Aboriginal Medical Services Alliance Northern Territory
Senate Standing Committee on Community Affairs
National Health and Hospitals Network Bill 2010

The Aboriginal Medical Services Alliance Northern Territory [AMSANT] welcomes the opportunity to provide a submission to the Community Affairs Legislation Committee on the National Health and Hospitals Network Bill 2010.

We note that the Bill:

> *Establishes the Australian Commission for Safety and Quality in Health Care as an independent statutory body and provides for: the functions and powers of the commission; appointment of members to the board of the commission; procedures of the board; the terms and conditions of employment, functions and powers of the Chief Executive Officer; staff and consultants; committees; and reporting and planning obligations of the commission.*

Our submission to the Community Affairs Standing Committee provides background on AMSANT's position on the National Health and Hospitals Network, our broad commitment to Safety and Quality in Health Care, and comments on the Bill.

1.0 Introduction

1.1 AMSANT represents the Aboriginal community-controlled health sector in the Northern Territory. Our emphasis is on the delivery of comprehensive primary health care to Aboriginal Territorians.

1.2 AMSANT is a member of the Northern Territory Aboriginal Health Forum [NTAHF], a tripartite body also made up of the Northern Territory and Commonwealth governments. As such, we are a major provider of policy advice on health issues to both governments.

1.3 At the heart of our work is the development of a practice—both clinical and social—that displays our strong and central commitment to Comprehensive Primary Health Care.

1.4 This model was codified at an international level at Alma Ata in 1978, and subsequently endorsed by the World Health Organisation (WHO) and the United Nations:

> *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.*

1.5 Primary health care is socially and culturally appropriate, universally accessible, scientifically sound, first level care.

1.6 It is provided by health services and systems with a suitably trained workforce comprised of multidisciplinary teams supported by integrated referral systems in a way that:

- gives priority to those most in need and addresses health inequalities;
- maximises community and individual self-reliance, participation and control, and;
- involves collaboration and partnership with other sectors to promote public health.

1.7 Comprehensive Primary Health Care includes health promotion, illness prevention, treatment and care of the sick, community development, advocacy and rehabilitation services.

1.8 Comprehensive Primary Health Care prioritises dealing with health as a holistic process, which includes a strong emphasis on working with families and the communities we live in.

2.0 AMSANT's commitment in principle to the NHHN reforms

2.1 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 Northern Territory. 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.

2.2 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.

2.3 For this reason—not directly linked to the current Senate inquiry—AMSANT advocates for the establishment of an Aboriginal Primary Health care Organisation in the Northern Territory as part of the "landscape" of NHHN reforms.

3.0 AMSANT's commitment to safety and quality in healthcare

3.1 Aboriginal Community Controlled Health Services (ACCHs) in the NT operate in a highly challenging environment, dealing with remoteness, high burden of illness and communities whose level of English fluency and education are often low.

3.2 Nevertheless, many community controlled services in the NT are leaders in safety and quality. There has been extensive uptake of quality initiatives such as ABCD and the Australian Primary Care collaborative in ACCHSs across the NT. Some services have demonstrated better outcomes through these programs than mainstream general practice. AMSANT contends that at least some of this success is due to the governance model of community control.

3.3 Nearly all ACCHSs delivering comprehensive primary health care services in the NT are either working towards or have become accredited under the RACGP standards. The RACGP standards are not able to capture the complexity of the work undertaken by ACCHSs as they are based around general practitioners rather than the model of comprehensive PHC which ACCHSs aspire to. However, the RACGP standards are the nationally accepted standard for clinical primary care and the sector accepts that ACCHSs should reach these standards.

3.4 ACCHSs are now complementing RACGP accreditation with other forms of accreditation for non-GP services (social & emotional wellbeing, dentistry, health promotion and prevention programs) as well as organisational standards including ISO (International Standards Organization) and QIC (Quality Improvement Council).

3.5 The proposed permanent Commission will consider binding standards across primary health care, but this will require coordination with relevant standards setting bodies for primary health care including the RACGP and other bodies such as QIC and ISO. This coordination will ensure that there is not further complexity with services needing to meet two or more different sets of standards in a workplace rather than just one. ACCHSs already operate in a complex and highly regulated environment: national standards set by the Safety and Quality Commission should not to add to this complexity.

3.6 Some of the blockages to accreditation for ACCHSs are related to infrastructure deficiencies which will require significant government funding to overcome. Therefore ACCHSs cannot always meet national standards, possibly including safety standards, due to lack of quality infrastructure and limited funding support from government.

4.0 Comments on the National Health and Hospitals Network Bill 2010

4.1 It is difficult to reach an unequivocal position on the National Health and Hospitals Network Bill 2010 as two related legislative measures, namely the establishment of the Independent Hospital Pricing Authority and the National Performance Authority. At this point, we want this to be noted, and for the Committee to note that the putative legislation may have unintended consequences with respect to the current Bill under consideration.

4.2 We note that under Section 12, the Commission's functions are limited

(a) for purposes related to:

(i) the provision of pharmaceutical, sickness or hospital benefits; or

(ii) the provision of medical or dental services …

It is unclear from this whether this would restrict the scope of the Commission's work so as to exclude from the Commission's oversight the work of multidisciplinary teams as is standard practice within comprehensive Aboriginal primary health care. This includes work, some of which are billable items under Medicare by Aboriginal Health Workers, nurses and allied health professionals. AMSANT is of the view that this apparent oversight should be clarified.

4.3 Similarly, we note that under Section 20 of the Bill relating to appointment to the Board of the Commission, no direct mention is made of the potential critical role the Commission might play

in Closing the Gap of Indigenous health outcomes. There is overwhelming evidence that Aboriginal people bear a disproportionate burden of disease, and that the most effective way of delivering enhanced outcomes is through comprehensive primary health care. AMSANT is therefore of the very strong view that one of the potential "attributes" the Minister should take account of is for a potential Board member to have "substantial experience or knowledge; and substantial standing" in "comprehensive Aboriginal primary health care" under Section 20 (3) of the Bill.