PRIMARY

HEALTH

CARE

ACCESS

PROGRAM

November 2002

OVERVIEW OF THE PRIMARY HEALTH CARE ACCESS PROGRAM (PHCAP)

Introduction

PHCAP is a program of health system reform to improve access to and provision of appropriate primary health care services for Aboriginal and Torres Strait Islander people at the local level (an overview of the Commonwealth strategic approach to Aboriginal and Torres Strait Islander health is at *Attachment A*).

PHCAP establishes a framework for the expansion of **comprehensive primary health care services** (more details about Indigenous comprehensive primary health care is in *Attachment°B)*, including:

- Clinical/medical care;
- Illness prevention services;
- Specific programs for health gain;
- Facilitating access to secondary and tertiary health services;
- Client / community assistance and advocacy on health-related matters within the health and non-health sectors; and
- The management and support structure.

PHCAP provides for increased comprehensive primary health care services in areas identified as having the highest relative need and capacity to utilise funding through a completed regional planning (*Attachment C* is a flow chart showing the process for implementation of PHCAP).

This will be achieved through an increase in resources and reforms to the local health system that include both mainstream and Indigenous specific services. Increased funds are expected to come from both mainstream and Indigenous specific funding sources. The focus is on developing or improving the local area primary health care *system* so that it is comprehensive, integrated and meets the needs of the local Aboriginal and Torres Strait Islander peoples.

The key objectives of PHCAP are:

1. Increased availability of appropriate primary health care services where they are currently inadequate;
2. Local health systems that better meet the needs of Aboriginal and Torres Strait Islander people; and
3. Individuals and communities that are empowered to take greater responsibility for their own health.

The implementation of PHCAP is based on the following principles. These will be the basis of a Memorandum of Understanding between the Commonwealth and the respective State°/°Territory as joint funders. The final wording will be negotiated in each State°/°Territory.

- Acceptance of a range of potential models for health service delivery, with the community control model preferred;
- Funding arrangements between the Commonwealth and State / Territory, which include:

- Maintenance of existing effort and an increase in resources beyond that level in line with existing arrangements in the Framework Agreements;
- Financial transparency through ongoing documentation of available and additional resources;
- Potential funds pooling and other joint service arrangements; and
- In the longer term, reinvestment of acute sector savings resulting from increased investment in primary health care services to improved health care for Indigenous people.

Role of Joint Regional Plans in the implementation of PHCAP
Under the Framework Agreements, each State/Territory has undertaken the development of a joint regional plan which identifies, at a broad regional level, current primary health care services and resources (both Indigenous specific and mainstream), gaps in services and needs, and priority areas.

The joint regional plan provides a transparent process in identifying health needs and priority areas for implementation of the program.

Partnerships
PHCAP is being implemented in partnership with the State or Territory Government, the community controlled health sector and ATSIC (see *Attachment D*). Aboriginal and Torres Strait Islander Health Forums / Partnerships in each State and Territory were formed as a result of the *Aboriginal and Torres Strait Islander Health Framework Agreements*, and have a key role in providing advice on priority areas and in developing implementation arrangements that best suit particular regions. The involvement of the community controlled sector and ATSIC is essential to ensuring that the implementation has meaningful involvement of local communities.

The implementation of PHCAP relies on cooperation and coordination between the Commonwealth and State/Territory Governments as joint funders. Agreement between the Commonwealth and State/Territory Governments (in the form of a Memorandum of Understanding) is a requirement before PHCAP funds are made available.

The Memorandum of Understanding will allow both parties to agree on the objectives of the program, commit both parties to the documentation of current resources and to maintaining or increasing resources for Aboriginal and Torres Strait Islander primary health care. Agreement will also be sought on the principle of identifying and applying any savings resulting from an increased Commonwealth investment in primary health care to Aboriginal and Torres Strait Islander health and would consider options for joint service delivery and where possible, the pooling of funding.

Working in partnership to implement PHCAP takes time but is acknowledged as the way forward to ensure high quality, acceptable and accessible primary health care services for Aboriginal and Torres Strait Islander Australians. The program has been well received in those locations where it is being implemented and was endorsed recently at a public health conference

> PHCAP is a landmark public health achievement in equitable, transparent financing arrangements for the development of primary health care services in Indigenous communities .. it addresses some of the major barriers that have previously been identified [1]

[1] Australian Public Health Association Conference Resolution, Nov 2000

Planning

Building on the regional plan, already completed in each State and Territory through the Framework Agreement s joint regional planning processes, local planning with the partners and local service providers to consider the gaps and needs will determine the most appropriate fund-holding and service delivery arrangements in each area. (See *Attachment E* for more details on the planning framework).

Local Area Selection

The current PHCAP resources from the Commonwealth allow the program to be implemented in some high priority local areas in the larger States and Territories and in at least one local area in the smaller States and Territories. Funding will be directed to local areas where regional planning has identified areas of highest needs and where there is the capacity to deliver effective services. So that local areas with high need and little current capacity are not excluded some funding is available for capacity building. (See *Attachment F* for more details on local area selection).

Financial Framework

PHCAP was introduced in the 1999-2000 Federal Budget to improve access to primary health care in areas where needs and capacity to utilise funds effectively have been identified through regional planning. The 2001/2002 Federal Budget provided additional funds from 2003/2004 which will allow PHCAP to commence in all States and Territories once their regional plan is completed (see *Attachment˚G* for a financial overview).

The PHCAP funding model involves both Commonwealth and State˚/˚Territory funds in a designated local area. This is in line with the joint responsibility between the Commonwealth and the States and Territories for Aboriginal and Torres Strait Islander health and the commitments made through the Framework Agreements on Aboriginal and Torres Strait Islander health to increase resources in line with need. Commonwealth contributions are across mainstream and Indigenous specific programs with, funding being for core activities based on per capita funding benchmarks.

Increases in funding through PHCAP will be stepped up over time in a way that takes account of capacity, relative need and availability of funds. The maximum Commonwealth contribution for core services is based on a per capita benchmark of two times the average use of MBS, taking into account existing Commonwealth contributions, with a remoteness loading to take account of the higher costs of service delivery in remote areas. *Attachment G* provides more information on the local area funding arrangements.

Attachments

Attachment A: Overview of the Commonwealth Strategic Direction in Aboriginal and Torres Strait Islander health
Attachment B: Indigenous comprehensive primary health care
Attachment C: PHCAP process
Attachment D: Partnerships
Attachment E: Planning Framework
Attachment F: Local Area Selection
Attachment G: Financial Overview

ATTACHMENT A

Overview of the Commonwealth Strategic Direction in Aboriginal and Torres Strait Islander Health

The Commonwealth first became involved in specific action to improve the health of Aboriginal and Torres Strait Islander people in the early 1970s, through the provision of grants to the States, then to the Aboriginal community Controlled Health Sector. The grants program (provided by ATSIC) supported the development of 175 ACCHSs and Substance Use services by 1994-95.

In 1994-95, the Department of Health and Aged Care was asked to take responsibility for ensuring that Aboriginal and Torres Strait Islander peoples health needs were being met within the health system. Responsibility for funding ACCHSs and Substance Use services was transferred from ATSIC in 1995-96. From that time a new national strategic approach was introduced.

The Office for Aboriginal and Torres Strait Islander Health (OATSIH) with the Department of Health and Ageing manages specific initiatives and its approach to improving Aboriginal and Torres Strait Islander health recognises that a long-term partnership is required to achieve sustainable gains in health status.

This is implemented by the Department through action across four broad objectives:

- Achieving comprehensive and effective health care for Aboriginal and Torres Strait Islander peoples through the development of infrastructure and resources;
- Addressing key health issues and risk factors impacting on health status;
- Improving the evidence base through effective data systems and evaluation and promoting the use of effective policy; and
- Improving communication with service providers and the general population

The objectives will be achieved through working on improving access to and the appropriateness of the mainstream system as well as Indigenous specific services and programs. Community controlled health services are a cornerstone of the strategy. OATSIH has a lead role in the Department of Health and Ageing for implementation of this approach.

ATTACHMENT B

Indigenous comprehensive primary health care

The term comprehensive primary health care refers to the broad range of primary health care services and the method of their delivery. This is consistent with the definition of primary health care presented in the World Health Organisation (WHO) Alma Ata Declaration.

Comprehensive primary health care for Aboriginal and Torres Strait Islander people is delivered through a range of preventative, promotive, curative and rehabilitative services.
Community involvement and community capacity-building strategies are important components of these services and influence their effectiveness (See *Better Health Care: Studies in the Successful Delivery of Primary Health Care Services for Aboriginal and Torres Strait Islander Australians,* Commonwealth of Australia, 2001, p.21).

Services Covered by Comprehensive Primary Health Care

The following health services are included within the scope of Indigenous comprehensive primary health care:

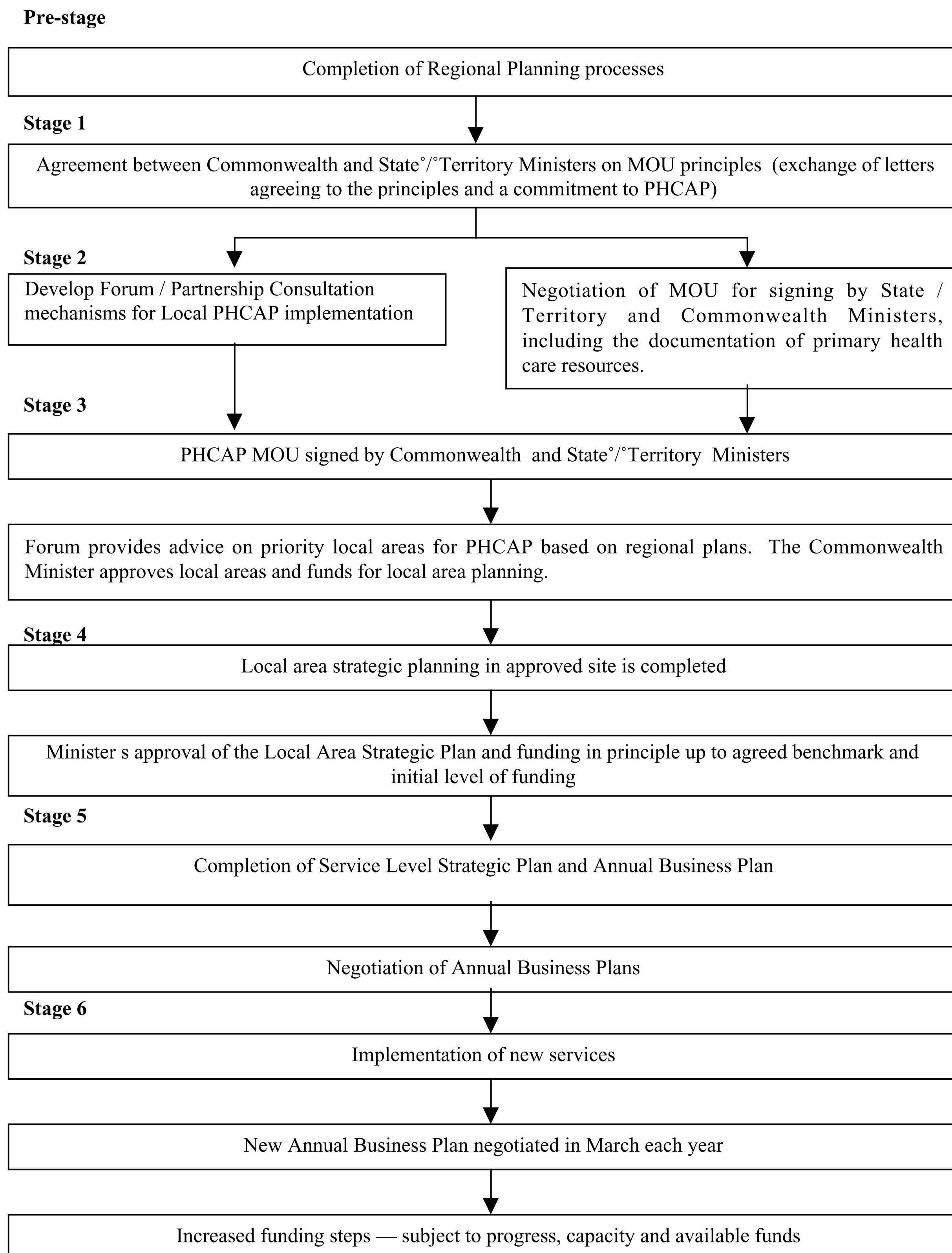
- clinical care covering the treatment of acute illness, emergency care and the management of chronic conditions;
- allied health services including dental and physiotherapy and counselors;
- population health programs such as immunisation, antenatal care, screening and specific health promotion programs (e.g. in nutrition, physical activity, STD and other communicable diseases control);
- Facilitation of access to secondary and tertiary health services;
- community health assessment planning and monitoring.
- community initiated activities dealing with the underlying causes of ill health and promotion of good health which require community action or agency to have any chance of success. They include areas such as:
    - ❑ substance use (including prevention, health promotion, education and counselling)
    - ❑ nutrition
    - ❑ emotional and social well being
    - ❑ environmental health
- special services aimed at particular target groups such as youth, frail aged and disabled people, male health and women s health, young mothers, school children etc.

These services can be provided through a mix of arrangements, including Indigenous specific, mainstream or a combination of these. Funding can also be used to support mechanisms to assist service providers to deliver better services and enable individuals and communities to become more involved in improving their health. These include:

- development and support for local community advisory and/or management boards;
- computer systems to facilitate quality care planning, medical record keeping, patient recall and monitoring of community health information;
- development of management systems that are financially accountable and include effective recruitment and termination practices;
- advocacy and policy development activities that provide opportunities for communities and organisations to advocate for their health needs and contribute to the development of policy that affects their health care;
- infrastructure at the community level such as staff housing and clinic facilities, functional transport facilities; and,
- training of staff and management/advisory boards.

Attachment C

Stages in the PHCAP Process



Attachment D

Partnerships

Framework Agreement
To facilitate the development of regional and local planning structures, *Agreements on Aboriginal and Torres Strait Islander Health* (Framework Agreements) were negotiated between the Commonwealth Government, State and Territory governments, ATSIC (or the Torres Strait Regional Authority in the Torres Strait Agreement) and NACCHO. These Framework Agreements are a tangible example of effective partnerships and were signed in each State and Territory (and the Torres Strait) between 1996 and 1999.

The Framework Agreement partnerships have fostered better understanding and appreciation of the roles and responsibilities of each of the signatories. In particular, it has increased the confidence of both the Commonwealth and each State and Territory in the shared commitment to increase real resources for Aboriginal and Torres Strait Islander health.

The partnership approach has also facilitated participation by the community sector in policy development and planning for mainstream health programs and those targeted to Aboriginal and Torres Strait Islander people.

Across Australia both the Commonwealth and the States/ACT have made a commitment under the Framework Agreement to increase resources in line with need. Through the Agreements all States and Territories have agreed that the responsibility for primary health care is shared with the Commonwealth and have made a commitment to maintain or increase the resources for primary health care. The Agreements for each State and Territory aim to improve health outcomes for Aboriginal and Torres Strait Islander people through:

- Improving access to both mainstream and Aboriginal and Torres Strait Islander specific health and health related programs which reflect the level of need;
- Increasing the level of resources allocated to reflect the higher level of need of Aboriginal and Torres Strait Islander people, including within mainstream services, and transparent and regular reporting for all services and programs; and
- Joint planning processes.

Memorandum of Understanding (MOU)
The MOU acknowledges the joint responsibility for Aboriginal and Torres Strait Islander health and sets the framework for cooperation between the Commonwealth and State/Territory governments in improving access by Aboriginal and Torres Strait Islander people to comprehensive primary health care services. It builds on principles of the Framework Agreements, including reform of the mainstream system to make it more responsive to the need of Aboriginal and Torres Strait Islander people.

The MOU establishes a financial framework that identifies and secures existing funding for comprehensive primary health care and allows new funding to be deployed in an equitable manner. It also commits both parties to accept a range of potential models for health service delivery, including the commonwealth model to transfer new or existing funding to Aboriginal community controlled health organisations as and when they are established.

The joint planning processes allow for full and formal Aboriginal and Torres Strait Islander participation in the determination of priorities.

Savings
Commonwealth and State/Territory governments agree to a collaborative and transparent process consistent with the principles of the Framework Agreements and regional planning processes in relation to the application of savings for the betterment of Aboriginal and Torres Strait Islander health.

Improved primary health care services are expected to result in savings in some areas, particularly the hospital sector. Such savings to State and Territory governments will need to be redirected to improve identified high need health services for Aboriginal and Torres Strait Islander people in that State or Territory , through pooled care arrangements or other services such as referral or specialist outreach.

Structures for Rollout under the Forums / Partnerships
There is a need to ensure a joint approach to the roll out of PHCAP. Within each jurisdiction there is a need to develop local implementation arrangements between the partners. The input of the local community controlled health sector and ATSIC is important to ensure that such arrangements will be relevant to the local situation.

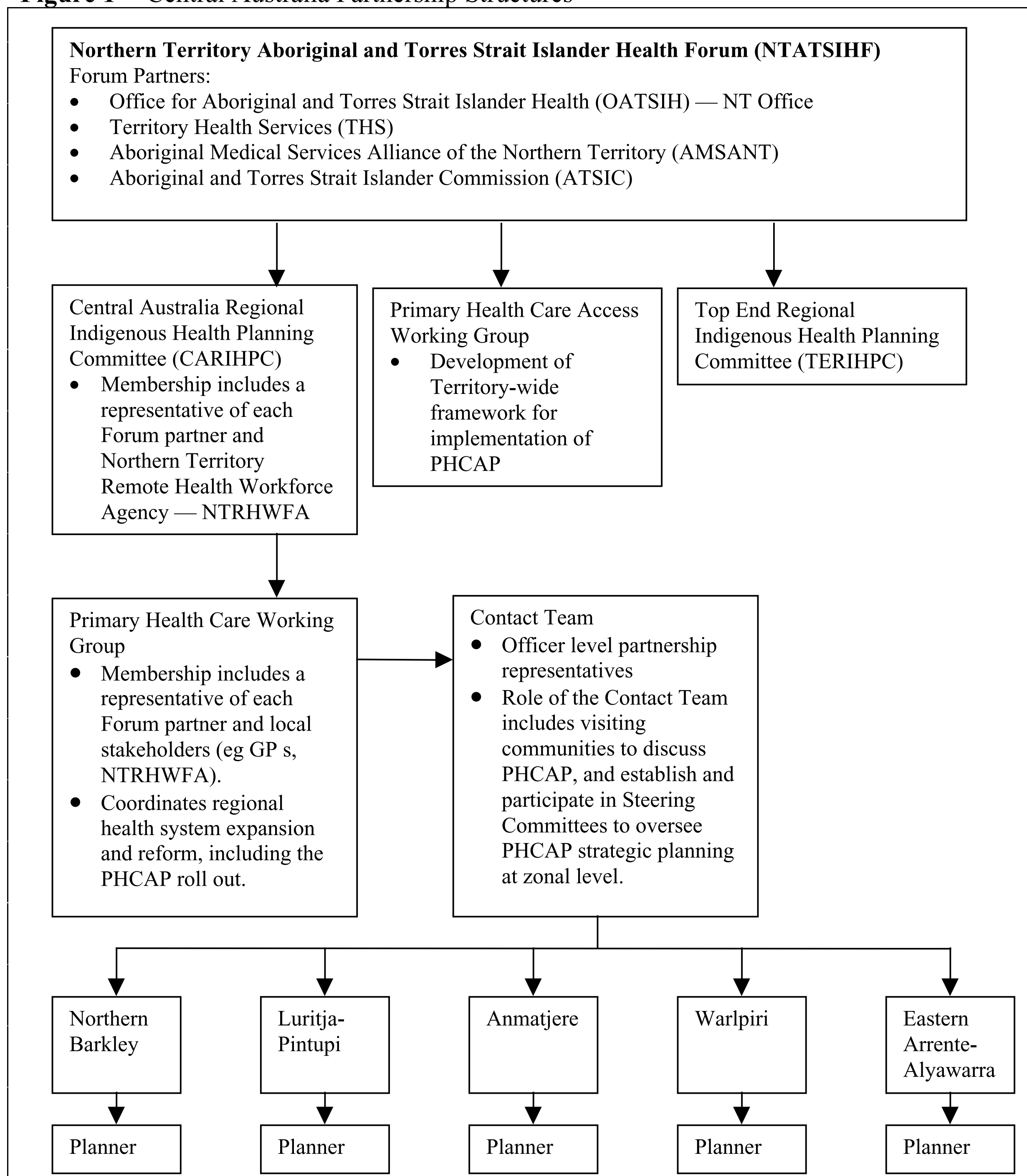
The diagrams below shows the structures put in place in the Northern Territory for the implementation of PCHAP in Central Australia and in South Australia. Each jurisdiction should determine the best way to implement PHCAP according to it s own circumstances.

Examples of Partnership arrangements in Central Australia (NT) and South Australia

Central Australian (Northern Territory) Partnership Structures (see also Figure 1)
In Central Australia, a strong partnership approach has been adopted in the roll out of PHCAP. CARIHPC s role was to develop the Central Australian Aboriginal Health Planning Study which identified needs based on gaps in current health services and priorities determined by local communities.

The Planning Study was the basis for the Northern Territory Aboriginal and Torres Strait Islander Health Forum recommending to OATSIH priority local areas to roll out PHCAP (these PHCAP structures fitted with existing Forum policy and planning arrangements). A Working Group was established to coordinate future expansion and reform of local health systems. The PHCAP roll out of five local areas in Central Australia is only part of the tasks of this group. The Contact Team (one representative from each partner) visits communities and explains PHCAP and establishes and participates in the zonal steering committees that supervise the strategic planning process for each zone.

Figure 1 Central Australia Partnership Structures



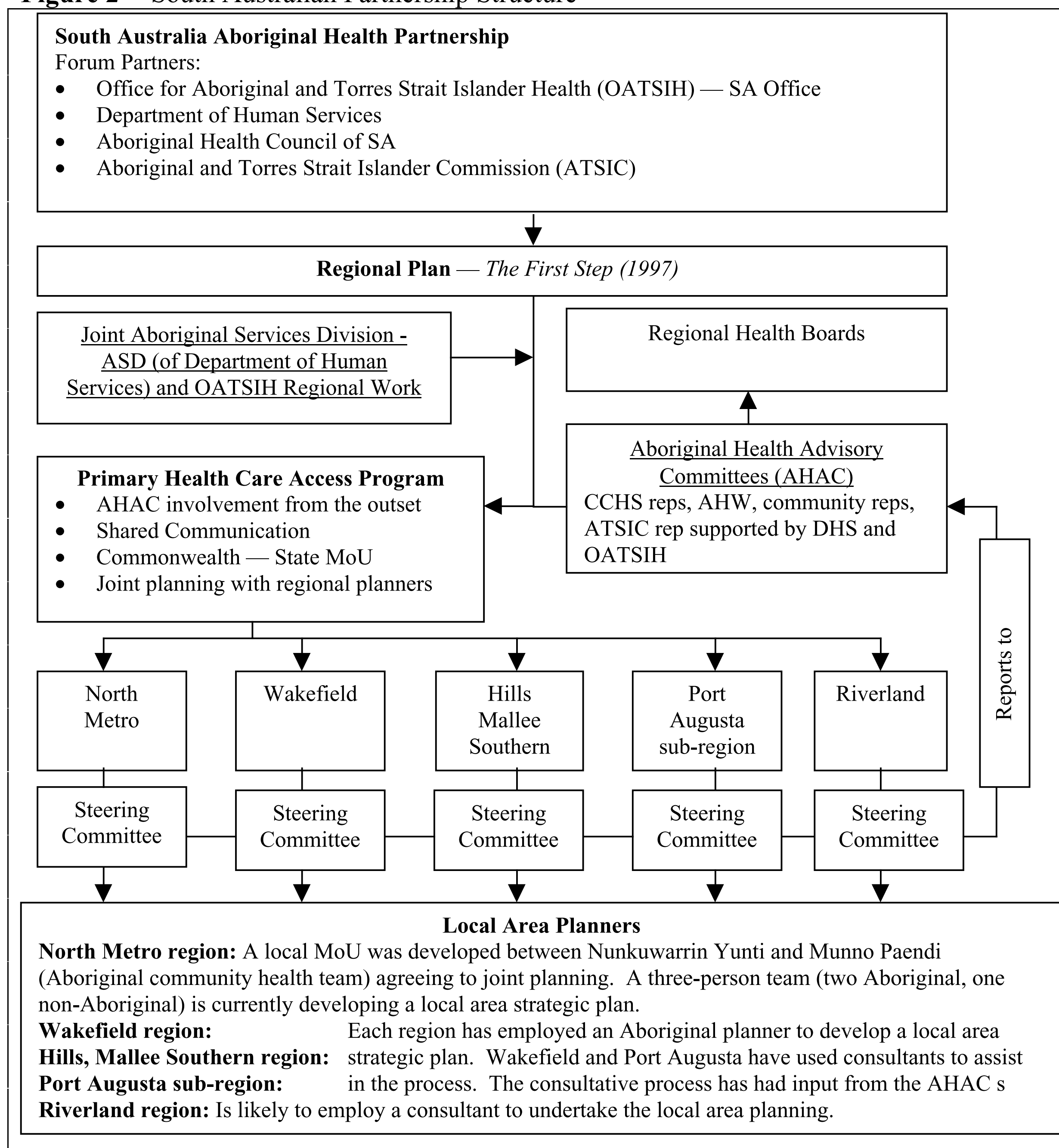
South Australian Partnership Structures (see also Figure 2)

Joint arrangements were in place prior to PHCAP. They centred on establishment and support for AHACs since 1996-97. Other partnership work was also done jointly eg the priority areas. The South Australian Regional Plan (*The First Step*) was completed in 1997. In each region in South Australia, a Regional Health Board was set up, including an Aboriginal and Torres Strait Islander representative. To support that representative, an Aboriginal Health Advisory Committee (AHAC) was set up.

PHCAP utilises the AHAC structure as part of the implementation of the program to ensure that there is adequate community input into the process. In each local area a steering committee has been formed to oversee the planning. The steering committees are sub

committees or working parties to the AHAC. They have AHAC representatives (including the chair) but also representation from the region - usually the Regional Planner, sometimes Regional General Manager and in one case also the health unit (hospital) CEOs. They report to the AHACs.

Figure 2 South Australian Partnership Structure



ATTACHMENT E

Planning Framework

Joint Regional Planning

The planning for PHCAP will build on the planning already completed through the Framework Agreement joint regional planning processes and any other local planning. Each State/Territory has developed a regional plan. The purpose of regional plans are to identify the current services and resources - both Indigenous specific and mainstream, identify the gaps and needs and identify the priority areas to assist funders to better target resources. In this way informed decisions can be made about how new funds (from any source - Commonwealth or State/Territory) which might become available can best be targeted and opportunities may be identified for improving the way existing services are delivered.

Local areas and services will be at different stages of development with some local areas having well established services and/or infrastructure in the area and others having minimal services. Utilising a strategic planning approach should strengthen community influence and accommodate the diversity of circumstances on the ground.

Structure of the Planning Framework

Planning is expected to occur at several levels and over various periods of time. At the local area level the planning process provides the opportunity to identify the needs, priorities and gaps in services considering the mix of services already existing (both Indigenous specific and mainstream) and how these can be improved and expanded to develop an effective and integrated local area health system. The local area health plan will also identify how the services should be delivered and who should deliver them as well as the governance and fund holding arrangements. The plan should consider the funding available from all sources as well as the PHCAP funds.

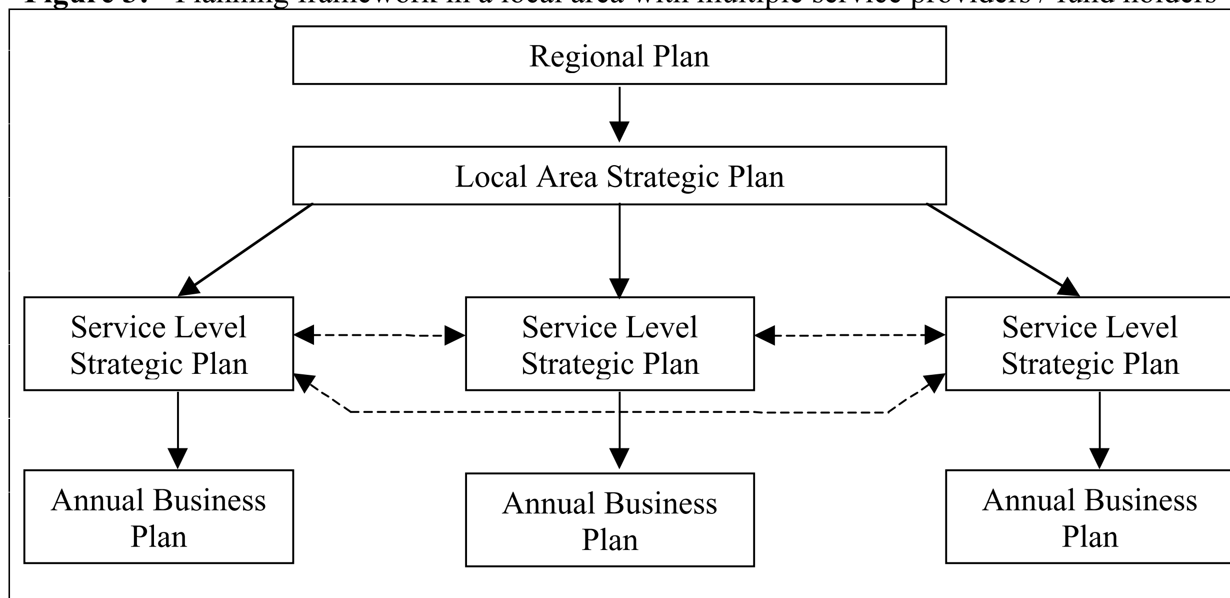
The local area planning process provides a significant opportunity to consider reforms of the local area health system, for example:

- Identification/filling of service gaps (eg maintain services and improving access so that services are acceptable to Aboriginal and Torres Strait Islander population or joint arrangements where mainstream services are provided through community controlled services eg doctors
- Improving linkages within system:
  - Looking at all the funding to an area and how it is currently spent provides opportunity to consider gaps / overlaps / duplications.
  - Developing sound links between local providers and specific services.
- Transfer of management of Indigenous specific health services from State / Territory to community control (greater Aboriginal and Torres Strait Islander input/control).

Service organisations will need to develop their service plans for the medium term, consistent with the local area health plan, as well as what can realistically be achieved from year to year through an annual business planning process. These annual plans will form the basis of the funding agreement with the Commonwealth and, where relevant, the State or Territory.

An annual business plan will need to be completed by each fund holder or service provider. The planning framework for this scenario is outlined in *Figure 3*.

Figure 3: Planning framework in a local area with multiple service providers / fund holders



PHCAP Planning Principles
It is likely that consultants will be engaged to facilitate the **local area health planning** process. It is expected that consultants would ensure that the planning process provides opportunities for all relevant community groups and stakeholders to be consulted, that existing resources and information are used (such as, existing regional and local health plans), that communities have the best possible information and support to enable them to decide what health services are most appropriate to meet their needs and that communities are aware of resources available (existing and potential).

Planning parameters

- Plans will need to:
  - develop an approach to ensure that the most basic primary health care services are available in the local area;
  - reflect community priorities and community involvement in their development; and
  - outline the proposed enhanced services, how these build on existing services, linkages to and increased access to mainstream services.
- Plans will need to reflect an increased focus on:
  - care planning and other better health practices;
  - population health measures;
  - emotional and social well being; and
  - substance misuse measures.

ATTACHMENT F

Local Area Selection

The funding currently available for PHCAP means that it can be implemented in a small number of areas within each State/Territory once regional planning has been completed. Aboriginal and Torres Strait Islander Forums / Partnerships will provide advice on priority local areas and the Commonwealth Minister for Health and Ageing will approve the allocation of Commonwealth funds to local areas.

Local area selection is to be made on the basis of need and capacity to utilise funds effectively. Forums / Partnerships use the Regional Plan to identify local areas of highest need. They may supplement this with updated information.

By targeting resources to selected local areas there is potential for distinct gains in Aboriginal and Torres Strait Islander health. By implementing on a scale that provides sufficient resources to deliver health services and work towards improving health outcomes, there is a greater possibility that local communities will benefit and the impacts will be clearly demonstrated.

Some local areas may be identified as high need areas, but lack sufficient capacity to implement PHCAP. In these situations, scope is available within the program to fund capacity building activity in the local area, which may enable local areas to access PHCAP in the future. The Forum/Partnership is expected to provide advice on priority local areas for capacity building if this is required.

The aim of capacity building is to support people in the community or community organisations to participate in health service planning, priority setting, influence local service delivery and manage health services. Capacity building funding can be used for community workshops, establishing health committees or boards and board training.

Forums / Partnerships have broad discretion in considering priority sites. However, it is expected that the process for considering priority sites will be evidence-based, transparent and robust.

The current funding will allow:

- *Round 1* - 15 new local areas, two capacity building local areas and continue the ACCTs
- *Round 2* - nine new local areas and some capacity building local areas
- *Round 3* - number of sites depends on funds availability after requests for Round 1 and Round 2 are determined. Allocations of the limited number of local areas will be on a competitive basis.

The Service Activity Reporting (SAR) and the modelling done with the Department indicates that local areas of 2-3,000 persons are the minimum required for sustainable service delivery. A population this size allows the area and/or service to:

- offer the range of services required;
- has the capacity to attract the right mix of staff; and
- make most effective use of resources.

The PHCAP funding is allocated to a local area for a population of up to 2000 people. The local area may have a larger population and the local area planning process should consider how the funds can best be used. This may be for a sub-population within the local area where the needs are greatest or to expand services more generally for the population. There may be the opportunity to expand to a bigger population coverage in future rounds depending on funding availability and continued priority.

ATTACHMENT G

Financial Overview

Budget

In the 1999-2000 Budget the Federal Government announced a new measure to address the poor health status of Aboriginal and Torres Strait Islander people by enabling better access to comprehensive primary health care services. Commonwealth funding contribution through this measure provided additional funding of $78.8˚million over four years, to be implemented in a few sites in areas where joint regional planning had been completed[2] and the four former Aboriginal Coordinated Care Trial sites.

The 2001-02 Budget announced an additional $19.7˚million each year from 2003-04, taking the total recurrent base for the program to $54.8 million per annum. This funding will be available within all States/Territories once their joint regional planning is complete[3]. The funding for PHCAP is shown in *Table 1*.

Table 1: PHCAP Funding 1999-2000 to 2004-05

	1999-2000 $m	2000-01 $m	2001-02 $m	2002-03 $m	2003-04 $m	2004-05 $m
2001-2002 Budget	-	-	0	0	19.7	20.5*
1999-2000 Budget	6.8	16.0	22.5	33.5	35.1*	36.7*
Total	6.8	16.0	22.5	33.5	54.8*	57.2*

* Indicative figures based on indexation

The Commonwealth has joint responsibility with State and Territory Governments for the provision of primary health care services to Aboriginal and Torres Strait Islander people. PHCAP enables improved health services to build on the existing Commonwealth and State/Territory resources and services. It also enables additional resources or increased access to be provided by the Commonwealth or States and Territories to be done in line with need.

The Commonwealth funding through PHCAP provides a contribution towards the overall cost of providing comprehensive primary health care to Aboriginal and Torres Strait Islander people. The level of this Commonwealth contribution is based on an MBS benchmark which takes account of the much poorer health status of Aboriginal and Torres Strait Islander people and the higher costs of service delivery in remote areas. It applies to the grant-funding component and takes account of MBS potential use and other related programs. Other Commonwealth programs such as PBS can be accessed in addition to this.

The PHCAP benchmark varies between regions to reflect the higher cost of service delivery in remote areas. In urban and rural areas the benchmark for the Commonwealth contribution has been set at two times the national average use of MBS (approximately $700 per capita) and at four times the national average use of MBS in remote areas (approx $1,400 per capita). The mix of funds within the benchmark will vary between regions to reflect the capacity to utilise Medicare.

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[2] At the time of the 1999-2000 Budget, joint regional plans were completed in Central Australia (NT), Queensland and South Australia. Therefore this round of funding was restricted to these areas and the former Aboriginal coordinated care trial sites.

[3] As at January 2002, all States and Territories had completed their joint regional plans, **except** Tasmania.

In many areas, the Commonwealth already provides funding for primary health care to Aboriginal and Torres Strait Islander people, such as base funding for Aboriginal Medical Services through OATSIH. This funding is included in the benchmark and the level of additional PHCAP funding will depend on the contribution already being made through existing Indigenous specific primary health care funding and estimated use of Medicare. The components of the Commonwealth Benchmark are reflected in *Figure 1*.

Figure 1 Components of the Commonwealth Benchmark

Total Commonwealth contribution (Commonwealth Benchmark)

Component	Description
Current Grants	Commonwealth funding that is attributable to Indigenous people that is either: • intended to directly compensate for lack of access to the MBS in respect of primary health care services; and / or • intended to compensate for additional costs of providing primary health care services in remote areas
Access to Medicare (Improved access to MBS — through better local service provision and enrolment arrangements)	Funding through PHCAP will allow for an increase in the number of or access to health professionals for a local area, including doctors. The extra doctors should lead to an increase in the number of claims through Medicare. The amounts for the use of MBS are an estimation of the current and potential increased use of Medicare (including pathology and specialist services).
Additional grant funding provided through PHCAP	This funding will be provided on top of the current funding and any funding accessed through Medicare.

The funding available from the 1999-2000 and 2001-02 Budgets will allow the program to be implemented in a few local areas in all States and Territories. If further funds become available the program can be implemented in additional local areas.

Staged Funding Process

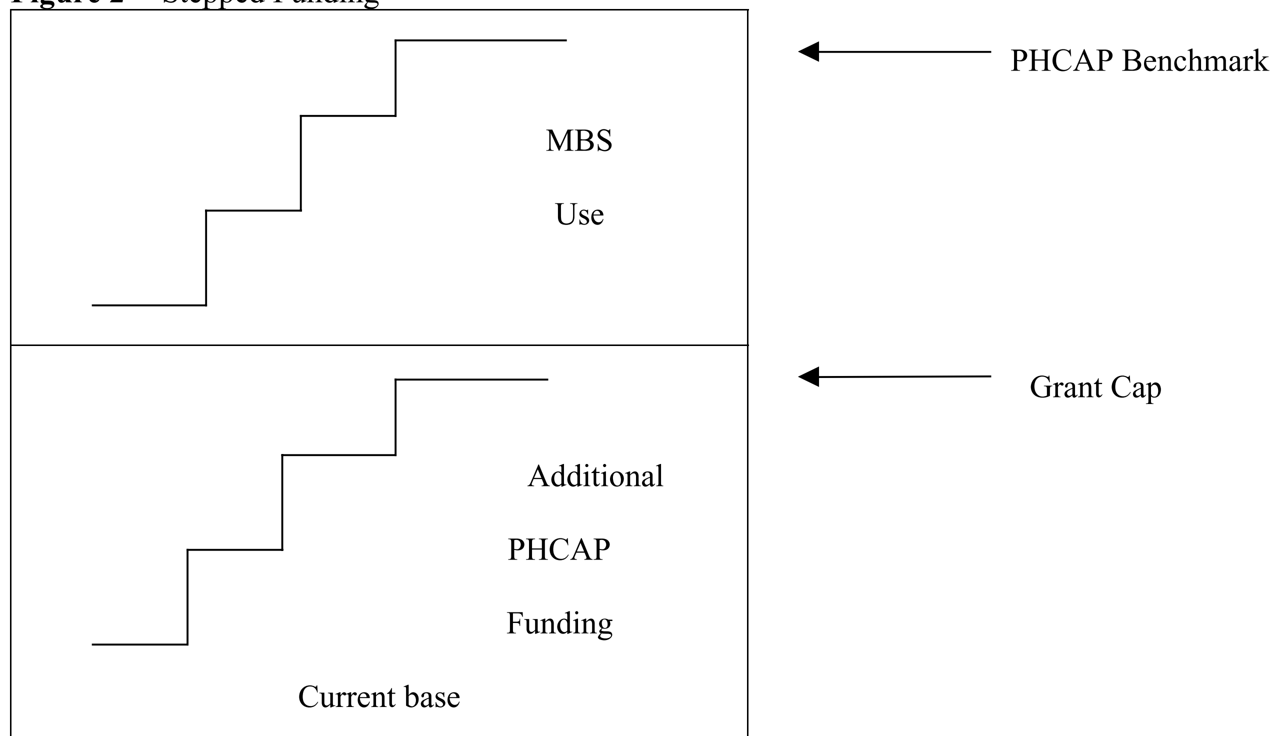
The intention of PHCAP is to allow health services to be built up in any given local area as the capacity of the local area to deliver the necessary mix of services is built up. Funding will be phased in and it is expected to take several years before full implementation is achieved.

Stepped funding

Agreed funding increases can be accessed once the local area has demonstrated the progress against agreed plans and capacity to further implement and on the basis that there is funding available. This will be done through steps.

It is assumed that as additional grant funding is made available to further develop the local health system, access to Medicare will improve. As such, it is expected that the usage of Medicare will increase in a stepped up process - as *Figure 2* demonstrates.

Figure 2 Stepped Funding



Funding Models

Initially PHCAP funding will be made available through a partial capitation model, which is a mix of grant funding and increased access to Medicare. The partial capitation model has Medicare payments made directly to the service provider from the Health Insurance Commission (HIC) along with grant funding.

Once the grant cap is reached, a move to a full capitation model can be considered. This is where the Medicare component is "cashed out" and all Medicare use is billed back by the HIC. This model will be suitable only in limited circumstances.

Funds Pooling

Where Commonwealth and State Government provide funds consideration may be given to joint funding arrangements and funds pooling. This is where Commonwealth and State / Territory funding is combined into a single fund, managed by a fund holder and has one funding agreement.

Integrated benchmark

There may be agreement between the Commonwealth and a State/Territory government to enter into an integrated funding arrangement where Commonwealth and State/Territory funding is considered together, and needs assessed against an integrated benchmark. This is especially applicable in regions where the State/Territory funding in the various local areas is widely spread.

The Commonwealth is negotiating an integrated funding benchmark in the Northern Territory.

Services and activities that PHCAP funds may be used for

The additional resources made available by the Commonwealth under PHCAP may be used to fund a range of comprehensive primary health care services. This is covered in Attachment B previously.

Services and activities that PHCAP will not fund

1. Secondary and tertiary services such as hospital and renal dialysis
2. Substance use residential rehabilitation services
3. Services that are a State/Territory responsibility (eg dental health) except where State / Territory and Commonwealth funds are pooled to a community organisation and able to be used flexibly across the range of comprehensive primary health care services.

Performance information

Reporting on performance assists services and OATSIH to determine potential further service development options and to consider funding increases. It is also useful to ensure that the accountability requirements of both funding bodies and communities are met.

Performance information may include the level and range of services provided, progress in establishing systems to help deliver primary health care services (such as patient information recall systems), assessment methods for determining health needs for the zone, population health programs and other special programs implemented in line with these needs and the progress towards individual care planning and implementation.