor Malcolm Battersby is Director of the Flinders Human Behaviour and Health Research Unit and leader of the Mental Health Science programs at Flinders University. His interest in behavioural science has been applied to understanding behavioural change in both health professionals and patients. Professor Battersby has led the development, evaluation and implementation of the Flinders Program™ of chronic condition management, now provided across Australia and internationally.

Tamara Mackean

Dr Tamara Mackean, a descendant of the Waljen Clan from the Eastern Goldfields of Western Australia, is a Public Health Medicine Registrar in the Disaster Management, Regulation and Planning Directorate of the WA Health Public Health Division. She is also a member of the NHMRC's Health Care Committee, a past President of the Australian Indigenous Doctors' Association and has expertise in Aboriginal and Torres Strait Islander health, rural and remote health, clinical governance, child health research and health systems research to improve quality and safety in health care.

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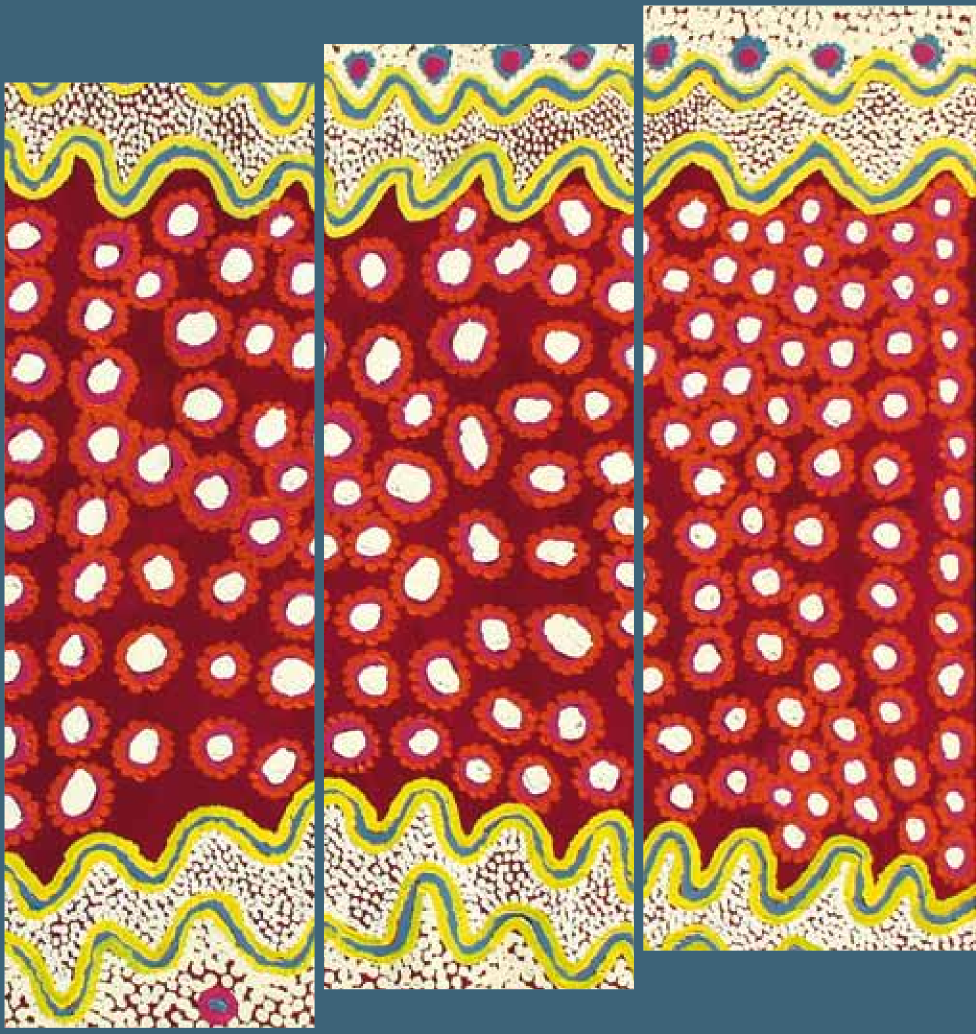
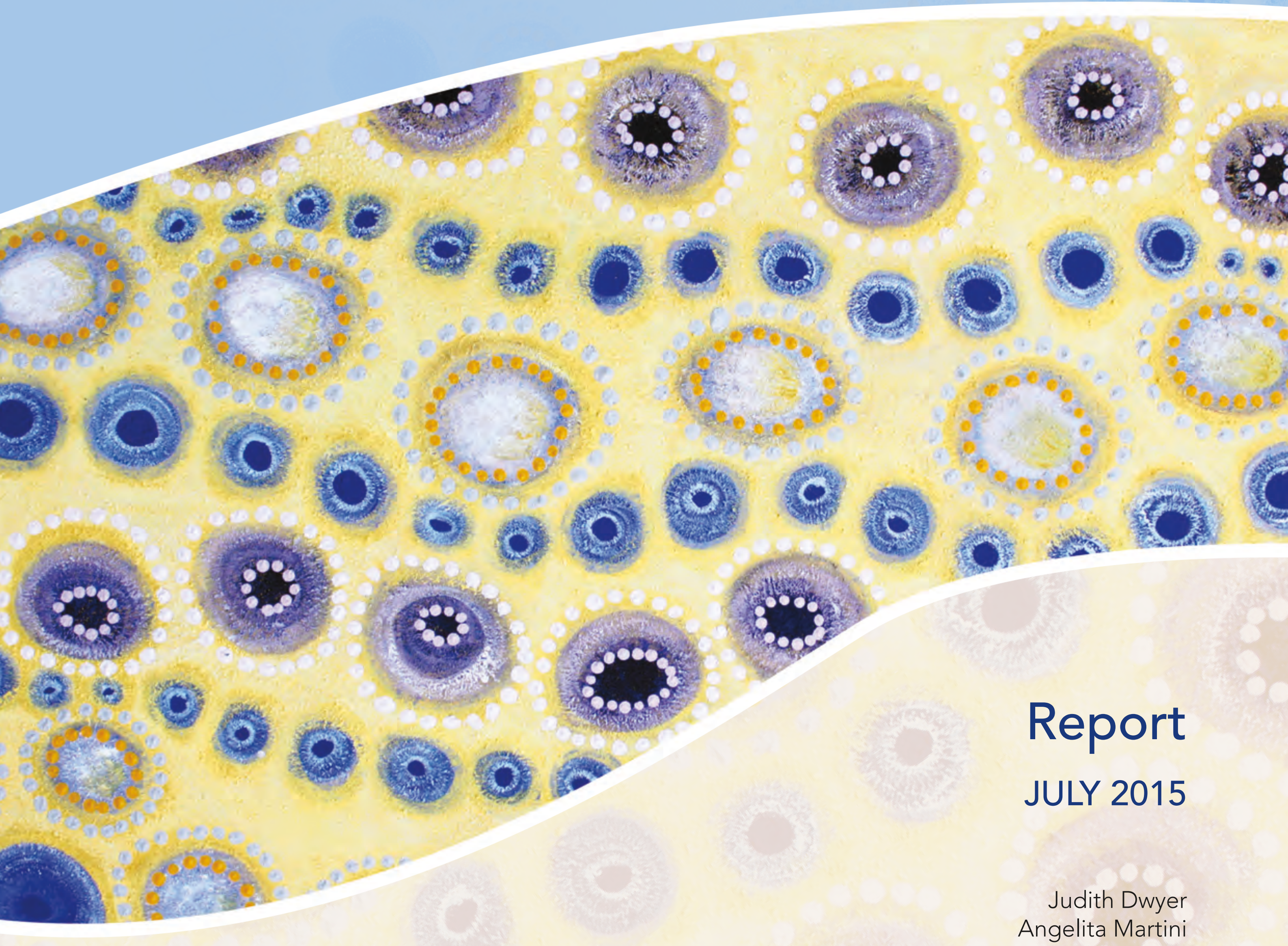


Appendix D: The road is made by walking

Dwyer J, Martini A, Brown C, Tilton E, Devitt J, Myott P & Pekarsky B 2015b, *The road is make by walking: Towards a better primary health care system for Australia’s First Peoples – Report*, Lowitja Institute, Melbourne.

The Road Is Made by Walking:

Towards a better primary health care system for Australia's First Peoples



Report

JULY 2015

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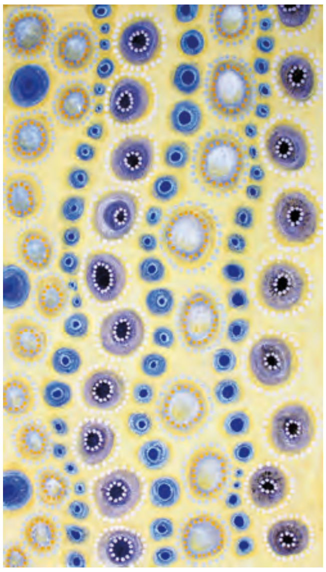
Cath Brown
Edward Tilton
Jeannie Devitt
Paula Myott
Brita Pekarsky

ARTWORK



About the artist

Karen Kulyuru was born in 1969 and raised in Ernabella (Pukatja) on the Anangu Pitjantjatjara/Yankunytjatjara Lands. Karen first learned to paint by watching her mother, and comes from a family of batik silk artists. She started painting at Ernabella Arts and Crafts many years ago. Karen lives in Adelaide with her family and children and regularly attends professional development workshops at Better World Arts. Her paintings have been exhibited extensively across Australia.

About the artwork

Tjukula (Rockholes) 2012
Acrylic and sand on canvas
61 x 107 cm
Better World Arts catalogue KKU0073

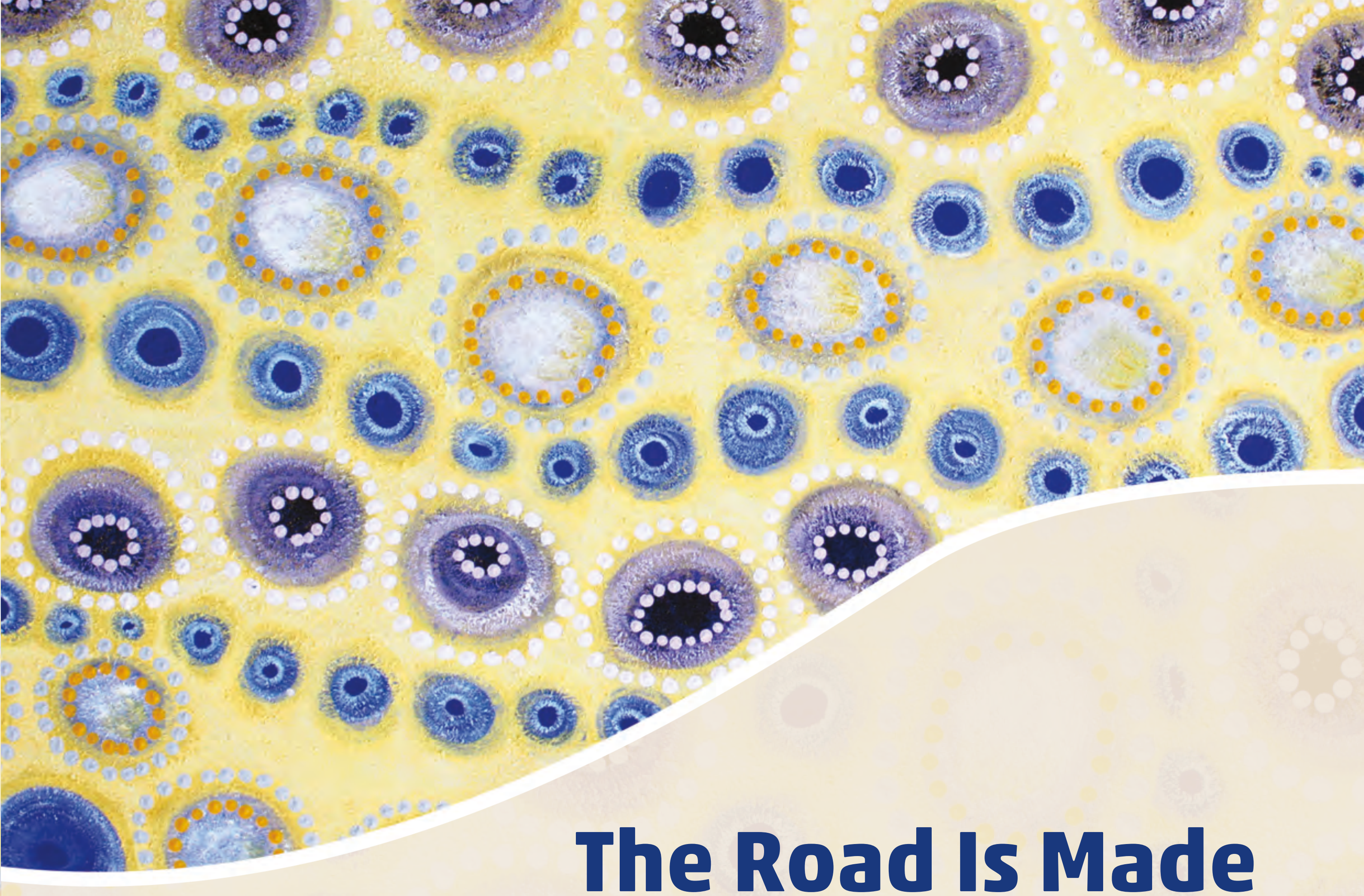
This painting was produced during the 'Manta' (earth) workshops. Karen describes her painting as Walka. Walka is any meaningful mark or pattern and may be an image on a cave wall, on rock or on sand and has cultural and ritual significance. It is used on the body during inma or ceremony. This painting is reminiscent of the designs that are created on batik. Karen's work is heavily influenced by the beautiful batik designs she painted alongside her mother Angkuna and sister Unurupa from the 1970s onwards in the Ernabella craft room.

Batik designs evolved from a mixture of traditional imagery, Indonesian influences, as well as the early Walka drawings painted at the Ernabella mission school in the 1940s and 50s. Karen's mother Angkuna was prolific in her craft making and produced beautiful lengths of fabric, many of which are in public and private collections. Karen painted batik for many years and this influence is still visible in her highly decorative, detailed paintings today.

Important traditional symbols are still placed within these works, including tjukula (rockholes represented by concentric circles), creek beds and bush foods for harvesting. This painting depicts rockholes (tjukula), and sandhills surrounding them. Karen is influenced by the beautiful colours and shapes of the landscape. She uses both desert tones and brighter hues in her works and often illustrates aspects of nature from the desert country where she grew up, to the flora here in Adelaide, where she has lived for many years.

REPORT TITLE

The title is taken from Antonio Machado's poem 'We make the road by walking' in *Selected Poems of Antonio Machado*, Louisiana State University Press, Baton Rouge, LA, 1978.



The Road Is Made by Walking:

Towards a better primary health care system for Australia's First Peoples

Report

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the Lowitja Institute
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Contents

Tables and Figures

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About this report

This publication is one of five that report on the work of the **Funding, Accountability and Results (FAR)** project, all published by the Lowitja Institute in 2015.

FAR is a study of reforms in primary health care for Aboriginal and Torres Strait Islander communities in the Northern Territory (between 2009 and 2014) and Cape York, Queensland (between 2006 and 2014). The study background, its aims and methods, case studies, findings and conclusions, and the suggested essential elements of reform are reported in the project report and the summary report.

Two brief histories of the project research partner organisations and a case study have also been prepared in order to contribute to the record of development of the broader Aboriginal community controlled health sector in Australia, to give context to the larger research study, and for our partners' own use.

Project report:

The Road Is Made by Walking: Towards a better primary health care system for Australia's First Peoples – Report

Judith Dwyer, Angelita Martini, Cath Brown, Edward Tilton, Jeannie Devitt, Paula Myott and Brita Pekarsky
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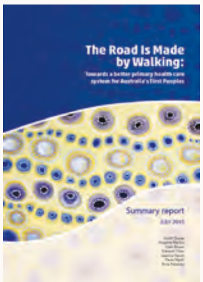
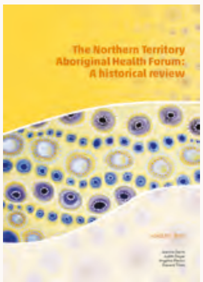


Project summary report:

The Road Is Made by Walking: Towards a better primary health care system for Australia's First Peoples – Summary Report

Judith Dwyer, Angelita Martini, Cath Brown, Edward Tilton, Jeannie Devitt, Paula Myott and Brita Pekarsky
ISBN 978-1-921889-42-4



The Northern Territory Aboriginal Health Forum: A historical review

Jeannie Devitt, Judith Dwyer, Angelita Martini and Edward Tilton
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Miwatj and East Arnhem: Case study

Paula Myott, Angelita Martini and Judith Dwyer
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Towards a History of Apunipima Cape York Health Council, 1994–2006

Edward Tilton, Angelita Martini, Cath Brown and Kristy Strout
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Abbreviations

ACCHO	Aboriginal Community Controlled Health Organisation
AMSANT	Aboriginal Medical Services Alliance Northern Territory
ATSIC	Aboriginal and Torres Strait Islander Commission
CCT	Coordinated Care Trial
CEO	Chief Executive Officer
COAG	Council of Australian Governments
CPHAG	Clinical and Public Health Advisory Groups
CYHHS	Cape York Health and Hospital Service
DoHA	Department of Health and Ageing
EASC	East Arnhem Steering Committee
EHSDI	Expanded Health Service Delivery Initiative
FAR	Funding, Accountability and Results
FNQRDGP	Far North Queensland Rural Division of General Practice
FRP	Final Regionalisation Proposal
GP	general practice
HAT	Health Action Team
HHS	Hospitals and Health Services
HSDA	Health Service Delivery Area
ICT	information and communications technology
IPHCI	Improving Primary Health Care Initiative
KPI	key performance indicator
MBS	Medical Benefits Schedule
NACCHO	National Aboriginal Community Controlled Organisation
NGO	non-government organisation
NT	Northern Territory
NTAHF	Northern Territory Aboriginal Health Forum
NTER	Northern Territory Emergency Response
NTH	Northern Territory Department of Health
OATSIH	Office for Aboriginal and Torres Strait Islander Health
PBS	Pharmaceutical Benefits Schedule
PHC	primary health care
PHCAP	Primary Health Care Access Program
PHRG	Primary Health Reform Group
PwC	PricewaterhouseCoopers
QAIHC	Queensland Aboriginal and Islander Health Council
RaDU	Reform and Development Unit
RFDS	Royal Flying Doctor Service
RPU	Regional Planning Unit
SOG	Senior Officers Group
USA	United States of America

Terminology

In keeping with usage in the Aboriginal Community Controlled Health sector, the term 'Aboriginal' is sometimes used in contexts that may also apply to Torres Strait Islander people. The term 'mainstream' is used to mean non-Indigenous institutions and organisations.

The names of all government departments and several other organisations have changed during the study. For simplicity, we use the names that were current in December 2014.

Executive summary

The research reported here is a study of reforms in primary health care (PHC) for Aboriginal and Torres Strait Islander communities in the Northern Territory (between 2009 and 2014) and Cape York, Queensland (between 2006 and 2014). In both places, the intention of the reforms was twofold: to establish a regional system of PHC provision with reliable access to care for all Aboriginal and Torres Strait Islander communities in the regions, and to increase community control of health care by transferring some or most of the responsibility for providing PHC from government health authorities to regional Aboriginal Community Controlled Health Organisations (ACCHOs). These were bold plans with long histories of development in both jurisdictions.

The study aimed to contribute two kinds of knowledge. The first concerns the question of how to implement health policy and health system reforms effectively. The second concerns the substance of the reforms needed to achieve the policy goal. That is, we aimed to learn about what needs to be changed, as well as how to implement the changes. The study, conducted from September 2011 to December 2014, was done so as to understand the reforms while they proceeded on their own timelines and agendas.

We aimed to provide a coherent description of reforms in PHC for Aboriginal and Torres Strait Islander communities in the Northern Territory and in Cape York, Queensland, and an analysis of what helped and what got in the way of progress, and what might be done differently in the future. The research was structured as a set of three case studies that focused on two reforms:

- the regionalisation program led by the Northern Territory Aboriginal Health Forum (NTAHF) between 2009 and 2014 and outlined in *Pathways to Community Control* (NTAHF 2009) (Case studies 1 and 2)
- the Transition to Community Control project in Cape York (Case study 3).

Although significant progress was made towards the development of a regional PHC system, the reforms were beset by implementation barriers and difficulties in authorisation, auspice and control; inadequate resources (money, time and capacity); and in working across cultures and in partnership.

The study considers implications for future development, in particular in regionalisation, for governance and stewardship, and in funding, contracting and accountability. It proposes six essential elements of substantive change that should be addressed in future work to develop a regional system of community controlled PHC for Aboriginal and Torres Strait Islander communities.

In order to commit to increased investment in community-governed PHC:

- governments require assurance of performance in delivery of high-quality care
- governments need to accept that the current methods of funding and contracting are not a suitable instrument to ensure performance in this context, and need to work with the sector to develop longer term and less complex and fragmented approaches.

In addition:

- the ACCHO sector requires long-term assurance of funding and acceptance of its role in the health system
- the sector and government need to accept the implications of a negotiated understanding of regionalisation and reformed engagement with each other
- all parties need to work together in an enduring structure for partnership and to develop a workable approach to reciprocal accountability.

Study conclusions

The study concludes that future reform programs will require:

- More secure authorisation and auspicing to succeed in this complex cross-agency and cross-cultural endeavour
- More attention to realistic time and resource allocations (both human and material) and the negotiation of explicit commitments
- Foundation on a solid explicit basis for working across cultures that acknowledges and mitigates the impacts of systemic racism and recognises the impacts of the different contexts in which community and government representatives work.

In relation to the future development of the PHC system for Aboriginal and Torres Strait Islander communities, the study concludes that:

- Future reforms should continue to use a regional approach, under Aboriginal community control, and should develop coherent regional systems for funding and governance, and for coordinating PHC services among all providers across the region
- Increased funding is needed to support adequate coverage and access to culturally safe PHC across and within regions, and levels should be based on the size of the regional populations (weighted for risk and cost factors) and distributed to providers within regions with fairness and transparency
- Enduring reform in the funding and accountability relationship between government and the ACCHO sector should be based on long-term contracts for bundled or pooled funds to support comprehensive PHC, and a modified accountability regime more suitable to the functioning of PHC and to the shared responsibilities of providers and governments.

Increased investment in community-governed PHC requires long-term commitment and strong leadership. The goal of equitable access for Aboriginal and Torres Strait Islander communities to PHC through a regionalised network of ACCHOs working with the mainstream health system is achievable, and action to achieve it should commence—or recommence—as soon as possible.

Introduction

The research reported here is a study of planned reforms in primary health care for Aboriginal and Torres Strait Islander communities in the Northern Territory (between 2009 and 2014) and Cape York, Queensland (between 2006 and 2014). In both places the intention of the reforms was twofold: to establish a regional system of PHC provision with reliable access to care for all Aboriginal communities in the regions and to increase community control of health care by transferring some or all of the responsibility for providing PHC from government health authorities to regional Aboriginal Community Controlled Health Organisations. These were bold plans, with long histories in both jurisdictions.

The process of reform in both places has been more difficult and complex than originally anticipated, and the results to date have fallen short of policy and timing expectations. Although this has been frustrating for all involved, substantial progress was made and many valuable lessons can be learned from the experience. This report examines the main lessons, and thereby seeks to contribute to greater success in continuing, and future, reform efforts of this nature. It aims to do this by providing a coherent description of what happened, an analysis of what helped and what got in the way of progress, and what might be done differently in the future.

This study is structured as a set of three case studies. In the Northern Territory, the first case study examines the Northern Territory Aboriginal Health Forum (NTAHF), which led the reform policy and process for the Northern Territory, and the second examines the East Arnhem Region (where Miwatj is the main regional ACCHO). For Queensland, one case study presents both the Queensland policy context and the experience of reform in Cape York (where Apunipima Cape York Health Council is the regional ACCHO).

Background to the reforms: The PHC system, the ACCHO sector and the policy environment

The Aboriginal community controlled health sector was initiated by Aboriginal and Torres Strait Islander people in the 1970s as a response to the continuing poor health of Aboriginal communities and the barriers and discrimination they faced in many mainstream health services. The ACCHO sector now constitutes a significant part of the Australian health system, with approximately 150 ACCHOs of varying size delivering PHC (NACCHO n.d.a; Martini et al. 2011) to between one-third and one-half of the Aboriginal and Torres Strait Islander population in rural, remote and urban settings (NHHRC 2009:87; NACCHO 2009:2–3).

Despite being recognised as centrally important to the delivery of PHC to Aboriginal and Torres Strait Islander communities since (at least) the acceptance of the 1989 National Aboriginal Health Strategy (NAHSWP 1989), the establishment of ACCHOs has been opportunistic rather than based on a coherent national plan. Instead, the distribution and relative size of ACCHOs has developed as the outcome of several factors, including state/territory government approaches to direct provision of PHC; the initiative of communities to establish ACCHOs and their success in persuading governments to resource them; the history, geography and cultural relationships of communities; local factors in the mainstream health system; and efforts by ACCHOs and governments to work towards equitable distribution of services as and when resources are available (Anderson & Sanders 1996; Shannon & Longbottom 2004).

The distribution and size of PHC services provided by state and territory governments is similarly contingent, affected by history and geography and the efforts of governments to ensure some level of coverage for all communities. The distribution and size of mainstream general practice (GP) services is affected by market forces (which generally favour cities and large population centres), incentives in the funding policies of government, and the preferences and capacities of practitioners. The resultant patchwork of services results in considerable inequity in access and difficulties in ensuring coverage for the whole population. This inequity is reflected in poorer health outcomes for Aboriginal and Torres Strait Islander and mainstream populations in rural and remote areas (AIHW 2014:7–10), although access to care is not the only factor underlying the observed differentials.

The ACCHO sector

ACCHOs aim to provide comprehensive PHC and to advocate on behalf of their communities for effective health policy and improved access to services and resources for health, including in the mainstream health system. The National Aboriginal Community Controlled Organisation (NACCHO) and state and territory affiliates are the peak bodies for the sector and take the lead in advocacy and in providing support for ACCHO member organisations. The structural relationships between the sector and governments are robust and long term. However, they are also characterised by heightened political sensitivity, partly as a result of the ACCHOs' combined role of service provider and representative organisation (Sullivan 2009).

The dual role of ACCHOs (service delivery and representation) has been formally accepted by all national and jurisdictional governments, which have committed to a policy framework that endorses comprehensive PHC provided by organisations that 'maximize community ownership and control' (NATSIHC 2003:1), and the Australian Government has renewed that position in the National Aboriginal and Torres Strait Islander Health Plan (Commonwealth of Australia 2013). Although these policy positions are not consistently supported in public administration or policy debate (Anderson 2006; Sullivan 2011:Ch 5), the sector does work, and needs to be supported and regulated, as part of the health system.

Policy support for community controlled health services is based on the significant history of achievements by the sector since the 1970s (Dwyer, Silburn & Wilson 2004; Shannon et al. 2002) against a background where access to care for Aboriginal and Torres Strait Islander people had been restricted both formally (in laws and regulations) and informally (in practices by mainstream hospitals and other health care providers) (Anderson et al. 2006).

There is a small body of evidence in the research literature regarding the effectiveness of the sector. Finding an appropriate benchmark is problematic. ACCHOs routinely provide care for an Aboriginal and Torres Strait Islander population with more serious and complex health needs; they frequently operate in rural, remote or outer-suburban areas unsuited to the business model of mainstream private practice; and they aim to provide comprehensive PHC that goes beyond the treatment of individual clients for discrete medical conditions (Mackay, Boxall & Partel 2014; Thompson et al. 2013; NACCHO 2014).

Available evidence supports the effectiveness of both the clinical and community services provided by ACCHOs. A recent review on the effectiveness of ACCHOs compared to mainstream PHC services found that although only a few studies directly compare the two service types, their performance is comparable (i.e. no evidence of difference in the clinical outcomes) (Thompson et al. 2013). The limitation of this review is that it was necessarily restricted to studies comparing ACCHOs and GPs only on the services provided in both models to the patients they reach, thus excluding many of the broader health promotion and prevention roles of ACCHOs, functions that are widely agreed to be important in building better health in disadvantaged communities.

This review was also unable to assess other relevant aspects of effectiveness, for example, the well-documented preference for community controlled health services by a majority of the Aboriginal and Torres Strait Islander population (e.g. Taylor et al. 2012:44). The ACCHOs' provision of the culturally secure care that underlies this preference helps to address problems of access to PHC and adherence to treatment regimes, both of which are recognised barriers against effective treatment for Aboriginal and Torres Strait Islander people across the health system (Askew et al. 2014a; Vos et al. 2010; Mackay, Boxall & Partel 2014; Thompson et al. 2013).

Despite these limitations, ACCHOs have been shown to be more effective within the narrower boundaries of clinical service provision. As one recent review (Mackay, Boxall & Partel 2014:6) concluded:

> some studies [show] that [ACCHOs] are improving outcomes for Aboriginal people, and some [show] that they achieve outcomes comparable to those of mainstream services, but with a more complex caseload.

In addition, there is good evidence that ACCHOs are effective in supporting the delivery of specialist services (Thompson et al. 2013), enhancing access for Aboriginal and Torres Strait Islander people. The increased effectiveness of the ACCHO model does come at a higher cost in terms of resources, as might be expected for the provision of care to high-need populations frequently located in rural or remote regions where the delivery of cross-cultural care is also often a significant challenge (Ong & Ahmed 2012).

ACCHOs also frequently provide services beyond individual clinical care, to attend to or advocate for clients and their families in relation to access to care, as well as broader determinants of health. This 'wrap around' approach is rarely part of mainstream practice but may be critical to support improved health outcomes. Key elements of such additional services include (see AMA 2011; Thompson et al. 2013; Mackay, Boxall & Partel 2014; NACCHO 2014; Askew et al. 2014b):

- assistance with client access to PHC (e.g. patient transport, outreach services)
- support for clients to overcome barriers to care elsewhere in the health system
- a focus on public health (e.g. skilled advocacy for positive change in addressing the social determinants of health)
- advocacy for high-level policy or system change
- a commitment to cultural security, both within the ACCHO itself and as an educator of mainstream services in the provision of culturally competent care
- formal, community-led structures for community participation, engagement, empowerment and control.

Internationally, there is some evidence of better health care and improved health outcomes in places where there has been a regional transfer of PHC services to community control. Lavoie et al. (2010) demonstrated decreased levels of avoidable hospitalisation for First Nations communities in Canada following the transfer of control of health services from government to the community. There is also some evidence that Māori providers in New Zealand have had an impact on both access to and quality of PHC (Ministry of Health 2004).

Within Australia, evaluations of the three Coordinated Care Trial transfers of health service to Aboriginal and Torres Strait Islander control in the 1990s (Katherine West, Sunrise and Tiwi Islands), although unable to demonstrate direct benefits in terms of health outcomes, documented improved PHC services, including better access to key health staff (doctors and Aboriginal Health Workers, in particular), an improved focus on population health/health promotion, better cultural security and increased employment of Aboriginal and Torres Strait Islander staff (Bailie, Menzies School of Health Research Local Evaluation Team & KWHB 2000; WHO 2003; DoHA 2007).

ACCHOs are also significant employers of Aboriginal and Torres Strait Islander people, with more than 3000 employed in the sector. It is claimed to be the largest industry employer of Aboriginal and Torres Strait Islander people in Australia (NACCHO 2014).

Policy settings: Need for reform of complex funding and regulation

The ACCHO sector (along with other providers of Indigenous-specific PHC) is funded and held accountable through a complex array of short- to medium-term funding contracts. This contrasts with the mainstream health system, where essential basic care is either provided directly by government or funded through long-term arrangements such as the Medical Benefits Schedule (MBS) and the Pharmaceutical Benefits Schedule (PBS).[1]

ACCHOs generally receive funding from both the Australian Government and jurisdictional health authorities, and also from family and community service departments and other government sources. Funding provides for a mix of basic PHC (including MBS-funded services) and a range of specific programs and purposes. Generally, each contract (or grant) has its own requirements for both financial and activity reporting. ACCHOs use the funding to provide a broad range of services from acute primary care and management of chronic diseases to dental clinics, mother and baby programs, sexual health services, broad health promotion, youth programs, hearing programs and so on.

The cost and efficiency problems caused by the complex contractual environment for Aboriginal services, in relation to both funding and reporting requirements, are well documented (e.g. Moran, Porter & Curth-Bibb 2014; Martin 2014; Eagar & Gordon 2008; Morgan Disney and Associates 2006) and generally acknowledged. The *Overburden Report* (Dwyer et al. 2009, 2011) has described the more fundamental problem in the current arrangements whereby the 'patching together' of many targeted funding programs works against the delivery of comprehensive PHC that is responsive to community needs. The direct and indirect costs of this are seen in compromised capacity to respond to local priority health needs, to attract and retain a skilled workforce, and to develop and then evaluate effective models of care, as well as in higher administrative workloads.

The piecemeal approach to funding undermines strategic, needs-based allocation of resources to regions or communities, and makes it highly challenging and complex to apply the usual methods (like funding formulas) to ensure equity. There is no single source of comprehensive information about the funding received by ACCHOs, and no overview of the associated reporting requirements. The frequently changing sources and purposes of funding also mean that it is not always clear what is intended to be covered by which source of funding. So, for example, particular activities like accreditation may be specifically funded in some places and at some times, but when the funding program ceases may not be replaced with additional 'built in' funds to cover these ongoing costs.

The sector has long recognised the need to reform funding and accountability arrangements so that they support the development of a robust PHC system for Aboriginal and Torres Strait Islander people. Governments have also recognised this problem (e.g. OATSIH 2010) and are sensitive to the charge of a failure in their stewardship responsibilities as they seek to 'close the gap' between health outcomes for Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians.

Commonwealth, state and territory governments face significant challenges in administering this complex funding system at both ends—the

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[1] Mainstream health non-government organisations are also subject to the burden of complex contractual environments, but are generally funded to provide a narrow range of services as part of essential basic care. This situation has been the subject of increasing concern and policy attention (Commonwealth of Australia 2009; Productivity Commission 2010).

process of allocation is disseminated among multiple programs and departments, and the recipient organisations are highly diverse in size, circumstance and robustness. Regionalisation is attractive to governments partly because it offers a method of reducing both types of complexity: allocations would be 'pooled' or 'bundled' at regional level, and funds would be allocated to a smaller number of larger (regional) ACCHOs. These changes could also reduce the need for staff in capital cities to be informed about local factors in order to make good decisions centrally, as these factors would be taken into account in decisions made at the regional level. Good decision making for local services at central levels is always a challenge and is made harder by the practice of frequent turnover among senior government officers.

The planned reforms had the potential to address the disconnect between policy goals (better health and health care) and funding and accountability methods through significant change in arrangements for the governance, delivery and funding of, and accountability for, PHC. The reforms generally aimed to make PHC for Aboriginal and Torres Strait Islander communities more effective through improvements in the methods and/or amount of funding; through streamlining accountability measures; through changes in the governance of health care providers (in keeping with the principles of community control); and in the ways that governments fulfil their stewardship responsibilities for the strength and sustainability of the health care system (NTAHF 2009a; QAIHC 2011; QH 2011b).

Experience of transfer of health care to Indigenous organisations

Indigenous health care organisations in Australia and comparable countries (Canada, New Zealand and the United States of America (USA)) have significant origins in community aspirations and organising (Anderson 2006; Lavoie 2004; Durie 1994). There are several common elements, despite important differences, between these countries in the cultures, histories, and legal and policy frameworks that have shaped health and health care for indigenous peoples. However, there have been two quite different pathways for the development of indigenous health services: ground-up development initiatives by communities or their representative organisations (particularly in New Zealand and Australia); and policy-driven transfers of ownership and governance of existing health services from government health departments to participating indigenous organisations (particularly in Canada and the USA) (Lavoie et al. 2005; Adams 2000).

The historic handover of responsibility for health care in discrete indigenous communities in Canada is a model of largely successful transfer. In 1989 Health Canada (through the First Nations and Inuit Health Branch) commenced a national process of transfer of primary health services from government provision to ownership by the local governments of the communities. This transfer was accompanied by significant changes in funding methods towards more relational contracts (i.e. more comprehensive, flexible and longer term funding) (Lavoie et al. 2005). More recently (2011–12) in British Columbia, responsibility for system stewardship and the allocation of funding to First Nations PHC organisations has been transferred from the First Nations and Inuit Health Branch to the British Columbia First Nations Health Authority (First Nations Health Council, Government of Canada & Government of British Columbia 2010).

In the USA the possibility of a shift from direct provision of health care by the Indian Health Service, a federal government organisation, to local community management evolved more slowly. Necessary legislative changes were made progressively from 1974 to 1994, making transfer gradually more workable, partly through increasing flexibility in funding arrangements (Adams 2000). Adam's (2000) study of transfer experience found that roughly one-quarter of eligible communities had taken up transfer (equivalent to community control as understood in Australia) and that communities that had been better served by the Indian Health Service (measured by numbers of indigenous managers and per capita expenditure on health) were less likely to undertake full transfer. The Indian Health Service retains some direct provision and national stewardship and reporting functions.

In New Zealand, health system changes in the 1990s provided a significant opportunity for Māori communities to develop and grow PHC services, but there was little direct transfer of existing clinics, staff or capital resources (Cunningham & Durie 1999). In Australia, direct transfer of PHC provision (including staff, records, capital equipment etc.) from government to Aboriginal and Torres Strait Islander organisations has largely been opportunistic and on a case-by-case basis, with the notable exception of transfers driven by the Coordinated Care Trials (see next page).

Although it is beyond the scope of this report to identify all cases across Australia where government PHC services have been transferred to community control, Table 1 lists significant known transfers since 1995 when the Australian Government Department of Health (henceforth the Department of Health) took over responsibility for the funding and administration of ACCHOs from the Aboriginal and Torres Strait Islander Commission (ATSIC).

Table 1: Transfers of significant clinics/health services to community control since 1995

Service	Jurisdiction	New auspice/incorporation	Year
Lajamanu	NT	Katherine West Health Board	1998
Kalkaringi	NT		
Timber Creek	NT		
Yarralin	NT		
Milikapiti	NT	Tiwi Health Board	1998–2003
Nguiu	NT		
Pirlangimpi	NT		
Ngukurr	NT	Sunrise Health Service	2005
Barunga	NT		
Wugularr	NT		
Bulman	NT		
Mataranka	NT		
Minyerri	NT		
Ngalkanbuy (Galiwin'ku)	NT	Miwatj	2008
Yirrkala	NT		2012
Ceduna Koonibba	SA	Ceduna Koonibba	2010
Pika Wiya	SA	Pika Wiya	2011
Yarrabah	QLD	Gurriny Yealamucka Health Service	2014

NT: Northern Territory; QLD: Queensland; SA: South Australia

Transfer in the Northern Territory was given powerful support by the Department of Health Coordinated Care Trial (CCT) program of the late 1990s and early 2000s (Commonwealth of Australia 2007), with transfers of 13 major clinics in remote areas to three new ACCHOs established under the CCT program. The three CCT sites were:

- **Katherine West Health Board**, which was established in 1998. All PHC services in the region were transferred to Aboriginal community control and government funds were pooled, with the Australian Government 'cashing out' MBS and PBS funds at the national average level (i.e. higher than existing levels for these communities). The increased funds led to a dramatic growth in PHC services across the region, including the first ever residential GP services and increased numbers of Aboriginal Health Workers, as well a greater focus on public health, health promotion and culturally secure care (Bailie, Menzies School of Health Research Local Evaluation Team & KWHB 2000).
- **Tiwi Health Board**, which was established through a similar process. The transition led to improved health promotion and prevention services (particularly in relation to mental health and chronic disease, and those tackling urgent local problems), an increased number and improved quality of primary health services, and greater employment of local people (WHO 2003). The Northern Territory Government resumed control of health services on the Tiwi Islands in 2003 as a result of the organisation's financial difficulties.
- **Sunrise Health Service**, which was established in 2002 and took over the delivery of PHC to the communities east of Katherine in the Northern Territory in 2005 using a funds-pooling/cash-out model. The evaluation of the transition found increased access to PHC services, improved community participation, upgrade of health service operations and infrastructure, and workforce development (DoHA 2007).

The remaining services in the Northern Territory transferred from Northern Territory Department of Health (NTH) clinics/centres to existing ACCHOs.

Two Aboriginal-specific PHC services in South Australia transferred from incorporation under the *Health Care Act 2008* (SA) to incorporation under the *Corporations (Aboriginal and Torres Strait Islander) Act 2006* (Cth) following changes to the structure of the government health system. However, these services already had their own largely Aboriginal boards (under the *South Australia Health Commission Act 1976* and in many ways consistent with the ACCHO model), and transfer was relatively straightforward. In Queensland one Aboriginal PHC service has transitioned to community control. The Yarrabah Health Service was established in 1980 and in 2000 began planning for the establishment of the Gurriny Yealamucka Health Services Aboriginal Corporation (three-year pilot/seeding grant). In 2010 the service co-located with the Queensland Health clinic and in 2014 transitioned to full community control of all PHC services for the Yarrabah people.

The experience of transfer has been largely successful, but it nevertheless involves several significant challenges. For government staff, transferring the employment relationship involves potential changes in security of tenure, leave entitlements, superannuation and other salary-related matters, and possible fears about stability of funding and marginalisation, as well as changes in accountability relationships. Transfer of funding is complicated by the roles of two levels of government with already complex funding relationships. And the transfer of material resources, including the management and potentially the ownership of PHC facilities, also requires planning and negotiation.

Large-scale transfer also brings questions of overall health system design and governance. Governments have responsibilities for health care that cannot be delegated and PHC services need to operate as part of a larger system. Although the Canadian and USA experiences demonstrate that these transitional challenges can be met, they require careful planning and management.

The case-by-case approach in Australia has not required major health system redesign, but the reforms in the Northern Territory and Queensland represent a (potential) departure from this approach. The experiences of Canada, and to a lesser extent the USA, indicate that systemic, policy-driven transfer is feasible, particularly for the discrete rural and remote Aboriginal communities of the Northern Territory and northern Queensland that are the subject of this study.

Theoretical framework

The prevailing policy, funding and accountability arrangements for the ACCHO sector have arisen from the interplay of two separate and opposing frameworks—self-determination and community control on the one hand, and the public administration methods known as New Public Management (Pollitt 1995), with its use of (competitive) funding and performance contracts, on the other.

The ACCHO sector arose in the early 1970s from community activism, and has pursued the goals of better health and health care, as well as self-determination—a 'by us, for us' movement (Shannon et al. 2002:45; Anderson 1994). The Aboriginal health movement was founded on the belief that Aboriginal community ownership (or control) of PHC would result in better access to care and therefore better health. Decision making would be in the hands of the community, be based on intimate knowledge of community needs, and not be compromised by competing priorities, wrong assumptions or negative attitudes about Aboriginal and Torres Strait Islander people.

Approximately 15 years after the founding of the first ACCHOs, governments began to be influenced by a set of ideas about the role of government (among other things) that have come to be known as neoliberalism. Governments, particularly in the English-speaking industrialised world, have pursued the application of neoliberalism to public administration through New Public Management (Pollitt 1995). This approach underlies the move to more explicit contracts for services, with the funder determining performance targets (cost, volume and quality).

There are several problems with this approach to contracting and accountability, including the assumption that the funder is able to determine the best approach to service delivery and the best use of resources (Sabel 2004). This is especially problematic when applied to funding of the community-based non-government organisation sector, where the rationale for using contractors rather than direct public sector delivery is based precisely on acknowledgment that the contracted non-government organisations know more about the needs of, and are closer to, the intended client groups, as is the case in Indigenous health care (Dwyer et al. 2014).

Contracting in health is characterised on a continuum from classical to relational contracting. Classical contracting seeks to specify in advance exactly what will be exchanged between the parties to the contract (as happens, for example, when a customer signs a contract to purchase a car or a hospital enters into a contract for cleaning services). Governments have sought to move towards more classical (and competitive) contracting partly to ensure that the providers of health care receiving government funding have the right incentives to deliver the volume, type and quality of care that government seeks and pays for. The problem of different interests and incentives is referred to as the principal:agent problem; that is, agents (the providers) and principals (the government funders) have different goals and incentives, and different access to information (the funder is largely dependent on the provider for accurate information about what they actually do and what difference it makes).

Relational contracting is an alternative approach, suitable for situations where it is difficult or impossible to specify completely the services that are required; where the development of a service system is necessary and requires long-term engagement; and where competitive market conditions do not apply (e.g. when there is only one possible provider, as is the case for many ACCHOs in remote communities) (Lavoie, Boulton & Dwyer 2010). Relational contracting seeks to avoid or minimise the agency problem through the alignment of incentives for both parties based on shared goals and alternative forms of risk-sharing, and a closer working relationship with more information exchange. In the private sector this approach is also known as alliance contracting, which is (Clifton et al. 2002):

> an agreement between parties to work cooperatively to achieve agreed outcomes on the basis of sharing risks and rewards [with] the potential to deliver substantial cost and quality benefits without the adversarial relationships common in more traditional contracts.

Lavoie (2005), in her study of contracting with indigenous health care providers in Australia, New Zealand and Canada, suggested that when indigenous PHC services are funded by an indigenous-specific funding body, the contractual environment is more relational; when they are funded from multiple mainstream sources, it tends to be more classical.

Internationally, the quasi-classical contracting approach is being questioned or reformed in indigenous health in New Zealand and Canada (Dwyer et al. 2014). Furthermore, attempts to introduce more classical contracting approaches for mainstream public health care—e.g. in New Zealand (Ashton 1998, 2007; Cumming & Scott 1998) and the United Kingdom (Goddard & Mannion 1998)—have largely failed, and have been replaced with funding methods that are enacted in relational contracts (i.e. long-term partnering approaches). These arrangements aim to preserve the benefits of separating the roles of funder and provider of health care, while also offering relative security to support a robust health care system.

Methods

The study was conducted during the period September 2011 to December 2014. It focused on the relationships between funders and providers, in particular on questions of contracting and accountability in the funding relationship, and also on governance and stewardship.

Research design

Contracting and public administration theory provided the major framework for this study, but we also drew on the literature supporting comprehensive PHC and on systems and governance theory.

The study was designed to accommodate two jurisdictions (Northern Territory and Cape York, Queensland). With Australian Government participation, both were working towards reform in health service delivery with some similar goals and methods, but also with important differences in context, population base, geography, political culture and resources.

The study was conducted as a set of embedded cases of health system reform, with data collection and analysis at two levels: the jurisdiction (state or territory) and regions/ACCHOs within the jurisdictions (Figure 1). This approach was appropriate to the nature of the reforms because it allowed for interactions between factors at each level.

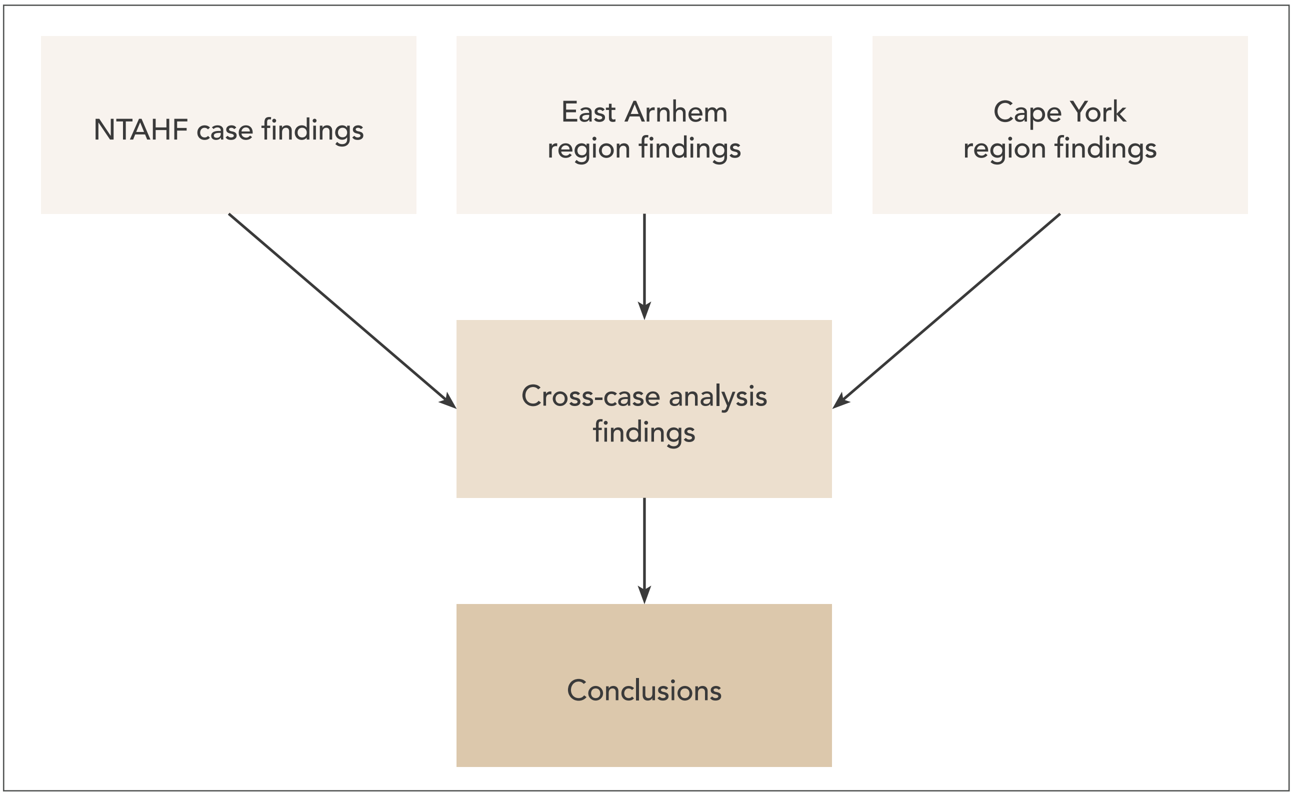

Figure 1: Method of analysis

We conducted three case studies:

- Case study 1: Pathways and regionalisation in the Northern Territory—the structures and processes to implement the intentions of the reforms articulated in *Pathways to Community Control* (NTAHF 2009a)
- Case study 2: Towards regionalisation in East Arnhem—Miwatj Health Aboriginal Corporation (Miwatj) and the structures and processes for developing a Final Regionalisation Proposal submitted to the NTAHF in 2012
- Case study 3: Transition to community control in Cape York—Apunipima Cape York Health Council (Apunipima) and the structures and processes to implement the intended transfer of operational responsibility for community clinics from Queensland Health to Apunipima, as articulated in the Deed of Commitment (CYRHF 2006a).

The case studies focused on two reforms:

- the regionalisation program outlined in *Pathways to Community Control* (NTAHF 2009a) (Case studies 1 and 2): the goal of the Pathways regionalisation program, which was led by NTAHF between 2008 and 2014, was to enhance access for Aboriginal people throughout the Northern Territory to culturally safe comprehensive PHC, based on regional organisation and community governance of care delivery
- the Transition to Community Control project in Cape York (Case study 3): the goal of this project was to integrate the management and delivery of PHC to Aboriginal communities in Cape York, by transferring responsibility for PHC services delivered by Queensland Health to Apunipima.

Figure 2 shows the main elements of the reforms and how they relate to each other; that is, the reforms were seen as an intervention intended to improve the PHC system—and to lead to better access to quality care that is responsive to community needs, thus having an impact on the health of clients and communities (right-hand side of the diagram). The interventions are shown as changes in the way funding is provided (the relational contracting box) and the way the funders and ACCHOs are accountable to each other and to other stakeholders. These changes are to be supported by changes in the governance of PHC services (by providers), and the ways that funders enact their stewardship responsibilities for the system. Each element was included in the reform policy documents, and the research was designed to enable us to understand changes in each of them.

We prepared three separate reports documenting the historical development of the NTAHF (Devitt et al. 2015) and the history leading up to the reforms in Miwatj (Myott, Martini & Dwyer 2015) and Apunipima (Tilton et al. 2015).

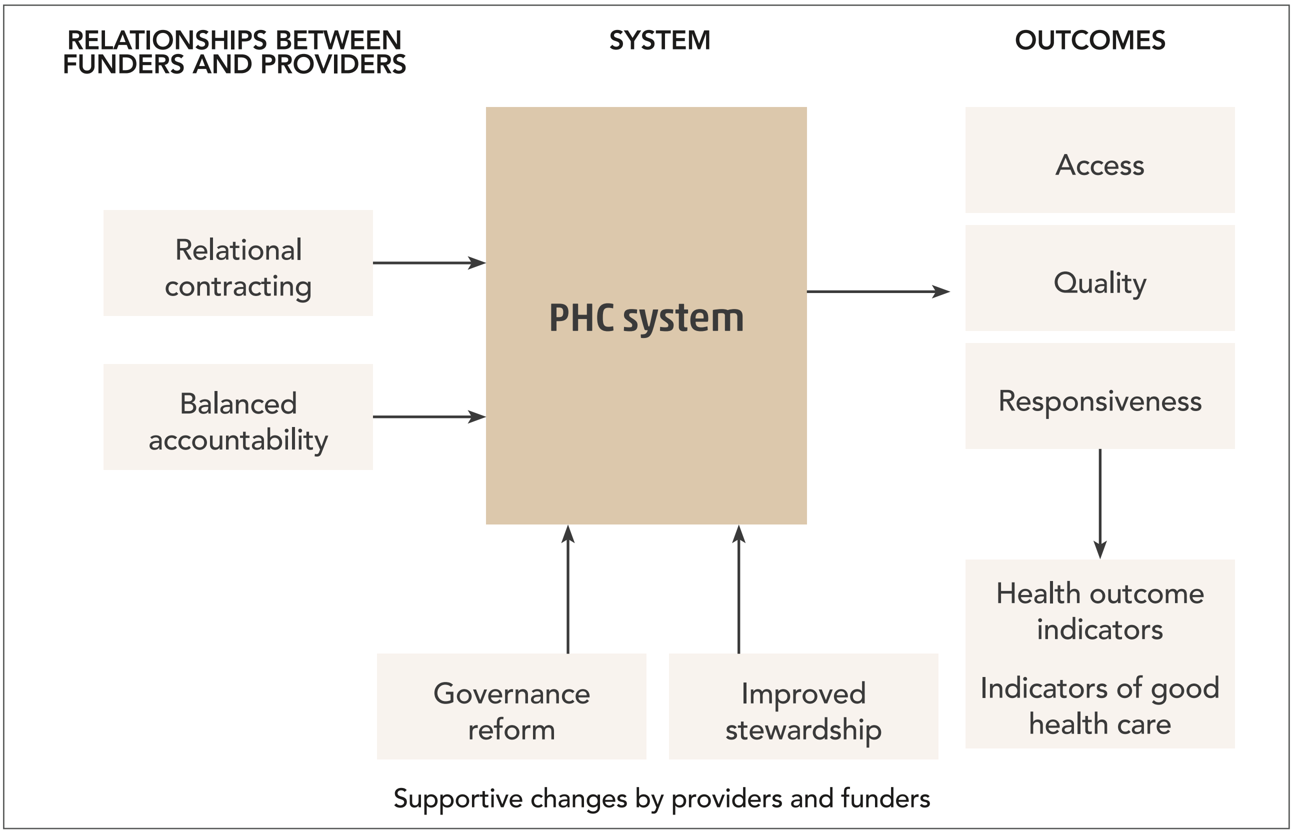

Figure 2: Conceptual framework of reforms

Study aims

We aimed to study the reforms as they developed. Specifically, we sought to answer these research questions:

1. How effective are the methods used to plan and implement the reforms; what are the critical factors that enable or impede implementation; and what are the gaps and why?
2. What are the implications of the reform experience for policy and practice in the funding and accountability arrangements for Aboriginal community controlled health services and their government funders?

Each of the case studies addresses both research questions. That is, the focus is both on understanding the structures and processes of the reforms, and on identifying the implications for future policy and practice in the PHC system for Aboriginal and Torres Strait Islander communities.

The study aimed to understand these complex reforms as they proceeded on their own timelines and agendas. The focus, resources, conduct and, indeed, existence of the reforms were vulnerable to political and bureaucratic change (including changes of government in the two jurisdictions and nationally). Although these contingencies were themselves events in the reform process from which knowledge could be gained, they did complicate study design and implementation. The original aim of the study was to examine both the process of the reforms and the early results. However, for several reasons limited actual transfer of services occurred during the study period.

Initiation and ethics

This study was developed through the Facilitated Development Approach of the Lowitja Institute (Brands & Gooda 2006), which involves collaborative development of topics for research projects, followed by the formation of proposals, research teams and research questions, and finally the signing of a contract with the Lowitja Institute. The Statement of Project Responsibilities was signed by the Lowitja Institute and Flinders University in August 2011.

Ethical approval was sought and received from four institutional ethics committees located in South Australia, the Centre and the Top End in the Northern Territory, and Cape York in Queensland. Formal agreements were negotiated with Apunipima and Miwatj, and the NTAHF formally endorsed the study. All study reports were shared in draft for validation by our research partners.

Data collection and analysis

Data collection was undertaken between November 2012 and October 2014. We conducted 69 interviews with 55 people involved in the reforms (ACCHO staff, ACCHO Board members, and other community representatives and public servants who had been involved).

We analysed 242 public and internal documents dealing with the reform processes and structures, financial information and policy considerations (some of which were relevant to more than one case study). We also engaged in less formal discussions with our research partners as the study progressed and presented preliminary results, circulated drafts of this report and discussed their interpretation with our research partners. Notes of those discussions also informed our analysis.

The three participant groups involved in the study were:

1. staff in the ACCHO sector: staff worked in Miwatj and the Aboriginal Medical Services Alliance Northern Territory (AMSANT) in the Northern Territory, and Apunipima and the Queensland Aboriginal and Islander Health Council (QAIHC) in Queensland; staff participants from these organisations were in a range of professional roles including executives and managers, primary care providers and policy officers
2. Aboriginal community representatives – mostly board members of Apunipima and Miwatj, and of the East Arnhem Steering Committee: these participants were/had been in formal corporate governance and community representative roles
3. government staff: public servants participating in this study were (or had recently been) employed by NTH, Queensland Health and the Department of Health in a range of professional roles, including as executives and managers, policy officers and primary care providers.

Participants were interviewed individually or, if preferred, in small groups. Of the total of 55 people who participated in semi-structured interviews (Table 2), 12 had served in more than one of the roles (above) during the period of the study (not necessarily simultaneously). Sixteen people were interviewed on more than one occasion. Interviews were undertaken in person and by telephone with people based in Darwin, East Arnhem Region, Cape York (Mapoon, Kowanyama), Cairns, Brisbane, Sydney, Canberra and Melbourne. Meetings were observed in Cairns, Darwin and Nhulunbuy. With participant consent, most interviews were audio recorded and professionally transcribed; for others, written notes were taken.

Table 2: Interviewees by participant group

Participant group	Number of participants
ACCHO staff	25
Community representatives	4
Community and ACCHO staff roles	8
Government staff	14
ACCHO and government roles	2
ACCHO, community and government roles	2
TOTAL	55

Table 3 identifies the number of participants interviewed for each study. There is overlap in contributions to the NTAHF and East Arnhem studies, with 10 NTAHF participants also contributing commentary for the East Arnhem Region case study.

Table 3: Interviewees by case study

Case study	Number of participants
1 NTAHF	18
2 East Arnhem Region	10 (+10)
3 Cape York	27
TOTAL	55

Interview transcripts and documents provided the data from which the narrative accounts in the case studies were written. Interviews were analysed thematically using categories derived from our conceptual framework, as was content of the documents, and the results were used to inform our interpretation of the nature of the barriers and enablers in the processes of reform and the implications for the future development of PHC for Aboriginal and Torres Strait Islander communities.

The analysis and interpretations in this report were also informed by the expertise of the research team. The team included people with extensive experience in research (health services, health economics and public health research) and in health policy and practice in the health system, in both the Aboriginal and Torres Strait Islander health sector and the mainstream sector. Profiles of the authors can be found at the end of this report.

Comments by interview participants are identified using unique numbers (for each person interviewed) and a brief title for their positions as follows:

- government staff (senior staff working or formerly working for funder agencies)
- ACCHO staff (senior staff of ACCHOs or their peak bodies)
- community representative (ACCHO Board or committee members).

Identifying information about internal documents that are not publicly available is included in the text, and they are not in the reference list. All such documents are the property of our research partners and copies were provided to the research team for our use in the conduct of this study.

Challenges in conducting the study

The NTAHF agreed to enable staff involved in the Pathways regionalisation program to participate in interviews, and for the research team to have access to relevant documents (as agreed by the agencies). However, agreements with NTH and the Department of Health for access to staff for interviews and to internal documents were not completed. A similar agreement was discussed with Queensland Health but not completed prior to the effective suspension of the Transition to Community Control project in 2012 (QH 2011b).

This challenge was addressed in several ways. Interviews were conducted with former public servants and discussions were held with Queensland Health staff (Cape York and Aboriginal Health Division and Policy Division), with NTH staff (the Chief Executive Officer and staff in Health Services, Remote Health and the Aboriginal Policy & Stakeholder Engagement Branch) and with Office for Aboriginal and Torres Strait Islander Health (OATSIH) staff based in Darwin and Canberra. We also used published documents, minutes of NTAHF and other meetings, and correspondence with ACCHOs, which provided a significant insight into government perspectives and decision making. Finally, consultations were held with study participants regarding our findings and conclusions, a process that enabled us to check the accuracy of our data and its analysis.

Case study 1: Pathways and regionalisation in the Northern Territory

This case study documents the work of the Northern Territory Aboriginal Health Forum (NTAHF) on the Pathways regionalisation program to establish a regional community controlled PHC system for Aboriginal people, as articulated in *Pathways to Community Control* (NTAHF 2009a) and subsequent documents. The case study is based on interviews with nine current and former government officials and nine ACCHO staff, and on analysis of 82 internal NTAHF papers and minutes and publicly available documents.

Background

The NTAHF is a formal partnership consisting (during the time of this study) of senior representatives of three parties: the Aboriginal Medical Services Alliance Northern Territory (AMSANT), the peak body of the ACCHO sector in the Northern Territory; the Northern Territory Department of Health (NTH); and the Australian Government Department of Health (the Department of Health). It was founded in 1998 under a Framework Agreement, which was renewed in 2007 (Northern Territory Government, Australian Government & AMSANT 2007; NTAHF Meeting #33 September 2006), and has a history of work on system development, with an emphasis on central planning and regional and local delivery of care. The role of the NTAHF is to develop cooperative approaches to policy and service delivery, consultation and joint planning, and service enhancement, with governments retaining 'final decision-making powers within their funding responsibilities' (Northern Territory Government, Australian Government & AMSANT 2007:7). The development and some of the achievements of the NTAHF are documented in *The Northern Territory Aboriginal Health Forum: An historical overview*, a paper published as part of this study (Devitt et al. 2015).

The regionalisation process

The Pathways regionalisation program was intended to enhance access for Aboriginal people throughout the Northern Territory to culturally safe comprehensive PHC based on regional organisation and community governance of care delivery.

Regional focus

From its first meeting, the NTAHF emphasised regional planning as an essential component of PHC service delivery in the Northern Territory, including in its approach to the Primary Health Care Access Program (1999–2004) (Gollow 2003:1) and the Coordinated Care Trials (1997–2005). This approach was also an integral, long-term part of Australian Government policy, and the NTAHF's progress—through its detailed regional services mapping and focus on delineating socially and culturally coherent regional units—has been recognised and commended at national level (NTAHF Meeting #8 May 2000).

The Intervention and funding for PHC reform and service expansion

The NTAHF was well placed to take advantage of additional funding flowing to the Northern Territory through the Northern Territory Emergency Response ('the Intervention' or NTER) declared by the Australian Government in June 2007, and the Closing the Gap initiatives that followed (NT Government 2015). The Expanded Health Service Delivery Initiative (EHSDI) arose out of negotiations conducted in April 2008 between AMSANT, NTH and the Department of Health (Allen + Clarke 2011:207). The Australian Government committed $99.7 million over two years from July 2008 to expand and improve health service delivery in remote parts of the Northern Territory. EHSDI funding was allocated to a range of measures, including the development of regions and the move to community control, development of hub services, and facilities and infrastructure development. Funding was also provided for additional clinical staff and for the establishment of the Remote Area Health Corps to bring health professionals to communities on rotation. Funding for additional services was allocated to regions on a basis designed to achieve funding equity for the Aboriginal population. Significantly, evaluation was also built in from the beginning, through a contract with consulting firm Allen + Clarke. Ambitious progress milestones were set, and there was a sense of urgency to ensure that the opportunity was not wasted.

The planning for EHSDI was collaborative, conducted initially through a group of Chief Executive Officers (CEOs) with representation of each NTAHF partner (NTAHF Meeting #40 June 2008). Governance and management of the EHSDI program was subsequently handed over to NTAHF (NTAHF Meeting #41 September 2008).

The momentum was continued through significant further Australian Government funding under the Closing the Gap in the Northern Territory National Partnership Agreement of July 2009, which provided $805 million over three years, including extension of the EHSDI (FaHCSIA 2012) and the Stronger Futures program ($3.4 billion over ten years) (Havnen 2012). The combined result for the health portfolio was $713.5 million over ten years, which enabled EHSDI activities to continue (including PHC service delivery and reform, the Remote Area Health Corps, and specialist and allied health services for conditions that bring a very high disease burden). This funding program, the Stronger Futures in the Northern Territory (Health) program, was implemented through a new National Partnership Agreement between the Northern Territory and the Australian Government (Australian Government 2013).

By 2009 the NTAHF had formulated eight EHSDI program goals (Allen + Clarke 2011:207) that clearly positioned the EHSDI initiative within the broader PHC reform objectives of the NTAHF, and included evaluation funding. The program of work funded through the NTER was to be evaluated over a five-year period (2009–13) and overseen by a Management Committee led by the Department of Health and Ageing (DoHA) (Allen + Clarke 2011). Although the Management Committee was formally structured as a subcommittee of the NTAHF, it had delegated decision-making power and its authority seems in practice to have been based with the Department of Health. The committee oversaw the Allen + Clarke evaluation conducted between 2009 and 2011 (NTAHF Meeting #44 April 2009), but no further action has been recorded.

Pathways to Community Control

Work towards the Pathways/regionalisation program commenced in 2005 and has its origins in the context of the Primary Health Care Access Program (see Devitt et al. 2015 for further information). The NTER was the trigger to finalise the *Pathways to Community Control* (NTAHF 2009a) document, and it was endorsed by the NTAHF in September 2008 (NTAHF Meeting #41 September 2008) and formally launched in November 2009. The Pathways document remains the only agreed NTAHF partners' statement on the meaning of 'community control' and potential ways to transition to a community controlled service. It envisaged a leadership role for NTAHF in pursuing this goal and became the guiding framework for the regionalisation program.

The Pathways document is subtitled, *An Agenda to Further Promote Aboriginal Community Control in the Provision of Primary Health Care Services*. It describes a number of PHC service models that are at different points along a continuum of increasing community participation and governance. At one end of the spectrum are services owned and operated by NTH in which Aboriginal community responsibilities are limited to appropriate use of the service and taking responsibility for their own health. At the other end is a regional

Aboriginal community board responsible for all aspects of owning and managing PHC services. Thus *Pathways* outlined the NTAHF's collective understanding of community control as the full expression of a potential continuum of participation by the Aboriginal community in the governance, management, planning and delivery of PHC.

Pathways states that its primary (policy) purpose is to increase the level of community participation and control in the health and family services sector in the Northern Territory and proposes a staged process of transformation, matched to communities' aspirations and capabilities (NTAHF 2009a:1). And while the document argues that both communities and public sector agencies potentially will require increased capabilities to support increased community participation, it identifies the capabilities of Aboriginal communities and boards of management as *threshold issues*, noting that 'These structures must be able to serve the community's interests, stay connected with the community's preferences and values and discharge strategic corporate responsibilities effectively' (NTAHF 2009a:23).

The document provides an outline—including an indicative five-year timeframe—for the staged implementation of increased community participation in health service provision, focused strongly on aspects of community engagement and demonstration of competence by community steering committees/boards.

In a straightforward statement, the foundational implementation document—*NT Regionalisation of Aboriginal Primary Health Care Guidelines—Supporting a Pathway to Regional Aboriginal Community Control* (version 6.2, endorsed 2010; henceforth, the Regionalisation Guidelines) (NTAHF 2010:11)—describes regionalisation as a two-pronged strategy: increasing Aboriginal community involvement in health decision making (community control) and improving service outcomes through better service coordination/integration (regional health service reform).

Reform through regionalisation

The notion of regionally based PHC services has been part of the NTAHF's agenda of PHC reform over many years. In summary, commitment to the following priorities for action to strengthen the PHC system for Aboriginal people and communities has been sustained:

- establishing a workable regional approach to PHC delivery
- undertaking needs-based planning
- addressing equity and transparency in funding allocations
- coordinating planning (through NTAHF)
- supporting community control of services
- improving capacity to monitor progress and assess outcomes
- increasing PHC funding and thus access to care.

NTAHF documents (NTAHF 2010:10) indicate that the partners had an agreed definition and a shared vision for regionalisation:

> Working together to improve health outcomes for all Aboriginal people in the Northern Territory through health system reform and the development of Aboriginal community controlled primary health care services which provide safe, high quality care and facilitate access to specialist, secondary and tertiary care.

Regionalisation referred to the reforms and arrangements that could potentially result in a single Aboriginal community controlled regional PHC service provider in each of the agreed Health Service Delivery Areas (HSDAs) (replacing or amalgamating both multiple smaller ACCHOs and Northern Territory Government clinics). It was understood as a staged approach that would include communities and providers in decision making at every step. In addition, the NTAHF agreed on the use of consistent terminology in all communications, and specifically the term 'regional Aboriginal Community Control' (NTAHF Meeting #47 December 2009).

Thus, from the outset, the concept of regionalisation specifically included the participation of Aboriginal communities in decision making about the direction of developments in their regions. Although the regional dimension of the reforms and the governance–management aspects would need to be attended to differently, it was clear that the reform agenda was premised on binding these two aspects together.

Planning and frameworks for implementation

The NTAHF established two central bodies: the Primary Health Reform Group to lead Northern Territory-wide planning and development work, and the Reform and Development Unit to support regional planning and development by communities and ACCHOs. Regional steering committees took the lead role within regions, supported by Clinical and Public Health Advisory Groups and regional planning units. These bodies, and the frameworks they developed, are described below.

Primary Health Reform Group and Clinical and Public Health Advisory Groups

The Primary Health Reform Group (PHRG) was a critical driving force in the planning and development work. It was established as a subcommittee of the NTAHF to manage the implementation of EHSDI 'on the ground' and was operational by October 2008. The PHRG was to lead implementation of the NTAHF reform agenda and OATSIH allocated a full-time senior officer to chair, convene and manage it (NTAHF Meeting #41 September 2008; NTAHF Meeting #42 December 2008).

The PHRG met at least fortnightly and reported directly to the NTAHF. It established and monitored working groups, planning committees and consultancies, including the Workforce Implementation group, the Core PHC Services Review Working Group and Patient Information Records Systems Group. It developed a comprehensive *Change Management Strategy* (2009–2011), including a risk assessment plan and a communications grid endorsed by the NTAHF in late 2009 (NTAHF Meeting #47 December 2009). The PHRG also had a role in overseeing the work of the Reform and Development Unit, located within and managed by AMSANT, and smaller regional units in Barkly and East Arnhem.

Regional Clinical and Public Health Advisory Groups (CPHAGs), made up of senior clinicians from the health services within the region, were also established in three regions. Their roles were to undertake joint planning, to advise on opportunities for service integration/coordination, and to provide advice to the regional board or governance bodies.

Reform and Development Unit

The Reform and Development Unit (RaDU) was established within AMSANT by 2009 (NTAHF Meeting #44 April 2009). It reported to the PHRG and was primarily responsible to engage with the regions—to communicate with, assist and support local communities to engage actively with the regionalisation agenda. The RaDU role was complex and included negotiating the definition of appropriate and viable regional HSDAs and assisting communities to develop regional steering committees. With the help of the PHRG, RaDU was tasked to develop templates and tools to assist regional steering committees and health service providers to engage with the agreed regionalisation process (NTAHF Meeting #44 April 2009). Until 2010–11, the RaDU had a staff complement of ten, including five full-time equivalent regional coordinators.

Local regional development units were established in Barkly in July 2009 and in East Arnhem in July 2011. These local planning units reported to the regional steering committees of their HSDAs.

By mid-2009, the PHRG had settled on four HSDAs—East Arnhem, West Arnhem, Barkly and Central Australia[2]—as showing the greatest

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[2] It was not then clear exactly how many HSDAs would emerge from the Central Australian region of interest.

potential to progress towards becoming regional services by the end of the year, and the RaDU focused its work on those areas (Allen + Clarke 2011:133).

In its brief paper *On the Same Track*, the RaDU presented a community engagement framework for Aboriginal health, including guiding principles, directions on consultation processes, consensus building and decision making (NTAHF Meeting #47 December 2009).

Regionalisation guidelines

The principal document guiding the regionalisation process was *NT Regionalisation of Aboriginal Primary Health Care Guidelines—Supporting a Pathway to Regional Aboriginal Community Control* (NTAHF 2010), which was developed by the PHRG (2009–10) and endorsed by the NTAHF (NTAHF Meeting #49 October 2010). It is a substantial document that outlines the full intent of the regionalisation reforms and describes stage one of a four-stage process (development, consolidation, implementation, evaluation) to establish a regional Aboriginal community controlled PHC service. It includes tools for the use of steering committees and their support staff (e.g. consultation report templates, communication messages and meeting procedure notes).

The guidelines detail the information required, and the process to be followed, by HSDAs submitting a Regionalisation Proposal to the NTAHF. The development stage itself comprised four steps culminating in a fully developed Final Regionalisation Proposal (FRP) (Table 4).

Table 4: Steps in development of Final Regionalisation Proposals

STEP A	Initial Community Consultation	• Inform communities and providers about regionalisation • See if communities are interested • Identify potential 'champions'
STEP B	Establish a Regional Steering Committee Establish a CPHAG	• Steering committee supports increased community control and participation through regional governance model • CPHAG supports service reform
STEP C	Develop initial Regional Proposal	• Identify steps, expertise, funding required to develop FRP • Determine which models to consult over • Seek funding to develop FRP
STEP D	Broad consultation to develop FRP	• Get stakeholder views on preferred governance model • Develop a model of governance based on above • Develop the FRP including governance, improved integration and coordination

The FRP was to be endorsed by the PHRG before progressing to the NTAHF for endorsement and then to the two governments for final endorsement, before moving on to the next stage of the process (consolidation). A regionalisation support kit was planned but there is no record of its production, and the 2010 Regionalisation Guidelines were apparently not reviewed as planned in 2011. Guidelines for the consolidation stage were drafted (NTAHF Meeting #51 March 2011) but not finalised.

Competence and capability framework

In early discussions the NTH noted that 'capability and capacity were standout issues with regard to community control' (NTAHF Meeting #31 March 2006). In line with this, the Pathways regionalisation program provides a framework for developing what it terms competent and capable service models, identifying levels of public sector and community responsibilities associated with each of nine models of service delivery. The Pathways regionalisation program commits the NTAHF partners to supporting Aboriginal communities to develop an increased capacity for engagement (where needed) and to releasing untapped potential and building new capabilities in support of community participation and control (NTAHF 2009a:9).

The development of a framework to assess the competence and capability of regional steering committees/governing boards was undertaken in 2011 (NTAHF Meeting #51 March 2011) and 2012. It was initially called the Competence and Capability Framework and was prepared by the NTH. The framework was developed for application only to community governance structures, not Northern Territory Government clinics. The draft version was trialled in regions, most recently by Miwatj in mid-2012.

However, participants reported that those who engaged with the assessment process experienced it not as a supportive step towards community control but, rather, as a process designed to demonstrate local inadequacies and thereby impede progress:

> standards were set so high that nobody could get through it… I'm not really against the idea of having a set of standards… but… some of those things—like the competence and capability framework—just make it seem impossible to get there… (Government staff 111)

The process was perceived by some in the ACCHO sector to be an extension of a generally excessive risk intolerance displayed by both levels of government:

> The toolkits and the community competency framework and so on—these are all based around a deficit approach to community control where, 'We can't trust you to do everything so if we make it so hard for you to get there we will have avoided any problems'… (ACCHO staff 114)

A more basic reason was suggested by some: that the complicated process was intended to mask 'what they really think—that blackfellas can't run these things' (ACCHO staff 118). Ultimately, the framework was reshaped and renamed the Regional Readiness Assessment Tool (FaHCSIA 2012:30).

Performance indicators and core elements of PHC

Based on years of collaborative development (Gollow 2003; NTAHF Meeting #25 September 2004; NTAHF Meeting #28 May 2005), a Northern Territory-wide electronic reporting system—the NT Aboriginal Health Key Performance Indicators—was implemented in 2009. In 2011 the NTAHF set a timetable for the first public report based on accumulated data from the reporting system (NTAHF Meeting #53 August 2011). From the outset, DoHA emphasised the need to concentrate on the clinical indicators (numbering 12 of 19) since the other domain indicators (management and support services; linkages, policy and advocacy; and community involvement) had a less well-developed evidence base (letter, Assistant-Secretary OATSIH to Assistant-Secretary NTH, November 2006; NTAHF Meeting #34 December 2006).

In tandem with the performance indicators work, the NTAHF continued to develop and refine definitions of the core functions of comprehensive PHC, with the most recent version (Tilton & Thomas 2011) endorsed by the NTAHF (NTAHF Meeting #54 December 2011) and more recently taken up nationally by NACCHO (Mohamed 2014). These are two important pieces of infrastructure for the development of a systematic approach to the PHC system.

Early progress not sustained

The first FRP was submitted by the Barkly Regional Committee in September 2010 (considered at NTAHF Meeting #50 in December 2010, only one meeting after formal endorsement of the Regionalisation Guidelines), indicating vigorous uptake of the opportunity in that region. In early 2011 Allen + Clarke reported that three HSDAs (West Arnhem (Red Lily), East Arnhem and Barkly) were progressing towards regionalisation (Allen + Clarke 2011:143). The progress of East Arnhem is documented in Case study 2, and NTAHF documents provide a chronology of the progress of other target HSDAs.

At the time of writing none of the four target HSDAs had established an endorsed regional service and only three (Barkly, East Arnhem and Red Lily) had submitted a FRP, with only the Barkly proposal having been provisionally endorsed by the NTAHF. The regionalisation process was formally halted in 2014, with no funding allocated in the 2014–15 federal Budget. The NTAHF is now focused on revitalising its own operation, and the parties have expressed the intention to recommit to the reforms and re-establish capacity to implement them. The rest of this case study examines a series of unmet challenges, decisions and (in)actions that led to delays in implementation of the planned reforms.

Limits of central capacity and decision making (2009–10)

The planning and policy implementation capacity of the NTAHF and its member organisations was increasingly stretched as regionalisation activities increased, with signs of problems emerging in 2009–10. The NTAHF continued to manage its pre-NTER projects and to respond to significant emerging issues, although this was not altogether satisfactorily in the views of some who felt that the NTAHF had been somewhat 'swamped' (ACCHO staff 104).

The earliest clear indication of capacity problems came from the PHRG in late 2009, when it reported on limitations that were hampering progress and proposed setting up a joint NTAHF Policy & Research Unit that:

> would report to the Chair of the NTAHF, be managed by a nominee selected by all partners; involve suitably qualified representatives seconded from each of the partners; and help form policy options on specific areas of agreed high priority for the NTAHF. (NTAHF Meeting #46 October 2009).

Although accepting that the workload of the PHRG was high, NTAHF members decided not to endorse either a trial or further planning on this topic. They expressed the view that this work needed to be carried out within existing resources (NTAHF Meeting #46 October 2009).

At the following meeting the NTAHF endorsed a strategy to increase capacity by establishing a panel of experts to support the PHRG (NTAHF Meeting #47 December 2009) but it seems that this panel was not established.

Capacity of the NTAHF and its member organisations

During this period of intense activity in the PHRG and RaDU, the indecisiveness of the NTAHF suggests that the accord of the partners (as expressed in their endorsement of the Pathways regionalisation program) was no longer strong. For example, in late 2009, following agreement at a Regionalisation Workshop (November 2009), the NTH presented a substantial draft paper 'to assist the NTAHF to develop an agreed long term vision through developing an agreed NTAHF Master Plan for the Aboriginal PHC System across the Northern Territory' (NTAHF 2009b:3). The paper is a global statement of system-wide reforms to be pursued in the Northern Territory, and although the NTAHF responded by endorsing its further development (NTAHF Meeting #47 December 2009), that decision was subsequently reversed (NTAHF Meeting #49 October 2010). Loss of commitment is also indicated by a lapse in the normal schedule of quarterly meetings during 2010.

The Allen + Clarke (2011:180) final evaluation report was positive about the achievements of the NTAHF and supportive of continued work in a partnership structure. However, it warned about the size and complexity of the task in what was then a tight timeframe, and the need for increased resourcing and policy capacity. The report concluded that the regionalisation program had been under-scoped and under-resourced, with no allocation of funding for implementation policy work, which fell mostly to the PHRG, whose members were already fully employed and were becoming overloaded (Allen + Clarke 2011:125).

Allen + Clarke also concluded that the absence of a unified, committed leadership in the NTAHF, and emerging ambivalence about regionalisation, created further difficulties. They suggested strongly that the NTAHF needed to clarify its role and to 'focus on governance and oversight, rather than the practical, operational implementation of the reforms' (Allen + Clarke 2011:141).

Suggesting that the 'three partners need to revise and refine their relationships, roles and responsibilities to respond to the current environment', Allen + Clarke (2011:125) also point to a more permanent but subtle and diffuse tension underlying the NTAHF partnership:

> Establishing a joint policy capacity would require each of the partners to relinquish some power. There does not appear to be a strong appetite for this despite clear evidence that each agency devolving power and changing concepts of accountability would increase efficiency and effectiveness.

Participants in this study emphasised personal commitment and a progressive 'ethos' in the relationships among key stakeholders. Recalling personal experience in a CCT, a participant (ACCHO staff 114) noted that:

> it was a philosophy of finding out how things could get done rather than finding ways to slow things down, if not stop them; it was a completely different ethos.

However, in this challenging period for the NTAHF, shifting levels of partner commitment to previously agreed policy positions exacerbated tensions between them. It is not surprising that Allen + Clarke also noted an inability by the NTAHF to resolve or address issues where there was a lack of consensus among partners on fundamentals; for example, on Hub Services (Allen + Clarke 2011:106) (i.e. shared services to support clinics and other activities within a region), an aspect of the planned reforms on which no progress was made.

Allen + Clarke concluded in early 2011 that the structures and resources needed to support and drive implementation had been under-scoped, and that while AMSANT (through the RaDU) had responsibility for this program, its expertise was primarily in the building of community capacity and negotiating the merger of ACCHOs. AMSANT was not well placed to manage other aspects, such as the decentralisation and transition of NTH services and growing and supporting new regional structures. Perhaps most clearly, it was not reasonable to expect that AMSANT could lead a process that effectively required the repositioning of system policy capacity by all the partners to focus on implementation (Allen + Clarke 2011:144).

Funds pooling arrangements not designed or planned

Funds pooling was an explicit element of regionalisation, to occur as part of the implementation stage (NTAHF 2009a:27), with a single regional 'fund holder'. 'Funds pooling' in this context means that funds allocated for PHC in the region by both governments (ideally from all programs and departments) would be partially or fully combined to support the provision of an agreed range of PHC services. The pooled funding model had been trialled in Aboriginal and Torres Strait Islander and mainstream organisations under the CCTs (Bailie, Menzies School of Health Research Local Evaluation Team & KWHB 2000) and was part of the plan for the Primary Health Care Access Program (PHCAP) (NTAHF Meeting #25 September 2004). Implementation of pooled funding had not been achieved before the PHCAP program ceased, despite funding being available, a matter of some frustration for the NTAHF (NTAHF Meeting #25 September 2004). However, pooled funding information had been available during PHCAP and was used to determine equitable funding allocations under PHCAP and in the work to allocate EHSDI funding.

AMSANT argued in late 2010 (NTAHF Meeting #49 October 2010) that the absence of work on pooled funding was likely to delay progress, noting that the regionalisation program did not include any detailed planning or financial modelling to define, scope and enable funds pooling.

It was agreed that NTH and OATSIH would 'document (for PHRG) current non-controversial community-based Comprehensive PHC expenditure in Red Lily and Barky HSDAs' (NTAHF Meeting #50 December 2010), but it is not clear whether either government subsequently presented the agreed data. The item was further discussed at two meetings in 2011 (NTAHF Meeting #51 March 2011; NTAHF Meeting #53 August 2011), and the NTAHF agreed that there needed to be 'a clear partner commitment on funds pooling as a first step' (NTAHF Meeting #53 August 2011). No further action was recorded.

Capital assets

There was a similar lack of progress on the question of ownership of capital assets to be transferred. This was seen as an example of the deteriorating relations within the NTAHF and the overemphasis by governments on avoiding risks:

> the two governments refused to do a joint survey of assets so they went off and did separate ones which were on different methodologies and, it ended up with no-one having access to either document… despite promises made in [the NTAHF] that we would. (ACCHO staff 114)

It is not surprising that cracks in the shared commitment to regionalisation became visible in relation to funding and the ownership of assets, as these are critical to both sides and create ongoing obligations and/or losses. But these are also technical matters, and lack of capacity to undertake the necessary analysis and negotiation also seems to have been an important barrier.

Complexities and challenges in HSDA development

A number of significant challenges were encountered in the regions (HSDAs), specifically community engagement, the burden on (unpaid) community leaders and establishing agreed HSDA boundaries.

Community engagement

RaDU/AMSANT initially led the community engagement aspect of regionalisation. Some participants suggested that, almost from the outset, there was misunderstanding and/or disagreement as to what the Pathways regionalisation program proposed. The establishment of viable regions and the Pathways concept both proved difficult to operationalise:

> turning part of the Northern Territory into primary health care regions and transitioning the governance of those services to Aboriginal community control was the bit we found hardest of all. (Government staff 111)

Reflecting on the overall approach, a senior government participant suggested that, in hindsight, communities could perhaps fairly conclude that they were being invited to select from a set of predetermined arrangements and processes rather than to develop a community-based regional approach. Having not been engaged in constructing the various arrangements and scenarios, they were then being invited to take a lead role to establish the program and, into the future, substantial responsibility to maintain it.

It also seems that confusion developed about the concept of a continuum of community control and governance (with various levels of community participation as outlined in the Pathways document), as opposed to a yes/no dichotomy. This occurred partly because of regular reference to existing local exemplars (Katherine West and Sunrise), both of which are at the most advanced level of regional community control. The idea of governance options 'got lost along the way' (Government staff 110).

Problems in communication are also seen as significant. NTAHF discussions of the Regionalisation Guidelines (NTAHF 2010) included commentary that they needed to be more 'community friendly', with complex documents to be produced in formats appropriate to community discussion (as had been intended).

Burden on (unpaid) community leaders

> there's a lot of what could have been considered promises made when we spoke to community people early on. (Government staff 111)

A more problematic outcome is the cumulative negative experience that eventually corrodes the goodwill of key community members. Noting that this process had begun years earlier, one participant recalled local senior Aboriginal men repeatedly asking about the progress on establishing their hoped-for regional health service, saying 'some of us want to see this in our lifetime' (ACCHO staff 117).

Aboriginal community members who take leadership positions in advocating for these kinds of reforms lay themselves open to blame and criticism when nothing ultimately changes. Arguments arose when people were either unclear about or not in agreement with proposals, and when inadequate communication created dissension within regions and communities. This had particular impacts on AMSANT in its community sector advocacy role.

> [Existing ACCHOs] were not feeling that they were effectively being listened to and engaged. And no-one had the ability or the skill to know how to manage that kind of change at the community level and it led to community people having conflict with each other. (ACCHO staff 117)

> I don't think it [AMSANT/RaDU] functioned to the level and to the requirement of the members… and the impact of regionalisation led to people not attending the [AMSANT] board meeting because of the conflict; you can [easily] sit at the board of AMSANT but when you're out there in the community and you know that this organisation [AMSANT] has all this staff, it has all these resources—it turned into major conflict, I have to say. (ACCHO staff 104)

The regionalisation process can neither progress nor succeed without the support of senior community leaders. Only they have the authority to facilitate and negotiate consensus on complex local issues such as boundaries, governance models and community participation. Membership of regional boards will necessarily be drawn from their number. The Regionalisation Guidelines (NTAHF 2010) spelled out a crucial and extensive role for regional steering committee/board members in developing the preferred governance model for their regions and in nurturing community participation. The expectation (by salaried government staff and others) that this investment of expertise and authority would be provided free of charge was not seen as reasonable. Community leaders were well aware that payment of board directors is standard practice for many boards in the broader health system but was explicitly ruled out by OATSIH policy, a matter that the RaDU sought to address (RaDU report to PHRG, 6 August 2009).

The issue was raised again more than a year later (RaDU report to PHRG, November 2010), and a lack of response from the NTH or the Department of Health was noted. In mid-2012 the issue was described by a long-term participant as 'big' in the context of the regionalisation progress and as a manifestation of institutional racism by another in the ACCHO sector:

> That was always an ongoing issue—about boards and board payments—people having to give up a lot of their time and not getting paid… So again that was a constant tension between DoHA and the other two partners. Like why would people volunteer their time and take on the responsibility and the accountability around running a big health service for nothing? And these are people who are really poor. (Government staff 108)

> issues of payment for board sitting fees and stuff like that which can't apply to our sector—I'm not sure why—but do apply to other funded sectors; and admin fees—Medicare Local can have 20 per cent admin fee but we can't for some reason. A whole lot of double standards that are, I think, to do with institutional racism. (ACCHO staff 103)

HSDA boundaries and service provider roles

Resolving HSDA boundaries and negotiating inter-service arrangements proved difficult. Boundary issues in Central Australia remained unresolved for three years, following the commencement of community meetings in late 2008 (RaDU report to PHRG, January 2011).

In particular, barriers arose when the planned reforms would potentially reconfigure regional relationships, and require some communities to relinquish existing local community control of health services. Regionalisation processes required communities to reach a stable, reportable consensus on many issues that are more likely to be held in a permanent state of negotiability:

> regionalisation… has proved to be very challenging for bureaucracies and for the Aboriginal people involved themselves. So how do… they come together under one community controlled structure, because that's what we're asking them to do. Massive areas, different languages, you know?… It's a huge challenge for Aboriginal mob, let alone for the established systems and bureaucracies. (ACCHO staff 103)

These concerns led to some loss of momentum in regional development (RADU report to PHRG, August 2009).

It also became clear that there was a serious mismatch between what Aboriginal community members considered a reasonable timeframe for planning a major reconfiguration of existing local social relations and the timetables established by funding agencies and government personnel. From the perspective of community representatives we interviewed, government officials had no real stake in the local outcomes since they were not part of the affected communities. The Allen + Clarke evaluation also noted dissatisfaction with activities at the HSDA level, particularly in engaging with local communities and service providers, and perceptions that progress on the ground was too slow (Allen + Clarke 2011:141).

Decline of NTAHF leadership (2011)

Allen + Clarke recommended that the regionalisation program should continue under NTAHF auspices, with a new plan, scope and resources and with stronger governance and leadership, including attention to increased policy capacity and to consumer voices. The recommendations were an opportunity for the NTAHF and its partners to review the current situation and either renew their commitment or change their direction.

In May 2011 the NTAHF partners agreed to form a working party to develop a response to the Allen + Clarke evaluation (NTAHF Meeting #52 May 2011) but this appears not to have been done. The Memorandum of Understanding Management Committee (overseeing evaluation activities) provided a further brief update at the August 2011 meeting (NTAHF Meeting #53, Agenda paper 3.5). It reported on a ministerial suggestion (from Warren Snowdon, Minister for Indigenous Health) to establish a special top-tier tripartite committee to make further progress.

It is difficult to determine precisely what happened after this but, clearly, from mid-2011 the NTAHF regionalisation reforms and the functioning of the NTAHF itself were compromised. There are no minutes of NTAHF meetings between mid-2011 and mid-2012. However, during this period blame and negativity about poor outcomes of the RaDU (reported by Allen + Clarke 2013b) continued, and the PHRG effectively collapsed. According to available records, the PHRG met 12 times in 2009, 22 times in 2010 and twice in February 2011, when the PHRG meeting records stop abruptly. The PHRG appears to have dissolved in the latter part of 2011 without formal closure. Given the pivotal role of the PHRG as the 'engine room' of regionalisation, and the scope of its activities, its collapse fatally weakened the regionalisation process: the 'PHRG had become tired and wasn't able to generate the same momentum in the face of what seemed like an increasingly impossible task' (Government staff 111).

Our interviews identified a further significant underlying problem—the souring of essential relationships between the parties, with loss of hard-won trust as government priorities changed. This was compounded by loss of corporate memory as key personnel moved on, the impact of lack of progress, a sense that all parties had lost commitment to the NTAHF and the sense that 'we've lost the leverage' (ACCHO staff 103).

The Senior Officers Group (2011–12)

At a critical time the Australian Government responded to the evident implementation difficulties by creating an alternative structure for decision making comprising a select group of the most senior officers in order to hasten progress. This led to irritation and confusion among participants, and the overall effect was seen as counterproductive.

In August 2011 the NTAHF formally noted the Minister's proposal for a 'top-tier' committee to review the Allen + Clarke report and develop a plan of action (NTAHF Meeting #53 August 2011, draft minutes). It would ensure that governance arrangements and the primary care reform process, including regionalisation, were on track (NTAHF Meeting #53 August 2011, Item 3.5).

This is the likely origin of the Senior Officers Group (SOG), sponsored by the Australian Government and intended to take over the role of the NTAHF in regionalisation. SOG was described in a communique to the December 2011 NTAHF Meeting (#54) as 'a new group formed to drive progress on regionalisation across the NT', with membership being a senior officer of each partner. Three key decisions are noted: commitment to work to a new set of guiding principles for regional reform; a plan to progress reform with the same four priority areas (Barkly, East Arnhem, West Arnhem and Central Australia); and implementation to be led by a team of staff from DoHA, NTH and AMSANT and co-located in AMSANT from January 2012.

Documents tabled at the meeting (entitled 'Regional reform of Aboriginal PHC services in the NT guiding principles' and 'Terms of reference for the SOG, membership and protocols') affirmed that SOG would be chaired by the Department of Health and NTH. We had no access to records of SOG meetings, but at least five meetings were held in 2012 and at least one meeting included discussion of transfer of services to ACCHOs. The establishment of SOG to progress regionalisation at a strategic level was noted in Part One of the Closing the Gap in the Northern Territory January–June 2012 reports (FaHCSIA 2013:24).

The SOG guiding principles are consistent with those in *Pathways to Community Control* (NTAHF 2009a) and the Regionalisation Guidelines (NTAHF 2010), with a restatement of the commitment to 'regional Aboriginal Community Controlled Health Services throughout the NT' (based on *Pathways to Community Control*) and to be 'governed and supported by a partnership between the existing partners'. A minimum population size of each HSDA (2500 people 'where possible') is described, along with a focus on equitable funding across regions. Community consultation and participation were to be sustained.

The establishment of SOG was a major loss of strategic positioning for AMSANT. The subsequent failure of SOG to act or even meet during much of 2012–13 was seen by participants as yet another obstacle to decision making and progress on regionalisation.

The Partnership Team of staff established by SOG continued to meet and work on regionalisation at the ground level during 2012, reporting to SOG. The team did not have an operational budget, and any regionalisation activities were to be authorised and funded by the Department of Health on a case-by-case basis. During early 2012 activity for the three proposed Central Australia HSDAs was described as 'frenetic' (Government staff 101a), with a focus on resolving HSDA boundaries. This activity ceased in August when

Australian Government funding became scarce. The partnership group meetings continued, though unproductively:

> And it's becoming a very, very frustrated process... there just doesn't seem to be any sort of follow up, any urgency, any passion, any commitment given to implementing and progressing regionalisation. (ACCHO staff 113)

When SOG was established, it was intended that this group would get regionalisation back on track. However, after a brief period of activity, it failed to do so and ceased to meet at all within months of its establishment, with the last meeting held in January 2012 and several planned meetings since being simply postponed. Having been given the fullest authority but not exercising it, SOG became an impediment to progress.

The regionalisation efforts stall (2012–13)

By around mid-2012 the regionalisation program had been significantly reduced in scope and resources, with the RaDU being reduced to a single officer working from the Central Australian AMSANT office and the NTAHF entering a period of inactivity.

During this period there was a significant loss of senior personnel across the NTAHF. The commencement of national health reforms in 2011, with major implications for personnel in the NTH and Department of Health, influenced several departures, and at least four key senior figures who had been integral to the regionalisation reform agenda left. Goodwill evaporated between the partners and disgruntled communities already involved in regionalisation were not seeing progress or even activity: 'during the later part of 2012 things seemed to have stalled' (ACCHO staff 117).

The formal relationship between the NTAHF and SOG was ambiguous and confused; the 'new' NTAHF role in regionalisation was unclear and without PHRG input the capacity of either the NTAHF or SOG to plan and implement progress was virtually non-existent, a problem exacerbated by SOG's failure to sustain its own activity.

In August 2012 the Australian Government imposed restrictions on government spending (Brinsden 2012). Funding was held by DoHA, and it took over the lead role in regionalisation (FaHCSIA 2013:24). There was a severe impact on regionalisation activities. As implementation of the reform agenda fell behind the expectations of the partners, relationships became strained to the point of destabilising the NTAHF:

> And I think [the NTAHF] floundered on lack of ability to implement the ideas that we'd had around regionalisation… We'd been at it for a number of years. There wasn't the sort of progress that you should expect to see with the amount of money that we'd expended on it. The [NTAHF] partners were increasingly… fractious around each other. (Government staff 111)

By August 2012 the regionalisation program had effectively stalled. In October 2012 the NTAHF met after a long hiatus (NTAHF Meeting #57). A complaint from Miwatj, on behalf of the East Arnhem Steering Committee, was on the agenda. It detailed the lack of any response to its FRP submitted in June and sought a statement from the NTAHF that it remained committed to the regionalisation program (letter, Miwatj to NTAHF, 26 September 2012). The NTAHF directed that the government partners separately provide feedback to East Arnhem on the proposal, that it was to be costed before the NTAHF would respond and, finally, reminded the East Arnhem Steering Committee that 'the process behind the FRP sits with the Senior Officers Group, not with [the NTAHF]' (NTAHF Meeting #57 October 2012). The government partners provided their feedback but there was no formal response from the NTAHF.

By the end of 2013 stage one (development) of the regionalisation process had not been completed for any HSDAs; their local regional planning units were not funded and there were no available funds to allow regional steering committees to meet. In a harsh assessment, a long-term participant remarked that 'Regionalisation has gone nowhere—a huge opportunity gone' (ACCHO staff 109).

As described by a participant, it was one thing to get agreement, but it was quite another to be confident that those decisions would be carried out:

> [The NTAHF] being a consultative body—not a decision-making body, you know, was an issue that came up a number of times. The ability of each of the partners to take away—if you call them—'decisions' made at [the NTAHF] or decisions influenced by [the NTAHF], and ensure that their constituencies agreed and took the steps required, was not nearly as strong as the goodwill in the room… at times. (Government staff 111)

Changes of government

In August 2012 the Northern Territory elections led to a change of government. The incoming government imposed further financial restrictions, including freezing staff numbers and limiting travel. In addition it announced a major restructure of the NTH, devolving responsibility for health service delivery to two regional statutory bodies (Top End Health Service and Central Australian Health Service).

The federal election in September 2013 also saw a change of government, an emphasis on financial stringency and a critical scrutiny of Indigenous affairs. This led to a restructuring of the administration of Indigenous affairs, and OATSIH's functions were split. The Indigenous Health Division continued management of funding and regulation of health services within DoHA, and policy functions were moved to the Department of Prime Minister and Cabinet.

Corporate governance problems (2012–13)

At around this time, there were several high-profile cases of reported management problems in community controlled services, including three delivering PHC services in the Northern Territory—Laynhapuy Homelands Aboriginal Corporation (ORIC 2012), Kakadu Health Service (Djabulukgu Association 2012) and Central Australian Aboriginal Congress (Skelton 2012). This had a negative impact on perceptions of the viability of community control as a governance and management model. Allen + Clarke (2011) reported similar issues in 2009–10 and had flagged the loss of confidence by key government officers in the community controlled sector:

> I'm just saying in the last 12 months (early 2012–13) we've [NTAHF] fallen into a very bad space. Look, it's also got to do with the collapse and difficulties of some major Aboriginal community controlled health services which I think has soured our relationship and the confidence of the Minister, the Federal [Health] Minister and Federal Indigenous Health Minister. That's what I think—so that he's now a bit pissed off and not confident in the process. (ACCHO staff 103)

Findings

Achievements

Health systems are complex and enduring. Although by 2014 the reform program was suspended, the underlying logic of regionalisation and the potential contribution of community controlled services have not changed. Within at least two regions, Barkly and East Arnhem, a community-based plan for regional health care has been developed and some changes in service delivery arrangements have been made (e.g. the transfer of Yirrkala Clinic from the NTH to Miwatj in East Arnhem).

Important infrastructure for regional PHC has been developed, with continuing relevance and use. The value of the statement of core elements of PHC (Tilton & Thomas 2011) and of the Northern Territory Aboriginal key performance indicators (KPIs) (Allen + Clarke 2011:133) has been noted above. The Continuing Quality Improvement Strategy, funded under the EHSDI allocations ($2.79 million per year over the intervening four years (Allen + Clarke 2013a:4)) as a result of NTAHF leadership, is also a nationally noted success. Considerable progress has been made towards establishing a consistent approach to continuing quality improvement across the Northern Territory. An evaluation of the strategy found that it had been 'successful in establishing quality improvement across the NT PHC sector', noting in addition that the strategy 'has capitalised on the rich history of PHC innovation in the NT' (Allen + Clarke 2013a:5). Three regional CPHAGs continued to function at least until 2014.

The preparedness of the NTAHF and its member organisations to take advantage of new funding provided under the NTER to pursue both PHC service expansion and the Pathways/regionalisation program is evidence of its value as an important resource for joint PHC system development. The contrast in the evaluation of EHSDI compared to the Child Health Checks (Allen + Clarke 2011), both introduced on short timeframes as part of the NTER, also supports this view.

Pathways to Community Control (NTAHF 2009a) is also of continuing relevance. Its development and release as a high-level statement of the position of the NTAHF partners was a significant achievement. Its significance was variously understood by participants in this study as a commitment to Aboriginal communities, a guide for reform work, a change of intention and role by the NTH, and a document that 'unpacked' the concept of community control, making it more practically accessible. Its conceptual focus on community control, and on partnership with government health authorities, as part of the health system, was a breakthrough, at least in intent.

> I know it was a long, torturous process in the development. That was a really important document for [the NTAHF] and a very important document for PHRG; it was used quite actively by PHRG in terms of the development of the reform process and thinking about what the reform process meant… (Government staff 108)

> First of all it was a document that promoted what the partners at the [NTAHF] had agreed to in terms of the regionalisation process. And I think that was important so there was no misunderstanding across not just the partners but the staff who work in the three partners… And the community Pathways document was at a language level that… the community could see that they are also equally important in the process. (ACCHO staff 104)

At the time of writing, there are indications that the NTAHF is undergoing renewal, and the *Pathways* document is identified as a key document to revisit. It is reasonable to assume that regionalisation will outlive the current hiatus because it offers a practical way to provide improved access to PHC services in rural and remote Northern Territory. The NTAHF has a long history of innovation and success as a collaborative and deliberative body (Allen + Clarke 2011:124), and the need for its existence and contribution endures.

Despite these significant contributions, this case study found four major areas of difficulty (addressed below) that brought the Pathways regionalisation program to a standstill by the end of 2014.

Establishing HSDAs and regional governance

Effective regional engagement depended on being able to operate in settings of significant social and cultural complexity where local communities held strong senses of identity, place and history. Some communities needed to consider the potential benefits of service networking in regions relative to what they perceived as likely loss of local autonomy, possibly including resources and funding. The time required in some regions to reach agreement on difficult issues had not been predicted, and some participants would argue that such issues were not well managed by the RaDU, AMSANT or the NTAHF. Significant community capital was expended in the work towards the development of regional structures and regionalisation proposals, but the potential return on this effort was not realised. AMSANT experienced a predictable conflict between its role as the advocate for the community controlled sector and its responsibility for regional implementation through the RaDU.

While endorsing the original concept of regional community controlled PHC, Allen + Clarke (2011:182) make the point that regionalisation and Aboriginal community control are not synonymous. In this case study, it seems that there were problems in relation to both elements. Some participants expressed concern that community control was being incrementally disconnected from the 'main game' of regional service provision. This was seen to have happened more by a selective emphasis on components of the agreed changes rather than by any explicit direction change. In suggesting that the Pathways document itself needs re-invigorating, a long-term participant noted, 'we're not hearing much about community control now, now it's about service delivery' (ACCHO staff 114).

The concept of organising health services on a regional basis has relevance everywhere, and particularly in rural and remote areas, for many reasons. It may be because of this 'common sense' appeal that the scope and nature of a regional structure to deliver health care and/or allocate funding is routinely under-specified. We suggest that the full implications of establishing regions as governance units, functioning as part of the Northern Territory health system and holding funds for PHC in the region, were not fully appreciated. Focus had been on developing the regions, but not on the overall governance, planning and resourcing of the resulting regional system (Government staff 501).

Authorisation, auspice and control

The Pathways regionalisation program was initiated by the NTAHF during a period of high optimism in a forum that was delivering competent advice to the Australian Government through its robust tripartite methods, technical knowledge and collaborative culture. Having converted the NTER into an opportunity for whole-of-system reform, the NTAHF also took on the primary implementation roles. The task was enormous, funding unprecedented and the timeframe tight. Pressure on the NTAHF, the partners and key decision makers became intense. Problems and differences emerged. Some could well have been anticipated (based on NTAHF experience in the PHCAP period) and/or given a more appropriate timeframe.

As a consultative and deliberative body, the NTAHF was not well placed to manage implementation of regionalisation. Each of the parties had responsibilities that could not be shared: the NTH for the Northern Territory health system; the Department of Health for federal government funding and policy for Aboriginal and Torres Strait Islander PHC; and AMSANT as the voice of the ACCHOs. The resources and responsibility for regionalisation were with AMSANT, even though some of the implementation work could only be done by government or by the partners acting together, a situation that may have contributed to relative inactivity by both government partners. The exercise of shared authority and responsibility by the NTAHF partners was always a challenge.

The outcomes of regionalisation in the Northern Territory have brought into question the role of the NTAHF. It had previously taken on responsibility for implementation, but this has been 'by exception' in relation to smaller projects. The formal agreement that established the NTAHF is explicit in its statement that the two levels of government 'have final decision-making powers within their funding responsibilities, and acknowledge their commitment to public accountability' (Northern Territory Government, Australian Government & AMSANT 2007:7).

In the end, there was a predictable reluctance to shift or share power and control, and, indeed, the government representatives were structurally unable to do so (their employers' powers and responsibilities cannot be transferred in this way). But some shifting and sharing (at least of information and resources) were required for the planning and policy work to be done and, ultimately, some transfers of power and control were explicitly intended. This contradiction could not be avoided, but it could have been discussed and managed more actively.

The loss of commitment to the Pathways regionalisation program by government and by some community representatives underlines the importance of the authorising environment for system reforms of this kind. It seems that higher levels of binding authorisation were required to enable the parties to hold to the agreed course of action, but changes in government, personnel and external disturbances intervened. In hindsight, it seems highly likely that the necessary levels of authorisation and support by governments were not locked in through established decision-making routines. That is not to say that CEOs and Ministers were unaware, but rather that given the implications of successful implementation, higher and more binding levels of authorisation were required.

It needs to be said that even if this had happened in the early stages, nothing can guarantee sustainability through changes of government and regimes. However, there are ways of 'locking in' decision making so that commitment is more secure, and this is a requirement worthy of further attention.

Capacity and resources

The NTH and the local office of the Department of Health had significant strengths in health policy, but there were some relevant gaps and existing staff lacked either the technical knowledge or the time required to undertake some tasks. The gaps in the policy and planning were significant, particularly work on funding models and the many requirements to transition between NTH and ACCHO service delivery, including human resources, operational requirements, facilities and equipment.

Similarly, although system functions essential to enabling regional health services to work were identified at several points, proposals for action were not accepted, or not acted on, partly but not only because of resource requirements.

Working across cultures

Some participants in this study saw the loss of momentum in the reform program as a result of lack of faith in the capacities of Aboriginal communities and their leaders. Turbulence in the health system arising from changes of government and mainstream reform, and losses of key individuals during the program, disrupted some longstanding relationships and exacerbated the problem of trust among the partners. A cluster of governance failures in Aboriginal organisations also contributed to this problem.

The difficulties of establishing good intercultural working relationships are well known, and many of those involved in these reforms had the skills and knowledge to mitigate their impact. Nevertheless, we suggest that this challenge remained implicit, was therefore not able to be openly addressed and managed, and had a (mostly) silent undermining effect on the efforts of those involved to make progress.

Conclusion: It was always going to be difficult

The NTAHF is the longest standing body of its type in Australia and has a history of significant achievement. There is much to learn from the difficulties experienced in this major reform effort that can strengthen the NTAHF's effectiveness while preserving the value of its corporate knowledge and good working relationships.

The Northern Territory CCTs of more than a decade ago provide an interesting antecedent to the regionalisation program. The evaluation of the Katherine West trial included this observation (Bailie, Menzies School of Health Research Local Evaluation Team & KWHB 2000:41):

Seen from afar, the Katherine West CCT might appear to be a relatively simple innovation in health service delivery involving a funding 'top-up' and the introduction of new clinical practices. In reality it involves far more profound changes, including:

- A radical shift in power relationships within the Katherine West region, insofar as these relate to health services
- Challenges to culturally entrenched beliefs and practices, both among Aboriginal people, but, even more so, within the dominant society, and
- Structural change within the health system.

None of these things can be implemented easily or quickly.

Regionalisation in the Northern Territory was more complex in several ways, not least because it lacked federal Cabinet-level engagement and enduring endorsement by the Northern Territory Government; and, unlike the CCT regions, the Pathways regionalisation program would need to reshape health care in areas with existing ACCHOs and NTH services. It is not surprising that it proved overwhelmingly difficult.

Case study 2: Towards regionalisation in East Arnhem

This case study documents the engagement of the Miwatj Health Aboriginal Corporation (Miwatj) and the communities and leaders of the East Arnhem Region in the planning and implementation of the Pathways regionalisation program led by the NTAHF from 2009 to 2014. The study is based on interviews with 20 people—14 ACCHO staff (including three people who also served in community representative roles), five current and former government staff and one community representative—and on analysis of 98 publicly available or internal NTAHF and Miwatj documents.

Background

East Arnhem, situated in the far north-eastern corner of the Northern Territory mainland, has a population of around 10,000 people, covers approximately 33,000 square kilometres, and comprises ten major remote communities (Milingimbi, Ramingining, Galiwin'ku, Gapuwiyak, Yirrkala, Gunyangara, Umbakumba, Angurugu, Milyakburra and Numbulwar), many homelands and outstations, and two towns (Nhulunbuy and Alyangula). Five of the 10 communities are located on islands, which exacerbates the challenges of providing services in this large remote region.

East Arnhem is culturally rich and linguistically diverse, with three major language groupings—Yolngu (Yolŋu), Nunggubuyu and Warnindilyakwa. Within each of these major language blocks are multiple local dialects and variants.

PHC is provided to the people of East Arnhem by four organisations, including the Top End Health Service, an agency of the NTH, and three community controlled PHC providers: Miwatj, the Laynhapuy Homelands Association and the Marthakal Homelands Association. Figure 3 (see next page) shows the location of the health services.

Miwatj was established in 1992, with support from the ATSIC Miwatj Regional Council. From the beginning, Miwatj's objectives have included developing a regional approach and ultimately controlling the development and delivery of health services in the region (Miwatj 2011), and it has approached the Pathways regionalisation program as a way of 'implementing the original vision of the founders of Miwatj: one health board to represent all Aboriginal people in the region' (Miwatj 2013).

Miwatj is governed by a regionally representative elected board based on the original three ATSIC wards—Barra, Bulunu and Mamarika. The current Miwatj Board includes the Anindilyakwa Land Council Chair and others from Groote Eylandt, as well as senior leaders from the Numbulwar region (Miwatj 2014).

Notwithstanding a period of difficulties in the early 2000s, Miwatj has continued to develop and diversify. It now provides PHC and public health programs across the region through four sites (Nhulunbuy, Gunyangara, Galiwin'ku and Yirrkala). It is funded from multiple sources, with the Northern Territory and Australian governments being the largest funders, followed by the Northern Territory Medicare Local (which is itself funding by the Australian Government). Funding for core PHC is provided by the Indigenous Health Division of the Department of Health and, since 2013, Australian Government funding for other health programs has been provided by the Department of Prime Minister and Cabinet.

The Top End Health Service operates Gove District Hospital and nine community clinics. Laynhapuy and Marthakal Homelands Associations provide PHC and other services to the smallest homeland communities/ outstations. Laynhapuy provides mobile PHC to approximately 1000 people in 19 homelands,

Figure 3: East Arnhem Region health services
(Source: map produced by Primary Health Care Funding Policy Section, OATSIH, 18 February 2011, Commonwealth of Australia)

dispersed across an area of some 10,000 square kilometres, including one off shore island (LHAC n.d.). Management of many clients is shared by Miwatj and Laynhapuy's Yirrkala Health Centre and this arrangement requires a close working relationship between clinicians.

Marthakal provides mobile primary health services to a population of between 250 and 400 people living on 13 outstations located over an area of 15,000 square kilometres (Marthakal Homelands Resource Centre 2012). Marthakal Health and the (Miwatj) Ngalkanbuy Clinic at Galiwin'ku have formal arrangements to share care and patient records, and staff work closely together.

The regionalisation process

The people of East Arnhem approached the proposed regionalisation of health care with a well-established understanding of its potential benefits, arising from engagement with broader regional action, including through opposition to mining (Fitzgerald 2001:207–12) and experience with the ATSIC Regional Council and national leadership.

East Arnhem Regionalisation Proposal (2007–12)

In keeping with the long-held aspirations of the Yolŋu people for self-governance, and the original vision of Miwatj as a regional health service, Miwatj commenced work towards regionalisation prior to the development of *Pathways to Community Control* (NTAHF 2009a).

In 2007 the Miwatj Chair, the CEO and Mr Terry Yumbulul, a senior Yolŋu clan leader, made a regionalisation study trip to Katherine West Health Board, a successful regional community controlled health service established in 1998 (EASC 2010). Subsequently, in July 2008 Miwatj commissioned Mr Yumbulul as liaison officer to discuss the regionalisation proposal with communities across East Arnhem.

The East Arnhem Steering Committee (EASC) was established in September 2008 with the goal of preparing a detailed plan and proposal for regionalisation. The EASC met quarterly until the Initial Regionalisation Proposal was submitted in December 2010 (EASC 2010) and monthly from February 2011 to June 2012, when the FRP was submitted to the NTAHF. During this period EASC membership comprised 21 representatives from all major communities in East Arnhem (with the exception of Ramingining[3]) and representatives of the NTAHF partners (i.e. NTH, 2; AMSANT, 3; Department of Health, 2). AMSANT provided secretarial services until July 2011. All participants were engaged in developing the FRP.

Regional activities were well underway in East Arnhem by the time the NTAHF, in late 2010, endorsed the Regionalisation Guidelines (NTAHF 2010). During the period 2008–12 the EASC worked systematically through the four steps of stage one (development), leading to submission of the FRP, as summarised in Table 5 and described on the next page.

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[3] The Ramingining representative had passed away and no replacement had been offered.

Table 5: East Arnhem regionalisation development timeline

STEP A	Initial Community Consultation	Mid-2008 liaison officer appointed, consultations carried out during 2008–09
STEP B	Establish Regional Committee Establish a CPHAG	September 2008 EASC established February 2011 CPHAG established March 2011 Communicare Users Group established
STEP C	Develop Initial Regionalisation Proposal	December 2010 Initial Regionalisation Proposal submitted to NTAHF
STEP D	Broad consultation to develop FRP	July 2011 Regional Planning Unit established with two employees and 12 months' funding December 2011 community consultation report tabled at EASC (Christie et al. 2011) June 2012 FRP submitted to NTAHF

The East Arnhem CPHAG was established in February 2011 and met regularly (every six to eight weeks). Its original role was to provide advice to the EASC on developing a regional health service plan and on improving coordination of services, and it continues with the latter function.

The East Arnhem CPHAG includes representatives from the PHC services and the NTH/Top End Health Service (including Gove Hospital). CPHAG is the first joint planning forum for Aboriginal PHC in the region and continued to be a successful collaborative structure, 'building very good relationships for service delivery in the region' (J. Woltman, personal communication, 12 June 2013).

CPHAG focused on some of the key building blocks for strengthening health systems (WHO 2007), such as workforce development, with the goal of increasing the numbers, skills and career pathways for Aboriginal staff. It also established a Communicare Users Group to support a regional approach to an electronic client information system. In July 2011 Miwatj was funded for 12 months under the NTAHF regionalisation budget to operate a Regional Planning Unit (RPU). The unit, with two full-time employees, supported the EASC and CPHAG meetings and coordinated work towards the FRP. Funding for the RPU ceased as of July 2012, but one position was maintained by Miwatj to progress the agreed NTAHF regionalisation program. The EASC was no longer able to meet due to the costs of bringing together representatives from across this large region.

Design of regional governance (2009–12)

The EASC and government representatives had different concerns about the structures and processes for regional governance, and tensions became apparent early in the process.

The question of whether to establish a new overarching regional board or to adapt the Miwatj Board was considered by the EASC (in a governance workshop held in mid-2009) and later at a special meeting of Indigenous EASC members and regional leaders. There was considerable debate on the wisdom of establishing yet another regional entity[4] and the meeting decided that the Miwatj Board would be the board of management for the proposed regional health service (minutes of this

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[4] At around this time, in mid-2008, the Northern Territory Government had moved to establish an East Arnhem Shire Council, which also sought representation from the region. By 2013 Mr Banambi Wunungmurra was both the Shire Council Chair and the EASC Chair.

meeting were not taken). A year later, following a second governance workshop in August 2011, the EASC formally endorsed the existing Miwatj Board (with adjusted representation) as the East Arnhem Regional Health Board (EASC 2011). The Miwatj constitution was subsequently amended so that at least one homeland representative from each ward would be included. Other changes were made to enable non- Indigenous people to become members of Miwatj and to enable the Board to establish committees and advisory groups (Minutes, Miwatj Annual General Meeting 2012).

As noted in the 2012 FRP (EASC 2012:25):

> It is important to keep in mind that the Miwatj Regional Health board is also made up of representatives from across the whole region and will include specific representation by Homelands people so they will all have a commitment to ensuring the best outcomes for the whole region.

This approach was contested in discussions with the Department of Health on the grounds of inadequate (male and female) representation of each community (ACCHO staff 502). Further concern was expressed about the way the EASC envisaged linking into the existing complex East Arnhem health service provider landscape. Government representatives preferred one regional ACCHO (as intended in *Pathways to Community Control* (NTAHF 2009a)) and were concerned about the EASC decision to adapt the Miwatj Board for regionalisation rather than creating a single overarching board (to encompass governance of all three ACCHOs).

The EASC FRP outlined an alliance model (Figure 4) to provide a formal partnership with regional health service providers, Laynhapuy and Marthakal, which had opted to remain as independent organisations.

Specifically, the FRP noted (EASC 2012:24):

> Miwatj Health will continue to be a regional health service provider—transitioning NTH clinics incrementally. The Miwatj Regional board would develop a regional alliance agreement (similar in scope and function to [the Memorandum of Understanding]) with all the primary health care service providers in East Arnhem including NTH.

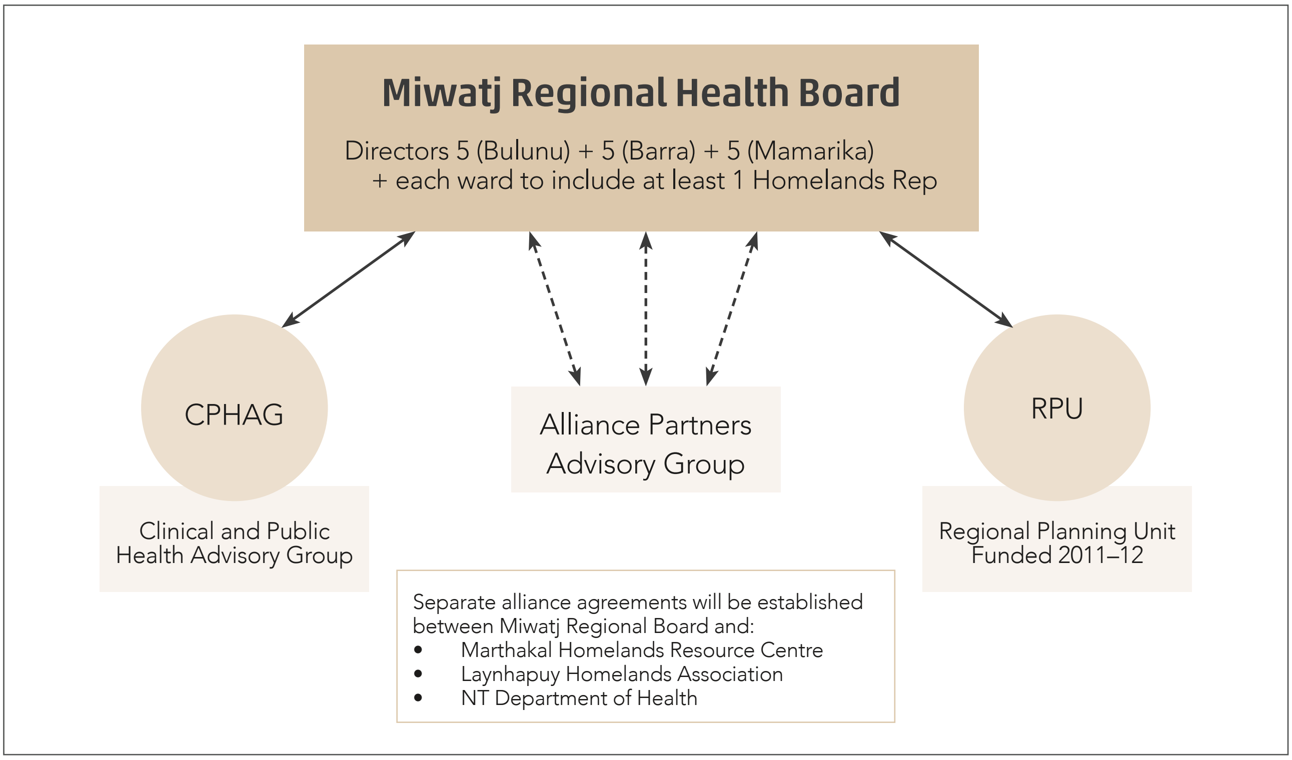

Figure 4: East Arnhem Region Alliance Model

The alliance agreement would be signed by the board of each organisation, or a senior delegate in the case of the NTH, and would include guiding principles and provision for sharing data and linking the clinical information system (Communicare), as well as for collaboration on shared concerns. It was envisaged that joint working groups would address issues and opportunities for all service providers and make recommendations to the Miwatj Board.

Under this arrangement the Miwatj Board would be the regional lead entity and the funds holder. The EASC argued in its FRP that within the proposed alliance model there would be a cultural component of reciprocal obligation between the Miwatj Regional Health Board and the East Arnhem Alliance partners when they committed to this approach. Asked directly whether communities were concerned that Miwatj was 'taking over', a senior EASC member noted that EASC members 'are on a lot of committees, they know what's happening; we're not taking over all the clinics and services, we're concentrating on funding and access to services everywhere' (Community representative 503).

It was also envisaged that parties to the agreements might change over time, allowing for an incremental approach to service transition. In particular, the Groote Eylandt people might eventually choose to establish their own regional health service. However, at the time of the FRP they were represented on the EASC and the Miwatj Board.

Formal community consultation (2011)

In mid-2011 the EASC commissioned Charles Darwin University to undertake a community consultation on regionalisation with the results to be included in the FRP. The consultation was conducted in local Aboriginal languages, by East Arnhem Aboriginal staff who were trained and supported by experienced academics. The consultation survey methods included a sampling strategy to achieve coverage of all relevant groups and the overall goal was to consult with 360–70 adults across East Arnhem 'to establish a reasonable level of agreement on a regional PHC service model and governance structure' (Christie et al. 2011:11). Clinic staff and non-Indigenous community members were not included, in the expectation that the NTH and AMSANT would also conduct consultations with their staff/stakeholders (Christie et al. 2011:12). Ultimately, 401 men and women were surveyed. As well as reporting community views, Christie et al. (2011:10) also spelled out the complexities of community consultation and communication in the region, noting that 'the story behind the health reforms is complex and multi-layered, and the reform process constantly changing and evolving'.

Although about half of those participating were positive about the regionalisation proposal, others wanted more information. The authors reported that 'the more informed people felt about the health reforms, the more positive and supportive they were of the reforms and the regionalisation process' (Christie et al. 2011:1). The authors noted that the survey was conducted late in the process when some important decisions had already been made by the EASC and community leaders (Christie et al. 2011:11).

Regionalisation proposal not endorsed by the NTAHF (2012)

The submission of the FRP in June 2012 coincided with a period of disarray in the NTAHF, and the EASC did not receive a formal response. The Miwatj CEO wrote to the NTAHF in September 2012 to report that although he had been advised that the government partners had concerns, his requests for specific concerns to be communicated had been unsuccessful.

The NTAHF decided that the members should provide separate written responses to Miwatj and noted that the NTAHF itself was no longer empowered to endorse FRPs (see Case study 1 for more information). The Department of Health (Northern Territory office) responded promptly with a short letter advising that further work would be required and addressing the perceived conflict of interest for the Miwatj Board in its capacities as 'a sub-regional provider and a regional board' (letter, Department of Health (NT) Manager to Miwatj CEO, 10 October 2012). The letter also requested that EASC/Miwatj prepare a plan for 'health reform activity' and further community consultation. Details of the EASC's endorsement of all components of the FRP were also requested, and a provisional offer of further funding (up to $200,000) was made.

Some of these requests were seen as unreasonable or already addressed in the FRP. All NTAHF partners were represented at and participated in the EASC meetings during 2011–12, when the FRP was developed and endorsed, and the community consultation process had been thorough and well conducted. The Department of Health considered that a detailed plan for implementation was required prior to sign-off on the FRP, whereas the EASC considered that sign-off was needed first, given the significant investment (of resources and community good will) that would be required and also given the CPHAG's existing work on key aspects of regional health system reform. Differences on the question of a single ACCHO board for all services in the region and the role of the Miwatj Board were unresolved.

On 22 January 2013 Miwatj (RPU) provided a response to a senior Department of Health officer (via email and a discussion paper (titled 'Miwatj Discussion Paper January 2013'), giving detailed attention to the issue of potential conflicts of interest and the mechanisms designed to ensure maximum participation and transparency. The paper detailed changes made to the Miwatj constitution and drew attention to the reality of the multiple 'kin and clan', cultural and organisational linkages among the senior regional leadership (such as the presence of board members of both Laynhapuy and Marthakal on the Miwatj Board) and the members' preferences for the existing arrangement.

A further letter in March 2013 from the Department of Health to Miwatj described the alliance agreement model as 'a solid first step in building a governance approach that represents the East Arnhem communities' and outlined further requirements, including a detailed five-year plan and timeframe for 'bringing new communities into the governance structure' and for 'efficiencies produced by shared purchasing arrangements for health services and administration' (letter from Department of Health (NT) Manager to the Chair of the EASC, 12 March 2013). The provisional offer of funding, to be provided after the completion of the work, was also affirmed (subject to receipt of a revised budget proposal).

No further developments in relation to the FRP occurred during the period of this study, although Miwatj has continued work on the development of a regional PHC service.

Transitioning Yirrkala Clinic (2012)

At the same time as the FRP was submitted (mid-2012), Yirrkala Clinic transitioned from being an NTH service to being a community controlled service as part of Miwatj.

Yirrkala is a small township located 15 kilometres from Nhulunbuy. It has a population of around 1000 and is the largest Yolŋu community on the East Arnhem peninsula (PwC 2012:5). The town site was established by Methodist missionaries in 1934. Mission staff later established a small hospital, which was handed over to the Northern Territory Government in the mid-1970s with a staff of Aboriginal Health Workers and one nurse from the Nhulunbuy Hospital (Read 1983:19–23). There had been discussions about transfer to Miwatj since the 1990s, when the clinic was noted to be underfunded.

Discussions commenced again in 2008 and an agreement on the transfer of Yirrkala to Miwatj was completed by December 2011, with Miwatj taking over day-to-day management of the clinic in July 2012.

Miwatj engaged PricewaterhouseCoopers (PwC) to undertake a financial and service analysis of the Yirrkala transition process. PwC reported that Yirrkala's KPI results were below average and it lacked accreditation by Australian General Practice Accreditation Ltd (AGPAL) prior to transfer (the clinic is now accredited), and that a broader range of services (health promotion and illness prevention, chronic disease management programs) were offered following transfer (PwC 2012:21).

The transfer of operating funds from the NTH to Miwatj was contentious and delayed (letter, CEO Miwatj to NTAHF, 26 September 2012). The allocation of overhead costs (management and support costs such as information and communications technology (ICT)) was the focus of concern. The question of direct allocation by the Australian Government to Miwatj or allocation via the NTH was also debated. The funding was resolved (without a specific allocation for overhead costs) following a threat of a Christmas shutdown of the clinic.

Although the NTH had explicitly excluded the Yirrkala transfer from the NTAHF regionalisation processes (letter, CEO Miwatj to NTAHF, 26 September 2012), the stringent requirements of the Competence and Capability Framework were applied as a condition of approval to transfer. The framework was completed with support from PwC and showed good results. PwC noted that although all parties recognised that they were learning how to do transition, there was a 'high level of uncertainty that impacted on the relationship management of the transition process' (PwC 2012:22). It suggested that future such exercises should include clear agreements on financial and other data to be shared among the parties, including timeframes for delivery and early attention to ICT and data-sharing systems. PwC also emphasised the need for timely documented confirmation of all contractual obligations to be transferred, especially employee contracts and entitlements (PwC 2012:22).

This experience of transfer of a remote NTH clinic has highlighted some technical and relationship challenges that are likely to apply to future transfers. The relative paucity of local clinic infrastructure, such as ICT, and the challenge of quantifying and transferring overhead costs are important matters of concern to Miwatj and the Australian Government. It can also be expected that Northern Territory Government staff will resist a change in their employment arrangements in the absence of clear up-front guarantees of 'no disadvantage'. There was also a sense in this case that staff were not comfortable working for an Aboriginal organisation or lacked confidence in management capability—a view also expressed to a senior community leader: 'they said we didn't have the expertise' (Community representative 503)—or did not want the NTH to lose ownership:

> Well when we're talking about regionalisation… there'd also been that sort of resistance… I don't think Territory Health were particularly keen to transition. You know, these were their clinics. (ACCHO staff 116)

Miwatj funding contracts and performance

Given concern about the governance and management capability of Miwatj, it is relevant to describe its funding contracts and its performance.

Miwatj had experienced growth in funding associated with the Northern Territory EHSDI program starting in 2009–10, growing from total funding of more than $9 million in 2008–09 to more than $17 million in 2013–14. In the 2013–14 financial year it received funding in 14 separate contracts or schedules, requiring 167 reports. Reports were for a range of funders and were required quarterly, six-monthly and annually.

The Northern Territory Aboriginal Health KPIs (unpublished data, 2013) and Miwatj records document several indicators of effectiveness in provision of PHC:

- provision of an MBS health assessment that exceeds the national average (aged 0–4) in Galiwin'ku, Nhulunbuy and Gunyangara (Northern Territory Aboriginal Health KPIs)[5]
- the lowest proportion of babies born with low birth weight (11 per cent), compared to East Arnhem as a whole (19 per cent) and the Northern Territory (14 per cent) (2013) (Northern Territory Aboriginal Health KPIs)
- immunisation that exceeds the Northern Territory average rate in all age brackets (2011, 2012 and 2013) (Australian Immunisation Registry)

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[5] No comparative data for Yirrkala was provided until the following reporting cycle.

- significant increase in episodes of care at Yirrkala following transfer to Miwatj from the NTH; in 2013 the first complete calendar year that Yirrkala was part of Miwatj, episodes of care increased by 408 per cent to 11,420 (Northern Territory Aboriginal Health KPIs) from the previous level of 2794
- a significant increase in the proportion of patients whose allergy status was recorded in their files in Yirrkala, as required for accreditation; in May 2014 recorded allergy status had increased from 10 per cent to more than 60 per cent[6]
- increased employment of qualified Aboriginal and Torres Strait Islander people; of 139 employees, 79 are Indigenous workers (56 per cent).

We suggest that this is a typical pattern of performance by a competent ACCHO—managing complex program funding to deliver effective PHC.

Regionalisation work continues (2012–14)

By late 2012 it was clear to Miwatj and the EASC that the NTAHF regionalisation program had come to a standstill. The Miwatj RPU was no longer funded and the EASC was unable to meet. After intense investments of time and resources for almost five years, the regionalisation initiative was losing momentum in East Arnhem.

However, Miwatj retained regionalisation as a key organisational priority. It did not proceed with the formal alliance structure proposed in the FRP, but took the view that existing arrangements for working relationships with Laynhapuy and Marthakal functioned well and that Miwatj is well placed to manage any future transfers of NTH clinics.

Miwatj has actively canvassed support for regionalisation, including meeting in December 2012 with the Northern Territory Minister for Health (David Tollner), who gave a written commitment to transfer remaining Northern Territory clinics in North East Arnhem and, subject to agreement with the Anindilyakwa Land Council, those in South East Arnhem, specifically Groote Eylandt and Numbulwar (personal communication, CEO Miwatj Health, February 2013). The Minister lost the health portfolio one month later and senior staff of the department expressed concern about resistance to transfer among regional NTH staff whose jobs may have been affected by transfer. The existence of this concern has been confirmed (but not endorsed) by a senior officer in a meeting with NTH Minister Lambley in July 2014 (Miwatj Health RPU Manager, personal communication, 14 September 2014).

Miwatj is pursuing a strategy of incremental regionalisation through the transfer of willing clinics to the community-control model. In areas such as Groote Eylandt and Numbulwar, where community controlled services have never existed, there is scope for the development of a separate regional service. In the meantime, the regionally inclusive Miwatj Board structure offers senior leaders in the region an opportunity to participate in debate, to pursue the growth of health services and to assess the potential benefits of regionalisation for their own communities.

The CPHAG continued to meet and has established a Regional Clinical Governance Network to provide advice and support on clinical matters. The scaled-down RPU continued to function funded by Miwatj. The RPU has established a relationship with the Cape York-based Jawun Indigenous Corporate Partnerships program, which has enabled the development of an advocacy policy and supportive resources and a change management strategy for use in future clinic transition processes.

At the time of writing, Miwatj was in discussion with the NTH about the possible transfer of the Milingimbi Health Centre to a community controlled model within Miwatj, with the support of the Minister of Health (Lambley 2014).

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[6] Extracted from the East Arnhem Communicare Database.

Despite sometimes difficult relations with the NTH regarding regionalisation, Miwatj continues to take opportunities to progress its regional agenda, noting that 'to achieve the outcomes we all want, real partnerships are crucial' (Miwatj CEO cited in Lambley 2014).

Findings

Achievements

This case study documents the development in one region of a plan for regionalisation, and the challenges and achievements of the project. There was some practical progress, including developments towards regional community governance for health services, and the full transfer of the clinic for one community. But in spite of these achievements, the results fall short of success in efforts to implement the reforms intended in the original *Pathways to Community Control* document (NTAHF 2009a). This section addresses the major issues influencing this outcome.

Regionalisation as a path to self-determination

Miwatj has demonstrated that it remains strongly committed to regionalisation because, from the outset, it has linked increased regional autonomy with self-determination and better health outcomes. East Arnhem Aboriginal people have a narrative of regionalisation and increased autonomy that reaches back more than 50 years to the Bark Petitions and the Gove Land Rights Case (*Milirrpum v Nabalco Pty Ltd* (1971) 17 FLR 141). That narrative continues to inform decision making and to draw in local leaders. The announcement of the EHSDI funding and the NTAHF decision to use some of the funds to establish regional community controlled health services presented the East Arnhem communities with an opportunity to progress their existing vision. Miwatj was well prepared prior to the release of the *Pathways* document, and by the time the NTAHF (2010) Regionalisation Guidelines were released in late 2010 leaders and the community had been working on their ideas for almost four years. They were unprepared for either the months of silence following the submission of their FRP in mid-2012 or the subsequent additional requirements that were apparently based on a perception by government officers that their regionalisation plans were ill-conceived and too risky.

Miwatj continues to see itself as having a broader role than the delivery of PHC, a view that is consistent with that of the ACCHO sector nationally. As a staff member explained:

> I think you've got to look at success in many ways. Service delivery is an important part, it's what we're funded to do, but it's more than that. It's what organisations like this do to the hope of people, I think that's the important thing, that people are proud to be… part of Miwatj in one way or another… Everyone that's got jobs are real jobs, so the community is proud of Miwatj… This is our organisation and I think that's really important and that's the way it's got to be if you're going to build people. (ACCHO staff 402)

Authority and decision making

The processes of regionalisation were seen in some ways as revisiting established community decisions and adding requirements for new consultations and agreements. There was considerable pressure to renew decisions already made, which led to some community conflict without leading to implementation of the desired reforms: 'So, you know, we wasted a lot of time and money and effort' (ACCHO staff 402).

The responses of government officers to the Miwatj FRP were also affected by the tight budget situation of 2011–12 (particularly for the Australian Government) and the apparent withdrawal of high-level support for the regionalisation process. During the period covered by this study, changes of government at both the Northern Territory (August 2012) and national levels (September 2013) brought financial stringencies and the defunding of some health programs. There were several changes of Northern Territory Health Minister and a major restructuring of the Northern Territory health system.

There is some resentment in Miwatj and the EASC membership about what is perceived as a lack of respect for community authority and ways of making decisions. In the period after the FRP was submitted, there was a sense of new requirements being set rather than a genuine dialogue or engagement: as a senior community representative observed, 'the goalposts seem to be moving all the time' (Community representative 401). Invitations, including in writing, were made to the Department of Health (Northern Territory) and NTH staff to explain their requirements to the Miwatj Board, the EASC and the community, but none were accepted:

> we also challenged our fellow key stakeholders from the Department of Health and Community Services, 'could you come to the table and actually give us the feedback?' (Community representative 401)

This period led to perceptions of a lack of respect by government officials for community leaders and Elders and a lack of understanding of their essential role in progressing regionalisation:

> The fundamental things with the Elders—and [we'll] say over and over again—'engage with us, inform us but truly respect and value us because we are the solution to succeed and actually contribute to our society'. (Community representative 400)

> They need to start realising that we've done everything what's achievable and manageable. How many more [times] do we have to be scrutinised, continue what we're doing. And what about the Department of Health and OATSIH? They need to be scrutinised just as well because it is taxpayers' money. (Community representative 401)

Loss of commitment to regional community control, lack of trust in ACCHOs

There was an evident loss of commitment among the NTAHF government partners to the community control model (Allen + Clarke 2011:141). *Pathways to Community Control* (NTAHF 2009a) is unambiguous, with its subtitle spelling out *An Agenda to Further Promote Aboriginal Community Control in the Provision of Primary Health Care Services*. The document goes on to state that 'Parties have agreed that community controlled governance of health services is the optimal expression of the right of Aboriginal people to participate in decision making' (NTAHF 2009a:5).

The Pathways document does not use the terms 'participation' and 'community control' interchangeably. Rather, it argues that increased participation—in all phases and/or aspects of a community health service—is the pathway to community control. Participation is a means to an end, not an end in itself. The linking of regionalisation with community control was further clarified in an NTAHF agreement to use consistent terminology in all communications, specifically the term 'regional Aboriginal Community Control' (NTAHF Meeting #47 December 2009).

However, the document (NTAHF 2009a:5) also discusses the complex meaning of 'community control':

> community control refers to the principle that Aboriginal communities have the right to participate in decision making that affects their health and wellbeing. It also refers to the organisational model of Aboriginal community controlled health services that has existed for more than 30 years.

The document also identifies the capabilities of Aboriginal communities and boards of management as threshold issues within this framework: 'These structures must be able to serve the community's interests, stay connected with the community's preferences and values and discharge strategic corporate responsibilities effectively' (NTAHF 2009a:23). Here the emphasis is on the interface between community interests, preferences and values and the effective management of a corporate health entity. That is, effective governance of a community controlled service will reflect community values and require response to community preferences; it will be connected to its constituents.

But there were shifts in government commitment to these goals and ideas. Following a regionalisation workshop in Alice Springs in 2013, Allen + Clarke (the facilitators) reported that the NTAHF partners no longer shared an understanding of the relationship between the central concepts of community control and regionalisation, with Department of Health officers expressing the view that community control involves 'Aboriginal communities being given opportunities to participate in health service planning' and the NTH also emphasising community participation (Allen + Clarke 2013b:4). Thus community control is conflated with participation, and regionalisation is separated. However, the NTAHF (2010:10) had previously indicated that the partners had an agreed definition and a shared vision for regionalisation, which is:

> Working together to improve health outcomes for all Aboriginal people in the Northern Territory through health system reform and the development of Aboriginal community controlled primary health care services which provide safe, high quality care and facilitate access to specialist, secondary and tertiary care.

The impact of several high-profile governance failures or problems in Aboriginal organisations during this period added to a sense of concern about the governance capability of the community control model and influenced the thinking of politicians, as well as public servants.

The experience was a dispiriting one with particular consequences for continuing community engagement. Although noting that he and his countrymen are 'patient people', a senior community representative said that he worried about his board colleagues losing interest because they had not heard anything for so long; he added that when such intense work and discussion apparently lead to nothing changing, 'the criticism and blame falls back on us' (Community representative 503).

The Miwatj Chair commented on:

> what we feel is a very hard-handed, double standard approach you have taken to the regionalisation process in East Arnhem despite all good work the Steering Committee and Miwatj Health has done to reform health service delivery for our people of the past five years. (Letter, Miwatj Chair to Department of Health NT Manager, 17 July 2013)

Conclusion

Miwatj and the EASC vigorously pursued the opportunity to transfer PHC services to regional community control because it fitted well with their vision for the future. But it seems that the timing of the submission of the FRP—coinciding with a period of dysfunction in the NTAHF and indolence on the part of the SOG (which was intended to speed up the process through effective decision making)—led to its failure.

We have relied on documentary evidence to interpret the perspectives of government officers but have been unable to clarify why dialogue was lacking. It seems likely that the failure to secure agreement with the two existing ACCHOs in the region to amalgamate with Miwatj was an important barrier from government perspectives (in spite of the principle of no forced amalgamations). It also seems that the stated intention to accept FRPs was no longer being honoured, and government responses were designed to discourage persistence by the EASC/Miwatj.

Whatever the barriers, the fact that there were no opportunities for frank discussion among the parties seems to have sealed the fate of the FRP. This approach is reminiscent of the ungainly conclusion of the PHCAP program (NTAHF Meeting #25 September 2004; Rosewarne & Boffa 2004).

A comment by Smith (2008:83–4) in relation to the abandonment of the Building Stronger Regions, Stronger Futures policy suggests that this is a recurring problem worthy of attention in its own right:

> What had happened? The sudden demise of the [Building Stronger Regions, Stronger Futures] policy owed much to the ideological dissatisfaction and implementation difficulties experienced by government bureaucrats in trying to accommodate Indigenous ideas about 'regions' and representation for local government, and their consensus modes of decision-making about these matters. Discussion and decision making took time, internal negotiation and sensitive facilitation—all of which challenged the capacity, commitment and resources of the NT and Australian Governments. The political imperative for fast results chaffed at the more measured pace of voluntary regionalisation, and in the meantime, several NT community and association councils had collapsed owing to poor financial administration and governance.

Case study 3: Transition to community control in Cape York

This case study explains work towards the transition of PHC for Aboriginal and Torres Strait Islander communities in Cape York from Queensland Health to Apunipima Cape York Health Council from 2006–14, following the signing of a Deed of Commitment (CYRHF 2006a) with the Queensland Government (and other parties, including the Department of Health) in 2006. A more detailed account of the development of Apunipima is provided in the report *Towards a History of Apunipima Cape York Health Council, 1994–2006* (Tilton et al. 2015).

This case study is based on analysis of 111 documents, and on interviews with 27 people, including seven who had been involved in two capacities, and two who had been involved in three capacities during the period under study. Thus 21 people had occupied ACCHO roles; 11 had been community representatives, and nine had served in government roles. We had limited access to interviews with current Queensland Health staff or to minutes and other outputs of forums convened by government.

Background

Apunipima was established in 1994 at an historic four-day meeting of Aboriginal and Torres Strait Islander community representatives from across the region at the Pajinka Wilderness Lodge at the tip of Cape York. The new organisation drew on community concern about the availability and appropriateness of existing health services, and the conviction that it was time for the communities to have more say in their health care. Its establishment also came with strong support from the Cape York Land Council and the ATSIC Regional Council.

The development of an Aboriginal and Torres Strait Islander voice for health in Cape York also found support in government, particularly among senior regional officials who realised that the existing health system was failing to improve the health of Aboriginal and Torres Strait Islander people and that a new approach that extended beyond the narrow confines of clinic-based acute care was needed.

Initially, Apunipima focused on advocating for better health care, with funding provided by the ATSIC Regional Council. Apunipima rapidly developed a national profile, adding its voice to the then widespread campaign for systemic action on Aboriginal and Torres Strait Islander health.

Soon after its establishment, Apunipima attracted grants from several other funders, and established health promotion, sexual health, social and emotional wellbeing, suicide prevention, alcohol and smoking, women's health and family violence programs. Apunipima pursued a partnership approach to making services more appropriate for Aboriginal communities, and was successful in building relationships with partner organisations, including funders.

Despite the strong relationships and its success, by around 2000 there was an increasing realisation within Apunipima that advocacy alone was not enough to change the way the health system operated.

The regionalisation process

The signing of a Queensland Framework Agreement by both governments and the Queensland Aboriginal and Islander Health Council (QAIHC) in 2002[7] underpinned the re-

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[7] An earlier (1996) Queensland Framework Agreement did not include the community controlled sector as a signatory.

establishment of the Cape York Regional Health Forum in 2005, and this body commissioned the Cape York Institute to develop a model for comprehensive PHC services in Cape York. The resulting 'Health Reform Project and Social Enterprise Proposal' (CYI 2005) recommended that Apunipima take on the delivery of comprehensive PHC services for Cape York, resourced through the pooled funding of existing Queensland Health expenditure, plus additional, new Australian Government funds from the PHCAP (McDonald 2003)[8] and other mainstream sources, including Medicare (CYI 2005:12,13). Apunipima was to reform its governance structures with a smaller governing board, including representation from the Cape York Institute, funders (Queensland Health and Department of Health) and outside expertise as needed (CYI 2005:22,52).

On the basis of the proposal, the Cape York Regional Health Forum endorsed a Cape York Regional Health Strategy in January 2006 (CYRHF 2006b:27). The Apunipima Board accepted the recommendations of the Regional Health Strategy, and those of the original health reform proposal (CYI 2005). In doing so, the Board recognised the significant changes and capacity building that would be required (ACYHC 2006:3). A Deed of Commitment, which endorsed the strategy including the role of Apunipima and the concept of funds-pooling, was signed by all parties in August 2006, with a target date for full implementation by June 2011.

Early promise: Intensive work within Apunipima (2006–07)

The period immediately following these commitments was one of concentrated activity for Apunipima as it accepted the challenge of transitioning from an organisation with about 20 staff members and a focus on advocacy to an organisation that would take responsibility for PHC services across Cape York (ACYHC 2006:3; Coombe 2008).

In 2006 a Transition Planning Unit was established within Apunipima, funded jointly by the Department of Health and Queensland Health. It reported to a steering committee made up of representatives of the Department of Health and Queensland Health, the Cape York Institute, the Royal Flying Doctor Service (RFDS), the Far North Queensland Rural Division of General Practice (FNQRDGP) and QAIHC. Apunipima undertook an extensive round of engagement with local communities to present the new model of community controlled health care to the Aboriginal and Torres Strait Islander people of Cape York and to seek their endorsement. As the Chairperson of Apunipima reported, 'In principle, the communities have welcomed the idea of community control with the qualifier that they do not want to see a decrease in service quality' (ACYHC 2006:3).

Apunipima also led the establishment and strengthening of the Health Action Teams (HATs) (Coombe, Haswell-Elkins & Hill 2008). Whereas, previously, the HATs had varying degrees of local support and engagement, now they were established in every community except Aurukun, with resourcing from the Australian Government's Building Healthy Communities Initiative. A skills audit of HAT members was carried out and training was provided (through RFDS and FNQRDGP) to support them in their important role (ACYHC 2007:102).

A new constitution (under the federal *Corporations (Aboriginal and Torres Strait Islander) Act 2006*) and a modified board structure were endorsed at the Apunipima Annual General Meeting late in 2006 and, following the new constitution's approval by the Office of the Registrar of Indigenous Corporations in May 2007, a new (smaller) board was in place by September 2007. The new board had membership along the lines endorsed in the Cape York Health Strategy, including ex-officio membership from government health departments and private enterprise (ACYHC 2007:99).

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[8] PHCAP was a federal government initiative announced in the 1999–2000 Budget to improve Aboriginal and Torres Strait Islander access to comprehensive primary health care in areas identified through regional planning processes.

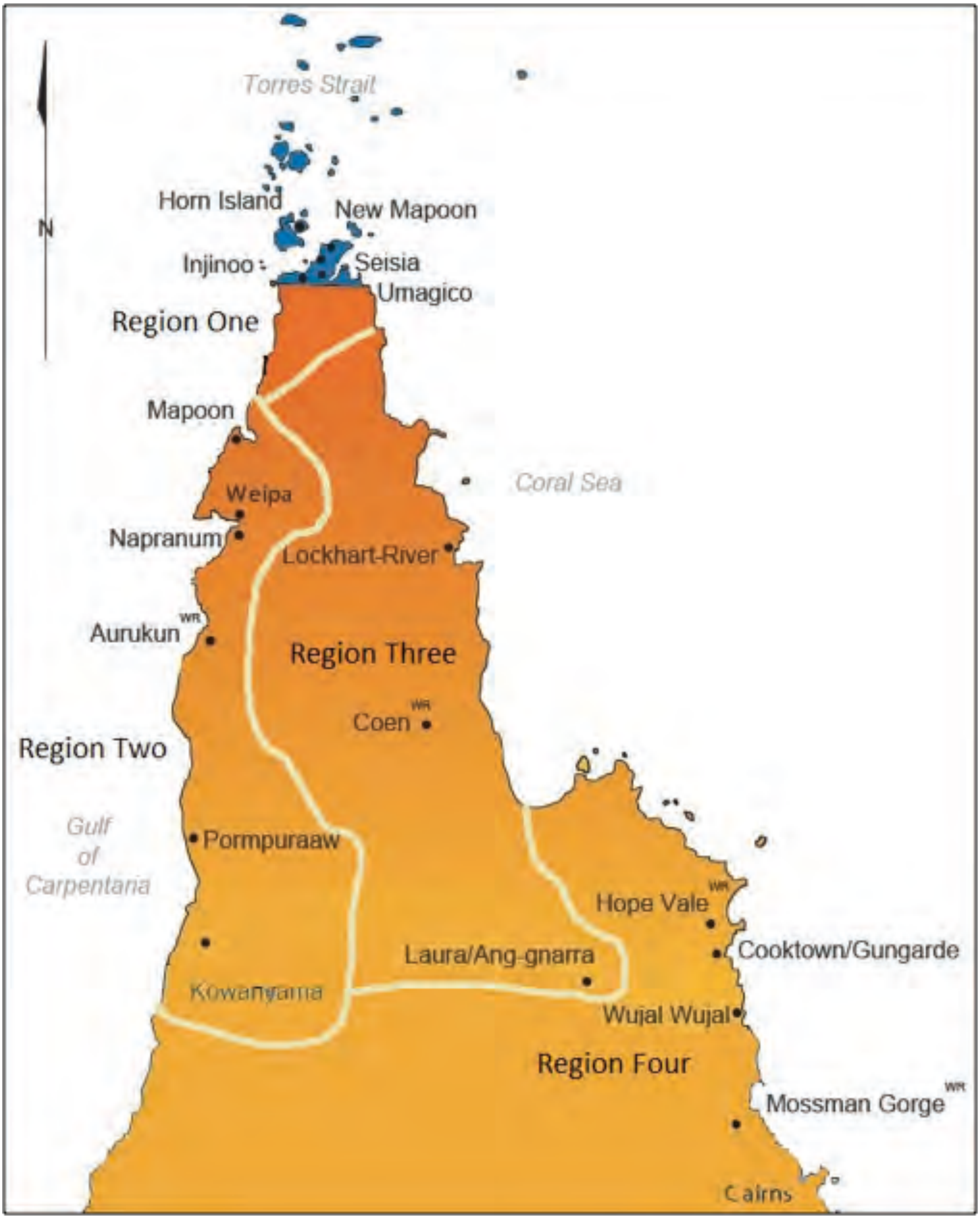

Figure 5: Cape York Health Regions served by Apunipima, 2014
(Source: ACYHC n.d.)

Emerging doubts within government (2006–07)

Apunipima's intensive work to implement the Deed of Commitment was supported by both governments, but early doubts emerged within these agencies about the transition to community control.

Within Queensland Health, the importance, and even legitimacy, of the Deed of Commitment was questioned. As one Queensland Health staff member of the time recalled:

> [It] wasn't something that was, I suppose, marketed, acknowledged by Queensland Health… it wasn't something that was openly talked about… there was no supporting documentation… I think it was again one of those things that was on the spur of the moment. You've got a commitment to something but what does that commitment need and to what extent? (Government staff 200)

Significantly, broader events in Queensland undermined the focus on the transition process. Incidents at the Bundaberg Regional Hospital in 2005 (Bundaberg Hospital Commission of Enquiry 2005) had led to a major review of health services in the state, and in 2006 Queensland Health underwent substantial reforms, including halving the number of health districts from 38 to 20 new 'health areas' (Robertson 2008), reforms that consumed much policy capacity and management attention.

The Department of Health also raised early concerns about the capacity of Apunipima:

> there were a number of concerns, from members of the Steering Committee, with the transition planning project… Government agency concerns appeared to be grounded in whether Cape communities and Apunipima [were] capable of delivering the necessary health services. This raised further concerns that government may not continue to fund the project. (ACYHC 2007:96)

Despite a review of the transition project in early 2007, and reorientation of its goals to meet Department of Health concerns, additional federal program funding available at the time was not directed to Apunipima. Much of it, in particular from the Improving Primary Health Care Initiative (IPHCI), was instead directed to mainstream organisations in the region, specifically the RFDS and regional GP Division, albeit in contracts specifying that funding was to be transitioned to Apunipima at the end of three years. In the views of one non-Indigenous professional, the lack of significant funding at this early phase of transition may have deprived Apunipima of the critical mass of resources needed to address issues of capacity (Community representative 311).

Attempts to set the terms of transition (2007–08)

During 2007 and 2008 Apunipima, with the support of the broader community controlled health sector in Queensland, responded to the emerging doubts about transition with several major pieces of work aimed at furthering implementation of the Deed of Commitment.

In late 2007 Apunipima set out a roadmap for the transition to community control (ACYHC 2007). The Cape York Health Reform Proposal (ACYHC 2007) moved the focus beyond simply the organisational changes Apunipima needed to put in place (although these were acknowledged) and on to what was needed in reform of service delivery if the transition to community control was to effectively address health disparity in Cape York. In particular, this would mean a reorientation of PHC to be comprehensive, including a focus on the social, emotional and spiritual wellbeing of communities, as well as action on maternal and child health, chronic disease and substance abuse (ACYHC 2007:29–36).

The health reform proposal envisaged a phased transition process, with Apunipima to take on the purchaser role in a purchaser–provider model within two years (2009–10) and direct responsibility for service delivery under community control within five years (2012–13) (ACYHC 2007:8). Action was to begin immediately, with the first communities

(Kowanyama and Pormpuraaw) to be transitioned by June 2008 (ACYHC 2007:9). Significantly, the proposal did not address the funding of the new model, and although a section addressing funds-pooling was signalled, it was not completed (ACYHC 2007:54).

At the same time, QAIHC commissioned the University of Wollongong to determine the most appropriate funds-pooling model to be applied in Cape York and also in Yarrabah, which was going through a parallel process (QAIHC 2007:6). The resulting report examined several funds-pooling models in detail. A simple 'cash out' model transferring funding for services existing at that time would see Apunipima's funding rise to $30 million per year, with the majority of this (around $24 million per year) to be transferred to the organisation from Queensland Health for its network of health clinics (Eagar & Gordon 2008:17).

This model was rejected by the authors because it would merely 'lock in' existing under-resourcing and inequity. Instead, a 'cash up' model based on 'equity of input' was recommended, under which funding would be increased to match average national levels of per capita MBS and PBS funding, adjusted for location and other variables. The recommended total funding pool in this case was just over $50 million per year—being roughly the existing funding of Apunipima ($6 million), plus the cost of delivering existing services ($24 million from Queensland Health) plus an additional $20 million from the Australian Government (Eagar & Gordon 2008:18). The financial implications of this approach were significant, but their impact on the enthusiasm of government for the transition process is not documented.

Opportunities for transition (2008–10)

The Deed of Commitment envisaged a staged transition to community control across the whole region. However, in this period Apunipima also showed itself capable of acting opportunistically to progress transition to community control. In late 2008 Apunipima prepared a detailed proposal for immediate transition in two communities, Mapoon and Mossman Gorge (ACYHC 2008). Prompted by perceived support for transition at the highest levels of Queensland Health, Apunipima selected these two communities because their relatively small size, lack of substantial government staff and investment, their functioning HATs and strong local community support made them ideal sites to get immediate 'runs on the board' (ACYHC 2008:5, 11).

Different models of community control were to be adopted in each site. At Mapoon, Queensland Health was to continue to provide the health centre infrastructure and employ its existing clinical staff, and a more 'family centred' model of PHC was to be provided through additional chronic disease programs, with staff to be employed by Apunipima. A local Aboriginal health centre manager was proposed as the key point for the coordination of care, community consultation and reorientation of services (ACYHC 2008:7). In Mossman Gorge, where Queensland Health had no community-based staff, the model was more straightforward, with Apunipima to provide management and coordination in conjunction with the local community council (ACYHC 2008:13).

Apunipima proposed that these services could be transitioned almost immediately (in the first half of 2009) with additional funding of about $300,000 per year for each site (ACYHC 2008:17). Notwithstanding the substantial work done within Apunipima to prepare for transition, it was not until 2008 that the delivery of the first permanent PHC services by Apunipima commenced, starting with the employment of maternal and child health workers using Department of Health funds. This increased the size of the organisation from about ten to about 30 staff (ACYHC 2012:16).[9]

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[9] Apunipima continued to be funded for and deliver numerous short-term prevention and health promotion programs following the Deed of Commitment, as it had in the period 1994 to 2006.

The following years saw even more dramatic increases, as IPHCI funds were transferred from RFDS and FNQRDGP to Apunipima after three years as planned. Accordingly, as one senior health official at the time recalls:

> those positions and programs were transferred to [the] community controlled sector by 2010. I think that was very significant because it moved the organisation from being an advocate, capacity and policy organisation to one of being a service delivery organisation of significance. (Government staff 700)

These new positions were to work alongside the existing Queensland Health clinics, which maintained their clinical focus.

Late in 2009 the Mossman Gorge health service became the first (and to date only) community health service in the region to be wholly transitioned to community control. The proposal for the transfer of Mapoon had apparently not been accepted, but Apunipima employed PHC managers in Coen and Mapoon to progress community control in those communities (ACYHC 2012:17).

Regional planning for transition stalls (2010)

By 2010 the community controlled sector had developed a high-level model for community controlled PHC in Cape York, including a roadmap for its implementation and an overall estimate of the funding required. While Apunipima was advancing its model of community controlled family-centred PHC where it could, and growing as a PHC provider, regional planning for transition seemed to have stalled.

One reason for this lack of progress seems to have been loss of commitment to the Cape York Regional Health Forum as a regional structure for collaborative planning and decision making. Its continuing role was acknowledged, but as one senior Aboriginal participant noted:

> There was never a structure put in to progress that, not the hint of a structure to progress that, it was just 'here, okay, go out and do it yourself'. (ACCHO staff 319)

By 2010 it appears that the forum, once described as the most effective regional health forum in Queensland, had ceased to meet. This situation is seen as resulting from lack of government leadership and failure to engage the forum in planning the introduction of programs for the region. Key personnel with a commitment to the transition project had moved on during this period and the practical realities of transition, in particular the funding implications, had become apparent.

In the case of Queensland Health, the realisation that transition would mean a very substantial transfer of funds to Apunipima may have been influential. The need to deal with complex industrial relations issues surrounding the transfer of existing employees was also exacerbated by the continuing antagonism to Aboriginal control among Queensland Health staff in the region, especially those working in community clinics and who were most likely to be affected personally. The reasons for this hostility included the fear of losing job security, wages or benefits, and the Queensland Nurses Union, although supportive in principle of the transition to community control, came to believe that 'The Apunipima experience is already providing an example of attempts to undermine terms and conditions of employment for nurses' (QNU 2012).

For many Aboriginal participants, the opposition of local non-Indigenous government staff was deeply rooted in disbelief in the capability of Aboriginal people and a distrust of Aboriginal organisations: 'I'll say blunt on record… that they don't want to work for a black organisation' (Community representative 306).

Although senior Queensland Health departmental officers based in Brisbane remained cautiously supportive, these concerns may have been a significant disincentive for substantive engagement with the transition process at the regional level.

For the Australian Government there were also significant financial implications, as became very clear through the 2008 Eager and Gordon report. This, plus reported concerns about the governance of Apunipima, may also have contributed to less enthusiastic commitment to participate in the Cape York Regional Health Forum, the only available regional mechanism for advancing joint planning and implementation of transition.

The lack of commitment to an authoritative regional decision-making body to progress and oversee transition to community control had a profound influence. In parallel with Miwatj in East Arnhem, Apunipima switched from pursuing the 'big picture' of the Deed of Commitment to an opportunistic approach in which it sought to progress local transition as and when possible.

The national agenda and state-wide processes (2008 onwards)

During the early years of the Cape York transition project, the idea of transitioning PHC for Aboriginal communities to community control was becoming a state-wide issue. In 2006, partly triggered by the Cape York Deed of Commitment and a similar document for Yarrabah, and partly by the Queensland Government's health reforms, QAIHC committed to pursuing an agreed policy framework for transfer of Aboriginal and Torres Strait Islander PHC to community control across the state (QAIHC 2006).

QAIHC continued to advocate for this policy framework for the next few years (QAIHC 2007:6; QAIHC 2009:19), but it was not until 2009 that it secured a commitment from both Queensland Health and the Department of Health to the development of a policy framework to guide and expand transition to community control across Queensland. QAIHC also made a commitment to its member organisations to begin regionalising its own services by relocating some functions to five community controlled 'support hubs' (QAIHC 2010:6,19).

QAIHC's intervention seemed to have helped 'kick start' a policy focus on the need for reform of PHC in Aboriginal and Torres Strait Islander communities. However, at that time the national agenda was profoundly shaping action at the state level.

The Council of Australian Governments (COAG) 2008 *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes* set ambitious targets to address Aboriginal and Torres Strait Islander disadvantage (COAG 2008:1). Australian Government funding of $1.6 billion was allocated nationally over four years from 2009–10, with states and territories to make their own contributions ($162.22 million in the case of the Queensland Government) (COAG 2008:17).

In 2010 Queensland Health published *Making Tracks toward Closing the Gap in Health Outcomes for Indigenous Queenslanders by 2033* (QH 2010a), a jurisdictional plan under the national commitment to Closing the Gap. Although this contained only a high-level commitment to the principle of community control, the first triennial implementation plan (2009–10 to 2011–12) committed to developing a state-wide framework to support the delivery of PHC to Aboriginal and Torres Strait Islander communities, including options for governance and funding. It also committed to support the development of a community controlled health service in Cape York, to implement alternative approaches to PHC delivery and to work to secure sustainable Australian Government PHC funding (QH 2010b:35).

With the backing of the Queensland Minister for Health, a Joint Working Group was set up (including membership from QAIHC, Apunipima, key unions, other service delivery agencies, and both Queensland Health and the Department of Health) with the specific task of developing 'a Transition to Community Control (T2CC) Strategic Policy Framework and a package of policy resources, including a monitoring and evaluation framework' (QH 2011c).

The Draft Strategic Policy Framework (QH 2011b) was released the following year and drew on the work of the Joint Working Group and consultations with stakeholders, as well as the work of the Northern Territory Aboriginal Health Forum (QH 2011b:4). It identified Yarrabah, Mapoon and Kowanyama as pilot sites, and outlined a staged process for transition to community control (Figure 6).

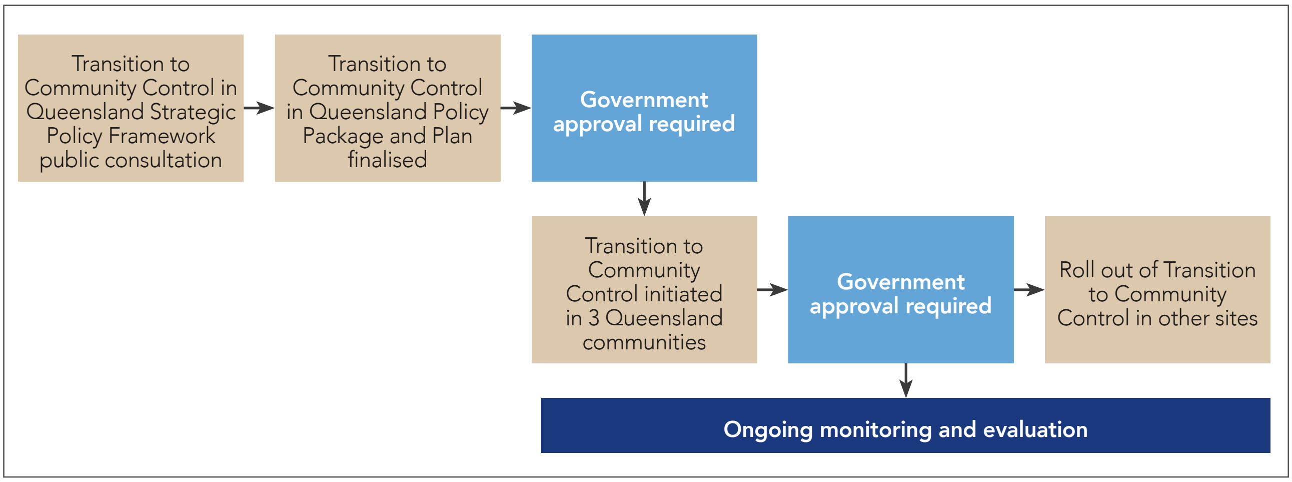

Figure 6: Process for transition to community control in Queensland
(Source: QH 2011b:18)

The policy direction was entirely consistent with transition in Cape York, and Cape York and Yarrabah were acknowledged as the 'first cabs off the rank', but it seems that these processes delayed progress within Cape York:

> We were ready and set, ready to go and when it became diluted in this state wide process—where there wasn't actually anyone else that was transitioning so I still don't understand that. So they started negotiating with QAIHC around this Queensland wide transition and we're going 'it's just us. You just negotiate with us directly if you want to…' (ACCHO staff 316)

Formal commitment by Queensland Health to 'partnerships between peak Indigenous bodies, such as the Apunipima Cape York Health Council, Divisions of General Practice, the Royal Flying Doctor Service and the Australian and state governments' was maintained (QH 2011a, 2012) but progress (including on the draft strategic framework) was impeded by intervening reforms in the Queensland health system as a whole. In response to the *National Health Reform Agreement* (COAG 2011), Queensland Health was to be broken up, with statutory bodies under regional boards (Hospitals and Health Services or HHS) taking responsibility for health service delivery, including PHC. The Cape York Health and Hospital Service (CYHHS) was established under the *Hospital and Health Boards Act 2011* (Qld) and came into being on 1 July 2012 (QH 2012).

Work within Queensland Health on transition to community control continued, and a draft Readiness Assessment Tool was produced in an attempt to 'ensure that the objectives and principles of Transition to Community Control are maintained' (QH 2012:2). However, under the terms of the new Act, these decisions were now clearly in the hands of the HHSs, not central office, and at best the readiness assessment could provide 'guidance on strategic and operational issues to consider and resolve before an HHS moves funding and/or staff' to an ACCHO (QH 2012:2).

In Cape York there were discussions between Apunipima and the CYHHS about progressing the readiness assessment. However, when it appeared that Apunipima would be required to go back to communities to discuss the transition to community control yet again, Apunipima declined to do so. The parallel with the Miwatj experience in East Arnhem is striking.

During this period underlying problems of complexity in funding and accountability requirements continued, and in some ways increased. From 2010 there was an increase in funding to Apunipima (from about $4 million in 2008–09 to more than $20 million in 2013–14), and a subsequent rapid rise in reporting requirements, particularly from the Australian Government. In the 2013–14 financial year, funding was received in 31 contracts (17 funding, 14 subcontracts/consultancy contracts), which required 74 reports.

Reports were required quarterly, six monthly and annually. They covered financial, clinical, health program and strategic data and planning, and variously extended in scope from whole of region and whole of organisation to individual communities and programs. Other reporting requirements included fortnightly and quarterly conference calls with funding body contract managers, and responding to ad hoc requests for information relating to schedules, events, photographs and stories. Senior Apunipima staff members were also expected to regularly travel to capital cities to meet with government officials.

A hybrid service system

By 2014, 20 years after the establishment of Apunipima and eight years after the signing of the Deed of Commitment, the commitment to full community control of Cape York PHC services had not been realised.

Apunipima had succeeded in refocusing from advocacy and short-term health-related projects and had become a major provider and partner in the delivery of PHC to the Aboriginal communities of Cape York. It delivered chronic disease services across all Cape York communities; employed maternal and child health workers in all communities except Kowanyama, Pormpuraaw and Napranum; delivered GP services in Napranum, Mapoon, Mossman Gorge, Hopevale, Wujal Wujal and Laura; and employed two community paediatricians, one public health medical officer and two chronic disease physicians (ACYHC 2012:19).

These extra resources were reported by health staff and community members to have improved access to health care for Aboriginal and Torres Strait Islander people in the region:

> I reckon it's come forward a long way because… before it was really hard to see a specialist… but now with Apunipima on board as well they're bringing in their teams and they're bringing in men's health team and women's health team, all your diabetes educators—because you've got two lots doing it now it really cuts down on waiting times. (Community representative 307)

However, only one Cape York community—Mossman Gorge—could be said to be under full community control. In all other communities a hybrid PHC system was in place and the newly formed CYHHS (the Queensland Health body responsible for health service delivery in the Cape) had responsibility for clinical care delivered from its health centres, with Apunipima responsible for a range of allied health, chronic disease, and maternal and child health services that were often (but not always) delivered by staff based in Cairns rather than in the community.

This part-way situation has led to poor service coordination and conflict, including allegations that Apunipima workers (particularly Aboriginal and Torres Strait Islander workers) are not treated as respected equals by Queensland Health staff; that Apunipima services are simply a 'duplication' of Queensland Health roles; that visiting Apunipima staff are 'just another visiting service' for Queensland Health staff to 'manage'; and that poor cultural safety for clients and Aboriginal staff in Queensland Health clinics acts as an access barrier.

The transfer of all Queensland Health services in the region to CYHHS removed or diluted the capacity of Queensland Health to make decisions about transitioning services to community control. There was an attempt to further the transition to community control through the establishment of a CEO's Group comprised primarily of the CEOs of the CYHHS and Apunipima. Although this group was expected to meet regularly to sign-off on steps along the transition pathway, its meetings were sporadic and un-minuted and it soon stopped playing an active role. By the end of 2012 it appeared that the transition to community control was no longer on the agenda of the CYHHS (CYHHS 2013, 2012).

Despite widespread dissatisfaction with the process of transition, and disappointments and setbacks, many Aboriginal and Torres Strait Islander people remained committed to transition while being realistic about the difficulties:

> even though there's been a lot of barriers put up with community control, that is a long term aspiration and it's something that we'll still continue to fight for… saying 'you have made a commitment to close the gap. This is one way of getting the commitments met in Cape York. Why aren't you supporting it?' (ACCHO staff 314)

Findings

Apunipima entered the Deed of Commitment from a position of considerable strength. Its origins in strong, united Aboriginal community action across Cape York, its support from other Aboriginal organisations, the development of an independent voice along with strong relationships with government, and a supportive policy context in the early years all provided a solid foundation.

In the years following the signing of the Deed of Commitment, some progress has been made but continuing problems have contributed to the overall lack of progress in implementing the commitments of 2006.

Achievements of transition

Despite the problems encountered in the transition to community control, the extra resources acquired by Apunipima over this period improved access to PHC for Aboriginal and Torres Strait Islander people as the organisation successfully grew from being primarily an advocacy body to being a major service provider, with services for one community transitioned to full community controlled PHC. As noted above, many community members remain committed to transition.

Authorisation and auspice

The lack of an authoritative, collaborative regional body to progress transition to community control was critical. The Cape York Regional Health Forum filled this role during 2005 and 2006 and was instrumental in gaining commitment to transition. However, after 2006 it seems to have rapidly lost energy and focus, and was replaced by a succession of poorly resourced committees or meetings, with no apparent process for negotiating and making decisions about critical transition matters. Regional decision making seems to have been deferred in favour of intervening state-wide processes (through QAIHC and the development of Queensland Health's draft strategic framework), which cut across the capacity for focused attention on transition in Cape York itself.

Throughout the period 2006 to 2012 all parties to the Transition to Community Control project operated in a highly unstable health policy and political environment. Queensland Health had three major restructures during the period (2005, 2008 and 2011), and the current structure devolved responsibility for hospital and health services in Cape York to a regional statutory body. Other challenges for Queensland Health (such as the major problems in the surgical service at Bundaberg Hospital and dysfunction in a new payroll system) further complicated attempts to focus on transition for Queensland as a whole and for Cape York.

The COAG commitments of 2008, and the introduction of wide-ranging national health reforms, including the creation of Medicare Locals, contributed to a volatile environment where policies and personnel changed frequently. Progress was undermined by the continual need for Apunipima to develop new relationships with, and seek new commitments from, government staff, and to reset its own course towards regional community control as new policies and organisations were created around it.

Implementation not adequately resourced

Inadequate resourcing of the transition process was also a barrier to progress. In 2006 and 2007 funding was provided to support the Transition Planning Unit at Apunipima, and to engage and train HATs to fill the gap between region-wide structures of community control and local communities. However, this resourcing did not last. Many interviewees commented on the fact that support for HATs and for processes of engagement with communities was neither continuous nor sufficient for the task of maintaining engagement and support across the whole region. As a result, the energy and enthusiasm for transition dissipated in some communities. Some Aboriginal interviewees expressed a desire for a better relationship between Apunipima and local communities, citing, in particular, the need for improved consultation and better information flow.

Community control is still contested

Mainstream hostility to Aboriginal community control, especially at the local health centre level, was seen by many as a significant impediment to progress. Within Queensland Health uncertainty about job security, salaries and other entitlements under a community controlled service caused disquiet, and there appears to have been little organised effort to address these concerns. Significantly, while supportive in principle of the transition to community control, the Queensland Nurses Union was in dispute with Apunipima about the wages and conditions of its nurses.

However, many Aboriginal people interviewed for this study considered that some of the difficulty of achieving transition goes more deeply, to a reluctance to cede control to Aboriginal people and organisations—that is, that systemic racism proved a strong but unacknowledged barrier to progress. According to this view, Apunipima, as an Aboriginal organisation, was held to higher levels of accountability than mainstream services during the transition period, and the technical difficulties of achieving transition (e.g. for staff salaries and conditions) were both overestimated and inadequately managed by funding agencies.

High-profile governance problems in some Aboriginal organisations elsewhere in Australia seem to have increased the perception of risk in Aboriginal organisations generally. Again, this perception has its parallel in East Arnhem. Government doubts about capacity and governance during this period were seen to have led to increasing levels of micro-management and a reporting overburden.

Regional governance

The inherent difficulties of managing and governing a health organisation across a highly diverse and geographically large region of communities, clans and language groups made good corporate governance a challenge. In particular the composition and skills of the board members came into focus, and there were competing demands between the local, regional and national roles of the organisation. This remained an area of tension, despite substantial reforms, including a change in board membership. The Apunipima Board was restructured in accordance with various recommendations, but the changes led to some Aboriginal community-level criticisms about whether board members could represent their communities if they were actually from 'somewhere else' (Community representative 304).

Regional PHC services remain split

The decision of government not to fund Apunipima for service delivery (through the IPHCI funding) in 2006–07, but rather to fund other agencies for three years with a view to transfer to Apunipima in 2009–10, was a setback. The opportunity to better integrate PHC (by bringing together clinical and preventive care) was missed. The fragmentation of PHC remains a challenge for care coordination, requiring complex interactions between agencies, and could be expected to reduce the extent to which extra resources lead to improved health outcomes. We note that this split is common across Queensland in smaller and more remote communities, though it is less common in the rest of Australia.

Costs of the new model

With the focus on transition, there was a lack of consideration of the underlying adequacy of access to PHC in Cape York and the need to increase the total funding to the region in order to achieve equity of access. Rather, the focus was on getting better outcomes from existing resources through improving the acceptability and integration of PHC services. Eagar and Gordon (2008) argued cogently for an increase in total funding on the grounds of equitable access, and brought the potential cost implications for government into sharp focus. It became clear that if transition was to make a significant difference to health outcomes, additional investment of some tens of millions of dollars from the Department of Health and Queensland Health would be required. Although the problem of inequitable access was pre-existing, the transition project did bring the problem into clearer focus. We suggest that the planned creation of a regional ACCHO, with responsibility for PHC delivery to a significant regional population, made the concept of population-based funding possible and thus made inequity at least potentially more visible.

Funding complexity not addressed

A shift to some form of funds-pooling was explicitly part of the plan for transition, but no serious attention was paid to the policy or technical requirements of this goal. Apunipima's funding remained a complex mix of long- and short-term contracts, most of them with quite specific and narrow program goals. During the period of this study, the amount, complexity and short-term nature of the funding contributed to problems of rapid staff turnover, the undermining of long-term relationships and expertise, conflict at the community level, and an increasingly high administrative burden.

Conclusion

This case study documents a continuing commitment to the development of a regional community controlled PHC service for Cape York by Apunipima and regional community leaders. It also highlights a continuing policy commitment by Queensland Health to regional community control that has not been backed with an effective development and implementation strategy, during a period of frequent broad change in the state's health system. The transfer of PHC services to full community control in Yarrabah (just south of Cairns) in 2014 (Hume 2014) is evidence of a continuing commitment by Queensland Health to transition and to addressing the problems of split service delivery in small communities. The challenge of developing a coherent approach to PHC for Aboriginal and Torres Strait Islander people both in Cape York and state-wide remains.

Findings and Conclusions

This study examined planned reforms as they developed in order to answer these research questions:

1. How effective are the methods used to plan and implement the reforms; what are the critical factors that enable or impede implementation; and what are the gaps and why?
2. What are the implications of the reform experience for policy and practice in the funding and accountability arrangements for Aboriginal community controlled health services and their government funders?

In this section we analyse the critical factors that caused delays and lack of progress in the implementation of the planned reforms (addressing our first research question). We then discuss the implications of the reform experiences for the future development of the PHC system for Aboriginal and Torres Strait Islander communities (addressing our second research question).

Two important limitations should be considered in interpreting the findings and conclusions that follow. First, the data is limited by the relative lack of formal interviews with current government staff, a limitation we sought to address through use of published and internal documents, as well as interviews with relevant former government staff members. Second, the study was conducted in two of eight Australian jurisdictions, largely in non-urban areas, so caution in interpreting the relevance of the findings for other jurisdictions and for urban settings is needed.

Barriers to implementation

The planned reforms were beset by implementation barriers and difficulties. Many of them are common in public administration, not least in health, in which successful reform is often a story of sustained commitment in the face of severe impediments thrown up in shifting political and policy environments. Sidney Sax (1984) described this situation, and the uneasy alliances that form among complex sets of empowered stakeholders, as 'a strife of interests'.

Authorisation, auspice and control

In both the Northern Territory and Queensland, there were problems in the authorisation of the reforms, with high-level commitments not being matched with secure structures and processes for sharing power and control in order to manage the reforms.

For governments, the level of organisational and policy change during the period (including changes in elected governments in all three jurisdictions, departmental restructures and shifts of individual senior decision makers) had an impact on both commitment to and interpretations of the reforms, and brought requirements for all parties to renew and redevelop relationships and procedures.

The responsibility placed on Aboriginal participants in the reforms to represent the community, and the associated social and cultural obligations they took on, were a challenge that was often underestimated by funding agencies. This role was also undermined by changes in government decisions or a lack of action. There was also a perception by participants that government did not acknowledge the legitimacy of ACCHOs and their role in shaping the dialogue about community control of the health sector, nor their cultural/spiritual accountability to current and past Aboriginal leaders. The lack of understanding by government of the cultural obligations of the ACCHO sector to their communities was seen as a significant barrier to progress.

A continuing partnership between governments and the Aboriginal community controlled health sector was an essential requirement of the reforms. However, there was a mutual perception of failure to maintain commitment to agreed timelines and processes, and a sense of significant stress on established relationships and mutual trust. At its worst, there was a sense of misuse of processes to avoid the need to make decisions.

Our first conclusion is that future reform efforts will require more secure authorisation and auspicing to succeed in this complex cross-agency and cross-cultural endeavour.

The challenge is to find an adequate auspice for the planned reforms when they require partnership across multiple structures and agencies of government and the non-government sector. This raises the question of what kind of arrangement would be capable of retaining authority for long-term cross-boundary reform work and managing the major processes of implementation, while also enabling each party to feel a sufficient sense of ownership and control to manage the risks. In the case of the Northern Territory, if the NTAHF did not hold sufficient authority, and AMSANT proved to be an ineffective auspice for the role of coordinator of reform work, what is a feasible alternative?

There are several options. The CCT program was carried through to completion on the strength of strong federal ministerial leadership and effective contractual arrangements among the trial partners. Alternatively, it would be possible in states and territories to establish a statutory authority with the mandate to implement agreed reforms. This would also require some form of reliable agreement with the Australian Government to ensure continuing commitment.

Secure, high-level authorisation and auspice is also needed for risks to be manageable. New risks (e.g. the risk of improvements not being measurable within the required timeframes) can appear larger (for those in government who are taking the risks) than old ones (which may be very serious, including continuation of poor health outcomes). The difference between success and failure in reform may come down to the capacity to manage heightened risk, and thus to maintain confidence and keep the reforms going.

Inadequate resources: Money, time and capacity

One reason for the challenges in the reforms we studied was that the work had been underestimated—in complexity, the timelines, and the skill and resource requirements. In each case study the need for adequate resourcing of the change process was insufficiently recognised and accommodated. There was a common understanding that the jurisdictions were not adequately resourced to implement the reforms, although additional (EHSDI) funding in the Northern Territory was an important enabler.

There was an evident lack of clarity about the size and cost of the reform process by both governments and ACCHOs. The complexity of achieving community controlled care when there are multiple communities with disparate populations and health needs was underestimated. This problem was compounded by changing Commonwealth and jurisdictional government priorities that affected the allocation of resources for change.

The complex changes involved in the planned reforms required a range of specialised knowledge and skills, from clinical perspectives to cultural knowledge, financial analysis, planning, organisational and community development, governance and policy analysis. Problems with the availability and/or deployment of skilled staff were recognised in the Northern Territory as early as 2008 (Allen + Clarke 2009).

A sense of dismay about timing was mutual. At the community level there was widespread dissatisfaction with government delays in decision making and in implementing the reforms, for which the reasons were not apparent. Governments, on the other hand, were frustrated by the length of time required to negotiate change and develop momentum in some communities.

The sense within government agencies that all the resources come from them is one barrier. Although it is true that Aboriginal communities and organisations cannot contribute significant funds to major reforms, they are necessarily required to contribute in other ways, in particular through leadership, cultural authority and relationships, time, energy and knowledge. These contributions need to be honoured, and also need to be reliably available for agreed tasks. Neither of these things can be ensured unless these contributions are explicitly negotiated.

Our second conclusion is that future reform efforts will require more attention to realistic time and resource allocations (both human and material) and the negotiation of explicit commitments.

More realism about the requirements at the beginning would improve the chances of success and make the process more robust to challenge and change.

Working across cultures, in partnership

The barriers discussed above—inadequate authorisation and resources—are the classic errors of project management in many industries. The third is more particular to partnerships between government and Aboriginal and Torres Strait Islander organisations.

Working across cultures and in partnerships is difficult, yet this is an inescapable part of the reform program. Relationships among the major parties to this reform—represented by government health authorities and the ACCHO sector—are often robust and effective, but are also characterised by a mutual lack of trust. This can be attributed to separate interests of funders and providers, and to the intercultural nature of the relationship and the pervasive and too often unacknowledged impacts of systemic racism.

One important underlying barrier to mainstream competence in working across cultures is systemic racism (the ways in which discriminatory effects are built into care systems, with or without intention) and its counterpart, which is sometimes called 'racism anxiety'—the fear of causing offence or being accused of racism. While racism was rarely overtly expressed, it was considered by many participants to be an important underlying influence. This problem is a given in Aboriginal and Torres Strait Islander health care, but is not often discussed. It is perhaps time to move beyond silent acceptance of the difficulties and find ways to acknowledge and manage them openly.

Finding good ways to work across cultures is an outstanding challenge, despite the fact that there is much skill and experience among some of the people involved. It seems that the knowledge held by individuals in government departments and mainstream health organisations is not yet sufficiently encoded in organisational cultures. Such encoding is essential for systematising the relevant knowledge and skills (so that progress is not dependent on outstanding individuals or derailed by turnover of leaders).

This study has described the particular challenges faced by communities and community leaders in working towards the development of a regional system. Many of the challenges, as well as the strengths, are deeply shaped by traditional and contemporary Aboriginal and Torres Strait Islander cultures—in the ways in which relationships and roles within and between communities are structured and in many important aspects of spiritual, social, emotional, economic and geographic relationships and requirements. These aspects are seen by participants to have been misunderstood and their significance underestimated in the reforms.

For government health departments, there is a significant mismatch between the processes and timelines expected of them in budget cycles and by central agencies and minister's offices on the one hand, and the requirements of community engagement and development on the other. There was also a perceived mistrust by government of Aboriginal and Torres Strait Islander capacity to manage major organisations.

Thus the challenge of working across community and government sectors is also significant, given the different priorities, meanings, timelines, goals and interests that the partners hold. This work is also cross-cultural. Both kinds of intercultural challenges can only be addressed if they are openly acknowledged, explored and made part of the work program.

Our third conclusion is that future reform programs need to be founded on a solid explicit basis for working across cultures that acknowledges and mitigates the impacts of systemic racism, and recognises the impacts of the different contexts in which community and government representatives work.

Methods of incorporating the requirements of the partners need to be found, tested and shaped in ways that work for all the partners—that is, this needs to be done in a business-like way, with respect and a sense of safety for all participants.

Implications for future development

We have addressed above the major barriers to effective implementation of the reforms arising from the *methods* used. Our second research question addressed the substance of the intended reforms—that is, what does the experience of the reforms tell us about the requirements for the future, about the funding and accountability relationship, and about the governance and stewardship arrangements that are needed for an effective PHC system for Aboriginal and Torres Strait Islander communities?

At the broadest level, the sources of the problems encountered in these case studies lie in a mismatch between the policy goals and their logic, on the one hand, and their implementation on the other—the decisions, processes, structures, timelines and resources, the maintenance of commitment beyond electoral cycles and the tenure of senior public servants. This is not surprising—it is perhaps the most common problem in the implementation of public policy. But this highlights the most fundamental question—is it the policy goals or the reform design and implementation that need to change?

This study accepted long-established national policy commitments to the development of the ACCHO sector, and did not set out to investigate the merits of this policy direction. However, it needs to be said that nothing emerging in this study suggests that the policy direction should be changed. The goal of improving access to essential health care for Aboriginal and Torres Strait Islander people and communities remains critical. The policy logic—to systematise the governance, funding and organisation of the ACCHO sector as the major provider of comprehensive PHC for Aboriginal communities (particularly but not only in regional, rural and remote areas) operating within the broader health system—has its foundations in many years of policy development and community aspirations and organising, and is supported by the available evidence about effectiveness.

The goal of setting up the system on a regional basis also has a strong rationale, particularly in the geographic realities of rural and remote areas but also for larger cities (coordination of care is generally achieved in regional networks). It is also consistent with the technical requirements for effective PHC, which needs a critical mass of health care workers and other resources without which essential PHC is necessarily compromised. However, more attention is needed to harmonise ACCHO and mainstream regional approaches.

Continuation, in some form, of the work described in this study is needed. What, then, are the implications of our results for the future development of the PHC system for Aboriginal communities?

Regionalisation and implications for governance and stewardship

There has been a tendency in Australian health policy debates for regionalisation to be seen as a simple and straightforward restructuring of existing health care arrangements. Those who are now engaged in implementing Local Health Networks and Primary Health Networks can attest to the complexity of 'making' a health care region.

The New South Wales public health care system has perhaps the most sustained experience, and in that jurisdiction serious attention has been given to the many requirements, including regional governance, regional funding allocation, equity in funding on a population basis without excessive transaction costs, fairness for provider agencies, the development of networks of care, and the role of the central health department in a regionalised system. The growing experience of regionalisation as part of mainstream health reform may be helpful to the development of a better understanding of what is involved, although there are important differences between the needs and imperatives of the acute system and PHC (both mainstream and ACCHO) in this regard.

The development of a regional system of PHC for Aboriginal communities has implications for the design of the health system as a whole. Importantly, the governance of regions at jurisdictional level, and the structures and methods by which ACCHOs and the mainstream system articulate with each other within each region and at jurisdiction level, requires the attention of all (Kelaher et al. 2014). The technical methods and governance structures for the allocation of pooled or bundled funding to regions and thence to providers is a major task, as is the collection and analysis of data to guide regional planning and assess results.

Stewardship, or the careful and responsible management of the system for Aboriginal and Torres Strait Islander health, is something that all organisations can contribute to but can only be achieved by governments. There was an apparent absence of formal consideration of the implications of the reforms for the stewardship roles of governments. The reforms in Cape York, Queensland and the Northern Territory clearly offered an opportunity and a need for better systematic integration of ACCHOs in the jurisdictions' public health systems. The Northern Territory regional clinical reference groups were a practical approach to working together at the level of clinicians in the region, but there was no evidence that anything like this sort of approach was developed at higher system levels. For example, implications of regionalisation for the governance of the Northern Territory PHC system as a whole were not considered or addressed.

The pattern of split roles in PHC in rural Queensland (with clinical services provided by Queensland Health and broader health programs provided by ACCHOs) is another significant system feature that is seen as problematic, and is at least challenged by the reform intentions.

Regionalisation has mixed implications for communities. For some, it brings an opportunity to participate in developing a major community controlled service on the basis of transfer of government services. For others, it brings a requirement to relinquish local control in favour of regional development. This was a significant challenge in all three case studies.

The requirement for full amalgamation of local ACCHOs into a single regional ACCHO as a precondition of transfer is a significant barrier to the staged development of service integration and fails to allow for credible alternatives such as that developed in East Arnhem. Flexibility would enable suitable regional/community alternatives to be accommodated in central/government plans.

It appears that regionalisation was seen in government as a way to honour the policy intention to support the development of the ACCHO sector while also addressing some concerns about the governance of ACCHOs. That is, there would be fewer boards with directors drawn from larger populations attracting more scrutiny by communities. However, although governance concerns clearly influenced government agencies, these concerns largely appear not to have been aired or negotiated in relevant forums—but remain a significant barrier to reform and need to be addressed. Concurrently with this study, the sector has acknowledged the need to strengthen governance and has taken action (NACCHO n.d.b) with Australian Government support. The question of systemic racism in shaping the perception of fragile governance also needs to be addressed.

Our fourth conclusion is that future reforms in the PHC system for Aboriginal communities should continue to use a regional approach under Aboriginal community control, and should develop coherent regional systems for funding and governance, and for coordinating PHC services among all providers across the region.

Success in doing this will depend partly on genuine engagement by government with communities and the ACCHO sector, and a flexible approach to pathways towards regional governance.

Funding levels, contracting and accountability

Both reform programs ruled out addressing the question of the overall adequacy of funding levels for PHC for Aboriginal and Torres Strait Islander people, a constraint that was ameliorated in the Northern Territory in the short term by the availability of additional time-limited funding (EHSDI and its successors). However, it is notable that the transfers that occurred as part of the Coordinated Care Trials included significant additional funding that enabled an increase in services. In at least some of the participating organisations, improved access and expanded services in the regional communities were observed, as well as reductions in avoidable hospitalisations (i.e. those that are necessary because of lack of access to PHC) (Commonwealth of Australia 2007; McDonald 2003:6). These outcomes, and the relative success of larger, better funded services elsewhere, carry the strong implication that an adequate funding base is required and should be the subject of policy goals and targets that can be expected to result in improved health status indicators. We note that not all trial sites were successful (as was also the case in the mainstream health system).

Both governments and the ACCHO sector support the goal of equitable allocation of funding on a population basis. The allocation of funding for a regional population (weighted for risk and cost factors) is not straightforward, but is a tested method for achieving more equitable access to care. In the case of under-served (often rural and remote) regions, additional funding, not simply reallocation, is required to achieve levels capable of supporting adequate access to PHC. Regional allocations then require distribution to service providers, and this is also a complex task that requires a mandated structure and process that is transparent and fair to providers, communities and citizens.

Our fifth conclusion is that increased funding is needed to support adequate access to culturally safe PHC across and within regions, and that levels should be based on the size of the regional populations (weighted for risk and cost factors) and distributed to providers within regions with fairness and transparency.

The pooling or bundling of funds was an explicit intention of the reforms in the Northern Territory (NTAHF 2009a:27) and in Cape York (CYRHF 2006a:9). However, we found no evidence of substantial work within government on the methods for achieving this change, which would involve both high-level approvals and significant technical workup. Both Apunipima and Miwatj addressed these questions in their planning and submissions (EASC 2012; ACYHC 2007) as outstanding requirements, but the work was not progressed in joint forums or negotiations.

We found a similar pattern of inactivity in relation to the systematic sharing of needed base-line information, such as the funding of clinics to be transferred, their service data and the extent of coverage of the area population. In the Northern Territory, modelling of the funding for infrastructure and services that would be required for provision of the identified core PHC services was not undertaken. In Cape York the funding implications (for equitable health care provision) were identified (Eagar & Gordon 2008) but not addressed.

For jurisdictional governments there is also a potential financial conflict of interest in the transfer of services from government to ACCHO ownership. They will experience marginal reductions in their operating costs, but ACCHOs will require funding at (or close to) the average operating costs for the equivalent services. The transfer or redeployment of staff is also likely to involve a cash cost.

A lack of attention to the question of reform in the accountability regime (i.e. the number and nature of reports required etc.) is notable. The East Arnhem and Apunipima case studies both show an increase in funding from the 2009–10 financial year, and a rapid rise in reporting requirements, particularly from the Australian Government. Compliance with reporting requirements was costly, and both Apunipima and Miwatj had the added burden of cost and time in dealing with external consultants and the associated meeting and reporting requirements, as well as the costs of travel to capital cities for meetings with funders.

Our sixth conclusion is that enduring reform in the funding and accountability relationship between governments and the ACCHO sector should be based on long-term contracts for bundled or pooled funds to support comprehensive PHC, and a modified accountability regime more suitable to the functioning of PHC, and to the shared responsibilities of providers and governments.

What needs to be done? The essential elements of reform

Our six conclusions highlight the implications of this study for the future implementation of system reforms. The analysis also suggests that future work to develop a regional system of community controlled PHC for Aboriginal and Torres Strait Islander communities needs to address six essential elements of substantive change (summarised in Table 6), almost all of which were explicitly or implicitly included in the reforms we studied.

Table 6: Elements of substantive change

Element	Explanation	Status
REGIONAL COMMUNITY CONTROL Establish regional PHC system, based on ACCHO sector and community governance	The establishment of a regional system of PHC would enable progress towards reliable access to the range of essential PHC services including referrals to specialised care across the country and ensure cultural safety. Models of regionalisation must allow for adaptation by regions and support coordination of care among all relevant regional providers. Strong community governance is essential.	Included
ENGAGEMENT Operating as part of the larger health system, engaged with other providers and with funders	Clarity of roles and coordination between mainstream and ACCHO providers would improve coordination of care for patients, and access to specialised care. Engagement between funding agencies and ACCHOs in addressing issues of mutual concern is needed to improve working relationships, address systemic racism and enhance reciprocal accountability.	Included
POOLED FUNDING Funded through long-term pooled or bundled funding contracts	Reform in contracting (towards fewer longer-term contracts) is needed to support comprehensive PHC, to enable equity in funding, to enhance efficiency for both funders and providers, and to provide a more suitable basis for meaningful accountability.	Included, but not developed
GOVERNANCE AND STEWARDSHIP Community governance at regional level; stewardship by government	Attention to governance in the ACCHO sector focused on the challenges of regionalising governance; governments take stewardship responsibility for long-term development of a robust PHC system; all parties need to take a business-like approach to identifying and resolving their concerns in these areas.	Included implicitly; some aspects undeveloped
ACCOUNTABILITY Accountable to communities and mutually accountable with funders	ACCHOs need to be accountable to communities for effective care, access and responsiveness, and reciprocally accountable with funders to meet contractual obligations to each other. Governments need to be accountable for equity in funding and access to care, and the mainstream health system for ensuring equitable access to culturally competent care.	Included implicitly, but not addressed
FUNDING LEVEL Funded to achieve equitable coverage for Aboriginal and Torres Strait Islander people, according to need	Increased funding for regional Aboriginal and Torres Strait Islander PHC is needed to close recognised equity gaps, according to need and rural/remote costs. In absolute terms, the funding gap is not large, but some reallocation to regional PHC, and increases over time, are required.	Explicitly excluded

The experiences of the Northern Territory and Cape York have revealed the full scope and requirements for system reform 'at scale'. The reforms set out to establish regional systems of PHC for Aboriginal and Torres Strait Islander communities under various forms of community governance (the result of local and regional decisions and capacities, within policy guidelines), operating as part of/in partnership with the public health system and funded through long-term pooled funding contracts. In some cases, this situation almost already exists (for example, in Katherine West and Sunrise) and in others, including Miwatj and Apunipima, most of the essential elements on which to build successful reform are in place.

Although there was attention to governance in each case study, and each implicitly required more attention to stewardship by governments, these matters remained problematic. The need for working across cultures and accommodating different priorities, goals and values while enacting mutual respect is an important underlying contributor to governance and stewardship challenges. What is needed is a business-like approach to identifying, discussing and resolving or accommodating concerns and conflicts.

Both reforms also implicitly entailed some changes in the model of accountability between the ACCHOs and their government funders and between ACCHOs and the communities they serve, even though this element was less well articulated. Although additional funding (i.e. to fund equitable access to PHC for Aboriginal and Torres Strait Islander communities) was explicitly excluded, this need has been identified in several economic analyses (e.g. Deeble et al. 1998; Eagar & Gordon 2008). The funding requirement is substantial but achievable. Indeed, the funding made available for 'Closing the Gap' would cover much of this gap if it was allocated accordingly.

Implementing the six essential elements of substantive change would require commitment and accommodation from governments, Aboriginal and Torres Strait Islander communities and the ACCHO sector. In order to commit to increased investment in community-governed PHC:

- governments require assurance of performance in delivery of high-quality care
- governments need to accept that the current methods of funding and contracting are not suitable to ensure performance in this context, and need to work with the sector to develop longer term and less complex and fragmented approaches.

In addition:

- the ACCHO sector requires long-term assurance of funding and acceptance of its role in the health system
- the sector and government need to accept the implications of a negotiated understanding of regionalisation and reformed engagement with each other
- all parties need to work together in an enduring structure for partnership and to develop a workable approach to reciprocal accountability.

These are not simple matters, and long-term commitment is required, along with strong leadership. But they are not mysterious or impossible.

We conclude that the goal of equitable access to PHC through a regionalised network of ACCHOs working with the mainstream health system is achievable, and that action to achieve it should commence/recommence as soon as possible, with a firm commitment by all parties to see the reform through to completion.

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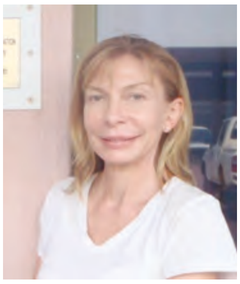
Dr Angelita Martini is a Senior Lecturer in the Centre for Health Service Research in the School of Population Health at the University of Western Australia. Her current research is focused on the health needs of vulnerable Western Australians, and models of care in cancer services. She has extensive experience in research coordination, tertiary education and curriculum development roles in medicine, nursing, Aboriginal studies and public health. Angelita has held management positions in the private and public sectors, both nationally and internationally, in health, education and correctional services.

Ms Cath Brown is a Noonuccal woman from Minjerribah [North Stradbroke Island] off Brisbane. In 2007 she took up a Research Officer position at James Cook University, within the School of Indigenous Australian Studies Empowerment Research Program, to become involved in the delivery of the Family Wellbeing Program. Cath facilitated the empowerment program with Aboriginal and Torres Strait Islander individuals, groups and organisations predominantly in North Queensland. She has completed a Graduate Diploma in Indigenous Health Promotion, graduated Master of Public Health [Health Promotion] and has begun a research Masters looking at Aboriginal health advocacy.

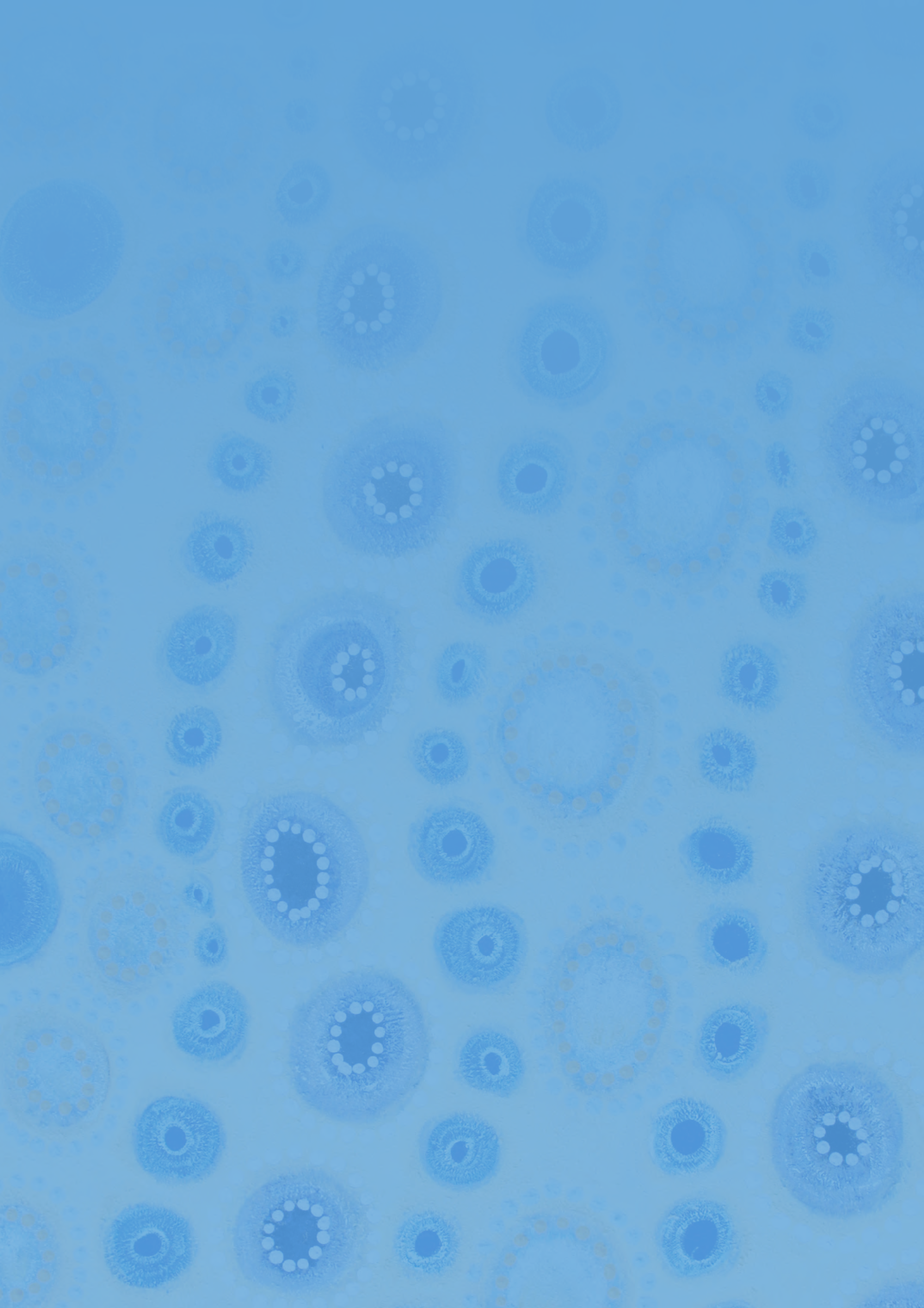
Mr Edward Tilton has more than 20 years of experience in the Aboriginal and Torres Strait Islander health field, with particular expertise in primary health care planning, community development, policy development and consultative processes. He has worked for the Aboriginal community controlled health sector at a local, jurisdictional and national level, as well as for the Northern Territory Government. He currently provides consultancy services to a wide range of Aboriginal community controlled services, government departments, and research agencies across the country, specialising in the complex and culturally diverse environments of northern and central Australia.

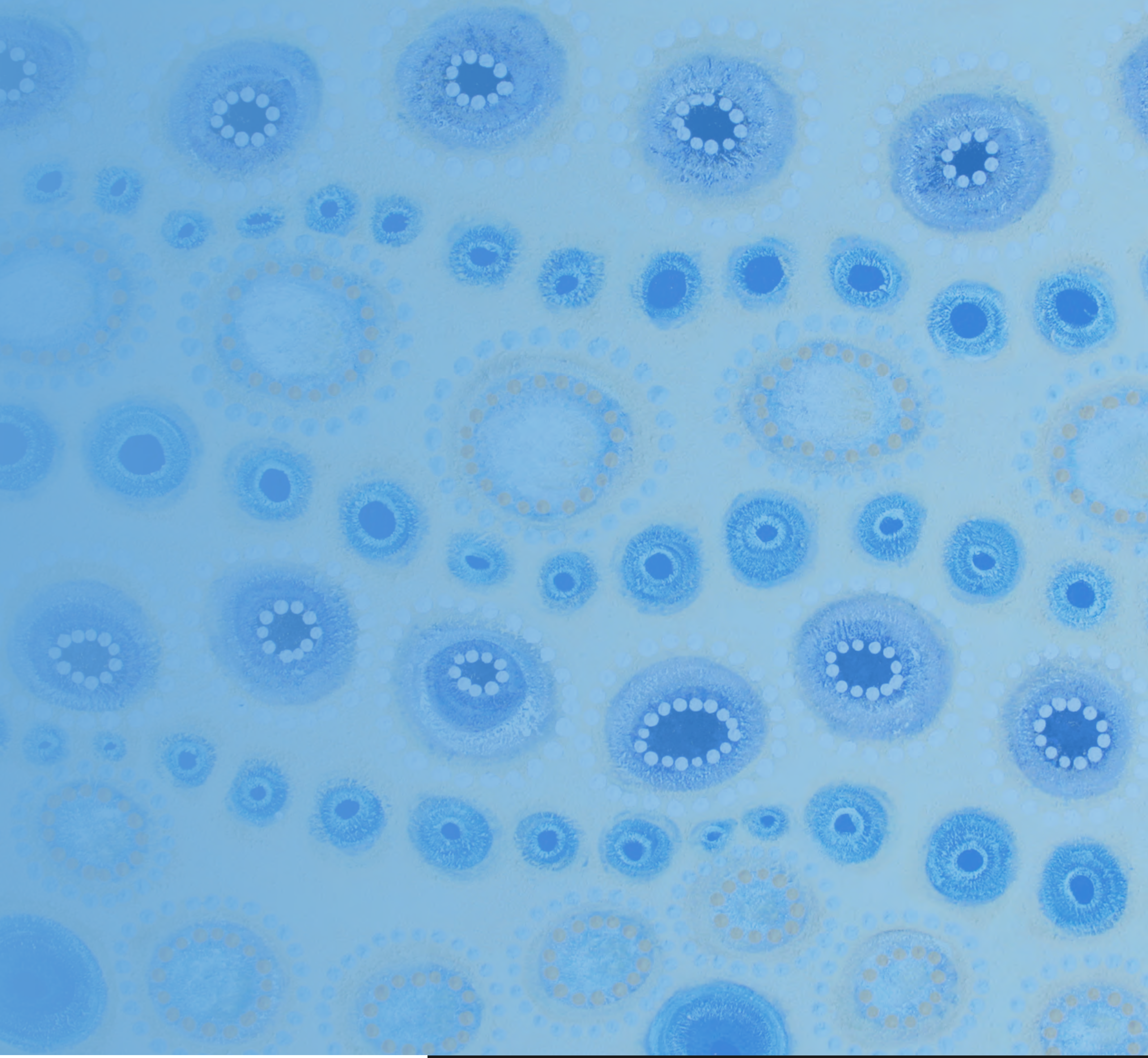
Dr Jeannie Devitt is an anthropologist with more than 30 years of experience working with Aboriginal people in the Northern Territory particularly in remote areas. Jeannie has worked primarily for Aboriginal community controlled organisations including the Northern and Central Land Councils, Indigenous Health Services, Indigenous Community Councils and Legal Services as an employee and as a consultant. She was a Senior Research Fellow with the Cooperative Research Centre for Aboriginal Health from the late 1990s, and has undertaken nationally funded Aboriginal health research projects, as well as research commissioned by the Australian Government in relation to kidney disease within Indigenous communities. She is currently employed by the Menzies School of Health Research in Darwin.



Ms Paula Myott is a public health professional with 20 years of experience working in the Aboriginal health and international development fields, and expertise in program design and management. She was employed by Miwatj Health as Director of Regional Health Reform during this project. Paula has worked in government and in non-government organisations (NGOs) and has executive level management experience. Her roles have included establishing frameworks for stakeholder engagement and management in complex contexts and leading organisational change processes. Paula has worked with all levels of government as a NGO stakeholder on the research:policy:implementation cycle, and is currently working on a PhD with Flinders University focused on accountability between governments and ACCHOs.

Dr Brita Pekarsky has worked as a health economist since 1991 in the areas of pharmaceutical regulation and primary health care. Her involvement with Aboriginal and Torres Strait Islander health started in 1997 when she worked on the evaluation of the Aboriginal Coordinated Care Trials. Brita's research focus is on how we can improve the health of the community by improving the way in which primary care services in the Aboriginal health sector are financed. She is a private consultant economist and also has an appointment at Wardliparingga, the Aboriginal Health Unit at the South Australian Health and Medical Research Institute.





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