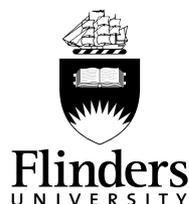# the Overburden report:

## Contracting for Indigenous Health Services

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Kim O'Donnell
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## Logo design

The logo represents the journey of the research team, travelling and talking with public servants and health service staff about the way primary health care is funded and regulated for Aboriginal and Torres Strait Islander peoples. The half circles represent people sitting; yarning up. The looping track represents the research journey backwards and forwards, checking information in the literature and cross-checking information with participants to ensure the facts are captured to tell the story *right way*.

# Abbreviations

ACCHS       Aboriginal Community Controlled Health Service

CEO         Chief Executive Officer

CRCAH       Cooperative Research Centre for Aboriginal Health

DEEWR       Department of Education, Employment and Workplace Relations

DHF         Department of Health and Families

DHS         Department of Human Services

DoHA        Department of Health and Ageing

FaHCSIA     Department of Families, Housing, Community Services and Indigenous Affairs

HR          human resources

ICT         information and communication technology

MBS         Medical Benefits Schedule

NACCHO      National Aboriginal Community Controlled Health Organisation

NGO         non-government organisation

OATSIH      Office for Aboriginal and Torres Strait Islander Health

ORIC        Office of the Registrar of Indigenous Corporations

PBS         Pharmaceutical Benefits Scheme

PHC         primary health care

SAMSIS      Secure Aboriginal Medical Service Information System

SAR         Service Activity Reporting

SDRF        Service Development and Reporting Framework

# Some Important Terms Defined

**Aboriginal and Torres Strait Islander Community Controlled Health Services (ACCHSs):** this term is used for agencies that are incorporated under the governance of a (predominantly) Aboriginal and/or Torres Strait Islander community Board, rather than being owned by government or non-Indigenous owners (referred to as non-government organisations or NGOs in this report). Many ACCHSs are members of peak bodies in each State and Territory— representative organisations that provide services to the member organisations (corporate support, strategic planning advice and assistance, help with funding negotiations, etc.) and advocate on behalf of members with governments and other parts of the health industry. Each State and Territory peak body is an affiliate of the national peak body—the National Aboriginal Community Controlled Health Organisation.

**Funding and regulation:** in this project, the terms *funding* and *regulation* are used to mean the finances that primary health care providers receive largely from governments, the conditions of funding, reporting requirements and accountability measures, and the way the providers and funders relate to each other.

**Indigenous:** we acknowledge the objections of some Aboriginal and Torres Strait Islander people and organisations to this term. It is used sparingly in this report where appropriate, for example, *non-Indigenous people*. It is also used where repetition of *Aboriginal and Torres Strait Islander* would make the text harder to read. This has enabled us to avoid the abbreviation *ATSI* to apply to people (we do use it to apply to organisations, such as *OATSIH*). The word *Indigenous* is capitalised in keeping with current practice, to indicate its specific use to apply to Australian Aboriginal and Torres Strait Islander peoples. It is not capitalised when used generically.

**Mainstream:** this is a term used in Australia to refer to non-Indigenous systems, institutions and practices.

**Overburden:** this term comes from the mining industry, where it is used to refer to the soil, rock and other materials that must be removed to get to the ore. We use it to mean the administrative work that has to be done by providers to acquire, manage, report on, and account for the funding they use to deliver services; and by funders to allocate, manage, monitor, acquit and report on the funding and the services and other activities it was used for. These are necessary functions, and can generate useful information for decision making, operational management, service quality and improvement, as well as for assessing outcomes and justifying further funding. But this is an overhead expense and effort, and should be kept to a minimum.

**Primary health care (PHC):** the *National Strategic Framework for Aboriginal and Torres Strait Islander Health* (NATSIHC 2003:17) identifies that PHC includes at least the following elements:

- clinical services (for management of chronic and communicable disease, acute care and emergency care)

- illness prevention services (including population health programs such as immunisation, screening programs and environmental health programs)

- specific programs for health gain (e.g. antenatal care, nutrition, physical activity, social and emotional wellbeing, oral health and substance misuse)

- access to secondary and tertiary health services and related community service (such as aged and disability services).

The concept of PHC is grounded in the Declaration of Alma-Ata, which resulted from the 1978 International Conference on Primary Health Care. There are several elements within the declaration that serve to constitute PHC:

> *It is the first level of contact of individuals, the family, and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process* (WHO 1978:VI).

The declaration further asserts that:

> *Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination* (WHO 1978:VI).
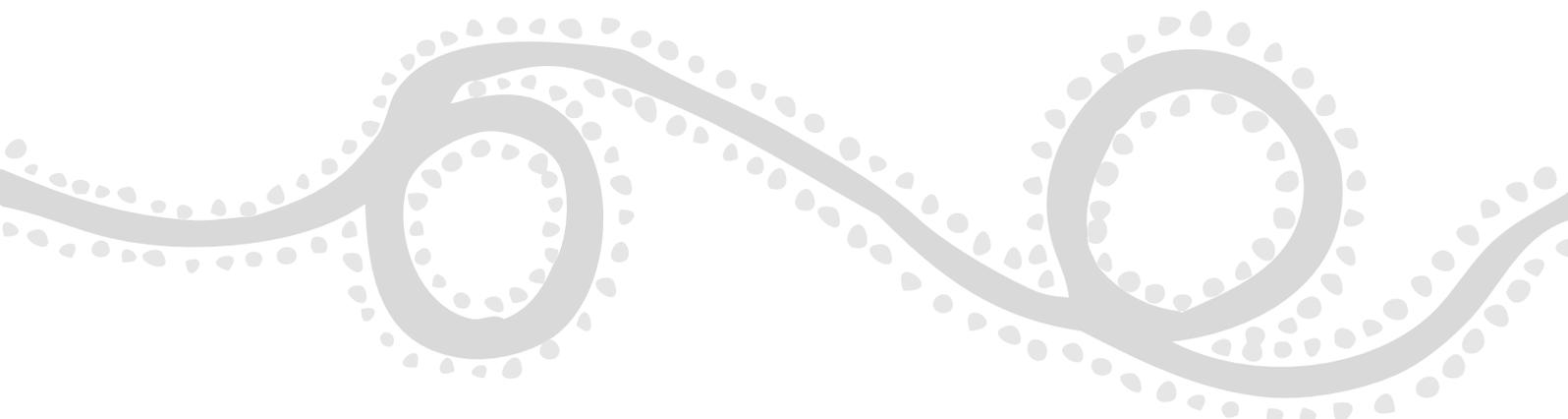
# Executive Summary

In Australia, Aboriginal and Torres Strait Islander community health organisations play a significant role as providers of essential primary health care (PHC) in rural, remote and urban settings. Australian governments have developed policies and funding programs to support this growing health sector. But the current arrangements for funding are much criticised. Providers complain about fragmented funding programs, with too many reports required. Government staff also experience problems with administering these funds, with high workloads in processing and managing a multitude of programs and grants, and some lack of compliance by providers, particularly with activity reporting requirements.

This project aims to expand our understanding of these problems and find better ways of funding and regulating PHC for Aboriginal and Torres Strait Islander communities. Specifically, this report seeks to answer these questions:

- What are the major enablers and impediments to effective PHC delivery embedded in the current frameworks of funding and accountability for PHC services to Aboriginal and Torres Strait Islander people in Australian States and Territories?

- How could the effectiveness of funding and accountability arrangements be improved, drawing on insights from current Australian practice and international comparisons?

## Contracting in health

Indigenous-specific health providers in Australia, Canada and New Zealand have emerged mainly as not-for-profit, community-governed PHC organisations. The relationship between the government and indigenous service providers is governed by contracts in all three countries.

Contracts are arrangements by which government funders specify the services they are *purchasing* for the community, and providers undertake to deliver them. These arrangements are specified in *service or funding agreements*, which are contracts between the funder (generally government) and the provider. Contracting creates some problems, but it is used by governments in many countries as a mechanism to enable community-based indigenous health services to be funded to provide improved access and responsiveness.

The theoretical framework for this study is based on contract theory, particularly the distinction between classical and relational contracts. Classical contracting is the traditional model for an exchange of goods or services for money. Relational contracting recognises the interdependence of contractor and supplier, and seeks to maximise the common interests of the parties in the enterprise. In the commercial sphere, this approach (known as alliance contracting) has become more common. The typical features are a long time frame, arrangements for sharing of profits and risk sharing.

The evidence from research indicates that the funding of Aboriginal and Torres Strait Islander Community Controlled Health Services (ACCHSs) in Australia is more suited to relational contracting. Relational contracting is preferred when the services are broad ranging (e.g. PHC) rather than narrow (e.g. contracting for specific immunisation or medical imaging services); when there is not a competitive market among providers; and when maintaining long-term relationships with providers for health services is important for continuity of care, workforce sustainability and system development.

**Project methods**

We collected and analysed three main kinds of data. They are:

1. Government funding program guidelines and policies in relation to PHC funding for ACCHSs and contract documents. These documents were analysed to produce 'a big picture' of the policy and program environment in each jurisdiction and to guide interviews and other project data collection and interpretation.

2. Interviews with senior staff from national and most State and Territory health authorities and a national sample of ACCHSs. Interviews were audio-recorded, transcribed and analysed to identify the main themes.

3. Financial reports of a sample of 21 ACCHSs for the financial year 2006–07. We collated this information to improve our understanding of the complex ways in which ACCHSs are funded.

**Current government funding and regulation practice**

The bulk of PHC funding to ACCHSs in Australia is provided by the Commonwealth Government, which funds virtually all ACCHSs from many different funding programs. Most State and Territory health authorities provide relatively smaller amounts of funding from several different program areas or divisions within the authority and from multiple funding programs (each with their own guidelines and activity reporting requirements).

The funding and regulatory practices of Australian governments are complex and fragmented, and bring a heavy burden of acquiring, managing, reporting and acquitting funding contracts to both sides of the funding relationship. These problems arise partly from a lack of consistency in the reporting requirements of national and State/Territory government funders, and are compounded, in the majority of health authorities, by internal structures that separate responsibility for policy and relationship development from responsibility for contract management. These arrangements complicate communication tasks and reduce the knowledge management capacity of the funder.

Health authority staff are aware of these problems and there is a widespread effort to address them. However, it seems that the implementation of intended reforms is slow and patchy, particularly where cooperation between two levels of government, or different government departments, is required.

**ACCHS funding and income**

We identified 145 ACCHSs across Australia that are engaged in providing comprehensive PHC for their communities, and we analysed detailed financial data from a representative sample of 21 agencies. More than half the ACCHSs in the sample reported income of between $1 million and $2 million, with an average of about $5 million. The number of separate funding grants received by ACCHSs in our sample ranged from six to 51, with an average of 22 per ACCHS.

About 80 per cent of *total funding* to sample agencies was provided by the Commonwealth, with 19 per cent coming from the States and Territories and the remaining 1 per cent from local and non-government sources. Almost two-thirds of grants were funded by the Commonwealth and 29 per cent by the States and Territories.

On average, Commonwealth grants were larger. Some program allocations were very small, with 2 per cent being for amounts of less than $1000, mostly for one-off purposes. A further 13 per cent were between $1000 and $2000. Nearly 60 per cent of programs allocated less than $100,000 to agencies in the sample. Allocations that exceeded $1 million were primarily core funding to operate comprehensive PHC services or nursing homes.

Just over half of the grants came from health-specific programs, and 30 per cent of grants were for broader community or social programs. There were 68 different programs from which funds were received by one or more of the 21 agencies in our sample. Just over half (11) of the 21 agencies received funding that was identified as core funding for PHC and/or clinical services, making up an average of about half of their total funding. The remaining 10 were funded from several specific-purpose programs.

The current funding regimes are almost entirely constructed as short- to medium-term contracts. But in practice the approach in health authorities and in ACCHSs is to treat much of this funding as ongoing. This pattern—the majority of program funding being ongoing in practice, but both sides having to contend with yearly funding applications—has also been documented in the Indigenous services field more broadly.

Although both funders and ACCHSs regard much of the annually or triennially renewed funding as effectively ongoing, and act accordingly (e.g. in appointing staff), this situation is problematic. It also raises the question of the value of constructing funding as short to medium term if in reality most of it is long term.

## Perspectives of funders and providers

There was general recognition that the current funding arrangements are too complex and inefficient for both sides, but also that definitive solutions are hard to find. The complex contractual environments in which ACCHSs work are not monitored or managed in any consistent way. They have emerged from a series of unlinked policy and program decisions, and simply grown over time.

Funders in most jurisdictions have moved to simplify and consolidate contracts, and to lengthen the standard funding term to three years. There are many barriers to this goal, including the nature of budget appropriations, and the need for cooperation among levels of government and different departments.

Both funders and providers consider themselves to be in long-term funding relationships, and tend to act in accordance with this belief. Relationships of trust between individuals are seen as important enablers of effective accountability, problem solving and decision making. Although classical contracts predominate, and bring a high reporting burden, the pattern of dispute resolution also indicates that the sector is regulated as a relational environment.

Heightened political sensitivity, and the related need to demonstrate strong accountability, tends to reinforce burdensome reporting requirements that seem to have limited utility.

## Conclusion

Our examination of the current practices and policies of health authorities has identified characteristics of the funding relationship that are important barriers to good practice, as well as some enabling factors.

The complex contractual environment for ACCHSs and their funders is largely shaped by a classical approach to contracts, though often with a vocabulary and management environment that invokes relational contracts.

This tends to undermine the benefits of both forms. Those involved think and behave in ways that belie the intentions of classical contract provisions (such as avoiding expectations of ongoing funding); but the advantages of relational contract forms (such as reduced transaction costs) are not realised either.

Governments are committed to the development of a robust comprehensive PHC sector, but the classical contracting model is not adequate to support the achievement of this goal. We suggest that implementation of government policy commitments will require a different way of thinking about the relationship between government and the sector, with implications for both sides. We further suggest that the framework of relational (or alliance) contracting provides methods for improving both efficiency and effectiveness.

Accordingly, we suggest the following principles against which options for good practice in funding and regulation could be evaluated:

1. Long-term contracting for core PHC is the basis for the funder–provider relationship.

2. Core PHC funding allows flexibility for local priority setting, in accordance with agreed plans.

3. Data collection and monitoring are simplified and information is shared, based on sound performance and health outcome indicators.

4. Transaction costs are reduced and complexity is managed through a single main long-term contract and good contract management.

5. Risks for both sides are managed and capacity on both sides is enhanced.

No administrative arrangement is perfect, or perfectly implemented. Any approach will solve some problems, and create others. We suggest that relational contracting offers a sound alternative framework for redesigning the funding and accountability relationships for this critical sector of the Australian health system, thereby reducing administrative costs, improving performance and, ultimately, maximising the PHC contribution to closing the health gap between Indigenous and non-Indigenous Australians.
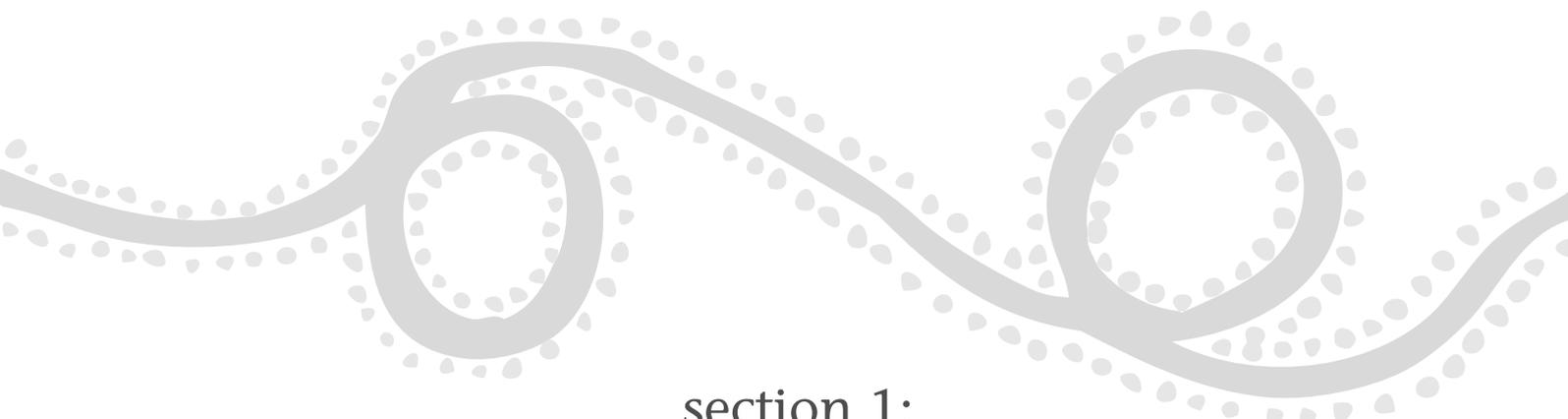
# section 1:
# Introduction

Health and health care are high priorities for indigenous peoples around the world, and this is reflected in the United Nations Declaration on the Rights of Indigenous Peoples (UN 2007:Articles 23 and 24). In recent decades, indigenous peoples in many countries have sought to secure more control over community-based health services, in the hope of improving access and responsiveness.

Governments have responded by developing contractual relationships with indigenous health organisations that now provide a spectrum of primary health care (PHC) services, ranging from health promotion and prevention to primary intervention and rehabilitation services. This shift echoes the Declaration of Alma-Ata and the Ottawa Charter's commitment to popular engagement in service planning and delivery (WHO 1978, 1986; WHO Department of Communicable Disease Prevention and Health Promotion 1997).

In Australia, Aboriginal and Torres Strait Islander community health organisations play a significant role as providers of essential PHC in rural, remote and urban settings. Australian governments have developed policies and funding programs to support this growing health sector. The guiding policy document is the *National Strategic Framework for Aboriginal and Torres Strait Islander Health*, signed by all Australian health ministers in 2003 (NATSIHC 2003). It affirms:

*Within the health system, the crucial mechanism for improving Aboriginal and Torres Strait Islander health is the availability of comprehensive primary health care services. Effective and appropriate primary health care services must be available to all Aboriginal and Torres Strait Islander peoples. These services should maximise community ownership and control, be adequately funded, have a skilled and appropriate workforce and be seen as a key element of the broader health system* (NATSIHC 2003:1).

It goes on to outline the commitment of all Australian governments to nine principles, including community control of PHC services, local decision making about health care needs and priorities, and accountability of all parties. This policy intention has not yet been implemented effectively, despite much sustained effort and several implementation plans (Commonwealth of Australia 2007; Australian Government 2008).

PHC funding provided to Indigenous agencies is intended to improve the health of Aboriginal and Torres Strait Islander people by supporting good health care, while also meeting the need for accountability to communities and to governments. Another important enabling goal is to make it possible for PHC providers to recruit and retain skilled staff. But the current arrangements for funding are much criticised. Providers complain about fragmented

funding programs, with too many reports required, and too many strings attached. Government staff also experience problems with administering these funds, with high workloads in processing and managing a multitude of programs and grants, and some lack of compliance by providers, particularly with activity reporting requirements.

This project aims to expand our understanding of these problems and find better ways of funding and regulating PHC for Aboriginal and Torres Strait Islander communities, from the point of view of Indigenous PHC provider organisations, as well as government agencies. Funded by the Cooperative Research Centre for Aboriginal Health (CRCAH), the project is a partnership between researchers at Flinders University (South Australia), the Australian Institute of Aboriginal and Torres Strait Islander Studies (Australian Capital Territory) and the University of Northern British Columbia (Canada). The idea for the project emerged from discussions with people in the Aboriginal and Islander PHC sector about their priorities for research, and was endorsed by the CRCAH Board. It has been supported by a national reference group, which includes representation of major stakeholders on both sides of the funding relationship and others with relevant expertise.

In this report we first outline the context and aims of the project. This is followed by a brief summary of current funding practice in indigenous health, nationally and internationally, and in the Australian mainstream health system, with a focus on the use of contracting for PHC. A summary of the methods we used for collecting and analysing data then follows. The results are given in three sections, covering funding arrangements in each State and Territory, as well as nationally; the sources and amounts of funding used by a sample of Aboriginal Community Controlled Health Services (ACCHSs); and the views and experiences of a sample of providers and funders. On the basis of this information, we outline the major current problems and a framework for better practice, incorporating the kind of changes that might reduce administrative overload while still meeting accountability requirements and improving the efficiency and effectiveness of PHC services.

# Context and aims

The dominant model for delivery of Indigenous-specific PHC in Australia is through community-controlled organisations that incorporate principles of self-determination with PHC principles in their approaches to governance and management, priority setting and health care delivery. Efforts to implement funding programs and accountability arrangements based on national policy and these principles are characterised by conflicting goals among multiple parties and by implementation difficulties. These difficulties arise in a context of underlying contestation regarding claims for collective participation and control over health care resources by Aboriginal and Torres Strait Islander communities, in spite of official policy pronouncements that support those claims (Anderson 2006).

The sources of these difficulties also include the complexity of allocation and administration of funds in the form of contracts from multiple funding sources (typically national, State/Territory, and some local government and non-government organisations [NGOs], and, often, allocations from multiple funding programs within one department or organisation). The resulting contractual environment is characterised by 'a multiplicity of fragmented, often proposal-driven, contracts with high administrative costs' (Lavoie 2005:2). Lavoie concludes that Indigenous agencies that are funded by an Indigenous-specific government authority are better able to provide comprehensive services and are advantaged administratively and financially.

There have been several studies investigating the question of the appropriate level of funding for PHC services for Aboriginal and Torres Strait Islander people (Econtech 2004; Deeble *et al.* 1998; Beaver & Zhao 2004) and all have recommended significant increases to achieve equity of access with non-Indigenous Australians, including meeting the additional costs of remoteness and cultural appropriateness of care. This study does not address the question of adequate funding levels, but we recognise that inadequate funding is an important factor limiting the capacity of ACCHSs to

achieve their health care goals. There has also been significant policy and program innovation to make mainstream funding programs more accessible to Aboriginal and Torres Strait Islander people and their health care providers, including the Coordinated Care Trials (DoHA 2001) and the Primary Health Care Access Program (Rosewarne & Boffa 2004), as well as changes to regulations governing access to subsidised medical services and medicines (Kelaher *et al*. 2004; Medicare Australia 2009).

On the ground, PHC providers aiming to provide high-quality, culturally appropriate services and programs continue to struggle with shifting funding lines, complex reporting requirements, competing policy priorities and sometimes difficult working relationships. In government departments, staff experience difficulties in assisting agencies to meet accountability requirements, and in negotiating tensions that affect PHC providers and arise from within, and external to, Aboriginal and Torres Strait Islander communities.

So far, however, the way that Indigenous-specific PHC services are funded and regulated across jurisdictions has not been systematically investigated. Likewise, the experience of government officers has not been documented. What is lacking is a comparative review that identifies the features of the different forms and shapes of the PHC funding system and relationships and analyses their strengths and weaknesses from the points of view of both the PHC providers and the funders.

Although we have drawn on research and experience in broader Aboriginal and Torres Strait Islander administration (including Morgan Disney and Associates 2006; Sullivan 2006, 2008, 2009), the issues are different for health, for several reasons. Importantly, the responsibility for funding Aboriginal and Torres Strait Islander health services was transferred from the Aboriginal and Torres Strait Islander Commission to the Commonwealth Department of Health in the mid-1990s. Subsequently, Indigenous-specific health programs and structures have not been folded into the whole-of-government mechanisms of the Office of Indigenous Policy Coordination and the Indigenous Coordination Centres (FaHCSIA 2009).

The purpose of this report is to broaden our understanding of the opportunities and constraints experienced by Indigenous PHC providers. Specifically, it seeks to answer these research questions:

• What are the major enablers and impediments to effective PHC delivery embedded in the current frameworks of funding and accountability for PHC services to Aboriginal and Torres Strait Islander people, in Australian States and Territories?

• How could the effectiveness of funding and accountability arrangements be improved, drawing on insights from current Australian practice and international comparisons?

**the Overburden report:** Contracting for Indigenous Health Services
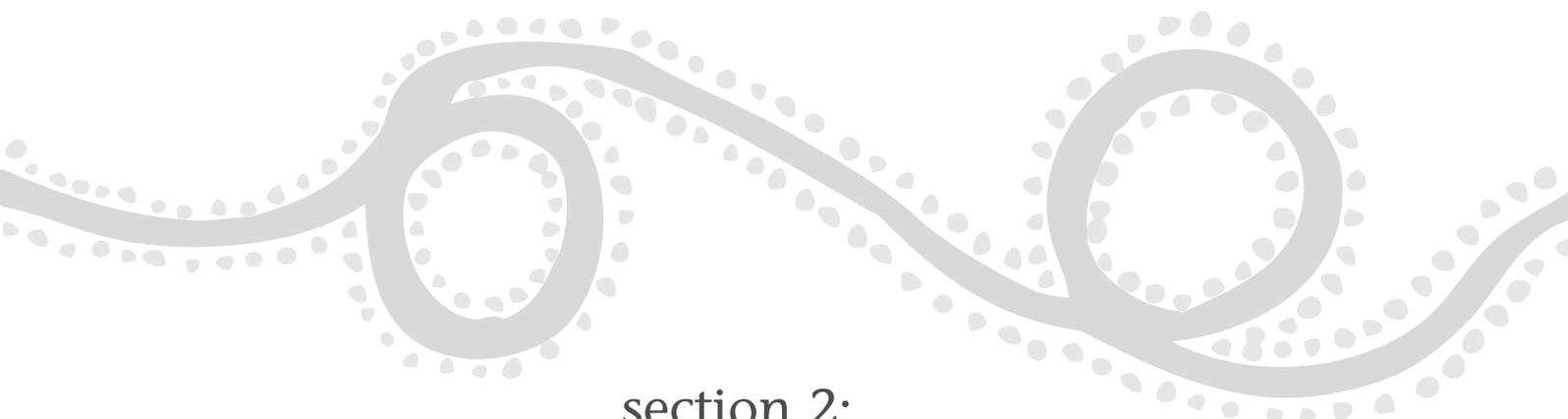
# section 2:
# Analytical Framework— Contracting in Health

National policy for Aboriginal and Torres Strait Islander health care emphasises participation, community control, partnerships and comprehensiveness of PHC services (NATSIHC 2003). However, implementation is dominated by reliance on cumbersome coordination arrangements for planning and funding, and uncoordinated contracting with the ACCHS sector for service delivery.

Contracts in this context are arrangements by which government funders specify (broadly or in detail) the services or other activities they are *purchasing* on behalf of the community, and providers undertake to deliver those services or activities. These arrangements are generally specified in *service agreements* or *funding agreements*, which are contracts between the funder (generally, government) and the provider (in this case, the ACCHSs). In the mainstream health system, contracts and contract-like arrangements have been used in aspects of government funding for health care since the 1980s (e.g. output-based models like casemix for hospitals).

Although contracting in practice creates some problems, contracting is used by governments in many countries as a mechanism to enable community-based indigenous health services to be funded to provide improved access and responsiveness, particularly in Canada, New Zealand and Australia (Lavoie et al. in press).

In this section we first review relevant aspects of the funding and regulation of systems for PHC in Australia, Canada and New Zealand, and for the Australian mainstream system. We then present an analytical framework derived from comparative research that we have used to examine and assess current funding arrangements, and address the concept of accountability that underlies the requirement for reporting.

# Indigenous health care: International comparisons

Although significant differences exist, Australia, Canada and New Zealand share much in terms of history, interests and debates. First, indigenous peoples in all three countries self-identify as such and are internationally recognised as indigenous by the United Nations' Working Group on Indigenous Populations because of their prior occupancy of their lands; the voluntary perpetuation of their cultural distinctiveness; their self-identification as indigenous; and their experience of subjugation, marginalisation, dispossession, exclusion and discrimination by the dominant society (UN Working Group on Indigenous Populations 1996). Second, each country shares a history of conquest by Britain and permanent settlement by a majority of people who shared similar values among themselves. Third, in each country, English common law prevails to varying extents, along with majority representative democratic government, and these approaches displaced traditional forms of governance, at least at the official level. Fourth, each country adopted some policies inspired by social Darwinism that were eventually displaced by post-assimilationist accommodations (Armitage 1995; Havemann 1999).

In all three countries, indigenous people seek greater control over community-based PHC services for their populations. Policies have emerged validating indigenous health services, and public funding has been allocated specifically to support these organisations. These policies have become understood as an endorsement of indigenous self-determination. The words vary, but the discourses are similar. Self-determination is to replace earlier policies of assimilation by promoting indigenous participation in policy development and in service delivery. Although Australian governments have recently moved away from the concept of self-determination (Anderson 2006), it remains as a fundamental underpinning in Aboriginal and Torres Strait Islander health policy in the form of endorsement

for community control (NATSIHC 2003:2). Finally, indigenous people in these countries experience comparable economic situations (marginalised populations in prosperous industrialised countries—*fourth world in first world*).

In these countries indigenous people comprise a small part of the total population—2.5 per cent in Australia (ABS 2008a), 3.8 per cent in Canada (Statistics Canada 2008) and 14.6 per cent in New Zealand (Statistics New Zealand 2008). Indigenous people in all three countries utilise PHC services less often than non-indigenous people (Alford 2005). All countries have dual systems for PHC services: mainstream (non-indigenous) and indigenous-specific PHC service providers. Mainstream systems consist of PHC, which is primarily delivered by general practitioners or allied health practices (backed up by tertiary and secondary services). Indigenous people may access both types of PHC.

Indigenous-specific health providers in Australia, Canada and New Zealand have emerged mainly as not-for-profit community-governed PHC organisations. The relationship between the government and indigenous service providers is governed by contracts in all three countries.

Canada and Australia have federal and provincial/State jurisdictions, and both levels of government have responsibilities for indigenous health and health care. In Canada the federal government has responsibility for funding PHC services for First Nations people who live on reserves. PHC for all indigenous people who do not live on reserves (about 40 per cent of the population) is provided by the mainstream health system (along with a small number of urban indigenous-specific health organisations) and funded through many (mainly provincial government) authorities. This on–off reserve separation creates access problems, as people who do not live on reserves are not entitled to on-reserve services. The federal government transferred the responsibility for the management and delivery of on-reserve PHC services to communities, commencing in 1989. The funding arrangements for these 'transferred services' are based on a single long-term contract and competitive project or new initiative funding (Lavoie *et al.* 2005).

New Zealand has a unitary political system. New Zealand's health care system has been decentralised through the formation of 21 District Health Boards, each of which acts as the sole purchaser of public health services for its regional populations, as well as being the *owner of* most public health services (hospitals and other health care providers). Primary health organisations bring together all PHC providers for a defined population under the governance of community-based authorities. Maori providers are funded through multiple small contracts (Lavoie 2004).

In Australia the relative roles of Commonwealth (federal) and State/Territory governments in funding Indigenous-specific services, and other care for Aboriginal and Torres Strait Islander people, are overlapping and unclear. Both Commonwealth and State/Territory governments provide direct funding for Indigenous-specific health service providers in remote Aboriginal and Torres Strait Islander communities and in regional and urban settings, and also have overlapping roles in the mainstream health system.

Thus, although there are important differences in health systems, all three countries share a reliance on indigenous-specific PHC providers for a significant proportion of the total PHC used by indigenous people, and a contractual approach to funding. The basic structural features of funding in the three systems are shown in simplified form in Figure 1. Please note that the actual pathways of funding for any individual PHC organisation are much more complex in all three countries.

The policies and practices outlined above arose partly from concern about wide health disparities—*the gap*—between the health status of indigenous and non-indigenous people. In Canada and New Zealand indigenous health is worse than the mainstream populations (Anderson *et al.* 2006), but the gap is not as wide as in Australia. Table 1 illustrates health status comparisons.

**Figure 1:** PHC funding models
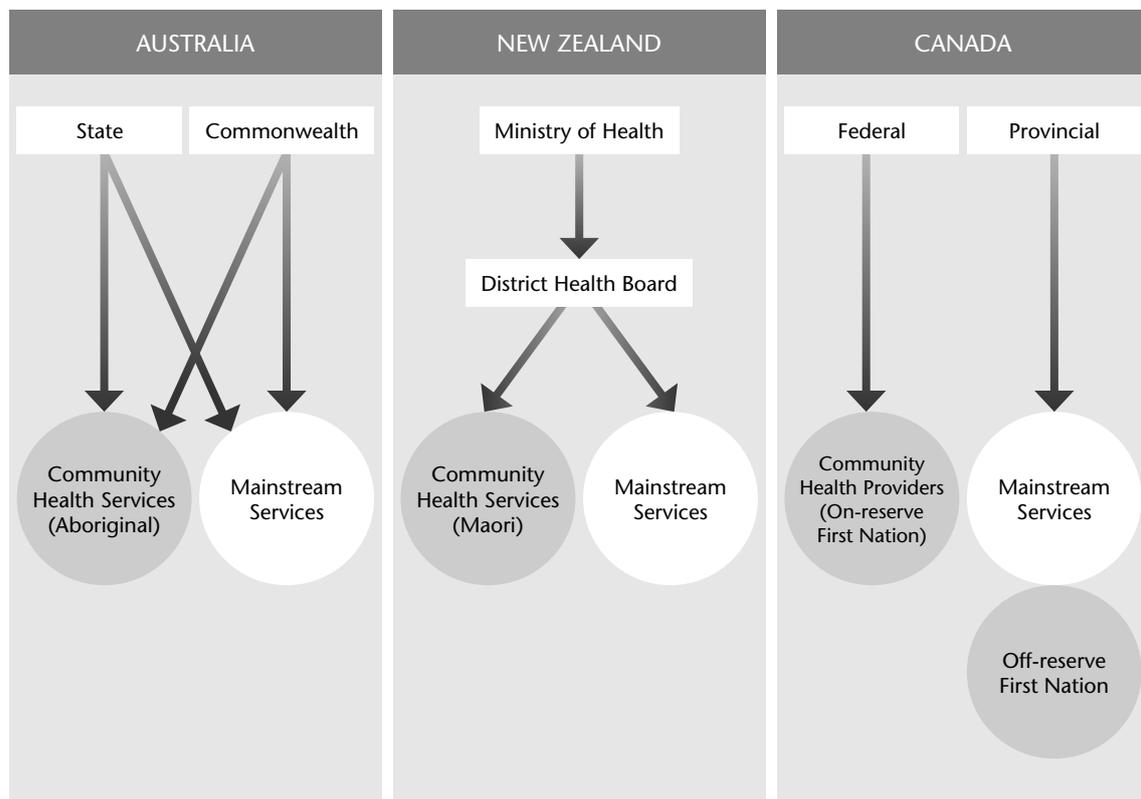
**Table 1:** Indigenous health status in Australia, New Zealand and Canada

| Measure | Australia | | New Zealand | | Canada | |
|---|---|---|---|---|---|---|
| | Indigenous | All | Maori | All | Aboriginal | All |
| Male life expectancy | 59* | 77* | 67.2** | 74.3** | 68.9# | 76.3# |
| GAP (years) | −18 | | −7.1 | | −7.4 | |
| Female life expectancy | 65* | 82* | 73.2** | 81.1** | 76.6# | 81.8# |
| GAP (years) | −17 | | −7.9 | | −5.2 | |
| Infant mortality (deaths/1000 births) | 14.3# | 4.7# | 8.9# | 5.7# | 6.4# | 5.3# |
| GAP (extra deaths/1000 births) | 9.6 | | 3.2 | | 1.1 | |
| Low birth weight | 13%# | 6%# | 8%# | 6%# | 5%# | 6%# |
| GAP (low birth weight %) | 7% higher | | 2% higher | | 1% lower | |

Sources:
* AIHW 2008
**Statistics New Zealand 2008
#Oxfam Australia 2007

There may be many reasons for the greater health gap affecting Australian Indigenous people, of which access to PHC is one major factor (Robert Griew Consulting 2008; Dwyer, Silburn & Wilson 2004). Researchers have also suggested that the lack of a legislative or treaty basis on which to establish responsibility and rights between governments and Indigenous communities is important (Ring & Firman 1998). In Australia both Commonwealth and State/Territory governments can provide direct funding for Indigenous-specific health care, but neither are clearly responsible for this function. We suggest that these are important underlying factors that affect the funding and regulation of PHC services for Aboriginal and Torres Strait Islander people.

# Funding and regulation of PHC in the mainstream Australian system

Governments fund approximately two-thirds of all health care costs in Australia, but only about one-third of total health expenditure is allocated to public sector providers (public hospitals and other community-based services, mostly owned and operated by State governments) (Foley 2008:4). The remainder is spent in the private for-profit or non-government sectors. The Commonwealth Government's share of direct funding goes almost entirely to the private and non-government sectors, partly through the Medical Benefits Schedule (MBS), which reimburses fee-for-service payments to doctors, diagnostic service providers and some other health professionals, and through the Pharmaceutical Benefits Scheme (PBS) to pharmacists for the supply of prescribed medicines. MBS and PBS are *uncapped* fee-for-

service payment arrangements (that is, the annual cost to government is determined by the level of utilisation rather than by a budget cap). Subsidies for private health insurance premiums are another major uncapped cost. Local government plays an important role in many States and Territories, particularly in relation to environmental health. Local government is a small provider of funding to NGOs (Indigenous and mainstream) for health and community services.

The Commonwealth provides grant funding to a few non-Indigenous NGOs directly (such as the Royal Flying Doctor Service and Family Planning Australia). But grant funding accounts for a very small proportion of federal government direct funding. General practitioners and others funded through fee-for-service enjoy some benefits (access to an uncapped scheme where more patient visits translate into more funding and comparatively simple billing and reporting requirements), but they also experience high levels of administrative burden in the processes required for access to the schemes, and for some payment types (Parsons 2003).

One major criticism of the fee-for-service regime is that the reliance on market forces to ensure supply of health care providers does not work in rural and remote areas because the population is too small to support medical or pharmacy practices on the fee-for-service payments. The Commonwealth Government has in recent years introduced some measures that aim to improve the supply of doctors and other health professionals in rural and remote areas (Bartlett & Duncan 2000), but rural and remote Australia remains under-supplied (ABS 2008b).

Some aspects of PHC are provided directly by State/Territory governments, which also fund NGOs through grants or contracts. The pattern varies around the country, but the services funded through one or another of these methods include maternal and child health, mental health, public dental services, drug and alcohol services, community health centres, community rehabilitation and a range of other services to particular population groups.

Mainstream NGOS in some sectors funded by the Commonwealth and State/Territory governments also experience problems of fragmentation of funding and reporting (that is, they are funded by several sources for different aspects of one service) similar to those experienced in the ACCHS sector (Council of Social Services NSW 2008).

The arrangements for funding and regulation of PHC in Australia are generally seen as fragmented and unsatisfactory, and policy attention is turning increasingly to the use of alternative methods of ensuring access to care. The National Health and Hospitals Reform Commission (NHHRC 2008) has recommended sweeping changes that would reduce or remove overlapping government roles, and 'defragment' the primary health care sector by moving all responsibility for PHC to the Commonwealth Government. The National Primary Health Care Strategy also promises to address these problems (DoHA 2008a).

The ACCHS sector occupies a unique position as a predominantly grant-funded major provider of essential PHC to Aboriginal and Torres Strait Islander communities, providing approximately 1.5 million episodes of care to Aboriginal and Torres Strait Islander Australians in 2005–06 (DoHA & NACCHO 2008).

# Study framework and approach

The methods used in this study are presented in detail in Appendix 1. In this section we give a brief overview of the theoretical framework and the approach we took. We set out to investigate the impact of funding programs as implemented in terms of administrative complexity, the burden of funding conditions, and of reporting and accountability requirements, and the effect on health care delivery and on the workforce (recruitment and retention).

## Theoretical framework

The theoretical framework for this study is based on contract theory, particularly the distinction between classical and relational contracts (Macneil 1978). Classical contracting is the traditional model for an exchange of goods or services for money. Relational contracting recognises the interdependence of contractor and supplier, and seeks to maximise the common interests of the parties in the enterprise. In the commercial sphere, this approach has become more common with the move to outsourcing of certain aspects of businesses and is sometimes called *alliance contracting*. The typical features are a long time frame, arrangements for sharing of profits above predicted levels, and risk sharing for the unpredictable aspects of the shared business.

Classical contracts have a clear purpose and short duration. Before entering into the contractual relationship, both actors need to know exactly what will be exchanged, and contracts tend to be specific and detailed. Classical contracts concern discrete transactions and have limited flexibility, as the main concern is the exchange itself. Future interaction and asymmetry of information are not acknowledged in classical contracts. For example, the purchase of fuel from a petrol station involves a short transaction that is limited in scope, is measurable and has no foreseeable future. In contrast, relational contracting is based on mutual interest, flexibility and cooperation, as well as on trust among the actors. Relational contracting assumes that transactions are likely to reoccur, and recognises that the nature of the contracted services makes it difficult to specify and monitor outputs. Relational contracts are, therefore, less detailed in this regard (Palmer 2000).

Classical contracting is more formal and enforceable than relational contracting, due to more explicit specification of terms. Relational contracts more often rely upon self-enforcing mechanisms to guarantee the fulfilment of the contract, as each party wants to maintain its reputation and credibility, as well as good relationships (Perrot 2006).

Both contracting styles are applied in the health sector. Palmer and Mills (2003, 2005) found that contracting in health services is more relational and less formal in situations where there is a lack of competition, and thus there is a degree of mutual dependency between the provider and the purchaser. The purchaser needs the provider to deliver a wide range of health services (e.g. for rural populations, especially when there is no public provider). On the other hand, providers need secure incomes, as the market is limited in rural areas.

When the services to be provided under the contract are broad ranging, contracts are more likely to be relational than when, for example, a specific service such as diagnostic testing is being purchased. Insurance-type purchasers may use more classical contracts as compared to government purchasers. Insurers have defined members and may insure for services that can more easily be specified, and in markets that offer more competition among providers. Government purchasers are more focused on meeting their obligations to provide services for the population, and therefore are more likely to use relational contracts (Palmer & Mills 2003, 2005; Macinati 2008; Parker, Harding & Travis 2000). Experience in New Zealand indicates that maintaining long-term relationships with contracted providers for health services is seen as important, because frequent changing of providers disrupts or prevents the development of trust-based relationships of care, risks interruption of the continuity of service for consumers, and may be costly in terms of staff redundancy and possible legal action or adverse media coverage (WHO 2004). The differences between relational and classical contracting identified in the literature are represented diagrammatically below.

Another type of contractual partnering relationship is known as *alliance contracting*. Alliance contracting was first used in Australia in the 1990s for major infrastructure projects, and since then for many public–private partnering projects. Alliance contracting is based on the principle of risk sharing among participants and a *no fault, no blame approach*

**Figure 2:** Contracting in health—classical versus relational

- Competitive
- Transaction can be specified in advance
- Rigid
- Discrete transaction (short term contract)
- More formal/more legal enforcement
- Less risk sharing
- Auditing is for control

- Negotiation and collaboration
- Difficult to detail transaction in advance
- Flexible
- Long term contract
- Less formal/less legal enforcement
- More risk sharing
- Trust - mutual benefit
- Auditing is for strategic planning

Classical ⟵⟶ Relational

- Urban setting
- Selective service
- Insurance company as purchaser
- Selective member as consumer
- Non-clinical service
- Contracting with private provider

- Rural Setting
- Wide range of services
- Government as purchaser
- General population as consumer
- Clinical service
- Contracting with public institution

to problem solving in the relationship. There are three types of compensation models: cost-based (reimbursement based on provider's cost using an open book approach); a fee for normal corporate overhead and profit; and gainshare/painshare provisions (rewards for good performance and risks of poor performance are shared between participants). In alliance contracting the participants have incentives to focus on what is best for the project or service and on better risk management, and to ensure transaction cost reductions. However, alliance contracting requires more involvement from senior managers than traditional contracts, brings increased risk of decision-making deadlock and needs acceptance of risk by all participants (Department of Treasury and Finance Victoria 2006; Queensland Government Chief Procurement Office 2008).

Alliance contracting is seen as suitable for projects or services where there is uncertainty in the product, where the main focus of the buyer is improvement or breakthrough performance rather than just regular business,

for large projects, and in situations where there is considerable risk (Turner & Simister 2001). Ruuska and Teigland (2008) found that alliance contracting works better in environments where there is a joint problem-solving task, where communication is continuous, and where alliance members have the capacity to resolve conflicts through discussion to each participant's satisfaction. This approach is essentially relational contracting, and Australian governments have considerable existing experience in its use (although largely not in the health sector).

Building on the work of Williamson (2000), Macneil (1985, 2000) and Lavoie *et al.* (2005, in press), we have adopted a framework that distinguishes between classical and relational contracts. The framework contrasts relational and classical contracts in terms of the nature of funding, the priority-setting process, monitoring, transaction costs and risks, and is summarised in Table 2.

**Table 2:** Contract characteristics

|  | Classical contractual environments | Relational contractual environments |
|---|---|---|
| **Description** | Organisations access funding for programs through a number of separate classical contracts to fund a complement of primary health care services | Funding agency engages with a provider in a long-term flexible contract to fund a core set of ongoing primary health care services |
| **Nature of funding** | Short-term, competitive, unstable from year to year | Long-term, non-competitive, population-based, stable |
| **Priority setting** | Funder allocates funding to meet nationally defined priorities | Promotes priority setting based on the pattern of needs experienced by patients and their relationship with the provider |
|  | Funding agreements focus on individual interventions (e.g. immunisations) or single activities (e.g. workshops) | Promotes comprehensive primary health care and population approaches (e.g. prevention, health promotion, primary care treatment and rehabilitation services) |
| **Monitoring** | Explicit output requirements facilitate contract monitoring for single contracts | Contract monitoring more challenging for purchaser and costs may offset transaction cost savings |
|  | Reporting requirements associated with multiple contracts are onerous | Reporting requirements can be lower |
| **Transaction costs** | High administrative costs associated with a single contract are compounded with multiple contracts | Relational contract carries lower transaction costs for both the funder and provider, may be partly offset by relationship-building and negotiation costs |
| **Risk** | Higher financial risk for the provider, who bears the responsibility to secure and acquit funding | Considerable management risk for purchaser in case of non-performance, and viability risk for the provider if the contract is not renewed |

Source: Lavoie, Boulton & Dwyer (in press)

## Contracting and accountability

Macneil's theory of relational contracts reframes the contract as 'relations in which exchanges occur' (Macneil 2000:878). What Macneil acknowledges is that contracts do not occur in a social and relational vacuum. Rather, contractual relationships are best understood as extensions of social relationships. In this context, the contract becomes a microcosm of the overall relationship between the funder and the provider, with the relationship generally articulated through contractual provisions for accountability. These requirements make accountability visible in public administration. But accountability is also about power and the discharging of responsibility *between* stakeholders, in this case the state and indigenous organisations. In the indigenous context, accountability is about social relations inscribed and informed by a legal framework, macro-policy statements, history and localised understanding.

Hughes Tuohy (2003) suggests that accountability requires three things: the identification of responsibility; the provision of information; and the availability of sanction. She discusses how through much of the twentieth century, the role of the state has been that of a 'principal' in a trust-based principal–agent relationship. Decisions over the provision of care by non-government

**Table 3:** Dimensions of accountability

|  | Classical contractual environments | Relational contractual environments |
|---|---|---|
| **Political accountability** | Related to the broader context of credibility and trust, and carries intangible indicators | Purchaser to government<br>Provider to purchaser<br>Provider to clients |
| **Reciprocal accountability** | Ensured through an appropriate dispute resolution process and third-party monitoring | Between purchaser and provider |
| **Performance accountability** | Monitoring of contracted output based on established standards where stated, and resulting impact on outcomes | Purchaser to government<br>Provider to purchaser<br>Provider to clients |
| **Financial accountability** | Appropriate and prudent use of public funding | Provider to purchaser |

Source: adapted from Cumming & Scott 1998 and Hughes Tuohy 2003

providers, mainly physicians, were based on trust and the delegation of authority. The shift to contract-defined relationships associated with *New Public Management* has reshaped the role of the state from a trust-based delegation to that of contract monitoring first focused on deliverables (outputs) and, increasingly, on the reporting of a variety of performance indicators (results and outcomes) that can be audited to ensure quality in care provision. In the process, the state is increasingly defining how care should be provided.

Table 3 highlights four dimensions of accountability. The purchaser requires accountability for the use of public funding. The purchaser also requires performance accountability. An aggregation of providers' performance may be used to inform government on the performance of the overall system, assuming that the performance data available to, or produced by, providers are standardised and can be aggregated in a cost-effective manner. Clients are also interested in provider accountability. Measures of reciprocal accountability ensure that both parties can be held to the terms of the contract. Finally, political accountability is related to the broader context of credibility and trust, carries intangible indicators, and is more closely related to the culture, context, history and tensions influencing decision making in health care.

However, an important aspect of community-controlled organisations is missed in this formal analysis. The community organisations can represent and, in a sense, embody the clients. As Rowse (2005) points out, indigenous people require community-sector organisations to become visible as citizens. These organisations are not simply providers (the intermediary between clients and purchasers). As the representative voice of clients they, themselves, can demand accountability from the government that purchases the services. They have the right to this downwards accountability not only as the representative of citizens, but as the representative of a unique kind of citizen—indigenous people.

Reporting requirements are pragmatic extensions of accountability, generally defined in contracts. The link between accountability and reporting is poorly articulated in the literature. A study undertaken by the Auditor General of Canada (1996:Ch.13) investigated accountability practices from a First Nations perspective. This report considers accountability in the context of reciprocity, discusses the importance of transparency for both parties, and looks at obligations as a mechanism to foster better understanding and trust. The report highlights the distinction between performance and financial reporting to serve government needs and the same to serve community needs, noting that the format, if not the message, is necessarily different. It also suggests that responsibility in reporting should be aligned with capacity, but does not define the relationship between government needs for

accountability and reporting requirements. The report was exploratory in nature and did not attempt to offer pragmatic solutions.

Current trends in accountability seem to require the elaboration of information systems that can inform on the performance of individual providers and, once performance indicators are aggregated, on the overall performance of the system. The realisation of this objective is, however, complex and costly (Light 2001). In Australia and internationally, there has been significant work in recent years towards the development of meaningful and theoretically informed performance indicators at the level of the health system (e.g. WHO 2000; Canadian Institute for Health Information & Statistics Canada 2000; National Health Performance Committee 2004), including for indigenous health (AHMAC 2006). There has been less attention to the development of indicators that are useful to *providers* of health care and can also be aggregated to generate information on the performance of the overall *system* (e.g. Sibthorpe 2004).

The slim but growing literature on quality in health care purchasing appears to support the development of provider-driven, and therefore provider-appropriate, standards of quality in service delivery (Buetow 2004; Crampton *et al.* 2004; Gross 2004; Ovretveit 2003). This is recommended as a cost-effective and appropriate answer to purchasers' concerns that also protects the need for services to remain responsive to local needs in service delivery.

## Project methods

We received ethical approval for this project from the Flinders University Social and Behavioural Research Ethics Committee, and the Aboriginal Health Research Ethics Committee of South Australia.

We searched government websites for funding program guidelines and funding policies in relation to PHC funding for ACCHSs. Other documentation was collected from government websites, health authorities, and ACCHSs and their peak bodies. These include 2006–07 annual reports and financial statements, as well as some 2006–07 and

2007–10 Office for Aboriginal and Torres Strait Islander Health (OATSIH) and State/Territory contractual agreements. These documents were analysed to generate an overview of the policy and program environment in each jurisdiction and to guide interviews and other project data collection and interpretation.

We interviewed 20 senior officers responsible for Aboriginal and Torres Strait Islander health policy and funding in most States and Territories and the Commonwealth Government. We sought to construct both a description of the current funding and regulation of PHC providers from their perspective, and an understanding of the major areas of successes and challenges.

In order to gain an understanding of the experiences and perspectives of PHC providers, we also interviewed 23 Chief Executive Officers (CEOs) and finance staff of a sample of ACCHSs around the country. With the help of State/Territory peak bodies, we purposefully selected staff from a range of locations (urban, rural and remote), and from large and small, and new and established agencies.

We audio-recorded the interviews, and transcribed them. The interviews were then analysed to identify common ideas or themes—that is, the factual information and ideas and opinions in the text were extracted, grouped and analysed for their meanings.

Given the nature of the study, maintaining confidentiality for those we interviewed (particularly those in government departments) is difficult. We discussed this problem with all participants, and explained that we would take great care in our reporting of the interviews to avoid giving clues. All interviewees recognised and accepted the reality of this problem.

We used the financial reports of a sample of 21 ACCHSs to do a financial analysis of their government income in 2006–07. We collated this information to improve our understanding of the complex ways in which ACCHSs are funded, and to identify how the situation might be improved.

The results are presented in the following sections.
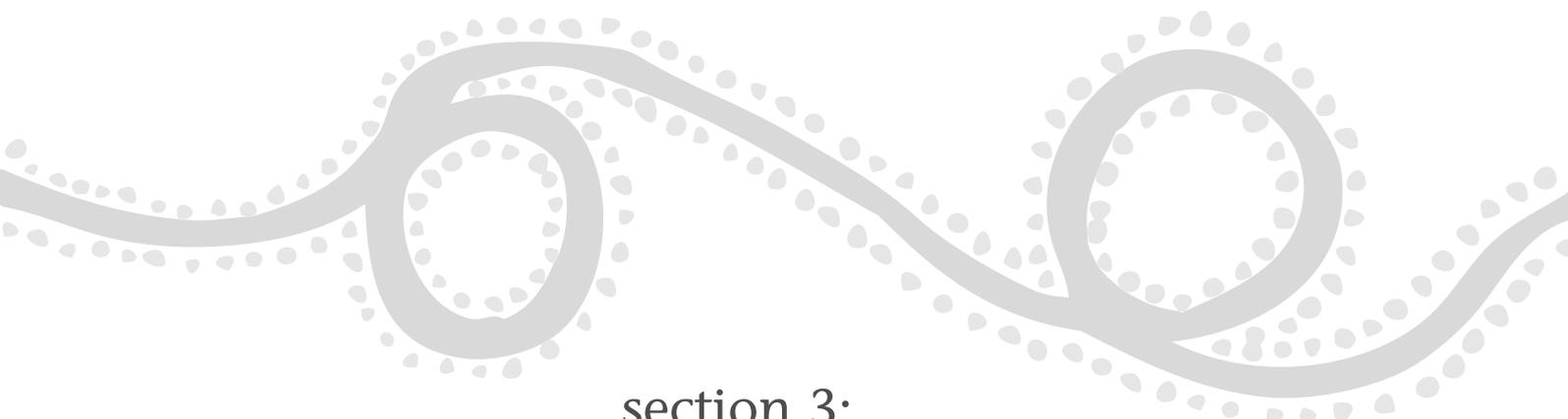
## section 3:
# Current Government Funding and Regulation Practice

In this section we summarise the funding practice and regulatory structures of State, Territory and Commonwealth health authorities in relation to ACCHSs.

Based on detailed analysis of a sample of ACCHSs (See Section 4), we estimate that the bulk (approximately 80 per cent) of PHC funding to ACCHSs is provided by the Commonwealth Government, including 63 per cent from the Department of Health and Ageing (DoHA) through OATSIH, which provides funding to virtually all ACCHSs in Australia. Within DoHA, OATSIH has operational responsibility for policy development, funding allocation, contract management and reporting for services for Indigenous health, including services provided by ACCHSs and mainstream providers of Indigenous-specific services. However, other divisions of DoHA (such as the Ageing and Aged Care Division) also provide funding to ACCHSs, along with other Commonwealth departments.

In contrast, most State and Territory health authorities provide relatively smaller amounts of funding to ACCHSs from several different program areas or divisions within the authority. Decisions about allocation of funding are generally made in program branches (e.g. community services,

disability, mental health, ageing, acute care etc.), but funding is generally delivered through corporate finance or procurement divisions that are responsible for contractual arrangements with the non-government sector. ACCHSs also receive funding from other government departments, such as those responsible for justice and children.

Most State and Territory health authorities have multiple funding programs (each with their own program guidelines and specific activity reporting requirements), but unified financial guidelines. Service agreements or contracts are often constructed so that there is one agreement but several *schedules* (sections attached to the agreement that specify the amounts and purposes of different program grants, and the data about the funded services or activities that are required). During the year, if there is a change in the amount of funding to be provided, variations to the service agreement are issued, and they become part of the agreement.

In most States and Territories, tripartite regional forums (with representatives of OATSIH, the jurisdictional health authority and the Aboriginal and Torres Strait Islander health sector) are convened to plan and develop health services for the communities.

**Table 4:** Major funding categories

| Length of funding commitment | |
|---|---|
| Ongoing | Funding that is assumed to continue unless a decision is made to cease (also referred to by funders and service providers as *recurrent*) |
| Medium term | Funding allocated for three to five years |
| Short term | Funding allocated for less than three years |
| **Purpose** | |
| Core operating | Funding for PHC delivery, administration, rent etc., including relevant salaries and goods and services |
| Health program | Funding for a specific health intervention or health promotion activity, sometimes defined as *body part* funding (e.g. ear health, cervix screening) and sometimes for other specified health programs (e.g. home support for people with chronic illness) |
| Project | One-off funding to buy equipment, meet a priority training need, for capital projects, or to trial new initiatives or meet urgent care needs |

We were able to obtain some model or actual service agreement forms and associated funding guidelines from most State/Territory and Commonwealth health authorities. These were analysed to identify funding program lines, purpose and eligibility requirements, funding timeframes, allocation processes, reporting requirements, and auditing and dispute resolution procedures. These sources were checked in interviews with health authority and ACCHS staff, and augmented with information from government websites.

# Funding categories

Because the funding arrangements are complex, it is necessary first to specify the major characteristics of funding types we observed. The categories of funding programs shown in Table 4 were derived from government websites and publications, as well as from commissioned reports, and were tested and refined in discussion with interviewees. They categorise funding according to two factors: length of funding commitment (ongoing, medium term or short term) and purpose of funding (core operating, health program and project).

The policies and practices vary among jurisdictions, and a brief summary of each (as at the time of writing, early 2009), is presented below.

# Australian Capital Territory

**Total population:** 334,200; **Indigenous population:** 4000 (1.2 per cent)

There is one ACCHS in the Australian Capital Territory that receives funding from ACT Health in the form of a service funding agreement managed on behalf of ACT Health by the Aboriginal and Torres Strait Islander Health Unit. The ACCHS also receives grant funding from other branches of ACT Health and other ACT government departments. The Aboriginal and Torres Strait Islander Health Unit leads the funding negotiation process, is the point of contact for the ACCHS, and acts as a broker and collector of reports. Thus, the unit is responsible for collecting program reports on behalf of other areas within ACT Health that also provide funding to the ACCHS. The ACCHS is also directly funded by the Commonwealth through OATSIH. ACT Health began a three-year funding cycle in 2004.

Distinctive features of funding in the Australian Capital Territory are:

• one ACCHS

• three-year single funding contract since 2004

• consolidated distribution, liaison and reporting line for program funding (but not all grants) through the Aboriginal and Torres Strait Islander Health Unit.

# New South Wales

**Total population:** 6,817,200; **Indigenous population:** 148,200 (2.2 per cent)

There are 53 ACCHSs operating in New South Wales that are funded by NSW Health. Several branches within the Department of Health provide funding to NGOs (primarily ACCHSs) to deliver PHC services to Aboriginal people. NSW Area Health Services (the regional bodies responsible for delivery of public health care in New South Wales) also provide some funding to ACCHSs.

Funding is coordinated through the relevant program branch, with financial administration through the Department of Health's Finance and Business Management Branch. New South Wales uses one- to three-year funding contracts, with three-year funding made available to ACCHSs that demonstrate high capacity and a low-risk approach to management.

The Centre for Aboriginal Health (within the Department of Health) and OATSIH have agreed that all funding provided by both agencies to ACCHSs will be encapsulated in one three-year Funding and Performance Agreement using the OATSIH Service Development and Reporting Framework (SDRF) as the basis (more information about the SDRF is given in the national government section below). This is seen as a way to decrease the administrative burden and additional cost incurred by both the ACCHSs and the department, as well as a way to directly involve the ACCHSs in planning for comprehensive service delivery, management, linkages and coordination, and community involvement. It is also intended to improve communication and interaction between branches within the department and with OATSIH, and to facilitate development and evaluation of key performance indicators across similarly funded programs (whether New South Wales or Commonwealth). Finally, the arrangement is intended to provide for detailed yearly planning within triennial funding periods, and improve timeliness of grant approval processes.

Distinctive features of funding in New South Wales are:

- one- to three-year funding agreements with schedules for separate grants and six-monthly financial and activity reporting

- a long-held plan to move to unified Commonwealth/State funding agreements.

# Northern Territory

**Total population:** 210,700; **Indigenous population:** 66,600 (31.6 per cent)

There are 16 ACCHSs in the Northern Territory. The Northern Territory Department of Health and Families (DHF) provides funding to nine ACCHSs and directly provides clinical care to some Aboriginal communities. There have been some transfers of clinical services from DHF to ACCHSs, and vice versa.

Several separate divisions and program branches within DHF allocate funding for different services, and it is distributed by the Financial Services Branch. DHF has moved from one- to three-year single contracts with separate schedules for specific programs. Single contracts have replaced the previous practice of separate contracts for different program funding grants. Financial and activity reporting is required every six months.

Two ACCHSs, Katherine West Health Board and Sunrise Health Services, have negotiated three-year tripartite agreements between themselves and the Northern Territory and Commonwealth governments. Under Phase Three of the Northern Territory Intervention, the Northern Territory government is working with Aboriginal organisations and OATSIH (through the pre-existing Regional Planning Forums) and moving towards pooled funding to create regional ACCHSs as single providers for defined regions, similar to Katherine West and Sunrise.

The Northern Territory Aboriginal Health Forum, a collaboration between the Aboriginal Medical Services Association of the Northern Territory and its member

organisations, DHF and OATSIH, has developed a jurisdiction-wide system for reporting key performance indicator data on Aboriginal health. Data delivery commenced on 1 July 2008.

Distinctive features of funding in the Northern Territory are:

- a move from one- to three-year funding agreements and six-monthly financial and activity reporting

- transfer of some clinical primary care services from DHF to ACCHSs and vice versa

- three-year tripartite funding agreements with Katherine West Health Board and Sunrise Health Services, and a move towards funding single regional ACCHSs with a view to extending pooled funding to other providers.

# Queensland

**Total population:** 4,091,500; **Indigenous population:** 146,400 (3.6 per cent)

There are 25 ACCHSs in Queensland, many of which are funded by Queensland Health. Traditionally, Queensland Health has itself undertaken direct delivery of clinical primary care in rural and remote Aboriginal communities, with OATSIH funding small ACCHSs in those communities to deliver non-clinical services only. Larger ACCHSs in urban and regional centres are funded by OATSIH for comprehensive PHC services and may also attract funding from Queensland Health for particular programs.

Queensland Health funds the non-government sector, including ACCHSs, largely through its Health Services Purchasing and Logistics Branch, and is moving from one- to three-year funding contracts with separate performance schedules. Performance reporting (i.e. reporting against service targets) is required every six months, and financial and activity reporting is quarterly. ACCHSs also receive funding from other departments of the Queensland Government.

A long-term agreement has been signed between Queensland Health, OATSIH and Apunipima (the ACCHS for the Cape York region), which will enable the transfer of clinical services from Queensland Health to Apunipima over some 10 years.

Distinctive features of funding in Queensland are:

- direct delivery of Indigenous-specific clinical primary care by Queensland Health in rural and remote Aboriginal communities

- a move to three-year funding contracts with six-monthly performance reporting and quarterly financial and activity reporting

- funding by OATSIH of small ACCHSs in rural and remote communities for non-clinical care only

- experimentation in Cape York through a long-term transfer agreement between Apunipima ACCHS, OATSIH and Queensland Health.

# South Australia

**Total population:** 1,568,200; **Indigenous population**: 26,000 (1.7 per cent)

There are 10 ACCHSs in South Australia funded by the Department of Health. The Aboriginal Health Division is responsible for policy and coordination, but no longer directly funds most services (the exceptions being the peak body, the Aboriginal Health Council of South Australia, and two specialised services). Remaining ACCHSs receive funding through mainstream regional health services, using procurement processes that apply to all NGOs funded by SA Health. Contracts are uniformly for one year, with an intention to move to three-year funding agreements. SA Health uses a single contract with several schedules.

Distinctive features of funding in South Australia are:

- one-year contracts with schedules and six-monthly financial and activity reporting

- the intention to move to three-year contracts.

# Tasmania

**Total population:** 489,900; **Indigenous population:** 16,900 (3.5 per cent)

There is one ACCHS in Tasmania that provides regional clinics and is funded by OATSIH. The Tasmanian Department of Health and Human Services employs an Aboriginal Health Policy Officer.

A distinctive feature of funding in Tasmania is:

- the State government does not fund ACCHSs.

# Victoria

**Total population:** 5,128,300; **Indigenous population:** 30,800 (0.6 per cent)

There are 34 Aboriginal community-controlled organisations funded by the Victorian Department of Human Services (DHS), approximately 20 of which provide a broad range of PHC. DHS has recognised the complexity of funding arrangements for ACCHSs and, following a comprehensive review, has recently made a commitment to reduce the number of separate funding lines and to simplify reporting arrangements (to align more closely with OATSIH reporting). Implementation is planned to occur progressively during 2009–10.

Within DHS there is a Koori Human Services Unit, which takes a policy and coordination role, but is not the provider of funding to ACCHSs. Funding is allocated by program divisions within the department, and then distributed through eight regions. The

regions enter into service agreements with service providers. An officer in each region is charged with negotiating and maintaining an overview of the multiple funding lines provided to each NGO in his or her region. The department is also reviewing its internal arrangements of roles and responsibilities for Aboriginal affairs, with the intention of improving its way of working with Aboriginal organisations.

Contracts are for one or three years, with six-monthly financial reporting and quarterly activity reporting.

Distinctive features of funding in Victoria are:

- a mix of one- and three-year single funding agreements with schedules, and six-monthly financial reporting and quarterly activity reporting

- the role of regions in liaison with ACCHSs

- the DHS review and commitment to reducing the complexity of funding and reporting for ACCHSs, and improving its internal arrangements for working with Aboriginal organisations.

## Western Australia

**Total population:** 2,059,000; **Indigenous population:** 77,900 (3.8 per cent)

There are approximately 20 ACCHSs located in diverse settings across Western Australia, with 16 funded by the Western Australian Department of Health through the Office of Aboriginal Health (OAH) from a range of seven funding programs. OAH has a specific PHC program budget and purchases services from the non-government sector. ACCHSs also receive funding from the Drug and Alcohol Office within the Department of Health and from the Department for Child Protection and the Department for Communities.

There is a mix of one- and three- to five-year funding contracts. WA Health intends to move to three- to five-year contracts depending on satisfactory reporting and

compliance. Financial and activity reporting is six-monthly. There are two reporting templates currently in use, including one developed by OAH. OAH is working with OATSIH towards a single reporting framework, based on the OATSIH SDRF, although separate financial reports will continue to be required for acquittal purposes. Key performance indicators are being reviewed to make them more focused on outcomes.

Distinctive features of funding in Western Australia are:

- a mix of one- and three- to five-year funding agreements, with six-monthly financial and activity reporting

- OAH within the Department of Health manages funding to ACCHSs

- progress towards a single activity reporting framework for both WA Health and OATSIH based on the OATSIH SDRF.

## Commonwealth Government

In contrast to the situation in most other jurisdictions, OATSIH carries responsibility for both funding and policy for Indigenous PHC. It provides direct funding for Aboriginal and Torres Strait Islander PHC and related purposes to 245 agencies, 80 per cent of which are Indigenous-specific, and 20 per cent of which are mainstream agencies providing Indigenous-specific services (OATSIH 2008).

The total number of ACCHSs (i.e. those whose mandate focuses on the provision of PHC) across the nation is approximately 150 (145 in 2008). Funding is also allocated to ACCHSs by other divisions of the Department of Health and Ageing and by other federal government departments.

OATSIH is progressively introducing a single, comprehensive three-year funding agreement (with separate schedules for discrete funding lines), subject to certain conditions, including

annual submission of an SDRF plan and satisfactory performance against an annually applied Risk Assessment Framework.

The SDRF was developed in 2004 in consultation with the National Aboriginal Community Controlled Health Organisation (NACCHO) and its affiliates 'with the aim to standardise the non-financial reporting requirements of OATSIH funded organisations' (DoHA 2008b:ii). The framework is designed to assist ACCHSs to plan and report effectively on their utilisation of OATSIH funding, and 'to have greater input into how funding should be used to meet local community health service needs' (DoHA 2008b:ii). Activity, outcomes and progress with the agreed strategies are then reported twice a year against the targets in the SDRF. The SDRF covers service delivery, management, linkages and coordination, community involvement and future directions, but not capital works. Organisations may use the SDRF as a single plan for all activities and funding (including that received from other governments) at their discretion. As noted above, in the Northern Territory, New South Wales, Queensland, Victoria and Western Australia, there is movement towards streamlining State and Commonwealth activity reporting for providers through use of the SDRF.

OATSIH introduced the Service Activity Reporting (SAR) Framework in 1997–98 as a way to measure service provider output and to support accountability for funding. Since then, other reporting frameworks have been introduced, including SDRF, the Drug and Alcohol Services Report, the Urban Brokerage Services Report, the Bringing them Home and Council of Australian Governments Mental Health Counsellor Positions Reports, the Health@Home Plus Nurse Home Visits Report, and Healthy for Life Services Reports. OATSIH has signalled its intention to reduce the number of separate collections and improve the efficiency of this regime (OATSIH 2009).

In 2004–05 OATSIH developed a Resource Allocation Model in conjunction with the implementation of the Primary Health Care Access Program (Commonwealth of Australia 2007:41). The model was intended to enable allocation of funds based on Indigenous population and measures of poor access such as low use of mainstream funding through the MBS and PBS. It has been used to guide the allocation of new funds as they become available.

OATSIH has long recognised the concerns of the sector regarding the increasing administrative and reporting burden arising from multiple funding sources. A recent review aimed to streamline reporting, reduce duplication and ensure that data collected are relevant both to the funding body and to the providers (DoHA 2008b).

Distinctive features of national government funding are:

- the role of OATSIH as the main funder of ACCHSs, as well as the focus for policy and program development and funding within the health portfolio

- a single funding agreement with separate schedules for specific program grants and movement from annual to triennial funding

- the intention to move to funding based on regional Indigenous population levels and relative access to mainstream-funded services such as MBS and PBS.

# Summary: Jurisdictional funding characteristics

Table 5 summarises the funding and reporting arrangements and pathways for distribution of funds to ACCHSs, as reported by health authorities in Australian jurisdictions.

**Table 5:** Jurisdiction health authority funding characteristics

| Government | Funding contracts | Reporting | Allocation Pathway |
|---|---|---|---|
| **Australian Capital Territory** | Three years | Six-monthly financial & activity | The Aboriginal and Torres Strait Islander Health Unit distributes funding. The unit manages the majority of service agreements, and is the liaison and reporting line for most program funding. |
| **New South Wales** | One to three years | Six-monthly financial & activity | Several program branches coordinate funding, with financial administration through the Department's Finance and Business Management Branch. NSW Area Health Services also provide some funding to ACCHSs. |
| **Northern Territory** | One to three years OR Three-year tripartite | Six-monthly financial & activity | Several separate divisions and program branches within the Department allocate funding for different services, and it is distributed by the Financial Services Branch. |
| **Queensland** | One to three years | Quarterly financial & activity | Funding is allocated to ACCHSs largely through the Health Services Purchasing and Logistics Branch. |
| **South Australia** | One year | Six-monthly financial & activity | Funding through mainstream regional health services, using procurement processes that apply to all NGOs funded by SA Health. |
| **Tasmania** | | | No State-funded ACCHSs. |
| **Victoria** | One to three years | Six-monthly financial & quarterly activity | Funding through program divisions within the department, distribution through eight regions that enter into service agreements with the ACCHSs. |
| **Western Australia** | One year OR Three to five years | Six-monthly financial & activity | Funding, liaison and service agreement management is through the Office of Aboriginal Health, which has a specific PHC program budget. |
| **Commonwealth Government (OATSIH)** | One to three years | Six-monthly financial & activity OR Quarterly financial & activity | OATSIH is the main funder of ACCHSs with a consolidated focus for policy, funding and program development within the health portfolio. |

Please note that this simplified summary illustrates the typical pattern from the jurisdictional perspective, and masks the complexity for ACCHSs that receive this funding in the form of many different grants, from several different government departments. The complexity for recipients is explored in Section 4.

# Reporting and accountability requirements

This section highlights reporting requirements in three of the four dimensions of accountability outlined in Table 3. The dimension of political accountability is discussed in Section 5.

## Financial accountability

As detailed above, the reporting requirements of different governments and different departments within one government vary. Typically, financial reporting is required every quarter or six-monthly, with audited financial statements annually. Some funding programs require *line* reporting and explanation of variances by line (i.e. information on expenditure on different types of goods and services and salary or wages costs); others require line reporting but no explanation of variances, implying budgetary line flexibility.

## Performance accountability

Activity or performance reporting requirements are similarly mixed. Most funding programs specify reporting of quantitative data about services delivered and recipients and sometimes location. In addition to reporting of activity levels (*heads through the door*), some programs require reporting of clinical and related indicators of effectiveness or health impact (such as proportion of patients with diabetes whose sugar levels are well controlled, or proportion of expectant mothers who receive adequate antenatal care). On the other hand, capital and project grants tend to require narrative reports and/ or progress indicators.

The SDRF is potentially a major step towards a nation-wide standardised accountability template, at least for forward planning and financial reporting. The SDRF seems to be useful as a tool for managers to improve planning and for managers and funders to review the process of service delivery, as well as to increase staff accountability. However the implementation of the SDRF has several limitations. Currently the SDRF is largely used only for programs funded by OATSIH and not for State/Territory or other Commonwealth programs. The development of plans and targets is a complex undertaking, and ACCHSs that are new to this way of working may struggle to articulate realistic plans and targets.

The sector is assisted with reporting and strategic planning by the State/Territory peak bodies, and through SAMSIS (Secure Aboriginal Medical Service Information System). SAMSIS is an initiative of the ACCHSs, funded by OATSIH. It is a repository and report generator that assists ACCHSs to process and report required service data. SAMSIS can generate reports based on aggregated data at regional, State or national level (SAMSIS n.d.).

Our review of the funding program guidelines and contract forms indicated several potential problems, and these were supported by comments from both funders and providers during interviews. Areas of potential or known challenges were:

- duplication of reporting on a single service or activity when it is funded from more than one source

- different data definitions used in reporting requirements of different governments or departments

- different information needs of the providers for purposes of management, decision making and quality improvement, on the one hand, and information needs of funders for accountability and higher level reporting, on the other

- the SAR system and the SDRF tend to duplicate data entry and reporting. The SAR is a basic *head count* of patients seen in clinics, and has provided useful data at the central level and for basic monitoring by ACCHSs.

## Reciprocal accountability

The annual auditing requirements in most of the standard contract forms are in line with current government practice. In 2007–08 OATSIH introduced a Risk Assessment Framework, with a requirement for annual completion and sanctions for poor results. The risk assessments may also be conducted at other times, for example, where there has been a sudden and significant change in the Board and/or management, or where the organisation is being considered for a significant increase in funding from OATSIH (OATSIH 2007). The risk assessment is a standard OATSIH requirement of ACCHSs, and is undertaken in addition to their voluntary participation in Australian national accreditation processes.

The dispute handling provisions in the standard contract forms are similarly in line with generally accepted practice, requiring that both parties work constructively in a spirit of goodwill in the funding and delivery of services and initiate discussions with the other party to resolve concerns in the first instance. If a dispute arises that cannot be resolved, the agreements provide for the parties to take the issue to a higher level for resolution.

Reciprocal accountability for the fulfilment of each party's obligations to the other (one of the four dimensions of accountability) is principally enacted through audit and dispute resolution procedures. The current provisions appear to be one-sided, focusing primarily on the compliance of providers.

## In conclusion

Our review of the funding and regulatory practices of Australian governments confirms the complexity and fragmentation of funding arrangements, and the perceived heavy burden of acquiring, managing, reporting and acquitting funding contracts for both sides of the funding relationship. These problems arise partly from a lack of consistency in the reporting requirements of national and State/Territory government funders. And they are compounded, in the majority of health authorities, by internal structures that separate responsibility for policy and relationship development from responsibility for contract management. Although these arrangements may have other advantages for the health authorities, we suggest that in relation to Indigenous health services they complicate communication tasks and reduce the knowledge management capacity of the funder (i.e. its ability to ensure that information about agencies and funding issues is shared and available to all who might need it).

There is also evidence of general awareness of these problems and a widespread effort to address them. However, it seems that the implementation of intended reforms is slow and patchy, particularly where cooperation between two levels of government, or different government departments, is required.
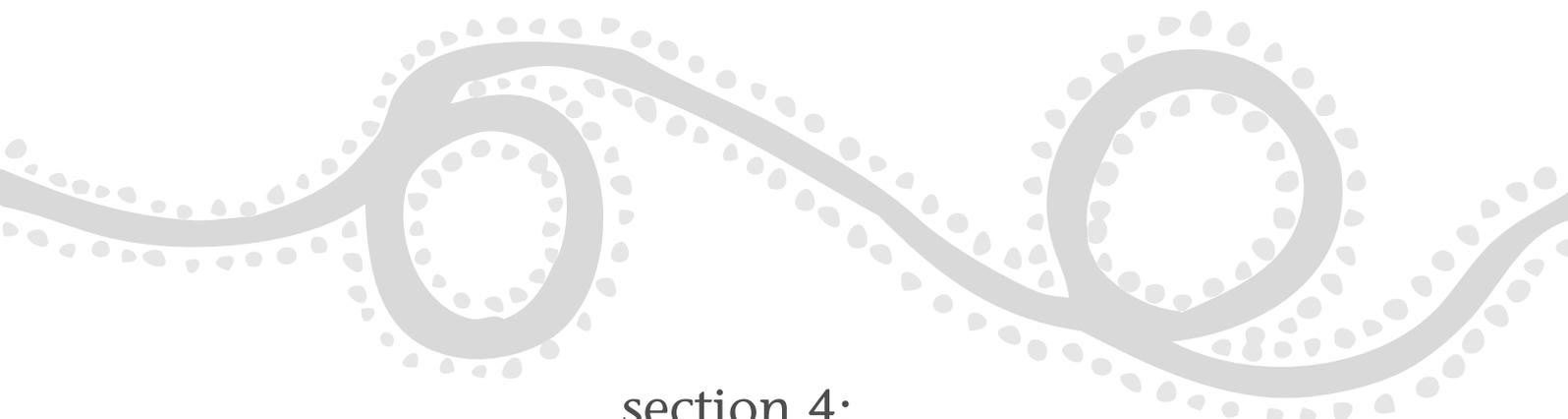
# section 4:
# ACCHS Funding and Income

In this section we report the results of a study of funding received by ACCHSs in 2006–07. This study was conducted to bridge an important knowledge gap, as we were unable to identify an available source of consolidated information about the funding received by ACCHSs.

According to our inclusion criteria (i.e. Aboriginal and Torres Strait Islander community-controlled agencies providing a range of PHC services), we identified 145 ACCHSs across Australia. Table 6 shows the distribution of these agencies, and the distribution of those included in our study sample.

Financial information (audited statements) from 42 ACCHSs was available from the Office of the Registrar of Indigenous Corporations (ORIC). We also collected financial/audit reports for 2006–07 from a convenience sample of ACCHSs that had published detailed financial reports or provided them directly to the project team. Financial reports with limited information about programs, funding amounts and sources of income were excluded from this aspect of the study. We were able to acquire detailed financial statements for the 2006–07 financial year in 21 cases, representing 14 per cent of the total number of agencies.

**Table 6:** ACCHSs providing comprehensive PHC in 2008

| State/Territory | ACCHSs in the sector (n=145) | | ACCHSs in the sample (n=21) | |
|---|---|---|---|---|
| | Number | Percentage | Number | Percentage |
| New South Wales | 53 | 37 | 5 | 24 |
| Queensland | 25 | 17 | 4 | 19 |
| Victoria | 20 | 14 | 2 | 9.5 |
| Western Australia | 20 | 14 | 4 | 19 |
| Northern Territory | 15 | 10 | 3 | 14 |
| South Australia | 10 | 7 | 2 | 9.5 |
| Australian Capital Territory | 1 | 1 | 1 | 5 |
| Tasmania | 1 | 1 | 0 | 0 |
| **TOTAL** | **145** | **101*** | **21** | **100** |

*Error due to rounding

**Figure 3:** Total income of sample ACCHSs



Mean =$5,513,574.89
Std. Dev.=$3,962,174.866
N =21
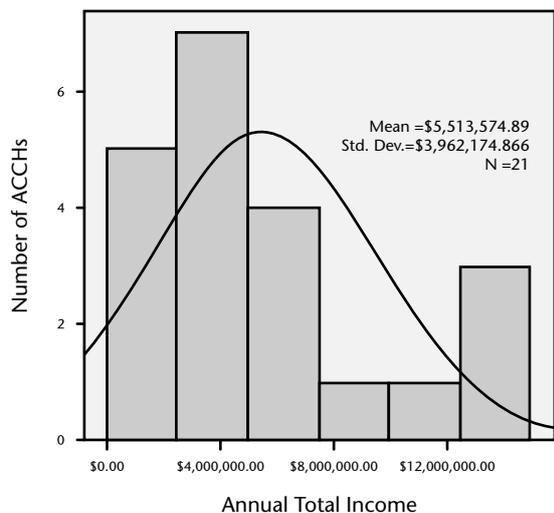
**Figure 4:** Total income of ACCHSs in ORIC reports



Mean =$4,699,467.17
Std. Dev. =$3,713,749.668
N =42
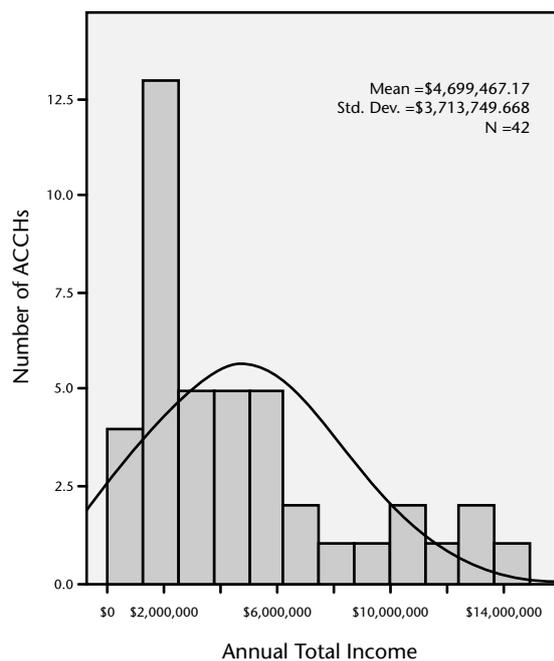
We analysed this information to generate a profile of the scale and complexity of separate allocations received by the ACCHS sector.

The sample is close to being representative of the sector geographically, although New South Wales and Victoria are under-represented (See Table 6). We were also able to compare the total income of the sample organisations with the 42 that had their financial reports for the year 2006–07 on the ORIC website. The sampled ACCHSs have larger average incomes than those reporting on the ORIC database, although the range is similar (see Figures 3 and 4).

Income from internal businesses, membership fees, grants carried forward from the previous year, and income without a clear source of funding (such as sundry, miscellaneous or recovered costs from project funding) were excluded from the data. The source of income was then categorised as being either Commonwealth, State/Territory, local government or other (donations and other NGOs). Programs or projects reported by ACCHSs were categorised as health service, community service, or infrastructure and support (capital, management, human resources (HR) or information and communication technology (ICT)). The distinction between health service and community service is sometimes difficult to make, but we included it because of some important observed differences in the funding processes.

# Amount and range of funding to sample ACCHSs

More than half the ACCHSs in the sample reported income of between $1 million and $2 million, comparable to the ORIC sample. The *average* amount of income reported was about $5 million, slightly higher than in the ORIC sample (by 17 per cent). The income profile of the sample ACCHSs is shown in Figure 3 (ranging from just under $600,000 to $14 million), virtually the same as the ORIC sample (see Figure 4).

The number of separate funding grants received by ACCHSs in our sample ranged from six to 51, as shown in Figure 5, with an average of 22 funding grants per ACCHS.

This complexity in number and types of grants used to fund ACCHSs could theoretically be typical of the situation for those NGOs in Australia funded by government for health and other services. Although we have not found any national data that compare ACCHSs and mainstream providers, the following graph illustrates an analysis on this question conducted by DHS

Victoria in 2005/06. DHS compared the types and amounts of funding that it allocated to Aboriginal, community health, non-government and local government agencies. Different types of funding are categorised as *activities*, and the numbers of different types of activities are shown on the horizontal axis. The vertical axis shows the total amount of funding in dollars for those activities. This analysis demonstrates that, dollar for dollar, Indigenous agencies provide a broader range of services and face a higher administrative burden than mainstream agencies.

**Figure 5:** Number of grants reported by each sample ACCHS
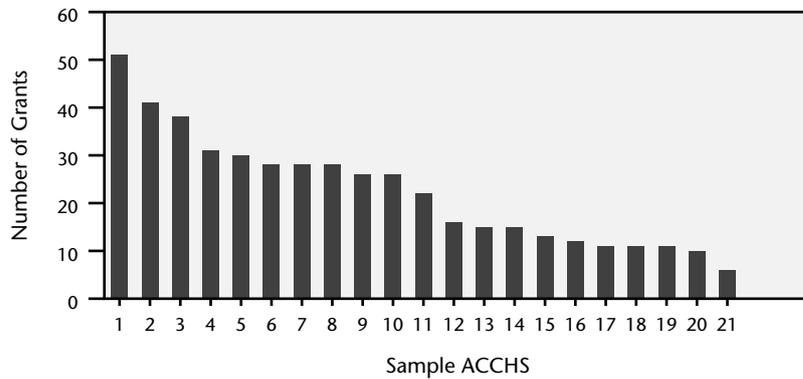


**Figure 6:** Activity funding to Aboriginal and other agencies (DHS Victoria)
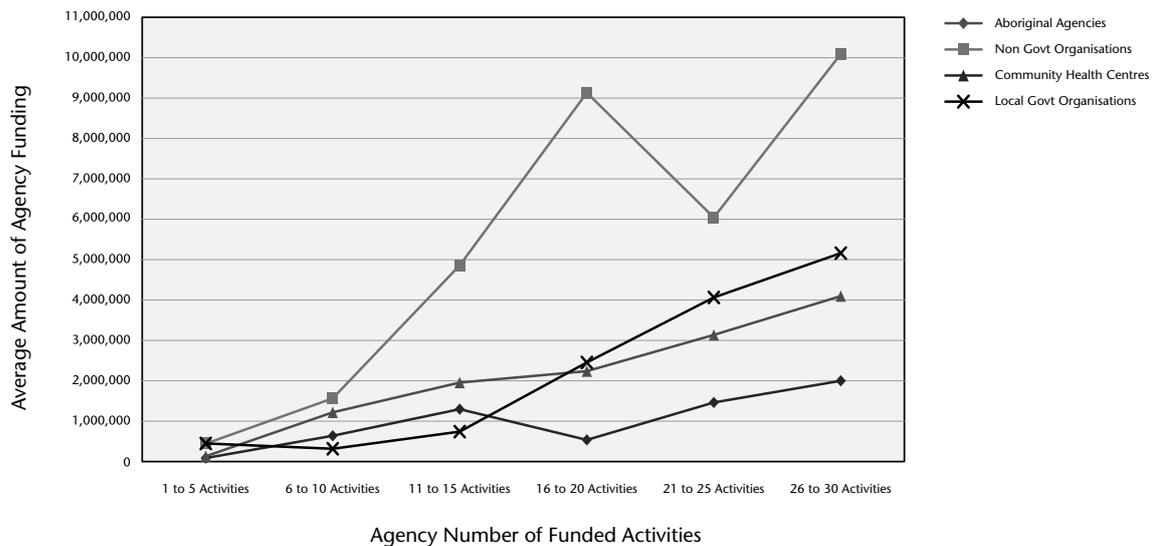


Source: Data supplied by DHS, Victoria, and used with permission. The graph was produced as part of the department's efforts to improve the way it works with Aboriginal community-controlled organisations.

Note: An *activity* is a type of service, regardless of how much of that service is funded.

# Sources of funding

In 2006–07 about 80 per cent of *total funding* to sample agencies was provided by the Commonwealth, with 19 per cent coming from States and Territories and the remaining 1 per cent from local and non-government sources. The *number of separate funding grants* received by ACCHSs ranged from six to 51, with 66 per cent of programs being funded by the Commonwealth and 29 per cent being funded by States/Territories (see Figures 7 and 8).

The Department of Health and Ageing and the Department of Families, Housing, Community Services and Indigenous Affairs are the top two Commonwealth funding departments. About 70 per cent of total grants were funded by these departments. Some Commonwealth departments, such as the Department of Sport and Recreation, allocated funding from just one program. Others, such as the Attorney General's Department and the Department of Education, Employment and Workplace Relations (DEEWR), supported between two and 20 programs.

On average, Commonwealth grants were larger. Some program allocations were very small, with 2 per cent of health and non-health program grants to ACCHSs in our sample being for amounts of less than $1000, mostly for one-off purposes. A further 13 per cent of allocations were between $1000 and $2000. As shown in Figure 9, and consistent with the findings of the *Red Tape* report (Morgan Disney and Associates 2006:44), nearly 60 per cent of programs allocated less than $100,000 to agencies in the sample. Smaller allocations (less than $100,000) may still bring onerous reporting requirements, and lower compliance from recipients, as demonstrated in a Victorian study of funding to Aboriginal community-controlled organisations funded by DHS (Effective Change 2008:12). Allocations that exceeded $1 million were primarily core funding to operate comprehensive PHC services or to operate nursing homes.

**Figure 7:** Percentage of funding programs by main sources



Commonwealth

State

Local Government

Others
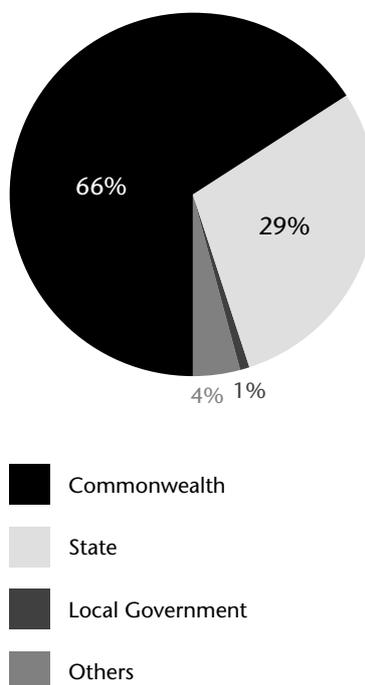
**Figure 8:** Percentage of funding amount by main sources



Commonwealth

State

Local Government

Others
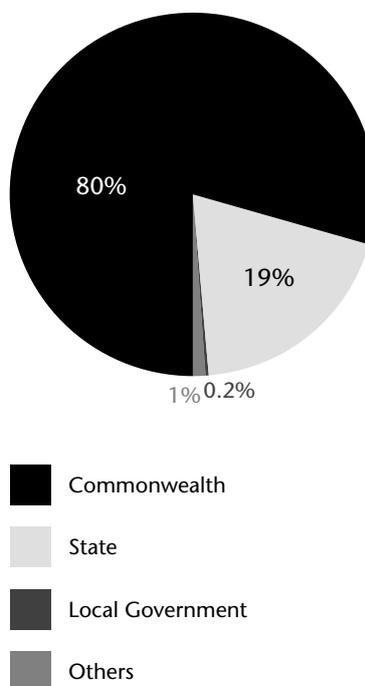
# Range of services/ purposes

Just over half (52 per cent) of the grants (but 71 per cent of total funds) came from health-specific programs, and 30 per cent of grants (but 20 per cent of total funds) were for broader community or social programs. These included grants relating to family violence or family reunion, child protection, child care, youth services, community housing or hostels, cultural or art performances, advocacy, employment support, or assistance for people with financial difficulties. Health grants included community aged care or nursing homes; home and community care; dental services; eye health; hearing health; chronic disease management or prevention, including diabetes and asthma; mental health; sexual health; AIDS or blood-borne diseases; nutrition; women's, children's, adolescent or men's health; substance use; health promotion; and patient transport assistance. Around 16 per cent of grants were designated for infrastructure and support services, such as educational programs for workers or training or incentive payments, or for specific grants for particular operating costs, such as the impact of the Goods and Services Tax. This amount also included capital grants (3 per cent of all program funding) ranging from $3000 to $700,000 for maintenance, new buildings or to buy equipment (Figure 10).

There were 68 different programs from which funds were received by one or more of the 21 agencies in our sample. A detailed list is given in Appendix 2.

Most of the 21 agencies (18) received funding that was identified as core funding for PHC and/or clinical services. The remaining 3 were funded from various specific-purpose programs only. Of those that received core funding, it made up just under half of their total funding (44 per cent) on average, with a range of 14 per cent to 73 per cent.

**Figure 9:** Percentage of grant allocations by amount of grant



- ■ <$1,000
- ▢ $1,000-$10,000
- ▨ >$10,000-$50,000
- ▨ >$50,000-$100,000
- ▨ >$100,000-$500,000
- ■ >$500,000-$1,000,000
- ▢ >$1,000,000
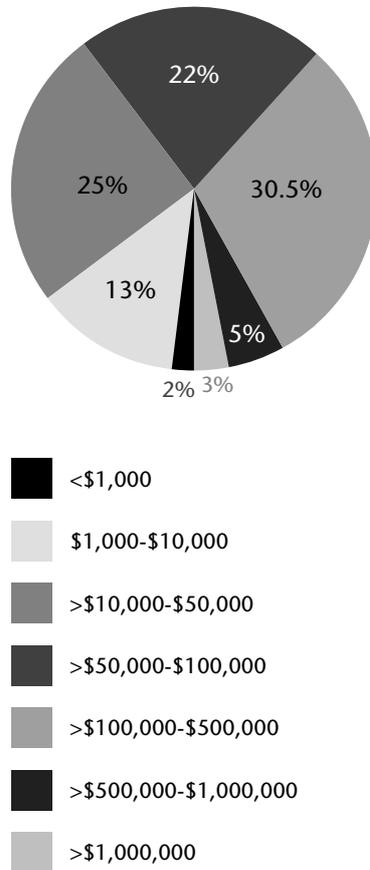
**Figure 10:** Grant categories



- ■ Health
- ▢ Community Services
- ▨ ICT, Capital, Human Resources, Management
- ▨ Other
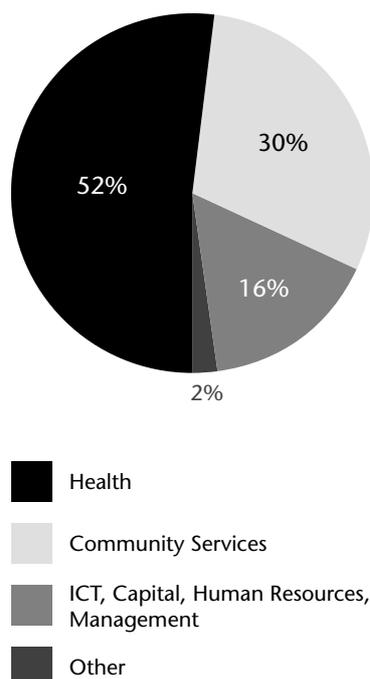
# Ongoing, short-term and one-off funding programs

Security of funding for ACCHSs providing PHC is an important factor affecting their ability to recruit and retain staff, to invest in service development and to plan for future community needs. The current funding regimes are almost entirely constructed as short- to medium-term contracts. But the underlying practice in health authorities and in ACCHSs is often to treat much of this funding as 'ongoing unless…'. We examine the question of funding security in this section.

In our sample it was common for a single health activity to receive ongoing funding, as well as one-off funding (e.g. a mothers and babies program with funding from another source to provide baby gift packs). One activity can also be funded by more than one source, such as when the Commonwealth and a State or Territory provide funding to support the same service (see Appendix 2 for examples). This pattern—the majority of program funding being ongoing in practice, but providers having to contend with yearly funding applications—has also been documented in the Indigenous services field more broadly (Morgan Disney and Associates 2006). The pattern indicates that ACCHSs are active and successful in their pursuit of multiple funding sources. But it also indicates fragmentation of funding, which tends to work against integration of service delivery, and a level of insecurity, which works against confident planning and development.

Funding for programs that constitute what is normally understood to be comprehensive PHC—such as sexual health, immunisation, maternal and child health, hearing, nutrition, chronic disease, eye health, mental health and substance use—was more likely to be regarded as ongoing (as reported by ACCHSs in their annual reports and financial statements). Funding for programs often considered as broader community or social programs (although often still central to comprehensive PHC)—such as those that address family and community issues,

domestic violence, child protection, financial assistance and youth programs—were less likely to be ongoing, as were management services such as ICT support. Cultural or art performance, transportation and quality improvement programs tended to be funded as one-off projects.

Figure 11 shows the breakdown of reported ongoing funding versus one-off funding for the small number of agencies that provided this data (about 37 per cent of all grants reported).

This proportion can be compared to the 89 per cent effectively ongoing or recurrent funding to Aboriginal organisations (including but not limited to ACCHSs) found in the Red Tape report (Morgan Disney and Associate 2006:49) and shown in Table 7 opposite.

**Figure 11:** Ongoing funding versus one-off funding



- ■ Ongoing
- ▢ One off
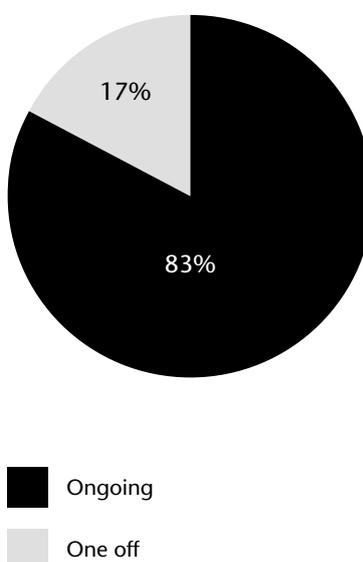
**Table 7:** Funding and allocation categories in the *Red Tape* report

| Stability | Type of program funding grants | Percentage |
|---|---|---|
| More stable funding | **Recurrent:** recurrent grant on formula basis (e.g. for municipal services) | 7% |
| | **Multi-year:** ongoing program with three-year funding allocation and annual budget submission | 16% |
| | **Yearly renewable:** ongoing or multiple year programs with annual application process and one-year funding grant | 66% |
| | **Sub-total:** ongoing or renewable funding | 89% |
| Less stable funding | **One-off:** one-off grants for projects of fixed duration | 10% |
| | Capital grant | 1% |

A Victorian study (Effective Change 2008:16) found a comparable level—a 74 per cent/26 per cent breakdown between ongoing and fixed-term funding. Although there are differences in the terms used in each of these sources, it seems that the majority of funding is effectively (but not contractually) ongoing, provided organisations meet contract obligations in service delivery and are seen to be operating efficiently and effectively. One-off funding seemed generally appropriate in our sample, in that it was provided for genuinely short-term purposes (such as a community ceremony). However, it is likely that smaller ACCHSs, in particular, are more likely to rely on inappropriate short-term funding, and our sample was probably not representative for this problem.

Although both funders and ACCHSs regard much of the annually or triennially renewed funding as effectively ongoing, and act accordingly (e.g. in appointing staff), this situation is acknowledged as problematic. It also raises the question of the value of constructing funding as short to medium term if in reality most of it is long term.

# Conclusion

The data reported above present a picture of a complex funding and contractual environment, characterised by fragmentation and duplication in relation to the purposes, reporting and monitoring of funds and their application to service delivery and corporate support functions. In Figure 12 below, we illustrate the funding aspect of this situation for a typical ACCHS in receipt of funding from 25 different sources, for seven separate services or programs on the ground. Please note that the categorisation of funding at source by governments does not match the way services are delivered in practice, so the financial and activity reporting realities are even more complex.

**Figure 12:** Typical funding to a medium-sized ACCHS



Services of a medium-sized ACCHS
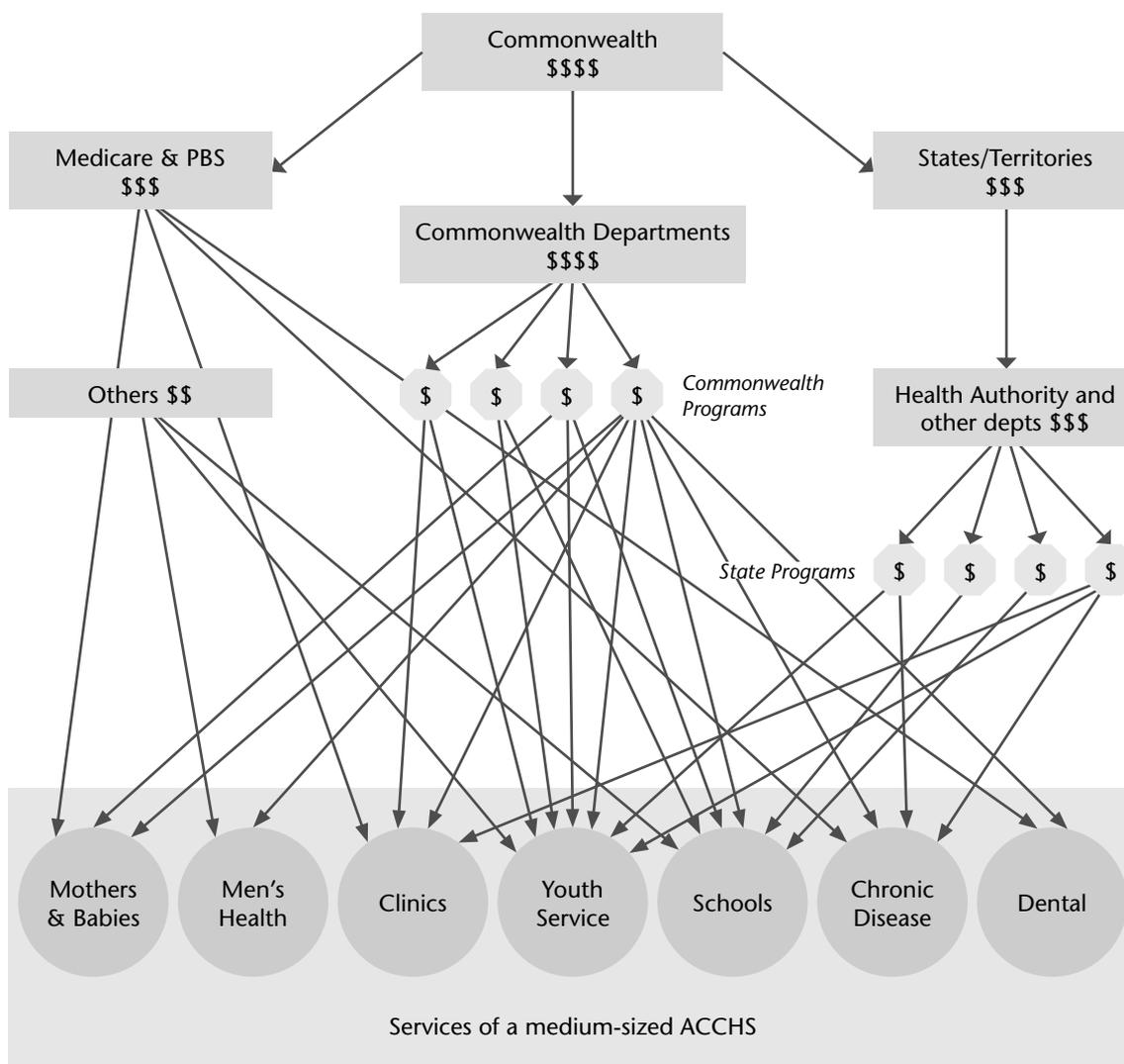
In summary, these data are consistent with previous analysis (Morgan Disney and Associates 2006; Effective Change 2008) and indicate that:

- although core funding for PHC is provided to some agencies, there are many *add-ons* requiring separate contracting provisions, separate accounting and reporting;

- some ACCHSs undertake a very broad range of health and community service roles for their communities, and attract funding from several portfolios;

- there is insufficient adjustment of reporting requirements related to the size and purpose of grants;

- ACCHSs need to devote significant resources to acquiring and managing money, which is likely to be disproportionately high compared to mainstream agencies; and

- the effort required by all parties arising from the construction of virtually all funding as short to medium term, and the lack of security it entails for ACCHSs and their PHC services, may be unnecessary given that most funding is effectively ongoing.

# Perspectives of Funders and Providers

In this section we report on the results of interviews with senior staff of ACCHSs and central health authorities of the national and most State/Territory governments. The analysis of the interview data is organised using headings based on our contracting framework, as shown in Table 2 above, and is informed by the accountability framework shown in Table 3. The interview questions are given at the end of Appendix 1.

Twenty senior staff from national and most State and Territory health authorities were interviewed between February and June 2008. One State chose to respond in writing, and one declined on the basis that the State does not directly fund ACCHSs. Responsibilities of those interviewed varied from PHC policy and strategic planning to management of funding contracts and broad Aboriginal health financial program management. Seven participants had primarily financial roles, and 13 had broader policy or mixed roles. Five staff identified as Aboriginal or Torres Strait Islander.

Between June 2008 and February 2009 we interviewed 23 CEOs and senior finance staff or managers of ACCHSs in most States and Territories. Most (70 per cent) of the CEOs interviewed were Aboriginal or Torres Strait Islander people, while less than half of the finance and management staff (40 per cent) were Aboriginal or Torres Strait Islanders. They worked in ACCHSs that span the full range of size, location and organisational *age*, but overall the agencies represented were somewhat less remote, larger and older.

Each interviewee was assigned a unique identifier. In reporting on our analysis in this section, we show the identifiers to indicate the sources of the data on which the analysis is based (the letter *H* indicates health authority staff and the letter *A* indicates ACCHS staff; *M* indicates a management role and *F* indicates a finance role). Quotes are attributed by identifying the sector and role of the speaker.

# Nature of funding

Health authority staff and ACCHS staff confirmed that funding is complex to acquire and administer, and endorsed the need for simplification and flexibility (14HM, 8HF, 1HM, 6HF, 18HM). ACCHS staff reported that there are too many funding lines, too many service agreements and too much overlap (13AM, 8AM, 12AF):

> There are lots of buckets of money from lots of different programs from the same funder that are addressing the same issues, but with a different name (ACCHS CEO).

Both groups contrasted core PHC funding (funding that enables the operation of clinics, other PHC services, and related support, management and infrastructure services) with program or *body part* funding (funding that is directed to specific activities for specific conditions or health risks). Core funding for comprehensive PHC was seen to enable more independence and flexibility, allowing ACCHSs to continuously implement and adapt programs to meet local needs.

> The actual cost of running and providing a service needs to be taken into consideration. [The agency] provides a lot of community activities, a lot of other things that we don't get funded for… We are transparent. We are accountable to all of our funding organisations. We do justify, but global funding that matches the actual costs of providing a service that we provide on a holistic basis would be the best outcome (ACCHS CEO).

Interviewees spoke about the problem of using condition-specific health program funding to deliver services when core PHC services are not adequately funded:

> unless you've got core primary health care money to deliver the basic minimal level of primary health care, you can't deliver a health service based on programmatic, organ-specific, disease-focused programs because that becomes selective primary health care and unless you've got core primary health care you're never going to be in a position to offer other relevant programs based on the community needs (ACCHS CEO).

> we make assumptions that everybody has access to a point of PHC… We make assumptions that everybody has equal right of access and they don't. We haven't gone in and argued a strategic approach to overcome this challenge (Health Authority Manager).

Although some ACCHS staff reported that program grants can align well with agency activities, so that separate reporting on program grants can be useful internally as well as meeting external requirements (13AM, 2AF, 22AM), there was repeated comment on the problem of integrating funding programs that are focused on specific diseases or interventions with those that are for comprehensive PHC (8AM, 10AM, 20AM), and about the constraints against shifting resources to other areas that are underfunded but important to balance service delivery (2AF, 12AM, 9AM, 3AM).

## Basis of funding allocation

Government finance officers were asked about the basis for determining funding levels, and confirmed that funding for ACCHSs was based on a combination of population (number of people served), historical (based on last year's allocation) and policy or political factors (e.g. in marginal seats in an election year, or when a related policy decision has an impact).

Some health authority staff stated that funding levels for many ACCHSs have not been reviewed for years.

> there's the historical component. One of the challenges is that it's always been there so we don't challenge it and we don't say how can we improve it or what do we need to do to value add in terms of budget increase or better access to services or streamlining the way we do things. Budgets were acquired in a period of substantial growth and what has tended to happen is that Aboriginal health budget allocations have remained reasonably static, partly because we've not taken a strategic approach in developing a business case to argue for an increase in funding proportional to the health need of [Aboriginal and Torres Strait Islander] people. We've tended to take a project-

*focused approach. What we've not done, I don't think, in any of the jurisdictions, is sat down and asked what is the strategic budget we would need for the next five years and then build a strong business case* (Health Authority Manager)*.*

ACCHS staff commented on the tendency for funding program grants not to include funding for essential components of service delivery, such as transportation (9AM, 7AM, 14AM, 2AM, 13AM) and human resources capacity building (3AM, 17AF, 8AM, 11AF), a problem that was also acknowledged by health authority staff (1HM, 16HF, 9HF). The need to allocate components of individual staff salaries to different program grants for the same or like purposes (e.g. different aspects of diabetes care) was noted to be both difficult conceptually (1HM, 2AF) and time consuming (3AM, 1HM, 4AF).

> *When we're dealing with health issues, [we need to determine] how much and what needs to be done to address the issues holistically and yet government provides a piecemeal funding approach* (ACCHS CEO)*.*

Capital funding (e.g. for new buildings) is also complicated. Governments are understandably more reluctant to provide capital funding for assets that will not be owned by the government (9HF). But there is also the problem that lack of clarity about the responsibilities of each level of government means that capital investment decisions must often be made by both levels of government acting together. One health authority finance officer acknowledged a recent significant decrease (by more than 90 per cent) in the capital and maintenance budget, which occurred during the transfer of funding responsibility from one division to another within the health authority.

> *The state government [is] happy to put dollars into mainstream services because they're assets of the Minister. They're not willing to give infrastructure on Aboriginal land because assets would belong to the people* (Health Authority Finance Officer)*.*

## Funding is sustained but uncertain

Both health authority and ACCHS staff affirmed that they see their relationships as long term, even though most funding is allocated annually or for three years. However, uncertainty about the continuity of funding was reported to cause several problems, including periods of operating without knowledge of funding allocations, problems in meeting timelines for the spending of funds, and the effects of uncertainty on planning and operational decision making, on workforce sustainability and on the quality or volume of service provision.

Funders reported that most funding is expected to be ongoing in practice, and that they understand that staff members are often appointed on an ongoing basis (1HM, 2HM). They noted that administrative practices (e.g. arrangements to continue core funding at the beginning of a financial year before contracts were ready) were based on an assumption of continuation. They also acknowledged the problem of insecure funding:

> *There is a reasonable assumption that an ACCHS will receive continual funding but this is not contracted in a way that would make them feel secure* (Health Authority Manager)*.*

Some ACCHS staff acknowledged a role for short-term funding as part of the total funding mix (10AM, 3AM, 1AM) but most reported that short-term funding is problematic because of the amounts involved (8AM, 15AM, 17AF ), the difficulties of recruiting to short-term positions (8AM, 9AM, 2AM, 14AM), the burden of administration and reporting (18AM, 15AM, 3AM), the problem of discontinuing services in the face of community expectations (11AF, 8AM, 13AM, 17AF, 19AF), the difficulty of demonstrating outcomes from short-term interventions, and the problems for planning and strategic direction setting (11AF, 19AF, 1AM, 5AF). Some reported advantages of short-term funding were essentially related to inadequacies in longer term funding (such as its use to fill unfunded gaps in existing services) (8AM, 10AM, 1AM). Other advantages included additional resources to conduct short-term health promotion activities (18AM, 13AM, 10AM, 1AM), to

conduct projects such as evaluations (18AM) or one-off events (16AM), and for developing new local programs (10AM).

Health authority staff generally agreed with the perspective of ACCHS staff, while noting that short-term funding provides greater flexibility for the funder (5HF, 9HF, 20HM). They also endorsed concern about the difficulty of demonstrating outcomes on the basis of short-term funding arrangements, the reputational risk of real or perceived failure, and the problem of 'good work falling by the wayside' (1HM, 13HM). They also commented on the lack of capacity for rigorous evaluation, or long-term planning, the problem of workforce sustainability, the additional reporting burden, and the tendency for short-term funding to require a focus on activity more than outcomes (13HM, 20HM). The shift by OATSIH and some State and Territory governments to three-year funding was noted as a positive step.

## Machinery of government adds to the problems

Health authority finance officers affirmed that it was not possible for their departments to give an accurate account of the funding that ACCHSs receive from their own governments (whether Commonwealth or State/Territory), let alone the other level of government. This may reflect their management focus on specific contracts, but it means that overall monitoring of the adequacy or trends in funding to ACCHS, or indeed for Indigenous-specific services more broadly, is not possible. It also makes it difficult to assess the burden of administration these agencies must carry in the complex contractual environment in which they operate.

Different funding processes and formulae exist across divisions within some State and Territory health authorities. So, for example, indexation (annual adjustment for inflation) may be calculated differently

within and between departments of the one government. These inconsistencies can constitute a barrier to more integrated funding or contracting arrangements, and tend to add to complexity for funding recipients:

*It's a program line and we still fund Aboriginal organisations completely, irrespective of what other government programs are also funding them to do. This can get into a situation where Aboriginal organisations can struggle to cope. They're not doing so well in the programs they've already got. Other program areas aren't necessarily aware of this and overload them* (Health Authority Manager)*.*

Finance staff in most jurisdictions said that new program funding is distributed by the Commonwealth Government to the State or Territory too often and too late, contributing to the problem of timely allocation to ACCHSs, and the pressure to recruit staff and spend quickly.

*The Commonwealth rolls something out every week, it's challenging then for us to put things on the ground… It took a year to get the program funding to us for a three- to four-year program, we've already lost a year before we even get on the ground. We're a year behind in our reporting, a year behind in our achievements, hence we're a year behind in [managing] our under expenditure, or our potential to lose dollars. Because we're behind, the funding to our [ACCHSs] is behind* (Health Authority Finance Officer)*.*

There were several comments from both sides on the problem of late allocation of funding, with ACCHSs continuing to operate on the assumption or promise of allocations. Cash-flow difficulties (5AF, 3AM, 16HF, 21AF), pressure to spend before the end of the contract period (16AM, 5AF) and impacts on operational decisions (9AM, 10AM) were reported, as was the negative impact on capacity to make and pursue longer term plans (8AM, 14AM, 12AM, 15AF, 10AM, 9HF).

*All we want is funding certainty so that we can really start to give some long-term commitments to our programs on the ground* (ACCHS CEO)*.*

The majority of senior officers with responsibility for Aboriginal and Torres Strait Islander health policy who were interviewed had very little direct responsibility for the allocation of funds, or the management of funding contracts, a role that tends to be undertaken either by specific program branches (e.g. acute care, community, disability, mental health etc.) or by centralised departmental contract management or business units in others. In some cases, this is a recent change from a previous structure in which funding, contract management and policy development were united in a branch or division focused on Aboriginal and Torres Strait Islander health. OATSIH is the main exception—it controls the funds, manages the contracts, is responsible for policy development, and acts as the purchaser of services from ACCHSs and mainstream providers. In the jurisdictions, the predominant separation of policy leadership from financial management (sometimes related to current government procurement procedures) may tend to exacerbate the complexity of accountability arrangements (through 'serving two masters').

The practice of requiring funds to be spent by the end of the financial year was seen as a problem by several ACCHS interviewees (9AM, 3AM, 6AF, 17AF). They noted that there are many reasons why funds may be unspent at the end of the year (including delays in funding allocation or in staff recruitment). Such funds may still be required in order to sustain the service in the subsequent year (6AF, 2AF) or to enable ACCHSs to balance unspent program funds and deficits (3AM, 9AM) or to respond to local priorities (13AM).

## Impact on workforce

Funding levels are also seen to impact on the capacity of ACCHSs to recruit and retain staff. Health authority staff recognised that when support and administrative costs (e.g. for transport for an outreach worker) are not included in program funding, the result can be inequitable salary structures. In some jurisdictions, pay differentials result from ACCHSs having a different industrial award from that applying in mainstream health care organisations:

> *a different award means they pay at a lesser rate so we've got this incredible differential which in a sense is unfair because you have two people doing the same work but they're paid different salaries. I suppose it would equate to the argument where men would do the same job as women in the past and there was a gender salary differential, which is problematic* (Health Authority Manager)*.*

About two-thirds of health authority staff said the administration associated with the provision of programs and reporting requirements is not factored into the funding allocated to ACCHSs. Once the ACCHS factors in a percentage (around 20 per cent) to cover administration, the funding is reduced somewhat and the ACCHS is unable to offer salaries commensurate with mainstream salaries.

> *we don't factor that in for ACCHSs. I think, somewhere, there has to be a debate by jurisdictions around the issues that if we fund programs in ACCHSs or in Aboriginal organisations, we need to build in the administration costs because if we don't do this, we tend to rob Peter to pay Paul, which means that we don't offer a salary that's commensurate with the salaries in the mainstream system. If I were to appoint, for example, Otitis Media Coordinators in [State], the salary rate that would be paid to a person in an [ACCHS] would be much less than a person paid within our jurisdictional positioning because at least we have a set of reference points in terms of State awards that apply for any employee working within the public sector* (Health Authority Manager)*.*

The problem of salary differentials was highlighted by several ACCHS interviewees (13AM, 9AM, 16AM, 12AM). They also focused on the effect of short-term program funding on workforce insecurity (14AM, 17AF, 9AM) and the availability of in-service training (3AM):

> We're training good Aboriginal people up in the health work, but obviously the departments and other health organisations are snapping them up and paying them substantially more money, so it's really a difficult journey for retention of staff as well (ACCHS CEO).

# Priority setting

Interviewees identified two main problems with the current use of priority funding programs for specific conditions or interventions. The first concerns the need for an adequate base of core PHC funding, so that targeted funding can be used as intended—to direct more resources to underserved areas, or areas of high opportunity for health gain. As noted above, if the PHC funding base is inadequate or absent, targeted funding tends to be 'patched together' and used to meet demand-driven core PHC needs.

> If I can't find money in a dental bucket then I'm going to find money in a primary health care bucket or a maternal bucket, but it's all primary health care. So that's where I think shoe-horning yourself into specific areas— ears or eyes or kids or adults or renal or asthma or whatever it is—actually becomes more problematic. Little amounts of money, I think, is always hard as opposed to a generic bucket that is primary health care, which is what we do (ACCHS Manager).

Almost all health authority staff recognised a national lack of coordinated strategic approaches to improving access to healthcare for Indigenous people. One suggested the need for a national access and equity policy (1HM).

Three-quarters of the health authority staff said that priorities are set centrally, and based, among other things, on nationally aggregated data that necessarily gloss over local and regional differences. These priorities are set to maximise government resources and to respond to Commonwealth directives more quickly. They noted the lack of a consistent approach within government that is inclusive of ACCHSs in setting these priorities.

The second set of problems relates to the inevitable tension between local and national priority setting. This was noted by several ACCHS interviewees, who commented on the problem of *top down* decisions without consultation on local priorities or without regard to the strategic approach of the organisation (8AM, 7AM, 1HM, 22AM). They noted a lack of consultation with service providers (11AF, 5AF, 12AM, 14AM) and that some of the centrally designed programs are not actually needed by the community (7AM, 8AM).

> So we're never asked our opinion about where—in our community—what might be our priority and how might they fund those, which I suspect would be different all over Australia and so we have these national targets and programs that are developed out of Canberra but we don't know who they consult to get those ideas from (ACCHS CEO).

> I think from a government's perspective their priorities and how they allocate money differs from how we identify what our priorities are, because we do it from the community up; they do it from the politicians down (ACCHS CEO).

ACCHS interviewees commented on their political, performance and financial accountability being both to government and to their communities. Conflicting funding and service priorities can leave ACCHSs caught in the middle (5AF, 8AM), engaged in ongoing consultation with communities to make sure that programs can run smoothly (15AF) and in parallel negotiations with funding authorities.

*Part of the self-determination is to develop this local health clinic, made up of the local Aboriginal people and the senior people they elected by themselves, and generally that works. Occasionally clan priorities come into conflict with what's best for the organisation but nevertheless quite often the health committee will be told by the [State] government what goes and what does not go and yet their charter is to be self-determining and be involved in making their own decisions. So sometimes we have a problem with that* (ACCHS Finance Manager).

However, several ACCHS interviewees reported collaboration or discussion between the funding body and the ACCHS in deciding on programs and approaches (15AF, 10AM, 3AM).

# Monitoring

The need for accountability results in the implementation of monitoring mechanisms. This was recognised as necessary by all participants. However, the nature and volume of the data required to satisfy reporting requirements, as well as the arrangements for their collection and reporting to funders, add considerable transaction costs for ACCHSs and funders. An ACCHS CEO referred to the sense of being regarded both as effective and subject to what the CEO regarded as excessive scrutiny:

*Even with, like, our service getting rewarded, you know… we're the first organisation that OATSIH will look at for anybody to come in and have a look at how we're running our service and stuff… but you're constantly being surveyed, you're being audited…* (ACCHS Deputy CEO).

ACCHS staff commented on a lack of collaboration among State and Commonwealth funding authorities, and the lack of a standard reporting format (6AF, 18AM, 15AM). This is particularly burdensome for activity reporting (6AF, 16AM, 10AM, 12AM, 9AM, 20AM, 7AM).

Line budgeting and the lack of standard templates are seen as major contributing factors (5AF, 17AF, 14AM, 9AM). The move to single funding agreements is welcomed, but does not necessarily reduce the burden of reporting, as separate schedules or numerous variations impede the promised simplicity of single agreements.

One finance officer related a situation where funding for a single service for one target group routinely requires eight reports. The ACCHS serves a local community that crosses over four sub-regions (in two separate regions) as defined by one non-health funder. It runs a service for one target group that reaches two sub-sets of people who are of interest to the department, and therefore the service is funded from two programs. Thus the ACCHS is required to produce eight reports every six months on the finances and activities of the service. The service is not very big (total funding is less than $200,000), and is coordinated by one person. The salary and goods and services costs incurred by this one person are routinely split eight ways. Staff in the funding department know that such precise accuracy is unlikely, and collaborate with the finance officer to agree on ways to avoid some of the absurdities of this situation. The finance officer reports that the routine financial reports are automated and, after setting up, the time taken is not great (except for variations) but the activity reporting is more difficult.

Some health authority staff also acknowledged the need (and indeed pressure) for government to change its reporting regime (10HM, 2HM), to streamline the reporting process and lessen the reporting burden, while also linking funding with meaningful health outcome data (6HF, 14HM, 7HF, 1HM). Health authority staff also acknowledged the problem of inconsistent requirements and timelines between State and Commonwealth government departments, and the failure to consistently adapt reporting requirements when funding amounts are low.

*We actually don't give them a template to acquit the grants, so they make it up or they might just not do it* (Health Authority Manager).

Some ACCHS managers felt that the burden of reporting to State/Territory funding bodies is higher in proportion to the amount of funding (3AM, 17AF). Other concerns for ACCHS staff included 'shifting goalposts', where funding rules and guidelines were changed without notice or negotiation (13AM, 18AM, 11AF).

Some CEOs of ACCHSs felt that they were over monitored, with a focus on financial probity rather than performance or planning (6AF, 9AM, 20AM). Some regretted what they perceived as a reduction in the willingness of funding staff to undertake more positive forms of monitoring, such as site visits, perhaps due to the cost (20AM, 1AM). Some suggested that the level of monitoring, reporting and risk assessment required of ACCHSs is higher than those for mainstream agencies (8AM, 13AM, 9AM), and others that they feel 'dictated to' by health authority project officers (6AF, 11AF, 20AM).

*I think they try to become, in effect, a de facto manager of the health service, rather than just funding it, buying the services, if you like, which is exactly what they should be doing* (ACCHS Finance Manager).

*We're the most over-reported and protected sector. You look at divisions of [general practice], you look at some of those mainstream health organisations and you look at the reporting arrangements that they have versus what Aboriginal organisations have. We have to report on every little thing* (ACCHS CEO).

*Each program that we receive funding for all require different formatted data collection* (ACCHS Finance Officer).

Some health authority staff also felt that overall accountability requirements for ACCHSs were more stringent than those for mainstream agencies (10HM, 9HF, 1HM). Although underlining the need for communities to justify expenditure of public funds, they noted an excessive amount of justification through reporting, particularly when 'you're talking small amounts of funding. There's got to be a balance' (Health Authority Manager).

The majority of health authority finance staff agreed that ACCHSs (particularly rural and remote ones) struggle to keep up with government reporting compliance for a number of reasons, including lack of ICT and the staff to generate reports.

*Remote locality of organisations getting the proper skilled-based people is a big issue* (Health Authority Finance Officer)*.*

*Some services don't have up-to-date technology, or don't know how to use the technology* (Health Authority Finance Officer)*.*

*Big [ACCHSs]… have the expertise and the money to provide reports. The small [ACCHSs] struggle with it. There's a lack of skills to report at this level* (Health Authority Finance Officer)*.*

## Reporting is often not used well

Health authority staff in five jurisdictions reported that the data collected from most ACCHSs are more accurate and more up to date than data collected from mainstream services.

One ACCHS manager believed that the time and effort to collect data and generate reports was not justified by value for internal purposes (14AM). Another expressed frustration about barriers to sharing data:

*There's a lot of debate going on about privacy and confidentiality. Like we even had an issue with our auditors wanting to know how complete the project was and asking to see data—and they've got the medical people in the organisations saying, 'oh, I can't show you that, it's all privacy and confidentiality' and the like* (ACCHS Finance Manager)*.*

But others valued the data for performance and quality management (8AM, 9AM), and commented on the value of the SDRF (15AF, 5AF) and the data generated from the ICT system *Communicare* (17AF, 10AM). However, there was widespread agreement

that ACCHSs hardly ever get feedback from funding bodies on their performance reporting, except when there is something wrong or clarification of a report is needed (20AM, 6AF, 14AM, 10AM, 9AM, 1HM, 12AM, 18AM, 17AF, 19AF, 5AF, 10AM).

> *We send things to the department and the left hand doesn't know what the right hand is doing* (ACCHS Finance Manager)*.*

Health authority staff noted the multiple purposes of data collections, including improving efficiency and healthcare delivery, identifying gaps in health care and monitoring the compliance of ACCHSs. Some expressed confidence that the data are well used:

> *We're required to report to federal government on all sorts of activities. The data will go to business and performance managers, it will go to a database to identify where the gaps are. It probably does go back to communities but they don't recognise it. It doesn't sit on a shelf as such. Stuff that works really well, we can roll out* (Health Authority Manager)*.*

> *We do use the information, it's important for us to be able to acquit the money, and look at what is reported against, what they've spent, make sure they're using our money for the purpose that we ask them to and whether or not they're delivering adequately. This is important because we're responsible for public money. We need to be able to be accountable to our department and to the tax payer. If we get a ministerial brief or a question on notice, we've got that information on hand to say, yes, the money has been used appropriately* (Health Authority Manager)*.*

Others expressed concern:

> *Data is passed on to the policy people. A lot of programs are really driven from Canberra and Head Office and they encompass everybody. Outcomes are decided centrally. We could do more, some of the stuff we collect doesn't get utilised as much as we'd like* (Health Authority Finance Officer)*.*

Some participants on both sides commented on the need for better skills in analysing and assessing the importance of data about both financial and health care performance.

> *The measures need to be revisited to fit within the new Commonwealth agenda. Whatever data we collect demonstrates that [ACCHSs] value-add to the State's health care system and vice versa* (Health Authority Manager)*.*

Funders also identified the lack of skills within their departments in assessing the reports.

> *There's also lack of skill level within our own agency of officers who assess reports to determine whether the report is satisfactory* (Health Authority Finance Officer)*.*

## Different data are needed

Health authority staff identified several areas where better data are needed, including the problem of identifying Aboriginality in mainstream services, and the lack of focus on Aboriginal and Torres Strait Islander people in mainstream data collections. More relevant to ACCHS activities, they noted the need for nationally consistent good quality data and more and more rigorous evaluation of the success of interventions:

> *The ACCHSs data is a lot more rigorous in terms of identifying Aboriginality and other identifiers. Legislation was passed last year to record Aboriginal identifier on the pap smear register. It's mandated on death certificates/death register. There is an Aboriginal identifier upon admission but some staff feel uncomfortable and don't ask the question, some people don't want to identify, some people identify sometimes and not other times* (Health Authority Manager)*.*

> *The biggest issue is about Aboriginal identification. We've been looking at death recently and there's very little ability to collect Indigenous death* (Health Authority Manager)*.*

*The whole data collection needs to be improved so that, at the end of the day, we get more meaningful data so we can actually see what it is we're achieving, based on what it is we're funding. Another problem we encounter is communities are so transient, that we get possibly a misrepresentation of data* (Health Authority Manager).

*A lot of the data we actually collect, is probably not that beneficial, it doesn't really tell us where the improvements have been made* (Health Authority Finance Manager).

*Data is not one-way—it's two-way because when we combine our data with [ACCHS] data, then what you've got is a powerful piece of information that can be used within the national arena. Because in some cases what we don't do is use the data to show that we are doing things well and that we are closing gaps. We always tend to use data in a negative way and we've got to get out of the negatives and deficits. There is some extremely good stuff happening that is being driven by Aboriginal people or being driven in partnership with non-Indigenous people* (Health Authority Manager).

## One-way accountability

*One-way accountability* is a term used by ACCHS interviewees to describe the lack of accountability of funding bodies to ACCHSs (18AM, 12AM). They also noted lack of reporting back to ACCHS unless they have failed to meet funding body expectations:

*the accountability is put back on our organisations and NGOs and that, too, comes into play with the risk management, where funding bodies give us a risk management level but, at the same time, the accountability is not on them to provide that as well… We're accountable but who is keeping them accountable?* (ACCHS CEO).

Although the need for monitoring and reporting was recognised by all interviewees, there was concern about the usefulness, and the actual use, of much of the monitoring data. Further, there was a sense that ACCHSs are subjected to higher levels of scrutiny, possibly related to the relative lack of trust and credibility extended to them by funders and others. This finding suggests that monitoring mechanisms for ACCHSs are aligned more closely with public/political perceptions of the sector (and perhaps perceptions of Indigenous people themselves) than with overall performance of the sector and actual utility of the data. It further illustrates the problematic nature of maintaining accountability, for both funders and providers, in a situation of heightened political sensitivity and lower trust.

# Transaction costs

Transaction costs in this context are the resources that are used in planning, negotiating, monitoring and accounting for the use of funding contracts, and they are incurred by both funders and providers. ACCHS interviewees referred to the time and energy required for several types of transaction costs: costs of acquiring funding, which tend to be proportionally higher for smaller grants; costs of preparing and submitting reports (outlined above); and the costs in financial accounting and administrative energy of managing multiple contracts. Several ACCHS staff commented on the workload involved in acquiring multiple grants for what is essentially PHC:

*But there's still a lot of room for improving that because having to… deliver a comprehensive primary health care service you have to still go and find other monies. So that… increases your administrative load and also loading of staff, I suppose, in the organisation generally* (ACCHS CEO).

Health authority staff also acknowledged the resources consumed in designing, allocating, managing and analysing reports and acquitting grants, as outlined below.

## Achievement of ACCHSs in acquiring funding

A small number of health authority staff said that there is a need for government to recognise and acknowledge the financial management skills of ACCHSs that use what little funding they have in the most effective way:

> *Many [ACCHSs] have built their service up by putting together all these little grants into what effectively was an operating budget. We need to recognise reality and say that these people have worked out how to use this totality of the money for best effect* (Health Authority Manager)*.*

Several ACCHS staff indicated that their agencies had decided not to make submissions when small grants with substantive reporting requirements were offered because of the proportionally high costs of administration.

Health authority finance officers said that the reason for not giving an ongoing commitment to funding is to retain the ability to end funding of an agency if it is assessed as not meeting responsibilities.

> *Funding is not contracted long term in the service agreement because there's the government funder mentality that if the service provider responsibilities aren't being met, that the government can't get out of the contract* (Health Authority Finance Officer)*.*

This is an important consideration for funders, and would need to be addressed in any funding reform (e.g. through hold-back provisions).

## High volumes of monitoring and reporting

There was general agreement among health authority and ACCHS staff that the burden of reporting is too high, and that the level is linked to the nature of the funding programs and the reliance of ACCHSs on two levels of government. Current moves in several States towards streamlining data collection and reporting requirements are yet to be consistently implemented. Further, the tendency in recent years for governments to tighten reporting requirements for all recipients of funding has worked in the opposite direction.

> *By having short-term contractual agreements, the onus falls on the service provider. The reporting on activity data has increased, work has gone up and the process has become more formal with less room for negotiation* (ACCHS CEO)*.*

> *It's a serious problem. It affects the efficiency and effectiveness of the programs offered by the recipient. In one ACCHS, the manager has to manage twenty-seven quarterly reports and financial statements and annual reports. When does she get time to run the organisation? It's been talked about but it's not been resolved* (Health Authority Manager)*.*

Financial reporting was regarded as less problematic than activity reporting by many interviewees. However, there was some comment in relation to the costs for smaller and more remote services. Auditors are more costly in rural and remote areas and are not always available in the timelines required by government. One health authority manager (1AM) said that when this occurs, instead of withholding funding, funders should go to the ACCHS to find out why auditing reports are late and assist them.

# Risk

## Relationships

Interviewees on both sides of the relationship between ACCHSs and health authorities reported on good, as well as poor, relationships and experiences of lack of trust. About half of the ACCHS staff noted good relationships or communication with OATSIH (2AM, 10AM, 2AM, 10AM, 15AM, 1HM, 4AF, 18AM, 12AM, 9AM, 21AF), whereas just over a quarter said they enjoyed good working relationships with their State funding body (8AM, 10AM, 6AF, 12AM, 9AM, 8AM). Some health authority staff also acknowledged having very few problems with the ACCHSs they fund because of good working relationships between individual departments and ACCHS staff (18HM, 4HF). ACCHS staff endorsed the importance of individual relationships (8AM, 18AM, 20AM, 3AM) and mutual trust and understanding (15AM).

When ACCHS interviewees spoke about problems with health authority staff showing distrust or withholding information, or being reluctant to assist ACCHSs with problems on the ground (18AM, 11AF), they suggested that this arose when funding bodies saw ACCHSs as isolated or not being part of the whole health system (7AM, 6AF). ACCHS staff saw lack of knowledge about community organisations and communities by health authority project managers or finance managers (12AM, 5AF, 1AM) as a source of inflexibility, of difficulties in discussing problems and reluctance to approve proposals from the ACCHSs (1AM, 18AM, 11AF).

> *It would be great to have a different relationship with OATSIH or the Commonwealth Government where we were viewed as an integral part of the health system, that we are playing an important role in our region. If that was the view that was taken, we could have completely different funding arrangements that were based on an annual or three- or four-year budget, that there was a commitment to the region, that we would have flexibility to move money around without having to go back all the time for every minor thing* (ACCHS CEO).

A focus on compliance was sometimes resented by ACCHS staff, and multiple reporting requirements were seen to create tensions between funders and ACCHSs.

> *They almost feel a bit like the enemy at the moment. I find whenever you deal with them you're constantly struggling, constantly fighting. They're always asking for bits of paper and proof of things having been done and always holding up the funds because something hasn't arrived* (ACCHS Finance Manager).

Given the importance of person-to-person relationships, it is not surprising that interviewees recognised the need for functioning communication channels and some stability in the staff responsible for them.

ACCHS interviewees noted the need for having one long-term project officer in the funding body who understands the circumstances of each ACCHS and can act as a single entry and information point between ACCHS and the funding body (21AF, 5AF). However, they also noted that project officers often change (e.g. four project officers in 16 months) and there are gaps between appointments (1AM, 21AF, 19AF, 17AF). The problems arising from this instability were seen to include changing perspectives and understanding of issues (19AF), leading to duplication of effort and delayed implementation of programs (5AF, 9AM).

> *They come with different skill sets and different interpretations of what the requirements of the funding agreement are. In the seven months that I've been here we've gone through four project officers and I'm in the process of breaking in the fourth, training the fourth. They do tend to handover and get a briefing, I suppose, of where the organisation is at, but then their interpretation of that is different to the previous person* (ACCHS CEO).

## Capacity problems

ACCHS staff generally need to build relationships and communication with many project officers from various funding sources (1HM). Some noted communication and coordination difficulties within funding bodies that impact on the timeliness of release of funds (3AM, 11AF), and that State and Commonwealth health authority staff tend to seek to shift the blame for problems to each other (13AM, 19AF). Several ACCHS staff also commented on the restricted decision-making capacity of health authority project officers:

> *And their decision-making ability is very, very restricted. It has to go to central office and it sort of gets lost in that—and the people that I've had to speak to in central office…* (ACCHS CEO)*.*

Health authority and ACCHS staff said capacity varies in ACCHSs due to several factors: size and operating age of the ACCHS, geographic location, problems with access to telecommunications and ICT, leadership, lack of standard reporting templates, too many reports required, and difficulties recruiting and retaining staff particularly in rural and remote areas (where costs of food, transportation and housing are higher). One health authority program manager said that although they know the services are being delivered, ACCHSs need to articulate this in reports (11HM).

Lack of governance training and capacity for ACCHS board members was mentioned by several health authority and ACCHS staff. A senior ACCHS manager (8AM) said there is a need to allocate special administrative funding for the operation of Boards of Management. Others said ACCHSs were undervalued by mainstream services and that they were not seen as complementary but as competition for funding (13AM, 9AM). One CEO of an ACCHS said ACCHS capacity was affected by the number of deaths in Aboriginal communities and how important it is for staff to attend to 'sorry business'.

> *And I've found one of the greatest problems has been with the sorry business and I've really come to realise how remote we are, how they can't get to those places and how important it is for them to be there* (ACCHS CEO)*.*

A CEO of an ACCHS said that one of the strengths is that the majority of the board members are Indigenous people. This was seen to be advantageous because they help to explain the business of the ACCHS to community members in their own language. Having regular staff meetings with the board also increases transparency and strengthens working relationships. One CEO provided an example of the capacity of the board to protect the service and pursue good practice in the face of pressures from the funder to jump into service delivery before the organisation was ready:

> *they put on the table and said 'we can give you a lot of money for alcohol and other drug service delivery; you've got to have it now and do the services now', and all of our Board sat around this table and said to [government] mob—and they're good people, really good people, trying to do the right thing—[the Board] said, 'no, what we want to do first is we want it step by step. We don't want to do what happened in previous programs, to blindly go and deliver services'. I mean, how does that work? 'First of all, we want to discuss it, we want to have basically a needs assessment, work out what we need to do.' And they said, 'oh, you can't really do that, it's service delivery. You've got problems. Alcohol's a problem', so in the end they [government] came back round to us and said, 'no, we'll do it your way'. So we've just completed our needs assessment now and we're now ready to develop our model* (ACCHS CEO)*.*

Several ACCHS CEOs suggested that the practice of community control is compromised because some board members lack the writing and conceptual skills to respond to the accountability and reporting expectations of funders:

> *All of my Board [members] are flat out if they've gone to Grade 8 or 9 and yet they're being asked to run a multi-million dollar organisation… Never been CEOs, haven't been senior management, and yet we're saying, 'we want you to come in here and set the strategic directions for an organisation that has million dollar incomes' and it's really unfair* (ACCHS CEO).

> *Well, if we're going to manage [this organisation] we need to get a Board that is able to function as a proper Board and that's why I think the whole concept of community control is flawed, because the way you can get onto a Board is by the amount of people that you have at the [annual general meeting], not by having the expertise to actually contribute to the Board in terms of where that organisation's going* (ACCHS Finance Manager).

Two interviewees (7AM, 15AM) spoke about the important role of their boards in discussions about problems and progress, while two others (1HM, 8AM) commented on the need to build board capacity. Others noted that larger organisations enjoy a better negotiating position (2AM) and employ more staff to comply with reporting requirements (7AM, 10AM, 18AM).

The difficulties of running health care services in very remote areas were also discussed. Higher costs, transportation and housing problems (20AM, 8AM) in remote areas also influence the ACCHS capacity to recruit and retain staff (16AM). Health authority staff also commented on the difficulties of running smaller and more remote organisations, and misuse of funds through, for example, overuse of food and fuel vouchers (1HM).

## Dispute resolution

Approaches to dispute resolution tend to support the view that staff on both sides operate on the assumption of a relational contract environment. Several health authority and ACCHS staff said disputes are settled quickly when there are good working relationships between management staff of both agencies. Having one point of contact between health departments and ACCHSs is seen as a positive step to strengthen communication and prevent or manage misunderstandings and disputes. Phone calls and face-to-face meetings convened early when issues arise were viewed as the best ways to resolve disputes, particularly by ACCHSs. Discussions with funding bodies were focused on matters like the need to simplify reports (2AM, 22AM) and the problems with late reporting (9AM), with collaboration (3AM, 9AM) and with the need to reallocate funds to ACCHS priority areas (12AM, 3AM), and problems with the timely release of allocated funding or retention of unspent funding at financial year end (3AM, 13AM, 2AF). Several interviewees from ACCHSs mentioned the need to bypass the normal communication chain to talk directly with the decision maker when disputes cannot be settled locally (8AM, 19AF).

On the other hand, there was some reference to the use of formal auditing or the threat of installing an administrator as a compliance measure, or in response to a community complaint. One CEO spoke of the need to:

> *engage in appropriate ways rather than to have the threat of an administrator coming in because you're $70,000 over on a budget* (ACCHS CEO).

# Conclusion

Although there was general recognition that the current funding arrangements are too complex and are inefficient for both sides of the funding agreements, there was also recognition that definitive solutions are hard to find. Health authority staff, in particular, understood that some sources of the problem lie in the way funds are appropriated by parliaments, as one health authority manager explained:

> *It seems to be a significant barrier as to how governments appropriate and distribute funds, and measure outcomes. I think technically it's quite difficult to imagine how you can simplify it. As you go down the line, funding gets fragmented into different programs and then across the sectors as well* (Health Authority Manager)*.*

Interviews with staff on both sides of the funding relationship have provided an insight into their perceptions of several important characteristics of current practice. The main points are summarised here.

- The complex contractual environment in which ACCHSs work is acknowledged by funders, but not monitored or managed in any consistent way. It has emerged from a series of unlinked policy and program decisions, and has simply grown over time.

- Recognition of the administrative overburden has led funders in most jurisdictions to move to simplify and consolidate contracts, and to lengthen the standard funding term to three years. There are many barriers to this goal, including the nature of budget appropriations, and the need for cooperation among levels of government and different departments.

- Although recognising that virtually all funding is short or medium term, both funders and providers consider themselves to be in long-term funding relationships and tend to act in accordance with this belief.

- Relationships of trust between individuals are seen as important enablers of effective accountability, problem solving and decision making. The effectiveness and (in)stability of formal communication channels is a problem in this regard.

- Heightened political sensitivity, and the related need to demonstrate strong accountability, tends to reinforce burdensome reporting requirements that seem to have limited utility.

- Although classical contracts predominate, and bring a high reporting burden, the pattern of dispute resolution—which is reported as being largely trust based or relational in character—indicates that the sector is regulated as a relational environment. This finding is consistent with the evidence presented in Section 4.

# Discussion and Conclusion

This project aimed to identify the major enablers and impediments to effective PHC delivery embedded in current funding and regulation arrangements for PHC services for Aboriginal and Torres Strait Islander people, and to analyse the policy and practice implications for both funders and providers of PHC. We used a framework derived from contract theory and adapted for analysing contracting for PHC. Our examination of the current practices and policies of health authorities has identified characteristics of the funding relationship that are important barriers to good practice, as well as enabling factors. We discuss each of these main characteristics below, and then draw out the policy implications. Finally, we seek to integrate this material into a framework for better practice in funding and regulation that suggests the characteristics health policy makers, program managers and recipients of funding should aim to achieve.

## Current funding and regulation: Barriers and enablers

### Fragmented funding is a barrier to integrated PHC

Our review of the funding and regulatory practices of Australian governments confirms the complexity and fragmentation of funding, and the heavy burden of acquiring, managing, reporting and acquitting funding contracts for both providers and funders. As we noted at the beginning of this report, this problem affects Indigenous organisations across many portfolio areas (housing, land, education etc.) and is widely recognised.

ACCHSs operate in a complex contractual environment, where their services and operations are funded from a wide-ranging mix of core operating grants and program- or project-specific grants, virtually all formulated as short or medium term (maximum of three years). There is some evidence that the contractual arrangements for Aboriginal and Torres Strait Islander organisations are more complex than for mainstream organisations. This additional complexity arises at least partly because ACCHSs provide a broad range of essential PHC, rather than undertaking

roles that are supplementary to mainstream public health care. It may also be related to the fact that they do so in an arena of heightened political sensitivity.

The effects of fragmentation are most severe for those without core funding. Even for those that do have core PHC funding grants, there are many add-ons requiring separate contracting provisions, and separate accounting and reporting. There is a mismatch between the application of tightly targeted funding guidelines and the broad responsive purpose and nature of PHC. ACCHSs argue that separate funding and reporting requirements applied to different aspects of the same service can intrude on the design and conduct of integrated services. Some staff on both sides of the funding relationship acknowledge a degree of artificiality in the allocation of costs as a result.

## Unmanaged complexity and transaction costs impede efficiency

The complex contractual environment in which ACCHSs work is acknowledged by funders, but not monitored or managed in any consistent way across funders and programs. It has emerged from a series of policy and program decisions in both levels of government, and has simply grown.

The complexity of funding exposes funders and providers to additional administrative costs in acquiring, tracking, reporting on and acquitting multiple grants. There is insufficient adjustment of reporting requirements related to the size and purpose of grants. ACCHSs need to devote significant resources to acquiring and managing money, resources that are likely to be disproportionately high compared to mainstream agencies. However, financial reporting is seen as less onerous (and is better complied with) than activity reporting.

This situation is compounded by the disseminated nature of allocation and distribution pathways for funding to ACCHSs within many health authorities. The recognition by interviewees of the relatively more effective approach of OATSIH to the funding relationship highlights this problem.

Recognition of the administrative overburden has led funders in most jurisdictions to explore opportunities to simplify and consolidate contracts, and to lengthen the standard funding term to three years. Although important gains have been made, there are many barriers to this goal, including the nature of budget appropriations, and the need for cooperation among levels of government and different departments. There is a risk that the problems of reporting for one-year contracts may be simply transferred to the schedules attached to longer term contracts, with no overall improvement in efficiency. Implementation of intended reforms (such as use of standardised templates for reporting to both Commonwealth and State/Territory governments) is slow and patchy, particularly where cooperation between two levels of government, or different government departments, is required.

## Long-term relationship behaviour enables trust and enhances capacity

Relationships of trust between individuals are seen as important enablers of effective accountability, problem solving and decision making. The effort required by all parties arising from the construction of virtually all funding as short to medium term, and the lack of security it brings for ACCHS, may be unnecessary given that most funding is effectively ongoing in practice.

The operating assumptions of both funders and providers highlight the paradox of short-term allocations. Staff on both sides tend to consider themselves to be in long-term funding relationships, and to act in accordance with this belief in some important ways. It should be noted that this belief is probably not widely shared in the broader bureaucracy and higher echelons (which have

a larger role in determining the formal nature of funding contracts). Hence the paradox of explicit short- to medium-term funding agreements with behaviour on both sides that rests on an assumption of longer term funding relationships.

Although there was little direct discussion of the impact of race and racism, there is evidence of lack of trust on both sides. This feature of inter-cultural relationships between Indigenous and other Australians has been studied in the general community for Reconciliation Australia by Auspoll (2009), which found a significant amount of goodwill but a serious lack of trust. A similar pattern is likely to apply among funders and providers in the ACCHS sector.

We suggest that mistrust is also reinforced by the political sensitivity of Indigenous issues, which touch the raw nerve of foundational ideas of national identity (see, for example, Dixson 1999:43; Sullivan 2009b). Indigenous representative organisations are in a double-bind: the political sensitivity provides a way of getting attention for their members' needs, but it tends to lead to the kind of over-administration documented in this report. Similarly, government policy and program staff confront a heightened need to demonstrate value for money and the challenges of political sensitivity when they respond to non-compliance by ACCHSs with accountability measures.

## Data for monitoring and performance management are compromised

*Oversight for the health of the forest has been replaced by repeated exercises of counting trees. The problem is one of both volume and format* (First Nations and Inuit Health Branch employee, quoted in Lavoie *et al.* 2005:108).

Governments in Australia are increasingly concerned with ensuring value for money in the expenditure of public funds, and have sought to achieve this goal through tightly focused allocations and detailed requirements for reporting by recipients on what has been done with the money. Although the

goals of ensuring value for money and its use as intended are sound, the impact of the measures enacted in pursuit of these goals is counterproductive. Performance accountability is compromised: the pursuit of efficiency by inappropriate means has led to inefficiencies that may compromise the performance of the sector as a whole.

Both funders and providers in this study strongly supported the need for good data and good analysis of service effectiveness. They also acknowledged that reporting on funded PHC services was too focused on 'counting heads through the door', to the detriment of capacity for monitoring and reporting health impact. As noted above, compliance with activity reporting is seen to be lower than with financial reporting. This may be partly due to the threat of sanctions being more vigorously applied to financial reporting problems, and may also reflect better standardisation and computerisation of financial reporting.

Progress is being made in data collection and reporting systems, with some consolidation of systems for data extraction and analysis. Data linkage in support of clinical care is also seen to be improving: for example, in the Northern Territory where Health Connect enables important patient information (such as medication usage) to be accessed in multiple clinics with patient consent.

However, current practice means that activity reporting required from ACCHSs is seen as demanding, and not helpful enough for internal performance monitoring. Although funders reported on the value of data for use in support of policy decisions and ongoing funding allocations, providers saw the data they send to health authorities as going into a black hole, with no useful feedback (such as comparisons with data from like services) or with feedback that is too delayed to be useful.

This is a complex problem, and progress is being made at the policy level towards measures of health service output and impact that are both valid and meaningful (AHMAC 2006; Sibthorpe 2004). Further, a recent OATSIH review of reporting requirements (OATSIH 2009) foreshadows a reduction in duplication, a focus on outputs and outcomes in relation to OATSIH-funded work, and more timely feedback.

However, our analysis suggests that the well-known problem of the reporting black hole is an almost inevitable result of the nature of the approach to funding. That is, reporting on tightly specified short-term funding for specific activities is likely to focus on those things that can be *counted* immediately (usually, the activities themselves) and specifically attributed to the relevant grant, to the detriment of a focus on indicators of intermediate or longer term outcomes, or broader measures of health and wellbeing.

## National priority funding impedes responsiveness to local priorities

Governments seek to direct funding to national or jurisdictional health priorities, and to modes of care or interventions that are seen to be effective. On the other hand, local and regional providers of care for Aboriginal and Torres Strait Islander communities seek flexibility to respond to the pattern and priorities of need in their communities, and to take up local opportunities to make a difference. Tension between these goals is inevitable, and both are important. Staff in ACCHSs acknowledge that targeted priority funding is often *on target* locally; and both official policy statements and staff in health authorities acknowledge that locally determined priorities are important. Tension would be lessened, and efficiency enhanced, if targeted funding was not needed to replace or top up core PHC funding. More flexibility is also needed to enable government contract managers to respond to local needs (e.g. through negotiated variation in the application of targeted funds).

Tightly specified contractual arrangements do not provide the balance required in managing this tension. More flexibility and more accommodation for population-based approaches to health are needed.

## Current practice: classical and relational contract paradox

The complex contractual environment for ACCHSs and their funders is largely shaped by a classical approach to contracts, though often with a vocabulary and management environment that invokes relational contracts. This situation is summarised in Table 8, highlighting the ways in which current practice incorporates elements of both classical and relational contracting. This tends to undermine the benefits of both forms. Those involved think and behave in ways that belie the intentions of classical contract provisions (such as avoiding expectations of ongoing funding); but the advantages of relational contract forms (such as reduced transaction costs) are not realised either. The same phenomenon has been reported elsewhere (Allen 2002; Palmer & Mills 2003).

**Table 8:** Current practice—classical and relational contracting paradox

|  | **Classical contractual characteristics** | **Relational contractual characteristics** |
|---|---|---|
| Nature of funding | Short-term contracts, sometimes competitive | *BUT, most funding is ongoing in practice, and decisions are based on that assumption* |
|  |  | Long-term relationships among funders and providers are valued |
| Priority setting | National or jurisdictional priorities are funded short- to medium-term | Some core funding for PHC (mostly from OATSIH) enables local priority setting, but may not support sufficient broad-based PHC |
|  | ACCHSs have little capacity to influence application to their communities |  |
|  | Funding agreements focus on single interventions not PHC, and tend to emphasise individual care rather than population health | Core PHC funding enables population approaches |
| Monitoring | Short-term contracts focus on short-term outputs | There is progress towards good, standardised health and health care indicators, but implementation lags |
|  | Multiple data collections are costly |  |
|  | Data are not used as much or as well as needed |  |
| Transaction costs | Unmanaged complexity drives transaction costs for both parties | *BUT, good communication and longer term relationships reduce some costs* |
| Risk | Complexity and number of contracts undermine compliance with accountability | *BUT, good communication and longer term relationships reduce some risks* |
|  | Providers risk default and withdrawal of funding | *BUT, funder capacity to withdraw funding is compromised because funders depend on providers to deliver access to essential health care* |
|  | Provider capacity is sometimes not adequate |  |

# Towards a framework of good practice in funding and regulation

Current practice in funding and regulation is derived from a classical contracting model, which we argue is wrongly applied to the ACCHS sector. Although the classical contracting approach may be appropriate for some subcontracting of specific aspects of care by government, it is not adequate for the development of a robust comprehensive PHC sector. There are three important grounds for reform of the complex contractual environment in which ACCHSs operate:

1. Aboriginal and Torres Strait Islander communities experience poor health and poorer access to PHC. There is an urgent need to improve access to culturally safe, effective care as part of efforts to *close the gap*.

2. The sector occupies a unique position, endorsed in policy and practice, as a provider of essential PHC care, but current funding methods are not appropriate to this role.

3. The additional investment in PHC that is acknowledged as needed should be made in ways that offer better efficiency and effectiveness than the current arrangements.

As noted at the beginning of this report, governments are committed:

> *Within the health system, the crucial mechanism for improving Aboriginal and Torres Strait Islander health is the availability of comprehensive primary health care services. Effective and appropriate primary health care services must be available to all Aboriginal and Torres Strait Islander peoples. These services should maximise community ownership and control, be adequately funded, have a skilled and appropriate workforce and be seen as a key element of the broader health system* (NATSIHC 2003:1)*.*

The National Strategic Framework goes on to outline the commitment of all Australian governments to nine principles, three of which are directly relevant to the question of better practice in funding and regulation:

> ***Community control of primary health care services:*** *supporting the Aboriginal community controlled health sector in recognition of its demonstrated effectiveness in providing appropriate and accessible health services to a range of Aboriginal communities and its role as a major provider within the comprehensive primary health care context. Supporting community decision-making, participation and control as a fundamental component of the health system that ensures health services for Aboriginal and Torres Strait Islander peoples are provided in a holistic and culturally sensitive way…*

> ***Localised decision making:*** *health authorities devolving decision making capacity to local Aboriginal and Torres Strait Islander communities to define their health needs and priorities and arrange for them to be met in a culturally appropriate way in collaboration with Aboriginal and Torres Strait Islander health and health related services and mainstream health services…*

> ***Accountability:*** *including accountability for services provided and for effective use of funds by both community-controlled and mainstream health services. Governments are accountable for effective resource application through long-term funding and meaningful planning and service development in genuine partnership with communities. Ultimately, government is responsible for ensuring that all Australians have access to appropriate and effective health care* (NATSIHC 2003:2–3)*.*

We suggest that implementation of these commitments will require a different way of thinking about the relationship between government and the sector, with implications for both sides. We further suggest that the framework of relational (or *alliance*) contracting provides methods for improving both efficiency and effectiveness.

Accordingly, we suggest the following principles against which options for good practice in funding and regulation could be evaluated. Each is supported with some descriptive text outlining ways in which these principles could be addressed.

1.  **Long-term contracting for core PHC is the basis for the funder–provider relationship. In such an arrangement, contracts of at least five years, with renewability, would be negotiated.** Expectations and required service levels would be specified through a negotiated agreement such as OATSIH's Service Development and Reporting Framework approach. Funders would appoint senior contract managers with contract management expertise and with delegations that enable them to make decisions in relation to the situations and needs of particular ACCHSs and communities. Annual negotiations would review and adjust service delivery levels and targets based on the SDRF and the uptake of additional funding.

    Other funding methods are complementary. Classical contracts (shorter term, specific interventions or purposes) would be used on the margins to complement long-term core PHC funding. Core PHC funding grants could also be complemented with fee-for-service or other output-based funding arrangements, such as MBS and PBS. Capital funding could be explicitly built in to funding formulae, and/or separately identified through an agency-specific accumulation fund and jointly managed.

2.  **Core PHC funding allows flexibility for local priority setting, in accordance with agreed plans.** National priorities and, where feasible, non-health funding are integrated at national or State level and distribution is negotiated as part of annual plans. Resultant allocations are folded into the main contract. These priorities integrate into a defined and resourced basket of essential PHC services.

3.  **Data collection and monitoring are simplified and information is shared, based on sound performance and health outcome indicators.** A single reporting framework and standard data dictionary provide parameters for policy and program managers in designing reporting requirements. Changes are designed nationally, and information is collected and analysed by an independent body (e.g. Australian Institute of Health and Welfare) with advice from funders and providers.

    Reciprocal accountability is enacted through improved access for ACCHSs and other providers to aggregated information about ACCHS performance, and the performance of the mainstream health system in responding to community health needs and priorities, and contributions to *closing the gap* (e.g. data on hospitalisation of Indigenous people for ambulatory care sensitive conditions).

4.  **Transaction costs are reduced and complexity is managed through a single main long-term contract and good contract management.** Both contracts and compliance requirements are simplified and transaction costs for both sides reduced. Service reporting focuses on outputs and indicators of outcomes, not inputs. Contract management services could be offered to non-health funders by health contractors to enable inclusion of non-health funding in the single main contract.

5.  **Risks for both sides are managed.** Risk for the provider is reduced through stability and flexibility of core PHC funding, and clearer communication and reporting lines. Risks for the funder are managed through contractual provisions regarding non-compliance, backed up with normal risk management and quality assurance methods. Provider capacity is also enhanced through adequate levels of core funding and adaptation of governance models to size and complexity (consistent with the principle of community control).

## Implications for government structures and policies

There are many policy prescriptions for improving funding and regulation practice. The National Health and Hospitals Reform Commission (NHHRC 2008) has proposed a National Aboriginal and Torres Strait Islander Health Authority, which would take overall responsibility for funding PHC for Indigenous people and would operate as a large purchasing authority, along the lines of current arrangements in the Department of Veterans' Affairs for health care for entitled veterans. This is consistent with the Commission's recommendation that the Commonwealth take over responsibility for all PHC.

However, there are also great risks in any such change, particularly when political accountability is heightened. ACCHSs have been effective in maximising their sources of income, and centralisation of funding responsibility could remove this opportunity. The sector may well be concerned about opening up the funding currently provided to them by OATSIH to competition from mainstream providers.

Our purpose in this paper has been to study the effectiveness of current arrangements, and to formulate our findings as a set of principles or criteria that could be applied to assess potential improvements. The development of practical ways of implementing funding and regulation measures based on these criteria is itself a complex task, with both technical and policy problems to be solved.

No administrative arrangement is perfect, or perfectly implemented. Any approach will solve some problems, and create or exacerbate others. We do not suggest that relational contracting is a cure-all, but rather that it offers a sound alternative framework for redesigning the funding and accountability relationship for this critical sector of the Australian health system, thereby reducing administrative costs, improving performance and, ultimately, maximising the PHC contribution to closing the health gap between Indigenous and non-Indigenous Australians.
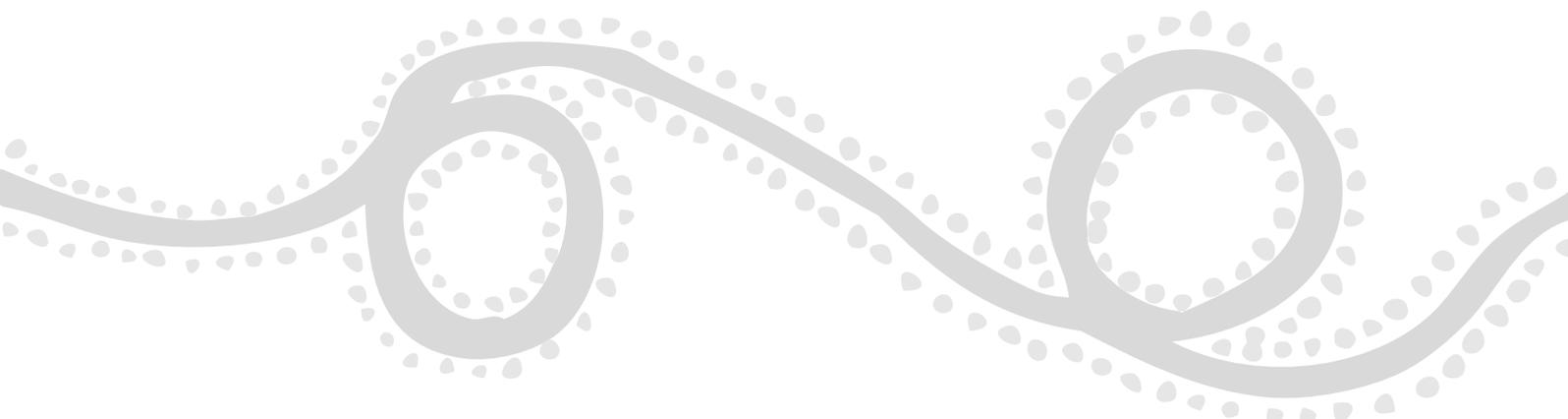
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# Appendix 1:
# Study Methods

In this appendix we give a more extended account of the methods we used in the study.

## Scope

Our scope of interest was defined as funding and accountability mechanisms that are applied by federal and State/Territory governments to fund Indigenous-specific PHC service providers; and impacts and related issues for those providers and the funders (including relationships between them). Thus, we sought to examine the funding programs, and their associated conditions (services to be delivered, reporting, auditing, dispute resolution etc.) from which funding is provided by governments to ACCHSs. The program may be Indigenous-specific or mainstream. The providers of interest are, therefore, those that are primarily engaged in delivering PHC to Aboriginal and/or Torres Strait Islander people, and who are substantially governed by a board chosen from among the populations they serve. We excluded Aboriginal organisations that have a broader social or community role and provide a single health service (e.g. a visiting mental health nurse) or a narrow range of health services (e.g. drug and alcohol services only). This exclusion was based on our interest in the complex contractual environments for ACCHSs that seek to provide comprehensive PHC for their communities.

## Desk-review of policy documents

We searched government websites for funding program guidelines and funding policies in relation to PHC funding for ACCHSs. This continues to be a work in progress, as these documents are difficult to access. The information relating to specific program funding, including some contractual agreements, was obtained during interviews with funding authority staff and the ACCHS management staff.

Other documentation was collected from government websites, health authorities, and ACCHSs and their peak bodies. These include 2006–07 annual reports and financial statements, as well as some 2006–07 and 2007–10 OATSIH and State/Territory contractual agreements.

These documents were analysed to generate an overview of the policy and program environment in each jurisdiction and to guide interviews and other project data collection and interpretation. Draft descriptions of arrangements in each jurisdiction were prepared and checked with health authority staff who had participated in interviews (see below).

## Interviews with senior health authority staff

A purposive sample of senior Aboriginal health policy and finance staff was identified from websites and local knowledge. We contacted the chief executives and the senior Aboriginal and Torres Strait Islander health policy officer in each State and Territory and in the Australian Department of Health and Ageing seeking interviews with a senior officer and with an officer responsible for funding arrangements for the sector. The purpose of the interviews was qualitative: to construct both a description of the current funding and regulation of PHC providers from their perspective, and an understanding of the major areas of successes and problems. Semi-structured interviews lasting approximately one to one-and-a-half hours were conducted with 20 consenting officers. (The interview outlines are at the end of this appendix.) These interviews were audio-recorded, transcribed and analysed as described below.

## Interviews with ACCHS staff

In order to gain an understanding of the experience and perspectives of PHC providers, we sought to interview a purposive sample of senior staff of ACCHSs. We contacted State and Territory NACCHO affiliates (that is, the peak body for PHC providers) requesting their nomination of PHC providers that we might approach for interviews. We also requested that the nominated agencies include a range of locations (urban, rural and remote), size and complexity, and age.

We contacted the CEOs of each nominated agency, and sought an opportunity to conduct an interview with the CEO and with the senior finance officer. Interviews with 23 ACCHS staff were conducted. They were semi-structured, and took one to one-and-a-half hours. (The interview outlines are at the end of this appendix.) These interviews were audio-recorded, transcribed and analysed as described below.

## Data analysis

Transcriptions of the interviews were entered into tables for grouping and analysis. The tables were analysed to identify common ideas or themes—that is, the factual information, ideas and opinions in the text were extracted, grouped and analysed using the method of thematic analysis (Liamputtong & Ezzy 2005:257–85).

Two members of the project team (Kim O'Donnell and Judith Dwyer for the health authority staff, and Kim O'Donnell and Uning Marlina for the ACCHS staff) conducted preliminary coding, generating categories from the data and grouping the themes into categories after two to three interviews. These were then discussed with other members, refined on the basis of discussion and consensus, and further developed as the interviewing and analysis proceeded. New themes were added as the material accumulated and new groupings emerged.

Each interviewee was assigned a unique identifier. In reporting on our analysis in Section 5, we show the identifiers we assigned to each interviewee to indicate the sources of the data on which the analysis is based. Quotes are attributed by identifying the sector and role of the speaker.

The numbers interviewed on each side of the funding relationship are roughly equal, which is not reflective of the relative numbers in the two workforce segments (senior staff in ACCHSs and senior staff in Aboriginal health policy in health authorities). This weighting was chosen because our interest was in the relationship and transactions between the funders and providers of PHC for Indigenous Australians.

## Confidentiality

Given the nature of the purposive sampling in this study, maintaining confidentiality for those we interviewed (particularly those in government health authorities) was difficult. We discussed this problem with all participants, and explained that while informed readers may make assumptions about who was interviewed, we would take great care in our reporting of interview data to avoid giving clues to the identity of interviewees, and to avoid enabling readers to attribute particular views or comments to individual interviewees. All interviewees recognised and accepted the reality of this problem.

## Construction of funding database

The acquisition of information about funding programs proved to be more difficult than we had anticipated. Funding guidelines for each program are often not publicly available; staff in health authorities tend to have limited knowledge of activities outside their immediate areas of responsibility; many different sections of government health authorities are involved and there seems not to be a central repository of information specific to Aboriginal and Torres Strait Islander health care providers; and many other departments at each level of government are providers of funding, particularly portfolios responsible for families and community services, legal services, aged and disability care, and children's services.

We therefore turned to analysing the information published by PHC providers in their audited financial statements and annual reports. Using information from NACCHO and its affiliates' websites (the Aboriginal Health Council of Western Australia, the Aboriginal Medical Services Association of the Northern Territory, the Queensland Aboriginal and Islander Health Council, the Aboriginal Health Council South Australia, the Victorian Aboriginal Community Controlled Health Organisation, and the Aboriginal Health and

Medical Research Council), as well as OATSIH and ORIC, we developed a list of ACCHSs that provide (comprehensive) PHC services in Australia. This study was conducted to bridge an important knowledge gap, as we were unable to identify an available source of consolidated information about the funding received by ACCHSs.

Where there was doubt about the role of the agency (i.e. is it in the business of providing PHC as defined?), we reviewed websites and other documents (such as annual reports that were available). As noted above, we excluded organisations that were not primarily focused on health care, even though they were providing single aspects of PHC (e.g. a mental health nursing service, a youth service, or a drug and alcohol service) as part of a broader community role.

A database was designed to enable the enumeration and analysis of discrete funding lines by funder, by jurisdiction, by PHC provider, and by amount and period of funding. Data were collected from provider agencies that agreed to participate, from annual reports where they were publicly available, and from financial and other returns filed with ORIC by PHC providers and available on the ORIC website.

## Development of a *good practice* framework

Based on contracting and accountability theory—and on our analysis of current practice and trends, of the perspectives of funders and providers, and the findings of other relevant studies—we developed an analysis of the major problems and strengths of current contracting practice. We then used this analysis to construct a framework that articulates criteria which define the requirements for good practice in funding and regulation, in the light of current Australian practice—that is, it is focused on the opportunities for improvement.

## Interview outline: Health authority questions

1. Please describe your role in relation to the funding and regulation of PHC services for Aboriginal and/or Torres Strait Islander people?

2. Within the Department of Health (or other title)—what is the pathway for allocation and distribution of funding for ATSI (Aboriginal and Torres Strait Islander) PHC services? Are there problems about coordination and communication in relation to funding and reporting?

3. Could you give us an overview of the ATSI PHC providers that receive funding from the State or Territory government in your State/Territory?

4. Could you explain the roles of the various areas of the Department in funding and regulating Aboriginal health services?

5. As you know, we're interested in understanding the details of all the funding programs through which funds are provided to ATSI PHC providers, including reporting and acquitting processes, timing etc., in 2007/08. We're interested in both Aboriginal-specific and mainstream funding programs; and Aboriginal-specific health care providers. We're using 3 broad categories at this stage—ongoing core funding; health program funding (e.g. funding from a 3-year program on eye health); and project funding (e.g. funding to trial or demonstrate a model or approach to health care). Do you think this is the right set of categories?

6. What are the advantages and disadvantages of short-term funding (1–3 years) from your point of view? What about longer term funding (5–10)?

7. If the Department wanted to move to more long-term funding, what would be the main barriers to making that change?

8. What do you think about the reporting requirements in this funding, and how the recipients cope with it?

9. What about the basis for allocation to ATSI PHC services—does the Department use population-based methods, historical, submission-based? Is the balance right? How would you like to see it changed? What are the barriers that would get in the way?

10. PHC providers often complain about the problem of priorities being set centrally and funding being targeted to those priorities, rather than their having the flexibility to decide what services should be provided locally. How well do you think that the arrangements and incentives for priority-setting work at the moment? What changes would you like to see? What are the barriers against change?

11. Is your office aware of concerns among funding recipients about the complexity of funding programs and reporting requirements? How serious do you think the problem is and why? What are the most significant barriers to change in this regard? How does/would the Department capture this information? Have any changes been made in response?

12. Do recipients of funding experience problems in complying with reporting/ and or auditing requirements? Why?

13. Thinking about the reporting data collected from ATSI PHC services by your department—what is it used for? Are there data that aren't used, or aren't used well? Are there things you'd like to collect but can't? Are the data passed on to other authorities or bodies?

14. If you had the power, what practical changes would you like to make to improve the effectiveness of funding and accountability processes?

## Interview outline: ACCHS CEO/ Finance Officer questions

1. Please describe your role in your organisation, and in particular in relation to funding and accountability requirements?

2. As you know, we're interested in establishing the current state of play in funding and regulation for your service. What would you say are the best aspects of the funding you receive from all government sources? What are the problems that you experience?

3. Your last annual report lists these sources of funding [show table]. Is this list up to date and complete? Can you identify which are ongoing in practice and which are one-off or term limited?

4. How would you characterise the relationships you have with funding bodies—what are the good aspects? What are the bad aspects? Do you think there are common interests?

5. Can you describe the ways in which short-term funding is an advantage to your organisation? And what are the disadvantages?

6. In your experience, are the data collected for external accountability purposes also useful for your internal management or review purposes, or is it more the case that you double up collection and reporting?

7. In your experience are data about the same services required in different formats for different reporting requirements? Can you give specific examples?

8. Do you get useful reports back from your funding bodies based on the data your agency and others like it submit? Please describe.

9. Do you experience difficulties reconciling your reporting obligations to funders with your accountabilities to the community and to the board? And alternatively, are they sometimes a helpful reference point?

10. Some of the funding programs your agency receives are for the prevention, early diagnosis or treatment of particular diseases. What are the advantages of this vertical approach to funding PHC? What are the disadvantages? In your experience does this way of funding cause particular administrative or operational problems? Please explain the specifics. [Probe—need to 'fudge' funding purpose or guidelines in order to meet local needs, or just to take comprehensive PHC approach?]

11. If you had the power, what are the most important changes you would want to make in the way funding is administered?

12. Could we have a copy of your '06–07 annual report? Is this available in soft copy? Some ACCHO annual reports have a list of the programs funded, the amount of funding and the source of funding. Does your annual report have this list? If not, could we gain access to such a list?
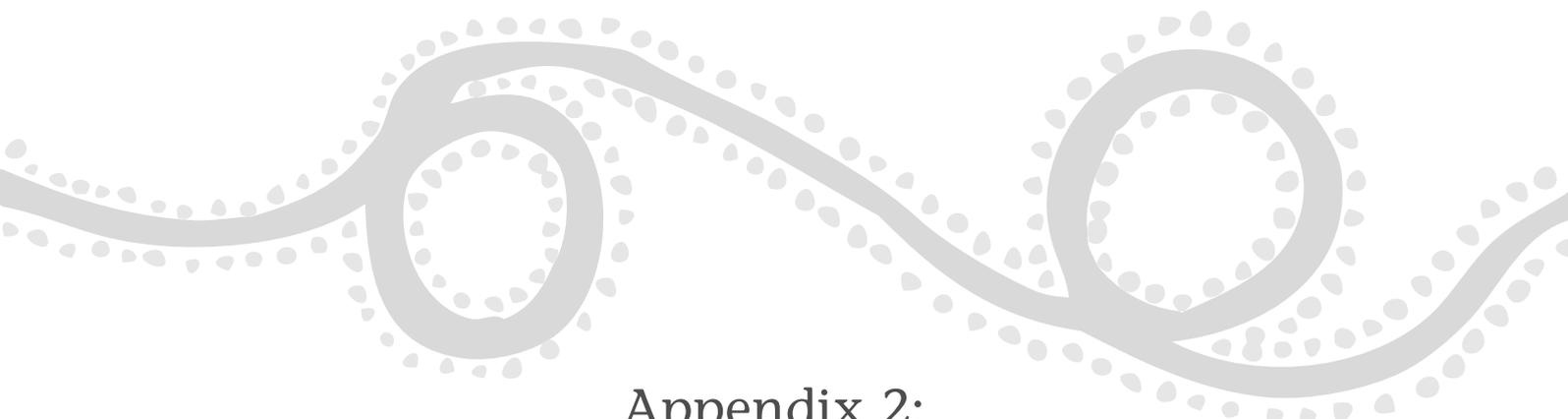
# Appendix 2:
# Funding Programs Reported by Sample ACCHSs

**Health program funding to 21 sample ACCHSs in 2006–07**

| Program name | Program description | Main source of funding |
|---|---|---|
| Aboriginal Health Promotion and Chronic Care | Support for community health services and ACCHSs to work collaboratively to improve health outcomes for Aboriginal people with, or at risk of, chronic disease | State health authorities |
| Adult continuing care | Assessment, treatment and continuing care and case management for adults with a mental illness | State health authority |
| After-hours clinic | To enable clinic hours to be extended | DoHA |
| Aged care and respite house | Provide low and high residential care, as well as aged care packages in the community | DoHA |
| Best Start | Improve health, education and development for Aboriginal children from birth to five years | State department of child protection |
| Bringing Them Home | Support for individuals and families, and related services to communities, affected by the forced removal of children | DoHA |
| Building Healthy Communities | To support people with chronic diseases | DoHA |
| Child and maternal health | Support, information and advice regarding parenting, child health and development, child behaviour, maternal health and wellbeing, child safety, immunisation, breastfeeding, nutrition and family planning. Parent groups and an opportunity to meet other parents in the local area | DoHA State health authority |

| | | |
|---|---|---|
| Child health | Immunisation, school-aged screening, child growth monitoring in the under-fives and nutrition. Includes health promotion, disease prevention, surveillance and screening. Focus on improving child health through early detection, early intervention and follow-up treatment or referral to tertiary services | DoHA |
| Chronic diseases | Provide treatment, prevention and early detection of chronic illnesses such as asthma, cancer, cardiovascular disease, diabetes mellitus, musculoskeletal conditions and stroke | DoHA |
| Dental | School dental care, emergency and adult dental care, dental health promotion for people with diabetes and chronic illnesses, people with missing teeth, and young adults | State health authority |
| Disabilities support | Direct help for those with disabilities | State health authority |
| Dog Health | To improve the health of animals in remote Indigenous communities by controlling disease and parasites, which could be passed on to people, particularly children, who come into close contact with the animals | DoHA<br>FaHCSIA |
| Eye Health Program | To improve the eye health of Indigenous people | DoHA |
| Falls prevention | To prevent older people from falling | DoHA |
| Health promotion and education | To deliver health promotion or education for various health issues | DoHA<br>State health authority |
| Healthy for life | Maternal and child health, prevention and care for people with a chronic condition | DoHA |
| Hearing Health | To improve the ear health and hearing of Indigenous people | DoHA |
| Home and Community Care | Support for daily living meal preparation and delivery, laundry, personal assistance, cleaning and transportation | DoHA<br>State health authority |
| Home-based outreach support | Support to people with mental illnesses in their home, as well as for homeless people | State health authority |
| Male health | Male sexual health, health education and health checks | State health authority |
| Maternity care enhancement | Support for women in postnatal period | State health authority |
| Medical specialist outreach | To improve access for people living in rural and remote Australia to medical specialist services | NGO |
| Mobile clinic | Mobile imaging with relay to specialists in capital city | State health authority |
| Nutrition | To improve healthy eating habit | State health authority |
| Patient Assistance Transport Scheme | Financial support for country patients and approved escorts to cover some travel and accommodation costs (for travel over 100 kilometres) to receive specialist medical treatment not locally available | State health authorities |

| | | |
|---|---|---|
| Petrol Sniffing Prevention | Reduce incidence and impact of petrol sniffing in a defined area of remote Australia by providing Opel fuel, monitoring of treatment and respite | DoHA |
| Physiotherapist | Physiotherapy services | State health authority |
| Podiatry | To provide podiatry service | State health authority |
| Primary Health Care Access Program | Expansion of comprehensive primary health care including clinical care, illness prevention and early intervention activities | DoHA |
| Public and Environmental Health | Public health intervention, focused on housing and health *hardware*, and other social determinants of health | State health authority |
| Self-management | Improve health and wellbeing of those with a chronic illness by encouraging active management, better communication with families and general practitioners | DoHA |
| Sexual Health and Blood Borne Virus Strategy | Prevention of spread of HIV, other sexually transmitted infections and blood-borne viruses in communities by maintaining data on testing, treatment and contact tracing of sexually transmitted infections (including chlamydia, gonorrhoea, syphilis, HIV and trichomonas) | DoHA |
| Social and Emotional Wellbeing | To improve the wellbeing of Aboriginal and Torres Strait Islander communities using a broad definition, including but not limited to mental health | DoHA |
| Substance or alcohol abuse/ misuse | Prevention, emergency/detoxification, and treatment for individuals and families at risk of or affected by substance abuse | DoHA State health authority |
| Suicide prevention | Addressing suicide prevention across the community and strengthening population health approaches to reducing risk of suicide | DoHA |
| Uwankara Palyanku Kanyintjaku | Public health intervention focused on housing and health *hardware* and other social determinants of health | State health authority |
| Women's health | Education, support, screening, clinical care and follow-up for young women's health education, reproductive health, cervical and breast screening, staff support and ongoing education | DoHA State health authorities |

## Community and social program funding to sample ACCHSs

| Program name | Program description | Main source of funding |
|---|---|---|
| Carer crisis support | Support carers, families and friends of people with mental illness with information, financial assistance or general support | State health authority |
| Child abuse | Prevention and early detection of child abuse | FaHCSIA |
| Child care | Provide childcare services | FaHCSIA<br>State health authority |
| Community benefit | One-off project funding for work to improve wellbeing, quality of life, community participation and life management skills of disadvantaged individuals and communities; and to develop and strengthen communities across metropolitan, rural and remote regions | State health authority |
| Community Development Employment Projects | Employment in community initiatives to develop participants' work and employment skills | DEEWR |
| Community engagement | Engaging families and community to address various problems from education, health, family violence or social interaction problems | State community services department |
| Emergency Relief Program | Assists people in immediate financial crisis | FaHCSIA |
| HOPE–SRA | Address the complex interface between antisocial behaviour and education | FaHCSIA |
| In-home support | Assist Aboriginal families to improve parenting capacity and health, development, learning and wellbeing of Aboriginal children aged zero to three years | State health authority |
| Indigenous Family Violence | To prevent and reduce Indigenous family violence and child abuse through safe houses, night patrols, counselling services, support workers, perpetrator programs and education programs | FaHCSIA<br>State health authority |
| Indigenous parenting program | Strengthen parenting skills and support the development, learning and wellbeing of Indigenous children | FaHCSIA |
| Kinship | To provide support for family members who look after children | State health authority |
| Link Up Program | Tracing, locating and reuniting Aboriginal and Torres Strait Islander people forcibly removed from their families and communities | DoHA |
| National Aborigines and Islanders Day Observance Committee | Supports celebration of Indigenous culture | FaHCSIA |

| | | |
|---|---|---|
| Night patrol | Safety through transport home or to refuges and safe houses for people at risk of offending or victimisation | FaHCSIA |
| | | Attorney General's Department |
| Our Journey to Respect | Intergenerational violence prevention program targeting young Aboriginal males 14–18 years | State health authority |
| Safe House | Temporary accommodation for women and children who are victims of family abuse | FaHCSIA |
| Sport and recreation | To provide assistance to develop sport and recreation activities in the community | Department of Sport and Recreation |
| Whiz Kidz | Support kids to be active and do more physical activity | FaHCSIA |
| Youth art performance | Performing arts opportunities for Indigenous children, young people and their communities | FaHCSIA State arts department |
| Youth leadership program | To train Indigenous youth to be inspiring and effective leaders who will make positive differences to the lives of Indigenous people | FaHCSIA |

**Management, HR and ICT funding to sample ACCHSs**

| Program name | Program description | Main source of funding |
|---|---|---|
| Fringe Benefit Tax | A tax payable by employers for benefits paid to an employee or the employee's associate in place of salary or wages. Examples of benefits include a car, car parking, low interest loan and payments of private expenses | DoHA |
| Health worker training | Certificates II, III, IV in Aboriginal and Torres Strait Islander Primary Health Care, Certificate IV Community Care and Aboriginal and Torres Strait Islander Primary Health Care (Practice), or administrative and information technology training to help people to get jobs, as well as training for general practitioners, nurses and other health professionals | DoHA<br>DEEWR |
| Managed health network | Secure network that connects general practitioners, specialists, hospitals, age cared facilities and allied health providers through a series of services and applications such as shared electronic health records, secure communication and tele-health | DoHA |
| Patient Information Recall System | This provides database, a patient's medical record inside clinics and to offsite medical officers at the time of the consult, electronic pathology results and other correspondence, electronically lodged Medicare claims | DoHA |
| Project Ferret | IT system to support chronic disease prevention and management programs | State department of health |
| Quality Improvement Initiatives | To support the implementation of quality improvement initiatives in the ACCHS | DoHA |
| Service Development Reporting Framework | To support the implementation of SDRF program | DoHA |

**Judith Dwyer** is Professor and Head of Health Care Management in the Flinders University School of Medicine, where she teaches in a Master of Health Administration and conducts research on health systems and services. She is a former Chief Executive of Southern Health Care Network in Melbourne and Flinders Medical Centre in Adelaide, and was the inaugural President of Women's Hospitals Australasia. She grew up in rural Queensland, and has a long-standing interest in health care for Aboriginal and Torres Strait Islander people.

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**Patrick Sullivan** is an anthropologist who has studied the engagement of Aboriginal people with the Australian public sector since his introduction to the Kimberley region, Western Australia, in 1983. Much of his professional life has been spent working with independent Aboriginal organisations. He is the author of numerous scholarly articles, as well as practical reports, and the book *All Free Man Now: Culture, Community and Politics in NW Australia* (Aboriginal Studies Press, Canberra, 1996).