Northern Territory Government

AMSANT

Australian Government
Department of Health and Ageing

Northern Territory Aboriginal Health Forum

Core functions of primary health care:

a framework for the Northern Territory

Prepared for the NTAHF by

Edward Tilton
(Edward Tilton Consulting)

and

David Thomas
(the Lowitja Institute)

October 2011

Edward Tilton Consulting

the Lowitja INSTITUTE
Australia's National Institute for Aboriginal and Torres Strait Islander Health Research

Incorporating the Cooperative Research Centre for Aboriginal and Torres Strait Islander Health

STRUCTURE OF THE CORE FUNCTIONS OF PRIMARY HEALTH CARE FRAMEWORK FOR THE NORTHERN TERRITORY

Domain 1: Clinical Services

Services delivered to individual clients and/or families, in both clinic and home / community settings, including treatment, prevention and early detection, rehabilitation and recovery, and clinical support systems.

- **1.1 Treatment**
- **1.2 Prevention & early intervention**
- **1.3 Rehabilitation and recovery**
- **1.4 Clinical support systems**

Domain 2: Health Promotion

Non-clinical measures aimed to improve the health of the community as a whole. Health promotion includes a range of activities from building healthy public policy to providing appropriate health information and education, and encourages community development approaches that emphasise community agency and ownership.

- **2.1 Building healthy public policy**
- **2.2 Creating supportive environments**
- **2.3 Supporting community action and development**
- **2.4 Health information, education and skills development**
- **2.5 Orienting health services towards health promotion**
- **2.6 Evidence and evaluation in health promotion**

Domain 3: Corporate Services & Infrastructure

Functions to support the provision of health services, including the availability and support of well-trained staff, financial management, infrastructure, information technology, administration, management and leadership, and systems for quality improvement across the organisation

- **3.1 Management and leadership**
- **3.2 Workforce and HR management**
- **3.3 Staff development, training and education**
- **3.4 Financial management**
- **3.5 Administrative, legal & other services**
- **3.6 Infrastructure and infrastructure management**
- **3.7 Information technology**
- **3.8 Quality systems**

DOMAIN 4: Advocacy, Knowledge & Research, Policy & Planning

Includes health advocacy on behalf of individual clients, on local or regional issues, or for system-wide change; the use of research to inform health service delivery as well as participation in research projects; and participation in policy and planning processes (at the local / regional / Northern Territory and national levels)

- **4.1 Advocacy**
- **4.2 Knowledge and research**
- **4.3 Policy and planning**

Domain 5: Community Engagement, Control & Cultural Safety

Processes to ensure cultural safety throughout the organisation, engagement of individual clients & families with their own health & care, participation of communities in priority setting, program design & delivery, and structures of community control & governance.

- **5.1 Engaging individual clients with their health and care**
- **5.2 Supporting community participation**
- **5.3 Governance and community control**
- **5.4 Cultural safety**

Contents

Acknowledgments

The preparation of this Framework would not have been possible without the guidance, advice and assistance of many people and organisations.

The Commonwealth Department of Health and Ageing funded the development of the Framework. The project was carried out under the guidance of a Working Group of the Northern Territory Aboriginal Health Forum, including representatives of the Aboriginal Medical Services Alliance Northern Territory (AMSANT), the Northern Territory Department of Health, the Commonwealth Department of Health and Ageing, and General Practice Network Northern Territory.

The Working Group's guidance was fundamental to the development of the Framework.

Many thanks also to our Technical Advisory Group (Professor Ian Anderson, Professor Judith Dwyer, Dr Bev Sibthorpe and Professor Shane Houston) for their invaluable thoughts and advice.

We also consulted experienced policy makers, practitioners and researchers in a number of fields, including those relating to the areas of alcohol and other drugs, aged and disability, early childhood development / family support, and mental health / social and emotional well being. Their input is gratefully acknowledged.

Last – but not least – were the many service provider organisations, government and non-government, who took time to talk to us and inform us of their work and their goals. We hope that this Framework does justice to the scope of their practice and to their aspiration for better health and well-being for Aboriginal people across the Northern Territory.

Edward Tilton
David Thomas

INTRODUCTION

Background

Attempts to define a set of core functions of Aboriginal[1] primary health care in the Northern Territory go back to the mid-1990s.

At that time, the community controlled health sector was working with the Northern Territory and Commonwealth health departments to establish a collaborative and systematic approach to primary health care planning and delivery. An agreed suite of core primary health care functions was seen as important both as a guide to the allocation of resources and to assist in service planning.

Over subsequent years there was considerable discussion and refinement of these early attempts (see box on right). However these were all, to a greater or lesser extent, partial, because they:

- focused on clinical services (especially treatment services), with less attention to non-clinical population health approaches or to functions to support effective service delivery (corporate services, community engagement and control etc);
- focused on health services in the remote context, rather than services to the Aboriginal community as a whole (a substantial proportion of Northern Territory Aboriginal people live in Darwin and surrounds, or in one of the regional centres of Alice Springs, Nhulunbuy, Tennant Creek, and Katherine);
- were written from an explicitly government or community controlled health service perspective; or
- focused on access and resourcing issues, rather than the comprehensive description of core functions.

Core functions of primary health care: Key Northern Territory documents

- Central Australian Aboriginal Congress (nd. [1998?]). Aboriginal primary health care: core functions. Unpublished paper, Alice Springs.
- Freeman P and Rotem A (1999). Essential Primary Health Care Services for Health Development in Remote Aboriginal Communities in the Northern Territory, WHO Regional Training Centre for Health Development - University of New South Wales.
- AMSANT (Aboriginal Medical Services Alliance Northern Territory). "Administration Manual for Aboriginal Primary Health Care Services in the Northern Territory." Retrieved 22 September, 2010, from http://www.amsantmanual.com/03aboriginalhealth.html.
- Northern Territory Aboriginal Health Forum (Technical Working Group) (2007). Indigenous access to core primary health care services in the Northern Territory.
- Centre for Remote Health (2009). Core services across the lifepsan: a brief consultancy conducted by the Centre for Remote Health to contribute to the ongoing refinement of the DHF Core Primary Health Care Services Initiative. Northern Territory Department of Health and Families.

The development of an agreed set of core functions of primary health care in the Northern Territory was given impetus through the 2008 Federal Budget announcement of $99.7 million to expand health service delivery in Aboriginal communities, with the roll-out of the funding to be planned collaboratively by the three Northern Territory Aboriginal Health Forum (NTAHF) partners[2].

In this context, an agreed set of core primary health care functions was agreed to be essential to support planning and to direct and underpin decisions about health service structures and delivery.

What is this Framework?

This document aims to build on the substantial work in the area of core primary health care functions to date, and to bring it together into a comprehensive set of core functions that can be agreed by all partners of the NTAHF and be applicable to regionally-based Aboriginal primary health care across the Northern Territory[3].

This document is therefore a guide to a comprehensive approach to Aboriginal primary health care at a regional level in the Northern Territory that:

- **uses a comprehensive model of primary health care** which includes all the functions necessary for effective regional comprehensive primary health care services;
- **focuses on the core functions of primary health care delivered or accessed through a regional level primary health care service** (that is, in terms of the current reform process, at the Health Service Delivery Area level); and
- **is applicable to all organisations delivering primary health care services to Aboriginal communities in the Northern Territory**, while taking account of how individual functions or domains might be implemented under different:
    - governance structures (community control / government / other)
    - service structures across a region (dispersed / single location / other)
    - locations (urban / rural / remote)

It is also worth noting what this document is <u>not</u>. It is not:

- *a prescriptive list* of functions that all primary health care services 'must' deliver. Services operate under many constraints including resourcing levels, availability of staff and infrastructure quality and availability, and must also take into account local and regional health needs and community priorities[4];
- *a literature review* of all functions of comprehensive primary health care. It is however informed by the evidence (lists of further reading for reference are included), as well as drawing upon current best-practice and expert opinion. It also draws on previous work in the area[5];
- *the last word*. Just this Framework builds on the work that has already been done in the Northern Territory and beyond, it is expected that in the future it will be reviewed, updated and refined.

Purpose of the Framework

There are many uses to which this core primary health care functions framework could be put. However, it is written primarily as:

- a policy document that can be used to establish an agreed position on the functions of comprehensive primary health care in the Northern Territory;
- a framework for planning of primary health care services across the Northern Territory, including through the 'regionalisation' process;

- a tool for planning and evaluation of primary health care services at a regional (Health Service Delivery Area) level either by a single regional primary health care service, or by groups of services operating within an HSDA. To assist with this process, a summary document formatted for use as a planning and evaluation tool has also been developed.

Why comprehensive primary health care?

The definition of 'primary health care' has generated much discussion and disagreement over the years. The 1978 World Health Organization's *Declaration of Alma Ata* advanced a comprehensive view that saw primary health care's role not just in terms of treatment of illness, but also as including health promotion and illness prevention, promotion of community and individual self-reliance and participation, and intersectoral action to address what would now be called the social determinants of health (that is those issues such as poverty, housing, education, and food supply which underlie the health of populations)[6]. This 'comprehensive' view of primary health care has been contrasted with selective (disease-focused) approaches to primary health care, or to those approaches that concentrate more exclusively on the treatment of illness[7].

Whatever the status of these disagreements in the past, today in Australia there is a broad consensus that primary health care is to be defined comprehensively rather than narrowly, especially when it comes to improving the health of disadvantaged populations such as that of Australia's Aboriginal and Torres Strait Islander peoples[8]. The Australian Primary Health Care Research Institute for example, uses the following definition of primary health care as:

> *Socially appropriate, universally accessible, scientifically sound first level care provided by a suitably trained workforce supported by integrated referral systems and in a way that gives priority to those most in need, maximises community and individual self-reliance and participation and involves collaboration with other sectors. It includes the following:*
>
> - *health promotion*
> - *illness prevention*
> - *care of the sick*
> - *advocacy*
> - *community development*[9].

This definition has been accepted by key general practitioner groups[10] and is similar in spirit and content to those advanced by community controlled health service representative bodies[11] and accepted in key government policy documents[12].

The need for seeing primary health care functions from this more comprehensive perspective that goes beyond the 'standard' clinical services has been given further support recently in the review of the Commonwealth Government's Child Health Check Initiative and Expanded Health Service Delivery Initiative:

> *A long-term funding pathway is essential for continued expansion and reform of the remote NT primary health care (PHC) system. This should be based on an accurate costing model for providing core PHC services in the NT ... Further reform of the remote NT PHC system should consider broadening the scope of primary care to*

include a wider range of services and a stronger link with social determinants of health[13].

For these reasons, it is a comprehensive model of primary health care that was used in developing this Framework.

A comprehensive approach in practice

The development of this Framework started with the definition adopted by all parties to the NTAHF over ten years ago[14]:

A. *Clinical Services* (primary clinical care, clinical prevention, support systems)
B. *Support Services* (staff training and support, management systems, infrastructure and access to systems and services external to the service)
C. *Special Programs* (community initiated activities dealing with the underlying causes of ill health)
D. *Advocacy and Policy Development*

As well as rounding out, refining and re-ordering these domains, a fifth was added – 'Community engagement, control and cultural safety' – in recognition that all parties have now agreed that these issues (particularly those of community engagement and control) are fundamental to the delivery of effective primary health care services[15].

These five 'domains' were the starting point during the consultation process with experienced practitioners, researchers, service delivery organisations, and policy makers (see Appendices for an outline of the project methodology and a list of those consulted). Significantly, no participant in the consultation process questioned this broad model as appropriate for Aboriginal primary health care in the Northern Territory.

However, the reality for many primary health care services includes a sense of being overwhelmed by acute care demand. This is understandable given that the communities they serve have high levels of morbidity, and that being able to see a doctor, nurse or Aboriginal Health Worker when sick is a key and legitimate demand of the Aboriginal members of those communities. Under these conditions, it could be expected some might look at the broad scope described in this Framework and object that it is simply not possible to carry out all of these functions 'on top of' dealing with the sick.

However, it should be noted that *first*, consistent with the evidence, expert-opinion and best-practice, this Framework is consciously aspirational. It is a pointer towards a model of primary health care that can deliver sustainable changes in population health as well as increased effectiveness of treatment approaches. Implementing this model fully is likely to require both an increase in resources and reform in the way primary health care is delivered. To simply describe what is possible within current resources or within current minimum practice risks accepting and ultimately reinforcing the status quo, failing to recognise the need for making and informing change at a time where there is a universal commitment to 'closing the gap'.

Second, these are the functions expected to be delivered and/or accessed at a regional (HSDA) level of approximately 2000 to 3000 people. It is not expected that every individual health centre will have all of these services onsite (although it is expected that

they have systems in place to ensure access to the full range of functions, or that they will advocate for access those functions where they are not available).

Third, some of the functions – for example, corporate services including recruitment of staff, payment of wages, provision of buildings and vehicles, maintenance – might already be provided (possibly off-site or from another organisation such as another Government department), but may not be recognised as part of the primary health care sector. The aim has been to include these often hidden but critical 'supporting' functions because deficits in these areas frequently have substantial impacts on service and program effectiveness. At a time when there is a major move to devolving the delivery of primary health care to a regional/HSDA level under community-control, it is critical that these functions are acknowledged and resourced appropriately.

Last, many elements of the Framework *are* already being delivered by many primary health care services across the Northern Territory. Indeed, the approach has been to document the scope of best practice on the ground, recognising the achievements as well as the goals of those services across the Northern Territory.

Using this framework

The final structure of the Framework is therefore based around five domains:

Domain 1: Clinical Services

Domain 2: Health Promotion

Domain 3: Corporate Services and Infrastructure

Domain 4: Advocacy, Knowledge and Research, Policy And Planning

Domain 5: Community Engagement, Control and Cultural Safety

When using this framework, the following related points should be kept in mind.

First, primary health care cannot be reduced to a simple set of 'interventions' to be simply 'applied' to the community. The term 'primary health care' itself refers to a complex and holistic system which includes at least three inter-related meanings: primary health care as the first level of care within a health system, as a particular approach to the delivery of care that emphasises community participation, intersectoral collaboration and integration, and as a strategy for reorienting the way a health system works[16].

This Framework attempts to do justice to this complexity of primary health care, particularly as it has developed within the Aboriginal and Torres Strait Islander context. One result is that the five domains are not congruent categories, that is, they are not made up of the same type of things. Their relationship with each other is therefore not simple.

One way to look at the relationship of the domains is set out in the following diagrams. Diagram 1 shows three sets of *service functions*: clinical services, health promotion and advocacy. These functions are delivered by the primary health care service directly to the Aboriginal community or individuals, to support or improve their health.

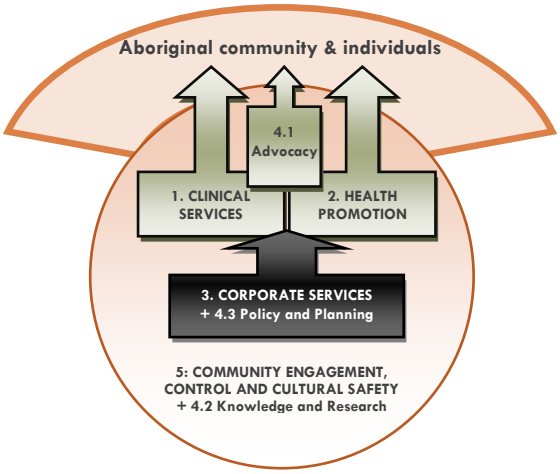
Diagram 1: Service functions

However, *support functions* are required in order to deliver the service functions. These may include a variety of corporate functions plus policy and planning processes. See Diagram 2.

Diagram 2: Service functions + Support functions

Last, there are what might be called *enabling functions*. Principally these include processes for community control, engagement and participation, cultural safety and the use of knowledge and evidence to inform practice. In contrast to the other functions, these need to embedded across the whole organisation to enable its effectiveness. See Diagram 3.

Diagram 3: Service functions + Support functions + Enabling functions



The scheme presented in the above diagrams is not exact – the use of Continuous Quality Improvement approaches across the organisation, for example, could be argued to be

as much a 'enabling function' as a 'support function'. However, the relationships described above should give some sense of the holistic and complex nature of primary health care.

The domains are thus strongly inter-related. For example, staff involved in clinical services can be expected to work closely with non-clinical health promotion programs; the effectiveness of their work is closely connected to the recruitment, training and support of staff and the provision of adequate infrastructure; how they provide their services must be informed by knowledge and evidence, and staff should be involved in planning processes within and possibly beyond the organisation; and over all, the effectiveness of their services is profoundly connected to their ability to engage individual clients in their own health, to work with and for the local community, and to provide culturally safe services.

A further implication is that the domains are not equivalent to 'programs' within an organisation. Some functions may be spread across different organisational units, some may be accessed from outside the primary health care service, and some (such as those relating to Continuous Quality Improvement, or community engagement) need to be embedded in the operations of all aspects of an organisation.

Last, primary health care is not just about the delivery of a set of curative or preventive interventions aimed at the community, but also about the development and maintenance of a network of relationships that promote and sustain health. These networks can have multiple dimensions. They can be place-based (for example, between health centres and local government organisations, schools, stores etc), systemic (for example, between primary health care services and education and training providers, research institutions, providers of corporate services), or more narrowly focused on patient care (for example, referral pathways and processes agreed between a primary health care service and its clinical partners).

Developing and maintaining robust and sustainable networks of these kinds is a critical part of the primary health care task that requires recognition and resourcing. Of course, the challenges of this task are greater where service integration is not made a priority – for example, where funding is directed not through established services but through new organisations or those whose core business is not Aboriginal primary health care.

The structure of this framework

Domains, sub-Domains and functions

Each section of the Framework will examine each of five domains of comprehensive primary health care in detail, and include:

- an outline of the 'sub-domains' or 'sections' under each Domain;
- the agreed Aboriginal Health Key Performance Indicators (AHKPIs) for the Northern Territory relevant to that Domain;[17]
- a list of further readings that inform thinking in the Domain (this is not a full list of references but the documents that practitioners, planners and policy makers may want to read for more in-depth understanding of the Domain);

- a short background to the Domain, noting any key evidence, challenges, and lessons from practice; and
- a tabular list of sub-Domains or sections (1 per page) that include a list of the individual functions under that Sub-Domain (on the left) and a more detailed discussion and justification for their inclusion where necessary (on the right).

Note that there is some overlap of functions between some of these domains. For ease of use overlapping functions may be included more than once (so all functions relating a particular sub-domain appear on one page users of the Framework continually being referred to other areas of the document.

Specific areas for further development

The project was also asked to look at four 'specific areas' that have not generally been well-integrated into comprehensive primary health care and/or not well resourced at the primary care level. These are:

A.	**Alcohol, tobacco and other drugs**
B.	**Early childhood development and family support**
C.	**Aged and disability**
D.	**Mental health / social & emotional health & well being**

A section on each of these, following a similar but shorter format as for the Domains, is placed at the end of the Framework. Two points should be noted in relation to these sections:

- their inclusion in separate sections does not imply that their delivery is separate from the core business of primary health care – the functions described under each will naturally fall under one or more of the Domains; and
- these are the critical areas for further development as identified by the NTAHF partners at this stage – other areas may be examined in similar detail in future iterations of this Framework (oral health, in particular, was mentioned by several respondents as meriting further attention).

Regional, 'hub', and higher level services

The focus of this Framework is regional, and the functions listed under each sub-Domain and each 'specific area' should optimally be provided by a regional primary health care service for an HSDA of around 3,000 people.

However, there are some critical services which are delivered from higher levels in the health system – from multi-regional 'hubs' or at a Northern Territory / Central Australia – Top End level. These might include, for example, emergency and evacuation services, birthing services, or specialized support for and training of staff.

While they do not provide such services, ensuring access to them is an important role of a regional primary health care service. In this case, 'ensuring access' specifically means assisting clients or staff to overcoming any barriers (social, cultural, physical etc) to access to these higher level services.

In the lists of functions under each sub-Domain (and in the 'specific areas') these functions are identified with the term **'ensure access to'**, flagging that the role of the primary health care service is not to provide the function themselves, but to ensure that clients / staff are able to access such functions and that they are assisted to do so. 'Ensuring access to' other services and networks has, of course, a resource implication for the primary health care service.

Some functions are identified with **'ensure access to / provision of'** which flags that the function either:

- may have some elements that could be delivered at the regional level, and some that could be delivered at a higher level – for example cultural orientation could consist of ensuring access to generic cultural orientation on arrival in the Northern Territory, followed by more specific orientation delivered at the regional level; or

- may be delivered at either the regional or a higher level, depending on funding, staffing, infrastructure, health needs, community priorities etc.

Life stages and specific services

Some previous descriptions of 'core primary health care functions' in the Northern Territory have focused on 'packages' of services needed for specific population groups or types of conditions. For example, the Centre for Remote Health document adopted this approach for services in remote areas delivered by the Northern Territory Department of Health[18].

This current Framework adopts a different approach to core primary health care functions. Following the structure adopted by the NTAHF in 2000, it attempts a description not solely on the basis of services delivered, but of all the functions necessary for effective primary health care. This is in keeping with its role as a policy document with a focus on planning at a regional level.

Under this conceptual model, services needed for each life-stage or condition are spread across several domains (if not, actually, all five). Attempts to map detailed service lists across all the Domains would both undermine the strategic intent of this Framework, and result in an unwieldy document that would be difficult for planners and regional primary health care service deliverers to use.

For those interested in detailed program delivery design rather than regional level and organisation planning, the service lists provided in the Centre for Remote Health document remain a valuable resource.

Generic tool for planning and evaluation

A separate summary document formatted for use as a planning and evaluation tool at a regional (Health Service Delivery Area) level has also been developed.

Notes for Introduction

[1] Given the Northern Territory focus of this Framework, the term 'Aboriginal' is used throughout rather than 'Aboriginal and Torres Strait Islander' or 'Indigenous', unless referring to populations outside of the Northern Territory where the broader terms are used.

[2] The Aboriginal Medical Services Alliance Northern Territory (AMSANT representing the community controlled health services, the Northern Territory Department of Health, and the Commonwealth Department of Health Ageing.

[3] While developed specifically for primary health care for the Aboriginal population, this Framework may have broader applicability for other populations.

[4] For similar reasons, the Framework does not prioritise core functions. Clearly functions related to, for example, chronic disease early detection & management, or maternal & child health, are fundamental to effective primary health care. We assume that public health and clinical expertise is available within and beyond regional health services to take account of such priority areas of service delivery.

[5] In particular, the Centre for Remote Health's work commissioned by the Northern Territory Department of Health and the report by the Northern Territory Aboriginal Health Forum's Technical Working Group. See Centre for Remote Health (2009). Core services across the lifespan: a brief consultancy conducted by the Centre for Remote Health to contribute to the ongoing refinement of the DHF Core Primary Health Care Services Initiative. Northern Territory Department of Health and Families. and Northern Territory Aboriginal Health Forum (Technical Working Group) (2007). Indigenous access to core primary health care services in the Northern Territory.

[6] World Health Organization (1978). Declaration of Alma-Ata. International Conference on Primary Health Care, Alma-Ata, USSR.

[7] Magnussen, L., J. Ehiri, et al. (2004). "Comprehensive versus selective primary health care: lessons for global health policy." Health Aff (Millwood) **23**(3): 167-176.

[8] Commonwealth Department of Health and Ageing (2009). Primary Health Care Reform in Australia: Report to Support Australia's First National Primary Health Care Strategy. Canberra, Commonwealth of Australia.

[9] Australian Primary Health Care Research Institute (APHCRI). "What is Primary Health Care?" Retrieved 22 September, 2010, from http://www.anu.edu.au/aphcri/General/phc_definition.php.

[10] Australian Medical Association. (2010). "Primary Health Care." Retrieved 22 September, 2010, from http://ama.com.au/node/5992.; Australian Divisions of General Practice. (2005). "Primary Health Care Position Statement." Retrieved 22 September, 2010, from http://www.agpn.com.au/__data/assets/pdf_file/0006/16269/20051026_pos_AGPN-Primary-Health-Care-Position-Statement-FINAL.pdf.

[11] National Aboriginal Community Controlled Health Organisation (NACCHO). "Primary health care." Retrieved September 2010, from http://www.naccho.org.au/definitions/primaryhealth.html.

[12] Northern Territory Aboriginal Health Forum (2000). Core functions of primary health care, National Aboriginal and Torres Strait Islander Health Council (NATSIHC) (2003). National Strategic Framework for Aboriginal and Torres Strait Islander Health: Framework for action by Governments. Canberra, NATSIHC.

[13] Allen and Clarke (2011). Evaluation of the Child Health Check Initiative and the Expanding Health Service Delivery Initiative: Summary report. Canberra, Department of Health and Ageing.

[14] Northern Territory Aboriginal Health Forum (2000). Core functions of primary health care.

[15] See especially: Northern Territory Aboriginal Health Forum (2008). Pathways to community control: an agenda to further promote Aboriginal community control in the provision of Primary Health Care Services.

[16] National Centre for Epidemiology and Population Health (1991). Building a picture: the role of primary health care in health promotion. National Better Health Program Monograph Series. Primary health care review. Canberra. **1**.

[17] Northern Territory Aboriginal Health Forum (2008). NT Aboriginal Health Key Performance Indicators Definitions (version 1.3.1 December 2008). Department of Health and Aging - NT Department of Health and Families - Aboriginal Medical Services Alliance of the Northern Territory.

[18] Centre for Remote Health (2009). Core services across the lifespan: a brief consultancy conducted by the Centre for Remote Health to contribute to the ongoing refinement of the DHF Core Primary Health Care Services Initiative. Northern Territory Department of Health and Families.

DOMAIN 1: CLINICAL SERVICES

Services delivered to individual clients and/or families, in both clinic and home / community settings, including treatment, prevention and early detection, rehabilitation and recovery, and clinical support systems.

KEY ELEMENTS

1.1 Treatment

1.2 Clinical prevention and early intervention

1.3 Rehabilitation and recovery

1.4 Clinical support systems

KPIs

AHKPI 1.1	Number of episodes of health care and client contacts.
AHKPI 1.2	Timing of first antenatal visit for regular clients delivering Indigenous babies.
AHKPI 1.3	Number and proportion of low, normal and high birth weight Indigenous babies.
AHKPI 1.4	Number and proportion of Indigenous children fully immunised at 1, 2 and 6 years of age.
AHKPI 1.5	Number and proportion of children less than 5 years of age who are underweight.
AHKPI 1.6	Number and proportion of children between 6 months and 5 years of age who are anaemic.
AHKPI 1.7	Number and proportion of clients aged 15 years and over with Type II Diabetes and/or Coronary Heart Disease who have a chronic disease management plan.
AHKPI 1.8	Number and proportion of resident clients aged 15 years and over with Type II Diabetes who have had an HbAIc test in the last 6 months.
AHKPI 1.9	Number and proportion of diabetic patients with albuminuria who are on ACE inhibitor and/or ARB.
AHKPI 1.10	Number and proportion of Indigenous clients aged 15 to 55 years who have had a full adult health check.
AHKPI 1.11	Number and proportion of Indigenous clients aged 55 years and over who have had a full adult health check in the past 12 months.
AHKPI 1.12	Number and proportion of women who have had at least one PAP test during reporting period.

BACKGROUND

'Closing the gap' in health between the Aboriginal and non-Aboriginal community requires action across the whole health system, and even beyond it in addressing the social determinants of health. However, this should not obscure the continuing need for the treatment and prevention of illness using clinical methods[1].

The areas of effective primary clinical care are well-documented. For the purposes of this framework, they include treatment, clinical prevention and early detection, and rehabilitation and recovery[2] as well as systems for direct support of clinical services[3]. These areas of comprehensive primary health care are those that most services operating in the Northern Territory deliver well, and often accord strongly with workforce skills and with community expectations.

Some of the key factors for the delivery of clinical care in the Northern Territory Aboriginal context include the following.

First, *ensuring availability of clinical services* for the whole of the Aboriginal population. Barriers to access may include physical (distance, lack of transport, poor roads), economic (cost of getting to the health centre or costs of treatment / medicines), cultural (cultural safety of services), or social (including historical experience of Aboriginal people with health services, social pressures). One implication for addressing access issues is that 'clinical services' are not just delivered 'in the clinic': home and community-based care are important where appropriate and possible.

Second, *chronic disease and maternal and child health* are critical areas for action. Chronic disease accounts for 70% of the excess burden of disease experienced by Australian Indigenous people[4] and deficits early in life (including before birth) can predispose people to a lifetime of ill health, including to the development of chronic disease later in life[5]. Mental health conditions are the most common disease group contributing to ill health, causing 16.3% of the burden of disease in the Northern Territory, with anxiety and depression being the most common conditions[6].

Third , *coordination of clinical care*[7]. In many Aboriginal communities, primary health care services form the only stable access points to the health system in environments marked by fragile or non-existent service infrastructure. Critical services may be difficult to access for all of the reasons outline above. In these circumstances, primary health care services play a key role in ensuring access to diagnostic and treatment services for their clients. Facilitating patient access across critical transition points (e.g. community to hospital) as well as integrating services from outside the local level (e.g. visiting specialists) are key tasks for primary health care services.

Fourth, *multidisciplinary teams with good clinical governance*. The complementary roles of Aboriginal Health Workers, nurses and general practitioners, supported by specialists and allied health professionals are critical to address the complex needs of many Aboriginal clients[8]. All members of the multidisciplinary team need to work together in ways that does not place unreasonable requirements on patients to organise their own care.

Fifth, *approaches that encourage and support self-care and self-management*, particularly in the case of chronic disease and including mental health[9].

Last, *adequate staffing levels*. Most primary health care services experience high – sometimes overwhelming – demand for acute care from communities with high rates of sickness, and where service delivery is complicated by the complex needs of clients and cross-cultural practice. Having adequate staff to allow the time needed in consultations to deliver quality outcomes – and to ensure that resources for both clinical and non-clinical prevention work, is essential.

The effectiveness of clinical services is strongly related to the strength of other domains in this Framework. There is thus a close relationship between this Domain and those relating to broad health promotion approaches (**Domain 2**), management and support (**Domain 3**), advocacy and the use of evidence (**Domain 4**) and the engagement and participation of individual clients and the whole community (**Domain 5**).

FURTHER READING

- Centre for Remote Health (2009). Core services across the lifespan: a brief consultancy conducted by the Centre for Remote Health to contribute to the ongoing refinement of the DHF Core Primary Health Care Services Initiative. Northern Territory Department of Health and Families.
- Northern Territory Aboriginal Health Forum (Technical Working Group) (2007). Indigenous access to core primary health care services in the Northern Territory.
- System Performance and Aboriginal Policy Division (Josif D) (2008). Universal Core Service Framework, Performance Indicators and Workforce Implications. Northern Territory Department of Health and Families. Darwin

OTHER SOURCES

- Aboriginal Health & Medical Research Council (1999). Primary, secondary and tertiary health care services to Aboriginal communities: Core functions of Primary Health Care in Aboriginal Community Controlled Health Services (ACCHS). AH&MRC Monograph Series Volume 1 Number 1. Sydney.
- Freeman P and Rotem A (1999). Essential Primary Health Care Services for Health Development in Remote Aboriginal Communities in the Northern Territory, WHO Regional Training Centre for Health Development - University of New South Wales
- Powell Davies G, Harris M, et al. (2006). Coordination of care within primary health care and with other sectors: A systematic review. Sydney, Research Centre for Primary Health Care and Equity, School of Public Health and Community Medicine, UNSW

1.1 Treatment

- **First contact treatment of illness and injury** using evidence-based standard treatment practices and protocols
- **Continuing management of chronic illness,** including development and implementation of chronic disease management plans, support for self-care approaches, dispensing of medicines, and monitoring for adverse effects
- **24 hour after hours on-call service,** including access to the advice of a doctor either on site or via telecommunications
- **Provision of essential drugs** including provision of medicine kits to designated holders
- **Ensure access to / provision of oral health services,** including acute and on-going dental treatment
- **Ensure access to / provision of 24 hour emergency care,** including:
  - response to emergency incidents including assessment, treatment, stabilization and evacuation
  - ensure access to disaster management planning, preparedness, response and recovery
  - ensure access to / provision of training for staff, including with local emergency services
  - support for staff following incidents
- **Ensure access to specialist treatment services** in the community or through referral, including effective transfer of care [see **Section 1.4 Clinical support systems**]
- **Ensure access to / provision of allied health treatment services** in the community or through referral, including effective transfer of care [see **Section 1.4 Clinical support systems**]
- **Palliative care treatment** in cooperation with and with the support of palliative care specialists

Aboriginal communities are marked by high levels of morbidity, and the demand on local primary health care providers for acute care is consequently high. Meeting this demand safely, effectively and appropriately is a central task for any health service delivering care in the Aboriginal world.

A well-resourced, adequately staffed multi-disciplinary team is critical for the delivery of quality care to clients with complex needs.

Attention should be given to access issues to encourage members of the whole community to seek treatment (in particular, early in the course of a disease or illness, rather than when it becomes critical). This includes addressing cultural safety issues through appropriate clinic design and use, provision of services in a way that respects local cultural practices, employment of and respect for local Aboriginal staff, and use of appropriate language and communication styles. Other barriers (like shame or social sanctions) may also need to be addressed.

Provision of emergency care is not technically the role of primary health care (although of course, ensuring access to emergency care when it is needed, is). However, many Aboriginal primary health care services – particularly in remote areas – are by necessity involved in the provision of emergency care until the arrival of specialist emergency services, or the evacuation by road or air of the client.

Effective treatment is supported by the use of approved treatment guidelines (for example the *CARPA Standard Treatment Manual*, the Women's Business Manual)

The local primary health care team needs to work collaboratively with visiting specialists and other health care providers to provide the best treatment for community members.

Refer to **Specific Areas A to D** for treatment functions related particularly to alcohol, tobacco and other drugs, early childhood development and family support, aged and disability, and mental health / social and emotional well-being.

1.2 Prevention and early intervention

- **Maternal health services,** including:
  - *Antenatal care* including engagement of woman and family in routine reviews, coordination of access to external service providers *[Examples: ultrasound, pathology, referral to prenatal accommodation, specialist referral],* and antenatal health education *[Examples: nutrition, breast-feeding, self-care, alcohol and drug use, smoking])*
  - *Ensure access to birthing services*
  - *Postnatal care* for mother and baby, including home visits, follow up of any pregnancy problems, depression screening, health education, chronic disease screening and management
- **Child health services,** including immunisation, nutrition, hearing health, developmental screening / follow up, action on all issues affecting child health *[Examples: alcohol and other drug issues, availability healthy food*. See also **Specific Area B: Early childhood development & family support**].
- **Screening and early detection of disease** through appropriate health checks, including:
  - early childhood development checks
  - growth monitoring and action
  - screening of school-aged children
  - adult health checks (including Well Women's / Well Men's health checks)
  - older persons health checks]
- **Chronic disease management and prevention of complications** including recall systems, individual client health education, self-management approaches
- **Immunisation programs**
- **Communicable disease control actions** including notifications *[Examples: STI / BBV, Rheumatic Heart Disease, trachoma, TB]*
- **Support for and coordination with health promotion approaches** *[see **Domain 3: Health Promotion**]*
- **Brief interventions** *[Examples: smoking, nutrition, alcohol, physical activity, emotional well-being]*. See **Specific Area A: Alcohol, tobacco & other drugs**]
- **Old people's checks** including regular review, screening for age related conditions *[Examples: vision/ hearing problems, ability to care for themselves]*

Clinical prevention and early intervention have become the focus of primary health care services for the Aboriginal community in recent years.

This has stemmed from the growing evidence that, firstly, chronic diseases contribute the majority of the 'health gap' between Indigenous and non-Indigenous Australians, and secondly, that the first few years of life (including the months before birth) powerfully shape a person's health and susceptibility to disease over the whole life-course.

Screening should be integrated into regular health checks across the life-course, can be delivered in a planned way for particular disease risks (for example screening for cancer, STIs, oral health, hearing health mental health) or delivered opportunistically for individual clients.

Individual health education for clients at risk and/or their families should take account of 'health literacy' approaches, cultural safety and communication issues [see **Domain 5**], and location – the clinic and the demands surrounding it are not necessarily the best setting for these activities. Appropriate members of the multidisciplinary primary health care team, particularly Aboriginal Health Workers, should be consulted and involved where appropriate.

Brief interventions have been shown to have a positive effect on smoking, alcohol consumption, nutrition, and physical activity levels in mainstream populations, though the evidence is weaker for Indigenous communities. Good clinical governance, established quality improvement systems and appropriate supporting materials are important to ensure brief interventions are delivered consistently but appropriately.

Chronic disease management includes mental health problems, which benefit from regular review and relapse prevention. Mental health issues also frequently occur with other chronic diseases such as diabetes or heart disease.

1.3 Rehabilitation and recovery

- **Care for clients following treatment or discharge from hospital or other institution (with support from external specialised services)** including:
  - implementation of rehabilitation plans following trauma, illness or complications of chronic disease *[Examples: cardiac rehabilitation, stroke rehabilitation, respiratory rehabilitation]*
  - follow up and care following alcohol and other drug treatment [See also **Specific Area A: alcohol, tobacco and other drugs**]
  - mental health recovery and relapse prevention including recall and regular assessment and recognition of crisis management [See also **Specific Area D: Mental health / Social and Emotional Well Being**]
- **Use of case-management / case coordination approaches** to ensure access to a full range of services to support rehabilitation and recovery, including regular assessment and review processes *[Examples: allied health services, mental health services, disability services]*
- **Adequate support for patients during rehabilitation and recovery,** including support for their carers and family members

The goal of rehabilitation and recovery care is to return clients recently treated or discharged from hospital or another institution to independent living.

Close links to allied health and clinical expertise are required, and a case-management or case-coordination approach used to ensure that this goal is met.

The local primary health care service will need to provide care directly, with routine reviews of chronic illness, provision of medicines, education and support for patients and families, and also to support rehabilitation plans. They also play an important coordination role, collaborating with allied health or clinical specialists, to ensure the patients receive specialised support either through outreach visits or tele-health support.

Members of the local primary health care team may need training and support from specialists and allied health professionals.

Advocacy for the needs of individual clients may also be involved [see **Section 4.1 Advocacy**]

Recognition of stress and the physical, psychological and financial impact on carers and effective support for the carers will assist in promoting more successful outcomes for the client.

Mental health recovery includes a return to some meaningful function within the community based on the person's own aspirations, despite the possible presence of lingering symptoms or disability [see **Specific Area D: Mental health / Social and Emotional Well Being**]

Relapse prevention involves assisting individuals and their carers to understand precipitants of relapse and identification of early warning signs. A relapse plan for response to early warning signs and a plan for response to a crisis assist to minimise the risk of relapse and the potential harm should relapse occur.

1.4 Clinical support systems

- **Comprehensive health and family wellbeing information system,** including:
  - medical and case records
  - population register and recall system to support population health activities
  - chronic disease register and recall system to support management of chronic disease;
  - data collection for evaluation / quality assurance
- **Quality systems,** including clear and effective clinical governance processes , use of endorsed guidelines and standard treatment manuals, and active participation in quality processes and CQI [and see **Section 3.8 Quality systems**]
- **Pharmacy services,** including reliable supply of medicines, ensure access to visiting pharmacists (including for Quality Use of Medicines support and Home Medicine Reviews), management of s.100 contracts, meeting of legal obligations and responsibilities
- **Ensure access to visiting specialist and allied health services** in the health centre, in the community or through tele-health [*Examples: psychologists, dentists, physicians, physiotherapists, speech pathologists, paediatricians, palliative care, occupational therapists, diabetes educators]*
- **Ensure access to hospital, diagnostic or specialist services through referrals,** [see **Section 3.5 Administrative, legal and other services**] including
  - liaison with client, family and carers
  - referrals, booking, confirming of appointments
  - patient travel *[Examples: source and support escorts, ensure accommodation]*
  - hospital liaison and discharge processes
  - advocacy regarding access *[Examples: patient travel, road / air strip infrastructure]*
- **Ensure access to / provision of training, education and support** for all members of the primary health care team [see **Section 3.2**]
- **Availability and maintenance of appropriate health service infrastructure** [see **Section 3.6**]
- **Provision and maintenance of standard medical equipment** [see **Section 3.6**]
- **General administration support for clinical services** [*Examples: reception, appointments, filing, Medicare billing* – see **Corporate Services and Infrastructure Sections 3.4 and 3.5**]

With the increasing complexity of primary health care, and the need for local services to provide coordination of care for clients with often complex needs, effective primary health care is increasingly reliant on clinical support systems.

Well-developed, resourced and organised support is also important to maximise the efficiency of the primary health care team.

Primary health care managers need specific training and support to effectively undertake this role. This includes development, maintenance, and active engagement with wider clinical support networks and expertise.

The functions in this area are those particularly related to supporting the effectiveness of clinical services. Note the overlap between this area and **Domain 3: Corporate Services & Infrastructure** , particularly:

3.2 Staff development, training and education

3.5 Administrative, legal and other services

3.6 Infrastructure and infrastructure management

3.8 Quality systems

Notes for Domain 1: Clinical Services

[1] Vos, T., B. Barker, et al. (2007). The burden of disease and injury in Aboriginal and Torres Strait Islander peoples 2003. Brisbane, School of Population Health, The University of Queensland.

[2] World Health Organization (1978). Alma-Ata: Primary Health Care.

[3] World Health Organization (2007). Everybody business : strengthening health systems to improve health outcomes : WHO's framework for action. Geneva, World Health Organization.

[4] Vos, T., B. Barker, et al. (2007). The burden of disease and injury in Aboriginal and Torres Strait Islander peoples 2003. Brisbane, School of Population Health, The University of Queensland.

[5] Eades, S. (2004). Maternal and Child Health Care Services: Actions in the Primary Care Setting to Improve the Health of Aboriginal and Torres Strait Islander Women of Childbearing Age, Infants and Young Children. Darwin: Menzies School of Health Research.

[6] Zhao Y, You J, et al. (2009). Burden of disease and injury in the Northern Territory, 1999-2003. Department of Health & Families. Darwin

[7] Powell Davies G, Harris M, et al. (2006). Coordination of care within primary health care and with other sectors: A systematic review. Sydney, Research Centre for Primary Health Care and Equity, School of Public Health and Community Medicine, UNSW, Wakerman, J., J. Humphreys, et al. (2006). A systematic review of primary health care delivery models in rural and remote Australia 1993-2006, Australian Primary Health Care Research Institute.

[8] Dwyer, J., K. Silburn, et al. (2004). National Strategies for Improving Indigenous Health and Health Care. Canberra, Commonwealth of Australia.

[9] See for example Ah Kit, J., C. Prideaux, et al. (2003). "Chronic disease self management in Aboriginal Communities: Towards a sustainable program of care in rural communities." Australian Journal Of Primary Health - Interchange **9 (2-3)**: 168-176.

DOMAIN 2: HEALTH PROMOTION

Non-clinical measures aimed to improve the health of the community as a whole. Health promotion includes a range of activities from building healthy public policy to providing appropriate health information and education, and encourages community development approaches that emphasise community agency and ownership.

KEY ELEMENTS

2.1 Building health public policy

2.2 Creating supportive environments

2.3 Supporting community action and development

2.4 Health information, education and skills development

2.5 Orienting health services towards health promotion

2.6 Evidence and evaluation

KPIs

Note that broadly-based action on health promotion as described in this Domain will affect many of the AH KPIs agreed by the Northern Territory Aboriginal Health Forum as relating to Health Services (which are listed in full under **Domain 1: Clinical Services***). This applies particularly to those AH KPIs relating to child and maternal health (1.2 Antenatal visits, 1.3 birth weight, 1.5 underweight children, and 1.6 anaemia).*

AHKPI 3.17 Report on service activities (position papers, collaborative meetings and services, published papers, policy submissions, participative research).

AHKPI 4.18 Report on community involvement in determining health priorities and strategic directions through any of the following: health boards; steering committees; advisory committees; community councils; health councils

AHKPI 4.19 Show evidence of appropriate reporting to community on progress against core PIs

BACKGROUND

Consistent with the *Ottawa Charter for Health Promotion*[1], which remains the key international statement in the field, health promotion for the purpose of this Framework is the process of enabling people to increase control over their circumstances and environment and thus to improve their health[2]. As such, it is an important part of comprehensive primary health care.

Broadly speaking, this Domain consists of non-clinical approaches that focus on the prevention of ill health and the promotion of good health across whole communities[3]. Such approaches can be effective in improving population health and wellbeing, reducing the burden of chronic disease and injury, and addressing health inequities[4]. While they require close collaboration with clinical services focused on the treatment of individuals, they often require quite different methodologies and skills to be successful[5].

The *Ottawa Charter* sets out five key areas for action: building healthy public policy, creating settings and environments that are supportive of good health, supporting community action, educating and informing the community, and reorienting health services towards these approaches.

Action across the whole range of these strategies is required. This may involve a mix of activities including health education, skills development, social marketing, community action and advocacy at the local and system-wide levels. Successful approaches will be multi-faceted and integrate health care, community education, community development, and advocacy[6]. Programs that focus on individual behaviour change alone (through information or education, for example) are not well-evidenced and, especially in cross-cultural, resource-poor environments marked by intergenerational disadvantage, risk 'victim-blaming'[7].

Health promotion requires a broad approach to addressing the determinants of health, many of which will lie outside the direct responsibility of health sector service delivery. For example, there is strong evidence that effective family support and stimulation of learning in early childhood leads to significant reduction in adult risk (for example, obesity and smoking) and improved wellbeing [See **Specific Area B Early Childhood Development and family support**]. Important examples in the Northern Territory context also include the evidence surrounding reduced chronic disease risk associated with access to traditional country and the maintenance of outstation lifestyles for Aboriginal people[8] and the effect of regulation of alcohol supply on reducing alcohol-related harm[9].

At all stages, the Aboriginal community needs to be involved in the design, implementation and evaluation of health promotion measures. The response to local priorities must also be informed by what evidence already exists, whether from Aboriginal Australia or other situations (especially those where poverty, social marginalisation and cross-cultural issues affect service delivery). In the face of a relative scarcity of evidence in the Australian Aboriginal context, programs must give evaluation and self-reflective practice a high priority[10].

Health promotion interventions need to be properly resourced, with attention to the provision of support to staff, the provision of ongoing funding and the development of community capacity. One-off, transitory and "pilot" programs will not have a sustained impact[11].

Note that functions in this domain are closely related to those in **Domain 1: Clinical Services**, **Domain 4: Advocacy, Knowledge and Research, Policy and Planning** and **Domain 5: Community Engagement, Control and Cultural Safety**.

FURTHER READING

- Baum, F. (2007). The new public health (third edition). Oxford, Oxford University Press.
- Northern Territory Department of Health (2011). Health Promotion Strategic Framework 2011 - 2015. NT Department of Health. Darwin.
- Rose, G. (1985). "Sick individuals and sick populations." International Journal Epidemiology 14: 32–38
- The International Union for Health Promotion & Education (2002). Evidence of Health Promotion Effectiveness. Shaping Public Health in a New Europe. A Report for the European Commission.
- World Health Organization (1986). Ottawa Charter for Health Promotion. First International Conference on Health Promotion

OTHER SOURCES

- Australian Health Ministers' Advisory Council (2011). Aboriginal and Torres Strait Islander Health Performance Framework Report 2010. AHMAC. Canberra.
- Commission on Social Determinants of Health (2008). Final Report. Closing the Gap in a Generation. Health Equity through Action on the Social Determinants of Health, World Health Organization
- Dwyer, J., K. Silburn, et al. (2004). National Strategies for Improving Indigenous Health and Health Care. Canberra, Commonwealth of Australia.
- Northern Territory Department of Health and Families. (2007). "The Public Health Bush Book (2 volumes)." Available from http://www.health.nt.gov.au/Health_Promotion/Tools_for_Good_Practice/index.aspx
- People's Health Movement. (2000). "People's Charter for Health." from http://www.phmovement.org/en

2.1 Building healthy public policy

- **Participate appropriately in building healthy public policy** to support the health of the community through positive system-level change, including:
  - identifying and gathering data on social determinants of health *[Examples: educational outcomes, poverty and social exclusion, addiction, health system funding and program design]*
  - building alliances with other sectors and organisations, and between health professionals, policy-makers and the community, to better understand and address system-level determinants of health *[Examples: Really Caring for Kids Coalition, People's Alcohol Action Coalition, Close the Gap]*
  - participating in forums for positive policy, legislative and regulatory change *[Examples: media campaigns, high-level policy forums, lobbying, professional organisations, participation in Health Impact Assessments to guide planning processes across sectors]*

Building healthy public policy is about ensuring that structural barriers to health are addressed through public policy including legislation, fiscal measures, taxation and organizational change.

There is strong evidence that this is one of the most effective ways of improving the health of populations.

This requires taking the broadest view of the drivers of ill health, and working to ensure that they are addressed. Creating relationships and working across sectors and organisations is a key strategy for success in building healthy public policy.

Note that the functions described here are similar to those described in **Section 4.1 Advocacy**, relating to system-level advocacy.

2.2 Creating supportive environments

- **Establish core workplace policies and practices** to support a healthy, non-discriminatory and productive workplace environment *[Examples: Occupational Health and Safety, Equal Employment Opportunities, Respectful Behaviour Policies]*
- **Integrate health promotion principles in organisational policies and practices** to create a supportive environment and set an example for other locations *[Examples: non-smoking policies, no grog policies, policies on healthy catering for health service functions, work-life balance measures]*
- **Advocate at the local community level to address determinants of health** in the local environment, including:
  - identification of factors contributing to illness or risk in the community *[Examples: poor housing, lack of access to affordable healthy food]*
  - work with other organisations *[examples: schools, local government, shops]* to develop local strategies to reduce health risk
  - work with other organisations on appropriate enforcement of regulations and agreed guidelines *[Examples: Environmental health and housing standards for remote housing, alcohol restrictions, smoking bans, licensing of community stores]*

Supporting the creation of physical, social and cultural environments which promote health is essential. This includes work both within the primary health care service and outside of it.

Workplaces have been identified as key locations for health promotion efforts, both in terms of occupational health and safety, but also by integrating health promotion principles into the way an organisation operates. Primary health care services in particular can create a supportive and healthy environment for staff and clients, and set an example for other organisations through creating and enforcing healthy workplace policies.

In the community, health services can help to ensure that the health implications of local conditions are understood and addressed by other local or regional organisations. This includes identification of health threats, and health promoting action to address them in collaboration with other organisations.

Note that some of the functions described here are similar to those described in **Section 4.1 Advocacy**, relating to community-level advocacy. See also **Specific Area A: Alcohol, tobacco and other drugs**.

2.3 Supporting community action and development

- **Community involvement in the identification of health needs and in prioritising and planning of health services**
- **Support for the community to make informed decisions** *[Example: appropriate presentation of information to the community about health issues and effective approaches to addressing them]*
- **Mechanisms for feedback to the community on health service performance,** including service activity, Key Performance Indicators and local / regional health data
- **Involvement of the community in evaluation of the organisation and health programs**
- **An inclusive approach that ensures that all groups in a community are given a chance to participate** (including geographically or socially isolated groups)
- **Support for development of local capacity** to maximise community members' ability to participate in community action and development
- **Employment of and respect for local Aboriginal community members**
- **Ensure access to / provision of training and support for staff in participative approaches to service delivery**

Community development approaches form a key part of health promotion. Community development in health seeks to empower people and their communities in a way that improves individual and collective health status.

In this process, the community and its representatives have a role in defining the issues to be addressed and the approaches to be taken – not just in participating in issues and processes that have been defined elsewhere.

At the same time, services have an important role in informing the community about the key health issues they face from the perspective of the public health professional, and also about the evidence for effective measures to address them.

Effective health promotion approaches have been found to be those that include community control or significant input into design and implementation; genuine consultative processes; respect for diversity within communities and across regions, and evaluation and feedback to the community.

Approaches which embody these principles – especially in remote or regional settings marked by great distances and local difference – are resource intensive.

Staff trained in and/or oriented to community development approaches are essential, and the building of honest relationships with communities, their leaders, and organisations is fundamental.

Note that the functions described here closely related to those described in **Section 5.3 Community participation**.

2.4 Health information, education and skills development

- **Development and provision of appropriate group health education:**
  - on key health issues *[Examples: antenatal education, child health, sexual health, alcohol and other drugs, chronic disease management]*; and/or
  - for key population groups [*Examples: school children, young people, first time mothers, old people etc*] [See **Section 1.2 Prevention and early intervention** regarding individual client health education / brief interventions]
- **Development and provision of appropriate community information** on key health issues, using the involvement of local Aboriginal staff and community members as well as health expertise *[Examples: patient information brochures, posters, local radio announcements, online resources, media releases]*
- **Involvement of local Aboriginal staff and community members** in identification of health issues, and design, presentation, and evaluation of all health education and health information sessions or materials
- **Address cross-cultural issues** through involvement of local Aboriginal staff and senior community members, including respect for local community variability across regions
- **Address language and literacy issues** in contexts where English is not the first language or where Aboriginal English is predominant
- **Awareness and use of health literacy and 'strength-based' approaches** to empower clients in making healthy choices avoiding 'victim-blaming' and supporting the diversity of groups within the community

Health promotion that focus solely on efforts to change individual behaviour – especially in cross-cultural contexts marked by inter-generational disadvantage – have been critiqued in recent years as at best ineffective and at worst counter-productive.

However, approaches which seek to increase individual knowledge and skills in a way that supports social and personal development and which are integrated into a broader continuum of health promotion activities are generally supported[1].

Effective approaches to increasing community access to health information, education and skills require high levels of community participation at all stages, particularly in identifying issues of concern to the community, methods and styles for engaging target groups, designing of information / education sessions and evaluation.

Aboriginal Health Workers and other Aboriginal staff have a key role to play in addressing these issues. However, their position as community members must be respected; it may not be appropriate for them to be – or to be seen to be – the local advocates to all of the community on all health issues.

Lack of health literacy is likely to be a barrier to effective health care, especially in remote areas. Addressing health literacy issues is complex and involves actions from both within the health system (e.g. designing processes appropriate to the needs and abilities of the client population, health education) and from outside it (e.g. education sector). [See also **Section 5.1 Engaging individual clients with their health care**]

Addressing language and cultural issues is also critical to good primary health care. Use of language services, including access to interpreters and translation services, cross-cultural training of health professionals and the close involvement of local Aboriginal staff are important.

[1] Mass media campaigns have also been credited with success (in particular in relation to smoking) but for different reasons: through mass coverage of entire populations, even low success rates on an individual level can translate into worthwhile effects at a population level. There is ongoing debate as to the effectiveness of such campaigns in Aboriginal communities. In either case, development of mass-reach media campaigns lies outside the boundaries of primary health care.

2.5 Orienting health services towards health promotion

- **Organisational, clinical and public health leadership that is committed to community prevention approaches** as a key part of comprehensive primary health care including planning to ensure that non-clinical public health activities are maintained in the face of acute care demand
- **Recruitment of health professionals trained or experienced health promotion and public health,** including specialised health promotion staff *[Examples: community-development approaches, full range of health promotion activities, change management]*
- **Recruitment, training and support of local Aboriginal staff** as leaders and facilitators of non-clinical health promotion approaches
- **Maintenance of sufficient infrastructure and resources for community prevention programs** *[Examples: space at health centre, accommodation, vehicles etc]*
- **<u>Ensure access to / provision of</u> training to support health promotion approaches,** including orientation of all members of the primary health care team to the full range of health promotion activities
- **<u>Ensure access to</u> specialist advice and support for health promotion staff,** including for existing evidence of effective programs / approaches, planning, and evaluation.

Primary health care services seeking to shift the focus of their services away from just treatment of illness to a more balanced approach that includes community prevention programs are likely to face several challenges.

First, particularly in regional and remote areas, many health centres face high levels of acute care demand. Shifting resources away from this aspect of care may be seen as a risk for the organisation. It may also be difficult to 'quarantine' staff with health promotion responsibilities from acute demand, particularly if they have acute care skills as well.

Second, is the lack of availability of primary health care staff trained in non-clinical prevention methods. Recruitment, retention and training of staff with health promotion skills is likely to require reorientation of effort in many cases. Further, while Aboriginal Health Workers and other Aboriginal staff are likely to be central to any genuine attempt at community prevention approaches, it cannot be assumed that their Aboriginality and knowledge of the community *in themselves* equip them for effective community prevention work – they too are likely to need appropriate support and training in public health methodologies.

Third, lack of space and physical infrastructure (particularly in remote locations) is likely to privilege more 'urgent' acute care over longer-term prevention, including for example, issues such as space within the health centre, accommodation for locally-based or visiting public health staff, and availability of vehicles.

Last, community prevention approaches require time and the building of effective partnerships with other organisations and relationships with the community. Maintaining these in an environment marked by short-term project funding and high staff turnover may be a challenge.

2.6 Evidence and evaluation in health promotion

- **Ensure health promotion programs take account of the evidence and principles for success** of such programs both within Indigenous Australia and other marginalized populations, while retaining sensitivity to local community priorities
- **Ensure the local community decision-makers are informed about what evidence exists for addressing issues they identify**
- **Use health promotion continuous quality improvement and/or planning and evaluation approaches** *[Example: Quality Improvement Program Planning System]* to better document health promotion work and to build a more robust evidence-base in relation to remote and Aboriginal health promotion practice [See **Section 3.8 Quality systems**]
- **Build evaluation into all stages of health promotion approaches,** including fostering on-going self-reflective practice and involving the community in evaluation processes

Broadly based health promotion processes that seek to change a population's health through non-clinical methods are agreed to be effective and some principles have been identified for success. Successful measures tend to:

- be multi-faceted (for example incorporating health care, community development and regulatory components)
- be well-resourced over a significant time-period
- work in partnership with other organisations and sectors
- genuinely involve the community in design, implementation and evaluation.

Similarly, some approaches are not well-evidenced – health promotion that focuses solely on changing individual behaviours, or short-term, one-off projects, for example.

Measuring the effectiveness of health promotion is difficult, and the evidence of 'what works' in specifically Australian Indigenous contexts is sparse. Because of this – and because of the importance placed on addressing local community priorities – some innovation is both necessary and desirable. However, this innovation must take account of what evidence *does* exist (drawing from what is known for Indigenous Australia, but also from other contexts marked by poverty and marginalization) and be designed accordingly.

Under these conditions, evaluation and self-reflective practice need to be given a high priority. Evaluation needs to be built into programs from the design phase and made part of practice (rather than, for example, being seen as a stand-alone activity to be completed in the last few weeks of a program). In order to build the evidence in the field as a whole, evaluation processes should be explicitly looking for and documenting what does not work, as well as what does in a program.

Notes for Domain 2: Health Promotion

[1] World Health Organization (1986). Ottawa Charter for Health Promotion. First International Conference on Health Promotion.

[2] See also Australian Health Ministers' Advisory Council (2011). Aboriginal and Torres Strait Islander Health Performance Framework Report 2010. AHMAC. Canberra.

[3] While there is no absolute dividing line between clinical / non-clinical measures, for the purpose of this Framework, *clinical* health measures which are sometimes included in broad definitions of health promotion (such as immunisation and screening programs) are dealt with under **Domain1: Clinical services.**

[4] Northern Territory Department of Health (2011). Health Promotion Strategic Framework 2011 - 2015. NT Department of Health. Darwin.

[5] Rose, G. (1985). "Sick individuals and sick populations." International Journal Epidemiology **14**: 32–38.

[6] The International Union for Health Promotion & Education (2002). Evidence of Health Promotion Effectiveness. Shaping Public Health in a New Europe. A Report for the European Commission, Australian Health Ministers' Advisory Council (2011). Aboriginal and Torres Strait Islander Health Performance Framework Report 2010. AHMAC. Canberra.

[7] Baum, F. (2007). The new public health (third edition). Oxford, Oxford University Press.

[8] Rowley, K. G., A. Gault, et al. (2000). "Reduced prevalence of impaired glucose tolerance and no change in prevalence of diabetes despite increasing BMI among Aboriginal people from a group of remote homeland communities." Diabetes Care **23**(7): 879-881, Rowley, K. G., K. O'Dea, et al. (2008). "Lower than expected morbidity and mortality for an Australian Aboriginal population: 10-year follow-up in a decentralised community." MJA **188**: 283-287.

[9] Gray, D., S. Saggers, et al. (2000). "Beating the grog: an evaluation of the Tennant Creek liquor licensing restrictions." Aust N Z J Public Health **24**(1): 39-44.

[10] National Health and Medical Research Council (2006). Cultural competency in health: A guide for policy, partnerships and participation. Canberra, Commonwealth of Australia.

[11] Griew, R., E. Tilton, et al. (2008). A Review of evidence regarding chronic disease prevention in Aboriginal and Torres Strait Islander communities. A Report for the Australian Population Health Development Principal Committee (APHDPC). Canberra.

DOMAIN 3: CORPORATE SERVICES AND INFRASTRUCTURE

Functions to support the provision of health services, including the availability and support of well-trained staff, financial management, infrastructure, information technology, administration, management and leadership, and systems for quality improvement across the organisation.

KEY ELEMENTS

3.1 Management and leadership

3.2 Workforce

3.3 Staff development, training and education

3.4 Financial management

3.5 Administrative, legal and other services

3.6 Infrastructure and infrastructure management

3.7 Information technology

3.8 Quality systems

KPIs

AHKPI 2.13 Report on unplanned staff turnover (where possible by occupation) over each 12 month period.

AHKPI 2.14 Report on recruits (excluding locums) completing an orientation and induction program, including cultural awareness.

AHKPI 2.15 Report on overtime workload.

AHKPI 2.16 Report on quality improvement systems including the use of best practice guidelines; e.g. CARPA.

BACKGROUND

Health systems are often thought of as consisting of health services such as, for example, acute care, immunizations or health promotion. However, the extent to which such health services are able to be effective depends to a large extent on how they are supported and organised[1]. Every organisation delivering primary health care therefore needs well-organised and resourced corporate support functions if its services to the community are to be effective. This is true whatever the governance structure or scale of the organisation.

A changing policy environment, increasingly complex funding and reporting arrangements, increases in resources and a growth in the size and complexity of primary health care services, have all resulted in an increased administrative load and higher levels of corporate skills required throughout organisations[2]. The effect of this complex environment in creating an administrative 'overburden' particularly on community controlled health services has been well-documented and recognised[3].

In this environment, it is particularly the case that many of the key barriers to or enablers of sustainable primary health care innovation and effectiveness are to be found in what could broadly be called the corporate domain: in the supply of skilled staff, building relationships with other organisations, the level and complexity of funding, infrastructure, and the existence of quality improvement systems across the whole organisation[4].

As with many of the other functions in this Framework, primary health care service delivery organisations do not necessarily need to deliver all corporate functions themselves. Some may be out-sourced through centralised or shared organisations (as may be the case with Government Departments, or with 'hub' style arrangements[5]). In all cases the important issue is that the service delivery organisation has processes in place to guarantee the effective delivery of the function.

Costs of administrative support and corporate functions of all kinds are likely to be significantly higher for services delivered in remote areas.

FURTHER READING

- AMSANT (Aboriginal Medical Services Alliance Northern Territory). "Administration Manual for Aboriginal Primary Health Care Services in the Northern Territory." http://www.amsantmanual.com/03aboriginalhealth.html.
- Dwyer, J., O'Donnell K, et al. (2009). The Overburden Report: Contracting for Indigenous Health Services. Darwin, Cooperative Research Centre for Aboriginal Health.
- Silburn, K., A. Thorpe, et al. (2010). Taking Care of Business: Corporate Services for Indigenous Primary Healthcare Services. Darwin, Cooperative Research Centre for Aboriginal Health.
- Wakerman, J., J. Humphreys, et al. (2006). A systematic review of primary health care delivery models in rural and remote Australia 1993-2006, Australian Primary Health Care Research Institute.

OTHER SOURCES

- Australian Health Ministers' Advisory Council (2011). Aboriginal and Torres Strait Islander Health Performance Framework Report 2010. AHMAC. Canberra.
- Brailsford, R. (2006). No Visible means of support: A discussion paper exploring the case for a centralised resource agency to support the Northern Territory Aboriginal community controlled health service network. Darwin Cooperative Research Centre for Aboriginal Health and the Aboriginal Medical Services Alliance Northern Territory.
- Donato, R. and L. Segal (2010). "The economics of primary healthcare reform in Australia - towards single fundholding through development of primary care organisations." Aust N Z J Public Health **34**(6): 613-619.
- Hunt, J. and D. E. Smith (2006). Building Indigenous community governance in Australia: Preliminary research findings. Canberra, Centre For Aboriginal Economic Policy Research. **Working Paper No. 31/2006**
- Jackson, T. and M. Sorgenfrei (2003). Cross-Cultural Management and NGO Capacity Building: How Can Knowledge Transferability Be Managed Across Cultures?, The International NGO Training and Research Centre. **Praxis Note 3**.
- Shannon, C. and H. Longbottom (2004). Capacity Development in Aboriginal and Torres Strait Islander Health Service Delivery – Case Studies. Aboriginal and Torres Strait Islander Primary Health Care Review: Consultant Report No 4, Office of Aboriginal and Torres Strait Islander Health.

3.1 Management and leadership

- **Management and leadership that supports effective, accountable and flexible service delivery models** appropriate to the service delivery area and able to respond to changing policy and funding environments, including:
  - **leadership that motivates and supports staff**, establishing a clear sense of purpose and strategy based on agreed goals, and ensuring staff are resourced & supported to achieve them
  - **management and leadership processes that support accountability** to funding agencies and to the community [see **Domain 5**]
  - **processes to recognise, support and integrate Aboriginal leadership and management styles**
  - **effective partnerships between management, corporate and health professional leadership** (especially clinical / public health leadership) through organisational structures and reporting / advisory mechanisms, to promote effective services and a focus on a comprehensive approach to primary health care
- **Coordination with external agencies** at the organisational level
- **Systems to support management and service delivery leaders** within an organisation *[Examples: management training, support staff]*, especially for Aboriginal staff
- **Succession planning** for senior positions
- **Sound management of resources, systems, programs and projects** that enable, organise and monitor service delivery
- **Risk management processes** to identify and manage risk *[Examples: workforce supply, key staff, service viability, IT systems]*
- **Participation in planning implementation of system development processes at local, regional and Territory levels**

The complexity of comprehensive primary health care, the high level of need in Aboriginal communities, changing policy and funding environments, and the necessity of developing and maintaining strong networks and relationships between the primary health care service and other organisations, all place a high premium on leadership and good management.

Organisational and service delivery leaders need to be supported in their roles, and managers must work together to ensure different areas of the organisation are integrated rather than operating as separate 'silos'. Succession plans should be in place for key positions.

Cross-cultural issues relating to Aboriginal management and leadership styles and priorities may need to be recognised and addressed.

Provision of management training and adequate support staff and systems are necessary to ensure robust and flexible organisational leadership.

Risk management and disaster recovery processes may also be necessary.

Note that issues relating to governance of community controlled health services are dealt with under **Domain 5: Community engagement, participation and cultural safety** below.

3.2 Workforce and HR management

- **Effective and appropriate staff recruitment processes**
- **Staff induction and orientation** *[Examples: cultural safety training, organisational history and structure, service delivery environment]*
- **Staff support** (including conflict resolution and counselling)
- **Industrial relations,** including grievance procedures, staff termination practices (including exit interviews)
- **Systems to cover planned and unplanned leave and other vacancies** *[Example: locum services]*
- **Staff performance management and appraisal systems**
- **Workforce planning** to ensure continued availability of skills within the organisation and/or region
- **Policies and practices to support a healthy, safe, non-discriminatory and productive workplace environment** *[Examples: Occupational Health and Safety policies, Equal Employment Opportunities, Respectful Behaviour Policies, staff security processes including on-call arrangements, duress alarms etc]*
- **HR processes that encourage and support Aboriginal employment**
- **Processes to manage rehabilitation of injured or ill staff and workers' compensation matters**
- **Monitoring and internal reporting on key workforce indicators** to ensure effective workforce management
- **Ensure access to staff support services** *[Examples: Employee Assistance Services, unions and professional organisations]*
- **Support for student / trainee placements as part of health workforce development** *[Examples: medical, nursing, allied health, Aboriginal Health Worker]*

The effectiveness of primary health care service delivery in Aboriginal Australia is frequently limited by workforce issues.

Appropriately skilled staff may be unavailable, especially in regional and remote areas; staff turnover may be high undermining the effectiveness of many programs; and education, training and support services may be unavailable. Short-term or project-based funding can also undermine the building of an effective workforce.

Despite these challenges, some organisations are very successful in recruiting and retaining quality staff. Robust and appropriate HR management is an important factor.

Primary health care services also play a significant role in health workforce development, for example through placements for students and trainees.

Recruiting and supporting Aboriginal staff, especially local Aboriginal staff, should be a key strategy to address workforce issues and to strengthen service capacity to provide culturally safe services and engage effectively with the community [see **Domain 5: Community engagement, participation and cultural safety**].

Aboriginal health care services can be demanding and sometimes stressful paces to work. Staff deal with high levels of health need, in resource-poor contexts, in uncertain environments. Many staff may be new to Indigenous Australia, to the Northern territory, or to primary health care, or to all three. Consequently, at all levels of an organisation staff may experience stress, conflict, and 'burn-out' and may need high levels of support in order to do their jobs effectively.

Effective orientation – including in cultural safety – will assist staff to deal with the demands they face and to provide effective services.

Local health service managers are often drawn from the ranks of clinical staff. They may need particular support and professional development to ensure they have the skills necessary to manage their local primary health care team.

3.3 Staff development, training and education

- **<u>Ensure access to / provision of</u> education, training and development for all staff** to ensure they are appropriately skilled for the jobs they are expected to carry out, including:
  - **Aboriginal Health Worker education**
  - **Continuing Professional Development** for health professionals
  - **Professional development for managers in HR and management skills,** including at the local health service level
  - **Continuing staff development for non-professional staff** *[Examples: administration, reception, cleaners and drivers etc]*
- **Performance appraisal processes that identify staff training and development needs**
- **<u>Ensure access to / provision of</u> ongoing training and support in cultural safety** to ensure all staff are able to practice in a culturally secure manner
- **<u>Ensure access to / provision of</u> training of health staff in the management and presentation of major illnesses** including in the use of standard treatment guidelines and protocols
- **Staffing arrangements that provide staff the time to attend training and in-services** *[Examples: adequate staffing levels, flexible working arrangements]*

Staff development, training and education are key strategies in all health services. It is even more important where many health staff are new to the Aboriginal primary health care sector.

High staff turnover, the continually changing nature of health care, the need to keep skills up to date, and the need to reinforce culturally safe practice require on-going rather than one-off (e.g. at induction) approaches to staff training and development.

Aboriginal staff may need specific processes of training and development to support their recruitment and retention in the organisation. This includes Aboriginal professional staff, managers and administration staff, as well as Aboriginal Health Workers, Aboriginal Community Workers etc.

3.4 Financial management

- **Strong and transparent financial management systems** underpinned by compliance with national and Territory legislation and standards
- **Accurate and timely financial reporting** to funding agencies
- **Preparation of meaningful financial reports for Aboriginal governing bodies** (community controlled health services)
- **Management of complex set of accounts with multiple funding sources** and a mix of recurrent and non-recurrent funding, including:
  - **monitoring spending and budget compliance,** and ensuring programs have meaningful and timely budget reports
  - **payroll and staff entitlements**
  - **maximising opportunities for income generation** from Medicare and other sources
  - **financial delegation processes**
  - **billing processes** (including Medicare)
  - **procurement processes** *[Examples: medical, office supplies, capital equipment]*
  - **purchasing of clinical services** *[Examples: allied health, specialist services]*
  - **assistance with development of funding submissions**

Appropriate and effective financial planning and management is an essential foundation for all primary health care services.

Transparency of financial management processes is necessary both externally (for accountability) and internally to enable program areas to have clarity about funding and budgets to underpin good planning and reduce risk.

For community controlled health services, a key challenge remains the well-documented complexity, variability and changeability of funding arrangements and reporting formats.

3.5 Administrative, legal and other services

- **System for the development, dissemination and update of organisational policies and procedures,** including accessing / adapting relevant policies from other services or sources *[Example: AMSANT Administration Manual]*
- **Document and data management** *[Examples: patient information, reminder and recall systems, Medicare processing systems, general filing]*
- **Local services support** including cleaning, gardening, reception, and filing
- **Systems to support organisation of patient transport, bookings to referred services, and follow ups** [see **Section 1.4 Clinical support services**]
- **Support for organisational change and development processes,** including restructuring and planning processes
- **Dealing with one-off or ad hoc requests for information** from funding agencies, other areas of a Government service, or other external bodies
- **Support for governing body processes** (community controlled health services) including reporting systems to ensure compliance with contractual and statutory obligations [See also **Section 5.3 Governance and community control**]
- **Clearly defined requirements and processes regarding medico-legal risk** for individuals and the organisation *[Examples: registration, appropriate indemnity / insurance levels]*
- **Public affairs, media and marketing**
- **Ensure access to / provision of legal services** *[Examples: for contract formulation and management, dispute resolution, advice regarding legislation, organisation rule-book / constitution issues etc]*

All services require adequate general administration and support services. Deficits are likely to impact on clients and service delivery staff. For example, lack of provision of cleaning services may lead to these functions having to be carried out by AHWs or nurses; lack of reception staff may lead to community frustration and 'no shows'.

For community controlled health services, complex funding streams, including a high proportion of one-off or single-issue projects, can result in under-resourced and fragmented administrative systems that limit overall service effectiveness.

Administrative support for patient travel and Medicare billing processes are necessary to support clinical services.

Support to deal with the media can be critical in ensuring sector or service perspectives are presented to the public in a constructive and considered fashion [see especially **Sections 2.1 Building health public policy** and **2.3 supporting community action and development**].

See **Section 1.4** for clinical support systems (including Patient Information and recall Systems, clinical training and support, etc)

3.6 Infrastructure and infrastructure management

- **Adequate and appropriate health service infrastructure** including clinics buildings, vehicles, and equipment
- **<u>Ensure access to / provision of</u> adequate and appropriate accommodation for staff** (residential and visiting) particularly in remote areas
- **Infrastructure and assets management,** including capital planning (in particular related to service expansion) and asset management and review processes
- **Infrastructure repairs and maintenance** (including vehicle management, housing etc)
- **Tenancy management** processes for staff and/or visiting service providers
- **Ensuring health service buildings meet appropriate design and safety standards** *[Examples: Disability Service Standards, Universal Design Principles]*
- **<u>Ensure access to / provision of</u> transport and coordination of transport for clients**
- **Advocacy as required on public infrastructure** (roads, airstrips etc) that affect client access to services

The lack of infrastructure or infrastructure that is of poor quality or inadequately maintained is likely to be a key limiter on service effectiveness, especially in remote areas. Key infrastructure that may be taken for granted in urban centres of Australia may be poor or non-existent in much of Aboriginal Australia.

Much health service infrastructure is outdated and in need of replacement or upgrade.

Adequate local accommodation for staff (including all members of the primary health care team) is critical to allow service expansion, and to reduce staff turnover.

Access to services through the provision and maintenance of a suitable number of health service vehicles is critical.

Issues of public infrastructure such as roads and airstrips, while beyond the direct responsibility of primary health care services, are nevertheless important issues upon which the health service may advocate for the needs of their community [see **Section 4.1 Advocacy**].

3.7 Information technology

- **Appropriate and reliable IT systems** to support coordination and integration of care, decision-making, quality assurance and accountability, and other functions
- **Systems and processes to enable connectivity and information sharing with other health providers** as appropriate
- **Telecommunications** *[Examples: email, satellite phone, phone and fax, tele-health]*
- **Management of IT contracts and service level-agreements**
- **IT systems planning** (including 'future-proofing' IT systems)
- **Hardware and software maintenance and upgrades**
- **Ensure access to / provision of technical IT training and support** for all areas of the organisation

Information Technology (IT) is a integral part of contemporary primary health care services. However, there are significant challenges in providing IT services for many Aboriginal health services.

Remote areas in particular face additional technical issues, high costs, and delays in upgrading or repairing IT systems.

Project-specific funding for community controlled health services can contribute to more general difficulties in strategic IT planning and infrastructure management.

Training in use of IT systems is likely to be an important issue, both for staff with low literacy / numeracy, and for staff unfamiliar with primary health care IT systems.

3.8 Quality systems

- **Quality systems, including support for Continuous Quality Improvement (CQI) processes across the organisation,** reporting and accreditation, and compliance with legislative requirements
- **Building capacity for CQI** including in areas relevant to corporate functioning to support regular organisational reflection, review and problem solving
- **Establish and support effective processes for clinical governance** that focus on quality care and patient outcomes through staff participation and leadership *[Examples: ensuring staff work within competencies, registration, risk management approaches, use of KPIs, clear lines of responsibility and reporting, clinical performance evaluation]*
- **<u>Ensure access to / provision of</u> support for clinical and organisational accreditation processes,** including:
  - undertaking accreditation assessment plans
  - developing and implementing accreditation work plans
  - understanding how accreditation will affect organisations
  - building expertise amongst Aboriginal staff to be accreditation surveyors
- **Encourage and support staff to develop, maintain and participate in professional networks** in clinical and non-clinical domains
- **Provision of appropriate health information to governing Boards, local councils, health committees and other relevant forums and service providers**
- **Developing documents and processes to support community input into CQI processes**
- **Appropriate and effective systems and processes to identify report and manage incidents and 'near misses'**

Continuous Quality Improvement (CQI) processes need to be embedded across the organisation. This includes not just clinical and health promotion functions – traditionally the focus of CQI processes – but all aspects of a comprehensive primary health care model.

Properly documented plans across the organisation provide a key tool for CQI processes, allowing each area of the organisation to reflect on its achievement against planned goals and the need for any improvements or changes [See **Section 4.3 Policy and planning**.

Accreditation processes (for example against ISO, QIC and AGPAL standards) represent a formal process to measure functions against standards. Such processes can be highly valuable in building and maintaining a high quality service. They also are highly resource intensive, requiring considerable staff time and administrative resources to complete successfully.

Where accreditation processes do not cover all aspects of comprehensive primary health care practice, the organisation may need to look for standards in specific areas [Example: the Commonwealth Government's '*National Standards for Mental Health Services*' in relation to mental health services].

CQI processes should include input from clients, other community organisations and the community.

While CQI processes should be adopted across all functions of the organisation, clinical governance processes need particular attention [See also **Section 1.4 Clinical support systems**].

Notes for Domain 3: Corporate Services and Infrastructure

[1] World Health Organization (2000). The world health report 2000: Health systems: improving performance. Geneva.

[2] Silburn, K., A. Thorpe, et al. (2010). Taking Care of Business: Corporate Services for Indigenous Primary Healthcare Services. Darwin, Cooperative Research Centre for Aboriginal Health.

[3] Hunt, J. and D. E. Smith (2006). Building Indigenous community governance in Australia: Preliminary research findings. Canberra, Centre For Aboriginal Economic Policy Research. **Working Paper No. 31/2006**, Dwyer, J., O'Donnell K, et al. (2009). The Overburden Report: Contracting for Indigenous Health Services. Darwin, Cooperative Research Centre for Aboriginal Health.

[4] Sibthorpe, B. M., N. J. Glasgow, et al. (2005). "Emergent themes in the sustainability of primary health care innovation." Med J Aust **183**(10 Suppl): S77-80. Wakerman, J., J. Humphreys, et al. (2006). A systematic review of primary health care delivery models in rural and remote Australia 1993-2006, Australian Primary Health Care Research Institute, Naccarella, L., D. Southern, et al. (2008). "Primary care funding and organisational policy options and implications: a narrative review of evidence from five comparator countries." Med J Aust **188**(8 Suppl): S73-76.

[5] Silburn, K., A. Thorpe, et al. (2010). Taking Care of Business: Corporate Services for Indigenous Primary Healthcare Services. Darwin, Cooperative Research Centre for Aboriginal Health.

DOMAIN 4: ADVOCACY, KNOWLEDGE AND RESEARCH, POLICY AND PLANNING

Includes health advocacy on behalf of individual clients, on local or regional issues, or for system-wide change; the use of research to inform health service delivery as well as participation in research projects; and participation in policy and planning processes (at the local / regional / Northern Territory and national levels).

KEY ELEMENTS

4.1 Advocacy

4.2 Knowledge and research

4.3 Policy and planning

KPIs

AHKPI 3.17. Report on service activities (position papers, collaborative meetings and services, published papers, policy submissions, participative research).

BACKGROUND

Advocacy is a key part of primary health care[1]. Fundamental to advocacy in health care is the recognition that many of the determinants of the health of individuals and communities lie outside the direct responsibility of even the most comprehensive health service. While not directly responsible for housing, education, employment or the supply of healthy food (for example), health services and practitioners nevertheless have a role in advocating on these and other determinants of health.

Advocacy to promote better health can take place on the level of individual clients, at the local community or regional level, or aim for system-wide change. In all cases, it requires the building of relationships with organisations outside the health service and even outside the health sector[2], for example, with education providers, local government, housing associations, shops etc.

Public health advocacy has emerged as one of the key developments in the field of primary health care over recent decades[3]. It seeks system-level change, addressing 'upstream' factors such as the regulatory environment, and policies and practices that can make it easier for individuals to make healthy choices[4]. The methods available for public health advocacy may be different for different organisations (especially for community-controlled / Government-run organisations).

Participation in high-level policy forums (such as the Northern Territory Aboriginal Health Forum and/or peak bodies and/or professional forums) can be important vehicles for advocacy for better health.

Research and knowledge are powerful tools for improving the evidence base of 'what works' in health and contributing to better health service delivery[5]. New ways of conducting research have emerged in the last twenty years that aim to involve Aboriginal people and communities at every stage of the research agenda, place particular emphasis on the translation of research findings into service and policy action, and use research as an opportunity for the transfer of knowledge and skills[6].

Health service delivery organisations are increasingly using applied research methods to address service delivery issues, either by themselves or in collaborative relationships with researchers or research organisations – a health service might contract a research anthropologist to provide advice on the cultural safety of its buildings and services, for example. The Cooperative Research Centre for Aboriginal and Torres Strait Islander Health Research, its predecessor organisations, and its current host organisation, the Lowitja Institute, have become important advocates and exemplars of this approach[7].

Health planning can be demanding, but is essential for effective service delivery[8]. Well-planned services are able to make best use of resources available, and help health services maintain a focus on aspects of health care (such as community engagement, health promotion, prevention etc.) that may get overwhelmed in environments marked by high acute care demand.

The 'regionalisation' process currently underway across the Northern Territory places particular demands on health services, communities, and policy-makers as the jurisdiction moves towards single-providers under community control in each of the 14 Health Service Delivery Areas (HSDAs) in the Northern Territory[9].

Policy development in Aboriginal primary health care in the Northern Territory is a collaborative process, involving management and leadership from both levels of government and the community controlled health sector. Broad and effective participation in these processes maximises the chances that policy and planning at the highest level will be lead to better services 'on the ground'.

FURTHER READING

- Chapman, S. (2001). "Advocacy in public health: roles and challenges." Int J Epidemiol 30(6): 1226-1232.
- Commonwealth of Australia (2001). Better Health Care: Studies in the successful delivery of primary health care services for Aboriginal and Torres Strait Islander Australians. Canberra.
- Dwyer, J., K. Silburn, et al. (2004). National Strategies for Improving Indigenous Health and Health Care. Canberra, Commonwealth of Australia.
- National Health and Medical Research Council (2003). Values and Ethics: Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research. Canberra.
- Laycock, A., D. Walker, et al. (2011). Researching Indigenous Health: A Practical Guide for Researchers. Melbourne, The Lowitja Institute
- Northern Territory Aboriginal Health Forum (2010). NT Regionalisation of Aboriginal Primary Health Care Guidelines: Supporting a Pathway to Regional Aboriginal Community Control. Department of Health and Aging - NT Department of Health and Families - Aboriginal Medical Services Alliance of the Northern Territory.

OTHER SOURCES

- AMSANT (Aboriginal Medical Services Alliance Northern Territory). (2009). "Aboriginal health research policy." Retrieved 15 June 2011, from http://www.amsant.org.au/documents/article/147/AMSANT%20Research%20Policy%20as%20amended%20October%202010.pdf
- Baum, F. (2007). The new public health (third edition). Oxford, Oxford University Press
- Savigny, D. d. and T. Adam, Eds. (2009). Systems thinking for health systems strengthening, Alliance for Health Policy and Systems Research, World Health Organization.
- Silburn, K., A. Thorpe, et al. (2010). Taking Care of Business: Corporate Services for Indigenous Primary Healthcare Services. Darwin, Cooperative Research Centre for Aboriginal Health.
- World Health Organization (2008). The world health report 2008 : primary health care now more than ever.

4.1 Advocacy

- **Advocate for the health of individual clients** including those with special needs *[Examples: old people, those with disabilities or mental health issues]* including advocacy:
  - for access to other health services
  - on issues affecting an individual client's health *[Examples: client housing, welfare issues, advocacy on behalf of carers]*
  - on client's rights within and beyond the health system
  - referral of clients to other advocacy / information services as appropriate.
- **Advocate at the local community level** to address determinants of health which lie outside the direct responsibility of the health system, including:
  - identification of factors contributing to illness or risk in the community *[Examples: poor housing, lack of access to affordable healthy food]*
  - work with other organisations *[examples: schools, local government, shops]* to develop local strategies to reduce health risk
  - work with other organisations on appropriate enforcement of regulations and agreed guidelines *[Examples: Environmental health and housing standards for remote housing, alcohol restrictions, licensing of community stores]*
- **Participate appropriately in public health advocacy to support positive system-wide change,** including:
  - identify and gather data on social determinants of health with system-level impacts on health *[Examples: educational outcomes, poverty and social exclusion, addiction, health system funding]*
  - build alliances with other sectors and organisations, and between health professionals, policy-makers and the community, to address system-level determinants of health
  - participate in forums for policy, legislative and regulatory change *[Examples: media campaigns, high-level policy forums, lobbying, professional organisations]*

Many factors that affect the health of the individual lie outside the direct responsibility of the health system. Poor housing, lack of access to affordable healthy food, and lack of access to education are just some of the factors which have a powerful effect on the health of those in the community a health centre serves.

While primary health care staff are not directly responsible for these issues, advocating for them to be addressed is a core feature of comprehensive care.

Advocacy begins with individual clients, assisting them to address issues affecting their health and helping to ensure that their rights are respected. This level of advocacy is most important for the most marginalised members of society.

Other factors drive health outcomes across the whole community. Addressing these drivers of ill-health at the local or regional level is critical to building healthier communities in the long-term [see **Domain 2: Health Promotion**]. Services in the Territory have been successful, for example, in advocating for restrictions on local alcohol availability.

Some drivers of ill-health may require interventions at a system-wide level. Public health advocacy is about overcoming the structural barriers to health by working for healthy public policy including appropriate legislative frameworks (for example, regarding liquor licensing, or tobacco control).

Advocacy at the individual level is likely to involve similar activities whatever the governance structure of a health service. However, government and community controlled health services may have different methods for community-level and especially system-level advocacy.

Many non-government services, while mindful of their relationships with Government bodies, see forthright public advocacy as part of their core business. Advocacy in both government and non-government services must respect internal management and governance processes.

A common theme for all levels of advocacy is 'intersectoral collaboration' – working with other sectors and organisations to address the determinants of health [See **Domain 2: Health promotion**].

4.2 Knowledge and research

- **Assess requests for and negotiate participation in external research processes** *[Examples: assess the 'fit' of researcher priorities local health needs / priorities and the capacity for the local and wider communities to benefit from the research, negotiate research contracts, agreements and MOUs]*
- **Participate in external research processes (where appropriate)** in a way that protects the interests of clients and employees, is culturally safe and maximises Aboriginal participation and control, leads to knowledge and skills transfer, and produces useful and useable results
- **Develop local community priorities for research**
- **Carry out or commission applied research** on locally or regionally identified priorities to inform service design and practice
- **<u>Ensure access to / provision of</u> expertise to interpret research, evidence and 'best practice'** to inform and improve local service delivery
- **Participate as necessary in strategic collaboration to set priorities for Aboriginal health research** *[Examples: participation in governance and/or planning processes of research organisations]*

Research can play an important role in improving Aboriginal health and health service delivery.

Two developments over recent years impact in particular on primary health care services.

First is the volume of research being carried out with primary health care services used as sites for research projects. This has led to a greater burden on those running health services and on governance bodies as requests for participation need to be assessed and negotiated. Hosting research may also require time and resources from staff, and accommodation and space for researchers etc. Health services must balance these costs against possible benefits to the organisation and more broadly to health services elsewhere.

The second major development has been the emergence of new ways of doing research, allied with an increase in Aboriginal researchers. Principles of Aboriginal participation and control; the transfer of research into practice; and the provision of research and training opportunities for Aboriginal people are now considered best-practice for Aboriginal health research.

Research must be conducted in accordance with accepted ethical and professional standards and have appropriate Ethics Committee approval.

Applied research at a local or regional level includes service and quality improvement activities, needs assessments, program evaluations, and problem solving. Increasingly service delivery organisations are identifying their own applied research needs, and commissioning it to be carried out either under their own auspices or in partnership with external research organisations.

Primary health care organisations also need to ensure access to research, knowledge and evidence to inform their own practice, particularly clinical services [see **Domain 1**] and health promotion activities [see **Domain 2**]. This may need specialised skills in accessing and critical appraisal of the evidence, presenting it to community decision-makers, and adapting its lessons to local conditions and priorities.

4.3 Policy and planning

- **Organisational planning processes** that encourage and support reflective service delivery *[Examples: strategic planning every 3 to 5 years or as needed, annual business planning, workforce planning, infrastructure and IT planning]*
- **Service delivery planning at local level** that align with health priorities and higher level plans *[Examples: daily / weekly /monthly work plans for primary health care team]*
- **Participation in regional health planning processes** that include consultation with other service providers and the community and take into account drivers of health outside the direct responsibility of the health system
- **Participation in Northern Territory and national policy development processes** *[Examples: government policy development processes, participation in peak body policy processes]*
- **Support health service staff to participate in planning and policy development processes** *[Examples: organisational commitment, adequate resourcing of planning processes, staffing levels that allow participation, training for staff in planning and policy processes]*
- **Ensure community input into policy and planning processes**

Health planning at the local, organisational and regional level is a key feature of primary health care in the Northern Territory.

Planning increases the chances that a health service's activities will lead to desired results. In primary health care it is an important way of getting the best use of limited resources. It is also a way of ensuring that a service maintains focus on activities that will have the best result – for example, by ensuring that prevention and health promotion measures are not neglected.

Aboriginal health policy making in the Northern Territory is a collaborative exercise involving both Commonwealth and Northern Territory health departments and the community-controlled sector. Participation in these processes can be time-consuming (especially for those in management and leadership positions) and require resourcing.

Regional (Health Service Delivery Area) health planning processes are an agreed process that require substantial investment of time and resources from both government and community controlled health services.

All planning processes must:

- ensure appropriate community input, including by being conducted in a way that encourages and supports community participation; and
- be conducted in a way that is inclusive of all necessary members of the health organisation and the primary health care team.

Health practitioners and other health staff may need support to participate in health planning processes. In particular, policy and planning processes require skills that health staff may need training, mentoring or other support to develop.

Notes for Domain 4: Advocacy, Knowledge and Research, Policy and Planning

[1] See, for example: Australian Medical Association. (2010). "Primary Health Care." Retrieved 22 September, 2010, from http://ama.com.au/node/5992., Australian Primary Health Care Research Institute (APHCRI). "What is Primary Health Care?" Retrieved 22 September, 2010, from http://www.anu.edu.au/aphcri/General/phc_definition.php., and Australian Divisions of General Practice. (2005). "Primary Health Care Position Statement." Retrieved 22 September, 2010, from http://www.agpn.com.au/__data/assets/pdf_file/0006/16269/20051026_pos_AGPN-Primary-Health-Care-Position-Statement-FINAL.pdf.

[2] Commonwealth of Australia (2001). Better Health Care: Studies in the successful delivery of primary health care services for Aboriginal and Torres Strait Islander Australians. Canberra.

[3] World Health Organization (2008). The world health report 2008 : primary health care now more than ever.

[4] Chapman, S. (2001). "Advocacy in public health: roles and challenges." Int J Epidemiol **30**(6): 1226-1232.

[5] Savigny, D. d. and T. Adam, Eds. (2009). Systems thinking for health systems strengthening. , Alliance for Health Policy and Systems Research, World Health Organization.

[6] Laycock, A., D. Walker, et al. (2011). Researching Indigenous Health: A Practical Guide for Researchers. Melbourne, The Lowitja Institute.

[7] See Brands, J. and M. Gooda (2006). "Putting the users of research in the driver's seat: the Cooperative Research Centre for Aboriginal Health's new approach to research development." Australian Aboriginal Studies **2006**(2): 27-35., Arabena, K. and D. Moodie (2011). "The Lowitja Institute: building a national strategic research agenda to improve the health of Aboriginal and Torres Strait Islander peoples." Med J Aust **194**(10): 532-534.

[8] World Health Organization (2000). The world health report 2000: Health systems: improving performance. Geneva.

[9] Northern Territory Aboriginal Health Forum (2010). NT Regionalisation of Aboriginal Primary Health Care Guidelines: Supporting a Pathway to Regional Aboriginal Community Control. Department of Health and Aging - NT Department of Health and Families - Aboriginal Medical Services Alliance of the Northern Territory.

DOMAIN 5: COMMUNITY ENGAGEMENT, CONTROL AND CULTURAL SAFETY

Processes to ensure cultural safety throughout the organisation, engagement of individual clients and families with their own health and care, participation of communities in priority setting, program design and delivery, and structures of community control and governance.

KEY ELEMENTS

5.1 Engaging clients with their health

5.2 Community participation

5.3 Community control and governance

5.4 Cultural safety

KPIs

AHKPI 4.18 Report on community involvement in determining health priorities and strategic directions through any of the following: health boards; steering committees; advisory committees; community councils; health councils

AHKPI 4.19 Show evidence of appropriate reporting to community on progress against core PIs

Background

Lack of control in one's life, and the stress that this produces, is a key driver of ill-health [1]. Approaches that seek to empower individuals and communities demonstrate better health outcomes, and are therefore viable public health strategies, especially for marginalised groups[2].

The role of greater community involvement in developing responsive primary health care, higher quality, culturally safe services, and improved family and community functioning has been accepted by both levels of government and the community controlled health service sector in the Northern Territory[3]. Australia is also a signatory to international agreements that recognise the right of Indigenous peoples to be actively involved in developing and determining health programs, and delivering health services through their own institutions wherever possible[4].

For these reasons, maximising the ability of Aboriginal people and communities to engage with, participate in – and, if desired, control – their health service is a key primary health care function.

Approaches for the engagement of individuals and community participation need to be embedded throughout an organisation, and reflected in the way it does business at all levels. Cultural safety (or cultural security[5]) is foundational for this aim – to the extent that a service is not culturally safe, it can be expected to be unable to engage its clients and gain community participation in its programs.

Community control – the formal governance process by which the Aboriginal community controls and runs its own primary health care service – is the optimal expression of the right of Aboriginal people to participate in decision making. Such organisations have particular functions that require action and resourcing.

Community controlled health services have an inherent advantage when it comes to addressing issues of cultural safety, engagement and participation[6]. However, these matters can be expected to require on-going attention and action in all primary health care services, whatever their governance structure, scale and location.

Whatever the governance structure of a primary health care service, the employment of Aboriginal staff (and particularly local Aboriginal staff) at all levels of the organisation is crucial to progress in all aspects of community engagement, participation and control, and cultural safety.

To a greater extent than those functions identified in the rest of this Framework, the functions identified in this section are a *guide* for health services; health services may have their own, locally developed and equally effective methods of ensuring the cultural safety of their services, or the engagement, participation and control of their communities.

FURTHER READING

- Dunbar, T., N. Benger, et al. (2008). Cultural security: perspectives from Aboriginal people, Aboriginal Medical Services Alliance Northern Territory (AMSANT) / Northern Territory Department of Health and Families
- National Health and Medical Research Council (2006). Cultural competency in health: A guide for policy, partnerships and participation. Canberra, Commonwealth of Australia
- Northern Territory Aboriginal Health Forum (2008). Pathways to community control: an agenda to further promote Aboriginal community control in the provision of Primary Health Care Services.
- Northern Territory Department of Health and Community Services (NT DHCS) Aboriginal cultural security: an outline of the policy and its implementation. Systems Performance and Aboriginal Policy Unit. Darwin.
- Wallerstein, N. (2006). What is the evidence on effectiveness of empowerment to improve health? Copenhagen, WHO Regional Office for Europe. Health Evidence Network report.
- World Health Organization (2008). The world health report 2008 : primary health care now more than ever.

OTHER SOURCES

- AMSANT (Aboriginal Medical Services Alliance Northern Territory). "Administration Manual for Aboriginal Primary Health Care Services in the Northern Territory." Retrieved 22 September, 2010, from http://www.amsantmanual.com/03aboriginalhealth.html
- Hunt, J. and D. E. Smith (2006). Building Indigenous community governance in Australia: Preliminary research findings. Canberra, Centre For Aboriginal Economic Policy Research. **Working Paper No. 31/2006**
- Ratzan, S. and R. Parker (2000). Introduction. National Library of Medicine: Health literacy (bibliography on line). C. Selden, M. Zorn, S. Ratzan and R. Parker. Bethseda MD: National Institutes of Health, US Department of Health and Human Services.
- Silburn, K., A. Thorpe, et al. (2010). Taking Care of Business: Corporate Services for Indigenous Primary Healthcare Services. Darwin, Cooperative Research Centre for Aboriginal Health.
- United Nations. (2007). "United Nations Declaration on the Rights of Indigenous Peoples." from http://www.un.org/esa/socdev/unpfii/en/drip.html

5.1 Engaging individual clients with their health and care

- **Awareness and use of health literacy approaches** to empower clients in their dealings with the health system and their own health
- **Employment and support of local Aboriginal staff** to support engagement of clients in their health care and health literacy approaches
- **Use of self-care approaches for clients, involving family where appropriate** and including use of self-management planning
- **Training for primary health care staff in self-care / self-management approaches and health literacy**
- **Appropriate and accessible client and community feedback mechanisms**
  [Example: designated Aboriginal staff member as contact point for community feedback]

Health literacy – an individual's capacity to make appropriate health decisions based on their access to and understanding of health information and services – plays a key role in the engagement of clients with their own health and health care.

Health literacy approaches seek to empower individuals to obtain and understand health information and to use health services appropriately.

Aboriginal staff and particularly Aboriginal Health Workers can play an important role in encouraging and supporting clients to take responsibility for their health.

This may include – with other members of the primary health care team – supporting self-care approaches that involve the client and where appropriate their family in managing ill-health.

Staff – especially those from a non-primary health care background – may need support and training to be able to support client self-care approaches.

5.2 Supporting community participation

- **Community involvement in the identification of health needs and prioritising and planning of health services**
- **Support for the community to make informed decisions** *[Example: appropriate presentation of information to the community about health issues and effective approaches to addressing them]*
- **Mechanisms for feedback to community on health service performance,** including service activity and Key Performance Indicators
- **Involvement of the community in evaluation of the organisation and health programs**
- **An inclusive approach that ensures that all groups in a community are given a chance to participate** (including geographically or socially isolated groups)
- **Support for development of local capacity to maximise community members' ability to participate**
- **Employment of and respect for local Aboriginal community members**
- **<u>Ensure access to / provision of</u> training and support for staff in participative approaches to service delivery**

Aboriginal community participation is a key element of sustainable, effective and efficient primary health care. Community participation can take different forms and will not always be static.

Participation empowers a community (a benefit in itself) and helps ensure higher quality, more appropriate services.

All primary health care services – whatever their governance structure – need to ensure participatory processes are embedded in the way they do business.

Genuine community participation will require both resources and time, especially if conducted across a region.

The methods for participation will vary. For community controlled health services, the elected Board provides a key route for participation, but may not be enough by itself, especially on a regional level.

Local health advisory committees, regular community meetings, and employment of local Aboriginal staff are key methods to strengthen community participation for all primary health care services.

Effective participative approaches must include effective methods for community consultation (including the ability to inform communities of evidence and evidence-based approaches), and the capacity and willingness to translate community priorities into practice.

Reporting back to the community on service activity and outcomes is also key.

Building community capacity to participate may be required.

Genuine community participation will require the development of relationships of trust and honesty between the service and the community.

The needs of 'difficult to reach' groups (such as geographically isolated groups or outstations, or old people, disabled people, young people, or those with mental health issues) should be considered in developing participative approaches.

Barriers to participation include insufficient organisational resources, capacity or leadership, lack of cultural safety, and institutional barriers (bureaucracy / authoritarian structures, a history of top-down initiatives, racism, lack of representativeness, poor organisation).

5.3 Governance and community control

- **Appropriate and functional membership criteria, election processes and community Governance processes** in accordance with organisational constitution and legislative requirements [Examples: AGMs, Board meetings]
- **Board processes that encourage community participation, respond to community needs, and ensure appropriate feedback to the community**
- **Compliance with formal requirements of regulators and funding agreements**
- **Ongoing orientation and training for all Board members** on all aspects of their role *[Examples: the constitution, understanding of Board/management roles and responsibilities, the organisation, budget and funding sources, staff positions, service policies and procedures, mediation and conflict resolution, strategic and annual planning, standards of conduct and expectations of board members, managers, and staff and meeting timetable and processes]*
- **Board processes that encourage governance that is flexible and capable of change** *[Examples: methods for decision-making, problem solving, evaluation, planning, performance management, addressing conflict of interest, dispute resolution]*
- **Reporting systems to enable the Board to meet its contractual / statutory obligations and to support its role in strategic direction setting**
- **Support for the Board for business and other complex functions** *[Examples: Board advisory mechanisms, ensuring Board members have relevant skills]*
- **Board oversight of cultural safety of the organisation and its programs**
- **Community development approaches to increase the numbers of community members able to take up Board positions**
- **<u>Ensure access to / provision of</u> training for staff working with Boards**

While not all communities will have the same aspiration or capacity to formally manage the delivery of primary health care services, community controlled governance of health services is the optimal expression of the right of Aboriginal people to participate in decision making.

Systems of governance and community control vary widely. However, all community-controlled health services must have community mandate and support as well as meeting the formal requirements of government and other funders. Balancing these twin accountabilities is demanding and requires appropriate resourcing.

Regional governance structures are likely to be especially resource intensive if they are to ensure that all major communities / community groups are able to participate effectively in Board and its processes.

Boards where members speak English as a second language are likely to need further support.

Sustainable models of community control should work with and reinforce existing community or cultural decision making and authority structures.

The demands on Board members are increasingly complex. They have to manage community expectations, and balance community and cultural expectations with legal and fiscal obligations.

Note that Aboriginal Board members investment of their own time and energy is often significant. Many community-controlled organisations therefore feel it is appropriate to remunerate Board members for their time carrying out Board functions, consistent with their funding or contractual obligations. Note that current Commonwealth Government policy is that government funds can be used to address loss of income and costs to Board members, but not remuneration.

Note the linkage between this section and **Section 3.1 Management and leadership**.

5.4 Cultural safety

- **Organisational commitment to achieving culturally safe health care**
- **Employment of local Aboriginal people and the valuing of their role and advice**
- **Cultural orientation for non-Aboriginal staff** which
  - goes beyond 'cultural awareness' to develop skills and knowledge
  - is both 'generic' (e.g. to the Territory or a region) and 'specific' (to a local community, it's practices, places, and key people)
  - is ongoing as well as being part of induction processes
  - recognises the authority of local Aboriginal people in cultural matters
- **Cultural safety policies** which have been developed in consultation with communities and Aboriginal staff
- **Monitoring and evaluation of the effectiveness and appropriateness of cultural safety policies and orientation processes**
- **Inclusion of cultural competence as part of staff performance appraisal processes**
- **Attention paid to communication and language issues** (both written and spoken), including the use of interpreters or local Aboriginal staff as appropriate
- **Accessible and appropriate client and community feedback mechanisms** *[Example: designated Aboriginal staff member as contact point for community feedback]*
- **Sustainable mechanisms for gaining high level advice on cultural matters affecting service delivery** *[Examples: local cultural advisory body, Board sub-committee that includes Aboriginal staff / local community members and/or Board members]*

In recent years, the notion of 'cultural awareness' (which focused on practitioners' knowledge and attitudes about cultural issues) has been replaced by that of cultural safety or cultural security (which focuses on how practitioners and organisations behave and provide services).

There are many definitions of cultural safety. However, most include some or all of the following elements:

- service delivery that takes into account cultural issues, is competent and respectful, and results in improved interactions with Aboriginal people;
- a service environment that encourages Aboriginal clients to seek treatment and engage with their own health; and
- organisation structure and practice that supports and affirms Aboriginal rights and ways of being.

The particular definition and practice of cultural safety is highly diverse across the Northern Territory.

Cultural safety is an issue for all services delivering care to Aboriginal people, whether they are based in urban, regional, or remote locations.

Cultural orientation and re-orientation of non-Aboriginal staff is important. However, culturally safety must go beyond this and be embedded throughout an organisation's structure, policies and practices.

Employment of local Aboriginal people – and listening to and valuing their opinions – is a foundational strategy for ensuring the cultural safety of primary health care services. Service locations that are not culturally secure for Aboriginal staff are unlikely to be culturally secure for Aboriginal clients.

The cultural safety of a service can only be properly judged by Aboriginal people, and particularly Aboriginal service users.

Building relationships of trust and respect between clients and staff, and between staff will underpin all cultural safety activities.

Notes for Domain 5: Community engagement, control and cultural safety

[1] Wilkinson, R. and M. Marmot, Eds. (2003). The Social Determinants of Health The Solid Facts, World Health Organization. Tsey, K., M. Whiteside, et al. (2010). "Empowerment and Indigenous Australian health: a synthesis of findings from Family Wellbeing formative research." Health Soc Care Community **18**(2): 169-179.

[2] Wallerstein, N. (2006). What is the evidence on effectiveness of empowerment to improve health? Copenhagen, WHO Regional Office for Europe. **Health Evidence Network report**. See also World Health Organization (2008). The world health report 2008 : primary health care now more than ever.

[3] Northern Territory Aboriginal Health Forum (2008). Pathways to community control: an agenda to further promote Aboriginal community control in the provision of Primary Health Care Services.

[4] United Nations. (2007). "United Nations Declaration on the Rights of Indigenous Peoples." from http://www.un.org/esa/socdev/unpfii/en/drip.html.

[5] See Dunbar, T., N. Benger, et al. (2008). Cultural security: perspectives from Aboriginal people, Aboriginal Medical Services Alliance Northern Territory (AMSANT) / Northern Territory Department of Health and Families. For a discussion of the numerous terms used in this field.

[6] There is evidence that services under Indigenous community control produce better health outcomes. See Lavoie, J. G., E. L. Forget, et al. (2010). "Have investments in on-reserve health services and initiatives promoting community control improved First Nations' health in Manitoba?" Social Science & Medicine **71**(4): 717-724.

SPECIFIC AREAS

This Framework also examines four 'specific areas' identified by the Northern Territory Aboriginal Health Forum partners as generally not having been well-integrated into comprehensive primary health care and/or not well resourced at the primary care level.

These are:

SPECIFIC AREAS

A Alcohol, tobacco and other drugs

B Early childhood development and family support

C Aged and disability

D Mental health / social and emotional health and well being

A section on each of these, as they should be addressed from within a comprehensive primary health care model, follows. Note that their inclusion in separate sections does not imply that their delivery is separate from the core business of primary health care – the functions described under each will naturally fall under one or more of the five Domains described above.

Also, while these are the critical areas for further development as identified by the NTAHF partners at this stage, other areas may be examined in similar detail in future iterations of this Framework.

A. Alcohol, tobacco and other drugs

- **Assessment, brief intervention and treatment** (including pharmacotherapy, structural therapy and social support) [See **Section 1.1 Treatment** and **1.2 Prevention and early intervention**]
- **Case management and after care** (or long term care)
- **Health promotion activities to reduce supply, demand and harm** noting the importance of community engagement in these activities [See **Domain 2: Health promotion**]
- **Advocacy on individual, local, or systemic level to reduce levels of harm** [See **Section 4.1 Advocacy**]
- **Referral to appropriate alcohol and other drug specialist services** *[Examples: residential rehabilitation, detoxification services]*
- **Ensure access to / provision of training of and support of primary health care team** by specialist AOD services

Many principles for prevention and treatment of harm are similar for tobacco, alcohol and other drugs. The limited research evidence from Indigenous studies is broadly consistent with international evidence from other settings.

Clinical Services for this whole area are best provided by primary health care with the support of specialists, rather than by visiting specialists alone.

There is a need for training and management support of PHC staff to provide appropriate Clinical Services in this area. In particular clinicians may benefit from training with assisting patients with cannabis abuse.

A challenge is to balance the provision of both Clinical Services and Health Promotion services, at the same time as addressing the underlying social determinants of substance use [see **Domains 1, 2 and 4**]

Tobacco causes great harm to the health of the Aboriginal community, so it is encouraging that Indigenous smoking prevalence is falling. PHC staff can assist smokers to quit with brief interventions, more involved counselling and pharmacotherapy (e.g. Nicotine Replacement Therapy, varenicline and bupropion), referrals to Quit groups and courses, and referrals to telephone Quitlines.

The new *Prevention of Crime and Substance Misuse Act*, in effect from 1 July 2011, may lead to increased demand on local primary health care staff for brief interventions on alcohol in relation to the issuing of Banning Alcohol And Treatment (BAT) Notices to problem drinkers.

PHC staff have excellent opportunities to reduce exposure to second-hand smoke (SHS) by local health promotion and advocacy around smoke-free places, organisations, events, homes and cars. New NT Tobacco Control legislation can be used to support such local activities.

Assessment and brief intervention is important for alcohol, but it is important to separate the needs of heavy episodic consumption and long-term alcohol dependence, when brief intervention is usually insufficient (but may still have some effect). It is worth emphasising the potential contribution of the PHC team to long-term care or After Care (after residential or non-residential care for alcohol).

Imposed alcohol interventions, such as those as part of the NT Emergency and some local 'dry areas' legislation in towns, are unlikely to be as effective as those supported and driven by local Aboriginal communities (e.g. declaration of 'dry communities').

For individuals, however, and in spite of some concerns, court-mandated treatment can be effective.

Mental health problems are common among those patients with alcohol problems, and these mental health issues also must be addressed [See **Specific Area D**].

Substitution of non-sniffable Opal for petrol in central Australia has been useful in reducing petrol sniffing.

There are some specific issues for illicit drugs, e.g. those related to injecting drug use and further complications with polydrug use.

FURTHER READING

- Gray, D. and T. Wilkes (2010). Reducing alcohol and other drug related harm: Resource sheet no. 3. Closing the Gap Clearinghouse, Australian Institute of Health and Welfare / Australian Institute of Family Studies.
- Ivers, R. (2011). Anti-tobacco programs for Aboriginal and Torres Strait Islander people: Resource sheet no. 4. Closing the Gap Clearinghouse, Australian Institute of Health and Welfare / Australian Institute of Family Studies.
- Kruger, K., N. McMillan, et al. (2007). Talkin' Up Good Air: Australian Indigenous Tobacco Control Resource Kit. Commonwealth of Australia, Canberra, Centre for Excellence in Indigenous Tobacco Control.
- National Institute on Drug Abuse (2009). Principles of drug addiction treatment: a research-based guide (2nd Edition), U.S. Department of Human Services.

OTHER SOURCES

- Gray, D., A. Stearne, et al. (2010). "Indigenous-specific alcohol and other drug interventions: continuities, changes and areas of greatest need." from http://www.nidac.org.au/images/PDFs/rp20_indigenous.pdf.

B. Early childhood development and family support

- **An explicit focus on maternal and child health in primary health care delivery**, including accessible, appropriate and effective:
  - antenatal and postnatal care
  - immunisation
  - nutrition
  - hearing health
  - developmental screening and follow up
  - action on other issues affecting child health and development *[Examples: alcohol and other drug issues, availability of affordable healthy food]*
- **Delivery of well-resourced home visiting programs during pregnancy and the first years of life,** ensuring that these are designed consistent with the evidence and that they address issues of staff turn-over and support
- **Support and advocacy for early learning interventions** delivered from outside the primary health care sector
- **Participation in / provision of family support and parenting services** in universally accessed, non-stigmatized settings
- **Development of governance and service level links with education and child welfare organisations,** including referral pathways for children and families at risk

Strong evidence links early childhood development to health status throughout life, as well as to literacy, education, employment and many other social outcomes. It is a key investment in health.

Well-designed and resourced child screening and early detection programs are foundational to better health for Aboriginal communities [See **Section 1.2 Prevention and early intervention**].

Otherwise, there is a lack of solid research and quality evaluation in Indigenous Australia on early childhood, parent support and family interventions. However, international evidence can provide insights to what can be expected.

As far as possible, a range of early childhood development services including child and maternal health services, nurse home visiting, parenting and family support services, and early learning measures should be delivered in an integrated, sustained, and holistic way.

Primary health care services should have an explicit focus on clinical and health promotion measures to maximise the health and nutrition of children in their early years, including through accessible and appropriate high quality antenatal and postnatal care.

There is strong evidence from overseas that universal nurse home visiting programs delivering a structured early childhood development program delivers positive results in the health and development of children that persist into early adulthood. However, as with all measures in this area, design integrity and sustained programs are critical for success.

The development of family support and parenting services should be discussed with early childhood experts to develop and resource effective, evidence based programs that will result in improved child outcomes.

School readiness and early educational programs generally lie outside the responsibility of the health sector; however their demonstrated effectiveness over the life course make them a key intervention that primary health care services should endeavour to support wherever possible.

Well-designed family support and parenting programs have also been shown to have beneficial long-term effects.

FURTHER READING

- Irwin, L. G., A. Siddiqi, et al. (2007). Early Child Development: A Powerful Equalizer. Final Report. Geneva, the World Health Organization's Commission on the Social Determinants of Health.
- Olds, D. L., C. R. Henderson, Jr., et al. (1999). "Prenatal and infancy home visitation by nurses: recent findings." Future Child 9(1): 44-65, 190-191.
- Silburn SR, Robinson G, et al. (2011). Early childhood development in the NT: Issues to be addressed. Topical paper commissioned for the public consultations on the Northern Territory Early Childhood Plan. Darwin, Northern Territory Government.
- Silburn SR, Nutton G, et al. (2011). The First 5 Years: Starting Early. Topical paper commissioned for the public consultations on the Northern Territory Early Childhood Plan. Darwin, Northern Territory Government.

OTHER SOURCES

- Council of Australian Governments (2009). National Partnership Agreement for Indigenous Early Childhood Development.
- Sims, M. (2011). Early childhood and education services for Indigenous children prior to starting school: Resource sheet no. 7. Closing the Gap Clearinghouse, Australian Institute of Health and Welfare / Australian Institute of Family Studies.
- Sparling, J. "Highlights of Research Findings from the Abecedarian Studies." from http://www.teachingstrategies.com/content/pageDocs/Abecedarian-Research-Findings-Highlights.pdf.

C. Aged and disability

- **PHC Team contributes to and coordinates with multidisciplinary team**
- **Assessment, case management, therapy and regular review** by multidisciplinary team including appropriate allied health professionals
- **Management of acute and chronic medical conditions**
- **Advocacy for individuals,** especially for access to services and for needs of carers / families
- **Carer health**
- **Health Service buildings** and premises meet Disability Service Standards and Universal Design Principles
- **Ensure access to training of primary health care staff in aged and disability issues**
- **Health promotion in community** for 'Healthy Ageing' and for Disability Awareness
- **Inclusion of older people in community engagement processes** (e.g. Panels of Elders)
- **Inclusion of people with disabilities in community engagement processes,** especially but not only about their own care

Many of the issues and principles of care of aged care and disability services are similar.

The goal is independent living, mobility and functioning. Much of the support these patients need will not be medical, e.g. support with housing or employment. However, it is important for PHC services to ensure also that these patients do not miss out on good quality care and prevention of their acute and chronic conditions.

It is crucial to manage the connection between the PHC team and multidisciplinary teams with appropriate allied health professionals. This interaction is likely to look different in different settings.

Training of PHC staff and education and awareness training in the community by Allied Health Professionals in Aged and Disability Services will usually focus on issues raised from the case management of individual patients, and differ between PHC services. Similarly, advocacy and planning by the PHC service will often focus on the needs of a small number of local patients.

New challenges may emerge for PHC services from the governance arrangements for Aged and Disability Services: from 1 July 2011, Aged Care Assessment Teams (ACAT) and Home and Community Care (HACC) will be managed by the Australian Department of Health and Ageing.

FURTHER READING

- Cotter, P., I. Anderson, et al. (2007). Indigenous Australians: Ageing without longevity? Longevity and social change in Australia. A. Borowski, S. Encel and E. Ozanne. Sydney, University of New South Wales Press.
- Council of Australian Governments (2011). National Disability Strategy: 2010-2020. Canberra, Commonwealth of Australia.

OTHER SOURCES

- Productivity Commission (2010). Caring for older Australians: Draft Inquiry report. Canberra, Commonwealth of Australia.
- Productivity Commission (2010). Disability care and support: Draft report. Canberra, Commonwealth of Australia.

D. Mental health / social and emotional well being

- **Organisational recognition of social / historical determinants of social & emotional well being /mental health**
- **A multi-disciplinary team approach** that includes:
  - screening and early intervention
  - social and welfare support including access to employment, education and housing
  - evidence-based treatment (including counselling and pharmacotherapy) with the support of mental health specialists
  - referral as required for specialist mental health / SEWB services;
  - case-coordination / management including implementation of management plans in collaboration with mental health specialists
  - 24 hour on-call service, including access to the advice of a specialist mental health clinician
- **Mental health promotion and prevention measures** which engage the community *[Examples: mental health literacy, mental health first aid, early childhood programs – see **Specific Area B**]*
- **Well-supported Aboriginal Mental Health Workers / SEWB Workers**
- **A strong emphasis on cultural safety** [see **Section 4.1**] including involvement of / respect for Aboriginal staff, family and community members, and interpreters
- **Mental health recovery and relapse prevention** following treatment or acute inpatient care, including recall & regular assessment / review processes
- **Use of self-care approaches,** involving client's family where appropriate [See **Section 5.2. Engaging individual clients etc**]
- **<u>Ensure access to</u> training & support of primary health care team** by specialist mental health services / other providers
- **Inclusion of people with mental health issues in community engagement processes,** especially but not only about their own care

Aboriginal communities have significantly higher levels of mental illness than mainstream populations. Specific mental health issues often derive from a background of social and emotional deprivation, so holistic approaches to addressing mental issues are recommended.

Mental health and SEWB are strongly related to intergenerational effects of historical processes and policies (colonisation, dispossession, the Stolen Generations etc) as well as social determinants of health (lack of life-control, racism, poverty, 'malignant' grief).

Amongst other Indigenous peoples, increased levels of community control have been shown to be correlated with reduced suicide rates.

While there is no commonly agreed definition of primary mental health services, in the Aboriginal context it may include services provided by psychologists, counsellors, social workers, Aboriginal specialists (AMHWs / SEWB Workers) as well as other members of the primary health care team (AHWs, nurses, doctors etc).

Chronic disease approaches (screening self-care, case coordination / management etc) are relevant to mental health [See in particular **Section 1.2 Prevention and early intervention**].

Day to day management of clients with mental health issues, implementation of their care plans, and mental health screening are the responsibility of the local primary health care team, with the support of mental health specialists.

Client welfare and support services are also likely to be important for many clients.

Provision of services, including assessment and reviews, should be in community settings wherever possible, recognising the resource implications of this approach.

As well as addressing the broad mental health and SEWB needs of the community, consideration should be given to particular needs and sub-groups (e.g. men's SEWB, teenagers and suicide prevention).

Addiction issues (alcohol, tobacco, other drugs, gambling) are frequently background factors in Aboriginal mental health presentations [See **Specific Area A**]

Coordination of ongoing care – especially between primary health care teams and specialist services – is critically important. A significant barrier to this goal is multiple and uncoordinated service providers operating short-term programs on a contract basis.

FURTHER READING

- AMSANT (Aboriginal Medical Services Alliance Northern Territory) (2008). A model for integrating alcohol and other drug, community mental health and primary health care in Aboriginal Medical Services in the Northern Territory.
- Commonwealth of Australia (2009). Fourth national mental health plan: an agenda for collaborative government action in mental health 2009-2014. Department of Health and Ageing. Canberra.
- Garvey, D. (2008). "A review of the social and emotional wellbeing of Indigenous Australian peoples - considerations, challenges and opportunities." from http://www.healthinfonet.ecu.edu.au/sewb_review.
- Parker, R. (2010). Australian Aboriginal and Torres Strait Islander Mental Health: An Overview. Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice. N. Purdie, P. Dudgeon and R. Walker, Commonwealth of Australia.
- Parker, R. (2010). Mental Illness in Aboriginal and Torres Strait Islander Peoples. Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice. N. Purdie, P. Dudgeon and R. Walker, Commonwealth of Australia.

OTHER SOURCES

- Commonwealth of Australia (2010). National Standards for Mental Health Services. Canberra.
- Chandler, M. and C. Lalonde (1998). "Cultural continuity as a hedge against suicide in Canada's First Nations." Transcultural Psychiatry 35(2): 191-219.
- Priest, N. C., Y. C. Paradies, et al. (2011). "Racism as a determinant of social and emotional wellbeing for Aboriginal Australian youth." Med J Aust 194(10): 546-550.

APPENDIX 1: PROJECT METHODOLOGY

The Core *Primary Health Care Services Framework Refinement Project* ran from December 2010 to August 2011, under the guidance a Working Group of the Northern Territory Aboriginal Health Forum (see **Appendix 2** for details of membership). Regular meetings with the Working Group were held throughout the project.

The project had five stages as approved by the Working Group and detailed below.

Stage 1. Work with NTAHF partners to finalise project scope & methodology

The Working Group endorsed a project methodology which included the establishment of a Technical Advisory Group (TAG) of experienced researchers and academics in the field of primary health care to assist with the project (see **Appendix 2** for details of membership).

The TAG's role was to provide the project broad advice on comprehensive primary health care, especially as applied in the Aboriginal health context, and to help ensure that the Framework produced fits within the parameters of current thinking and takes proper account of existing evidence.

Stage 2. Identify key issues for development of framework and consultations

Interviews were held with each of the TAG members to provide input on contemporary evidence and literature and key issues regarding core primary health care functions, especially in the Aboriginal context.

Relevant policy, research and background documents were identified by the Working Group and reviewed.

Key questions and issues for the conduct of the consultations were identified.

The Working Group identified key informants for consultations and a consultation strategy was endorsed.

Stage 3. Consultations

A draft model of the Framework was produced to guide consultations, along with background to the project and key questions for informants to consider, including identification of key documents and evidence.

Consultations were held with a wide variety of informants (See **Appendix 2** for a full list). This included service delivery organisations, policy-makers, research experts and others, both within the Northern Territory and beyond.

Four community controlled health services were selected to be case studies to assist in the identification of best-practice examples. Selection was based on service structure / location:

- Katherine West Health Board (in-depth case study at health service delivering services across an entire remote region)

- Central Australian Aboriginal Congress (in-depth case study at long-established health service, in 'urban' location)
- Anyinginyi Health Aboriginal Corporation (teleconference with Management Team of health service based in regional town, progress made towards regionalisation of services)
- Sunrise Health Service Aboriginal Corporation (face-to-face meeting with senior managers, at health service delivering services across an entire remote region)

Stage 4. Produce core primary health care services framework

The draft Framework was produced taking into consideration the detailed notes taken during the consultation process, input from the TAG and the Working Group, and the substantial literature identified through these processes.

Comment on the draft Framework was sought from the TAG* (July 2011). The comment was on a strategic rather than detailed level, concentrating on identifying any major gaps or misinterpretations of evidence etc. This work was carried out by email. Comment from the TAG on the draft was generally very positive; specific comments and queries were addressed in preparation of the final Framework.

The Working Group reviewed the draft core functions framework in a full-day workshop. Comments from the Working Group as well as individual members were incorporated into the final Framework.

Stage 5. Liaison with and feedback to NTAHF Partners (throughout project)

Throughout the project, there was regular reporting and feedback processes to all NTAHF partners through the Working Group, including face to face meetings and provision of written reports.

* Excluding Shane Houston, who by July 2011 had left the Northern Territory and was no longer working directly in the Aboriginal and Torres Strait Islander primary health care field.

APPENDIX 2: CONSULTATIONS, GUIDANCE & ADVICE

Technical Advisory Group

- Ian Anderson (Director of Research & Innovation, The Lowitja Institute)
- Shane Houston (former Executive Director, Systems Performance & Aboriginal Policy, Northern Territory Department of Health)
- Judith Dwyer (Department of Health Care Management, Flinders University)
- Bev Sibthorpe (consultant with the Queensland Aboriginal and Islander Health Council)

Project Working Group Membership

Northern Territory Department of Health

- Douglas Josif, Chair (Health Development Regional Manager Top End)
- Penny Fielding (until June 2011) (Director, Aged and Disability Programs)
- Leonie Katekar (Chief Rural Medical Practitioner)
- Janet Rigby (Remote Health)
- Christine Connors (Health Development Branch)
- Bronwyn Hendry (Mental Health)
- Samantha Livesley (Aged and Disability Programs)
- Jo Wright (until June 2011) (Chief Rural Medical Practitioner)

Commonwealth Department of Health and Ageing

- Aumea Herman (Public Health Medical Advisor, OATSIH)
- Catherine Pledge, Secretary (until June 2011) (Remote Health Services Development Branch, OATSIH)
- Cate Lynch, Secretary (Remote Health Services Development Branch, OATSIH)

Aboriginal Medical Services Alliance Northern Territory

- Andrew Bell (Regionalisation Development Unit)
- John Boffa (Central Australian Aboriginal Congress)

General Practice Network Northern Territory

- Alison Faignez (until February 2011)
- Sue Korner

Organisations and people consulted

Northern Territory Department of Health

- Christine Connors
- Steve Gelding
- John Loudon
- Victor Nossar
- Janet Rigby
- Frank Wallner
- Jill Davis
- Bronwyn Hendry
- Samantha Livesly
- Rob Parker
- Kerrie Simpson
- Robyn Westerman
- Peter Frendin
- Megan Howitt
- Ian Norton
- Mark Ramjan
- Tricia Wake

Commonwealth Department of Health and Ageing

- Abbie Alcock
- Robin Hewson
- Craig Ritchie
- Sharon Appleyard
- Steven Himpson
- Michelle Clewett
- Peter Pearse

Community controlled health services

Sunrise Aboriginal Health Service

- Dale Campbell
- Graham Castine
- Ahmed Latif

Katherine West Health Board

- Sinon Cooney
- Sean Heffernan
- Liz Yates
- Rebecca Gooley
- David Lines
- Louise Harwood
- Christine May

Central Australian Aboriginal Congress

- Donna Ah Chee
- Christine Brown
- Caroline Lovell
- Ben Bartlett
- Tony Corcoran
- LeShay Maidment
- John Boffa
- Sascha Kowalenko

Anyinginyi Health Aboriginal Corporation

- Clarissa Burgen
- Barb Shaw
- Kathy Malla
- Other members of the AHAC Management Team
- Trevor Sanders

Other organisations and individuals consulted

- Malcolm Battersby (Flinders Human Behaviour and Health Research Unit)
- Phillipa Cotter (Charles Darwin University)
- Rob Curry (member of Australian Physiotherapists Association)
- Sven Silburn (Menzies School of Health Research)
- Lenny Cooper (CRANAPlus)
- Jon Currie (Addiction Medicine and Translational Neurobiology, St Vincent's Hospital)
- Dennis Gray (National Drug Research Institute, Curtin University of Technology)
- Carole Taylor (CRANAPlus)

REFERENCES

Aboriginal Health & Medical Research Council (1999). Primary, secondary and tertiary health care services to Aboriginal communities: Core functions of Primary Health Care in Aboriginal Community Controlled Health Services (ACCHS). AH&MRC Monograph Series Volume 1 Number 1. Sydney.

Ah Kit, J., C. Prideaux, et al. (2003). "Chronic disease self management in Aboriginal Communities: Towards a sustainable program of care in rural communities." Australian Journal Of Primary Health - Interchange **9 (2-3)**: 168-176.

Allen and Clarke (2011). Evaluation of the Child Health Check Initiative and the Expanding Health Service Delivery Initiative: Summary report. Canberra, Department of Health and Ageing.

AMSANT (Aboriginal Medical Services Alliance Northern Territory). "Administration Manual for Aboriginal Primary Health Care Services in the Northern Territory." Retrieved 22 September, 2010, from http://www.amsantmanual.com/03aboriginalhealth.html.

AMSANT (Aboriginal Medical Services Alliance Northern Territory) (2008). A model for integrating alcohol and other drug, community mental health and primary health care in Aboriginal Medical Services in the Northern Territory.

AMSANT (Aboriginal Medical Services Alliance Northern Territory). (2009). "Aboriginal health research policy." Retrieved 15 June 2011, from http://www.amsant.org.au/documents/article/147/AMSANT%20Research%20Policy%20as%20amended%20October%202010.pdf.

Arabena, K. and D. Moodie (2011). "The Lowitja Institute: building a national strategic research agenda to improve the health of Aboriginal and Torres Strait Islander peoples." Med J Aust **194**(10): 532-534.

Australian Divisions of General Practice. (2005). "Primary Health Care Position Statement." Retrieved 22 September, 2010, from http://www.agpn.com.au/__data/assets/pdf_file/0006/16269/20051026_pos_AGPN-Primary-Health-Care-Position-Statement-FINAL.pdf.

Australian Health Ministers' Advisory Council (2011). Aboriginal and Torres Strait Islander Health Performance Framework Report 2010. AHMAC. Canberra.

Australian Medical Association. (2010). "Primary Health Care." Retrieved 22 September, 2010, from http://ama.com.au/node/5992.

Australian Primary Health Care Research Institute (APHCRI). "What is Primary Health Care?" Retrieved 22 September, 2010, from http://www.anu.edu.au/aphcri/General/phc_definition.php.

Baum, F. (2007). The new public health (third edition). Oxford, Oxford University Press.

Brailsford, R. (2006). No Visible means of support: A discussion paper exploring the case for a centralised resource agency to support the Northern Territory Aboriginal community controlled health service network. Darwin Cooperative Research Centre for Aboriginal Health and the Aboriginal Medical Services Alliance Northern Territory.

Brands, J. and M. Gooda (2006). "Putting the users of research in the driver's seat: the Cooperative Research Centre for Aboriginal Health's new approach to research development." Australian Aboriginal Studies **2006**(2): 27-35.

Central Australian Aboriginal Congress (nd. [1998?]). Aboriginal primary health care: core functions. Unpublished paper. Alice Springs, Central Australian Aboriginal Congress.

Centre for Remote Health (2009). Core services across the lifespan: a brief consultancy conducted by the Centre for Remote Health to contribute to the ongoing refinement of

the DHF Core Primary Health Care Services Initiative. Northern Territory Department of Health and Families.

Chandler, M. and C. Lalonde (1998). "Cultural continuity as a hedge against suicide in Canada's First Nations." Transcultural Psychiatry **35(2)**: 191-219.

Chapman, S. (2001). "Advocacy in public health: roles and challenges." Int J Epidemiol **30**(6): 1226-1232.

Commission on Social Determinants of Health (2008). Final Report. Closing the Gap in a Generation. Health Equity through Action on the Social Determinants of Health, World Health Organization.

Commonwealth of Australia (2001). Better Health Care: Studies in the successful delivery of primary health care services for Aboriginal and Torres Strait Islander Australians. Canberra.

Commonwealth of Australia (2009). Fourth national mental health plan: an agenda for collaborative government action in mental health 2009-2014. Department of Health and Ageing. Canberra.

Commonwealth Department of Health and Ageing (2009). Primary Health Care Reform in Australia: Report to Support Australia's First National Primary Health Care Strategy. Canberra, Commonwealth of Australia

Commonwealth of Australia (2010). National Standards for Mental Health Services. Canberra.

Cotter, P., I. Anderson, et al. (2007). Indigenous Australians: Ageing without longevity? Longevity and social change in Australia. A. Borowski, S. Encel and E. Ozanne. Sydney, University of New South Wales Press.

Council of Australian Governments (2009). National Partnership Agreement for Indigenous Early Childhood Development.

Council of Australian Governments (2011). National Disability Strategy: 2010-2020. Canberra, Commonwealth of Australia.

Donato, R. and L. Segal (2010). "The economics of primary healthcare reform in Australia - towards single fundholding through development of primary care organisations." Aust N Z J Public Health **34**(6): 613-619.

Dunbar, T., N. Benger, et al. (2008). Cultural security: perspectives from Aboriginal people, Aboriginal Medical Services Alliance Northern Territory (AMSANT) / Northern Territory Department of Health and Families.

Dwyer, J., O'Donnell K, et al. (2009). The Overburden Report: Contracting for Indigenous Health Services. Darwin, Cooperative Research Centre for Aboriginal Health.

Dwyer, J., K. Silburn, et al. (2004). National Strategies for Improving Indigenous Health and Health Care. Canberra, Commonwealth of Australia.

Eades, S. (2004). Maternal and Child Health Care Services: Actions in the Primary Care Setting to Improve the Health of Aboriginal and Torres Strait Islander Women of Childbearing Age, Infants and Young Children. Darwin: Menzies School of Health Research.

Freeman P and Rotem A (1999). Essential Primary Health Care Services for Health Development in Remote Aboriginal Communities in the Northern Territory, WHO Regional Training Centre for Health Development - University of New South Wales.

Garvey, D. (2008). "A review of the social and emotional wellbeing of Indigenous Australian peoples - considerations, challenges and opportunities." from http://www.healthinfonet.ecu.edu.au/sewb_review.

Gray, D., S. Saggers, et al. (2000). "Beating the grog: an evaluation of the Tennant Creek liquor licensing restrictions." Aust N Z J Public Health **24**(1): 39-44.

Gray, D., A. Stearne, et al. (2010). "Indigenous-specific alcohol and other drug interventions: continuities, changes and areas of greatest need." from http://www.nidac.org.au/images/PDFs/rp20_indigenous.pdf.

Gray, D. and T. Wilkes (2010). Reducing alcohol and other drug related harm: Resource sheet no. 3. Closing the Gap Clearinghouse, Australian Institute of Health and Welfare / Australian Institute of Family Studies.

Griew, R., E. Tilton, et al. (2008). A Review of evidence regarding chronic disease prevention in Aboriginal and Torres Strait Islander communities. A Report for the Australian Population Health Development Principal Committee (APHDPC). Canberra.

Hunt, J. and D. E. Smith (2006). Building Indigenous community governance in Australia: Preliminary research findings. Canberra, Centre For Aboriginal Economic Policy Research. **Working Paper No. 31/2006**.

Irwin, L. G., A. Siddiqi, et al. (2007). Early Child Development: A Powerful Equalizer. Final Report. Geneva, the World Health Organization's Commission on the Social Determinants of Health.

Ivers, R. (2011). Anti-tobacco programs for Aboriginal and Torres Strait Islander people: Resource sheet no. 4. Closing the Gap Clearinghouse, Australian Institute of Health and Welfare / Australian Institute of Family Studies.

Jackson, T. and M. Sorgenfrei (2003). Cross-Cultural Management and NGO Capacity Building: How Can Knowledge Transferability Be Managed Across Cultures?, The International NGO Training and Research Centre. **Praxis Note 3**.

Kruger, K., N. McMillan, et al. (2007). Talkin' Up Good Air: Australian Indigenous Tobacco Control Resource Kit. Commonwealth of Australia, Canberra, Centre for Excellence in Indigenous Tobacco Control.

Lavoie, J. G., E. L. Forget, et al. (2010). "Have investments in on-reserve health services and initiatives promoting community control improved First Nations' health in Manitoba?" Social Science & Medicine **71**(4): 717-724.

Laycock, A., D. Walker, et al. (2011). Researching Indigenous Health: A Practical Guide for Researchers. Melbourne, The Lowitja Institute.

Magnussen, L., J. Ehiri, et al. (2004). "Comprehensive versus selective primary health care: lessons for global health policy." Health Aff (Millwood) **23**(3): 167-176.

Naccarella, L., D. Southern, et al. (2008). "Primary care funding and organisational policy options and implications: a narrative review of evidence from five comparator countries." Med J Aust **188**(8 Suppl): S73-76.

National Aboriginal and Torres Strait Islander Health Council (NATSIHC) (2003). National Strategic Framework for Aboriginal and Torres Strait Islander Health: Framework for action by Governments. Canberra, NATSIHC.

National Aboriginal Community Controlled Health Organisation (NACCHO). "Primary health care." Retrieved September 2010, from http://www.naccho.org.au/definitions/primaryhealth.html.

National Centre for Epidemiology and Population Health (1991). Building a picture: the role of primary health care in health promotion. National Better Health Program Monograph Series. Primary health care review. Canberra. **1**.

National Health and Medical Research Council (2003). Values and Ethics: Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research. Canberra.

National Health and Medical Research Council (2006). Cultural competency in health: A guide for policy, partnerships and participation. Canberra, Commonwealth of Australia.

National Institute on Drug Abuse (2009). Principles of drug addiction treatment: a research-based guide (2nd Edition), U.S. Department of Human Services.

Northern Territory Aboriginal Health Forum (2000). Core functions of primary health care.

Northern Territory Aboriginal Health Forum (2008). NT Aboriginal Health Key Performance Indicators Definitions (version 1.3.1 December 2008). Department of Health and Aging - NT Department of Health and Families - Aboriginal Medical Services Alliance of the Northern Territory.

Northern Territory Aboriginal Health Forum (2008). Pathways to community control: an agenda to further promote Aboriginal community control in the provision of Primary Health Care Services.

Northern Territory Aboriginal Health Forum (2010). NT Regionalisation of Aboriginal Primary Health Care Guidelines: Supporting a Pathway to Regional Aboriginal Community Control. Department of Health and Aging - NT Department of Health and Families - Aboriginal Medical Services Alliance of the Northern Territory.

Northern Territory Aboriginal Health Forum (Technical Working Group) (2007). Indigenous access to core primary health care services in the Northern Territory.

Northern Territory Department of Health (2011). Health Promotion Strategic Framework 2011 - 2015. NT Department of Health. Darwin.

Northern Territory Department of Health and Community Services (NT DHCS) Aboriginal cultural security: an outline of the policy and its implementation. Systems Performance and Aboriginal Policy Unit. Darwin.

Northern Territory Department of Health and Families. (2007). "The Public Health Bush Book (2 volumes)." from http://www.health.nt.gov.au/Health_Promotion/Tools_for_Good_Practice/index.aspx.

Olds, D. L., C. R. Henderson, Jr., et al. (1999). "Prenatal and infancy home visitation by nurses: recent findings." Future Child **9**(1): 44-65, 190-191.

Parker, R. (2010). Australian Aboriginal and Torres Strait Islander Mental Health: An Overview. Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice. N. Purdie, P. Dudgeon and R. Walker, Commonwealth of Australia.

Parker, R. (2010). Mental Illness in Aboriginal and Torres Strait Islander Peoples. Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice. N. Purdie, P. Dudgeon and R. Walker, Commonwealth of Australia.

People's Health Movement. (2000). "People's Charter for Health." from http://www.phmovement.org/en.

Powell Davies G, Harris M, et al. (2006). Coordination of care within primary health care and with other sectors: A systematic review. Sydney, Research Centre for Primary Health Care and Equity, School of Public Health and Community Medicine, UNSW.

Priest, N. C., Y. C. Paradies, et al. (2011). "Racism as a determinant of social and emotional wellbeing for Aboriginal Australian youth." Med J Aust **194**(10): 546-550.

Productivity Commission (2010). Caring for older Australians: Draft Inquiry report. Canberra, Commonwealth of Australia.

Productivity Commission (2010). Disability care and support: Draft report. Canberra, Commonwealth of Australia.

Ratzan, S. and R. Parker (2000). Introduction. National Library of Medicine: Health literacy (bibliography on line). C. Selden, M. Zorn, S. Ratzan and R. Parker. Bethseda MD: National Institutes of Health, US Department of Health and Human Services.

Rose, G. (1985). "Sick individuals and sick populations." International Journal Epidemiology **14**: 32–38.

Rowley, K. G., A. Gault, et al. (2000). "Reduced prevalence of impaired glucose tolerance and no change in prevalence of diabetes despite increasing BMI among Aboriginal people from a group of remote homeland communities." Diabetes Care **23**(7): 879-881.

Rowley, K. G., K. O'Dea, et al. (2008). "Lower than expected morbidity and mortality for an Australian Aboriginal population: 10-year follow-up in a decentralised community." MJA **188**: 283-287.

Savigny, D. d. and T. Adam, Eds. (2009). Systems thinking for health systems strengthening. , Alliance for Health Policy and Systems Research, World Health Organization.

Shannon, C. and H. Longbottom (2004). Capacity Development in Aboriginal and Torres Strait Islander Health Service Delivery – Case Studies. Aboriginal and Torres Strait Islander Primary Health Care Review: Consultant Report No 4, Office of Aboriginal and Torres Strait Islander Health.

Sibthorpe, B. M., N. J. Glasgow, et al. (2005). "Emergent themes in the sustainability of primary health care innovation." Med J Aust **183**(10 Suppl): S77-80.

Silburn, K., A. Thorpe, et al. (2010). Taking Care of Business: Corporate Services for Indigenous Primary Healthcare Services. Darwin, Cooperative Research Centre for Aboriginal Health.

Silburn SR, Nutton G, et al. (2011). The First 5 Years: Starting Early. Topical paper commissioned for the public consultations on the Northern Territory Early Childhood Plan. Darwin, Northern Territory Government.

Silburn SR, Robinson G, et al. (2011). Early childhood development in the NT: Issues to be addressed. Topical paper commissioned for the public consultations on the Northern Territory Early Childhood Plan. Darwin, Northern Territory Government.

Sims, M. (2011). Early childhood and education services for Indigenous children prior to starting school: Resource sheet no. 7. Closing the Gap Clearinghouse, Australian Institute of Health and Welfare / Australian Institute of Family Studies.

Sparling, J. "Highlights of Research Findings from the Abecedarian Studies." from http://www.teachingstrategies.com/content/pageDocs/Abecedarian-Research-Findings-Highlights.pdf.

Sunrise Health Service (2010). Sunrise way: a concept for change. Prepared by F McConnel for the Sunrise Way Steering Committee, Sunrise Health Service Aboriginal Corporation.

System Performance and Aboriginal Policy Division (Josif D) (2008). Universal Core Service Framework, Performance Indicators and Workforce Implications. Northern Territory Department of Health and Families. Darwin.

The International Union for Health Promotion & Education (2002). Evidence of Health Promotion Effectiveness. Shaping Public Health in a New Europe. A Report for the European Commission.

Tsey, K., M. Whiteside, et al. (2010). "Empowerment and Indigenous Australian health: a synthesis of findings from Family Wellbeing formative research." Health Soc Care Community **18**(2): 169-179.

United Nations. (2007). "United Nations Declaration on the Rights of Indigenous Peoples." from http://www.un.org/esa/socdev/unpfii/en/drip.html.

Vos, T., B. Barker, et al. (2007). The burden of disease and injury in Aboriginal and Torres Strait Islander peoples 2003. Brisbane, School of Population Health, The University of Queensland.

Wakerman, J., J. Humphreys, et al. (2006). A systematic review of primary health care delivery models in rural and remote Australia 1993-2006, Australian Primary Health Care Research Institute.

Wallerstein, N. (2006). What is the evidence on effectiveness of empowerment to improve health? Copenhagen, WHO Regional Office for Europe. **Health Evidence Network report**.

Wilkinson, R. and M. Marmot, Eds. (2003). The Social Determinants of Health The Solid Facts, World Health Organization.

World Health Organization (1978). Alma-Ata: Primary Health Care.

World Health Organization (1978). Declaration of Alma-Ata. International Conference on Primary Health Care, Alma-Ata, USSR.

World Health Organization (1986). Ottawa Charter for Health Promotion. First International Conference on Health Promotion.

World Health Organization (2000). The world health report 2000: Health systems: improving performance. Geneva.

World Health Organization (2007). Everybody business : strengthening health systems to improve health outcomes : WHO's framework for action. Geneva, World Health Organization.

World Health Organization (2008). The world health report 2008 : primary health care now more than ever.

Zhao Y, You J, et al. (2009). Burden of disease and injury in the Northern Territory, 1999-2003. Department of Health & Families. Darwin.