"The impact of current funding policies on the provision of Aboriginal primary health care"

Presentation to the 13th National Rural Health Conference, Darwin, 27th May 2015

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I would like to begin by acknowledging the traditional owners of the land on which we meet, the Larrakia people, and their elders past and present.

I would also like to acknowledge the conference organisers and, in fact, all those here who work so hard to provide health services to rural and remote communities, and particularly to Aboriginal communities.

I want to start by going way back, in fact some forty years back, to the beginning of what has been the most significant period of sustained improvements in Aboriginal health in the Northern Territory.

It has been nothing short of a revolution.

Last year we celebrated forty years of Aboriginal community controlled health services in the NT and twenty years since the Aboriginal Medical Services Alliance, or AMSANT, was established.

The first Aboriginal community controlled health service in the NT was the Central Australian Aboriginal Congress, or Congress. Congress was set up by community leaders in 1973 at a time when the health and social conditions of Aboriginal people were in an appalling state. Congress was born from community pressure. Aboriginal people took to the streets of Alice Springs in big demonstrations. One of Congress' first programs was supplying tarps to communities.

Congress led the way and was soon joined by other Aboriginal health services in different parts of the Territory: Urapuntja, Pintubi Homelands Health Servce, Wurli-Wurlinjang, Miwatj, Danila Dilba, and many others.

The history of the Aboriginal primary health care sector over those forty years is a whole story in itself. What I want to dwell on here is the health service model our sector has developed, the success it has achieved, and the impact of current funding policies on its future.

The development of community controlled health services was influenced by action internationally in the health community to develop the concept of primary health

care. The Aboriginal community controlled health model developed over time and with it the practice of comprehensive primary health care.

As most of you will know, this model of care is far more than the delivery of health services, and includes health promotion, illness prevention, treatment, care and rehabilitation. It recognises the need for advocacy and a community development approach and for cross-sectoral activity to address the social determinants of health. It is delivered through multidisciplinary teams and is at its core, evidence based.

Importantly, it is based on a core services model, which in addition to clinical services also incorporates services relating to: mental health and social and emotional well being; alcohol, tobacco and other drugs; early childhood development and family support; and aged and disability.

It's comprehensive nature is underpinned by a multi-disciplinary workforce with a high degree of coordination and team focus. We see this, for example, in relation to mental health and social and emotional well being and alcohol and other drug programs within our services. This approach allows for a holistic approach that cares for the whole person's needs and also encompasses prevention and community development.

A key aspect is our Aboriginal workforce. Aboriginal people are included at all levels of our workforce, from receptionists to CEOs and board members of our organisations. A key role is provided by Aboriginal Health Practitioners, who are registered health professionals providing clinical care, but who also act as cultural brokers, ensuring we have an effective and culturally secure clinical workforce.

This role also provides an important pathway for local Aboriginal people, particularly from remote communities, into the health workforce. And a pathway also—as exampled by Dr Stephanie Trust from the Kimberley, who we heard from earlier in the conference—into other health professions.

It's of grave concern to us that numbers of Aboriginal Health Practitioners have been in decline in the NT for a variety of complex factors, and there is an urgent need to reverse this decline.

This will require a stronger focus on providing appropriate training opportunities, including the need for educators to be placed within services.

The Aboriginal community controlled health services sector in the NT has a proud history of achievement.

Our services and clinicians have been at the forefront of health advancement, working with government sector colleagues and leading the development of better health systems, including sophisticated electronic patient records systems, the

development of a set of indicators to measure and report on progress, and the development and use of common compulsory clinical protocols.

We have led developments in areas such as eHealth and continuous quality improvement, or CQI systems. Adopting these new technologies has driven improvements in the efficiency, accountability and quality of health services.

We can also demonstrate that our service delivery model has led to a broader range of service delivery in integrated comprehensive primary health care with improved cultural safety and responsiveness to community needs.

This translates to improved front line services. For example, an NT Government clinic transferred to a community controlled heath service in the last few years has significantly increased the number of episodes of care.

Our services have also been strong advocates for their communities in issues ranging from alcohol control, access to basic infrastructure, and land rights.

A significant aspect of our service model has been the development of regionalised Aboriginal community controlled health services.

This has been an important innovation. Recognition that Aboriginal people, particularly in remote areas, had limited access to Medicare compared to the mainstream community, enabled an argument to be put to government for the "cashing out" of unaccessed Medicare funds, generating extra funds for primary health care and creating a mechanism for developing regional health services.

The Aboriginal Coordinated Care Trials in the NT and the Primary Health Care Access Program, announced in the budget of 1999, resulted in increased and more equitable program funding for Aboriginal primary health care. From this, two successful regional health services were established: Katherine West Health Board in 1999 and the Sunrise Health Service in 2005.

These services demonstrated that regionalised community control can produce better services and improved health outcomes. Rolling out this model across the Territory is a major objective of the joint planning process under the NT Aboriginal Health Forum. AMSANT is a foundation member of Forum along with the NT and Commonwealth governments.

In 2009, an agreement was signed by the Forum partners, committing Government to transition all Aboriginal primary health care services in the NT to Aboriginal community control.

This was a landmark achievement.

It represented over a decade's work by the Forum partners, with AMSANT, crucially, at the decision-making table with government.

We have much work to do in completing the processes of transition to regionalised community controlled health services.

The task has been given renewed energy and for this we appreciate the efforts of the Northern Territory and Commonwealth governments.

However, significant risks remain.

The success of our model requires adequate funding of the full set of core services that need to be delivered by regionalised health services. These are based on evidence, including needs assessment and identifying minimum population catchments, which we term 'Health Service Delivery Areas'.

A risk is that government may lose focus on the big picture through breaking up, or siloing the funding of programs that ideally should be funded through a single pooled funding model.

This in fact already happens, for example with the shifting of social and emotional wellbeing and alcohol and other drugs programs away from the Department of Health to the Department of the Prime Minister and Cabinet. Here, under the Indigenous Advancement Strategy, what has been applied is a fragmented, market based procurement approach based on open competitive tendering, where our services have to compete with all comers, including large contract-hungry NGOs, for the right to deliver what are core services under our model.

You might say what is wrong with the best tender getting the contract? Isn't that the best use of taxpayers' dollars?

AMSANT argues that applying an open competitive tendering process to Aboriginal specific areas of service delivery, such as Aboriginal primary health care, is inherently counter-productive.

It undermines community control and the holistic model that our sector has worked so hard to develop and that has been shown to be effective in urban centres through to the most remote parts of the NT.

Competitive tendering impedes the full development of our services.

In remote contexts, external providers who obtain contracts provide drive-in-drive-out or fly-in-fly-out services, usually not coordinated with the local health service.

For example, we have had the absurd situation in one small remote community of about 600 people where there were 17 different agencies providing programs in the area of social and emotional wellbeing.

Running over the top of each other.

Not coordinating.

Unnecessary duplication and waste.

Complete madness!

That is not value for taxpayers and it certainly isn't value for our communities.

Government investment would be better placed in supporting the full development of regionalised Aboriginal community controlled health services under the evidence-based model endorsed by governments themselves through the Aboriginal Health Forum.

Our organisations produce effective outcomes that we can demonstrate; and provide quality assurance in governance, management and service delivery.

Such an approach would allow more efficient, longer term funding and a properly resourced 'core services' approach, based on equity and evidence-based needs assessment.

This approach would also greatly contribute to other priority outcomes that the Government has identified, particularly in terms of sustainable Aboriginal employment, as well as providing experience and engagement in governance and management, and the development of community self-reliance and responsibility.

As mentioned in an earlier presentation, Aboriginal community controlled health services provide some of the strongest manifestations of self-determination that we see in this country.

External NGO providers, on the other hand, often lack community links, cultural knowledge and long-term commitment and capacity to deliver programs to Aboriginal people, and to develop and retain an effective Aboriginal workforce. The considerable additional benefits of having Aboriginal organisations employing local Aboriginal people to deliver services to their communities are usually not factored into open competitive tendering processes.

I can't finish without mentioning a couple of other significant barriers to progress in Aboriginal health improvement.

A significant factor in the slowing of health improvement is high rates of chronic disease, with evidence that the tide of chronic disease is still growing. The NT has

one of the highest rates of renal failure in the world with around 450 people on dialysis, with rates still climbing. Unless our health system is geared up to respond to this, the problem will continue to grow alarmingly.

We also know that critical areas of comprehensive primary health care, such as social and emotional well being services and early childhood programs, are resourced only in a few Aboriginal primary health care services, largely the urban services. We need to see expanded funding to allow such services to be accessed by all communities.

Strong advocacy is needed now more than ever. And that means advocacy for government to continue investment in primary health care and ongoing system reform, including further development of regional health services, and investment in quality improvement measures, better coordination between acute care and primary health care, and importantly, more focus on prevention.

The other side of the health equation, of course, is in relation to the non-health service factors—the social determinants of health. The health system can only do so much. We also know that other factors, such as early childhood, education, employment and housing need to improve significantly if we are to close the gap. Equally important are psychosocial factors, particularly empowerment.

To quote the eminent Sir Michael Marmot, Chair of the WHO Commission on the Social Determinants of Health: “Empowerment is key … we saw empowerment as having a material dimension—if you haven’t the money to feed your children you can’t be empowered; having a psycho-social dimension—having control over your life and not having lots of bad things happen to you; and a political dimension—having voice”.

If you think about this quote it’s not hard to see that our Aboriginal communities in the Northern Territory score a trifecta of disempowerment.

Underlying this are the ongoing impacts of racism that we know exists and that is a factor in poor mental health and physical health outcomes. Institutional racism is also present and affects the treatment Aboriginal people receive in health services and hospitals.

Here at AMSANT we are part of a growing awareness of the pervasive impacts of historical and ongoing trauma in our communities and the potential for significant improvement in outcomes by adopting trauma-informed approaches in service delivery.

To sum up.

The funding challenges for the future are large. We need sustained investment and continued innovation.

We need to continue the planned development of the Aboriginal primary health care sector. Strong regional Aboriginal community controlled health services remain our goal.

We are well placed in the NT with the current Aboriginal Health Forum, that includes all the major health players, soon to be joined by the new NT Primary Health Network.

As with the NT Medicare Local, AMSANT has taken a direct role as a shareholder of the new NT PHN along with the NT Government and Clinician's group.

Proper collaborative evidence-based health planning at the system level, will provide the platform that will enable the work of health practitioners and workers on the ground to reach its full potential.

We expect nothing less!

Thank you.