

# The Road Is Made by Walking:

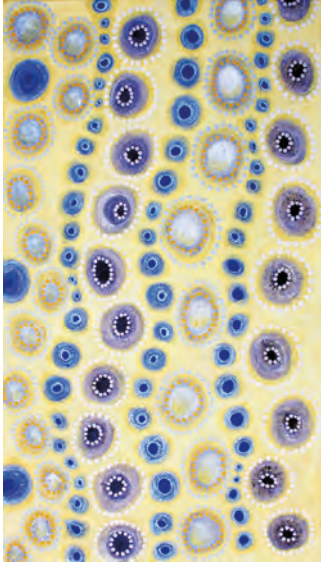
Towards a better primary health care  
system for Australia's First Peoples

Report

JULY 2015

Judith Dwyer  
Angelita Martini  
Cath Brown  
Edward Tilton  
Jeannie Devitt  
Paula Myott  
Brita Pekarsky

## ARTWORK



### About the artist

Karen Kulyuru was born in 1969 and raised in Ernabella (Pukatja) on the Anangu Pitjantjatjara/ Yankunytjatjara Lands. Karen first learned to paint by watching her mother, and comes from a family of batik silk artists. She started painting at Ernabella Arts and Crafts many years ago. Karen lives in Adelaide with her family and children and regularly attends professional development workshops at Better World Arts. Her paintings have been exhibited extensively across Australia.

### About the artwork

Tjukula (Rockholes) 2012

Acrylic and sand on canvas

61 x 107 cm

Better World Arts catalogue KKU0073

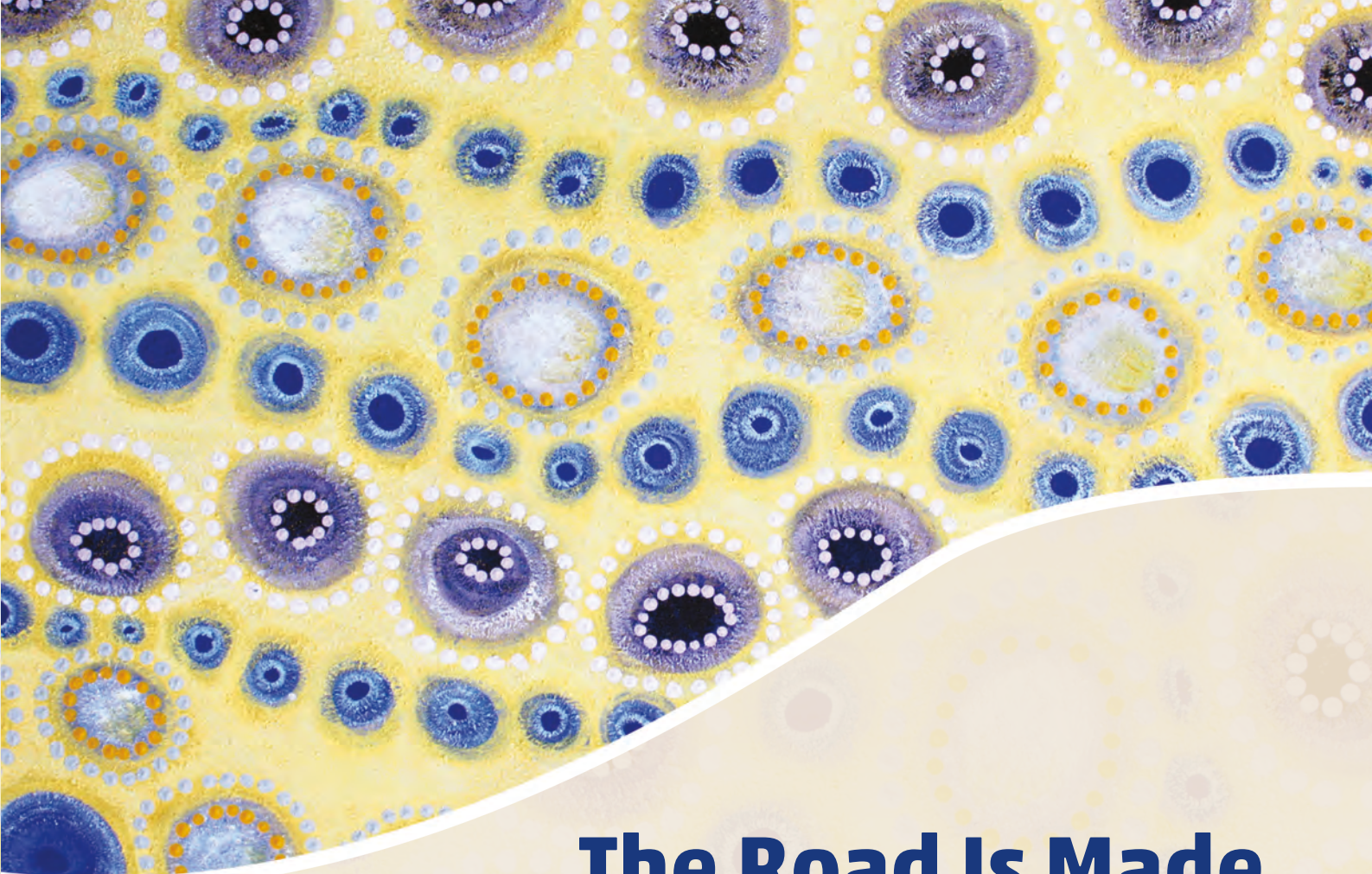
This painting was produced during the 'Manta' (earth) workshops. Karen describes her painting as Walka. Walka is any meaningful mark or pattern and may be an image on a cave wall, on rock or on sand and has cultural and ritual significance. It is used on the body during inma or ceremony. This painting is reminiscent of the designs that are created on batik. Karen's work is heavily influenced by the beautiful batik designs she painted alongside her mother Angkuna and sister Unurupa from the 1970s onwards in the Ernabella craft room.

Batik designs evolved from a mixture of traditional imagery, Indonesian influences, as well as the early Walka drawings painted at the Ernabella mission school in the 1940s and 50s. Karen's mother Angkuna was prolific in her craft making and produced beautiful lengths of fabric, many of which are in public and private collections. Karen painted batik for many years and this influence is still visible in her highly decorative, detailed paintings today.

Important traditional symbols are still placed within these works, including tjukula (rockholes represented by concentric circles), creek beds and bush foods for harvesting. This painting depicts rockholes (tjukula), and sandhills surrounding them. Karen is influenced by the beautiful colours and shapes of the landscape. She uses both desert tones and brighter hues in her works and often illustrates aspects of nature from the desert country where she grew up, to the flora here in Adelaide, where she has lived for many years.

## REPORT TITLE

The title is taken from Antonio Machado's poem 'We make the road by walking' in *Selected Poems of Antonio Machado*, Louisiana State University Press, Baton Rouge, LA, 1978.



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the  
**Lowitja**  
Institute

Australia's National Institute for Aboriginal and  
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**Flinders**  
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# About this report

This publication is one of five that report on the work of the **Funding, Accountability and Results (FAR)** project, all published by the Lowitja Institute in 2015.

FAR is a study of reforms in primary health care for Aboriginal and Torres Strait Islander communities in the Northern Territory (between 2009 and 2014) and Cape York, Queensland (between 2006 and 2014). The study background, its aims and methods, case studies,

findings and conclusions, and the suggested essential elements of reform are reported in the project report and the summary report.

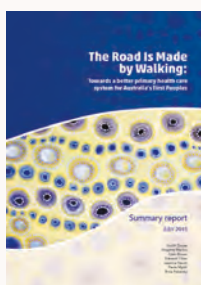
Two brief histories of the project research partner organisations and a case study have also been prepared in order to contribute to the record of development of the broader Aboriginal community controlled health sector in Australia, to give context to the larger research study, and for our partners' own use.



## Project report:

### ***The Road Is Made by Walking: Towards a better primary health care system for Australia's First Peoples – Report***

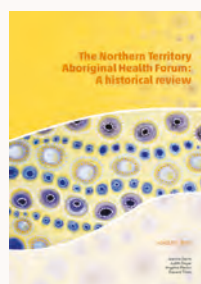
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## Project summary report:

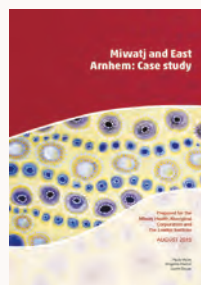
### ***The Road Is Made by Walking: Towards a better primary health care system for Australia's First Peoples – Summary Report***

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Jeannie Devitt, Judith Dwyer, Angelita Martini and Edward Tilton  
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Paula Myott, Angelita Martini and Judith Dwyer  
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### ***Towards a History of Apunipima Cape York Health Council, 1994–2006***

Edward Tilton, Angelita Martini, Cath Brown and Kristy Strout  
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# Abbreviations

<b>ACCHO</b>	Aboriginal Community Controlled Health Organisation	<b>IPHCI</b>	Improving Primary Health Care Initiative
<b>AMSANT</b>	Aboriginal Medical Services Alliance Northern Territory	<b>KPI</b>	key performance indicator
<b>ATSIC</b>	Aboriginal and Torres Strait Islander Commission	<b>MBS</b>	Medical Benefits Schedule
<b>CCT</b>	Coordinated Care Trial	<b>NACCHO</b>	National Aboriginal Community Controlled Organisation
<b>CEO</b>	Chief Executive Officer	<b>NGO</b>	non-government organisation
<b>COAG</b>	Council of Australian Governments	<b>NT</b>	Northern Territory
<b>CPHAG</b>	Clinical and Public Health Advisory Groups	<b>NTAHF</b>	Northern Territory Aboriginal Health Forum
<b>CYHHS</b>	Cape York Health and Hospital Service	<b>NTER</b>	Northern Territory Emergency Response
<b>DoHA</b>	Department of Health and Ageing	<b>NTH</b>	Northern Territory Department of Health
<b>EASC</b>	East Arnhem Steering Committee	<b>OATSIH</b>	Office for Aboriginal and Torres Strait Islander Health
<b>EHSDI</b>	Expanded Health Service Delivery Initiative	<b>PBS</b>	Pharmaceutical Benefits Schedule
<b>FAR</b>	Funding, Accountability and Results	<b>PHC</b>	primary health care
<b>FNQRDGP</b>	Far North Queensland Rural Division of General Practice	<b>PHCAP</b>	Primary Health Care Access Program
<b>FRP</b>	Final Regionalisation Proposal	<b>PHRG</b>	Primary Health Reform Group
<b>GP</b>	general practice	<b>PwC</b>	PricewaterhouseCoopers
<b>HAT</b>	Health Action Team	<b>QAIHC</b>	Queensland Aboriginal and Islander Health Council
<b>HHS</b>	Hospitals and Health Services	<b>RaDU</b>	Reform and Development Unit
<b>HSDA</b>	Health Service Delivery Area	<b>RFDS</b>	Royal Flying Doctor Service
<b>ICT</b>	information and communications technology	<b>RPU</b>	Regional Planning Unit
		<b>SOG</b>	Senior Officers Group
		<b>USA</b>	United States of America

## Terminology

In keeping with usage in the Aboriginal Community Controlled Health sector, the term 'Aboriginal' is sometimes used in contexts that may also apply to Torres Strait Islander people. The term 'mainstream' is used to mean non-Indigenous institutions and organisations.

The names of all government departments and several other organisations have changed during the study. For simplicity, we use the names that were current in December 2014.

# Executive summary

The research reported here is a study of reforms in primary health care (PHC) for Aboriginal and Torres Strait Islander communities in the Northern Territory (between 2009 and 2014) and Cape York, Queensland (between 2006 and 2014). In both places, the intention of the reforms was twofold: to establish a regional system of PHC provision with reliable access to care for all Aboriginal and Torres Strait Islander communities in the regions, and to increase community control of health care by transferring some or most of the responsibility for providing PHC from government health authorities to regional Aboriginal Community Controlled Health Organisations (ACCHOs). These were bold plans with long histories of development in both jurisdictions.

The study aimed to contribute two kinds of knowledge. The first concerns the question of how to implement health policy and health system reforms effectively. The second concerns the substance of the reforms needed to achieve the policy goal. That is, we aimed to learn about what needs to be changed, as well as how to implement the changes. The study, conducted from September 2011 to December 2014, was done so as to understand the reforms while they proceeded on their own timelines and agendas.

We aimed to provide a coherent description of reforms in PHC for Aboriginal and Torres Strait Islander communities in the Northern Territory and in Cape York, Queensland, and an analysis of what helped and what got in the way of progress, and what might be done differently in the future. The research was structured as a set of three case studies that focused on two reforms:

- the regionalisation program led by the Northern Territory Aboriginal Health Forum (NTAHF) between 2009 and 2014 and outlined in *Pathways to Community Control* (NTAHF 2009) (Case studies 1 and 2)
- the Transition to Community Control project in Cape York (Case study 3).

Although significant progress was made towards the development of a regional PHC system, the reforms were beset by implementation barriers and difficulties in authorisation, auspice and control; inadequate resources (money, time and capacity); and in working across cultures and in partnership.

The study considers implications for future development, in particular in regionalisation, for governance and stewardship, and in funding, contracting and accountability. It proposes six essential elements of substantive change that should be addressed in future work to develop a regional system of community controlled PHC for Aboriginal and Torres Strait Islander communities.

In order to commit to increased investment in community-governed PHC:

- governments require assurance of performance in delivery of high-quality care
- governments need to accept that the current methods of funding and contracting are not a suitable instrument to ensure performance in this context, and need to work with the sector to develop longer term and less complex and fragmented approaches.

In addition:

- the ACCHO sector requires long-term assurance of funding and acceptance of its role in the health system
- the sector and government need to accept the implications of a negotiated understanding of regionalisation and reformed engagement with each other
- all parties need to work together in an enduring structure for partnership and to develop a workable approach to reciprocal accountability.

## Study conclusions

The study concludes that future reform programs will require:

- More secure authorisation and auspicing to succeed in this complex cross-agency and cross-cultural endeavour
- More attention to realistic time and resource allocations (both human and material) and the negotiation of explicit commitments
- Foundation on a solid explicit basis for working across cultures that acknowledges and mitigates the impacts of systemic racism and recognises the impacts of the different contexts in which community and government representatives work.

In relation to the future development of the PHC system for Aboriginal and Torres Strait Islander communities, the study concludes that:

- Future reforms should continue to use a regional approach, under Aboriginal community control, and should develop coherent regional systems for funding and governance, and for coordinating PHC services among all providers across the region
- Increased funding is needed to support adequate coverage and access to culturally safe PHC across and within regions, and levels should be based on the size of the regional populations (weighted for risk and cost factors) and distributed to providers within regions with fairness and transparency

- Enduring reform in the funding and accountability relationship between government and the ACCHO sector should be based on long-term contracts for bundled or pooled funds to support comprehensive PHC, and a modified accountability regime more suitable to the functioning of PHC and to the shared responsibilities of providers and governments.

Increased investment in community-governed PHC requires long-term commitment and strong leadership. The goal of equitable access for Aboriginal and Torres Strait Islander communities to PHC through a regionalised network of ACCHOs working with the mainstream health system is achievable, and action to achieve it should commence—or recommence—as soon as possible.



# Introduction

The research reported here is a study of planned reforms in primary health care for Aboriginal and Torres Strait Islander communities in the Northern Territory (between 2009 and 2014) and Cape York, Queensland (between 2006 and 2014). In both places the intention of the reforms was twofold: to establish a regional system of PHC provision with reliable access to care for all Aboriginal communities in the regions and to increase community control of health care by transferring some or all of the responsibility for providing PHC from government health authorities to regional Aboriginal Community Controlled Health Organisations. These were bold plans, with long histories in both jurisdictions.

The process of reform in both places has been more difficult and complex than originally anticipated, and the results to date have fallen short of policy and timing expectations. Although this has been frustrating for all involved, substantial progress was made and many valuable lessons can be learned from the experience. This report examines the main lessons, and thereby seeks to contribute to greater success in continuing, and future, reform efforts of this nature. It aims to do this by providing a coherent description of what happened, an analysis of what helped and what got in the way of progress, and what might be done differently in the future.

This study is structured as a set of three case studies. In the Northern Territory, the first case study examines the Northern Territory Aboriginal Health Forum (NTAHF), which led the reform policy and process for the Northern Territory, and the second examines the East Arnhem Region (where Miwatj is the main regional ACCHO). For Queensland, one case study presents both the Queensland policy context and the experience of reform in Cape York (where Apunipima Cape York Health Council is the regional ACCHO).

## Background to the reforms: The PHC system, the ACCHO sector and the policy environment

The Aboriginal community controlled health sector was initiated by Aboriginal and Torres Strait Islander people in the 1970s as a response to the continuing poor health of Aboriginal communities and the barriers and discrimination they faced in many mainstream health services. The ACCHO sector now constitutes a significant part of the Australian health system, with approximately 150 ACCHOs of varying size delivering PHC (NACCHO n.d.a; Martini et al. 2011) to between one-third and one-half of the Aboriginal and Torres Strait Islander population in rural, remote and urban settings (NHHRC 2009:87; NACCHO 2009:2–3).

Despite being recognised as centrally important to the delivery of PHC to Aboriginal and Torres Strait Islander communities since (at least) the acceptance of the 1989 National Aboriginal Health Strategy (NAHSWP 1989), the establishment of ACCHOs has been opportunistic rather than based on a coherent national plan. Instead, the distribution and relative size of ACCHOs has developed as the outcome of several factors, including state/territory government approaches to direct provision of PHC; the initiative of communities to establish ACCHOs and their success in persuading governments to resource them; the history, geography and cultural relationships of communities; local factors in the mainstream health system; and efforts by ACCHOs and governments to work towards equitable distribution of services as and when resources are available (Anderson & Sanders 1996; Shannon & Longbottom 2004).

The distribution and size of PHC services provided by state and territory governments

is similarly contingent, affected by history and geography and the efforts of governments to ensure some level of coverage for all communities. The distribution and size of mainstream general practice (GP) services is affected by market forces (which generally favour cities and large population centres), incentives in the funding policies of government, and the preferences and capacities of practitioners. The resultant patchwork of services results in considerable inequity in access and difficulties in ensuring coverage for the whole population. This inequity is reflected in poorer health outcomes for Aboriginal and Torres Strait Islander and mainstream populations in rural and remote areas (AIHW 2014:7–10), although access to care is not the only factor underlying the observed differentials.

### The ACCHO sector

ACCHOs aim to provide comprehensive PHC and to advocate on behalf of their communities for effective health policy and improved access to services and resources for health, including in the mainstream health system. The National Aboriginal Community Controlled Organisation (NACCHO) and state and territory affiliates are the peak bodies for the sector and take the lead in advocacy and in providing support for ACCHO member organisations. The structural relationships between the sector and governments are robust and long term. However, they are also characterised by heightened political sensitivity, partly as a result of the ACCHOs' combined role of service provider and representative organisation (Sullivan 2009).

The dual role of ACCHOs (service delivery and representation) has been formally accepted by all national and jurisdictional governments, which have committed to a policy framework that endorses comprehensive PHC provided by organisations that 'maximize community ownership and control' (NATSIHC 2003:1), and the Australian Government has renewed that position in the National Aboriginal and Torres Strait Islander Health Plan (Commonwealth of Australia 2013). Although these policy positions are not consistently supported in public

administration or policy debate (Anderson 2006; Sullivan 2011:Ch 5), the sector does work, and needs to be supported and regulated, as part of the health system.

Policy support for community controlled health services is based on the significant history of achievements by the sector since the 1970s (Dwyer, Silburn & Wilson 2004; Shannon et al. 2002) against a background where access to care for Aboriginal and Torres Strait Islander people had been restricted both formally (in laws and regulations) and informally (in practices by mainstream hospitals and other health care providers) (Anderson et al. 2006).

There is a small body of evidence in the research literature regarding the effectiveness of the sector. Finding an appropriate benchmark is problematic. ACCHOs routinely provide care for an Aboriginal and Torres Strait Islander population with more serious and complex health needs; they frequently operate in rural, remote or outer-suburban areas unsuited to the business model of mainstream private practice; and they aim to provide comprehensive PHC that goes beyond the treatment of individual clients for discrete medical conditions (Mackay, Boxall & Partel 2014; Thompson et al. 2013; NACCHO 2014).

Available evidence supports the effectiveness of both the clinical and community services provided by ACCHOs. A recent review on the effectiveness of ACCHOs compared to mainstream PHC services found that although only a few studies directly compare the two service types, their performance is comparable (i.e. no evidence of difference in the clinical outcomes) (Thompson et al. 2013). The limitation of this review is that it was necessarily restricted to studies comparing ACCHOs and GPs only on the services provided in both models to the patients they reach, thus excluding many of the broader health promotion and prevention roles of ACCHOs, functions that are widely agreed to be important in building better health in disadvantaged communities.

This review was also unable to assess other relevant aspects of effectiveness, for example, the well-documented preference for community



controlled health services by a majority of the Aboriginal and Torres Strait Islander population (e.g. Taylor et al. 2012:44). The ACCHOs' provision of the culturally secure care that underlies this preference helps to address problems of access to PHC and adherence to treatment regimes, both of which are recognised barriers against effective treatment for Aboriginal and Torres Strait Islander people across the health system (Askew et al. 2014a; Vos et al. 2010; Mackay, Boxall & Partel 2014; Thompson et al. 2013).

Despite these limitations, ACCHOs have been shown to be more effective within the narrower boundaries of clinical service provision. As one recent review (Mackay, Boxall & Partel 2014:6) concluded:

**some studies [show] that [ACCHOs] are improving outcomes for Aboriginal people, and some [show] that they achieve outcomes comparable to those of mainstream services, but with a more complex caseload.**

In addition, there is good evidence that ACCHOs are effective in supporting the delivery of specialist services (Thompson et al. 2013), enhancing access for Aboriginal and Torres Strait Islander people. The increased effectiveness of the ACCHO model does come at a higher cost in terms of resources, as might be expected for the provision of care to high-need populations frequently located in rural or remote regions where the delivery of cross-cultural care is also often a significant challenge (Ong & Ahmed 2012).

ACCHOs also frequently provide services beyond individual clinical care, to attend to or advocate for clients and their families in relation to access to care, as well as broader determinants of health. This 'wrap around' approach is rarely part of mainstream practice but may be critical to support improved health outcomes. Key elements of such additional services include (see AMA 2011; Thompson et al. 2013; Mackay, Boxall & Partel 2014; NACCHO 2014; Askew et al. 2014b):

- assistance with client access to PHC (e.g. patient transport, outreach services)

- support for clients to overcome barriers to care elsewhere in the health system
- a focus on public health (e.g. skilled advocacy for positive change in addressing the social determinants of health)
- advocacy for high-level policy or system change
- a commitment to cultural security, both within the ACCHO itself and as an educator of mainstream services in the provision of culturally competent care
- formal, community-led structures for community participation, engagement, empowerment and control.

Internationally, there is some evidence of better health care and improved health outcomes in places where there has been a regional transfer of PHC services to community control. Lavoie et al. (2010) demonstrated decreased levels of avoidable hospitalisation for First Nations communities in Canada following the transfer of control of health services from government to the community. There is also some evidence that Māori providers in New Zealand have had an impact on both access to and quality of PHC (Ministry of Health 2004).

Within Australia, evaluations of the three Coordinated Care Trial transfers of health service to Aboriginal and Torres Strait Islander control in the 1990s (Katherine West, Sunrise and Tiwi Islands), although unable to demonstrate direct benefits in terms of health outcomes, documented improved PHC services, including better access to key health staff (doctors and Aboriginal Health Workers, in particular), an improved focus on population health/health promotion, better cultural security and increased employment of Aboriginal and Torres Strait Islander staff (Bailie, Menzies School of Health Research Local Evaluation Team & KWHB 2000; WHO 2003; DoHA 2007).

ACCHOs are also significant employers of Aboriginal and Torres Strait Islander people, with more than 3000 employed in the sector. It is claimed to be the largest industry employer of Aboriginal and Torres Strait Islander people in Australia (NACCHO 2014).

### **Policy settings: Need for reform of complex funding and regulation**

The ACCHO sector (along with other providers of Indigenous-specific PHC) is funded and held accountable through a complex array of short- to medium-term funding contracts. This contrasts with the mainstream health system, where essential basic care is either provided directly by government or funded through long-term arrangements such as the Medical Benefits Schedule (MBS) and the Pharmaceutical Benefits Schedule (PBS).<sup>1</sup>

ACCHOs generally receive funding from both the Australian Government and jurisdictional health authorities, and also from family and community service departments and other government sources. Funding provides for a mix of basic PHC (including MBS-funded services) and a range of specific programs and purposes. Generally, each contract (or grant) has its own requirements for both financial and activity reporting. ACCHOs use the funding to provide a broad range of services from acute primary care and management of chronic diseases to dental clinics, mother and baby programs, sexual health services, broad health promotion, youth programs, hearing programs and so on.

The cost and efficiency problems caused by the complex contractual environment for Aboriginal services, in relation to both funding and reporting requirements, are well documented (e.g. Moran, Porter & Curth-Bibb 2014; Martin 2014; Eagar & Gordon 2008; Morgan Disney and Associates 2006) and generally acknowledged. The *Overburden Report* (Dwyer et al. 2009, 2011)

has described the more fundamental problem in the current arrangements whereby the 'patching together' of many targeted funding programs works against the delivery of comprehensive PHC that is responsive to community needs. The direct and indirect costs of this are seen in compromised capacity to respond to local priority health needs, to attract and retain a skilled workforce, and to develop and then evaluate effective models of care, as well as in higher administrative workloads.

The piecemeal approach to funding undermines strategic, needs-based allocation of resources to regions or communities, and makes it highly challenging and complex to apply the usual methods (like funding formulas) to ensure equity. There is no single source of comprehensive information about the funding received by ACCHOs, and no overview of the associated reporting requirements. The frequently changing sources and purposes of funding also mean that it is not always clear what is intended to be covered by which source of funding. So, for example, particular activities like accreditation may be specifically funded in some places and at some times, but when the funding program ceases may not be replaced with additional 'built in' funds to cover these ongoing costs.

The sector has long recognised the need to reform funding and accountability arrangements so that they support the development of a robust PHC system for Aboriginal and Torres Strait Islander people. Governments have also recognised this problem (e.g. OATSIH 2010) and are sensitive to the charge of a failure in their stewardship responsibilities as they seek to 'close the gap' between health outcomes for Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians.

Commonwealth, state and territory governments face significant challenges in administering this complex funding system at both ends—the

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<sup>1</sup> Mainstream health non-government organisations are also subject to the burden of complex contractual environments, but are generally funded to provide a narrow range of services as part of essential basic care. This situation has been the subject of increasing concern and policy attention (Commonwealth of Australia 2009; Productivity Commission 2010).





process of allocation is disseminated among multiple programs and departments, and the recipient organisations are highly diverse in size, circumstance and robustness. Regionalisation is attractive to governments partly because it offers a method of reducing both types of complexity: allocations would be 'pooled' or 'bundled' at regional level, and funds would be allocated to a smaller number of larger (regional) ACCHOs. These changes could also reduce the need for staff in capital cities to be informed about local factors in order to make good decisions centrally, as these factors would be taken into account in decisions made at the regional level. Good decision making for local services at central levels is always a challenge and is made harder by the practice of frequent turnover among senior government officers.

The planned reforms had the potential to address the disconnect between policy goals (better health and health care) and funding and accountability methods through significant change in arrangements for the governance, delivery and funding of, and accountability for, PHC. The reforms generally aimed to make PHC for Aboriginal and Torres Strait Islander communities more effective through improvements in the methods and/or amount of funding; through streamlining accountability measures; through changes in the governance of health care providers (in keeping with the principles of community control); and in the ways that governments fulfil their stewardship responsibilities for the strength and sustainability of the health care system (NTAHF 2009a; QAIHC 2011; QH 2011b).

## Experience of transfer of health care to Indigenous organisations

Indigenous health care organisations in Australia and comparable countries (Canada, New Zealand and the United States of America (USA)) have significant origins in community aspirations and organising (Anderson 2006; Lavoie 2004; Durie 1994). There are several common elements, despite important differences, between these countries in

the cultures, histories, and legal and policy frameworks that have shaped health and health care for indigenous peoples. However, there have been two quite different pathways for the development of indigenous health services: ground-up development initiatives by communities or their representative organisations (particularly in New Zealand and Australia); and policy-driven transfers of ownership and governance of existing health services from government health departments to participating indigenous organisations (particularly in Canada and the USA) (Lavoie et al. 2005; Adams 2000).

The historic handover of responsibility for health care in discrete indigenous communities in Canada is a model of largely successful transfer. In 1989 Health Canada (through the First Nations and Inuit Health Branch) commenced a national process of transfer of primary health services from government provision to ownership by the local governments of the communities. This transfer was accompanied by significant changes in funding methods towards more relational contracts (i.e. more comprehensive, flexible and longer term funding) (Lavoie et al. 2005). More recently (2011–12) in British Columbia, responsibility for system stewardship and the allocation of funding to First Nations PHC organisations has been transferred from the First Nations and Inuit Health Branch to the British Columbia First Nations Health Authority (First Nations Health Council, Government of Canada & Government of British Columbia 2010).

In the USA the possibility of a shift from direct provision of health care by the Indian Health Service, a federal government organisation, to local community management evolved more slowly. Necessary legislative changes were made progressively from 1974 to 1994, making transfer gradually more workable, partly through increasing flexibility in funding arrangements (Adams 2000). Adam's (2000) study of transfer experience found that roughly one-quarter of eligible communities had taken up transfer (equivalent to community control as understood in Australia) and that communities that had been better served by the Indian Health Service

(measured by numbers of indigenous managers and per capita expenditure on health) were less likely to undertake full transfer. The Indian Health Service retains some direct provision and national stewardship and reporting functions.

In New Zealand, health system changes in the 1990s provided a significant opportunity for Māori communities to develop and grow PHC services, but there was little direct transfer of existing clinics, staff or capital resources (Cunningham & Durie 1999). In Australia, direct transfer of PHC provision (including staff, records, capital equipment etc.) from government to Aboriginal and Torres Strait

Islander organisations has largely been opportunistic and on a case-by-case basis, with the notable exception of transfers driven by the Coordinated Care Trials (see next page).

Although it is beyond the scope of this report to identify all cases across Australia where government PHC services have been transferred to community control, Table 1 lists significant known transfers since 1995 when the Australian Government Department of Health (henceforth the Department of Health) took over responsibility for the funding and administration of ACCHOs from the Aboriginal and Torres Strait Islander Commission (ATSIC).

**Table 1: Transfers of significant clinics/health services to community control since 1995**

Service	Jurisdiction	New auspice/incorporation	Year
Lajamanu	NT		1998
Kalkaringi	NT	Katherine West Health Board	
Timber Creek	NT		
Yarralin	NT		
Milikapiti	NT		1998–2003
Nguiu	NT	Tiwi Health Board	
Pirlangimpi	NT		
Ngukurr	NT		2005
Barunga	NT	Sunrise Health Service	
Wugularr	NT		
Bulman	NT		
Mataranka	NT		
Minyerri	NT		
Ngalkanbuy (Galiwin'ku)	NT	Miwatj	2008
Yirrkala	NT		2012
Ceduna Koonibba	SA	Ceduna Koonibba	2010
Pika Wiya	SA	Pika Wiya	2011
Yarrabah	QLD	Gurriny Yealamucka Health Service	2014

NT: Northern Territory; QLD: Queensland; SA: South Australia



Transfer in the Northern Territory was given powerful support by the Department of Health Coordinated Care Trial (CCT) program of the late 1990s and early 2000s (Commonwealth of Australia 2007), with transfers of 13 major clinics in remote areas to three new ACCHOs established under the CCT program. The three CCT sites were:

- **Katherine West Health Board**, which was established in 1998. All PHC services in the region were transferred to Aboriginal community control and government funds were pooled, with the Australian Government 'cashing out' MBS and PBS funds at the national average level (i.e. higher than existing levels for these communities). The increased funds led to a dramatic growth in PHC services across the region, including the first ever residential GP services and increased numbers of Aboriginal Health Workers, as well a greater focus on public health, health promotion and culturally secure care (Baillie, Menzies School of Health Research Local Evaluation Team & KWHB 2000).
- **Tiwi Health Board**, which was established through a similar process. The transition led to improved health promotion and prevention services (particularly in relation to mental health and chronic disease, and those tackling urgent local problems), an increased number and improved quality of primary health services, and greater employment of local people (WHO 2003). The Northern Territory Government resumed control of health services on the Tiwi Islands in 2003 as a result of the organisation's financial difficulties.
- **Sunrise Health Service**, which was established in 2002 and took over the delivery of PHC to the communities east of Katherine in the Northern Territory in 2005 using a funds-pooling/cash-out model. The evaluation of the transition found increased access to PHC services, improved community participation, upgrade of health service operations and infrastructure, and workforce development (DoHA 2007).

The remaining services in the Northern Territory transferred from Northern Territory Department of Health (NTH) clinics/centres to existing ACCHOs.

Two Aboriginal-specific PHC services in South Australia transferred from incorporation under the *Health Care Act 2008 (SA)* to incorporation under the *Corporations (Aboriginal and Torres Strait Islander) Act 2006 (Cth)* following changes to the structure of the government health system. However, these services already had their own largely Aboriginal boards (under the *South Australia Health Commission Act 1976* and in many ways consistent with the ACCHO model), and transfer was relatively straightforward. In Queensland one Aboriginal PHC service has transitioned to community control. The Yarrabah Health Service was established in 1980 and in 2000 began planning for the establishment of the Gurriny Yealamucka Health Services Aboriginal Corporation (three-year pilot/seeding grant). In 2010 the service co-located with the Queensland Health clinic and in 2014 transitioned to full community control of all PHC services for the Yarrabah people.

The experience of transfer has been largely successful, but it nevertheless involves several significant challenges. For government staff, transferring the employment relationship involves potential changes in security of tenure, leave entitlements, superannuation and other salary-related matters, and possible fears about stability of funding and marginalisation, as well as changes in accountability relationships. Transfer of funding is complicated by the roles of two levels of government with already complex funding relationships. And the transfer of material resources, including the management and potentially the ownership of PHC facilities, also requires planning and negotiation.

Large-scale transfer also brings questions of overall health system design and governance. Governments have responsibilities for health care that cannot be delegated and PHC services need to operate as part of a larger system. Although the Canadian and USA experiences demonstrate that these transitional challenges can be met, they require careful planning and management.

The case-by-case approach in Australia has not required major health system redesign, but the reforms in the Northern Territory and Queensland represent a (potential) departure from this approach. The experiences of Canada, and to a lesser extent the USA, indicate that systemic, policy-driven transfer is feasible, particularly for the discrete rural and remote Aboriginal communities of the Northern Territory and northern Queensland that are the subject of this study.

## Theoretical framework

The prevailing policy, funding and accountability arrangements for the ACCHO sector have arisen from the interplay of two separate and opposing frameworks—self-determination and community control on the one hand, and the public administration methods known as New Public Management (Pollitt 1995), with its use of (competitive) funding and performance contracts, on the other.

The ACCHO sector arose in the early 1970s from community activism, and has pursued the goals of better health and health care, as well as self-determination—a ‘by us, for us’ movement (Shannon et al. 2002:45; Anderson 1994). The Aboriginal health movement was founded on the belief that Aboriginal community ownership (or control) of PHC would result in better access to care and therefore better health. Decision making would be in the hands of the community, be based on intimate knowledge of community needs, and not be compromised by competing priorities, wrong assumptions or negative attitudes about Aboriginal and Torres Strait Islander people.

Approximately 15 years after the founding of the first ACCHOs, governments began to be influenced by a set of ideas about the role of government (among other things) that have come to be known as neoliberalism. Governments, particularly in the English-speaking industrialised world, have pursued the application of neoliberalism to public administration through New Public Management (Pollitt 1995). This approach underlies the move

to more explicit contracts for services, with the funder determining performance targets (cost, volume and quality).

There are several problems with this approach to contracting and accountability, including the assumption that the funder is able to determine the best approach to service delivery and the best use of resources (Sabel 2004). This is especially problematic when applied to funding of the community-based non-government organisation sector, where the rationale for using contractors rather than direct public sector delivery is based precisely on acknowledgment that the contracted non-government organisations know more about the needs of, and are closer to, the intended client groups, as is the case in Indigenous health care (Dwyer et al. 2014).

Contracting in health is characterised on a continuum from classical to relational contracting. Classical contracting seeks to specify in advance exactly what will be exchanged between the parties to the contract (as happens, for example, when a customer signs a contract to purchase a car or a hospital enters into a contract for cleaning services). Governments have sought to move towards more classical (and competitive) contracting partly to ensure that the providers of health care receiving government funding have the right incentives to deliver the volume, type and quality of care that government seeks and pays for. The problem of different interests and incentives is referred to as the principal:agent problem; that is, agents (the providers) and principals (the government funders) have different goals and incentives, and different access to information (the funder is largely dependent on the provider for accurate information about what they actually do and what difference it makes).

Relational contracting is an alternative approach, suitable for situations where it is difficult or impossible to specify completely the services that are required; where the development of a service system is necessary and requires long-term engagement; and where competitive



market conditions do not apply (e.g. when there is only one possible provider, as is the case for many ACCHOs in remote communities) (Lavoie, Boulton & Dwyer 2010). Relational contracting seeks to avoid or minimise the agency problem through the alignment of incentives for both parties based on shared goals and alternative forms of risk-sharing, and a closer working relationship with more information exchange. In the private sector this approach is also known as alliance contracting, which is (Clifton et al. 2002):

**an agreement between parties to work cooperatively to achieve agreed outcomes on the basis of sharing risks and rewards [with] the potential to deliver substantial cost and quality benefits without the adversarial relationships common in more traditional contracts.**

Lavoie (2005), in her study of contracting with indigenous health care providers in Australia, New Zealand and Canada, suggested that when indigenous PHC services are funded by an indigenous-specific funding body, the contractual environment is more relational; when they are funded from multiple mainstream sources, it tends to be more classical.

Internationally, the quasi-classical contracting approach is being questioned or reformed in indigenous health in New Zealand and Canada (Dwyer et al. 2014). Furthermore, attempts to introduce more classical contracting approaches for mainstream public health care—e.g. in New Zealand (Ashton 1998, 2007; Cumming & Scott 1998) and the United Kingdom (Goddard & Mannion 1998)—have largely failed, and have been replaced with funding methods that are enacted in relational contracts (i.e. long-term partnering approaches). These arrangements aim to preserve the benefits of separating the roles of funder and provider of health care, while also offering relative security to support a robust health care system.



# Methods

The study was conducted during the period September 2011 to December 2014. It focused on the relationships between funders and providers, in particular on questions of contracting and accountability in the funding relationship, and also on governance and stewardship.

## Research design

Contracting and public administration theory provided the major framework for this study, but we also drew on the literature supporting comprehensive PHC and on systems and governance theory.

The study was designed to accommodate two jurisdictions (Northern Territory and Cape York,

Queensland). With Australian Government participation, both were working towards reform in health service delivery with some similar goals and methods, but also with important differences in context, population base, geography, political culture and resources.

The study was conducted as a set of embedded cases of health system reform, with data collection and analysis at two levels: the jurisdiction (state or territory) and regions/ACCHOs within the jurisdictions (Figure 1). This approach was appropriate to the nature of the reforms because it allowed for interactions between factors at each level.

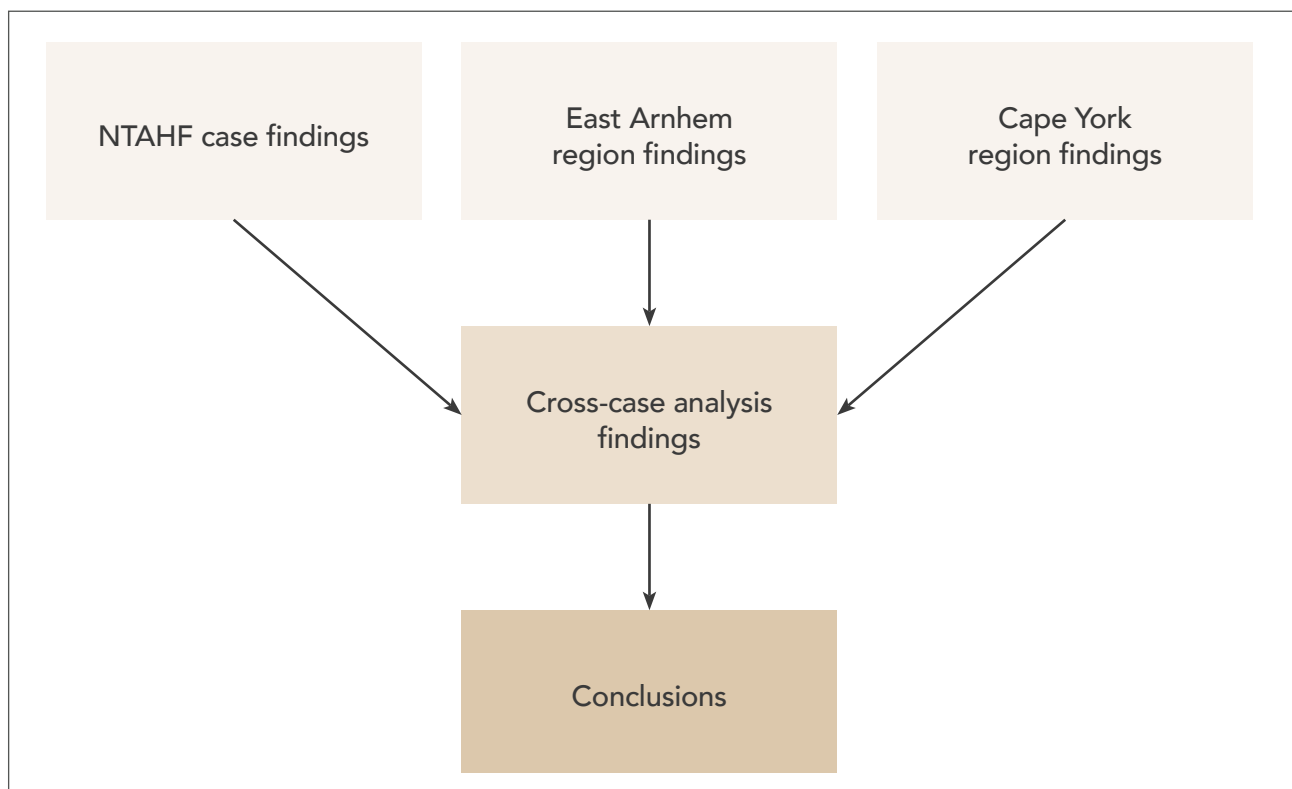


Figure 1: Method of analysis

We conducted three case studies:

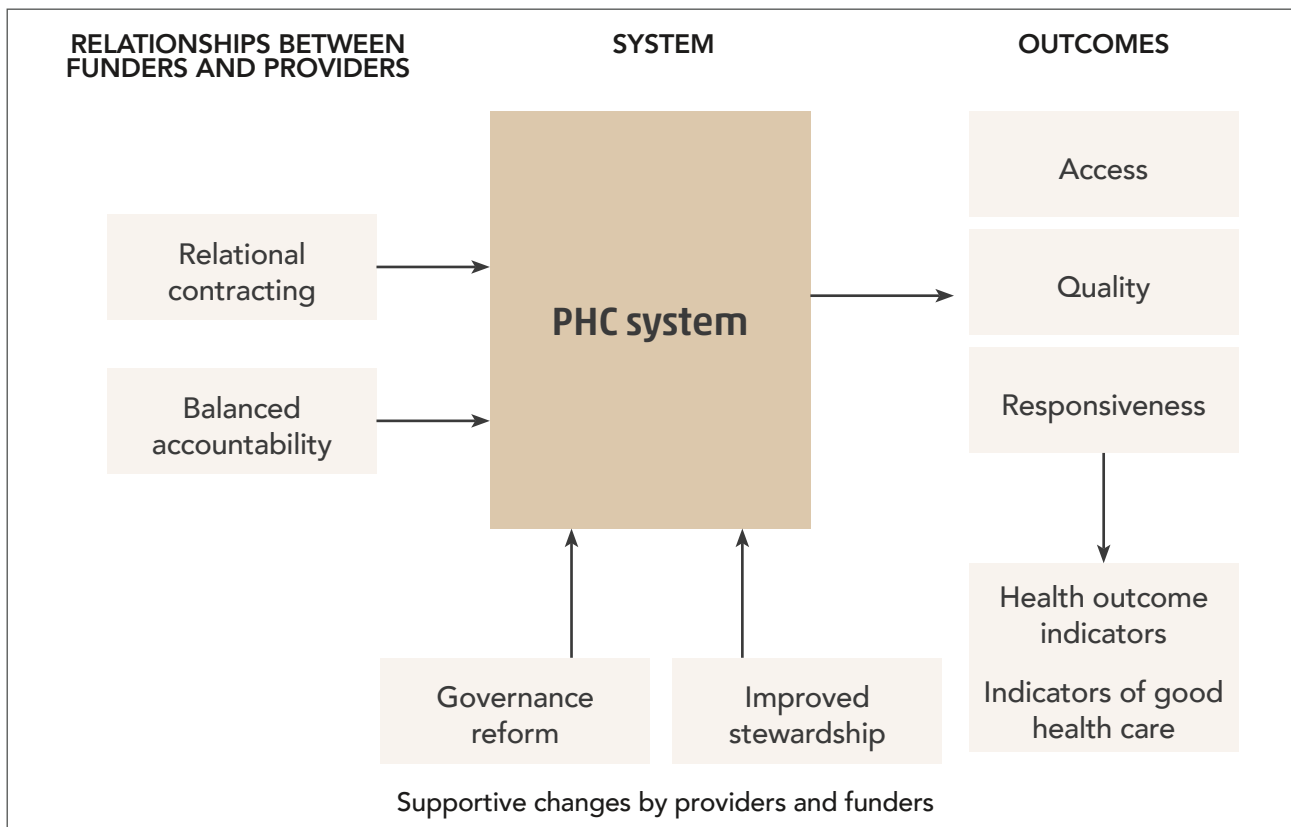
- Case study 1: Pathways and regionalisation in the Northern Territory—the structures and processes to implement the intentions of the reforms articulated in *Pathways to Community Control* (NTAHF 2009a)
- Case study 2: Towards regionalisation in East Arnhem—Miwatj Health Aboriginal Corporation (Miwatj) and the structures and processes for developing a Final Regionalisation Proposal submitted to the NTAHF in 2012
- Case study 3: Transition to community control in Cape York—Apunipima Cape York Health Council (Apunipima) and the structures and processes to implement the intended transfer of operational responsibility for community clinics from Queensland Health to Apunipima, as articulated in the Deed of Commitment (CYRHF 2006a).

The case studies focused on two reforms:

- the regionalisation program outlined in *Pathways to Community Control* (NTAHF 2009a) (Case studies 1 and 2): the goal of the Pathways regionalisation program, which was led by NTAHF between 2008 and 2014, was to enhance access for Aboriginal people throughout the Northern Territory to culturally safe comprehensive PHC, based on regional organisation and community governance of care delivery
- the Transition to Community Control project in Cape York (Case study 3): the goal of this project was to integrate the management and delivery of PHC to Aboriginal communities in Cape York, by transferring responsibility for PHC services delivered by Queensland Health to Apunipima.

Figure 2 shows the main elements of the reforms and how they relate to each other; that is, the reforms were seen as an intervention intended to improve the PHC system—and to lead to better access to quality care that is responsive to community needs, thus having an impact on the health of clients and communities (right-hand side of the diagram). The interventions are shown as changes in the way funding is provided (the relational contracting box) and the way the funders and ACCHOs are accountable to each other and to other stakeholders. These changes are to be supported by changes in the governance of PHC services (by providers), and the ways that funders enact their stewardship responsibilities for the system. Each element was included in the reform policy documents, and the research was designed to enable us to understand changes in each of them.

We prepared three separate reports documenting the historical development of the NTAHF (Devitt et al. 2015) and the history leading up to the reforms in Miwatj (Myott, Martini & Dwyer 2015) and Apunipima (Tilton et al. 2015).



**Figure 2: Conceptual framework of reforms**

## Study aims

We aimed to study the reforms as they developed. Specifically, we sought to answer these research questions:

1. How effective are the methods used to plan and implement the reforms; what are the critical factors that enable or impede implementation; and what are the gaps and why?
2. What are the implications of the reform experience for policy and practice in the funding and accountability arrangements for Aboriginal community controlled health services and their government funders?

Each of the case studies addresses both research questions. That is, the focus is both on understanding the structures and processes of the reforms, and on identifying the implications for future policy and practice in the PHC system for Aboriginal and Torres Strait Islander communities.

The study aimed to understand these complex reforms as they proceeded on their own timelines and agendas. The focus, resources, conduct and, indeed, existence of the reforms were vulnerable to political and bureaucratic change (including changes of government in the two jurisdictions and nationally). Although these contingencies were themselves events in the reform process from which knowledge could be gained, they did complicate study design and implementation. The original aim of the study was to examine both the process of the reforms and the early results. However, for several reasons limited actual transfer of services occurred during the study period.

## Initiation and ethics

This study was developed through the Facilitated Development Approach of the Lowitja Institute (Brands & Gooda 2006), which involves collaborative development of topics for research projects, followed by the formation



of proposals, research teams and research questions, and finally the signing of a contract with the Lowitja Institute. The Statement of Project Responsibilities was signed by the Lowitja Institute and Flinders University in August 2011.

Ethical approval was sought and received from four institutional ethics committees located in South Australia, the Centre and the Top End in the Northern Territory, and Cape York in Queensland. Formal agreements were negotiated with Apunipima and Miwatj, and the NTAHF formally endorsed the study. All study reports were shared in draft for validation by our research partners.

## Data collection and analysis

Data collection was undertaken between November 2012 and October 2014. We conducted 69 interviews with 55 people involved in the reforms (ACCHO staff, ACCHO Board members, and other community representatives and public servants who had been involved).

We analysed 242 public and internal documents dealing with the reform processes and structures, financial information and policy considerations (some of which were relevant to more than one case study). We also engaged in less formal discussions with our research partners as the study progressed and presented preliminary results, circulated drafts of this report and discussed their interpretation with our research partners. Notes of those discussions also informed our analysis.

The three participant groups involved in the study were:

1. staff in the ACCHO sector: staff worked in Miwatj and the Aboriginal Medical Services Alliance Northern Territory (AMSANT) in the Northern Territory, and Apunipima and the Queensland Aboriginal and Islander Health Council (QAIHC) in Queensland; staff participants from these organisations were in a range of professional roles including executives and managers, primary care providers and policy officers

2. Aboriginal community representatives – mostly board members of Apunipima and Miwatj, and of the East Arnhem Steering Committee: these participants were/had been in formal corporate governance and community representative roles
3. government staff: public servants participating in this study were (or had recently been) employed by NTH, Queensland Health and the Department of Health in a range of professional roles, including as executives and managers, policy officers and primary care providers.

Participants were interviewed individually or, if preferred, in small groups. Of the total of 55 people who participated in semi-structured interviews (Table 2), 12 had served in more than one of the roles (above) during the period of the study (not necessarily simultaneously). Sixteen people were interviewed on more than one occasion. Interviews were undertaken in person and by telephone with people based in Darwin, East Arnhem Region, Cape York (Mapoon, Kowanyama), Cairns, Brisbane, Sydney, Canberra and Melbourne. Meetings were observed in Cairns, Darwin and Nhulunbuy. With participant consent, most interviews were audio recorded and professionally transcribed; for others, written notes were taken.

**Table 2: Interviewees by participant group**

Participant group	Number of participants
ACCHO staff	25
Community representatives	4
Community and ACCHO staff roles	8
Government staff	14
ACCHO and government roles	2
ACCHO, community and government roles	2
<b>TOTAL</b>	<b>55</b>

Table 3 identifies the number of participants interviewed for each study. There is overlap in contributions to the NTAHF and East Arnhem studies, with 10 NTAHF participants also contributing commentary for the East Arnhem Region case study.

**Table 3: Interviewees by case study**

Case study	Number of participants
1 NTAHF	18
2 East Arnhem Region	10 (+10)
3 Cape York	27
TOTAL	55

Interview transcripts and documents provided the data from which the narrative accounts in the case studies were written. Interviews were analysed thematically using categories derived from our conceptual framework, as was content of the documents, and the results were used to inform our interpretation of the nature of the barriers and enablers in the processes of reform and the implications for the future development of PHC for Aboriginal and Torres Strait Islander communities.

The analysis and interpretations in this report were also informed by the expertise of the research team. The team included people with extensive experience in research (health services, health economics and public health research) and in health policy and practice in the health system, in both the Aboriginal and Torres Strait Islander health sector and the mainstream sector. Profiles of the authors can be found at the end of this report.

Comments by interview participants are identified using unique numbers (for each person interviewed) and a brief title for their positions as follows:

- government staff (senior staff working or formerly working for funder agencies)
- ACCHO staff (senior staff of ACCHOs or their peak bodies)

- community representative (ACCHO Board or committee members).

Identifying information about internal documents that are not publicly available is included in the text, and they are not in the reference list. All such documents are the property of our research partners and copies were provided to the research team for our use in the conduct of this study.

## Challenges in conducting the study

The NTAHF agreed to enable staff involved in the Pathways regionalisation program to participate in interviews, and for the research team to have access to relevant documents (as agreed by the agencies). However, agreements with NTH and the Department of Health for access to staff for interviews and to internal documents were not completed. A similar agreement was discussed with Queensland Health but not completed prior to the effective suspension of the Transition to Community Control project in 2012 (QH 2011b).

This challenge was addressed in several ways. Interviews were conducted with former public servants and discussions were held with Queensland Health staff (Cape York and Aboriginal Health Division and Policy Division), with NTH staff (the Chief Executive Officer and staff in Health Services, Remote Health and the Aboriginal Policy & Stakeholder Engagement Branch) and with Office for Aboriginal and Torres Strait Islander Health (OATSIH) staff based in Darwin and Canberra. We also used published documents, minutes of NTAHF and other meetings, and correspondence with ACCHOs, which provided a significant insight into government perspectives and decision making. Finally, consultations were held with study participants regarding our findings and conclusions, a process that enabled us to check the accuracy of our data and its analysis.



# Case study 1: Pathways and regionalisation in the Northern Territory

This case study documents the work of the Northern Territory Aboriginal Health Forum (NTAHF) on the Pathways regionalisation program to establish a regional community controlled PHC system for Aboriginal people, as articulated in *Pathways to Community Control* (NTAHF 2009a) and subsequent documents. The case study is based on interviews with nine current and former government officials and nine ACCHO staff, and on analysis of 82 internal NTAHF papers and minutes and publicly available documents.

## Background

The NTAHF is a formal partnership consisting (during the time of this study) of senior representatives of three parties: the Aboriginal Medical Services Alliance Northern Territory (AMSANT), the peak body of the ACCHO sector in the Northern Territory; the Northern Territory Department of Health (NTH); and the Australian Government Department of Health (the Department of Health). It was founded in 1998 under a Framework Agreement, which was renewed in 2007 (Northern Territory Government, Australian Government & AMSANT 2007; NTAHF Meeting #33 September 2006), and has a history of work on system development, with an emphasis on central planning and regional and local delivery of care. The role of the NTAHF is to develop cooperative approaches to policy and service delivery, consultation and joint planning, and service enhancement, with governments retaining 'final decision-making powers within their funding responsibilities' (Northern Territory Government, Australian Government & AMSANT 2007:7). The development and some of the achievements of the NTAHF are documented in *The Northern Territory Aboriginal Health Forum: An historical overview*, a paper published as part of this study (Devitt et al. 2015).

## The regionalisation process

The Pathways regionalisation program was intended to enhance access for Aboriginal people throughout the Northern Territory to culturally safe comprehensive PHC based on regional organisation and community governance of care delivery.

## Regional focus

From its first meeting, the NTAHF emphasised regional planning as an essential component of PHC service delivery in the Northern Territory, including in its approach to the Primary Health Care Access Program (1999–2004) (Gollow 2003:1) and the Coordinated Care Trials (1997–2005). This approach was also an integral, long-term part of Australian Government policy, and the NTAHF's progress—through its detailed regional services mapping and focus on delineating socially and culturally coherent regional units—has been recognised and commended at national level (NTAHF Meeting #8 May 2000).

## The Intervention and funding for PHC reform and service expansion

The NTAHF was well placed to take advantage of additional funding flowing to the Northern Territory through the Northern Territory Emergency Response ('the Intervention' or NTER) declared by the Australian Government in June 2007, and the Closing the Gap initiatives that followed (NT Government 2015). The Expanded Health Service Delivery Initiative (EHSDI) arose out of negotiations conducted in April 2008 between AMSANT, NTH and the Department of Health (Allen + Clarke 2011:207). The Australian Government committed \$99.7 million over two years from July 2008 to expand and improve health service delivery in remote parts of the Northern Territory. EHSDI funding

was allocated to a range of measures, including the development of regions and the move to community control, development of hub services, and facilities and infrastructure development. Funding was also provided for additional clinical staff and for the establishment of the Remote Area Health Corps to bring health professionals to communities on rotation. Funding for additional services was allocated to regions on a basis designed to achieve funding equity for the Aboriginal population. Significantly, evaluation was also built in from the beginning, through a contract with consulting firm Allen + Clarke. Ambitious progress milestones were set, and there was a sense of urgency to ensure that the opportunity was not wasted.

The planning for EHSDI was collaborative, conducted initially through a group of Chief Executive Officers (CEOs) with representation of each NTAHF partner (NTAHF Meeting #40 June 2008). Governance and management of the EHSDI program was subsequently handed over to NTAHF (NTAHF Meeting #41 September 2008).

The momentum was continued through significant further Australian Government funding under the Closing the Gap in the Northern Territory National Partnership Agreement of July 2009, which provided \$805 million over three years, including extension of the EHSDI (FaHCSIA 2012) and the Stronger Futures program (\$3.4 billion over ten years) (Havnen 2012). The combined result for the health portfolio was \$713.5 million over ten years, which enabled EHSDI activities to continue (including PHC service delivery and reform, the Remote Area Health Corps, and specialist and allied health services for conditions that bring a very high disease burden). This funding program, the Stronger Futures in the Northern Territory (Health) program, was implemented through a new National Partnership Agreement between the Northern Territory and the Australian Government (Australian Government 2013).

By 2009 the NTAHF had formulated eight EHSDI program goals (Allen + Clarke 2011:207) that clearly positioned the EHSDI initiative within the

broader PHC reform objectives of the NTAHF, and included evaluation funding. The program of work funded through the NTER was to be evaluated over a five-year period (2009–13) and overseen by a Management Committee led by the Department of Health and Ageing (DoHA) (Allen + Clarke 2011). Although the Management Committee was formally structured as a subcommittee of the NTAHF, it had delegated decision-making power and its authority seems in practice to have been based with the Department of Health. The committee oversaw the Allen + Clarke evaluation conducted between 2009 and 2011 (NTAHF Meeting #44 April 2009), but no further action has been recorded.

### Pathways to Community Control

Work towards the Pathways/regionalisation program commenced in 2005 and has its origins in the context of the Primary Health Care Access Program (see Devitt et al. 2015 for further information). The NTER was the trigger to finalise the *Pathways to Community Control* (NTAHF 2009a) document, and it was endorsed by the NTAHF in September 2008 (NTAHF Meeting #41 September 2008) and formally launched in November 2009. The Pathways document remains the only agreed NTAHF partners' statement on the meaning of 'community control' and potential ways to transition to a community controlled service. It envisaged a leadership role for NTAHF in pursuing this goal and became the guiding framework for the regionalisation program.

The Pathways document is subtitled, *An Agenda to Further Promote Aboriginal Community Control in the Provision of Primary Health Care Services*. It describes a number of PHC service models that are at different points along a continuum of increasing community participation and governance. At one end of the spectrum are services owned and operated by NTH in which Aboriginal community responsibilities are limited to appropriate use of the service and taking responsibility for their own health. At the other end is a regional



Aboriginal community board responsible for all aspects of owning and managing PHC services. Thus *Pathways* outlined the NTAHF's collective understanding of community control as the full expression of a potential continuum of participation by the Aboriginal community in the governance, management, planning and delivery of PHC.

*Pathways* states that its primary (policy) purpose is to increase the level of community participation and control in the health and family services sector in the Northern Territory and proposes a staged process of transformation, matched to communities' aspirations and capabilities (NTAHF 2009a:1). And while the document argues that both communities and public sector agencies potentially will require increased capabilities to support increased community participation, it identifies the capabilities of Aboriginal communities and boards of management as *threshold issues*, noting that 'These structures must be able to serve the community's interests, stay connected with the community's preferences and values and discharge strategic corporate responsibilities effectively' (NTAHF 2009a:23).

The document provides an outline—including an indicative five-year timeframe—for the staged implementation of increased community participation in health service provision, focused strongly on aspects of community engagement and demonstration of competence by community steering committees/boards.

In a straightforward statement, the foundational implementation document—*NT Regionalisation of Aboriginal Primary Health Care Guidelines—Supporting a Pathway to Regional Aboriginal Community Control* (version 6.2, endorsed 2010; henceforth, the *Regionalisation Guidelines*) (NTAHF 2010:11)—describes regionalisation as a two-pronged strategy: increasing Aboriginal community involvement in health decision making (community control) and improving service outcomes through better service coordination/integration (regional health service reform).

## Reform through regionalisation

The notion of regionally based PHC services has been part of the NTAHF's agenda of PHC reform over many years. In summary, commitment to the following priorities for action to strengthen the PHC system for Aboriginal people and communities has been sustained:

- establishing a workable regional approach to PHC delivery
- undertaking needs-based planning
- addressing equity and transparency in funding allocations
- coordinating planning (through NTAHF)
- supporting community control of services
- improving capacity to monitor progress and assess outcomes
- increasing PHC funding and thus access to care.

NTAHF documents (NTAHF 2010:10) indicate that the partners had an agreed definition and a shared vision for regionalisation:

**Working together to improve health outcomes for all Aboriginal people in the Northern Territory through health system reform and the development of Aboriginal community controlled primary health care services which provide safe, high quality care and facilitate access to specialist, secondary and tertiary care.**

Regionalisation referred to the reforms and arrangements that could potentially result in a single Aboriginal community controlled regional PHC service provider in each of the agreed Health Service Delivery Areas (HSDAs) (replacing or amalgamating both multiple smaller ACCHOs and Northern Territory Government clinics). It was understood as a staged approach that would include communities and providers in decision making at every step. In addition, the NTAHF agreed on the use of consistent terminology in all communications, and specifically the term 'regional Aboriginal Community Control' (NTAHF Meeting #47 December 2009).

Thus, from the outset, the concept of regionalisation specifically included the participation of Aboriginal communities in decision making about the direction of developments in their regions. Although the regional dimension of the reforms and the governance–management aspects would need to be attended to differently, it was clear that the reform agenda was premised on binding these two aspects together.

## Planning and frameworks for implementation

The NTAHF established two central bodies: the Primary Health Reform Group to lead Northern Territory-wide planning and development work, and the Reform and Development Unit to support regional planning and development by communities and ACCHOs. Regional steering committees took the lead role within regions, supported by Clinical and Public Health Advisory Groups and regional planning units. These bodies, and the frameworks they developed, are described below.

### **Primary Health Reform Group and Clinical and Public Health Advisory Groups**

The Primary Health Reform Group (PHRG) was a critical driving force in the planning and development work. It was established as a subcommittee of the NTAHF to manage the implementation of EHSDI 'on the ground' and was operational by October 2008. The PHRG was to lead implementation of the NTAHF reform agenda and OATSIH allocated a full-time senior officer to chair, convene and manage it (NTAHF Meeting #41 September 2008; NTAHF Meeting #42 December 2008).

The PHRG met at least fortnightly and reported directly to the NTAHF. It established and monitored working groups, planning committees and consultancies, including the Workforce Implementation group, the Core PHC Services Review Working Group and Patient Information Records Systems Group. It developed a comprehensive *Change*

*Management Strategy* (2009–2011), including a risk assessment plan and a communications grid endorsed by the NTAHF in late 2009 (NTAHF Meeting #47 December 2009). The PHRG also had a role in overseeing the work of the Reform and Development Unit, located within and managed by AMSANT, and smaller regional units in Barkly and East Arnhem.

Regional Clinical and Public Health Advisory Groups (CPHAGs), made up of senior clinicians from the health services within the region, were also established in three regions. Their roles were to undertake joint planning, to advise on opportunities for service integration/coordination, and to provide advice to the regional board or governance bodies.

### **Reform and Development Unit**

The Reform and Development Unit (RaDU) was established within AMSANT by 2009 (NTAHF Meeting #44 April 2009). It reported to the PHRG and was primarily responsible to engage with the regions—to communicate with, assist and support local communities to engage actively with the regionalisation agenda. The RaDU role was complex and included negotiating the definition of appropriate and viable regional HSDAs and assisting communities to develop regional steering committees. With the help of the PHRG, RaDU was tasked to develop templates and tools to assist regional steering committees and health service providers to engage with the agreed regionalisation process (NTAHF Meeting #44 April 2009). Until 2010–11, the RaDU had a staff complement of ten, including five full-time equivalent regional coordinators.

Local regional development units were established in Barkly in July 2009 and in East Arnhem in July 2011. These local planning units reported to the regional steering committees of their HSDAs.

By mid-2009, the PHRG had settled on four HSDAs—East Arnhem, West Arnhem, Barkly and Central Australia<sup>2</sup>—as showing the greatest

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2 It was not then clear exactly how many HSDAs would emerge from the Central Australian region of interest.



potential to progress towards becoming regional services by the end of the year, and the RaDU focused its work on those areas (Allen + Clarke 2011:133).

In its brief paper *On the Same Track*, the RaDU presented a community engagement framework for Aboriginal health, including guiding principles, directions on consultation processes, consensus building and decision making (NTAHF Meeting #47 December 2009).

### Regionalisation guidelines

The principal document guiding the regionalisation process was *NT Regionalisation of Aboriginal Primary Health Care Guidelines—Supporting a Pathway to Regional Aboriginal Community Control* (NTAHF 2010), which was developed by the PHRG (2009–10) and

endorsed by the NTAHF (NTAHF Meeting #49 October 2010). It is a substantial document that outlines the full intent of the regionalisation reforms and describes stage one of a four-stage process (development, consolidation, implementation, evaluation) to establish a regional Aboriginal community controlled PHC service. It includes tools for the use of steering committees and their support staff (e.g. consultation report templates, communication messages and meeting procedure notes).

The guidelines detail the information required, and the process to be followed, by HSDAs submitting a Regionalisation Proposal to the NTAHF. The development stage itself comprised four steps culminating in a fully developed Final Regionalisation Proposal (FRP) (Table 4).

**Table 4: Steps in development of Final Regionalisation Proposals**

<b>STEP A</b>	Initial Community Consultation	<ul style="list-style-type: none"> <li>• Inform communities and providers about regionalisation</li> <li>• See if communities are interested</li> <li>• Identify potential ‘champions’</li> </ul>
<b>STEP B</b>	Establish a Regional Steering Committee Establish a CPHAG	<ul style="list-style-type: none"> <li>• Steering committee supports increased community control and participation through regional governance model</li> <li>• CPHAG supports service reform</li> </ul>
<b>STEP C</b>	Develop initial Regional Proposal	<ul style="list-style-type: none"> <li>• Identify steps, expertise, funding required to develop FRP</li> <li>• Determine which models to consult over</li> <li>• Seek funding to develop FRP</li> </ul>
<b>STEP D</b>	Broad consultation to develop FRP	<ul style="list-style-type: none"> <li>• Get stakeholder views on preferred governance model</li> <li>• Develop a model of governance based on above</li> <li>• Develop the FRP including governance, improved integration and coordination</li> </ul>

The FRP was to be endorsed by the PHRG before progressing to the NTAHF for endorsement and then to the two governments for final endorsement, before moving on to the next stage of the process (consolidation). A regionalisation support kit was planned but

there is no record of its production, and the 2010 Regionalisation Guidelines were apparently not reviewed as planned in 2011. Guidelines for the consolidation stage were drafted (NTAHF Meeting #51 March 2011) but not finalised.

### **Competence and capability framework**

In early discussions the NTH noted that 'capability and capacity were standout issues with regard to community control' (NTAHF Meeting #31 March 2006). In line with this, the Pathways regionalisation program provides a framework for developing what it terms competent and capable service models, identifying levels of public sector and community responsibilities associated with each of nine models of service delivery. The Pathways regionalisation program commits the NTAHF partners to supporting Aboriginal communities to develop an increased capacity for engagement (where needed) and to releasing untapped potential and building new capabilities in support of community participation and control (NTAHF 2009a:9).

The development of a framework to assess the competence and capability of regional steering committees/governing boards was undertaken in 2011 (NTAHF Meeting #51 March 2011) and 2012. It was initially called the Competence and Capability Framework and was prepared by the NTH. The framework was developed for application only to community governance structures, not Northern Territory Government clinics. The draft version was trialled in regions, most recently by Miwatj in mid-2012.

However, participants reported that those who engaged with the assessment process experienced it not as a supportive step towards community control but, rather, as a process designed to demonstrate local inadequacies and thereby impede progress:

*standards were set so high that nobody could get through it... I'm not really against the idea of having a set of standards... but... some of those things—like the competence and capability framework—just make it seem impossible to get there... (Government staff 111)*

The process was perceived by some in the ACCHO sector to be an extension of a generally excessive risk intolerance displayed by both levels of government:

*The toolkits and the community competency framework and so on—these are all based around a deficit approach to community control where, 'We can't trust you to do everything so if we make it so hard for you to get there we will have avoided any problems' ... (ACCHO staff 114)*

A more basic reason was suggested by some: that the complicated process was intended to mask 'what they really think—that blackfellas can't run these things' (ACCHO staff 118). Ultimately, the framework was reshaped and renamed the Regional Readiness Assessment Tool (FaHCSIA 2012:30).

### **Performance indicators and core elements of PHC**

Based on years of collaborative development (Gollow 2003; NTAHF Meeting #25 September 2004; NTAHF Meeting #28 May 2005), a Northern Territory-wide electronic reporting system—the NT Aboriginal Health Key Performance Indicators—was implemented in 2009. In 2011 the NTAHF set a timetable for the first public report based on accumulated data from the reporting system (NTAHF Meeting #53 August 2011). From the outset, DoHA emphasised the need to concentrate on the clinical indicators (numbering 12 of 19) since the other domain indicators (management and support services; linkages, policy and advocacy; and community involvement) had a less well-developed evidence base (letter, Assistant-Secretary OATSIH to Assistant-Secretary NTH, November 2006; NTAHF Meeting #34 December 2006).

In tandem with the performance indicators work, the NTAHF continued to develop and refine definitions of the core functions of comprehensive PHC, with the most recent version (Tilton & Thomas 2011) endorsed by the NTAHF (NTAHF Meeting #54 December 2011) and more recently taken up nationally by NACCHO (Mohamed 2014). These are two important pieces of infrastructure for the development of a systematic approach to the PHC system.





## Early progress not sustained

The first FRP was submitted by the Barkly Regional Committee in September 2010 (considered at NTAHF Meeting #50 in December 2010, only one meeting after formal endorsement of the Regionalisation Guidelines), indicating vigorous uptake of the opportunity in that region. In early 2011 Allen + Clarke reported that three HSDAs (West Arnhem (Red Lily), East Arnhem and Barkly) were progressing towards regionalisation (Allen + Clarke 2011:143). The progress of East Arnhem is documented in Case study 2, and NTAHF documents provide a chronology of the progress of other target HSDAs.

At the time of writing none of the four target HSDAs had established an endorsed regional service and only three (Barkly, East Arnhem and Red Lily) had submitted a FRP, with only the Barkly proposal having been provisionally endorsed by the NTAHF. The regionalisation process was formally halted in 2014, with no funding allocated in the 2014–15 federal Budget. The NTAHF is now focused on revitalising its own operation, and the parties have expressed the intention to recommit to the reforms and re-establish capacity to implement them. The rest of this case study examines a series of unmet challenges, decisions and (in)actions that led to delays in implementation of the planned reforms.

## Limits of central capacity and decision making (2009–10)

The planning and policy implementation capacity of the NTAHF and its member organisations was increasingly stretched as regionalisation activities increased, with signs of problems emerging in 2009–10. The NTAHF continued to manage its pre-NTER projects and to respond to significant emerging issues, although this was not altogether satisfactorily in the views of some who felt that the NTAHF had been somewhat 'swamped' (ACCHO staff 104).

The earliest clear indication of capacity problems came from the PHRG in late 2009, when it reported on limitations that were hampering progress and proposed setting up a joint NTAHF Policy & Research Unit that:

would report to the Chair of the NTAHF, be managed by a nominee selected by all partners; involve suitably qualified representatives seconded from each of the partners; and help form policy options on specific areas of agreed high priority for the NTAHF. (NTAHF Meeting #46 October 2009).

Although accepting that the workload of the PHRG was high, NTAHF members decided not to endorse either a trial or further planning on this topic. They expressed the view that this work needed to be carried out within existing resources (NTAHF Meeting #46 October 2009).

At the following meeting the NTAHF endorsed a strategy to increase capacity by establishing a panel of experts to support the PHRG (NTAHF Meeting #47 December 2009) but it seems that this panel was not established.

## Capacity of the NTAHF and its member organisations

During this period of intense activity in the PHRG and RaDU, the indecisiveness of the NTAHF suggests that the accord of the partners (as expressed in their endorsement of the Pathways regionalisation program) was no longer strong. For example, in late 2009, following agreement at a Regionalisation Workshop (November 2009), the NTH presented a substantial draft paper 'to assist the NTAHF to develop an agreed long term vision through developing an agreed NTAHF Master Plan for the Aboriginal PHC System across the Northern Territory' (NTAHF 2009b:3). The paper is a global statement of system-wide reforms to be pursued in the Northern Territory, and although the NTAHF responded by endorsing its further development (NTAHF Meeting #47 December 2009), that decision was subsequently reversed (NTAHF Meeting #49 October 2010). Loss of commitment is also indicated by a lapse in the normal schedule of quarterly meetings during 2010.

The Allen + Clarke (2011:180) final evaluation report was positive about the achievements of the NTAHF and supportive of continued work in a partnership structure. However, it warned about the size and complexity of the task in what was then a tight timeframe, and the need

for increased resourcing and policy capacity. The report concluded that the regionalisation program had been under-scoped and under-resourced, with no allocation of funding for implementation policy work, which fell mostly to the PHRG, whose members were already fully employed and were becoming overloaded (Allen + Clarke 2011:125).

Allen + Clarke also concluded that the absence of a unified, committed leadership in the NTAHF, and emerging ambivalence about regionalisation, created further difficulties. They suggested strongly that the NTAHF needed to clarify its role and to 'focus on governance and oversight, rather than the practical, operational implementation of the reforms' (Allen + Clarke 2011:141).

Suggesting that the 'three partners need to revise and refine their relationships, roles and responsibilities to respond to the current environment', Allen + Clarke (2011:125) also point to a more permanent but subtle and diffuse tension underlying the NTAHF partnership:

*Establishing a joint policy capacity would require each of the partners to relinquish some power. There does not appear to be a strong appetite for this despite clear evidence that each agency devolving power and changing concepts of accountability would increase efficiency and effectiveness.*

Participants in this study emphasised personal commitment and a progressive 'ethos' in the relationships among key stakeholders. Recalling personal experience in a CCT, a participant (ACCHO staff 114) noted that:

*it was a philosophy of finding out how things could get done rather than finding ways to slow things down, if not stop them; it was a completely different ethos.*

However, in this challenging period for the NTAHF, shifting levels of partner commitment to previously agreed policy positions exacerbated tensions between them. It is not surprising that Allen + Clarke also noted an inability by

the NTAHF to resolve or address issues where there was a lack of consensus among partners on fundamentals; for example, on Hub Services (Allen + Clarke 2011:106) (i.e. shared services to support clinics and other activities within a region), an aspect of the planned reforms on which no progress was made.

Allen + Clarke concluded in early 2011 that the structures and resources needed to support and drive implementation had been under-scoped, and that while AMSANT (through the RaDU) had responsibility for this program, its expertise was primarily in the building of community capacity and negotiating the merger of ACCHOs. AMSANT was not well placed to manage other aspects, such as the decentralisation and transition of NTH services and growing and supporting new regional structures. Perhaps most clearly, it was not reasonable to expect that AMSANT could lead a process that effectively required the repositioning of system policy capacity by all the partners to focus on implementation (Allen + Clarke 2011:144).

### ***Funds pooling arrangements not designed or planned***

Funds pooling was an explicit element of regionalisation, to occur as part of the implementation stage (NTAHF 2009a:27), with a single regional 'fund holder'. 'Funds pooling' in this context means that funds allocated for PHC in the region by both governments (ideally from all programs and departments) would be partially or fully combined to support the provision of an agreed range of PHC services. The pooled funding model had been trialled in Aboriginal and Torres Strait Islander and mainstream organisations under the CCTs (Bailie, Menzies School of Health Research Local Evaluation Team & KWHB 2000) and was part of the plan for the Primary Health Care Access Program (PHCAP) (NTAHF Meeting #25 September 2004). Implementation of pooled funding had not been achieved before the PHCAP program ceased, despite funding being available, a matter of some frustration for the NTAHF (NTAHF Meeting #25 September 2004). However, pooled funding information had been available during PHCAP



and was used to determine equitable funding allocations under PHCAP and in the work to allocate EHSDI funding.

AMSANT argued in late 2010 (NTAHF Meeting #49 October 2010) that the absence of work on pooled funding was likely to delay progress, noting that the regionalisation program did not include any detailed planning or financial modelling to define, scope and enable funds pooling.

It was agreed that NTH and OATSIH would 'document (for PHRG) current non-controversial community-based Comprehensive PHC expenditure in Red Lily and Barky HSDAs' (NTAHF Meeting #50 December 2010), but it is not clear whether either government subsequently presented the agreed data. The item was further discussed at two meetings in 2011 (NTAHF Meeting #51 March 2011; NTAHF Meeting #53 August 2011), and the NTAHF agreed that there needed to be 'a clear partner commitment on funds pooling as a first step' (NTAHF Meeting #53 August 2011). No further action was recorded.

### **Capital assets**

There was a similar lack of progress on the question of ownership of capital assets to be transferred. This was seen as an example of the deteriorating relations within the NTAHF and the overemphasis by governments on avoiding risks:

**the two governments refused to do a joint survey of assets so they went off and did separate ones which were on different methodologies and, it ended up with no-one having access to either document... despite promises made in [the NTAHF] that we would. (ACCHO staff 114)**

It is not surprising that cracks in the shared commitment to regionalisation became visible in relation to funding and the ownership of assets, as these are critical to both sides and create ongoing obligations and/or losses. But these are also technical matters, and lack of capacity to undertake the necessary analysis and negotiation also seems to have been an important barrier.

## **Complexities and challenges in HSDA development**

A number of significant challenges were encountered in the regions (HSDAs), specifically community engagement, the burden on (unpaid) community leaders and establishing agreed HSDA boundaries.

### **Community engagement**

RaDU/AMSANT initially led the community engagement aspect of regionalisation. Some participants suggested that, almost from the outset, there was misunderstanding and/or disagreement as to what the Pathways regionalisation program proposed. The establishment of viable regions and the Pathways concept both proved difficult to operationalise:

**turning part of the Northern Territory into primary health care regions and transitioning the governance of those services to Aboriginal community control was the bit we found hardest of all. (Government staff 111)**

Reflecting on the overall approach, a senior government participant suggested that, in hindsight, communities could perhaps fairly conclude that they were being invited to select from a set of predetermined arrangements and processes rather than to develop a community-based regional approach. Having not been engaged in constructing the various arrangements and scenarios, they were then being invited to take a lead role to establish the program and, into the future, substantial responsibility to maintain it.

It also seems that confusion developed about the concept of a continuum of community control and governance (with various levels of community participation as outlined in the Pathways document), as opposed to a yes/no dichotomy. This occurred partly because of regular reference to existing local exemplars (Katherine West and Sunrise), both of which are at the most advanced level of regional community control. The idea of governance options 'got lost along the way' (Government staff 110).

Problems in communication are also seen as significant. NTAHF discussions of the Regionalisation Guidelines (NTAHF 2010) included commentary that they needed to be more 'community friendly', with complex documents to be produced in formats appropriate to community discussion (as had been intended).

### **Burden on (unpaid) community leaders**

there's a lot of what could have been considered promises made when we spoke to community people early on. (Government staff 111)

A more problematic outcome is the cumulative negative experience that eventually corrodes the goodwill of key community members. Noting that this process had begun years earlier, one participant recalled local senior Aboriginal men repeatedly asking about the progress on establishing their hoped-for regional health service, saying 'some of us want to see this in our lifetime' (ACCHO staff 117).

Aboriginal community members who take leadership positions in advocating for these kinds of reforms lay themselves open to blame and criticism when nothing ultimately changes. Arguments arose when people were either unclear about or not in agreement with proposals, and when inadequate communication created dissension within regions and communities. This had particular impacts on AMSANT in its community sector advocacy role.

[Existing ACCHOs] were not feeling that they were effectively being listened to and engaged. And no-one had the ability or the skill to know how to manage that kind of change at the community level and it led to community people having conflict with each other. (ACCHO staff 117)

I don't think it [AMSANT/RaDU] functioned to the level and to the requirement of the members... and the impact of regionalisation led to people not attending the [AMSANT] board meeting because of the conflict; you can [easily] sit at the board

of AMSANT but when you're out there in the community and you know that this organisation [AMSANT] has all this staff, it has all these resources—it turned into major conflict, I have to say. (ACCHO staff 104)

The regionalisation process can neither progress nor succeed without the support of senior community leaders. Only they have the authority to facilitate and negotiate consensus on complex local issues such as boundaries, governance models and community participation. Membership of regional boards will necessarily be drawn from their number. The Regionalisation Guidelines (NTAHF 2010) spelled out a crucial and extensive role for regional steering committee/board members in developing the preferred governance model for their regions and in nurturing community participation. The expectation (by salaried government staff and others) that this investment of expertise and authority would be provided free of charge was not seen as reasonable. Community leaders were well aware that payment of board directors is standard practice for many boards in the broader health system but was explicitly ruled out by OATSIH policy, a matter that the RaDU sought to address (RaDU report to PHRG, 6 August 2009).

The issue was raised again more than a year later (RaDU report to PHRG, November 2010), and a lack of response from the NTH or the Department of Health was noted. In mid-2012 the issue was described by a long-term participant as 'big' in the context of the regionalisation progress and as a manifestation of institutional racism by another in the ACCHO sector:

That was always an ongoing issue—about boards and board payments—people having to give up a lot of their time and not getting paid... So again that was a constant tension between DoHA and the other two partners. Like why would people volunteer their time and take on the responsibility and the accountability around running a big health service for nothing? And these are people who are really poor. (Government staff 108)



issues of payment for board sitting fees and stuff like that which can't apply to our sector—I'm not sure why—but do apply to other funded sectors; and admin fees—Medicare Local can have 20 per cent admin fee but we can't for some reason. A whole lot of double standards that are, I think, to do with institutional racism. (ACCHO staff 103)

### **HSDA boundaries and service provider roles**

Resolving HSDA boundaries and negotiating inter-service arrangements proved difficult. Boundary issues in Central Australia remained unresolved for three years, following the commencement of community meetings in late 2008 (RaDU report to PHRG, January 2011).

In particular, barriers arose when the planned reforms would potentially reconfigure regional relationships, and require some communities to relinquish existing local community control of health services. Regionalisation processes required communities to reach a stable, reportable consensus on many issues that are more likely to be held in a permanent state of negotiability:

regionalisation... has proved to be very challenging for bureaucracies and for the Aboriginal people involved themselves. So how do... they come together under one community controlled structure, because that's what we're asking them to do. Massive areas, different languages, you know?... It's a huge challenge for Aboriginal mob, let alone for the established systems and bureaucracies. (ACCHO staff 103)

These concerns led to some loss of momentum in regional development (RADU report to PHRG, August 2009).

It also became clear that there was a serious mismatch between what Aboriginal community members considered a reasonable timeframe for planning a major reconfiguration of existing local social relations and the timetables established by funding agencies and government personnel. From the perspective of community representatives we interviewed, government officials had no real stake in the

local outcomes since they were not part of the affected communities. The Allen + Clarke evaluation also noted dissatisfaction with activities at the HSDA level, particularly in engaging with local communities and service providers, and perceptions that progress on the ground was too slow (Allen + Clarke 2011:141).

### **Decline of NTAHF leadership (2011)**

Allen + Clarke recommended that the regionalisation program should continue under NTAHF auspices, with a new plan, scope and resources and with stronger governance and leadership, including attention to increased policy capacity and to consumer voices. The recommendations were an opportunity for the NTAHF and its partners to review the current situation and either renew their commitment or change their direction.

In May 2011 the NTAHF partners agreed to form a working party to develop a response to the Allen + Clarke evaluation (NTAHF Meeting #52 May 2011) but this appears not to have been done. The Memorandum of Understanding Management Committee (overseeing evaluation activities) provided a further brief update at the August 2011 meeting (NTAHF Meeting #53, Agenda paper 3.5). It reported on a ministerial suggestion (from Warren Snowdon, Minister for Indigenous Health) to establish a special top-tier tripartite committee to make further progress.

It is difficult to determine precisely what happened after this but, clearly, from mid-2011 the NTAHF regionalisation reforms and the functioning of the NTAHF itself were compromised. There are no minutes of NTAHF meetings between mid-2011 and mid-2012. However, during this period blame and negativity about poor outcomes of the RaDU (reported by Allen + Clarke 2013b) continued, and the PHRG effectively collapsed. According to available records, the PHRG met 12 times in 2009, 22 times in 2010 and twice in February 2011, when the PHRG meeting records stop abruptly. The PHRG appears to have dissolved in the latter part of 2011 without formal closure. Given the pivotal role of the PHRG as the 'engine room' of regionalisation, and the scope of its activities,

its collapse fatally weakened the regionalisation process: the 'PHRG had become tired and wasn't able to generate the same momentum in the face of what seemed like an increasingly impossible task' (Government staff 111).

Our interviews identified a further significant underlying problem—the souring of essential relationships between the parties, with loss of hard-won trust as government priorities changed. This was compounded by loss of corporate memory as key personnel moved on, the impact of lack of progress, a sense that all parties had lost commitment to the NTAHF and the sense that 'we've lost the leverage' (ACCHO staff 103).

### The Senior Officers Group (2011–12)

At a critical time the Australian Government responded to the evident implementation difficulties by creating an alternative structure for decision making comprising a select group of the most senior officers in order to hasten progress. This led to irritation and confusion among participants, and the overall effect was seen as counterproductive.

In August 2011 the NTAHF formally noted the Minister's proposal for a 'top-tier' committee to review the Allen + Clarke report and develop a plan of action (NTAHF Meeting #53 August 2011, draft minutes). It would ensure that governance arrangements and the primary care reform process, including regionalisation, were on track (NTAHF Meeting #53 August 2011, Item 3.5).

This is the likely origin of the Senior Officers Group (SOG), sponsored by the Australian Government and intended to take over the role of the NTAHF in regionalisation. SOG was described in a communique to the December 2011 NTAHF Meeting (#54) as 'a new group formed to drive progress on regionalisation across the NT', with membership being a senior officer of each partner. Three key decisions are noted: commitment to work to a new set of guiding principles for regional reform; a plan to progress reform with the same four priority areas (Barkly, East Arnhem, West Arnhem and Central Australia); and implementation to be led by a

team of staff from DoHA, NTH and AMSANT and co-located in AMSANT from January 2012.

Documents tabled at the meeting (entitled 'Regional reform of Aboriginal PHC services in the NT guiding principles' and 'Terms of reference for the SOG, membership and protocols') affirmed that SOG would be chaired by the Department of Health and NTH. We had no access to records of SOG meetings, but at least five meetings were held in 2012 and at least one meeting included discussion of transfer of services to ACCHOs. The establishment of SOG to progress regionalisation at a strategic level was noted in Part One of the Closing the Gap in the Northern Territory January–June 2012 reports (FaHCSIA 2013:24).

The SOG guiding principles are consistent with those in *Pathways to Community Control* (NTAHF 2009a) and the Regionalisation Guidelines (NTAHF 2010), with a restatement of the commitment to 'regional Aboriginal Community Controlled Health Services throughout the NT' (based on *Pathways to Community Control*) and to be 'governed and supported by a partnership between the existing partners'. A minimum population size of each HSDA (2500 people 'where possible') is described, along with a focus on equitable funding across regions. Community consultation and participation were to be sustained.

The establishment of SOG was a major loss of strategic positioning for AMSANT. The subsequent failure of SOG to act or even meet during much of 2012–13 was seen by participants as yet another obstacle to decision making and progress on regionalisation.

The Partnership Team of staff established by SOG continued to meet and work on regionalisation at the ground level during 2012, reporting to SOG. The team did not have an operational budget, and any regionalisation activities were to be authorised and funded by the Department of Health on a case-by-case basis. During early 2012 activity for the three proposed Central Australia HSDAs was described as 'frenetic' (Government staff 101a), with a focus on resolving HSDA boundaries. This activity ceased in August when



Australian Government funding became scarce. The partnership group meetings continued, though unproductively:

**And it's becoming a very, very frustrated process... there just doesn't seem to be any sort of follow up, any urgency, any passion, any commitment given to implementing and progressing regionalisation. (ACCHO staff 113)**

When SOG was established, it was intended that this group would get regionalisation back on track. However, after a brief period of activity, it failed to do so and ceased to meet at all within months of its establishment, with the last meeting held in January 2012 and several planned meetings since being simply postponed. Having been given the fullest authority but not exercising it, SOG became an impediment to progress.

### **The regionalisation efforts stall (2012–13)**

By around mid-2012 the regionalisation program had been significantly reduced in scope and resources, with the RaDU being reduced to a single officer working from the Central Australian AMSANT office and the NTAHF entering a period of inactivity.

During this period there was a significant loss of senior personnel across the NTAHF. The commencement of national health reforms in 2011, with major implications for personnel in the NTH and Department of Health, influenced several departures, and at least four key senior figures who had been integral to the regionalisation reform agenda left. Goodwill evaporated between the partners and disgruntled communities already involved in regionalisation were not seeing progress or even activity: 'during the later part of 2012 things seemed to have stalled' (ACCHO staff 117).

The formal relationship between the NTAHF and SOG was ambiguous and confused; the 'new' NTAHF role in regionalisation was unclear and

without PHRG input the capacity of either the NTAHF or SOG to plan and implement progress was virtually non-existent, a problem exacerbated by SOG's failure to sustain its own activity.

In August 2012 the Australian Government imposed restrictions on government spending (Brinsden 2012). Funding was held by DoHA, and it took over the lead role in regionalisation (FaHCSIA 2013:24). There was a severe impact on regionalisation activities. As implementation of the reform agenda fell behind the expectations of the partners, relationships became strained to the point of destabilising the NTAHF:

**And I think [the NTAHF] floundered on lack of ability to implement the ideas that we'd had around regionalisation... We'd been at it for a number of years. There wasn't the sort of progress that you should expect to see with the amount of money that we'd expended on it. The [NTAHF] partners were increasingly... fractious around each other. (Government staff 111)**

By August 2012 the regionalisation program had effectively stalled. In October 2012 the NTAHF met after a long hiatus (NTAHF Meeting #57). A complaint from Miwatj, on behalf of the East Arnhem Steering Committee, was on the agenda. It detailed the lack of any response to its FRP submitted in June and sought a statement from the NTAHF that it remained committed to the regionalisation program (letter, Miwatj to NTAHF, 26 September 2012). The NTAHF directed that the government partners separately provide feedback to East Arnhem on the proposal, that it was to be costed before the NTAHF would respond and, finally, reminded the East Arnhem Steering Committee that 'the process behind the FRP sits with the Senior Officers Group, not with [the NTAHF]' (NTAHF Meeting #57 October 2012). The government partners provided their feedback but there was no formal response from the NTAHF.

By the end of 2013 stage one (development) of the regionalisation process had not been completed for any HSDAs; their local regional planning units were not funded and there were no available funds to allow regional steering committees to meet. In a harsh assessment, a long-term participant remarked that 'Regionalisation has gone nowhere—a huge opportunity gone' (ACCHO staff 109).

As described by a participant, it was one thing to get agreement, but it was quite another to be confident that those decisions would be carried out:

[The NTAHF] being a consultative body—not a decision-making body, you know, was an issue that came up a number of times. The ability of each of the partners to take away—if you call them—'decisions' made at [the NTAHF] or decisions influenced by [the NTAHF], and ensure that their constituencies agreed and took the steps required, was not nearly as strong as the goodwill in the room... at times. (Government staff 111)

### **Changes of government**

In August 2012 the Northern Territory elections led to a change of government. The incoming government imposed further financial restrictions, including freezing staff numbers and limiting travel. In addition it announced a major restructure of the NTH, devolving responsibility for health service delivery to two regional statutory bodies (Top End Health Service and Central Australian Health Service).

The federal election in September 2013 also saw a change of government, an emphasis on financial stringency and a critical scrutiny of Indigenous affairs. This led to a restructuring of the administration of Indigenous affairs, and OATSIH's functions were split. The Indigenous Health Division continued management of funding and regulation of health services within DoHA, and policy functions were moved to the Department of Prime Minister and Cabinet.

### **Corporate governance problems (2012–13)**

At around this time, there were several high-profile cases of reported management problems in community controlled services, including three delivering PHC services in the Northern Territory—Laynhapuy Homelands Aboriginal Corporation (ORIC 2012), Kakadu Health Service (Djabulukgu Association 2012) and Central Australian Aboriginal Congress (Skelton 2012). This had a negative impact on perceptions of the viability of community control as a governance and management model. Allen + Clarke (2011) reported similar issues in 2009–10 and had flagged the loss of confidence by key government officers in the community controlled sector:

I'm just saying in the last 12 months (early 2012–13) we've [NTAHF] fallen into a very bad space. Look, it's also got to do with the collapse and difficulties of some major Aboriginal community controlled health services which I think has soured our relationship and the confidence of the Minister, the Federal [Health] Minister and Federal Indigenous Health Minister. That's what I think—so that he's now a bit pissed off and not confident in the process. (ACCHO staff 103)

## **Findings**

### **Achievements**

Health systems are complex and enduring. Although by 2014 the reform program was suspended, the underlying logic of regionalisation and the potential contribution of community controlled services have not changed. Within at least two regions, Barkly and East Arnhem, a community-based plan for regional health care has been developed and some changes in service delivery arrangements have been made (e.g. the transfer of Yirrkala Clinic from the NTH to Miwatj in East Arnhem).





Important infrastructure for regional PHC has been developed, with continuing relevance and use. The value of the statement of core elements of PHC (Tilton & Thomas 2011) and of the Northern Territory Aboriginal key performance indicators (KPIs) (Allen + Clarke 2011:133) has been noted above. The Continuing Quality Improvement Strategy, funded under the EHSDI allocations (\$2.79 million per year over the intervening four years (Allen + Clarke 2013a:4)) as a result of NTAHF leadership, is also a nationally noted success. Considerable progress has been made towards establishing a consistent approach to continuing quality improvement across the Northern Territory. An evaluation of the strategy found that it had been 'successful in establishing quality improvement across the NT PHC sector', noting in addition that the strategy 'has capitalised on the rich history of PHC innovation in the NT' (Allen + Clarke 2013a:5). Three regional CPHAGs continued to function at least until 2014.

The preparedness of the NTAHF and its member organisations to take advantage of new funding provided under the NTER to pursue both PHC service expansion and the Pathways/ regionalisation program is evidence of its value as an important resource for joint PHC system development. The contrast in the evaluation of EHSDI compared to the Child Health Checks (Allen + Clarke 2011), both introduced on short timeframes as part of the NTER, also supports this view.

*Pathways to Community Control* (NTAHF 2009a) is also of continuing relevance. Its development and release as a high-level statement of the position of the NTAHF partners was a significant achievement. Its significance was variously understood by participants in this study as a commitment to Aboriginal communities, a guide for reform work, a change of intention and role by the NTH, and a document that 'unpacked' the concept of community control, making it more practically accessible. Its conceptual focus on community control, and on partnership with government health authorities, as part of the health system, was a breakthrough, at least in intent.

I know it was a long, torturous process in the development. That was a really important document for [the NTAHF] and a very important document for PHRG; it was used quite actively by PHRG in terms of the development of the reform process and thinking about what the reform process meant... (Government staff 108)

First of all it was a document that promoted what the partners at the [NTAHF] had agreed to in terms of the regionalisation process. And I think that was important so there was no misunderstanding across not just the partners but the staff who work in the three partners... And the community Pathways document was at a language level that... the community could see that they are also equally important in the process. (ACCHO staff 104)

At the time of writing, there are indications that the NTAHF is undergoing renewal, and the *Pathways* document is identified as a key document to revisit. It is reasonable to assume that regionalisation will outlive the current hiatus because it offers a practical way to provide improved access to PHC services in rural and remote Northern Territory. The NTAHF has a long history of innovation and success as a collaborative and deliberative body (Allen + Clarke 2011:124), and the need for its existence and contribution endures.

Despite these significant contributions, this case study found four major areas of difficulty (addressed below) that brought the Pathways regionalisation program to a standstill by the end of 2014.

### **Establishing HSDAs and regional governance**

Effective regional engagement depended on being able to operate in settings of significant social and cultural complexity where local communities held strong senses of identity, place and history. Some communities needed to consider the potential benefits of service

networking in regions relative to what they perceived as likely loss of local autonomy, possibly including resources and funding. The time required in some regions to reach agreement on difficult issues had not been predicted, and some participants would argue that such issues were not well managed by the RaDU, AMSANT or the NTAHF. Significant community capital was expended in the work towards the development of regional structures and regionalisation proposals, but the potential return on this effort was not realised. AMSANT experienced a predictable conflict between its role as the advocate for the community controlled sector and its responsibility for regional implementation through the RaDU.

While endorsing the original concept of regional community controlled PHC, Allen + Clarke (2011:182) make the point that regionalisation and Aboriginal community control are not synonymous. In this case study, it seems that there were problems in relation to both elements. Some participants expressed concern that community control was being incrementally disconnected from the 'main game' of regional service provision. This was seen to have happened more by a selective emphasis on components of the agreed changes rather than by any explicit direction change. In suggesting that the Pathways document itself needs re-invigorating, a long-term participant noted, 'we're not hearing much about community control now, now it's about service delivery' (ACCHO staff 114).

The concept of organising health services on a regional basis has relevance everywhere, and particularly in rural and remote areas, for many reasons. It may be because of this 'common sense' appeal that the scope and nature of a regional structure to deliver health care and/or allocate funding is routinely under-specified. We suggest that the full implications of establishing regions as governance units, functioning as part of the Northern Territory health system and holding funds for PHC in the region, were not fully appreciated. Focus had been on developing the regions, but not on the overall governance, planning and resourcing of the resulting regional system (Government staff 501).

## Authorisation, auspice and control

The Pathways regionalisation program was initiated by the NTAHF during a period of high optimism in a forum that was delivering competent advice to the Australian Government through its robust tripartite methods, technical knowledge and collaborative culture. Having converted the NTER into an opportunity for whole-of-system reform, the NTAHF also took on the primary implementation roles. The task was enormous, funding unprecedented and the timeframe tight. Pressure on the NTAHF, the partners and key decision makers became intense. Problems and differences emerged. Some could well have been anticipated (based on NTAHF experience in the PHCAP period) and/or given a more appropriate timeframe.

As a consultative and deliberative body, the NTAHF was not well placed to manage implementation of regionalisation. Each of the parties had responsibilities that could not be shared: the NTH for the Northern Territory health system; the Department of Health for federal government funding and policy for Aboriginal and Torres Strait Islander PHC; and AMSANT as the voice of the ACCHOs. The resources and responsibility for regionalisation were with AMSANT, even though some of the implementation work could only be done by government or by the partners acting together, a situation that may have contributed to relative inactivity by both government partners. The exercise of shared authority and responsibility by the NTAHF partners was always a challenge.

The outcomes of regionalisation in the Northern Territory have brought into question the role of the NTAHF. It had previously taken on responsibility for implementation, but this has been 'by exception' in relation to smaller projects. The formal agreement that established the NTAHF is explicit in its statement that the two levels of government 'have final decision-making powers within their funding responsibilities, and acknowledge their commitment to public accountability' (Northern Territory Government, Australian Government & AMSANT 2007:7).



In the end, there was a predictable reluctance to shift or share power and control, and, indeed, the government representatives were structurally unable to do so (their employers' powers and responsibilities cannot be transferred in this way). But some shifting and sharing (at least of information and resources) were required for the planning and policy work to be done and, ultimately, some transfers of power and control were explicitly intended. This contradiction could not be avoided, but it could have been discussed and managed more actively.

The loss of commitment to the Pathways regionalisation program by government and by some community representatives underlines the importance of the authorising environment for system reforms of this kind. It seems that higher levels of binding authorisation were required to enable the parties to hold to the agreed course of action, but changes in government, personnel and external disturbances intervened. In hindsight, it seems highly likely that the necessary levels of authorisation and support by governments were not locked in through established decision-making routines. That is not to say that CEOs and Ministers were unaware, but rather that given the implications of successful implementation, higher and more binding levels of authorisation were required.

It needs to be said that even if this had happened in the early stages, nothing can guarantee sustainability through changes of government and regimes. However, there are ways of 'locking in' decision making so that commitment is more secure, and this is a requirement worthy of further attention.

### Capacity and resources

The NTH and the local office of the Department of Health had significant strengths in health policy, but there were some relevant gaps and existing staff lacked either the technical knowledge or the time required to undertake some tasks. The gaps in the policy and planning were significant, particularly work on funding models and the many requirements to transition

between NTH and ACCHO service delivery, including human resources, operational requirements, facilities and equipment.

Similarly, although system functions essential to enabling regional health services to work were identified at several points, proposals for action were not accepted, or not acted on, partly but not only because of resource requirements.

### Working across cultures

Some participants in this study saw the loss of momentum in the reform program as a result of lack of faith in the capacities of Aboriginal communities and their leaders. Turbulence in the health system arising from changes of government and mainstream reform, and losses of key individuals during the program, disrupted some longstanding relationships and exacerbated the problem of trust among the partners. A cluster of governance failures in Aboriginal organisations also contributed to this problem.

The difficulties of establishing good intercultural working relationships are well known, and many of those involved in these reforms had the skills and knowledge to mitigate their impact. Nevertheless, we suggest that this challenge remained implicit, was therefore not able to be openly addressed and managed, and had a (mostly) silent undermining effect on the efforts of those involved to make progress.

### Conclusion: It was always going to be difficult

The NTAHF is the longest standing body of its type in Australia and has a history of significant achievement. There is much to learn from the difficulties experienced in this major reform effort that can strengthen the NTAHF's effectiveness while preserving the value of its corporate knowledge and good working relationships.

The Northern Territory CCTs of more than a decade ago provide an interesting antecedent to the regionalisation program. The evaluation of the Katherine West trial included this observation (Bailie, Menzies School of Health Research Local Evaluation Team & KWHB 2000:41):

Seen from afar, the Katherine West CCT might appear to be a relatively simple innovation in health service delivery involving a funding 'top-up' and the introduction of new clinical practices. In reality it involves far more profound changes, including:

- A radical shift in power relationships within the Katherine West region, insofar as these relate to health services
- Challenges to culturally entrenched beliefs and practices, both among Aboriginal people, but, even more so, within the dominant society, and
- Structural change within the health system.

None of these things can be implemented easily or quickly.

Regionalisation in the Northern Territory was more complex in several ways, not least because it lacked federal Cabinet-level engagement and enduring endorsement by the Northern Territory Government; and, unlike the CCT regions, the Pathways regionalisation program would need to reshape health care in areas with existing ACCHOs and NTH services. It is not surprising that it proved overwhelmingly difficult.



# Case study 2: Towards regionalisation in East Arnhem

This case study documents the engagement of the Miwatj Health Aboriginal Corporation (Miwatj) and the communities and leaders of the East Arnhem Region in the planning and implementation of the Pathways regionalisation program led by the NTAHF from 2009 to 2014. The study is based on interviews with 20 people—14 ACCHO staff (including three people who also served in community representative roles), five current and former government staff and one community representative—and on analysis of 98 publicly available or internal NTAHF and Miwatj documents.

## Background

East Arnhem, situated in the far north-eastern corner of the Northern Territory mainland, has a population of around 10,000 people, covers approximately 33,000 square kilometres, and comprises ten major remote communities (Milingimbi, Ramingining, Galiwin'ku, Gapuwiyak, Yirrkala, Gunyangara, Umbakumba, Angurugu, Milyakburra and Numbulwar), many homelands and outstations, and two towns (Nhulunbuy and Alyangula). Five of the 10 communities are located on islands, which exacerbates the challenges of providing services in this large remote region.

East Arnhem is culturally rich and linguistically diverse, with three major language groupings—Yolngu (Yolŋu), Nunggubuyu and Warnindilyakwa. Within each of these major language blocks are multiple local dialects and variants.

PHC is provided to the people of East Arnhem by four organisations, including the Top End Health Service, an agency of the NTH, and three community controlled PHC providers: Miwatj, the Laynhapuy Homelands Association and the Marthakal Homelands Association. Figure 3 (see next page) shows the location of the health services.

Miwatj was established in 1992, with support from the ATSIC Miwatj Regional Council. From the beginning, Miwatj's objectives have included developing a regional approach and ultimately controlling the development and delivery of health services in the region (Miwatj 2011), and it has approached the Pathways regionalisation program as a way of 'implementing the original vision of the founders of Miwatj: one health board to represent all Aboriginal people in the region' (Miwatj 2013).

Miwatj is governed by a regionally representative elected board based on the original three ATSIC wards—Barra, Bulunu and Mamarika. The current Miwatj Board includes the Anindilyakwa Land Council Chair and others from Groote Eylandt, as well as senior leaders from the Numbulwar region (Miwatj 2014).

Notwithstanding a period of difficulties in the early 2000s, Miwatj has continued to develop and diversify. It now provides PHC and public health programs across the region through four sites (Nhulunbuy, Gunyangara, Galiwin'ku and Yirrkala). It is funded from multiple sources, with the Northern Territory and Australian governments being the largest funders, followed by the Northern Territory Medicare Local (which is itself funding by the Australian Government). Funding for core PHC is provided by the Indigenous Health Division of the Department of Health and, since 2013, Australian Government funding for other health programs has been provided by the Department of Prime Minister and Cabinet.

The Top End Health Service operates Gove District Hospital and nine community clinics. Laynhapuy and Marthakal Homelands Associations provide PHC and other services to the smallest homeland communities/outstations. Laynhapuy provides mobile PHC to approximately 1000 people in 19 homelands,



**Figure 3: East Arnhem Region health services**

(Source: map produced by Primary Health Care Funding Policy Section, OATSIH, 18 February 2011, Commonwealth of Australia)

dispersed across an area of some 10,000 square kilometres, including one off shore island (LHAC n.d.). Management of many clients is shared by Miwatj and Laynhapuy's Yirrkala Health Centre and this arrangement requires a close working relationship between clinicians.

Marthakal provides mobile primary health services to a population of between 250 and 400 people living on 13 outstations located over an area of 15,000 square kilometres (Marthakal Homelands Resource Centre 2012). Marthakal Health and the (Miwatj) Ngalkanbuy Clinic at Galiwin'ku have formal arrangements to share care and patient records, and staff work closely together.

## The regionalisation process

The people of East Arnhem approached the proposed regionalisation of health care with a well-established understanding of its potential benefits, arising from engagement with broader regional action, including through opposition to mining (Fitzgerald 2001:207–12) and experience with the ATSIC Regional Council and national leadership.

### East Arnhem Regionalisation Proposal (2007–12)

In keeping with the long-held aspirations of the Yolŋu people for self-governance, and the original vision of Miwatj as a regional health service, Miwatj commenced work towards regionalisation prior to the development of *Pathways to Community Control* (NTAHF 2009a).

In 2007 the Miwatj Chair, the CEO and Mr Terry Yumbulul, a senior Yolŋu clan leader, made a regionalisation study trip to Katherine West Health Board, a successful regional community controlled health service established in 1998 (EASC 2010). Subsequently, in July 2008 Miwatj commissioned Mr Yumbulul as liaison officer to discuss the regionalisation proposal with communities across East Arnhem.

The East Arnhem Steering Committee (EASC) was established in September 2008 with the goal of preparing a detailed plan and proposal for regionalisation. The EASC met quarterly until the Initial Regionalisation Proposal was submitted in December 2010 (EASC 2010) and monthly from February 2011 to June 2012, when the FRP was submitted to the NTAHF. During this period EASC membership comprised 21 representatives from all major communities in East Arnhem (with the exception of Ramingining<sup>3</sup>) and representatives of the NTAHF partners (i.e. NTH, 2; AMSANT, 3; Department of Health, 2). AMSANT provided secretarial services until July 2011. All participants were engaged in developing the FRP.

Regional activities were well underway in East Arnhem by the time the NTAHF, in late 2010, endorsed the Regionalisation Guidelines (NTAHF 2010). During the period 2008–12 the EASC worked systematically through the four steps of stage one (development), leading to submission of the FRP, as summarised in Table 5 and described on the next page.

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3 The Ramingining representative had passed away and no replacement had been offered.

**Table 5: East Arnhem regionalisation development timeline**

<b>STEP A</b>	Initial Community Consultation	Mid-2008 liaison officer appointed, consultations carried out during 2008–09
<b>STEP B</b>	Establish Regional Committee Establish a CPHAG	September 2008 EASC established February 2011 CPHAG established March 2011 Communicare Users Group established
<b>STEP C</b>	Develop Initial Regionalisation Proposal	December 2010 Initial Regionalisation Proposal submitted to NTAHF
<b>STEP D</b>	Broad consultation to develop FRP	July 2011 Regional Planning Unit established with two employees and 12 months' funding December 2011 community consultation report tabled at EASC (Christie et al. 2011) June 2012 FRP submitted to NTAHF

The East Arnhem CPHAG was established in February 2011 and met regularly (every six to eight weeks). Its original role was to provide advice to the EASC on developing a regional health service plan and on improving coordination of services, and it continues with the latter function.

The East Arnhem CPHAG includes representatives from the PHC services and the NTH/Top End Health Service (including Gove Hospital). CPHAG is the first joint planning forum for Aboriginal PHC in the region and continued to be a successful collaborative structure, 'building very good relationships for service delivery in the region' (J. Woltman, personal communication, 12 June 2013).

CPHAG focused on some of the key building blocks for strengthening health systems (WHO 2007), such as workforce development, with the goal of increasing the numbers, skills and career pathways for Aboriginal staff. It also established a Communicare Users Group to support a regional approach to an electronic client information system. In July 2011 Miwatj was funded for 12 months under the NTAHF regionalisation budget to operate a Regional

Planning Unit (RPU). The unit, with two full-time employees, supported the EASC and CPHAG meetings and coordinated work towards the FRP. Funding for the RPU ceased as of July 2012, but one position was maintained by Miwatj to progress the agreed NTAHF regionalisation program. The EASC was no longer able to meet due to the costs of bringing together representatives from across this large region.

### Design of regional governance (2009–12)

The EASC and government representatives had different concerns about the structures and processes for regional governance, and tensions became apparent early in the process.

The question of whether to establish a new overarching regional board or to adapt the Miwatj Board was considered by the EASC (in a governance workshop held in mid-2009) and later at a special meeting of Indigenous EASC members and regional leaders. There was considerable debate on the wisdom of establishing yet another regional entity<sup>4</sup> and the meeting decided that the Miwatj Board would be the board of management for the proposed regional health service (minutes of this

<sup>4</sup> At around this time, in mid-2008, the Northern Territory Government had moved to establish an East Arnhem Shire Council, which also sought representation from the region. By 2013 Mr Banambi Wunungmurra was both the Shire Council Chair and the EASC Chair.





meeting were not taken). A year later, following a second governance workshop in August 2011, the EASC formally endorsed the existing Miwatj Board (with adjusted representation) as the East Arnhem Regional Health Board (EASC 2011). The Miwatj constitution was subsequently amended so that at least one homeland representative from each ward would be included. Other changes were made to enable non-Indigenous people to become members of Miwatj and to enable the Board to establish committees and advisory groups (Minutes, Miwatj Annual General Meeting 2012).

As noted in the 2012 FRP (EASC 2012:25):

**It is important to keep in mind that the Miwatj Regional Health board is also made up of representatives from across the whole region and will include specific representation by Homelands people so they will all have a commitment to ensuring the best outcomes for the whole region.**

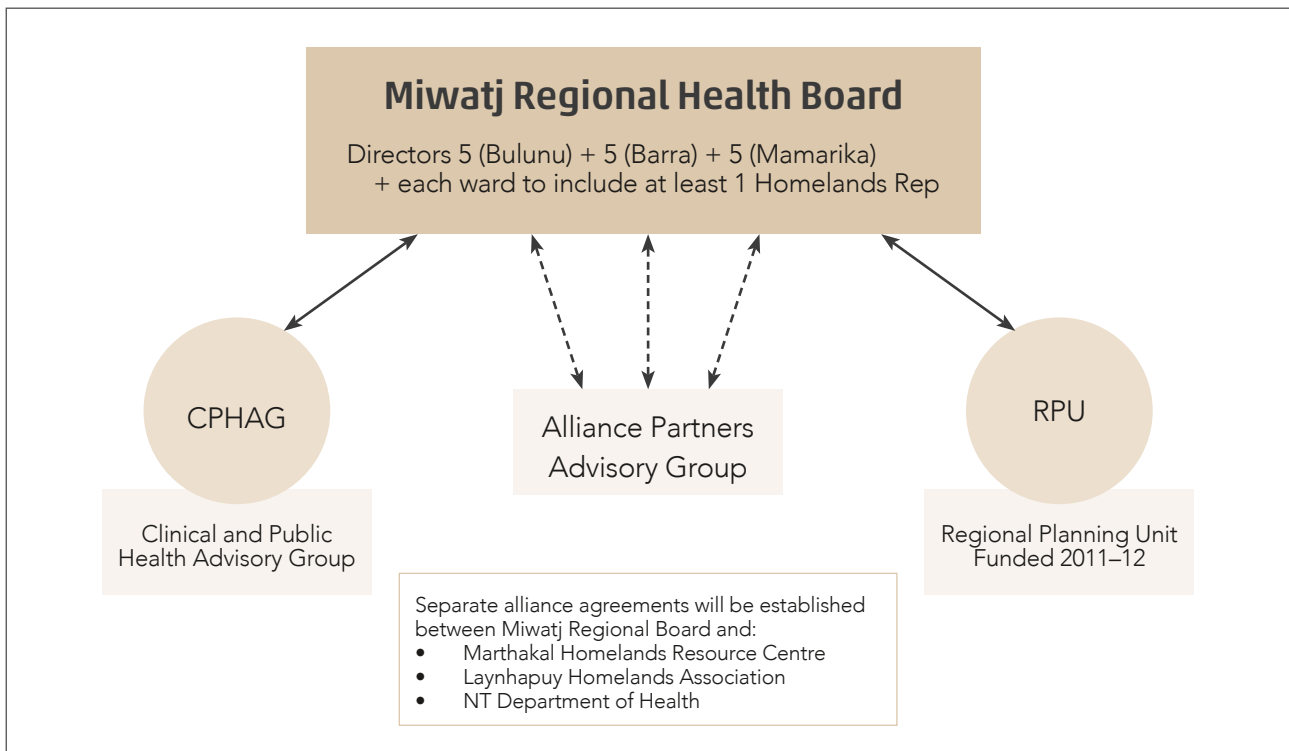
This approach was contested in discussions with the Department of Health on the grounds of inadequate (male and female) representation of each community (ACCHO staff 502). Further

concern was expressed about the way the EASC envisaged linking into the existing complex East Arnhem health service provider landscape. Government representatives preferred one regional ACCHO (as intended in *Pathways to Community Control* (NTAHF 2009a)) and were concerned about the EASC decision to adapt the Miwatj Board for regionalisation rather than creating a single overarching board (to encompass governance of all three ACCHOs).

The EASC FRP outlined an alliance model (Figure 4) to provide a formal partnership with regional health service providers, Laynhapuy and Marthakal, which had opted to remain as independent organisations.

Specifically, the FRP noted (EASC 2012:24):

**Miwatj Health will continue to be a regional health service provider—transitioning NTH clinics incrementally. The Miwatj Regional board would develop a regional alliance agreement (similar in scope and function to [the Memorandum of Understanding]) with all the primary health care service providers in East Arnhem including NTH.**



**Figure 4: East Arnhem Region Alliance Model**

The alliance agreement would be signed by the board of each organisation, or a senior delegate in the case of the NTH, and would include guiding principles and provision for sharing data and linking the clinical information system (Communicare), as well as for collaboration on shared concerns. It was envisaged that joint working groups would address issues and opportunities for all service providers and make recommendations to the Miwatj Board.

Under this arrangement the Miwatj Board would be the regional lead entity and the funds holder. The EASC argued in its FRP that within the proposed alliance model there would be a cultural component of reciprocal obligation between the Miwatj Regional Health Board and the East Arnhem Alliance partners when they committed to this approach. Asked directly whether communities were concerned that Miwatj was 'taking over', a senior EASC member noted that EASC members 'are on a lot of committees, they know what's happening; we're not taking over all the clinics and services, we're concentrating on funding and access to services everywhere' (Community representative 503).

It was also envisaged that parties to the agreements might change over time, allowing for an incremental approach to service transition. In particular, the Groote Eylandt people might eventually choose to establish their own regional health service. However, at the time of the FRP they were represented on the EASC and the Miwatj Board.

### **Formal community consultation (2011)**

In mid-2011 the EASC commissioned Charles Darwin University to undertake a community consultation on regionalisation with the results to be included in the FRP. The consultation was conducted in local Aboriginal languages, by East Arnhem Aboriginal staff who were trained and supported by experienced academics. The consultation survey methods included a sampling strategy to achieve coverage of all relevant groups and the overall goal was to consult with 360–70 adults across East Arnhem 'to establish a reasonable level of agreement on a regional PHC service model and governance structure' (Christie

et al. 2011:11). Clinic staff and non-Indigenous community members were not included, in the expectation that the NTH and AMSANT would also conduct consultations with their staff/stakeholders (Christie et al. 2011:12). Ultimately, 401 men and women were surveyed. As well as reporting community views, Christie et al. (2011:10) also spelled out the complexities of community consultation and communication in the region, noting that 'the story behind the health reforms is complex and multi-layered, and the reform process constantly changing and evolving'.

Although about half of those participating were positive about the regionalisation proposal, others wanted more information. The authors reported that 'the more informed people felt about the health reforms, the more positive and supportive they were of the reforms and the regionalisation process' (Christie et al. 2011:1). The authors noted that the survey was conducted late in the process when some important decisions had already been made by the EASC and community leaders (Christie et al. 2011:11).

### **Regionalisation proposal not endorsed by the NTAHF (2012)**

The submission of the FRP in June 2012 coincided with a period of disarray in the NTAHF, and the EASC did not receive a formal response. The Miwatj CEO wrote to the NTAHF in September 2012 to report that although he had been advised that the government partners had concerns, his requests for specific concerns to be communicated had been unsuccessful.

The NTAHF decided that the members should provide separate written responses to Miwatj and noted that the NTAHF itself was no longer empowered to endorse FRPs (see Case study 1 for more information). The Department of Health (Northern Territory office) responded promptly with a short letter advising that further work would be required and addressing the perceived conflict of interest for the Miwatj Board in its capacities as 'a sub-regional provider and a regional board' (letter, Department of Health (NT) Manager to Miwatj CEO, 10 October 2012). The letter also requested that EASC/Miwatj



prepare a plan for 'health reform activity' and further community consultation. Details of the EASC's endorsement of all components of the FRP were also requested, and a provisional offer of further funding (up to \$200,000) was made.

Some of these requests were seen as unreasonable or already addressed in the FRP. All NTAHF partners were represented at and participated in the EASC meetings during 2011–12, when the FRP was developed and endorsed, and the community consultation process had been thorough and well conducted. The Department of Health considered that a detailed plan for implementation was required prior to sign-off on the FRP, whereas the EASC considered that sign-off was needed first, given the significant investment (of resources and community good will) that would be required and also given the CPHAG's existing work on key aspects of regional health system reform. Differences on the question of a single ACCHO board for all services in the region and the role of the Miwatj Board were unresolved.

On 22 January 2013 Miwatj (RPU) provided a response to a senior Department of Health officer (via email and a discussion paper (titled 'Miwatj Discussion Paper January 2013'), giving detailed attention to the issue of potential conflicts of interest and the mechanisms designed to ensure maximum participation and transparency. The paper detailed changes made to the Miwatj constitution and drew attention to the reality of the multiple 'kin and clan', cultural and organisational linkages among the senior regional leadership (such as the presence of board members of both Laynhapuy and Marthakal on the Miwatj Board) and the members' preferences for the existing arrangement.

A further letter in March 2013 from the Department of Health to Miwatj described the alliance agreement model as 'a solid first step in building a governance approach that represents the East Arnhem communities' and outlined further requirements, including a detailed five-year plan and timeframe for 'bringing new communities into the governance structure' and for 'efficiencies produced by shared purchasing arrangements for health services

and administration' (letter from Department of Health (NT) Manager to the Chair of the EASC, 12 March 2013). The provisional offer of funding, to be provided after the completion of the work, was also affirmed (subject to receipt of a revised budget proposal).

No further developments in relation to the FRP occurred during the period of this study, although Miwatj has continued work on the development of a regional PHC service.

### **Transitioning Yirrkala Clinic (2012)**

At the same time as the FRP was submitted (mid-2012), Yirrkala Clinic transitioned from being an NTH service to being a community controlled service as part of Miwatj.

Yirrkala is a small township located 15 kilometres from Nhulunbuy. It has a population of around 1000 and is the largest Yolŋu community on the East Arnhem peninsula (PwC 2012:5). The town site was established by Methodist missionaries in 1934. Mission staff later established a small hospital, which was handed over to the Northern Territory Government in the mid-1970s with a staff of Aboriginal Health Workers and one nurse from the Nhulunbuy Hospital (Read 1983:19–23). There had been discussions about transfer to Miwatj since the 1990s, when the clinic was noted to be underfunded.

Discussions commenced again in 2008 and an agreement on the transfer of Yirrkala to Miwatj was completed by December 2011, with Miwatj taking over day-to-day management of the clinic in July 2012.

Miwatj engaged PricewaterhouseCoopers (PwC) to undertake a financial and service analysis of the Yirrkala transition process. PwC reported that Yirrkala's KPI results were below average and it lacked accreditation by Australian General Practice Accreditation Ltd (AGPAL) prior to transfer (the clinic is now accredited), and that a broader range of services (health promotion and illness prevention, chronic disease management programs) were offered following transfer (PwC 2012:21).

The transfer of operating funds from the NTH to Miwatj was contentious and delayed (letter, CEO Miwatj to NTAHF, 26 September 2012). The allocation of overhead costs (management and support costs such as information and communications technology (ICT)) was the focus of concern. The question of direct allocation by the Australian Government to Miwatj or allocation via the NTH was also debated. The funding was resolved (without a specific allocation for overhead costs) following a threat of a Christmas shutdown of the clinic.

Although the NTH had explicitly excluded the Yirrkala transfer from the NTAHF regionalisation processes (letter, CEO Miwatj to NTAHF, 26 September 2012), the stringent requirements of the Competence and Capability Framework were applied as a condition of approval to transfer. The framework was completed with support from PwC and showed good results. PwC noted that although all parties recognised that they were learning how to do transition, there was a 'high level of uncertainty that impacted on the relationship management of the transition process' (PwC 2012:22). It suggested that future such exercises should include clear agreements on financial and other data to be shared among the parties, including timeframes for delivery and early attention to ICT and data-sharing systems. PwC also emphasised the need for timely documented confirmation of all contractual obligations to be transferred, especially employee contracts and entitlements (PwC 2012:22).

This experience of transfer of a remote NTH clinic has highlighted some technical and relationship challenges that are likely to apply to future transfers. The relative paucity of local clinic infrastructure, such as ICT, and the challenge of quantifying and transferring overhead costs are important matters of concern to Miwatj and the Australian Government. It can also be expected that Northern Territory Government staff will resist a change in their employment arrangements in the absence of clear up-front guarantees of 'no

disadvantage'. There was also a sense in this case that staff were not comfortable working for an Aboriginal organisation or lacked confidence in management capability—a view also expressed to a senior community leader: 'they said we didn't have the expertise' (Community representative 503)—or did not want the NTH to lose ownership:

Well when we're talking about regionalisation... there'd also been that sort of resistance... I don't think Territory Health were particularly keen to transition. You know, these were their clinics. (ACCHO staff 116)

### Miwatj funding contracts and performance

Given concern about the governance and management capability of Miwatj, it is relevant to describe its funding contracts and its performance.

Miwatj had experienced growth in funding associated with the Northern Territory EHSDI program starting in 2009–10, growing from total funding of more than \$9 million in 2008–09 to more than \$17 million in 2013–14. In the 2013–14 financial year it received funding in 14 separate contracts or schedules, requiring 167 reports. Reports were for a range of funders and were required quarterly, six-monthly and annually.

The Northern Territory Aboriginal Health KPIs (unpublished data, 2013) and Miwatj records document several indicators of effectiveness in provision of PHC:

- provision of an MBS health assessment that exceeds the national average (aged 0–4) in Galiwin'ku, Nhulunbuy and Gunyangara (Northern Territory Aboriginal Health KPIs)<sup>5</sup>
- the lowest proportion of babies born with low birth weight (11 per cent), compared to East Arnhem as a whole (19 per cent) and the Northern Territory (14 per cent) (2013) (Northern Territory Aboriginal Health KPIs)
- immunisation that exceeds the Northern Territory average rate in all age brackets (2011, 2012 and 2013) (Australian Immunisation Registry)

5 No comparative data for Yirrkala was provided until the following reporting cycle.



- significant increase in episodes of care at Yirrkala following transfer to Miwatj from the NTH; in 2013 the first complete calendar year that Yirrkala was part of Miwatj, episodes of care increased by 408 per cent to 11,420 (Northern Territory Aboriginal Health KPIs) from the previous level of 2794
- a significant increase in the proportion of patients whose allergy status was recorded in their files in Yirrkala, as required for accreditation; in May 2014 recorded allergy status had increased from 10 per cent to more than 60 per cent<sup>6</sup>
- increased employment of qualified Aboriginal and Torres Strait Islander people; of 139 employees, 79 are Indigenous workers (56 per cent).

We suggest that this is a typical pattern of performance by a competent ACCHO—managing complex program funding to deliver effective PHC.

### Regionalisation work continues (2012–14)

By late 2012 it was clear to Miwatj and the EASC that the NTAHF regionalisation program had come to a standstill. The Miwatj RPU was no longer funded and the EASC was unable to meet. After intense investments of time and resources for almost five years, the regionalisation initiative was losing momentum in East Arnhem.

However, Miwatj retained regionalisation as a key organisational priority. It did not proceed with the formal alliance structure proposed in the FRP, but took the view that existing arrangements for working relationships with Laynhapuy and Marthakal functioned well and that Miwatj is well placed to manage any future transfers of NTH clinics.

Miwatj has actively canvassed support for regionalisation, including meeting in December 2012 with the Northern Territory Minister for

Health (David Tollner), who gave a written commitment to transfer remaining Northern Territory clinics in North East Arnhem and, subject to agreement with the Anindilyakwa Land Council, those in South East Arnhem, specifically Groote Eylandt and Numbulwar (personal communication, CEO Miwatj Health, February 2013). The Minister lost the health portfolio one month later and senior staff of the department expressed concern about resistance to transfer among regional NTH staff whose jobs may have been affected by transfer. The existence of this concern has been confirmed (but not endorsed) by a senior officer in a meeting with NTH Minister Lambley in July 2014 (Miwatj Health RPU Manager, personal communication, 14 September 2014).

Miwatj is pursuing a strategy of incremental regionalisation through the transfer of willing clinics to the community-control model. In areas such as Groote Eylandt and Numbulwar, where community controlled services have never existed, there is scope for the development of a separate regional service. In the meantime, the regionally inclusive Miwatj Board structure offers senior leaders in the region an opportunity to participate in debate, to pursue the growth of health services and to assess the potential benefits of regionalisation for their own communities.

The CPHAG continued to meet and has established a Regional Clinical Governance Network to provide advice and support on clinical matters. The scaled-down RPU continued to function funded by Miwatj. The RPU has established a relationship with the Cape York-based Jawun Indigenous Corporate Partnerships program, which has enabled the development of an advocacy policy and supportive resources and a change management strategy for use in future clinic transition processes.

At the time of writing, Miwatj was in discussion with the NTH about the possible transfer of the Milingimbi Health Centre to a community controlled model within Miwatj, with the support of the Minister of Health (Lambley 2014).

<sup>6</sup> Extracted from the East Arnhem Communicare Database.

Despite sometimes difficult relations with the NTH regarding regionalisation, Miwatj continues to take opportunities to progress its regional agenda, noting that 'to achieve the outcomes we all want, real partnerships are crucial' (Miwatj CEO cited in Lambley 2014).

## Findings

### Achievements

This case study documents the development in one region of a plan for regionalisation, and the challenges and achievements of the project. There was some practical progress, including developments towards regional community governance for health services, and the full transfer of the clinic for one community. But in spite of these achievements, the results fall short of success in efforts to implement the reforms intended in the original *Pathways to Community Control* document (NTAHF 2009a). This section addresses the major issues influencing this outcome.

### Regionalisation as a path to self-determination

Miwatj has demonstrated that it remains strongly committed to regionalisation because, from the outset, it has linked increased regional autonomy with self-determination and better health outcomes. East Arnhem Aboriginal people have a narrative of regionalisation and increased autonomy that reaches back more than 50 years to the Bark Petitions and the Gove Land Rights Case (*Milirrpum v Nabalco Pty Ltd* (1971) 17 FLR 141). That narrative continues to inform decision making and to draw in local leaders. The announcement of the EHSDI funding and the NTAHF decision to use some of the funds to establish regional community controlled health services presented the East Arnhem communities with an opportunity to progress their existing vision. Miwatj was well prepared prior to the release of the *Pathways* document, and by the time the NTAHF (2010) Regionalisation Guidelines were released in

late 2010 leaders and the community had been working on their ideas for almost four years. They were unprepared for either the months of silence following the submission of their FRP in mid-2012 or the subsequent additional requirements that were apparently based on a perception by government officers that their regionalisation plans were ill-conceived and too risky.

Miwatj continues to see itself as having a broader role than the delivery of PHC, a view that is consistent with that of the ACCHO sector nationally. As a staff member explained:

I think you've got to look at success in many ways. Service delivery is an important part, it's what we're funded to do, but it's more than that. It's what organisations like this do to the hope of people, I think that's the important thing, that people are proud to be... part of Miwatj in one way or another... Everyone that's got jobs are real jobs, so the community is proud of Miwatj... This is our organisation and I think that's really important and that's the way it's got to be if you're going to build people. (ACCHO staff 402)

### Authority and decision making

The processes of regionalisation were seen in some ways as revisiting established community decisions and adding requirements for new consultations and agreements. There was considerable pressure to renew decisions already made, which led to some community conflict without leading to implementation of the desired reforms: 'So, you know, we wasted a lot of time and money and effort' (ACCHO staff 402).

The responses of government officers to the Miwatj FRP were also affected by the tight budget situation of 2011–12 (particularly for the Australian Government) and the apparent withdrawal of high-level support for the regionalisation process. During the period covered by this study, changes of government at both the Northern Territory (August 2012) and national levels (September 2013) brought financial stringencies and the defunding of some



health programs. There were several changes of Northern Territory Health Minister and a major restructuring of the Northern Territory health system.

There is some resentment in Miwatj and the EASC membership about what is perceived as a lack of respect for community authority and ways of making decisions. In the period after the FRP was submitted, there was a sense of new requirements being set rather than a genuine dialogue or engagement: as a senior community representative observed, 'the goalposts seem to be moving all the time' (Community representative 401). Invitations, including in writing, were made to the Department of Health (Northern Territory) and NTH staff to explain their requirements to the Miwatj Board, the EASC and the community, but none were accepted:

**we also challenged our fellow key stakeholders from the Department of Health and Community Services, 'could you come to the table and actually give us the feedback?' (Community representative 401)**

This period led to perceptions of a lack of respect by government officials for community leaders and Elders and a lack of understanding of their essential role in progressing regionalisation:

**The fundamental things with the Elders—and [we'll] say over and over again—'engage with us, inform us but truly respect and value us because we are the solution to succeed and actually contribute to our society'. (Community representative 400)**

**They need to start realising that we've done everything what's achievable and manageable. How many more [times] do we have to be scrutinised, continue what we're doing. And what about the Department of Health and OATSIH? They need to be scrutinised just as well because it is taxpayers' money. (Community representative 401)**

## **Loss of commitment to regional community control, lack of trust in ACCHOs**

There was an evident loss of commitment among the NTAHF government partners to the community control model (Allen + Clarke 2011:141). *Pathways to Community Control* (NTAHF 2009a) is unambiguous, with its subtitle spelling out *An Agenda to Further Promote Aboriginal Community Control in the Provision of Primary Health Care Services*. The document goes on to state that 'Parties have agreed that community controlled governance of health services is the optimal expression of the right of Aboriginal people to participate in decision making' (NTAHF 2009a:5).

The Pathways document does not use the terms 'participation' and 'community control' interchangeably. Rather, it argues that increased participation—in all phases and/or aspects of a community health service—is the pathway to community control. Participation is a means to an end, not an end in itself. The linking of regionalisation with community control was further clarified in an NTAHF agreement to use consistent terminology in all communications, specifically the term 'regional Aboriginal Community Control' (NTAHF Meeting #47 December 2009).

However, the document (NTAHF 2009a:5) also discusses the complex meaning of 'community control':

**community control refers to the principle that Aboriginal communities have the right to participate in decision making that affects their health and wellbeing. It also refers to the organisational model of Aboriginal community controlled health services that has existed for more than 30 years.**

The document also identifies the capabilities of Aboriginal communities and boards of management as threshold issues within this framework: 'These structures must be able to serve the community's interests, stay connected with the community's preferences and values and discharge strategic corporate responsibilities effectively' (NTAHF 2009a:23). Here the emphasis is on the interface between community interests, preferences and values

and the effective management of a corporate health entity. That is, effective governance of a community controlled service will reflect community values and require response to community preferences; it will be connected to its constituents.

But there were shifts in government commitment to these goals and ideas. Following a regionalisation workshop in Alice Springs in 2013, Allen + Clarke (the facilitators) reported that the NTAHF partners no longer shared an understanding of the relationship between the central concepts of community control and regionalisation, with Department of Health officers expressing the view that community control involves 'Aboriginal communities being given opportunities to participate in health service planning' and the NTH also emphasising community participation (Allen + Clarke 2013b:4). Thus community control is conflated with participation, and regionalisation is separated. However, the NTAHF (2010:10) had previously indicated that the partners had an agreed definition and a shared vision for regionalisation, which is:

**Working together to improve health outcomes for all Aboriginal people in the Northern Territory through health system reform and the development of Aboriginal community controlled primary health care services which provide safe, high quality care and facilitate access to specialist, secondary and tertiary care.**

The impact of several high-profile governance failures or problems in Aboriginal organisations during this period added to a sense of concern about the governance capability of the community control model and influenced the thinking of politicians, as well as public servants.

The experience was a dispiriting one with particular consequences for continuing community engagement. Although noting that he and his countrymen are 'patient people', a senior community representative said that he worried about his board colleagues losing interest because they had not heard anything for so long; he added that when such intense

work and discussion apparently lead to nothing changing, 'the criticism and blame falls back on us' (Community representative 503).

The Miwatj Chair commented on:

**what we feel is a very hard-handed, double standard approach you have taken to the regionalisation process in East Arnhem despite all good work the Steering Committee and Miwatj Health has done to reform health service delivery for our people of the past five years. (Letter, Miwatj Chair to Department of Health NT Manager, 17 July 2013)**

## Conclusion

Miwatj and the EASC vigorously pursued the opportunity to transfer PHC services to regional community control because it fitted well with their vision for the future. But it seems that the timing of the submission of the FRP—coinciding with a period of dysfunction in the NTAHF and indolence on the part of the SOG (which was intended to speed up the process through effective decision making)—led to its failure.

We have relied on documentary evidence to interpret the perspectives of government officers but have been unable to clarify why dialogue was lacking. It seems likely that the failure to secure agreement with the two existing ACCHOs in the region to amalgamate with Miwatj was an important barrier from government perspectives (in spite of the principle of no forced amalgamations). It also seems that the stated intention to accept FRPs was no longer being honoured, and government responses were designed to discourage persistence by the EASC/Miwatj.

Whatever the barriers, the fact that there were no opportunities for frank discussion among the parties seems to have sealed the fate of the FRP. This approach is reminiscent of the ungainly conclusion of the PHCAP program (NTAHF Meeting #25 September 2004; Rosewarne & Boffa 2004).





A comment by Smith (2008:83–4) in relation to the abandonment of the Building Stronger Regions, Stronger Futures policy suggests that this is a recurring problem worthy of attention in its own right:

What had happened? The sudden demise of the [Building Stronger Regions, Stronger Futures] policy owed much to the ideological dissatisfaction and implementation difficulties experienced by government bureaucrats in trying to accommodate Indigenous ideas about 'regions' and representation for local

government, and their consensus modes of decision-making about these matters. Discussion and decision making took time, internal negotiation and sensitive facilitation—all of which challenged the capacity, commitment and resources of the NT and Australian Governments. The political imperative for fast results chafed at the more measured pace of voluntary regionalisation, and in the meantime, several NT community and association councils had collapsed owing to poor financial administration and governance.



# Case study 3: Transition to community control in Cape York

This case study explains work towards the transition of PHC for Aboriginal and Torres Strait Islander communities in Cape York from Queensland Health to Apunipima Cape York Health Council from 2006–14, following the signing of a Deed of Commitment (CYRHF 2006a) with the Queensland Government (and other parties, including the Department of Health) in 2006. A more detailed account of the development of Apunipima is provided in the report *Towards a History of Apunipima Cape York Health Council, 1994–2006* (Tilton et al. 2015).

This case study is based on analysis of 111 documents, and on interviews with 27 people, including seven who had been involved in two capacities, and two who had been involved in three capacities during the period under study. Thus 21 people had occupied ACCHO roles; 11 had been community representatives, and nine had served in government roles. We had limited access to interviews with current Queensland Health staff or to minutes and other outputs of forums convened by government.

## Background

Apunipima was established in 1994 at an historic four-day meeting of Aboriginal and Torres Strait Islander community representatives from across the region at the Pajinka Wilderness Lodge at the tip of Cape York. The new organisation drew on community concern about the availability and appropriateness of existing health services, and the conviction that it was time for the communities to have more say in their health care. Its establishment also came with strong support from the Cape York Land Council and the ATSIC Regional Council.

The development of an Aboriginal and Torres Strait Islander voice for health in Cape York also found support in government, particularly among senior regional officials who realised that the existing health system was failing to improve the health of Aboriginal and Torres Strait Islander people and that a new approach that extended beyond the narrow confines of clinic-based acute care was needed.

Initially, Apunipima focused on advocating for better health care, with funding provided by the ATSIC Regional Council. Apunipima rapidly developed a national profile, adding its voice to the then widespread campaign for systemic action on Aboriginal and Torres Strait Islander health.

Soon after its establishment, Apunipima attracted grants from several other funders, and established health promotion, sexual health, social and emotional wellbeing, suicide prevention, alcohol and smoking, women's health and family violence programs. Apunipima pursued a partnership approach to making services more appropriate for Aboriginal communities, and was successful in building relationships with partner organisations, including funders.

Despite the strong relationships and its success, by around 2000 there was an increasing realisation within Apunipima that advocacy alone was not enough to change the way the health system operated.

## The regionalisation process

The signing of a Queensland Framework Agreement by both governments and the Queensland Aboriginal and Islander Health Council (QAIHC) in 2002<sup>7</sup> underpinned the re-

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7 An earlier (1996) Queensland Framework Agreement did not include the community controlled sector as a signatory.

establishment of the Cape York Regional Health Forum in 2005, and this body commissioned the Cape York Institute to develop a model for comprehensive PHC services in Cape York. The resulting 'Health Reform Project and Social Enterprise Proposal' (CYI 2005) recommended that Apunipima take on the delivery of comprehensive PHC services for Cape York, resourced through the pooled funding of existing Queensland Health expenditure, plus additional, new Australian Government funds from the PHCAP (McDonald 2003)<sup>8</sup> and other mainstream sources, including Medicare (CYI 2005:12,13). Apunipima was to reform its governance structures with a smaller governing board, including representation from the Cape York Institute, funders (Queensland Health and Department of Health) and outside expertise as needed (CYI 2005:22,52).

On the basis of the proposal, the Cape York Regional Health Forum endorsed a Cape York Regional Health Strategy in January 2006 (CYRHF 2006b:27). The Apunipima Board accepted the recommendations of the Regional Health Strategy, and those of the original health reform proposal (CYI 2005). In doing so, the Board recognised the significant changes and capacity building that would be required (ACYHC 2006:3). A Deed of Commitment, which endorsed the strategy including the role of Apunipima and the concept of funds-pooling, was signed by all parties in August 2006, with a target date for full implementation by June 2011.

### **Early promise: Intensive work within Apunipima (2006–07)**

The period immediately following these commitments was one of concentrated activity for Apunipima as it accepted the challenge of transitioning from an organisation with about 20 staff members and a focus on advocacy to an organisation that would take responsibility for PHC services across Cape York (ACYHC 2006:3; Coombe 2008).

In 2006 a Transition Planning Unit was established within Apunipima, funded jointly by the Department of Health and Queensland Health. It reported to a steering committee made up of representatives of the Department of Health and Queensland Health, the Cape York Institute, the Royal Flying Doctor Service (RFDS), the Far North Queensland Rural Division of General Practice (FNQRDGP) and QAIHC. Apunipima undertook an extensive round of engagement with local communities to present the new model of community controlled health care to the Aboriginal and Torres Strait Islander people of Cape York and to seek their endorsement. As the Chairperson of Apunipima reported, 'In principle, the communities have welcomed the idea of community control with the qualifier that they do not want to see a decrease in service quality' (ACYHC 2006:3).

Apunipima also led the establishment and strengthening of the Health Action Teams (HATs) (Coombe, Haswell-Elkins & Hill 2008). Whereas, previously, the HATs had varying degrees of local support and engagement, now they were established in every community except Aurukun, with resourcing from the Australian Government's Building Healthy Communities Initiative. A skills audit of HAT members was carried out and training was provided (through RFDS and FNQRDGP) to support them in their important role (ACYHC 2007:102).

A new constitution (under the federal *Corporations (Aboriginal and Torres Strait Islander) Act 2006*) and a modified board structure were endorsed at the Apunipima Annual General Meeting late in 2006 and, following the new constitution's approval by the Office of the Registrar of Indigenous Corporations in May 2007, a new (smaller) board was in place by September 2007. The new board had membership along the lines endorsed in the Cape York Health Strategy, including ex-officio membership from government health departments and private enterprise (ACYHC 2007:99).

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<sup>8</sup> PHCAP was a federal government initiative announced in the 1999–2000 Budget to improve Aboriginal and Torres Strait Islander access to comprehensive primary health care in areas identified through regional planning processes.

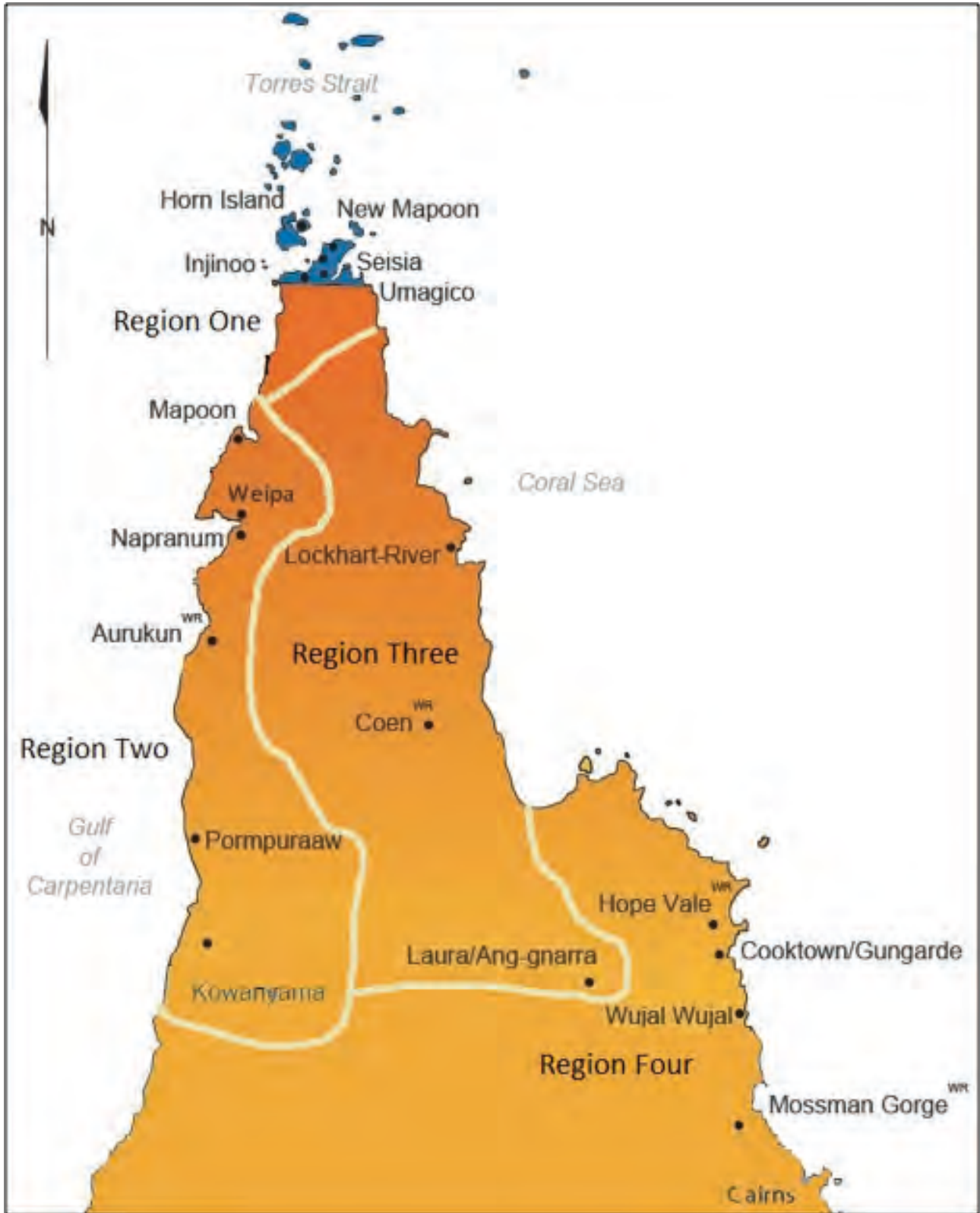


Figure 5: Cape York Health Regions served by Apunipima, 2014  
 (Source: ACYHC n.d.)



## Emerging doubts within government (2006–07)

Apunipima's intensive work to implement the Deed of Commitment was supported by both governments, but early doubts emerged within these agencies about the transition to community control.

Within Queensland Health, the importance, and even legitimacy, of the Deed of Commitment was questioned. As one Queensland Health staff member of the time recalled:

*[It] wasn't something that was, I suppose, marketed, acknowledged by Queensland Health... it wasn't something that was openly talked about... there was no supporting documentation... I think it was again one of those things that was on the spur of the moment. You've got a commitment to something but what does that commitment need and to what extent? (Government staff 200)*

Significantly, broader events in Queensland undermined the focus on the transition process. Incidents at the Bundaberg Regional Hospital in 2005 (Bundaberg Hospital Commission of Enquiry 2005) had led to a major review of health services in the state, and in 2006 Queensland Health underwent substantial reforms, including halving the number of health districts from 38 to 20 new 'health areas' (Robertson 2008), reforms that consumed much policy capacity and management attention.

The Department of Health also raised early concerns about the capacity of Apunipima:

*there were a number of concerns, from members of the Steering Committee, with the transition planning project... Government agency concerns appeared to be grounded in whether Cape communities and Apunipima [were] capable of delivering the necessary health services. This raised further concerns that government may not continue to fund the project. (ACYHC 2007:96)*

Despite a review of the transition project in early 2007, and reorientation of its goals to meet

Department of Health concerns, additional federal program funding available at the time was not directed to Apunipima. Much of it, in particular from the Improving Primary Health Care Initiative (IPHCI), was instead directed to mainstream organisations in the region, specifically the RFDS and regional GP Division, albeit in contracts specifying that funding was to be transitioned to Apunipima at the end of three years. In the views of one non-Indigenous professional, the lack of significant funding at this early phase of transition may have deprived Apunipima of the critical mass of resources needed to address issues of capacity (Community representative 311).

## Attempts to set the terms of transition (2007–08)

During 2007 and 2008 Apunipima, with the support of the broader community controlled health sector in Queensland, responded to the emerging doubts about transition with several major pieces of work aimed at furthering implementation of the Deed of Commitment.

In late 2007 Apunipima set out a roadmap for the transition to community control (ACYHC 2007). The Cape York Health Reform Proposal (ACYHC 2007) moved the focus beyond simply the organisational changes Apunipima needed to put in place (although these were acknowledged) and on to what was needed in reform of service delivery if the transition to community control was to effectively address health disparity in Cape York. In particular, this would mean a reorientation of PHC to be comprehensive, including a focus on the social, emotional and spiritual wellbeing of communities, as well as action on maternal and child health, chronic disease and substance abuse (ACYHC 2007:29–36).

The health reform proposal envisaged a phased transition process, with Apunipima to take on the purchaser role in a purchaser-provider model within two years (2009–10) and direct responsibility for service delivery under community control within five years (2012–13) (ACYHC 2007:8). Action was to begin immediately, with the first communities

(Kowanyama and Pormpuraaw) to be transitioned by June 2008 (ACYHC 2007:9). Significantly, the proposal did not address the funding of the new model, and although a section addressing funds-pooling was signalled, it was not completed (ACYHC 2007:54).

At the same time, QAIHC commissioned the University of Wollongong to determine the most appropriate funds-pooling model to be applied in Cape York and also in Yarrabah, which was going through a parallel process (QAIHC 2007:6). The resulting report examined several funds-pooling models in detail. A simple 'cash out' model transferring funding for services existing at that time would see Apunipima's funding rise to \$30 million per year, with the majority of this (around \$24 million per year) to be transferred to the organisation from Queensland Health for its network of health clinics (Eagar & Gordon 2008:17).

This model was rejected by the authors because it would merely 'lock in' existing under-resourcing and inequity. Instead, a 'cash up' model based on 'equity of input' was recommended, under which funding would be increased to match average national levels of per capita MBS and PBS funding, adjusted for location and other variables. The recommended total funding pool in this case was just over \$50 million per year—being roughly the existing funding of Apunipima (\$6 million), plus the cost of delivering existing services (\$24 million from Queensland Health) plus an additional \$20 million from the Australian Government (Eagar & Gordon 2008:18). The financial implications of this approach were significant, but their impact on the enthusiasm of government for the transition process is not documented.

### **Opportunities for transition (2008–10)**

The Deed of Commitment envisaged a staged transition to community control across the whole region. However, in this period Apunipima also showed itself capable of acting opportunistically

to progress transition to community control. In late 2008 Apunipima prepared a detailed proposal for immediate transition in two communities, Mapoon and Mossman Gorge (ACYHC 2008). Prompted by perceived support for transition at the highest levels of Queensland Health, Apunipima selected these two communities because their relatively small size, lack of substantial government staff and investment, their functioning HATs and strong local community support made them ideal sites to get immediate 'runs on the board' (ACYHC 2008:5, 11).

Different models of community control were to be adopted in each site. At Mapoon, Queensland Health was to continue to provide the health centre infrastructure and employ its existing clinical staff, and a more 'family centred' model of PHC was to be provided through additional chronic disease programs, with staff to be employed by Apunipima. A local Aboriginal health centre manager was proposed as the key point for the coordination of care, community consultation and reorientation of services (ACYHC 2008:7). In Mossman Gorge, where Queensland Health had no community-based staff, the model was more straightforward, with Apunipima to provide management and coordination in conjunction with the local community council (ACYHC 2008:13).

Apunipima proposed that these services could be transitioned almost immediately (in the first half of 2009) with additional funding of about \$300,000 per year for each site (ACYHC 2008:17). Notwithstanding the substantial work done within Apunipima to prepare for transition, it was not until 2008 that the delivery of the first permanent PHC services by Apunipima commenced, starting with the employment of maternal and child health workers using Department of Health funds. This increased the size of the organisation from about ten to about 30 staff (ACYHC 2012:16).<sup>9</sup>

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<sup>9</sup> Apunipima continued to be funded for and deliver numerous short-term prevention and health promotion programs following the Deed of Commitment, as it had in the period 1994 to 2006.



The following years saw even more dramatic increases, as IPHCI funds were transferred from RFDS and FNQRDGP to Apunipima after three years as planned. Accordingly, as one senior health official at the time recalls:

**those positions and programs were transferred to [the] community controlled sector by 2010. I think that was very significant because it moved the organisation from being an advocate, capacity and policy organisation to one of being a service delivery organisation of significance. (Government staff 700)**

These new positions were to work alongside the existing Queensland Health clinics, which maintained their clinical focus.

Late in 2009 the Mossman Gorge health service became the first (and to date only) community health service in the region to be wholly transitioned to community control. The proposal for the transfer of Mapoon had apparently not been accepted, but Apunipima employed PHC managers in Coen and Mapoon to progress community control in those communities (ACYHC 2012:17).

### **Regional planning for transition stalls (2010)**

By 2010 the community controlled sector had developed a high-level model for community controlled PHC in Cape York, including a roadmap for its implementation and an overall estimate of the funding required. While Apunipima was advancing its model of community controlled family-centred PHC where it could, and growing as a PHC provider, regional planning for transition seemed to have stalled.

One reason for this lack of progress seems to have been loss of commitment to the Cape York Regional Health Forum as a regional structure for collaborative planning and decision making. Its continuing role was acknowledged, but as one senior Aboriginal participant noted:

**There was never a structure put in to progress that, not the hint of a structure to progress that, it was just 'here, okay, go out and do it yourself'. (ACCHO staff 319)**

By 2010 it appears that the forum, once described as the most effective regional health forum in Queensland, had ceased to meet. This situation is seen as resulting from lack of government leadership and failure to engage the forum in planning the introduction of programs for the region. Key personnel with a commitment to the transition project had moved on during this period and the practical realities of transition, in particular the funding implications, had become apparent.

In the case of Queensland Health, the realisation that transition would mean a very substantial transfer of funds to Apunipima may have been influential. The need to deal with complex industrial relations issues surrounding the transfer of existing employees was also exacerbated by the continuing antagonism to Aboriginal control among Queensland Health staff in the region, especially those working in community clinics and who were most likely to be affected personally. The reasons for this hostility included the fear of losing job security, wages or benefits, and the Queensland Nurses Union, although supportive in principle of the transition to community control, came to believe that 'The Apunipima experience is already providing an example of attempts to undermine terms and conditions of employment for nurses' (QNU 2012).

For many Aboriginal participants, the opposition of local non-Indigenous government staff was deeply rooted in disbelief in the capability of Aboriginal people and a distrust of Aboriginal organisations: 'I'll say blunt on record... that they don't want to work for a black organisation' (Community representative 306).

Although senior Queensland Health departmental officers based in Brisbane remained cautiously supportive, these concerns may have been a significant disincentive for substantive engagement with the transition process at the regional level.

For the Australian Government there were also significant financial implications, as became very clear through the 2008 Eager and Gordon

report. This, plus reported concerns about the governance of Apunipima, may also have contributed to less enthusiastic commitment to participate in the Cape York Regional Health Forum, the only available regional mechanism for advancing joint planning and implementation of transition.

The lack of commitment to an authoritative regional decision-making body to progress and oversee transition to community control had a profound influence. In parallel with Miwatj in East Arnhem, Apunipima switched from pursuing the 'big picture' of the Deed of Commitment to an opportunistic approach in which it sought to progress local transition as and when possible.

### **The national agenda and state-wide processes (2008 onwards)**

During the early years of the Cape York transition project, the idea of transitioning PHC for Aboriginal communities to community control was becoming a state-wide issue. In 2006, partly triggered by the Cape York Deed of Commitment and a similar document for Yarrabah, and partly by the Queensland Government's health reforms, QAIHC committed to pursuing an agreed policy framework for transfer of Aboriginal and Torres Strait Islander PHC to community control across the state (QAIHC 2006).

QAIHC continued to advocate for this policy framework for the next few years (QAIHC 2007:6; QAIHC 2009:19), but it was not until 2009 that it secured a commitment from both Queensland Health and the Department of Health to the development of a policy framework to guide and expand transition to community control across Queensland. QAIHC also made a commitment to its member organisations to begin regionalising its own services by relocating some functions to five community controlled 'support hubs' (QAIHC 2010:6,19).

QAIHC's intervention seemed to have helped 'kick start' a policy focus on the need for reform of PHC in Aboriginal and Torres Strait Islander communities. However, at that time the national agenda was profoundly shaping action at the state level.

The Council of Australian Governments (COAG) 2008 *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes* set ambitious targets to address Aboriginal and Torres Strait Islander disadvantage (COAG 2008:1). Australian Government funding of \$1.6 billion was allocated nationally over four years from 2009–10, with states and territories to make their own contributions (\$162.22 million in the case of the Queensland Government) (COAG 2008:17).

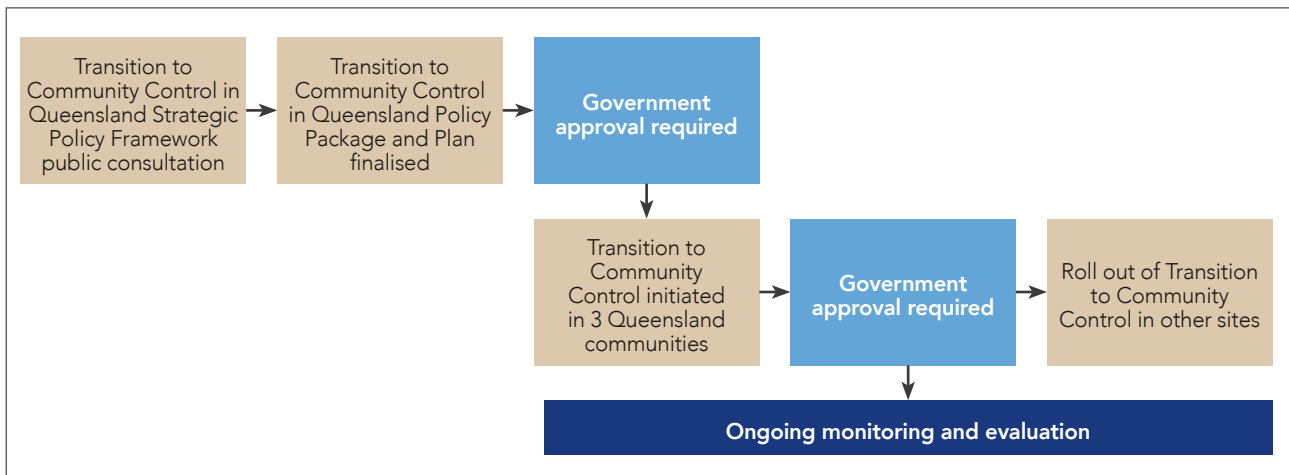
In 2010 Queensland Health published *Making Tracks toward Closing the Gap in Health Outcomes for Indigenous Queenslanders by 2033* (QH 2010a), a jurisdictional plan under the national commitment to Closing the Gap. Although this contained only a high-level commitment to the principle of community control, the first triennial implementation plan (2009–10 to 2011–12) committed to developing a state-wide framework to support the delivery of PHC to Aboriginal and Torres Strait Islander communities, including options for governance and funding. It also committed to support the development of a community controlled health service in Cape York, to implement alternative approaches to PHC delivery and to work to secure sustainable Australian Government PHC funding (QH 2010b:35).

With the backing of the Queensland Minister for Health, a Joint Working Group was set up (including membership from QAIHC, Apunipima, key unions, other service delivery agencies, and both Queensland Health and the Department of Health) with the specific task of developing 'a Transition to Community Control (T2CC) Strategic Policy Framework and a package of policy resources, including a monitoring and evaluation framework' (QH 2011c).

The Draft Strategic Policy Framework (QH 2011b) was released the following year and drew on the work of the Joint Working Group and consultations with stakeholders, as well as the work of the Northern Territory Aboriginal Health Forum (QH 2011b:4). It identified Yarrabah, Mapoon and Kowanyama as pilot sites, and outlined a staged process for transition to community control (Figure 6).







**Figure 6: Process for transition to community control in Queensland**

(Source: QH 2011b:18)

The policy direction was entirely consistent with transition in Cape York, and Cape York and Yarrabah were acknowledged as the ‘first cabs off the rank’, but it seems that these processes delayed progress within Cape York:

*We were ready and set, ready to go and when it became diluted in this state wide process—where there wasn’t actually anyone else that was transitioning so I still don’t understand that. So they started negotiating with QAIHC around this Queensland wide transition and we’re going ‘it’s just us. You just negotiate with us directly if you want to...’ (ACCHO staff 316)*

Formal commitment by Queensland Health to ‘partnerships between peak Indigenous bodies, such as the Apunipima Cape York Health Council, Divisions of General Practice, the Royal Flying Doctor Service and the Australian and state governments’ was maintained (QH 2011a, 2012) but progress (including on the draft strategic framework) was impeded by intervening reforms in the Queensland health system as a whole. In response to the *National Health Reform Agreement* (COAG 2011), Queensland Health was to be broken up, with statutory bodies under regional boards (Hospitals and Health Services or HHS) taking responsibility for health service delivery, including PHC. The Cape York Health and Hospital Service (CYHHS) was established under

the *Hospital and Health Boards Act 2011* (Qld) and came into being on 1 July 2012 (QH 2012).

Work within Queensland Health on transition to community control continued, and a draft Readiness Assessment Tool was produced in an attempt to ‘ensure that the objectives and principles of Transition to Community Control are maintained’ (QH 2012:2). However, under the terms of the new Act, these decisions were now clearly in the hands of the HHSs, not central office, and at best the readiness assessment could provide ‘guidance on strategic and operational issues to consider and resolve before an HHS moves funding and/or staff’ to an ACCHO (QH 2012:2).

In Cape York there were discussions between Apunipima and the CYHHS about progressing the readiness assessment. However, when it appeared that Apunipima would be required to go back to communities to discuss the transition to community control yet again, Apunipima declined to do so. The parallel with the Miwatj experience in East Arnhem is striking.

During this period underlying problems of complexity in funding and accountability requirements continued, and in some ways increased. From 2010 there was an increase in funding to Apunipima (from about \$4 million in 2008–09 to more than \$20 million in 2013–14), and a subsequent rapid rise in reporting

requirements, particularly from the Australian Government. In the 2013–14 financial year, funding was received in 31 contracts (17 funding, 14 subcontracts/consultancy contracts), which required 74 reports.

Reports were required quarterly, six monthly and annually. They covered financial, clinical, health program and strategic data and planning, and variously extended in scope from whole of region and whole of organisation to individual communities and programs. Other reporting requirements included fortnightly and quarterly conference calls with funding body contract managers, and responding to ad hoc requests for information relating to schedules, events, photographs and stories. Senior Apunipima staff members were also expected to regularly travel to capital cities to meet with government officials.

### A hybrid service system

By 2014, 20 years after the establishment of Apunipima and eight years after the signing of the Deed of Commitment, the commitment to full community control of Cape York PHC services had not been realised.

Apunipima had succeeded in refocusing from advocacy and short-term health-related projects and had become a major provider and partner in the delivery of PHC to the Aboriginal communities of Cape York. It delivered chronic disease services across all Cape York communities; employed maternal and child health workers in all communities except Kowanyama, Pormpuraaw and Napranum; delivered GP services in Napranum, Mapoon, Mossman Gorge, Hopevale, Wujal Wujal and Laura; and employed two community paediatricians, one public health medical officer and two chronic disease physicians (ACYHC 2012:19).

These extra resources were reported by health staff and community members to have improved access to health care for Aboriginal and Torres Strait Islander people in the region:

**I reckon it's come forward a long way because... before it was really hard to see**

**a specialist... but now with Apunipima on board as well they're bringing in their teams and they're bringing in men's health team and women's health team, all your diabetes educators—because you've got two lots doing it now it really cuts down on waiting times. (Community representative 307)**

However, only one Cape York community—Mossman Gorge—could be said to be under full community control. In all other communities a hybrid PHC system was in place and the newly formed CYHHS (the Queensland Health body responsible for health service delivery in the Cape) had responsibility for clinical care delivered from its health centres, with Apunipima responsible for a range of allied health, chronic disease, and maternal and child health services that were often (but not always) delivered by staff based in Cairns rather than in the community.

This part-way situation has led to poor service coordination and conflict, including allegations that Apunipima workers (particularly Aboriginal and Torres Strait Islander workers) are not treated as respected equals by Queensland Health staff; that Apunipima services are simply a 'duplication' of Queensland Health roles; that visiting Apunipima staff are 'just another visiting service' for Queensland Health staff to 'manage'; and that poor cultural safety for clients and Aboriginal staff in Queensland Health clinics acts as an access barrier.

The transfer of all Queensland Health services in the region to CYHHS removed or diluted the capacity of Queensland Health to make decisions about transitioning services to community control. There was an attempt to further the transition to community control through the establishment of a CEO's Group comprised primarily of the CEOs of the CYHHS and Apunipima. Although this group was expected to meet regularly to sign-off on steps along the transition pathway, its meetings were sporadic and un-minuted and it soon stopped playing an active role. By the end of 2012 it appeared that the transition to community control was no longer on the agenda of the CYHHS (CYHHS 2013, 2012).



Despite widespread dissatisfaction with the process of transition, and disappointments and setbacks, many Aboriginal and Torres Strait Islander people remained committed to transition while being realistic about the difficulties:

even though there's been a lot of barriers put up with community control, that is a long term aspiration and it's something that we'll still continue to fight for... saying 'you have made a commitment to close the gap. This is one way of getting the commitments met in Cape York. Why aren't you supporting it?' (ACCHO staff 314)

## Findings

Apunipima entered the Deed of Commitment from a position of considerable strength. Its origins in strong, united Aboriginal community action across Cape York, its support from other Aboriginal organisations, the development of an independent voice along with strong relationships with government, and a supportive policy context in the early years all provided a solid foundation.

In the years following the signing of the Deed of Commitment, some progress has been made but continuing problems have contributed to the overall lack of progress in implementing the commitments of 2006.

## Achievements of transition

Despite the problems encountered in the transition to community control, the extra resources acquired by Apunipima over this period improved access to PHC for Aboriginal and Torres Strait Islander people as the organisation successfully grew from being primarily an advocacy body to being a major service provider, with services for one community transitioned to full community controlled PHC. As noted above, many community members remain committed to transition.

## Authorisation and auspice

The lack of an authoritative, collaborative regional body to progress transition to community control was critical. The Cape York Regional Health Forum filled this role during 2005 and 2006 and was instrumental in gaining commitment to transition. However, after 2006 it seems to have rapidly lost energy and focus, and was replaced by a succession of poorly resourced committees or meetings, with no apparent process for negotiating and making decisions about critical transition matters. Regional decision making seems to have been deferred in favour of intervening state-wide processes (through QAIHC and the development of Queensland Health's draft strategic framework), which cut across the capacity for focused attention on transition in Cape York itself.

Throughout the period 2006 to 2012 all parties to the Transition to Community Control project operated in a highly unstable health policy and political environment. Queensland Health had three major restructures during the period (2005, 2008 and 2011), and the current structure devolved responsibility for hospital and health services in Cape York to a regional statutory body. Other challenges for Queensland Health (such as the major problems in the surgical service at Bundaberg Hospital and dysfunction in a new payroll system) further complicated attempts to focus on transition for Queensland as a whole and for Cape York.

The COAG commitments of 2008, and the introduction of wide-ranging national health reforms, including the creation of Medicare Locals, contributed to a volatile environment where policies and personnel changed frequently. Progress was undermined by the continual need for Apunipima to develop new relationships with, and seek new commitments from, government staff, and to reset its own course towards regional community control as new policies and organisations were created around it.

## Implementation not adequately resourced

Inadequate resourcing of the transition process was also a barrier to progress. In 2006 and 2007 funding was provided to support the Transition Planning Unit at Apunipima, and to engage and train HATs to fill the gap between region-wide structures of community control and local communities. However, this resourcing did not last. Many interviewees commented on the fact that support for HATs and for processes of engagement with communities was neither continuous nor sufficient for the task of maintaining engagement and support across the whole region. As a result, the energy and enthusiasm for transition dissipated in some communities. Some Aboriginal interviewees expressed a desire for a better relationship between Apunipima and local communities, citing, in particular, the need for improved consultation and better information flow.

## Community control is still contested

Mainstream hostility to Aboriginal community control, especially at the local health centre level, was seen by many as a significant impediment to progress. Within Queensland Health uncertainty about job security, salaries and other entitlements under a community controlled service caused disquiet, and there appears to have been little organised effort to address these concerns. Significantly, while supportive in principle of the transition to community control, the Queensland Nurses Union was in dispute with Apunipima about the wages and conditions of its nurses.

However, many Aboriginal people interviewed for this study considered that some of the difficulty of achieving transition goes more deeply, to a reluctance to cede control to Aboriginal people and organisations—that is, that systemic racism proved a strong but unacknowledged barrier to progress. According to this view, Apunipima, as an Aboriginal organisation, was held to higher levels of accountability than mainstream services during the transition period, and the technical

difficulties of achieving transition (e.g. for staff salaries and conditions) were both overestimated and inadequately managed by funding agencies.

High-profile governance problems in some Aboriginal organisations elsewhere in Australia seem to have increased the perception of risk in Aboriginal organisations generally. Again, this perception has its parallel in East Arnhem. Government doubts about capacity and governance during this period were seen to have led to increasing levels of micro-management and a reporting overburden.

## Regional governance

The inherent difficulties of managing and governing a health organisation across a highly diverse and geographically large region of communities, clans and language groups made good corporate governance a challenge. In particular the composition and skills of the board members came into focus, and there were competing demands between the local, regional and national roles of the organisation. This remained an area of tension, despite substantial reforms, including a change in board membership. The Apunipima Board was restructured in accordance with various recommendations, but the changes led to some Aboriginal community-level criticisms about whether board members could represent their communities if they were actually from 'somewhere else' (Community representative 304).

## Regional PHC services remain split

The decision of government not to fund Apunipima for service delivery (through the IPHCI funding) in 2006–07, but rather to fund other agencies for three years with a view to transfer to Apunipima in 2009–10, was a setback. The opportunity to better integrate PHC (by bringing together clinical and preventive care) was missed. The fragmentation of PHC remains a challenge for care coordination, requiring complex interactions between agencies, and could be expected to reduce the extent to which extra resources lead to improved health



outcomes. We note that this split is common across Queensland in smaller and more remote communities, though it is less common in the rest of Australia.

### Costs of the new model

With the focus on transition, there was a lack of consideration of the underlying adequacy of access to PHC in Cape York and the need to increase the total funding to the region in order to achieve equity of access. Rather, the focus was on getting better outcomes from existing resources through improving the acceptability and integration of PHC services. Eagar and Gordon (2008) argued cogently for an increase in total funding on the grounds of equitable access, and brought the potential cost implications for government into sharp focus. It became clear that if transition was to make a significant difference to health outcomes, additional investment of some tens of millions of dollars from the Department of Health and Queensland Health would be required. Although the problem of inequitable access was pre-existing, the transition project did bring the problem into clearer focus. We suggest that the planned creation of a regional ACCHO, with responsibility for PHC delivery to a significant regional population, made the concept of population-based funding possible and thus made inequity at least potentially more visible.

### Funding complexity not addressed

A shift to some form of funds-pooling was explicitly part of the plan for transition, but no serious attention was paid to the policy or technical requirements of this goal. Apunipima's funding remained a complex mix of long- and short-term contracts, most of them with quite specific and narrow program goals. During the period of this study, the amount, complexity and short-term nature of the funding contributed

to problems of rapid staff turnover, the undermining of long-term relationships and expertise, conflict at the community level, and an increasingly high administrative burden.

### Conclusion

This case study documents a continuing commitment to the development of a regional community controlled PHC service for Cape York by Apunipima and regional community leaders. It also highlights a continuing policy commitment by Queensland Health to regional community control that has not been backed with an effective development and implementation strategy, during a period of frequent broad change in the state's health system. The transfer of PHC services to full community control in Yarrabah (just south of Cairns) in 2014 (Hume 2014) is evidence of a continuing commitment by Queensland Health to transition and to addressing the problems of split service delivery in small communities. The challenge of developing a coherent approach to PHC for Aboriginal and Torres Strait Islander people both in Cape York and state-wide remains.

# Findings and Conclusions

This study examined planned reforms as they developed in order to answer these research questions:

1. How effective are the methods used to plan and implement the reforms; what are the critical factors that enable or impede implementation; and what are the gaps and why?
2. What are the implications of the reform experience for policy and practice in the funding and accountability arrangements for Aboriginal community controlled health services and their government funders?

In this section we analyse the critical factors that caused delays and lack of progress in the implementation of the planned reforms (addressing our first research question). We then discuss the implications of the reform experiences for the future development of the PHC system for Aboriginal and Torres Strait Islander communities (addressing our second research question).

Two important limitations should be considered in interpreting the findings and conclusions that follow. First, the data is limited by the relative lack of formal interviews with current government staff, a limitation we sought to address through use of published and internal documents, as well as interviews with relevant former government staff members. Second, the study was conducted in two of eight Australian jurisdictions, largely in non-urban areas, so caution in interpreting the relevance of the findings for other jurisdictions and for urban settings is needed.

## Barriers to implementation

The planned reforms were beset by implementation barriers and difficulties. Many of them are common in public administration,

not least in health, in which successful reform is often a story of sustained commitment in the face of severe impediments thrown up in shifting political and policy environments. Sidney Sax (1984) described this situation, and the uneasy alliances that form among complex sets of empowered stakeholders, as 'a strife of interests'.

## Authorisation, auspice and control

In both the Northern Territory and Queensland, there were problems in the authorisation of the reforms, with high-level commitments not being matched with secure structures and processes for sharing power and control in order to manage the reforms.

For governments, the level of organisational and policy change during the period (including changes in elected governments in all three jurisdictions, departmental restructures and shifts of individual senior decision makers) had an impact on both commitment to and interpretations of the reforms, and brought requirements for all parties to renew and redevelop relationships and procedures.

The responsibility placed on Aboriginal participants in the reforms to represent the community, and the associated social and cultural obligations they took on, were a challenge that was often underestimated by funding agencies. This role was also undermined by changes in government decisions or a lack of action. There was also a perception by participants that government did not acknowledge the legitimacy of ACCHOs and their role in shaping the dialogue about community control of the health sector, nor their cultural/spiritual accountability to current and past Aboriginal leaders. The lack of understanding by government of the cultural obligations of the ACCHO sector to their communities was seen as a significant barrier to progress.

A continuing partnership between governments and the Aboriginal community controlled health sector was an essential requirement of the reforms. However, there was a mutual perception of failure to maintain commitment to agreed timelines and processes, and a sense of significant stress on established relationships and mutual trust. At its worst, there was a sense of misuse of processes to avoid the need to make decisions.

**Our first conclusion is that future reform efforts will require more secure authorisation and auspicing to succeed in this complex cross-agency and cross-cultural endeavour.**

The challenge is to find an adequate auspice for the planned reforms when they require partnership across multiple structures and agencies of government and the non-government sector. This raises the question of what kind of arrangement would be capable of retaining authority for long-term cross-boundary reform work and managing the major processes of implementation, while also enabling each party to feel a sufficient sense of ownership and control to manage the risks. In the case of the Northern Territory, if the NTAHF did not hold sufficient authority, and AMSANT proved to be an ineffective auspice for the role of coordinator of reform work, what is a feasible alternative?

There are several options. The CCT program was carried through to completion on the strength of strong federal ministerial leadership and effective contractual arrangements among the trial partners. Alternatively, it would be possible in states and territories to establish a statutory authority with the mandate to implement agreed reforms. This would also require some form of reliable agreement with the Australian Government to ensure continuing commitment.

Secure, high-level authorisation and auspice is also needed for risks to be manageable. New risks (e.g. the risk of improvements not being measurable within the required timeframes) can appear larger (for those in government who are taking the risks) than old ones (which may be very serious, including continuation of

poor health outcomes). The difference between success and failure in reform may come down to the capacity to manage heightened risk, and thus to maintain confidence and keep the reforms going.

### **Inadequate resources: Money, time and capacity**

One reason for the challenges in the reforms we studied was that the work had been underestimated—in complexity, the timelines, and the skill and resource requirements. In each case study the need for adequate resourcing of the change process was insufficiently recognised and accommodated. There was a common understanding that the jurisdictions were not adequately resourced to implement the reforms, although additional (EHSDI) funding in the Northern Territory was an important enabler.

There was an evident lack of clarity about the size and cost of the reform process by both governments and ACCHOs. The complexity of achieving community controlled care when there are multiple communities with disparate populations and health needs was underestimated. This problem was compounded by changing Commonwealth and jurisdictional government priorities that affected the allocation of resources for change.

The complex changes involved in the planned reforms required a range of specialised knowledge and skills, from clinical perspectives to cultural knowledge, financial analysis, planning, organisational and community development, governance and policy analysis. Problems with the availability and/or deployment of skilled staff were recognised in the Northern Territory as early as 2008 (Allen + Clarke 2009).

A sense of dismay about timing was mutual. At the community level there was widespread dissatisfaction with government delays in decision making and in implementing the reforms, for which the reasons were not apparent. Governments, on the other hand, were frustrated by the length of time required to negotiate change and develop momentum in some communities.

The sense within government agencies that all the resources come from them is one barrier. Although it is true that Aboriginal communities and organisations cannot contribute significant funds to major reforms, they are necessarily required to contribute in other ways, in particular through leadership, cultural authority and relationships, time, energy and knowledge. These contributions need to be honoured, and also need to be reliably available for agreed tasks. Neither of these things can be ensured unless these contributions are explicitly negotiated.

**Our second conclusion is that future reform efforts will require more attention to realistic time and resource allocations (both human and material) and the negotiation of explicit commitments.**

More realism about the requirements at the beginning would improve the chances of success and make the process more robust to challenge and change.

### **Working across cultures, in partnership**

The barriers discussed above—inadequate authorisation and resources—are the classic errors of project management in many industries. The third is more particular to partnerships between government and Aboriginal and Torres Strait Islander organisations.

Working across cultures and in partnerships is difficult, yet this is an inescapable part of the reform program. Relationships among the major parties to this reform—represented by government health authorities and the ACCHO sector—are often robust and effective, but are also characterised by a mutual lack of trust. This can be attributed to separate interests of funders and providers, and to the intercultural nature of the relationship and the pervasive and too often unacknowledged impacts of systemic racism.

One important underlying barrier to mainstream competence in working across cultures is systemic racism (the ways in which discriminatory effects are built into care systems, with or without intention) and its counterpart, which is sometimes called ‘racism anxiety’—the fear of causing offence or being accused of racism.

While racism was rarely overtly expressed, it was considered by many participants to be an important underlying influence. This problem is a given in Aboriginal and Torres Strait Islander health care, but is not often discussed. It is perhaps time to move beyond silent acceptance of the difficulties and find ways to acknowledge and manage them openly.

Finding good ways to work across cultures is an outstanding challenge, despite the fact that there is much skill and experience among some of the people involved. It seems that the knowledge held by individuals in government departments and mainstream health organisations is not yet sufficiently encoded in organisational cultures. Such encoding is essential for systematising the relevant knowledge and skills (so that progress is not dependent on outstanding individuals or derailed by turnover of leaders).

This study has described the particular challenges faced by communities and community leaders in working towards the development of a regional system. Many of the challenges, as well as the strengths, are deeply shaped by traditional and contemporary Aboriginal and Torres Strait Islander cultures—in the ways in which relationships and roles within and between communities are structured and in many important aspects of spiritual, social, emotional, economic and geographic relationships and requirements. These aspects are seen by participants to have been misunderstood and their significance underestimated in the reforms.

For government health departments, there is a significant mismatch between the processes and timelines expected of them in budget cycles and by central agencies and minister’s offices on the one hand, and the requirements of community engagement and development on the other. There was also a perceived mistrust by government of Aboriginal and Torres Strait Islander capacity to manage major organisations.

Thus the challenge of working across community and government sectors is also significant, given





the different priorities, meanings, timelines, goals and interests that the partners hold. This work is also cross-cultural. Both kinds of intercultural challenges can only be addressed if they are openly acknowledged, explored and made part of the work program.

**Our third conclusion is that future reform programs need to be founded on a solid explicit basis for working across cultures that acknowledges and mitigates the impacts of systemic racism, and recognises the impacts of the different contexts in which community and government representatives work.**

Methods of incorporating the requirements of the partners need to be found, tested and shaped in ways that work for all the partners—that is, this needs to be done in a business-like way, with respect and a sense of safety for all participants.

## Implications for future development

We have addressed above the major barriers to effective implementation of the reforms arising from the *methods* used. Our second research question addressed the substance of the intended reforms—that is, what does the experience of the reforms tell us about the requirements for the future, about the funding and accountability relationship, and about the governance and stewardship arrangements that are needed for an effective PHC system for Aboriginal and Torres Strait Islander communities?

At the broadest level, the sources of the problems encountered in these case studies lie in a mismatch between the policy goals and their logic, on the one hand, and their implementation on the other—the decisions, processes, structures, timelines and resources, the maintenance of commitment beyond electoral cycles and the tenure of senior public servants. This is not surprising—it is perhaps the most common problem in the implementation of public policy. But this highlights the most fundamental question—is it the policy goals or the reform design and implementation that need to change?

This study accepted long-established national policy commitments to the development of the ACCHO sector, and did not set out to investigate the merits of this policy direction. However, it needs to be said that nothing emerging in this study suggests that the policy direction should be changed. The goal of improving access to essential health care for Aboriginal and Torres Strait Islander people and communities remains critical. The policy logic—to systematise the governance, funding and organisation of the ACCHO sector as the major provider of comprehensive PHC for Aboriginal communities (particularly but not only in regional, rural and remote areas) operating within the broader health system—has its foundations in many years of policy development and community aspirations and organising, and is supported by the available evidence about effectiveness.

The goal of setting up the system on a regional basis also has a strong rationale, particularly in the geographic realities of rural and remote areas but also for larger cities (coordination of care is generally achieved in regional networks). It is also consistent with the technical requirements for effective PHC, which needs a critical mass of health care workers and other resources without which essential PHC is necessarily compromised. However, more attention is needed to harmonise ACCHO and mainstream regional approaches.

Continuation, in some form, of the work described in this study is needed. What, then, are the implications of our results for the future development of the PHC system for Aboriginal communities?

## Regionalisation and implications for governance and stewardship

There has been a tendency in Australian health policy debates for regionalisation to be seen as a simple and straightforward restructuring of existing health care arrangements. Those who are now engaged in implementing Local Health Networks and Primary Health Networks can attest to the complexity of ‘making’ a health care region.

The New South Wales public health care system has perhaps the most sustained experience, and in that jurisdiction serious attention has been given to the many requirements, including regional governance, regional funding allocation, equity in funding on a population basis without excessive transaction costs, fairness for provider agencies, the development of networks of care, and the role of the central health department in a regionalised system. The growing experience of regionalisation as part of mainstream health reform may be helpful to the development of a better understanding of what is involved, although there are important differences between the needs and imperatives of the acute system and PHC (both mainstream and ACCHO) in this regard.

The development of a regional system of PHC for Aboriginal communities has implications for the design of the health system as a whole. Importantly, the governance of regions at jurisdictional level, and the structures and methods by which ACCHOs and the mainstream system articulate with each other within each region and at jurisdiction level, requires the attention of all (Kelaher et al. 2014). The technical methods and governance structures for the allocation of pooled or bundled funding to regions and thence to providers is a major task, as is the collection and analysis of data to guide regional planning and assess results.

Stewardship, or the careful and responsible management of the system for Aboriginal and Torres Strait Islander health, is something that all organisations can contribute to but can only be achieved by governments. There was an apparent absence of formal consideration of the implications of the reforms for the stewardship roles of governments. The reforms in Cape York, Queensland and the Northern Territory clearly offered an opportunity and a need for better systematic integration of ACCHOs in the jurisdictions' public health systems. The Northern Territory regional clinical reference groups were a practical approach to working together at the level of clinicians in the region, but there was no evidence that anything like

this sort of approach was developed at higher system levels. For example, implications of regionalisation for the governance of the Northern Territory PHC system as a whole were not considered or addressed.

The pattern of split roles in PHC in rural Queensland (with clinical services provided by Queensland Health and broader health programs provided by ACCHOs) is another significant system feature that is seen as problematic, and is at least challenged by the reform intentions.

Regionalisation has mixed implications for communities. For some, it brings an opportunity to participate in developing a major community controlled service on the basis of transfer of government services. For others, it brings a requirement to relinquish local control in favour of regional development. This was a significant challenge in all three case studies.

The requirement for full amalgamation of local ACCHOs into a single regional ACCHO as a precondition of transfer is a significant barrier to the staged development of service integration and fails to allow for credible alternatives such as that developed in East Arnhem. Flexibility would enable suitable regional/community alternatives to be accommodated in central/government plans.

It appears that regionalisation was seen in government as a way to honour the policy intention to support the development of the ACCHO sector while also addressing some concerns about the governance of ACCHOs. That is, there would be fewer boards with directors drawn from larger populations attracting more scrutiny by communities. However, although governance concerns clearly influenced government agencies, these concerns largely appear not to have been aired or negotiated in relevant forums—but remain a significant barrier to reform and need to be addressed. Concurrently with this study, the sector has acknowledged the need to strengthen governance and has taken action (NACCHO n.d.b) with Australian Government support. The question of systemic racism in shaping the perception of fragile governance also needs to be addressed.



**Our fourth conclusion is that future reforms in the PHC system for Aboriginal communities should continue to use a regional approach under Aboriginal community control, and should develop coherent regional systems for funding and governance, and for coordinating PHC services among all providers across the region.**

Success in doing this will depend partly on genuine engagement by government with communities and the ACCHO sector, and a flexible approach to pathways towards regional governance.

### **Funding levels, contracting and accountability**

Both reform programs ruled out addressing the question of the overall adequacy of funding levels for PHC for Aboriginal and Torres Strait Islander people, a constraint that was ameliorated in the Northern Territory in the short term by the availability of additional time-limited funding (EHSDI and its successors). However, it is notable that the transfers that occurred as part of the Coordinated Care Trials included significant additional funding that enabled an increase in services. In at least some of the participating organisations, improved access and expanded services in the regional communities were observed, as well as reductions in avoidable hospitalisations (i.e. those that are necessary because of lack of access to PHC) (Commonwealth of Australia 2007; McDonald 2003:6). These outcomes, and the relative success of larger, better funded services elsewhere, carry the strong implication that an adequate funding base is required and should be the subject of policy goals and targets that can be expected to result in improved health status indicators. We note that not all trial sites were successful (as was also the case in the mainstream health system).

Both governments and the ACCHO sector support the goal of equitable allocation of funding on a population basis. The allocation of funding for a regional population (weighted for risk and cost factors) is not straightforward, but is a tested method for achieving more equitable

access to care. In the case of under-served (often rural and remote) regions, additional funding, not simply reallocation, is required to achieve levels capable of supporting adequate access to PHC. Regional allocations then require distribution to service providers, and this is also a complex task that requires a mandated structure and process that is transparent and fair to providers, communities and citizens.

**Our fifth conclusion is that increased funding is needed to support adequate access to culturally safe PHC across and within regions, and that levels should be based on the size of the regional populations (weighted for risk and cost factors) and distributed to providers within regions with fairness and transparency.**

The pooling or bundling of funds was an explicit intention of the reforms in the Northern Territory (NTAHF 2009a:27) and in Cape York (CYRHF 2006a:9). However, we found no evidence of substantial work within government on the methods for achieving this change, which would involve both high-level approvals and significant technical workup. Both Apunipima and Miwatj addressed these questions in their planning and submissions (EASC 2012; ACYHC 2007) as outstanding requirements, but the work was not progressed in joint forums or negotiations.

We found a similar pattern of inactivity in relation to the systematic sharing of needed base-line information, such as the funding of clinics to be transferred, their service data and the extent of coverage of the area population. In the Northern Territory, modelling of the funding for infrastructure and services that would be required for provision of the identified core PHC services was not undertaken. In Cape York the funding implications (for equitable health care provision) were identified (Eagar & Gordon 2008) but not addressed.

For jurisdictional governments there is also a potential financial conflict of interest in the transfer of services from government to ACCHO ownership. They will experience marginal reductions in their operating costs, but ACCHOs will require funding at (or close to) the average

operating costs for the equivalent services. The transfer or redeployment of staff is also likely to involve a cash cost.

A lack of attention to the question of reform in the accountability regime (i.e. the number and nature of reports required etc.) is notable. The East Arnhem and Apunipima case studies both show an increase in funding from the 2009–10 financial year, and a rapid rise in reporting requirements, particularly from the Australian Government. Compliance with reporting requirements was costly, and both Apunipima and Miwatj had the added burden of cost and time in dealing with external consultants and the associated meeting and reporting requirements, as well as the costs of travel to capital cities for meetings with funders.

**Our sixth conclusion is that enduring reform in the funding and accountability relationship between governments and the ACCHO sector should be based on long-term contracts for bundled or pooled funds to support comprehensive PHC, and a modified accountability regime more suitable to the functioning of PHC, and to the shared responsibilities of providers and governments.**



# What needs to be done? The essential elements of reform

Our six conclusions highlight the implications of this study for the future implementation of system reforms. The analysis also suggests that future work to develop a regional system of community controlled PHC for Aboriginal and

Torres Strait Islander communities needs to address six essential elements of substantive change (summarised in Table 6), almost all of which were explicitly or implicitly included in the reforms we studied.

**Table 6: Elements of substantive change**

Element	Explanation	Status
<b>REGIONAL COMMUNITY CONTROL</b> Establish regional PHC system, based on ACCHO sector and community governance	The establishment of a regional system of PHC would enable progress towards reliable access to the range of essential PHC services including referrals to specialised care across the country and ensure cultural safety. Models of regionalisation must allow for adaptation by regions and support coordination of care among all relevant regional providers. Strong community governance is essential.	Included
<b>ENGAGEMENT</b> Operating as part of the larger health system, engaged with other providers and with funders	Clarity of roles and coordination between mainstream and ACCHO providers would improve coordination of care for patients, and access to specialised care. Engagement between funding agencies and ACCHOs in addressing issues of mutual concern is needed to improve working relationships, address systemic racism and enhance reciprocal accountability.	Included
<b>POOLED FUNDING</b> Funded through long-term pooled or bundled funding contracts	Reform in contracting (towards fewer longer-term contracts) is needed to support comprehensive PHC, to enable equity in funding, to enhance efficiency for both funders and providers, and to provide a more suitable basis for meaningful accountability.	Included, but not developed
<b>GOVERNANCE AND STEWARDSHIP</b> Community governance at regional level; stewardship by government	Attention to governance in the ACCHO sector focused on the challenges of regionalising governance; governments take stewardship responsibility for long-term development of a robust PHC system; all parties need to take a business-like approach to identifying and resolving their concerns in these areas.	Included implicitly; some aspects undeveloped
<b>ACCOUNTABILITY</b> Accountable to communities and mutually accountable with funders	ACCHOs need to be accountable to communities for effective care, access and responsiveness, and reciprocally accountable with funders to meet contractual obligations to each other. Governments need to be accountable for equity in funding and access to care, and the mainstream health system for ensuring equitable access to culturally competent care.	Included implicitly, but not addressed
<b>FUNDING LEVEL</b> Funded to achieve equitable coverage for Aboriginal and Torres Strait Islander people, according to need	Increased funding for regional Aboriginal and Torres Strait Islander PHC is needed to close recognised equity gaps, according to need and rural/remote costs. In absolute terms, the funding gap is not large, but some reallocation to regional PHC, and increases over time, are required.	Explicitly excluded

The experiences of the Northern Territory and Cape York have revealed the full scope and requirements for system reform 'at scale'. The reforms set out to establish regional systems of PHC for Aboriginal and Torres Strait Islander communities under various forms of community governance (the result of local and regional decisions and capacities, within policy guidelines), operating as part of/in partnership with the public health system and funded through long-term pooled funding contracts. In some cases, this situation almost already exists (for example, in Katherine West and Sunrise) and in others, including Miwatj and Apunipima, most of the essential elements on which to build successful reform are in place.

Although there was attention to governance in each case study, and each implicitly required more attention to stewardship by governments, these matters remained problematic. The need for working across cultures and accommodating different priorities, goals and values while enacting mutual respect is an important underlying contributor to governance and stewardship challenges. What is needed is a business-like approach to identifying, discussing and resolving or accommodating concerns and conflicts.

Both reforms also implicitly entailed some changes in the model of accountability between the ACCHOs and their government funders and between ACCHOs and the communities they serve, even though this element was less well articulated. Although additional funding (i.e. to fund equitable access to PHC for Aboriginal and Torres Strait Islander communities) was explicitly excluded, this need has been identified in several economic analyses (e.g. Deeble et al. 1998; Eagar & Gordon 2008). The funding requirement is substantial but achievable. Indeed, the funding made available for 'Closing the Gap' would cover much of this gap if it was allocated accordingly.

Implementing the six essential elements of substantive change would require commitment and accommodation from governments, Aboriginal and Torres Strait Islander communities and the ACCHO sector. In order to commit to increased investment in community-governed PHC:

- governments require assurance of performance in delivery of high-quality care
- governments need to accept that the current methods of funding and contracting are not suitable to ensure performance in this context, and need to work with the sector to develop longer term and less complex and fragmented approaches.

In addition:

- the ACCHO sector requires long-term assurance of funding and acceptance of its role in the health system
- the sector and government need to accept the implications of a negotiated understanding of regionalisation and reformed engagement with each other
- all parties need to work together in an enduring structure for partnership and to develop a workable approach to reciprocal accountability.

These are not simple matters, and long-term commitment is required, along with strong leadership. But they are not mysterious or impossible.

We conclude that the goal of equitable access to PHC through a regionalised network of ACCHOs working with the mainstream health system is achievable, and that action to achieve it should commence/recommence as soon as possible, with a firm commitment by all parties to see the reform through to completion.



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# Author biographies



Professor Judith Dwyer is Director of Research in the Department of Health Care Management at the Flinders University School of Medicine, and a former CEO of Southern Health Care Network in Melbourne, and of Flinders Medical Centre in Adelaide. She teaches in the Flinders' Master of Health Administration, and conducts research focused on health system governance and design, with a particular focus on Aboriginal health services. She served as a Research Program Leader for the Lowitja Institute from 2009–2014. Judith is the lead author of the popular text *Project Management in Health and Community Services*, 2nd edition.



Dr Angelita Martini is a Senior Lecturer in the Centre for Health Service Research in the School of Population Health at the University of Western Australia. Her current research is focused on the health needs of vulnerable Western Australians, and models of care in cancer services. She has extensive experience in research coordination, tertiary education and curriculum development roles in medicine, nursing, Aboriginal studies and public health. Angelita has held management positions in the private and public sectors, both nationally and internationally, in health, education and correctional services.



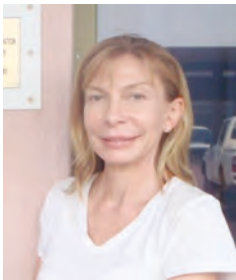
Ms Cath Brown is a Noonuccal woman from Minjerribah [North Stradbroke Island] off Brisbane. In 2007 she took up a Research Officer position at James Cook University, within the School of Indigenous Australian Studies Empowerment Research Program, to become involved in the delivery of the Family Wellbeing Program. Cath facilitated the empowerment program with Aboriginal and Torres Strait Islander individuals, groups and organisations predominantly in North Queensland. She has completed a Graduate Diploma in Indigenous Health Promotion, graduated Master of Public Health [Health Promotion] and has begun a research Masters looking at Aboriginal health advocacy.



Mr Edward Tilton has more than 20 years of experience in the Aboriginal and Torres Strait Islander health field, with particular expertise in primary health care planning, community development, policy development and consultative processes. He has worked for the Aboriginal community controlled health sector at a local, jurisdictional and national level, as well as for the Northern Territory Government. He currently provides consultancy services to a wide range of Aboriginal community controlled services, government departments, and research agencies across the country, specialising in the complex and culturally diverse environments of northern and central Australia.



Dr Jeannie Devitt is an anthropologist with more than 30 years of experience working with Aboriginal people in the Northern Territory particularly in remote areas. Jeannie has worked primarily for Aboriginal community controlled organisations including the Northern and Central Land Councils, Indigenous Health Services, Indigenous Community Councils and Legal Services as an employee and as a consultant. She was a Senior Research Fellow with the Cooperative Research Centre for Aboriginal Health from the late 1990s, and has undertaken nationally funded Aboriginal health research projects, as well as research commissioned by the Australian Government in relation to kidney disease within Indigenous communities. She is currently employed by the Menzies School of Health Research in Darwin.



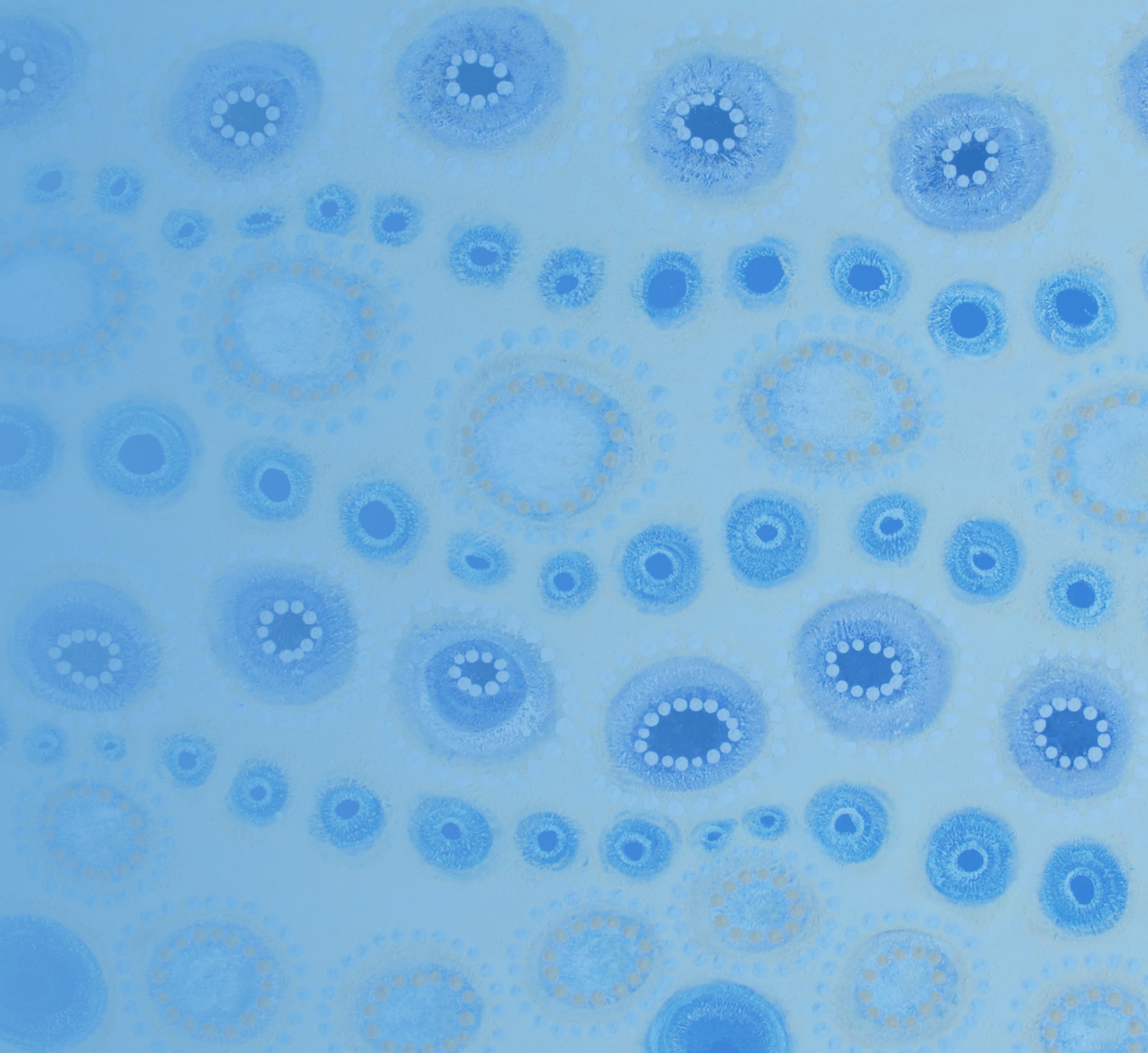
Ms Paula Myott is a public health professional with 20 years of experience working in the Aboriginal health and international development fields, and expertise in program design and management. She was employed by Miwatj Health as Director of Regional Health Reform during this project. Paula has worked in government and in non-government organisations (NGOs) and has executive level management experience. Her roles have included establishing frameworks for stakeholder engagement and management in complex contexts and leading organisational change processes. Paula has worked with all levels of government as a NGO stakeholder on the research:policy:implementation cycle, and is currently working on a PhD with Flinders University focused on accountability between governments and ACCHOs.



Dr Brita Pekarsky has worked as a health economist since 1991 in the areas of pharmaceutical regulation and primary health care. Her involvement with Aboriginal and Torres Strait Islander health started in 1997 when she worked on the evaluation of the Aboriginal Coordinated Care Trials. Brita's research focus is on how we can improve the health of the community by improving the way in which primary care services in the Aboriginal health sector are financed. She is a private consultant economist and also has an appointment at Wardliparingga, the Aboriginal Health Unit at the South Australian Health and Medical Research Institute.







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