Aboriginal Medical Services Alliance Northern Territory
Framework for development of
Primary Health Care Organisations in Australia
Response to Australian General Practice Network

The Aboriginal Medical Services Alliance of the Northern Territory (AMSANT) does not believe that the report, *Framework for Development of Primary Health Care Organisations in Australia,* is an adequate document for the planning of Primary Health Care Organisations in the Northern Territory.

AMANT supports in principle the development of Primary Health Care Organisations (PHCOs) and believes that implemented appropriately the NHHN reforms provide a framework to continue the improvements that have been developed under the *Primary Health Care Access Program* and continued with *Expanding Health Services Delivery Initiative* in primary health care service delivery to Aboriginal people in the NT.

AMSANT is very disappointed at the superficial manner in which this boundary modelling project has dealt with the complex and unique issues of the Primary Health Care System in the NT. In particular there is little acknowledgement or knowledge of the advanced process of primary health care reform in the Aboriginal primary health care sector that has been underway for some years through partnership between AMSANT, the NT Department of Health and Families (NT DHF) and the Office for Aboriginal and Torres Strait Islander Health (OATSIH). There is also scant recognition of the differences in models of service delivery between this sector and the mainstream primary health care sector in the NT.

AMSANT believes that a one size fits all approach to implementing Primary Health Care Organisations, despite major differences in local context, risks losing the opportunity to use the NHHN reforms to build on the effective and advanced work already underway in Aboriginal health in the Northern Territory. The national reforms must be implemented in a more thoughtful and considered way if they are to maximally contribute to closing the gap in Aboriginal life expectancy. The unique circumstances of the Northern Territory call for local solutions and we believe that local solutions consistent with the framework of the NHHN reforms are already well developed, but seemingly disregarded in this report. This is in spite of the facts that the health system reforms that have been implemented since 2000 have made a significant contribution to the improvements that are now occurring in Aboriginal health in the NT. For example, the gap is now closing for the life expectancy of Aboriginal women.[1]

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[1] Thomas, D; Condon, J; Anderson, Ian; Li, Shu Q; Halpin, S; Cunningham, J and Guthridge, S L. Long-term trends in Indigenous deaths from chronic diseases in the Northern Territory: a foot on the brake, a foot on the accelerator, *MJA* 2006; 185 (3): 145-149. Wilson, T., Condon, J., Barnes, T Northern Territory Indigenous Life Expectancy Improvements, 1967-2004, *ANZJPH* 2007, Vol 31, 184-8

The two major issues that are addressed in the report, boundaries and model for a PHCO are discussed in summary below:

Boundaries for Primary Health Care Organisation(s) in the Northern Territory.

> We agree that there needs to be serious consideration given to thinking beyond state and territory borders in developing a model for PHCO(s) in the NT. Factors that need to be considered include traditional cultural and social relationships, geographic factors, relationships of both providers and the community with secondary care services including access to hospitals and renal dialysis services, and the ability to institute effective support services for the primary health care sector.
>
> The boundaries in relation to the Northern Territory discussed in the AGPN project have some merit but need to be explored in far greater depth with both providers and communities.
>
> In short, there needs to be constructive consultation.

The Model of Primary Health Care Organisation(s) for the Northern Territory

> AMSANT strongly disagrees that a single PHCO, encompassing both the Aboriginal and mainstream primary health care sectors, should be implemented in the Northern Territory. A detailed discussion of this issue is included as Appendix 1.
>
> This AMSANT position is based on many years work on policy development; on the primary health care systems reform work we have been engaged in it the past few years; and on extensive discussion with our member services and their representatives on the AMSANT board.
>
> The AGPN paper pays scant attention to or recognition of the achievements in Aboriginal Primary health Care.

The AGPN modelling project is remarkable for its complete failure to consult with the Aboriginal Health Care sector in the NT, in particular with the peak body AMSANT, despite their acknowledgment of the need to do so. It appears to have as its main purpose to first prosecute a mainstream Divisions of General Practice agenda uniformly throughout Australia, independent of context, and then consult later.

The implementation of the NHHN reforms for Aboriginal Health Care in the NT needs to support and build on the reform work already in progress and be informed by detailed consideration of the directions of this work and discussion with key stakeholders.

The development of the PHCO(s) model should be informed particularly by discussion with the NT Aboriginal Health Forum (NTAHF).

The implementation of the NHHN reforms in relation to Aboriginal primary health care in the NT should take into primary consideration the NT Aboriginal Primary Health Care Reform Plan currently being developed and implemented, funded by the Australian Government through the *Expanded Health Services Delivery Initiative (EHSDI).* This should include an analysis of the recommendations made in the final report of the Child Health Check and EHSDI evaluators (Allen and Clarke) which is due for release shortly.

More detailed discussion is contained in the appendices listed below:

Appendix 1. The case of a separate Aboriginal PHCO for the Northern Territory

Appendix 2. An overview of existing NT Aboriginal Primary Health Care Reform

Appendix 3. Specific issues with methodology and assumptions of the AGPN Boundary Modelling project report.

AMSANT looks forward to further discussion and involvement in the key decisions in relation to implementation of this important initiative for Primary Health Care in the NT.

Appendix 1:

National Health and Hospital Reform: The Case for a Northern Territory Aboriginal Primary Health Care Organisation

Summary

Under the agreed National Health and Hospitals reforms the Commonwealth will take sole responsibility for funding primary health care and will develop primary health care through organisations known as Primary Health Care Organisations (PHCOs). These are proposed to be mapped to the same areas covered by the hospital networks. This is the biggest change to the Australian health care system since the introduction of Medicare.

AMSANT is concerned that the approach to establishing Primary Health Care Organisations ("Medical Locals") discussed to date offers a poor fit for Aboriginal primary health care in the NT. We believe strongly that a different approach is needed for Aboriginal primary health care in the NT if we are to maintain and build on the gains made in NT Aboriginal Primary Health Care Reform over the last few years and discussed in this paper. We propose that the establishment of a separate Aboriginal Primary Health Care Organisation is needed to maximise the health outcomes for Aboriginal and remote clients while allowing a mainstream PHCO to concentrate on the very different challenges faced in reforming primary health care delivery currently centred on mainstream models of General Practice.

The NT DHF has indicated that they also support the development of a separate NT APHCO as does the NT Labour Government. The NT Chief Minister Paul Henderson and the NT Minister for Health Kon Vatskalis both strongly support this model.

We see the National Health and Hospital Network reforms as offering a unique opportunity to build on many years of thinking and practical application around Aboriginal primary health care reform in the NT . The opportunity is there to develop an effective and sustainable system tightly focussed on Closing the Gap in health status between Aboriginal and non Aboriginal Australians, building on and informed by the evidence of recent effective structural reform. It is important that this opportunity is not lost through attempting to implement a "one size fits all" approach that fails to recognise the special strengths and needs of the Aboriginal Primary Health Care System in the NT.

Summary of arguments for a separate Aboriginal Primary Health Care Organisation.

AMSANT is requesting participation in discussion about implementation of the National Health and Hospitals (NHH) reforms in the NT. Specifically AMSANT is requesting that serious consideration be given to the formation of a NT Aboriginal Primary Health Care Organisation (APHCO).

As discussed above, The NHHN reforms have the potential to support the development of a well planned and integrated Aboriginal Primary Health Care system in the NT and are a logical progression of the primary health care system reform work already well developed. The reform of the NT Aboriginal Primary Health Care System, planning for which has been progressed in partnership by AMSANT, OATSIH and NT DHF, commencing under the *Primary Health Care Access Program* (PHCAP) and rapidly progressed in the last two years under the *Expanding Health Services Delivery Initiative* (EHSDI), puts the NT a good two years ahead of other jurisdictions in developing a cohesive and effective primary health care system for the Aboriginal population.

We believe that in order to take full advantage of the unique system reform work already underway there needs to be established a specific Aboriginal Primary Health Care Organisation in the NT.

It is important to recognise the special needs of establishing full community engagement in a cross cultural setting, the vast differences in the service delivery model, the current financial arrangements and the reforms already in progress which are supporting improvements in service delivery to Aboriginal people across the NT.

Why the need for a separate NT Aboriginal Primary Health Care Organisation[APHCO]?

1. **Engagement with consumers and communities**

The National Health and Hospitals Reform proposals have at their centre increasing links between health professionals, service providers and local communities.

Aboriginal Community Controlled Health Services (ACCHSs) across Australia have pioneered the development of health services that are strongly engaged with consumers and their communities.

The learnings of three decades in the Aboriginal Community Controlled Primary Health Care sector heavily influenced the original NHHR report.

NT ACCHSs are governed by the communities they serve.

Under this governance model, ACCHSs have pioneered the development of multi-disciplinary models of care with population health services strongly integrated with individual clinical care. The development of ACCHSs in the NT, including the more recent development of large remote area ACCHSs such as Katherine West Health Board and Sunrise Health Service, has successfully demonstrated models of governance and service delivery which have been able to integrate professional expertise with a very high level of community engagement and a strong Aboriginal voice in governance and management. There is now clear evidence that such organisations are significantly increasing access by Aboriginal people to a broad range of comprehensive primary health care services, as well as successfully advocating for their communities around the broader determinants of health.

The NT is unique amongst the states and territories in that while Aboriginal people remain a disempowered minority, they are a sizable minority of approximately 30 per cent of the population. This minority continues to account for a large majority of hospital admissions and morbidity. Mortality figures demonstrate that the health of Aboriginal people in the NT lags behind Aboriginal people in the rest of the country. A large proportion of the Aboriginal population lives in rural and very remote areas where mainstream models of delivering health services are not effective, and where the cost of achieving equity in access to health services is very high.

A major driver of the development of this model in ACCHSs has been the special needs inherent in empowering severely disadvantaged consumers and their communities to engage with health services dominated by professionals and “experts” from a different and dominant culture. This has resulted in the development of the models of care aspired to in the NHHN reforms, but to date poorly developed in mainstream primary care in Australia and actively and effectively resisted by professional interests.

Primary Health Care Organisations or “Medical Locals” based largely on an expanded role for former Divisions of General Practice will be an effective tool for improving mainstream primary health care based around the General Practice Model, including in the NT. We do not believe however that a single such model will deliver the benefits that the existing NT Aboriginal Primary Health Care Reform process aspires to in a sector based on Aboriginal Community Controlled Health Services. We believe that the important dynamics of community engagement and differences in service delivery in our sector are specialised to a degree that a single model is unlikely to be able to adequately support sustained and optimal reform in both mainstream and Aboriginal primary care.

In particular it would not be possible in our view to maintain the current successful dynamic of cross cultural engagement and empowerment with Aboriginal consumers within a PHCO whose business was largely the provision of primary health care health services to the non Aboriginal majority in major urban areas of the NT. In such an organisation non-Aboriginal professionals and consumers will, within their own culture context, move with ease to be the dominant voice in the governance of service provision; eroding both cultural safety and the provision of the special needs of Aboriginal people. The experience of Divisions of General Practice in the NT supports this view.

Historically the interests of organised medicine have been hostile to the broader development of a model of health care in which salaried health professionals work within an organisational framework where they are answerable to boards elected by the community. This opposition by the medical profession in particular led to the demise of the former Commonwealth Community Health Program which funded mainstream community controlled health services. There is still a fundamental divide between medical professional interests focussed on building a GP-owned primary health care system using a small business model, even if it includes other health professionals, and the Primary Health Care movement that is focussed on consumer and community engagement and control. The majority of the medical profession continue to support the former and are supported by private allied health interests. This is an important dynamic that the development of mainstream Medicare Locals will need to overcome if they are to deliver the benefits envisaged. It is however a set of issues that have been largely overcome in the Aboriginal Community Controlled sector which has a quite different set of issues to deal with.

This key policy tension has made it difficult for AMSANT in the past to work effectively with private GPs through the Divisions of General Practice. If there is a single NT PHCO, this tension will be played out to the probable detriment of Aboriginal Community Controlled Health Services and as a distraction from the real issues in Aboriginal health advancement.

We strongly believe therefore that a specific Primary Health Care Organisation for service provision to Aboriginal people in the NT is essential to most effectively support and further the gains made to date in the engagement of Aboriginal people in the governance and provision of health services. An Aboriginal Primary Health Care Organisation in the NT would recognise the existing local advances in PHC system reform and would offer the highest probability of success in ensuring the gains in Aboriginal engagement with the health care system would become NT wide. Conversely we believe that the development of a single PHCO would carry a significant risk of eroding many of the gains made thus far.

2. Current Aboriginal Primary Health Care Reform in the NT: working with evidence

Appendix 2 below details progress in the reform of the NT Aboriginal Primary Health Care system. The progress to date represents a unique partnership between the Commonwealth and NT governments and the Aboriginal Community Controlled sector. Since 2007 there has been a substantial investment by the Australian Government in this reform process which has accelerated the system reform work in parallel with a large expansion in primary health care service provision. The development of new community controlled health organisations has been modelled on the best evidence available for “what works” and is supported by system governance arrangements in which the Aboriginal Community Controlled sector participates as a full partner.

In the past, the development of regional ACCHSs has occurred in three cases through the Coordinated Care Trials (CCT) program. In a sense this was an experimental process. The current NT PHC reforms seek to build into the NT PHC system the key lessons learned through this process to facilitate the development of new health services based on the now strong evidence for approaches that will deliver health gains.

The NT Primary Health Care reform process has been overseen from its inception by the NTAHF. Prior to 2008 the *Primary Health Care Standing Committee* of NTAHF oversaw the development of the primary health care system under PHCAP. In 2008 the Primary Heath Reform Group (PHRG) was established under NTAHF to plan and develop the EHSDI funded initiatives and undertake system wide primary health care planning and reform.

As described in the attached document this work is now well developed and we believe has established the framework for the best integrated system for providing comprehensive primary health care in Australia.

It could be fairly argued that the Northern Territory leads the country in moving to provide comprehensive primary health care.

The current governance of the system reform process by the NTAHF and various working groups including PHRG is best seen a transitional arrangement. The three partners have from early in the process discussed the development of a single body, jointly governed, to oversee Aboriginal primary health care in the NT. Such a body has been envisaged to eventually supersede the current arrangement and provide the necessary stability and sustainability to continue and consolidate the reform process and deliver outcomes.

The establishment of an NT Aboriginal Primary Health Care Organisation would provide a very timely mechanism to capitalise on the work so far in a model entirely consistent with the NHH reform Australia wide, but recognising the unique situations in the NT.

On the other hand we believe that the formation of a single PHCO in the NT would carry a high risk of losing or stalling the progress of primary health care system reform already underway, and especially the reforms progressed so successfully under EHSDI funding.

3. Financing Aboriginal health in the NT

The NT has also led the way nationally on the critical issue of primary health care financing reform. The *Primary Health Care Access Program* (PHCAP) was announced in 1999 and one of the key elements of this new program was that new monies from the Australian government needed to be combined with existing expenditure from state and territory governments in order to properly fund existing and new Aboriginal community controlled health services. This was a key response to the 1995 evaluation of the National Aboriginal Health Strategy (Leeder et al 1995) which found that one of the main reasons that the strategy was never implemented was that there was never enough funding made available. This was partly due to the fact that states and territories never matched the Commonwealth investment dollar for dollar as they had agreed to do. Thus, the additional funding that could have been achieved for Aboriginal community controlled health service development through at least nominal funds pooling was never achieved. This unfortunately remains largely the case today.

A single NT APHCO receiving all of Australian Government and NT government Aboriginal PHC funds would finally provide a definitive funding solution to the cost shifting that has been a very long standing barrier to Aboriginal health advancement. Again the NT is in a unique position to achieve this.

As stated above, we're ahead of the game, and the gains we have made should not be abandoned.

In order to implement the PHCAP the NT undertook detailed costing studies of NT government primary health care outlays. Since 2001 the NTAHF has had good information on the total primary health care funds pool at the level of health planning areas with defined populations. Since this time, there has effectively been a nominal funds pool in the NT (see attached breakdo PHC funds in the NT

by health zone). No other jurisdiction in Australia has done this wown ofrk and has this information at hand.

Unfortunately this approach of nominal funds pooling has only proceeded to actual funds pooling supporting an Aboriginal Community Controlled Health Service a few cases, namely; Katherine West Health Board, Sunrise Health Service and the Utju Health Service at Areyonga. The first two of these were developed through the Coordinated Care Trials program and the third through PHCAP. The lack of actual funds pooling elsewhere has seen the development of two providers delivering health services within single health zones, a situation that has been fraught with difficulties and which all NTAHF partners agree is not ideal.

It has also proved very difficult to agree on an effective mechanism to achieve funds pooling to ensure more funds are delivered on the ground in Aboriginal communities. The NT government has identified a very large amount of "regional" primary health care expenditure, of the order of more than $50 million recurrent, which has never been made available to fund community based primary health care, although this was the original commitment as part of the PHCAP. Separation of funding has continued to mean separate service systems either at the community level with two providers, or at the regional level with a large number of very inefficient visiting services from regional centres which have been poorly integrated with community-based services.

In establishing an NT APHCO there is finally the opportunity to create a single funds pool, governed by a single body that would then have the responsibility of the building a single Aboriginal primary health care system. This would deliver a very large funding boost for community based Aboriginal primary health care expenditure. The current nominal primary health care funds pool in the NT is approximately $125 million which gives an average per capita primary health care expenditure for Aboriginal people of just over $2000 per head. These funds are distributed with a range of weightings which means that in the most areas funding is about $2700 per person, in Alice about $1900 per person and in Darwin less than $1000 per person.

These figures however exclude NTG "Regional" primary health care expenditure. The "regional" primary health care expenditure from the NT government amounts to another $75 million. The dual providers on some sites and the lack of integration of regional visiting services with on the ground primary health care creates duplication of effort and gross inefficiencies.

If the regional primary health care funds were included in the funds pool throughout the NT, as they largely were in the development of Katherine West Health Board and Sunrise Health Service, this would add approximately $1000 per capita. The total funds pool would be in the order of $200 million. This funding base could be further expanded by including in regional comprehensive primary health care services a range of vertical programs, including mental health and alcohol and other drugs, that we believe would deliver better outcomes by being integrated as part of core primary health care. This level of funding could ensure that every Aboriginal Health Service Delivery Area [HSDA] in the NT could provide the bulk of the agreed core primary health care services, <u>including currently poorly developed key areas such as early childhood services, social and emotional well being, critical community based counselling, therapeutic and rehabilitation services for people with depression, anxiety states, violence and addiction</u>.

These long standing primary health care financing problems could be rectified through the creation of an NT APHCO as a single funds holder, pooling all of the current primary health care funds in the NT including the regional PHC expenditure. This would provide a significant funding boost to Aboriginal community controlled health services throughout the NT. It would lead to a more efficient and effective health system with less duplication of effort and greater transparency and accountability. It would end the "blame game" and the long standing problem of cost shifting in PHC expenditure. This is in accordance with one of the main findings of the HHRC report.

Governance of an NT APHCO

The governance of NT Aboriginal Primary Health Care system is currently fragmented between OATSIH as a funder, NT DHF as both a funder and provider, the boards of ACCHSs with various combinations of legal agreements with both levels of government and NTAHF in which AMSANT also participates as the peak body. AMSANT welcomes the rationalisation of governance arrangements that will occur as the Australian Government becomes the sole funder of primary care.

In recent years the role of NTAHF has become more central as the lead body in an agreed process system wide reform. PHRG as mentioned above is the major working group of NTAHF in progressing service expansion and reform. NTAHF and PHRG commenced in late 2009 the formulation of a 10 year NT Aboriginal Health System reform plan.

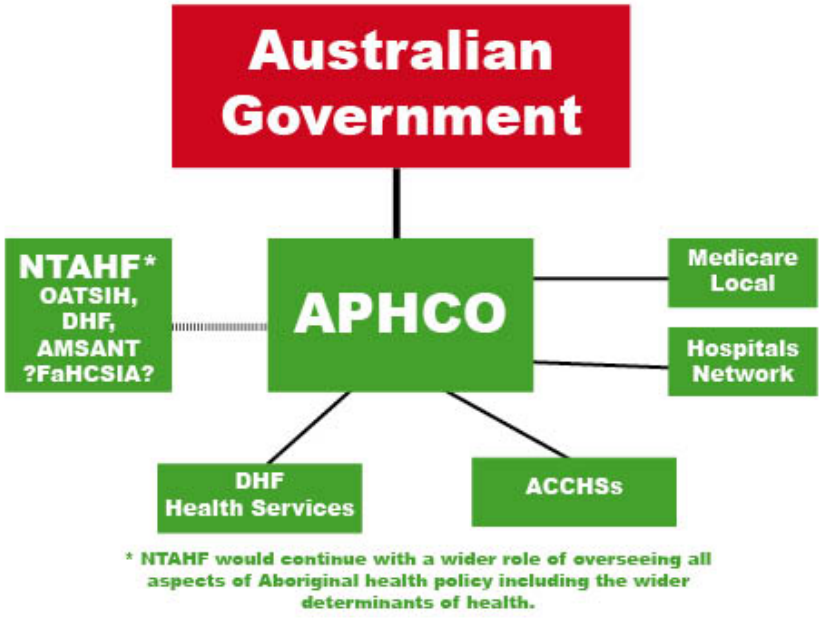
AMSANT believes that an NT APHCO developed as part of the NHHN should take over responsibility for reforming the NT Aboriginal primary health care system, continuing the current work of NTAHF/PHRG. Under an APHCO this would be a logical and smooth transition.

AMSANT considered three potential models for Governance of this APHCO:

1. NTAHF becomes the board of the APHCO
2. NTAHF + additional nominees constitute the Board of the APHCO, with a majority of Aboriginal members
3. The APHCO has a board independent of NTAHF, but with a majority of Aboriginal members.

At Walungurru on 6 June 2010 the AMSANT Board discussed the possible governance models. The third model above is the preferred AMSANT model with a separate incorporated APHCO board. NTAHF would continue with a wider role of overseeing all aspects of Aboriginal health policy including the wider determinants of health.

AMSANT supports this APHCO becoming the funds holder for all Aboriginal Primary Health Care in the NT including current "regional services" provided by DHF. The scope of the funding should be in keeping with the NTAHF definition of Core Primary Health Care Services.



Appendix 2:

NT Primary Health Care System Reform – Overview

Regionalisation:

Based on the success of the regional Community Controlled Aboriginal Health services, the Aboriginal primary health care system has been restructured into regions referred to as Health Service Delivery Areas (HSDAs). These areas, with higher populations than the previous PHCAP "zones", are designed to be large enough to have the capacity to deliver high quality expert services on a sustainable basis, while remaining at a size where close community engagement and community control can lead and enhance service delivery. It is envisaged that in each HSDA there will eventually be a single Aboriginal Community Controlled Health Service. The finalisation of the boundaries of HSDAs is near completion after a lengthy process of community consultation. There will be approximately fourteen HSDAs across the NT.

Following on from the launch of *Pathways to Community Control* in 2009, a series of tools is being developed to assist communities to plan and develop expanded health services under a community controlled model. These provide a structured approach that documents key milestones and processes for assessing competence and capability. Detailed planning led by the AMSANT Reform and Development Unit, OATSIH and DHF is now underway in several HSDAs, overseen by regional steering committees or "Interim Health Boards".

Funding allocation model for Aboriginal Primary Health Care Services:

A resource allocation formula has been jointly developed by the three partners to enable the allocation of new EHSDI funding across the NT. This treats all inputs from the Commonwealth and Territory Governments except Medicare in every region as a single "pool" and new resources are allocated based on a calculated bench-mark for each HSDA that factors in the varying costs of services delivery across the NT. For the first time this allocation is based on a single agreed formula across the NT that is independent of whether the service provider is the NT Government or a Community Controlled Organisation. It has allowed new funding to be preferentially allocated to the most resource poor areas of the remote NT, and has continued the "mixed mode" approach where services continue to be able to generate additional funding or support from other sources such as MBS, PBS and Practice Incentive Payments.

It is important that through the process of revising the definition of *core primary health care services*, this approach is extended to integrate into this model the funding of areas such as mental health, AOD and other key components of a comprehensive approach to primary health care, which until now have existed largely as separate non integrated vertical programs. It is also important that a "mixed mode" funding approach is maintained, at least until a fully costed and funded per capita approach to Comprehensive Primary Health Care is achieved.

An advantage of the adjusted per capita funding model, as opposed to program based or disease specific funding, is that it facilitates the development of locally responsive comprehensive primary health care across the lifespan.

As this approach treats funding from both levels of government as a virtual "funds pool" it is therefore a logical progression to a single Commonwealth stream of funding as proposed in the reforms. For established health services such as Katherine West and Sunrise who already operate under a funds pooling arrangement this considerably simplifies funding and legal agreements. For areas where services continue to be provided by the NT Government we would see the NT DHF as having a similar relationship to the Commonwealth as regional health boards. This will simplify the transitional process to new regional health boards, and is consistent with an integrated systems approach to Primary Health Care across the NT.

Funding expansion

Prior to EHSDI, combined funding for Aboriginal Primary Health Care in the NT (excluding MBS and PBS) was around $85m. EHSDI expanded funding by approximately $50m per annum (including the Remote Area Health Corp). This has allowed us to partially address the gaps in equity and the gaps in core primary health care service delivery. It has taken time to develop the capacity to apply this extra funding, but this current financial year the new annual funding will be fully allocated. In order to further address inequities and service delivery gaps there will need to be further funding expansion after EHSDI ends on June 30th 2012. We believe the national reforms offer a real opportunity to argue for funding expansion based on work currently underway including the revision of the definition of core primary health care services and costing study.

System Wide Enablers of Quality Primary Health Care

Historically across the NT there have been pockets of excellence and real achievement in improving Aboriginal heath but difficulty in applying these successes across the whole population or consistently over time.

In order to develop an effective Primary Health Care System, a number of system wide "enablers" in addition to those described above are being developed across the Government and non Government sectors by NTAHF/PHRG and other working groups. These include:

- NT Aboriginal Health Key Performance indicators
- Definition of Core Primary Health Care Services
- Proposed Core Primary Health Care Costing Study
- A single Primary Health Care Continuous Quality Improvement Framework
- Shared approaches to information technology including Patient Information systems, exchange of data and interoperability
- Development of a Hub Services Model (Services shared between HSDAs)
- Development of an expanded and more responsive model of Specialist Outreach

NT Aboriginal Primary health Care 10 year Reform Plan.

In December 2009 NTAHF approved a proposal for PHRG to commence development of a 10 year plan for Aboriginal primary health care in the NT. This is a major piece of work to integrate and develop in a coordinated fashion all of the work described above, utilising the World Health Organisation Health Systems Framework. This is a planning approach which is being adapted for the NT to analyse and develop the primary health care system around six key building blocks:

- Leadership and Governance
- Service Delivery
- Finance
- Medicines, Vaccines and Technologies
- Information
- Workforce

PHRG is currently working to map the primary health care system and identifying the key intervention points where further work needs to be applied to improve the system as a whole. We believe this work already underway will be the key to successfully applying the national reforms to Aboriginal Primary Health Care in the NT.

Appendix 3:

Specific issues with methodology and assumptions of the AGPN Boundary Modelling project report

Summary

The following specific references to aspects of *Framework for the development of Primary Health Care Organisations in Australia: AGPN Boundary Modelling Report* discuss key issues which in AMSANT's opinion render this report an adequate basis on which to proceed with PHCO development in the NT.

Overall the limitations of the scope and methodology, acknowledged by the authors, restrict the report to a quite generic view of primary health care service delivery across Australia, and pays little attention to significant differences in local context.

Stakeholders such as AMSANT are acknowledged as key players and the importance of consultation with key stakeholders in acknowledged. However there seems to be an assumption that the high level framework will be presented as a *fait accompli* before any such consultation occurs. There is no acknowledgment that the generic nature of this framework may in fact present serious barriers to the success of the reforms if local contexts not taken into account. The acknowledged "unique" nature of the Northern Territory makes this especially so.

A weakness of this approach in relation to the Northern Territory is that it fails to take any advantage of the considerable local expertise, the local good will and momentum in regard to Aboriginal Primary Health Care reform and the considerable progress already made over the last few years. The fact that this has happened outside the framework of Divisions of General Practice seems to have resulted in it being almost totally ignored, which is surprising, as it is arguably the most advanced system wide primary health care reform process in the country.

Detailed Discussion

1. *Participants in Consultation and subsequent Conclusions*

On *Page 4, t*he authors of the PHCO Boundary Modelling report concede that the timeframe for this report:

"meant that direct consultation on PHCO boundaries was limited to the national General Practice Network" (1.2.3)

As discussed above, this applies to all aspects of the report. In the Northern Territory the division of general practice is General Practice Network NT (GPNNT). There has been no discussion between either GPNNT , AGPN or the consultants with AMSANT or members of AMSANT in the production of this report. Further there has been no direct involvement of GNNT in the NT Aboriginal primary health care reform process, so the absence of knowledge of this process in the report is not surprising. It is surprising that while there authors acknowledge the role of AMSANT and the EHSDI

program, and the *"unique"* circumstances in the NT, there appears to have been no attempt to gain even a superficial, overview of the relationship of this to developing a PHCO.

The authors conclude that:

"Consultation with….the wider stakeholder networks will need to be addressed as part of the next phase.. " (1.2.3)

We believe that the conclusions already drawn for the Northern Territory at this phase are in fact very premature given the lack of stakeholder consultation. Further this, and the subsequent position papers produced by GPNNT lobbying to become the single PHCO in the NT by July 2011, with no consultation with AMSANT or its members, have raised anxiety in the Aboriginal Community Controlled Sector that rather than progressing the current reform agenda this will become a process of disempowering Aboriginal Community Controlled Health Services (ACCHs) as decision makers in the primary health care system.

2. Part 2 Modelling and Design Criteria.

On *Page 5*, the authors start from the premise:

"Primary Health Care Organisations are a new entity with no current precedents in the Australian health care system"

In fact within the Aboriginal community controlled health service sector there is a long and demonstrated history of successful regional "primary health care organisations" such as Nganampa Health Council, Katherine West and Sunrise Health Boards and on a larger scale, Kimberley Aboriginal Medical Services Council. The latter in particular reflects many of the aspects of the proposed PHCO model. These models also parallel in many aspects the model of PHCOs developed in New Zealand.

Further, policy development in this area has a long history of development in the Aboriginal Community Controlled health sector, both at a state and territory level, and nationally. As stated above this work needs to be given extensive consideration in the development of models that have impact on the sector.

We do not accept in the case of the Northern Territory that necessarily:

"PHCOs are expected to evolve from Divisions of General Practice"

Applying this as an assumption in all cases is a weakness of the report. In the Northern Territory Aboriginal Primary health Care Sector, there is an Australian Government funded process already underway, *The Expanded health Service Delivery Initiative*, under the auspices of NTAHF, that has as a component the development of a 10 year Aboriginal Primary Health Care Plan. The detail of this work, already advanced, is described earlier in this paper and in our view form the basis from which a PHCO for Aboriginal health in the NT should evolve.

3. *Modelling Criteria*

On *Page 7,* the authors describe the potential size of PHCOs.

The report states that these organisations:

"should have appropriate governance to reflect the diversity of clinicians and services forming comprehensive primary health care".

In strong contrast to this assumption, the emphasis in the Aboriginal Community Controlled Health sector is on governance by consumers, but integrating through good clinical governance processes and management processes the input of health expert, including but not limited to, clinicians. This reflects the very essence of successful models of health care in our sector, where services are responsible first to community needs.

Not only is quite different from the health professional dominated model assumed in the above statement, it is also, along with other boundary issues, a strong determinant of the optimal population size for such an organisation - if it is to reflect the level of consumer engagement in governance that is characteristic of our services.

We do not believe that a requirement of a minimum population size of 250,000 to 500,000 should be a key determinant in either discussion of the boundaries for PHCO(s) in the NT, or in forcing the development of a single organisation across two quite different sectors in the NT.

4. *"Planning Principle 1: Plan should follow function (page 11)"*

The proposal for an Aboriginal Primary Health Care Organisation outlined in Appendix 1 of this paper, and the systems reform planning undertaken by the NTAHF through the Primary Health Care Reform Group (PHRG) map out in considerable detail the functions of the primary health care sector in relation to Aboriginal health care provision in the NT, utilising a planning framework adapted from the WHO "*Systems Thinking"* planning framework.

Consistent with the stated principle that "form should follow function" this work needs to form the basis for planning the form of a Primary Health Care Organisation in this context. We believe that this work forms a far better developed framework on which to build the form of a PHCO to support Aboriginal primary care in the NT than the simple adoption of assumptions from the mainstream Australian primary health care system. The risk here is in fact of a very bad fit of *"form"* to *"function".*

5. *Planning Principle 2 "Plan for Communities using population principles (page11)"*

The authors on page 21, describe population characteristics of remote areas characteristic of most of the NT. They describe a model for PHCOs in these areas as service providers for a large range of services, as well as administrators of consortia (with ACCHs), commissioners of service delivery through funds pooling arrangements and providers of workforce support.

Before making recommendations for the NT we believe it would have been prudent to have taken some account of the currently developing and successful models of primary health care delivery in the Aboriginal health sector in the NT and then explored from the principle as previously stated of "form following function" the appropriate model in this environment.

What is described here is the current way some divisions of General Practice have attempted with very varying levels of success to work with ACCHs. If a single such organisation is developed in the NT across both mainstream general practice and ACCHs it is likely to result in a very contested environment due to conflict in governance models and competition for funding and other resources.