AMSANT Aboriginal Corporation
ICN 8253 | ABN 26 263 401 676
Level 1 Moonta House |43 Mitchell St NT 0800
Postal Address - GPO Box 1624 Darwin NT 0801
Email: reception@amsant.org.au Web: www.amsant.org.au

21 August 2023

AMSANT's Response to Future State of Mental Health (MH) and Integrated Care Team (ITC) Funding

The Aboriginal Medical Services Alliance Northern Territory (AMSANT) wishes to submit feedback on the **Co-design Yarn Discussion Paper and Pre-reading pack**, following a review by First Nations Co and Ninti One Limited of sector funding arrangements and service provider capability for Aboriginal and/or Torres Strait Islander mental health and suicide prevention services and the Integrated Team Care (ITC) Program for the Australian Government Department of Health and Aged Care.

Recently Ninti One hosted a "co-design yarn" in Darwin with the intended purpose of "exploring the key principles emerging from consultations… [and] co-designing future funding arrangements for First Nations mental health and suicide prevention services and the ITC programs. Under the *National Agreement on Closing the Gap, July 2020, Priority Reform One* the Australian Government has committed to formal partnerships and shared decision-making with Aboriginal and Torres Strait Islander people on matters of policy. The future state of funding arrangements for Aboriginal and Torres Strait Islandre mental health and chronic condition care coordination is a major policy matter. As such, this matter should have been tabled with the AMSANT Board and the NT Aboriginal Health Forum (NTAHF) at the outset, with appropriate governance and consultation mechanisms established for the NT.

The Productivity Commission's *Review of the National Agreement on Closing the Gap Draft Report, July 2023* states that "It is too easy to find examples of government decisions that contradict commitments in the Agreement, that do not reflect Aboriginal and Torres Strait Islander people's priorities and perspectives and that exacerbate, rather than remedy, disadvantage and discrimination" (p.2). If this is not going to be another example to add to the Productivity Commission's final report, **AMSANT calls for a meeting between** First Nations Co and Ninti One Limited**, AMSANT, and its members to come to an agreement on the process moving forward that enables Aboriginal people in the NT to:**

- ***Have a leadership role in the design and conduct of engagements;***
- ***Know the purpose and fully understand what is being proposed;***
- ***Know what feedback is provided and how that is being taken into account by governments in making decisions; and***
- ***Are able to assess whether the engagements have been fair, transparent and open.***

National Agreement on Closing the Gap, July 2020, Priority Reform 3 (59f)

For further information about the commitment of government in this regard, please refer to the *National Agreement on Closing the Gap, July 2020, Priority Reform 3*.

AMSANT's position on the future options put forward by Ninti One

AMSANT disagrees with all options put forward by Ninti One in the discussion paper:

1. Options 1, 3 and 4 will further exacerbate fragmentation, red tape, and administration costs, with the appeasement that these options would be "led" by First Nations' People. ACCHSs and ACCOs are already led by First Nations' people. The funding comes from DoHAC FNHD. A direct contractual relationship between the funder and funding recipient is all that is required, with savings (that would otherwise be spent on administration) invested in direct service delivery for Aboriginal and Torres Strait Islander people. If any of these options must be pursued it would be option 2, but AMSANTs current position is that we need to establish an Indigenous Primary Health Care Funding Authority for our core funding even though we appreciate that NACCHO is currently playing a role in funding specialist programs such as sexual health, RHD, and elder care.

2. Option 2 contains the same risks outlined above, **unless** there is a complete restructure of how **all** Aboriginal and Torres Strait Islander primary health care is funded, through the establishment of a national single source funding mechanism for ACCHS through the establishment of a National Aboriginal and Torres Strait Islander Health Authority (NATSIHA). This is aligned with what was recommended by the National Health and Hospitals reform Commission (NHHRC) in 2009[1], although would focus exclusively on PHC. This would include all aspects of comprehensive primary health care and not be restricted to MH and ITC funding.

   The NATSIHA would be a statutory authority accountable to the government of the day through the Minister for Health, governed by a board of experts with the majority being Aboriginal people. Its overall aim would be to oversee the strengthening and further development of Aboriginal and Torres Strait Islander PHC nationally by:

   - funding high quality, culturally appropriate PHC, allocating regional grant funding on the basis of an agreed funding formula / set of core services, with fee-for-service (e.g. Medicare) payments available in addition to the grant funding in a "mixed model" funding model;
   - prioritise ACCHSs for funding, and set up and monitor transition arrangements to community-control where ACCHSs do not already exist;
   - providing dedicated funding for capacity building to maximise the ability of each ACCHS to deliver the highest possible quality of care through trained and supported staff;
   - reporting regularly and publicly on funding and activity on a regional basis

   In the absence of a reform at this level, AMSANT does not support this option.

3. Option 5, that merely 'includes' ACCOs, is underpinned by the presumption that ACCHSs and ACCOs are inclined to lack capability, in comparison with mainstream services. This has been found to not be the case by numerous inquiries and research which demonstrate greater health gain through ACCHSs compared with mainstream services[2]. In terms of the capability of ACCHS and ACCOs, please refer to the evidence that has informed the *National Agreement on Closing the Gap (July 2020), Priority Reform Two: Building the Community Controlled Sector*.

[1] National Health and Hospitals Reform Commission. *A Healthier Future For All Australians*. 2009; Available from: https://www.cotasa.org.au/cms_resources/documents/news/nhhrc_report.pdf

[2] For example Vos T, et al., *Assessing Cost-Effectiveness in Prevention (ACE–Prevention): Final Report*. 2010, ACE–Prevention Team: University of Queensland, Brisbane and Deakin University: Melbourne

This evidence is significant enough for all parties to the agreement to acknowledge that:

*Aboriginal and Torres Strait Islander community-controlled services are **better for Aboriginal and Torres Strait Islander people, achieve better results, employ more Aboriginal and Torres Strait Islander people, and are often preferred over mainstream services**. Priority Reform Two received the strongest support in the 2019 engagements (43).*

Parties have also agreed that:

- *There is sustained capacity building and investment in Aboriginal and Torres Strait Islander community-controlled organisations which deliver certain services and address issues through a set of **clearly defined standards or requirements, such as an agreed model of care** (45a).*
- *Aboriginal and Torres Strait Islander community-controlled organisations which deliver common services have **a dedicated, reliable and consistent funding model** designed to suit the types of services required by communities, responsive to the needs of those receiving the services, **and is developed in consultation with the Peak body** (45d)*
- *Building strong community-controlled sectors to deliver Closing the Gap services and programs requires national effort and **joined up delivery** against all sector elements in agreed priority areas (48)*
- *Government Parties… implement measures to increase the proportion of services delivered by Aboriginal and Torres Strait Islander organisations, particularly community-controlled organisations including by:*
    - *Implementing funding prioritisation policies across all Closing the Gap outcomes that require decisions about the provision of services to Aboriginal and Torres Strait people and communities to **preference Aboriginal and Torres Strait Islander community-controlled organisations** and other Aboriginal and Torres Strait Islander organisations (55a)*

AMSANT's position on future funding arrangements for Aboriginal and Torres Strait Islander health.

Mental health services and care coordination for people with chronic conditions are integral to the **joined up delivery** (48) of Comprehensive Primary Health Care (CPHC) that **achieves better results** (43) for Aboriginal and Torres Strait Islander people. Aboriginal Community Controlled Health Services (ACCHS) have long been the leaders in the delivery of CPHC and already have in place **clearly defined standards and agreed models of care** (45a), supported by **established tripartite mechanisms for planning and decision-making** (59f).

There is much discussion about the need to achieve "integrated care" and that this type of care is best practice but what is often not appreciated is that ACCHS are the embodiment of integrated care as all the different services and programs are provided by a single employer. This is an essential condition of integrated care. There is evidence that once you have more than 3 employers providing care to a single client the outcomes are worse. There is much hype about achieving integrated care and "models of integrated care" in a health system that continues to fund siloed vertical programs through multiple employers rather than a single comprehensive primary health care service. This has been especially the case in mental health where far too many providers have been funded with no required links to primary health care services or even to each other. This is the opposite of integrated care. The separation of funding streams contributes to this type of service fragmentation which leads to worse outcomes. For these reasons, along with the imperative for governments' to meet their commitments

to Aboriginal and Torres Strait Islander people in the National Agreement on Closing the Gap, July 2020, AMSANT's position is:

- Prospectively, all funding for Aboriginal and Torres Strait Islander health, whether this be mental health, ITC or other, be pooled and integrated into the Indigenous Australian's Health Programme Primary Health Care Funding Model, and allocated equitably to ACCHS (wherever an ACCHS is established) through a single source of funding. This could take the form of a direct funding relationship between the Australian Government and ACCHS or be administered by a newly established National Aboriginal Health Authority (NATSIHA). In cases where an ACCHS is not established, funding is allocated to the most capable ACCO provider and/or as agreed by local ACCOs.
- All ACCHS and ACCOs retain the level of existing funding received for the purpose of CPHC, whether this be mental health, ITC, or otherwise. The IAHP funding model should not be applied retrospectively and funding re-allocated. No ACCHS or ACCO should be worse off.
- All funding currently held by mainstream providers for the purpose of Aboriginal and Torres Strait Islander health be transitioned to ACCHS and, where no ACCHS exists, funding is transitioned to the most capable ACCO provider and/or as agreed by local ACCOs.
- In addition, 30% of funding currently allocated for the purpose of mainstream health or the general population, whether it be mental health, ITC or otherwise, be pooled and re-allocated for the purpose of Aboriginal and Torres Strait Islander health.
- All funding for the purpose of Aboriginal and Torres Strait Islander health be administered by the DoHAC Indigenous Health Division through a single contract with each ACCHS/ACCO, including agreed KPIs and a single report.
- All future funding decisions be negotiated directly between the DoHAC Indigenous Health Division and ACCHS peak bodies through the established planning forums. In the NT, this is the NT Aboriginal Health Forum.

Appendix 1: Detailed response to proposed principles.

Appendix 2: Detailed response to proposed future options

Appendix 1: Detailed response to proposed principles

Governance	
1. First Nations communities lead the process	Active participation and leadership of First Nations communities in all stages of decision-making.
Agreed, noting the fact that AMSANT was not approached to partner in this work is of significant concern. Further, if funding were allocated on a population needs basis, Aboriginal communities can design their own services is ways that best meet their own needs.	
2. Place based and First Nations-led governance arrangements	First Nations communities to have leadership and decision-making authority, to ensure they are tailored to the unique needs of the specific location.
Agreed, noting that the governance of ACCHS and ACCOs is First Nations-led and place based.	
3. Ongoing and accessible feedback mechanisms	Empowering First Nations communities to provide feedback during service delivery, to build evidence base and enable continuous improvement.
Agreed, noting that ACCHS have highly sophisticated mechanisms for feedback and the use of data to information continuous quality improvement.	
4. Data sovereignty	Culturally safe data governance frameworks and protocols, consistent with Priority Reform 4 to give First Nations people access to, and the capability to use, locally relevant data and information - ensuring that data collection, storage, analysis, and sharing align with values, needs, and aspirations.
Agreed, noting that ACCHS and ACCOs provide the only real mechanism for true Aboriginal governance of Aboriginal health data.	
Design	
5. A true understanding and use of partnerships/co-design	Use of a partnership approach and/or co-design that fosters a genuine understanding of First Nations perspectives, knowledge, and experiences by actively involving community members as equal partners.
Agreed, noting again the fact that AMSANT was not approached to partner in this work is of significant concern. Further, if funding were allocated on a population needs basis, Aboriginal communities can design their own services is ways that best meet their own needs.	
6. Longer funding cycles	Transition to longer-term funding using a more flexible, relational approach to contracting.
Agreed. This is most easily achieved if funding is allocated on a population needs basis rather than constantly being shuffled to respond to political imperatives. The latter is why mental health and ITC funding, amongst a range of other funding 'buckets' landed with the PHNs in the first place.	

7. Universal coverage with no geographical gaps	Comprehensive arrangements to bridge geographical gaps and ensure universal access.
Agreed. This can be achieved if funding is allocated on a population needs basis.	
8. Consolidated, pooled funding	Combining available funding for nominated communities to maximise its reach and impact.
AMSANT agrees with consolidated, pooled funding for all communities and does not understand the reference to 'nominated' communities. This appears to contradict element 7 – universal access.	
9. Coordination and collaboration of data and funding	Strong coordination and collaboration of data and funding between governments and agencies for nominated communities
If funding were consolidated and managed by the FNHD of DoHAC, health funding would not need to be coordinated and data would be collected through a single mechanism, rather than the myriad of data collection and reporting mechanisms currently in play.	
10. Prioritising First Nations concepts of health	Prioritisation of First Nations health concepts in the design and delivery of programs and services for First Nations communities.
ACCHS and ACCOs are best aligned to prioritise Aboriginal concepts in the design and delivery of programs through Aboriginal governance mechanisms and flexible pooled funding that enables communities to design their own services in ways that meet their own needs.	
11. Needs based funding	Needs based funding using accurate evidence
Agreed, with funding being allocated to ACCHS and ACCOs according to need.	
Implementation	
12. Inclusive funding application processes	Funding application processes are designed to be inclusive and not favour large, well-resourced organisations.
If funding were allocated to ACCHS and ACCOs according to need, there would be no need for a funding application process.	
13. Flexibility to meet local and unique needs	Funding guidelines and parameters sufficiently flexible to enable local providers to deliver targeted responses based on identified need.
Agreed, noting that flexible funding is the only way to enable communities to design their own services in ways that meet their own needs.	
14. Outcome-based reporting and KPIs	Appropriate outcome measures that are culturally informed for reporting that reflect the goals of communities, including the holistic nature of health and wellness, reflecting community priorities and aspirations.
ACCHS already have a sophisticated system in place for reporting to the agreed National Aboriginal Health KPIs and a process for identifying KPIs for future reporting established with the FNHD of DoHAC.	

15. Consolidated and streamlined reporting	Quality-focused reporting that reduces the administrative burden and improves the efficiency of reporting.
The system in place for reporting to the agreed National Aboriginal Health KPIs is consolidated and streamlined.	
16. Transparent reporting of outcomes and sharing of data	Sharing of outcome data that is captured to support transparent understanding of service outcomes.
The system in place for reporting to the agreed National Aboriginal Health KPIs is transparent and includes mechanisms to share and compare de-identified data.	
17. Mechanisms and funding to support the First Nations workforce	Support the development, recruitment, and retention of a robust First Nations workforce enabled by a Culturally safe system. Collaborate with communities to design culturally safe training and education programs that build capacity and enhance skills
Agreed, noting that ACCHS and ACCOs "employ more Aboriginal people" (The National Agreement on Closing the Gap, Priority Reform 2 (43))	
18. Fair and transparent funding decisions	Clear and consistent criteria for funding eligibility and assessments. Enhance transparency with clear guidelines and information on funding opportunities, application procedures, and decision-making processes. Regularly communicating funding decisions and feedback to applicants.
Agreed, noting that allocating funding on a population needs basis is the most fair and transparent approach to making funding decisions.	
19. Interagency and jurisdictional collaboration	Governments to work together to share information and coordinate and pool funding.
Agreed, noting that if funding is allocated on a population needs basis and managed through a single contract with each ACCHS, the need for coordination is vastly reduced.	
20. Enhance the cultural safety of the non-Indigenous service sector	Upskill the non-Indigenous service sector (across health and other, related sectors) to ensure that First Nations peoples can access different services based on their preferences, knowing that all are culturally safe and can meet their holistic needs
Agreed, noting that this should be a principle of society.	
21. Service coordination	Enhance the ease with each services can safely cross-refer and/or coordinate the delivery of services to meet the holistic needs of First Nations peoples.
ACCHS are leaders in the delivery of CPHC and vastly reduce the need for cross-service referrals.	
22. One-stop-shop	Services to provide one-stop-shop access to health, wellbeing and social supports.
ACCHS are a one stop shop for CPHC.	

Appendix 2: Detailed response to the proposed future options

Future Options	AMSANT response
1. First Nations Regional Health and Wellbeing Bodies • The Department and PHNs handover their current roles via a staged transition process. • The Department funds First Nations Regional Bodies directly to lead the funding arrangements. • Note: these bodies are not service providers.	**AMSANT does not support this option.** • ACCHS are already First Nations' bodies. This proposes to introduce a layer of 'community-control' on top of existing community-control. • Alignment with Closing the Gap requires recognising that community-controlled organisations already exist and utilising the avenues that have already been established for the purpose of planning and decision-making, rather than creating another one with the mantra that it is "elevating" the role of First Nations people and communities. • The stated potential challenges and considerations are correct on all counts. This would add further complexity to an already complex and poorly integrated service system at a significant cost. This money could be invested in direct service delivery with benefits accruing in the form of *actually* closing the gap on Indigenous health.
2. First Nations organisation at the national level • The Department and PHNs handover their current roles via a staged transition process. • The Department funds the First Nations organisation to lead the funding arrangements. • Note: this organisation is not a service provider.	**AMSANT does not support this option** • AMSANT disagrees with this option **unless** there is a complete restructure of how **all** Aboriginal and Torres Strait Islander primary health care is funded, through the establishment of a national single source funding mechanism for ACCHS through the establishment of a National Aboriginal and Torres Strait Islander Health Authority (NATSIHA). • This option for the sole purpose of administration of mental health and ITC would add further complexity to an already complex and poorly integrated service system at a significant cost. This money could be invested in direct service delivery with benefits accruing in the form of *actually* closing the gap on Indigenous health.
3. First Nations organisations at the jurisdictional level • PHNs handover their roles to the respective jurisdictional First Nations organisation via a staged transition process. • The Department funds First Nations organisations to lead the funding arrangements in their jurisdiction. • Note: these organisations are not necessarily service providers.	**AMSANT does not support this option.** • Alignment with Closing the Gap requires recognising that community-controlled organisations already exist and utilising the avenues that have already been established for the purpose of planning and decision-making, rather than creating another one with the mantra that it is "elevating" the role of First Nations people and communities. • It appears this option is proposing that jurisdictional peaks take on the role of

	commissioner – as the peak for the NT, it would appear appropriate to consult with AMSANT prior to publicly consulting on this as an option for the NT.
4. First Nations community-controlled organisations or consortiums at a regional level • PHNs handover their roles to the respective organisations or consortiums via a staged transition process. • The Department funds the First Nations organisations to lead the funding arrangements in their regional areas.	**AMSANT does not support this option.** • Alignment with Closing the Gap requires recognising that community-controlled organisations already exist and utilising the avenues that have already been established for the purpose of planning and decision-making, rather than creating another one with the mantra that it is "elevating" the role of First Nations people and communities. • As much as AMSANT thinks this is a poor option for many reasons, the reference to significant 'upskilling' for ACCOs is offensive. Why would ACCOs be any different from any new mainstream commissioning body? • We have already learned the lessons from Medicare Locals doubling as commissioners and service providers. These do not need to be repeated.
5. Service providers (inc. ACCOs) to receive direct funding • PHNs handover their roles in sector commissioning and administration, via a staged transition process. • No regional commissioning body to replace PHNs for these funded programs. • The Department funds service providers directly.	**AMSANT supports this option for ACCHS and ACCOs.** • Service providers that are not community-controlled should not be preferenced. ACCHS and, where ACCHS are not established, ACCOs should be allocated funding according to population need, and have a direct contractual relationship with the First Nations Division of DoHAC. • If funding is allocated according to population need there is no need for another layer of 'formal' needs assessment • If funding is allocated according to population need, there is no risk that larger ACCOs will benefit – it is the population that benefits. • How does this option lead to the need for additional assistance for ACCOs to manage process/governance/reporting? • ACCHS are leaders in the country in the delivery of CPHC and if ACCHS or ACCOs have not already been commissioned by PHNs to deliver services they should have been. There appears to be a suggestion here that ACCOs are inferior to mainstream providers that are being presented as experts at joined up service delivery.