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1. Roles and responsibilities of different levels of government and simplifying funding arrangements in Aboriginal health.

Aboriginal people have been severely disadvantaged due to Commonwealth state buck passing, which is entrenched in the current federal structure and inadequate resources for primary health care services. In spite of the development of the National Aboriginal Health Strategy in 1989 this bureaucratic maze ensured that the strategy was never implemented and the vision that all Aboriginal communities would have their own Aboriginal community controlled health service was never realised. In response to this, the Aboriginal Medical Services Alliance NT (AMSANT) was formed in 1994 to advocate for the transfer of the responsibility for Aboriginal primary health care services from ATSIC to the DoHA (Attachment 1: Bartlett and Boffa 2005). The main aims of this effective campaign were:

- To gain access to mainstream funding sources such as the MBS and PBS rather than to be marginalised with ATSI specific funding
- To ensure there was a health literate bureaucracy in a new department – OATSIHS – who would have the necessary expertise
- The ensure that a senior minister with a cabinet position had responsibility for Aboriginal health rather than a junior minister with no cabinet position
- The establishment of Framework Agreements and joint planning forums in order to achieve a partnership approach between governments and the Aboriginal community controlled health sector
- Funding of peak advocacy bodies in Aboriginal health

- 3 year funding for Aboriginal health services with a single funding agreement to simplify the complexity of multiple funding sources.

It was hoped that with these new arrangements Commonwealth, state and territory governments and the community sector would work together to jointly fund new and expanded Aboriginal primary health care services using a needs based regional planning approach. Central to this was the concept of Medicare capitation payments and funds pooling and this approach was successfully trialed through the Aboriginal Coordinated Care Trials (ACCTs) although there were problems with the funding arrangements in these trials. In 1998 AMSANT developed a position paper "Possible funding arrangements for the development of Aboriginal primary health care services" (attachment 2) which suggested ways to improve on the funding problems encountered in the ACCTs. This paper informed the development of the Primary Health Care Access Program (PHCAP) in the 1999 federal budget. PHCAP combines needs based capitation payments with MBS and PBS funding in what is known as a "mixed mode" funding model. Aboriginal people's access to primary health care is benchmarked against the national per capita Medicare average with weightings given for increased morbidity (2x) and remoteness (up to 1.9)

A detailed analysis of these complex health financing reforms and their outcomes are contained in a number of papers. Firstly, in 2003 AMSANT prepared a submission to the Medicare Inquiry "Bulk Billing and Aboriginal Health: A Submission to the Senate Inquiry into Medicare" (attachment 3). Later that year Pat Anderson, the then CEO of AMSANT, gave a keynote address to the Australian Health Care Summit in Canberra. "Policy initiatives that really improve the health system for Indigenous Australians: The Northern Territory experience and the Primary Health Care Access Program." This paper was later published in the Health Issues Journal (attachment 4). In 2005 a detailed analysis of the implementation of the PHCAP in the Northern Territory was published in the Australian Journal of Primary Health (attachment 5). Finally, the AMSANT submission to the recent Productivity Commission review of the health workforce considers the financing issues with particular emphasis on the workforce shortage (attachment 6). These papers provide detailed analysis of the key issues in relation to the roles and responsibility of governments and funding arrangements for Aboriginal health.

Central to all of this is the key concept that in order to effectively fund comprehensive primary health care there needs to be grant payments plus Medicare. This key concept has been recognised by the Productivity Commission in their recent report on the Health Workforce as a key strategy to addressing the crisis in the recruitment ands retention of GPs in rural and remote areas. There needs to be major reform in the way that primary health care services are funded and the PHCAP program provides a sound model for the future.

There is now clear evidence that the new and expanded primary health care services that have been established through the PHCAP and better access to the MBS and PBS have made a substantive impact on Aboriginal health in the NT. Life expectancy fro Aboriginal people is now improving and some chronic diseases are in decline while the

rate of rise of others has slowed a great deal. The health status of babies and children is improving rapidly (attachments 7 & 8).

If funds pooling of PHC resources is going to work then it needs to be a requirement on all states and territories and not something that only occurs in the NT. In order for this to occur the Commonwealth needs to use its power through vertical fiscal imbalance to put pressure on sates and territories to pool all primary health care resources. Originally there was an MOU for the PHCAP that required the states and territories to funds pool but under pressure from the larger states the Commonwealth agreed to abandon the MOU and new PHCAP funds flowed to states that did not contribute their existing primary health care resources into a funds pool. The Northern Territory government is the only jurisdiction that has agreed to funds pool as part of the PHCAP. This lets the states and territories off the hook and will not lead to an effective integrated health system. There needs to be clear requirement on states and territories and there should be financial incentives for good performance in Aboriginal health and financial penalties for poor performance. This could be achieved through the Australian healthy Care Agreements or through the allocation of GST revenue.

If funds pooling cannot be made to work within states and territories at the local and regional level then other alternatives needs to be explored. The Health Reform Alliance called for the establishment of a national funds pooling authority that could then fund all primary health care services. Alternatively, the Commonwealth government could take sole responsibility for the funding of all primary health care and primary medical care services according to need. The states and territories could then have sole responsibility for the hospitals.

There is an urgent need to ensure that back passing and duplication cannot continue and that there is a system wide solution to this problem. There is also a need to protect the level of resources that are going into primary health care so that any system needs to ensure a clear separation and demarcation between the funding for PHC and that for hospitals. Hospitals are important and because of the political focus on waiting lists and acute care there is a real risk that funds will go to hospitals instead of primary health care. AMSANT is of the view that by better funding the primary health care sector including fully funding the Primary Health Care Access program we will see a further improvement in Aboriginal health status and eventually preventing hospital admissions. This is already being achieved through effective pre-discharge care planning in Alice Springs between the primary health care sector and Alice Springs Hospital.

Recommendations

1. The PHCAP needs to be fully funded and implemented

2. Funds Pooling needs to a central component of the PHCAP as long as the current model of Australian federalism remains in place. New Commonwealth funds under the PHCAP should be contingent on states and territories agreeing to pool their existing primary health care funds.

3. Funds pooling should occur at the local and regional levels if possible but if this cannot be achieved then a National Primary Health Care Funds Pooling Authority should be established with pooled Commonwealth, state and territory monies and this authority would then by the sole funder of Aboriginal primary health care services.

4. If states and territory governments will not agree to funds pooling then the Commonwealth should adopt sole responsibility for the funding of Aboriginal primary health care by reducing the allocation to the states and territories.

5. There should be a new MOU between the Commonwealth and states and territories on the PHCAP that includes financial incentives for good performance in improving access to Aboriginal primary health care services and financial penalties for poor performance

6. Responsibility for Aboriginal health should remain the responsibility of the DoHA and OATSIH.

7. In line with the Productivity Commission recommendation the PHCAP should be seen a good financing model for primary health care more broadly, especially in areas of GP undersupply.

8. Enhanced support needs to be given to the PHC sector to ensure greater uptake of the new Medicare items around multidisciplinary care planning and well persons screening as these can substantially reduce the burden of illness and the need for hospital care.

2. Quality improvement

Primary Health Care sector
AMSANT is committed to fostering the development of a continuous quality improvement approach amongst our member services. As part of this we have been working in partnership with the Northern Territory and Commonwealth governments on developing a core set of performance indicators for Aboriginal primary health care services (attachment 9). This have been developed from a more detailed list of indicators that were developed by a joint research project through the Cooperative research Centre in Aboriginal Health (attachment 10). Aboriginal health services are now beginning to report against these indicators in the NT.

In addition to this, many of our member services have been participating in the National Primary Care Collaboratives (NPCC) and have been able to demonstrate better outcomes on key performance measures for diabetes and coronary heart disease than mainstream general practice (for example see attachment 11 "Aboriginal Community Controlled Comprehensive Primary Health Care : better access, better service provision and greater health gain per dollar?" paper delivered by the Central Australian Aboriginal Congress to

the Australian Primary Health Care Research Institute Workshop, Melbourne, October 2005)

Recommendations

8. All primary health care services and primary medical care services should be accountable for the quality of their services to the community. This should occur through accountability to government for outcomes against key performance indicators and, in the case of community controlled health services, accountability to the community through regular reports to the elected board of governance.

9. All primary health care and primary medical care services should be accredited and there should continue to be significant financial incentives for this to occur

10. Consideration should be given in extending the model of community control as a means of ensuring greater accountability for the quality of services to the community.

Hospitals

Effective hospitals are an essential component of any health system and they need to have an effective working relationship with the PHC sector. The problems that Aboriginal people have experienced in the hospital system in the NT have been documented in many previous reports including the Kerr Review of the Central Australian health system in 1990 and the Royal Commission into Aboriginal Deaths in Custody (1991). Many of the problems with the NT hospitals system are not unique to the NT but are systemic problems in many rural and regional hospitals throughout Australia.

The first issue that is important within hospitals is the need for effective Quality Assurance systems that have some degree of transparency to the general public. NT hospitals should make public important QA data such as nosocomial infection rates, rates of iatrogenic morbidity and mortality, complication rates from major operations and procedures etc. This type of information is essential if consumers are to make informed choices about the risks involved in their proposed treatments. The major units should undergo regular internal audits and there also needs to be a process of regular, prospective mortality review. Such processes are linked to accreditation and AMSANT believes that all the NT hospitals are now accredited and that these types of processes are probably in place.

A critical aspect of quality in NT hospitals is related to the quality of the medical workforce within the hospitals. For many years the NT Medical Board has allowed the conditional registration of many Overseas Trained Doctors who are only allowed to work in the hospitals. Such doctors are not able to become members of Australian Specialist Colleges, as they do not have the necessary qualifications and experience. They are also far less likely to complain about the quality of care being provided as they are dependent on the good will of their employer for their livelihood – they cannot work elsewhere. While we recognise that many such doctors have been the backbone of the NT health

system for many years this should not be the way of the future and in recent years there has been a concerted effort to ensure that more specialists have their Australian qualifications and this is welcome. The NT hospitals need to be able to recruit and retain Australian trained specialists who are able to get their respective units accredited and therefore take on registrars from the relevant training programs. The NT hospitals provide great experience for such registrars who can rotate through the NT from large capital city teaching hospitals. Such registrars improve the standards of NT hospitals. AMSANT is aware of at least one incident in the past when such a registrar program was put in place and was discontinued in response to concerns about the quality of care raised by the registrars. We do not want to see this type of response in the future. AMSANT believes that Alice Springs and Royal Darwin hospitals need to be major teaching hospitals with strong links to capital city teaching hospitals to ensure all of the core specialties such as Medicine, Surgery, Paediatrics, Obstetrics and Gynaecology, Emergency Medicine, Ophthalmology, ENT, Orthopaedics, and Anaesthetics are well covered.

It is also essential for the hospitals to improve their provision of 'cultural comfort' to Aboriginal patients. For example, interpreting services are both insufficiently available and often under-utilised where they are available. Appropriate accommodation of close family members who have traveled great distances to be with the patient is very often unavailable.

The final issue that needs to be raised in this section is that of the role of the Aboriginal Liaison Officers. These positions were created following the recommendations of the Royal Commission into Aboriginal Deaths in Custody, but their role is now very different to what was proposed. They were meant to play a role to ensure adequate liaison between Aboriginal people in hospital and their family members, as well as being able to play a role as patient advocates within the hospital system. As such it was recommended that these positions be located in Aboriginal community controlled health services. The positions were instead located in the hospitals and their role has been a confused mix of three roles: interpreters, AHWs and liaison officers. As discussed above it is essential that hospitals and primary health care services have access to appropriately trained interpreters who are not attempting to perform other functions as well. It is our view that there is no role for AHWs employed within the secondary health system as AHWs - they are trained as primary health care practitioners and any attempt to locate them within the secondary health system will create a new subclass of hospital employees at the bottom of the hierarchy. There are too many vacancies for AHWs within PHC services to suggest that they should also be employed within hospitals. Finally, there is still a need for Aboriginal liaison officers to play the original role that the Royal Commission identified that of liaison between patients and their families, patients and support services including social security and the important role of 'patient advocate' within a system that many patients understand poorly. This role will be achieved most effectively if the Aboriginal liaison officers are located within the major Aboriginal community-controlled health services in each town where hospitals exist.

Recommendations

11. A process of effective mortality review needs to take place in all public hospitals as part of ongoing quality assurance.

12. All major departments in teaching hospitals, such as Alice Springs and Darwin hospitals, need to undergo regular audits and report on their findings to clinical meetings to which consideration should be given to inviting external practitioners.

13. All hospitals should be and remain accredited

14. Regional teaching hospitals, such as Alice Springs hospital, need to be teaching hospitals with registrars rotating form large capital city teaching hospitals in all of the major specialties.

15. A research project should be undertaken to determine what level of QA data should be made available to the general public but AMSANT believes that some degree of publicly available data is essential to maintain the quality of care in public hospitals. Part of this project would be the development of core performance indicators for hospitals.

16. Aboriginal interpreter services need to be available, at least by telephone, in all Aboriginal languages in all hospitals throughout Australia.

17. Aboriginal liaison officer positions need to be outsourced into the ACCHSs so that they can work within an environment that will support their work in the hospitals.

18. A policy of open disclosure of mistakes should be adopted within Australian hospitals adopting the type of no fault medical indemnity system that enables practitioners to be exempt form legal action as long as they admit to mistakes within the first 24 hours. Such a system ensures that mistakes are transparent and able to be used for the purpose of quality improvement.

19. Clear recognition that hospitals need to be large enough to do enough of particular procedures to maintain quality care and if they cannot meet a minum benchmark then they should not be able to perform the procedure or operation and patient should be funded to travel to a larger centre. Need to be much clearer about what smaller regional hospitals should be able to do compared with ;larger teaching centres

3. Private Health Insurance

As so few Aboriginal people in the NT currently have private health insurance and there are no private hospitals outside of Darwin AMSANT does not have a policy position of

private health insurance or suggestions on how it could be reformed. It is imperative that for the foreseeable future the public hospital system is well resourced and the PHCAP is fully funded irrespective of what changes are made to private health insurance.