Presentation to the Third Health Ministers Summit

Darwin, 30th July 2015

Marion Scrymgour, Chairperson, AMSANT

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 Assistant Minister for Health, Senator the Hon Fiona Nash; Minister for Health, the Hon John Elferink; the Hon Jack Snelling; the Hon Helen Morton, and other distinguished attendees.

AMSANT is very pleased to co-host this summit with the Northern Territory Minister for Health, the Honourable John Elferink MLA.

It's particularly significant for AMSANT, having last year marked 40 years of Aboriginal community controlled health services in the NT and 20 years since AMSANT was established.

This is an important opportunity for all of us working to improve the health and wellbeing of Aboriginal and Torres Strait Islander people, to share and collaborate on that journey for the important years ahead.

AMSANT's Aboriginal community controlled member services provide high quality comprehensive primary health care to our communities across the Northern Territory. We are working with government to progressively transition further services to community control and to continue to build on our shared record of improved health outcomes.

We have achieved a steady and in many ways remarkable health improvement in the NT that Dr Christine Connors will be presenting on shortly.

What I would like to do in my presentation is to briefly reflect the context and history of these health improvements that have laid strong foundations for the road ahead. And also some important lessons from what didn't work.

An important precursor was the National Aboriginal Health Strategy, or the NAHS, developed in 1989. The NAHS outlined a way forward for Aboriginal health built on the foundation of Aboriginal community controlled comprehensive primary health care. Our sector took a leading role in its development.

It was a good plan with some significant outcomes, but ultimately let us down in its implementation.

It resulted in the establishment of the Council for Aboriginal Health; State and Territory Tripartite Forums; a specialised health branch, the Office of Aboriginal Health; and a national Aboriginal community-controlled health organisation, which became NACCHO.

The Tripartite Forums proved to be an unwieldy and unsuccessful model for collaborative health planning, but other initiatives such as a specialised health branch and the establishment of NACCHO have been important developments.

Crucially, the NAHS was never properly funded. $232 million was allocated over five years: $171 million for housing and infrastructure, and $47 million nationally for Aboriginal health services. This was far less than the $3 billion estimated as necessary for full implementation of the NAHS, and states and territories failed to match the Commonwealth funding, resulting in a grossly under-funded health system.

At this time, in 1990, the Aboriginal and Torres Strait Islander Commission, or ATSIC, was established and assumed national responsibility for Indigenous health.

This proved to be a further mistake.

The resulting underfunding of Aboriginal health services meant Aboriginal health continued to languish.

In this era, our health services had to apply every year for their core funding from ATSIC. There were no three-year funding agreements and much uncertainty from year to year, making it very difficult to attract and retain staff. Very few new Aboriginal health services were set up as such services were not considered to be necessary to improve Aboriginal health.

The 1994 evaluation of the NAHS showed that, effectively, it was never implemented.

It was in this climate that AMSANT was formed in 1994 after a 3-day meeting of community controlled health services in Alice Springs. Its key objectives were: expanding community control; increasing resources; and improving training, salaries, and conditions for Aboriginal Health Workers.

AMSANT's first major campaign, alongside other stakeholders, was to have administrative responsibility for Aboriginal primary health care transferred from ATSIC to the Commonwealth Health Department.

This was a very controversial move but was based on the carefully reasoned assessment that Aboriginal health funding would be forever constrained unless funds could be accessed from mainstream health funding, especially MBS and PBS. There was also a need for a specialist department within the health department that understood and had special expertise in Aboriginal primary health care. The Office

for Aboriginal and Torres Strait Islander Health Services, or OATSIH, was formed in 1995.

The impact of the transfer on access to increased funds has been very dramatic. In the year of the transfer, in 1995, there was only $70 million available to fund Aboriginal primary health care, however there has been a continuing increase in this funding since then to more than $1 billion per year for Aboriginal health.

Securing increased funding was complemented with a campaign to improve administrative arrangements for Aboriginal primary health care. Setting up a transparent and accountable planning structure was a key objective.

The signing of the Framework Agreement between AMSANT and the NT and Commonwealth governments in April 1998 saw the planning structure come into being—the Northern Territory Aboriginal Health Forum.

It is through the Forum that collaborative needs based planning has occurred enabling crucial improvements to the health system throughout the NT.

And for the first time the Aboriginal community controlled health sector was at the table as an equal with government. AMSANT is the permanent chair of the Forum.

However, inadequate and inequitable funding remained a key problem.

There was a need for a completely new funding model that combined pooled grant funding with access to Medicare and the PBS. AMSANT successfully campaigned for the Commonwealth Government to adopt a new Integrated Funding model as part of the new Primary Health Care Access Program or PHCAP. This required the pooling of all Commonwealth and Territory grant funds as well as access to MBS and PBS, and this mixed mode funding model remains the current way Aboriginal health services in the NT are funded.

AMSANT and Forum secured increased and more equitable program funding for Aboriginal primary health care through PHCAP, which divided the NT up into 21 health zones based on geographic, cultural and social affiliations.

Two successful regional health services were subsequently established through the Aboriginal Coordinated Care Trials: Katherine West Health Board in 1999 and the Sunrise Health Service in 2005. Due to the severe limitations of the Medicare “cash out” approach, these services transited to PHCAP funding agreements in order to help secure their sustainability.

These services demonstrated that regionalised community control can produce better services and improved health outcomes. Rolling out this model across the Territory remains a major objective of the joint planning process under Forum.

Effectively rolling out this agenda required a further critical development that needs mention. Because in order to allocate increased funds effectively and equitably there

needed to be a clearer idea of what core services and programs should be funded in each health zone.

Forum set about developing the first version of the Core Functions of Primary Health Care in 2001, and this was used to direct the initial investment under the PHCAP. $30 million new investment over 5 years from 2001 to 2006 took the average investment from $600 per capita on average to about $1800. There was also a marked improvement in equity through the needs based planning process of the Forum compared with the prior heavily politicised funding allocations.

An updated version in 2007 was used in negotiating new investment provided under the Expanded Health Services Delivery Initiative, or EHSDI, that accompanied the NT Emergency Response in July 2007. $50 million in new investment was provided in return for identified core services and corresponding core indicators. This took the system up to the current average of about $2500 per capita.

A third version, developed in 2011, is still to be implemented. In this version there are five domain areas of comprehensive primary health care under which there are more detailed descriptors of key services and programs.

The key gap areas that have been addressed in the third version are in early childhood, family support, alcohol, tobacco and other drugs, and aged and disability services. New funding coming into the NT in these areas is not currently being allocated under a core services approach or within the planning mechanism of the Forum.

The significance of having the NT Aboriginal Health Forum as an effective, high-level health planning body with the Aboriginal sector at the table cannot be understated.

It has delivered demonstrably better outcomes in the NT.

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

This was a landmark achievement.

And this year the Forum has established the Pathways to Community Control Working Group to progress the regionalisation process.

And in what is a kind of return to the future for AMSANT, we are revisiting one of our founding objectives in developing the Aboriginal Health Worker workforce, now, of course, referred to as Aboriginal Health Practitioners. However, this time it is in partnership with the NT Government through the Back on Track program and with the support of Forum.

AMSANT is greatly heartened by the continuing contributions and commitment of the NT and Commonwealth governments to Aboriginal primary health care and to the Forum.

And we are especially pleased by the launching of a new Framework Agreement for the NT that is coinciding with this Summit.

The final message I want to leave you with relates to our concerns regarding the new National Aboriginal and Torres Strait Islander Health Plan. It is a good plan, as was the National Aboriginal Health Strategy all those years ago. History has shown that such plans fail at the implementation stage for three main reasons. Firstly, a lack of long-term commitment of funding. Secondly, a lack of commitment from states and territories to the concept of a national plan. And lastly, a lack of accountability.

We must learn from history and get this right. We need a ten-year funding commitment. We need the draft implementation plan to be endorsed by AHMAC. And we need key performance indicators that make everyone accountable. Annual reports on the progress against these indicators should be tabled in the Federal Parliament as part of the Closing the Gap commitment.

Anything less would be, in our opinion, inviting failure.

And we simply can't afford that.

Thank you.