the Overburden report:

Contracting for Indigenous Health Services

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This is a short summary of a full report about how Aboriginal Community Controlled Health Services are funded by governments. It reports on the high workload involved in accounting and reporting on the way that money is used for service delivery. And it suggests the basis for a better way—one that emphasises core primary health care funding and long-term relationships between services and funders.

Background

The Aboriginal Community Controlled Health Services (ACCHSs) sector is the only sector of the Australian health system that provides both an essential, comprehensive primary health care (PHC) service and does so from a base of fragmented funding contracts. ACCHSs are funded in more complex ways, and from more sources, than most other health care organisations (of equivalent size), so the amount of time and effort that goes into preparing and processing reports is out of proportion with the funding levels. On the other hand, reporting requirements are often focused on 'counting heads through the door' rather than monitoring people's health outcomes.

This project investigated the funding programs and reporting requirements for ACCHSs by exploring two questions:

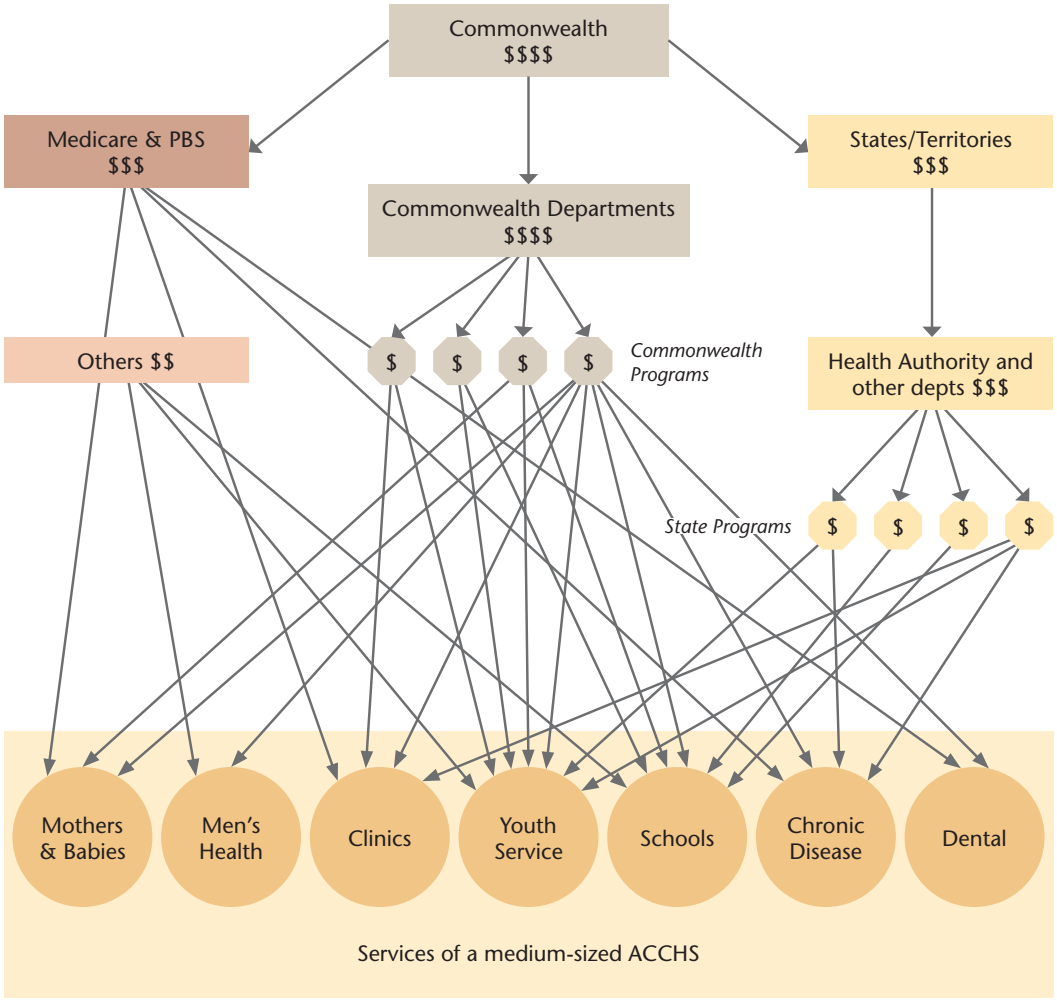
1 **What are the major enablers and barriers to effective PHC delivery in the current frameworks of funding and accountability for PHC services to Aboriginal and Torres Strait Islander people in Australian States and Territories?**

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

To estimate the burden of reporting and accountability experienced by ACCHSs, we gathered information about PHC funding programs, funding policies and individual health services' 2006–07 financial reports. We then interviewed staff of Aboriginal health services and government health authorities to test and refine the themes emerging from the documentation.

Contract theory has been used as the framework for analysing the characteristics of funding, reporting and accountability requirements, including the distinction between classical and relational contracts. Classical contracting is the traditional model for an exchange of goods or services for money. Relational contracting recognises the interdependence of contractor and supplier, and seeks to maximise their common interests. In the commercial sphere, this approach (known as alliance contracting) has become more common. The typical features are a long timeframe, arrangements for sharing of profits and sharing risks.

The following diagram shows typical funding pathways for an average ACCHS, with an annual budget of about $2 million. Because government funding is packaged in ways that do not match with how services are delivered on the ground, the reporting burden is very high.



Main Findings

1 Fragmented funding is a barrier to integrated Primary Health Care

Our study confirms the complexity and fragmentation of funding, and the heavy burden of acquiring, managing, reporting and acquitting funding contracts for both providers and funders. This problem affects Indigenous organisations across many portfolio areas (housing, land, education etc.) and is widely recognised.

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

> *It's a serious problem. It affects the efficiency and effectiveness of the programs offered by the recipient. In one ACCHS, the manager has to manage 27 quarterly reports and financial statements and annual reports. When does she get time to run the organisation? It's been talked about but it's not been resolved* (Health Authority Director).

2 Unmanaged complexity and transaction costs cause inefficiency

The complex contractual environment in which ACCHSs work is acknowledged by funders, but not monitored or managed in any consistent way across funders and programs. It has emerged from a series of policy and program decisions in both levels of government, and simply grown. ACCHSs need to devote significant resources to the acquiring and managing of money, which is likely to be disproportionately high compared to mainstream agencies.

> *I think somewhere, there has to be a debate by jurisdictions around the issues that if we fund programs in ACCHSs, or in Aboriginal organisations, we need to build in the administration costs because if we don't do this, we tend to rob Peter to pay Paul which means that we don't offer a salary that's commensurate with the salaries in the mainstream system* (State Health Authority Manager).

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

3 Long-term relationship behaviour enables trust and enhances capacity

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

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

> *I think you've got to invest in the relationship first* (Health Authority Manager).

4 Data for monitoring and performance management are compromised

Governments in Australia are increasingly concerned with ensuring value for money in the expenditure of public funds, and have sought to achieve this goal through tightly focused allocations and detailed requirements for reporting by service providers on what has been done with the money. Although the goals of ensuring value for money and its use as intended are sound, the impact of the measures used to achieve these goals works against efficiency. Accountability for results is compromised, and inefficiencies could compromise the performance of the sector as a whole.

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

> *We could do more, some of the stuff we collect doesn't get utilised as much as we'd like* (Health Authority Finance Officer).

5 National priority funding impedes responsiveness to local priorities

Governments seek to direct funding to national or jurisdictional health priorities, and to modes of care or interventions that are seen to be effective. On the other hand, local and regional providers of care for Aboriginal and Torres Strait Islander communities seek flexibility to respond to the pattern and priorities of need in their

communities, and to take up local opportunities to make a difference. Tension between these goals is inevitable, and both are important. Tightly specified contractual arrangements do not provide the balance required in managing this tension.

> *The Commonwealth rolls something out every week, it's challenging then for us to put things on the ground... It took a year to get the program funding to us for a 3–4 year program, we've already lost a year before we even get on the ground. We're a year behind in our reporting, a year behind in our achievements, hence we're a year behind in [managing] our under expenditure, or our potential to lose dollars. Because we're behind, the funding to our [ACCHS] is behind* (Health Authority Finance Officer).

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

6 Current practice: classical and relational contract paradox

The complex contractual environment for ACCHSs and their funders is largely shaped by a classical approach to contracts, but staff on both sides often speak and act as if they are partners in relational contracts. This means that the intended advantages for governments of the existing classical contracts (e.g. retaining the power to cease funding) are not achieved; while at the same time the advantages of relational contracting (such as long-term commitment to programs on the ground, reduced transaction costs and improved staff retention) are not achieved either.

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

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

Conclusions

Governments are committed to the development of a robust comprehensive PHC sector, but the classical contracting model is not adequate to support the achievement of this goal. We suggest that implementing government policy commitments will require a different way of thinking about the relationship between government and the sector, with implications for both sides. We further suggest that the framework of relational (or alliance) contracting provides methods for improving both health care delivery and accountability to government. It also recognises the long-term relationship between health authority and ACCHSs and seeks to maximise the common interests of the parties in the partnership. The following principles could be used to assess options for good practice in funding and regulation:

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

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

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

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

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

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

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A copy of the full report, *The Overburden Report: Contracting for Indigenous Health Services*, can be downloaded from the website of the Cooperative Research Centre for Aboriginal Health or of the Department of Health Management at Flinders University.

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