An analysis of the Primary Health Care Access Program in the Northern Territory: A major Aboriginal health policy reform

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This paper describes the development of and lessons learned in implementing the Primary Health Care Access Program (PHCAP) in the Northern Territory. The implementation of the PHCAP is a major Aboriginal health policy reform. PHCAP provides an opportunity for Aboriginal people to gain access to properly resourced comprehensive primary health care (PHC) services. PHCAP is described in its unique funding model that attempts to address tensions within the federal governance system. In this paper we argue that access to PHC services is a key determinant of health and that funding of PHC services has been inadequate and inequitable throughout the Northern Territory. The implementation of PHCAP is reforming the existing health system and leading to the establishment of new PHC services. We analyse the barriers encountered in this process. The PHCAP funding model is analysed for its adequacy and design strength to address federal relations. We consider issues of workforce shortage that will limit our capacity to implement the program and the need for effective regional PHC support services. We conclude that the basic funding model within PHCAP - a grant payment plus access to the Medicare Benefits Schedule and Pharmaceutical Benefits Scheme - is the best possible way to fund comprehensive PHC at the present time, and call for bipartisan party commitment to fully realise the potential of this program to address Aboriginal health inequalities.

Key words: *Aboriginal primary health care policy*

Aboriginal Australians experience a greater burden of ill health and have a substantially shorter life expectancy than non-Aboriginal Australians. Aboriginal people also have much lower levels of access to primary health care services (Australian Bureau of Statistics [ABS], 2003). This situation illustrates the "inverse-care law" - that those with the poorest health receive the least health care provision (Hart, 1971) and is strongly correlated to the inequitable distribution of the general practitioner workforce in Australia (Boffa, 2002).

Since the establishment of the Aboriginal Community-Controlled Health Organisations (ACCHOs) in the 1970s, these organisations have campaigned for a range of reforms to the Australian health care system to address the inequities in health service access and funding. There has been a strong emphasis on the development of quality community-controlled PHC services, having the ability to meet the particular health and cultural needs of their communities (Bartlett & Legge, 1994; National Aboriginal Community-Controlled Health Organisation [NACCHO], 1998).

Among a range of measures implemented to redress this inequity, the ACCHOs were instrumental in the development of the Primary Health Care Access Program (PHCAP). In the Northern Territory (NT) the aim of this program is to improve access and to improve the quality, types and range of PHC services available for Aboriginal people. PHCAP is designed to bring more resources to bear, via a flexible mixed mode pooled funding model. The funding is a mix of weighted Commonwealth direct capitation grants pooled with existing Territory funding for Aboriginal PHC services. It is a flexible model because, in addition to the grant payments, additional Medicare income generated by doctor/patient encounters is retained by the service. The Pharmaceutical Benefits Scheme (PBS) directly funds medicines in remote areas through Section 100 of the Act. The ultimate aim is for these to be Aboriginal community-controlled services (NT Aboriginal Health Forum [NTAHF], 2001a, 2001b). Community control of primary health services has been widely recognised as important both to ensure responsiveness of the service to community health needs and to maximise community empowerment through participation (National Centre for Epidemiology and Population Health, 1992; Royal Commission into Aboriginal Deaths in Custody,1991; World Health Organisation [WHO], 1978). The implementation of this program

will realise one of the key recommendations of the National Aboriginal Health Strategy Working Party (NAHSWP, 1989); that every Aboriginal community have its own community-controlled health service.

This paper is written from the perspective of two employees of one of the key ACCHOs involved in the formulation of the policies and program discussed. We believe that these issues have major implications, not only for Aboriginal health policy reform; they contain important lessons for the non-Aboriginal health system reform movement. We are unaware of any published literature documenting or analysing these issues from the perspective of other partners to the process; we hope that this paper helps address this gap and stimulates further analysis. We believe this paper may assist in creating a clearer picture surrounding the achievements in Aboriginal health policy reform that have been achieved under the current arrangements, and thus may help inform the current Aboriginal service delivery debate.

Access to Primary Health Care Services: a health determinant

The current state of Aboriginal health is caused, reproduced and stabilised through the complex interactions of a number of health determinants. Factors such as social class structure, levels of access to health services, employment opportunities, education services and welfare support services, and the degree of social exclusion and alienation are all strongly identified in the research literature as determinants of an individual's health through a range of biological pathways related to psychological stress and ill health (Najman & Smith, 2000; Marmot & Wilkinson, 1999; Evans, Barer, & Marmor, 1994). Colonisation, and its consequences, is an additional core determinant that is widely identified as causing poor health in Aboriginal populations (NAHSWP, 1989; Bartlett & Legge, 1994; Saggers & Grey, 1991).

Interpretations of the work of McKeown (1976) have popularised the notion that health systems have had little impact in improving the health of populations. Re-evaluations of this research have disproved the validity of this view, highlighting the impact of public health measures on improving population health (Szreter, 1988, 2002; Colgrove, 2002). The WHO (2000) attributes up to 50% of health gain since the Second World War in some countries as being attributable to health systems. Caldwell and Caldwell (1995), in the health transitions research that focused on comparative studies in the third world, identified the important role of participatory PHC services in improving health development. Starfield, in comparative studies both between and within western societies demonstrates the importance that access to primary care physicians and systems has on population health gain (Starfield, 1998, 1994; Shi, Starfield, Kennedy, & Kawachi, 1999). Kunitz, in his comparative studies of the health status of Indigenous peoples in a number of settler colonial states, identifies, the varying levels of access to PHC services as an important determinant explaining the differences in health status of the different populations (Kunitz, 1994, 2000, 2001; Kunitz & Brady, 1995). In Australia the demand for access to culturally appropriate quality PHC services for Aboriginal people was taken up by the ACCHOs from their inception in the early 1970s as one of a range of policy prescriptions required to drive health gain (Foley, 1982; Central Australian Aboriginal Congress [CAAC] 1975; Nathan & Leichleitner, 1983; Couzos & Murray, 2003). Contemporary Australian Commonwealth government health policy supports this policy approach (Dwyer, Silburn & Wilson, 2004; Commonwealth Grants Commission [CGC], 2001; McDonald, 2001; House of Representatives Standing Committee on Family and Community Affairs [HoRSCF&CA], 2000).

Inequity in health care financing

The Australian health care system is often characterised as being based upon principles of universality. The Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) are intended to provide universal health insurance coverage. Both are demand-driven schemes that are activated through accessing a medical practitioner. Aboriginal people who do not have access to PHC services employing general practitioners cannot trigger this demand and hence cannot access these schemes at the same level as non-Aboriginal Australians. There is therefore an inbuilt inequity in the system (Mooney, 2003a, 2003b).

The ACCHOs, through the Northern Territory peak body the Aboriginal Medical Services Alliance (AMSANT) and the National Aboriginal

Community-Controlled Health Organisation (NACCHO), lobbied for a series of reforms to the health system. They were joined by the Central Land Council, the Australian Medical Association (AMA) and the Cape York Land Council in successfully gaining support of the right and centre factions of the federal Australian Labor Party (ALP), then in government. Thus there was a critical convergence of interests between all three of the groups that Alford (1975) has described in his "structural interests" theory - the professional monopolists (AMA), the corporate rationalisers (ALP centre right factions) and the equal rights advocates represented here by the Aboriginal organisations.

This campaign led to the following structural reforms: the creation of the National Aboriginal Health Council; direct funding at both a national and regional level of the peak Aboriginal community health bodies to undertake further advocacy work; the signing of state/territory framework agreements in Aboriginal health and the consequent establishment of jurisdictional health planning forums; and the transfer of responsibility of funding for Aboriginal health from the Aboriginal and Torres Strait Islander Commission (ATSIC) to the Commonwealth Department of Human Services and Health (DHS&H, now Department of Health and Ageing [DoHA]) in 1995.

One of the key purposes of the campaign to have responsibility for Aboriginal health funding transferred from ATSIC to the Commonwealth DHCS was to gain access to mainstream funds to enable greater resourcing of the ACCHO network (Aboriginal Medical Service Alliance NT [AMSANT] 1999). Recognising the weaknesses of the demand-driven nature of the MBS and PBS systems for Aboriginal people, the campaign aimed to trigger a number of major changes in health financing. An immediate change occurred with the Commonwealth undertaking a rebasing exercise for the ACCHOs. This moved them to a secure funding base with global budgets and ongoing indexation, enabling, among other things, the provision of award wages and greater service planning certainty (Department of Health and Aged Care [DHAC], 1998). This report also recognised that needs-based regional planning was vital to identifying service gaps and funding priorities.

Both the Commonwealth and the ACCHOs commissioned research that documented the level of inequity in Aboriginal health care funding and the types of measures necessary to redress the situation to meet the real level of need within the Aboriginal community (Mooney, Jan, Palmer, & Wiseman, 1995; Bartlett, Duncan, Alexander and Hardwick, 1997; Keys-Young 1997; DHAC, 1998; Deeble et al., 1998; Jan, 2000; Australian Institute of Health & Welfare [AIHW], 2001).

The Deeble et al. (1998) and AIHW (2001) reviews of health care expenditure for Aboriginal people (Table 1.) have clearly demonstrated that Aboriginal people access MBS and the PBS at significantly lower rates than the non-Aboriginal population.

Table 1: Estimated benefit payments for Indigenous and non-Indigenous people through Medicare and PBS, per capita, from Deeble et al (1998) and AIHW (2001).

Item.	1995-96			1998-99		
	Indig. ($)	Non-Indig ($)	ratio	Indig. ($)	Non-Indig. ($)	ratio
Medicare	88	331	0.27:1	143.4	350.8	0.41:1
PBS	27	123	0.22:1	50.3	150.6	0.33:1
All Medicare and PBS	115	450	0.26:1	193.6	501.4	0.39:1

The change in levels of access between reporting periods reflects the MBS and PBS claims triggered by Aboriginal people who were already accessing PHC services -primarily through the ACCHOs, after the policy decisions to allow ACCHOs and remote clinics to access MBS payments on July 1 1996 and the introduction of the PBS Section 100 scheme in 1998 to allow remote areas clinics to be reimbursed for pharmaceutical dispensary (Keys-Young, 1997). It did not address the lack of access to PHC services, other than to increase the capacity of those existing services to provide a more enhanced and better funded service.

Utilising this evidence and the political momentum that had been generated since commencing the campaign in 1994, AMSANT pushed for a new co-ordinated funding approach for the development of Aboriginal PHC services (AMSANT, 1999). This proposal was adopted and came into being through the first allocation to the PHCAP in the Commonwealth 1999-2000 budget. Its implementation is through partnerships between

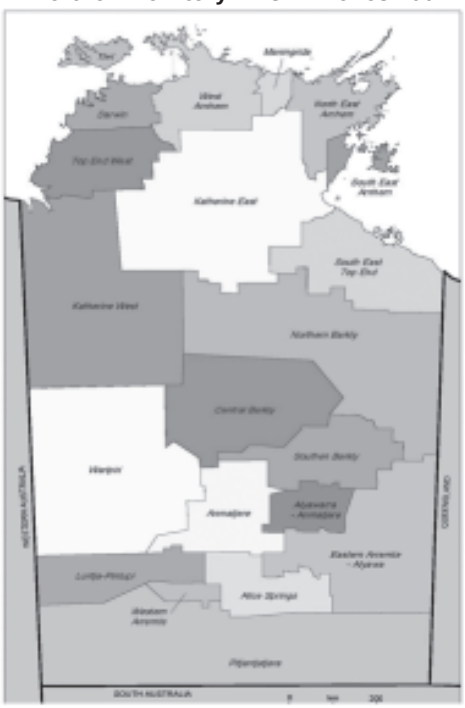
NACCHO (and affiliates), the Commonwealth and state/territory health departments and ATSIC. Research commissioned by AMSANT (Jan, 2000) estimated

$400 million was needed nationally to fund the program. To date, after three rounds of budget allocations, $64.8million has been allocated under the PHCAP program (NTAHF, 2001a; Department of Health and Ageing [DoHA], 2004). This means that, on top of existing allocations to Aboriginal community-controlled health services, around $281 million is now available for Aboriginal PHC services (Australian National Audit Office, 2003; DoHA, 2004).

The PHCAP Funding Model - the NT model

In the Northern Territory the PHCAP is being implemented on a zonal basis. These 21 zones (Figure 1) are, primarily, planning tools to create health services operated by communities with historical and contemporary affiliations, which can work successfully together to co-ordinate and share resources to develop robust primary health services under active Aboriginal community control. Ten zones are currently being implemented; in central Australia: Luritja-Pintupi, Anmatjere, Warlpiri, Alyawarra-Anmatjere, Northern Barkly; in the Top End: Katherine West, Darwin, South East Top End; and funded through the Co-ordinated Care Trials Katherine East and Tiwi.

Figure 1: Northern Territory PHCAP Zones 2001.



Source: Atlas of health-related infrastructure: 1999 Community Housing and Infrastructure Needs Survey. ATSIC, CRCATH.

expenditures on Aboriginal people are pooled with Commonwealth funds allocated for Aboriginal PHC services. Commonwealth allocations are calculated upon a weighted multiplier for average national MBS usage. Table 2 shows that current average national MBS usage (all Australians) is around $390 per capita. The multiplier on the Commonwealth contribution is comprised of two elements. One multiplier is in recognition of the increased costs of remote area delivery. This is factored at 2 times for the most remote areas, based upon RAMA ratings of remoteness, but there is no loading for rural areas. In the NT all health zones other than Darwin are rated as RAMA remote and are eligible for the multiplier. The other 2 times multiplier is in recognition of the increased morbidity suffered by the Aboriginal population compared to the non-Aboriginal population, and is applicable across Australia. The Commonwealth then deducts from this sub-total an estimate of the average Aboriginal Medicare usage figure, currently estimated as $220 per person for remote NT zones, in zones that choose the mixed mode funding option rather than full paid out capitation amount. Some of the problems in these calculations will be discussed below. The NT contribution is based upon the average per capita expenditure of existing community-based PHC services in the NT, around $684 per person (Warchivker, 2002). These two pooled funding sources provide an average per capita funding of around $2,000 to each zone. This pooled grant funding is then supplemented by any MBS generated income and access to the PBS through section 100. Where there is an existing ACCHO within a zone its Commonwealth grant is reallocated as part of the PHCAP allocation for that zone - this has already occurred in the transfer of the NT Aboriginal Co-ordinated Care Trails (CCT) to the PHCAP. In addition, services are eligible to apply for any targeted funding programs; for example, sexual health, eye health, or other announced programs. The allocation of these funds is undertaken via extensive community consultation in each zone leading to the development of a Health Service Plan for each zone. The pooled funding model has only been implemented in the Northern Territory to date. In other jurisdictions the state health departments have resisted undertaking this process and the Commonwealth has not insisted on this before allocating funds; the ACCHO peak bodies have also not pressed

the governments on this aspect of the model. In the NT substantial additional funds, the equivalent of six times the MBS benchmark, have been made available to the new services via the pooling of the Territory government component. In other jurisdictions new services have only had the Commonwealth per capita monies to utilise. The NT funds pooling model is now being examined in some other states.

Table 2: PHCAP mixed mode pooled funding - remote zone example.

Funding source and type	Per capita amount A$'s
Commonwealth: National average Medicare use ($390) per annum x2 for remoteness (780) and x2 for morbidity (780)	1560
Minus estimated average existing Medicare use after establishment of service	-220
Sub-total (Commonwealth)	1340
Plus NTDH&CS (av existing per capita)	684
Combined pooled sub-total	2024
Plus additional Medicare generated income.	

Through the Co-operative Research Centre for Aboriginal Health (CRCAH) there have been developed a set of key service performance indicators to enable the quality of services and programs to be assessed. In addition, the NTAHF partners are sponsoring, through the CRCAH, the development of a longitudinal study into the impact of PHC services in Aboriginal communities in the NT.

Table 3 shows what the NTAHF identified as being legitimate core functions for PHCAP funded Aboriginal PHC services in the NT (NTAHF, 2001c). This list was in part developed to guide the costing study of Territory Health department expenditures as discussed below.

Problems encountered in the roll out of PHCAP - the NT experience

This paper will consider the problems encountered in the roll out of PHCAP in the NT, primarily in the context of the experience of central Australia, where the process has been under way for some time. The further development of PHCAP in the NT is building upon these experiences.

Table 3: NTAHF Core functions of Aboriginal Comprehensive Primary Health Care.

1. Clinical Services
   Primary clinical care such as treatment of illness using standard treatment protocols, 24 hour emergency care, provision of essential drugs and management of chronic illness.
   Population health / preventative care such as immunisation, antenatal care appropriate screening and early intervention, STD and other communicable diseases control.
   Clinical support systems such as pharmaceutical supply system and a comprehensive health information system.

2. Support Services
   Internal to the health service
   Staff training and support such as AHW training, cross cultural orientation, continuing education
   Management systems that are adequately resourced, financially accountable and include effective recruitment and termination practices.
   Adequate infrastructure at the community level such as staff housing and clinic facilities, functional transport facilities
   External to the health service
   appropriate visiting specialists and allied health professionals, medical evacuation or ambulance services, access to hospital facilities, costs of transport and accommodation to access specialist and ancillary care , tertiary education and training

3. Special Programs
   Resources should be made available for community initiated activities dealing with the underlying causes of ill health and population health programs which seek to promote good health and prevent poor health. Communities should determine their own priorities. These programs require community action or agency to have any chance of success.
   They could include areas such as:
   Substance misuse, Nutrition, Emotional and social well being, Environmental health, Oral health
   Special services aimed at particular target groups such as youth, frail aged, and disabled people, men's health and women's health, young mothers, schoolchildren etc.

4. Advocacy and Policy Development
   Advocacy and policy development activities provide opportunities for communities and organizations to advocate for their health needs and contribute to the development of policy that affects their health care.

Another key outcome of the implementation of PHCAP has been to better structure health services around evidence-based core services and programs that are reflexive to community-identified needs.

Australian Federalism

The funds pooling mechanism in PHCAP is designed to manage the funding tension often present in the Commonwealth state/territory

relationship. However, overcoming the inherent complexities in the Australian federal government system has been one impediment to the swift implementation of PHCAP in the NT. As in other health policy areas, the divisions with this relationship have made planning at a Territory level extremely difficult (Duckett, 2002). A lengthy costing study of existing NT Department of Health Aboriginal PHC expenditure was undertaken in order to ensure that cost shifting from the Territory government to the Commonwealth would not occur. This study was complex for a number of reasons. The problems that can be encountered analysing health budgets when attempting to isolate particular expenditures by both population (Aboriginal) and sector (primary health) have been well documented (Deeble et al., 1998; AIHW 2001). Territory government budgetary methods added another layer of difficulty. Many programs had to be closely analysed for both their population coverage and sectional percentage. To what degree they were delivering primary health or secondary outreach services become a contested issue for some programs. Other difficulties arose around the ownership of existing capital investment. In all, over 10,000 cost centres were reviewed. Although the implementation of PHCAP was delayed, the study was extremely valuable. It established hitherto unknown levels of transparency in NT government expenditure. It laid the basis for confidence in the financial documentation around the funds pooling process (Mandala Consulting, 2003). In doing so it helped to achieve an integrated health system that makes Aboriginal community-controlled health services an essential part of the one integrated health system. It means that the Commonwealth and the Territory cannot turn a blind eye to or shift blame on the adequacy of Aboriginal health services because both governments are now intricately linked in their funding.

Building trust within the partnership

During the planning and development process with the Aboriginal communities the tensions between the Commonwealth/Territory were an issue again. Difficulties were compounded by the inclusion of AMSANT and ATSIC in the process. Many of the tensions were manifest in the workings of the Contact Team. The Contact Team was established to visit Aboriginal communities and organisations to build their knowledge of PHCAP and to involve them in the planning process. This consultation and communication strategy was also the mechanism for gaining nominations for the zone steering committees to develop the services. This strategy was essentially a community development task. Each partner had representation on the Contact Team. This design was meant to insure that all partner organisations were involved and by so doing would be satisfied with the nature of the information being imparted. In practice this became a very unwieldy and under-resourced process. Delay was caused by the necessity of having all partners participating before any activity was undertaken, and this tended to entrench positions of mistrust rather than build a team. The review of the first round implementation of PHCAP noted that insufficient resources were made available to build the capacity of the Contact Team to develop community development skills and to develop a team approach (Mandala Consulting, 2003).

In the first round of PHCAP funding only four of the eleven central Australian sites (zones) could be funded. There was a good evidence base, developed from the Central Australian Health Planning Study, later updated, to inform the selection process. The Central Australian Regional Indigenous Health Planning Committee (CARIHPC), a regional planning committee under the NTAHF, developed criteria to rank the zones. The criteria were: existing levels of per capita PHC expenditure; current population staffing ratios for general practitioners, nurses and Aboriginal health workers; existing health infrastructure; and the "capacity to benefit" (including local leadership, capacity to utilise funds, existing partnerships and capacity of existing organisations). Conflicting views between the partners at the CARIHPC level, particularly between AMSANT and the Territory Health department over the importance of the capacity to benefit criteria, caused a delay of several months from early 1999 into 2000. Eventually the decision on choosing the four sites was made by the full NTAHF in early 2000. A fifth zone was later included in January 2001 (Mandala Consulting, 2003).

Service planning

The development of Local Area Plans is a requirement in the planning process for the central Australian health zones. Consultants are engaged to work with the zone Steering Committees to

create a health service plan and a community governance plan. In the first round implementation in central Australia, lengthy delays were experienced in developing the consultancy briefs and choosing the consultants to work in each zone. This process took around nine months. The consultancies commenced in November 2002 running concurrently in all five zones and took about six months to complete.

Based upon the experience in developing the five central Australian health zones, it is now recognised that a more streamlined approach should be adopted in undertaking what is essentially a community development task. This conclusion is consistent with the documentation of the capacity building work that was undertaken by Scrymgour in the establishment of the Katherine West Health Board (KWHB, 2003). AMSANT is lobbying for each zone to have a Health Service Development Officer, skilled in community development, whose role it is to undertake, alongside the Aboriginal community, the community development work involved in creating these new services' governance structures. In addition, there needs to be a separate Health Service Manager funded to oversee the development of the Service Plan. The Commonwealth is not prepared to support both positions and is attempting to roll both duties into the one position. The likelihood of finding suitably qualified people with both sets of distinct skills and the ability to juggle these differing demands on site will be tested in the coming months with the employment of the new Health Services Development Officers in the Warlpari and Northern Barkly Health Zones.

Staged release of Commonwealth funding

In addition to the delays experienced in establishing the program at a community level -discussed earlier - a more fundamental structural impediment to the implementation of the program has been the Commonwealth's "drip feed" approach to budgetary allocation for PHACP (Anderson, 2003). The initial allocation of $78.8million over four years in 1999-2000 was followed by a further $19.7million per year in the 2001-2002 Commonwealth budget. The next allocation was a modest additional $40 million over four years in this year's budget. This limited funds release has caused concern and frustration for AMSANT keen to see the full roll out in the NT (Mandala Consulting 2003). It has also led to a population cap being placed upon all the second round sites, including two in the Top End of the NT. While there may be understandable caution on the part of the Commonwealth in allocating resources before seeing any services being implemented, for AMSANT the priority has always been the full implementation across the board, given the Central Australia Health Planning Study was already completed in 1997. To Aboriginal people with many years' involvement in health policy, the government, in not fully funding the program, seems to be replicating some of the mistakes made with the implementation of the NAHS a decade earlier (NAHS Evaluation Committee, 1994). In recent months there has been a willingness on the part of OATSIH to move more quickly to full funding, as zones demonstrate the capacity to recruit the necessary workforce and expend their existing funds.

Adequacy of the funding model

The funding model for PHCAP in the NT has been built upon the experience of the Aboriginal and Torres Strait Islander Co-ordinated Care Trails (CCTs) - the first trials of funds pooling in Aboriginal health. These trials, particularly the Katherine West Health CCT, demonstrated: improved access to a wider range of more appropriate services; increased ability to manage services locally; successful pooling of funds (with greater flexibility); communities changing services to meet local needs; and the benefits of having an autonomous health board focused on PHC provision (KPMG Consulting, 2001a). However, the CCTs had some inherent funding problems; these have been addressed in the PHCAP NT model. Under the CCTs, per capita Medicare entitlements for each region were capped and allocated as a block grant. This created uncertain financial burdens upon the services as they were financially liable for medical encounters outside the region as well as pathology, diagnostic imaging and the other usual MBS expenses for all their clients. It also stretched budgets when greater than expected levels of service usage occurred. The PHCAP (NT) model overcomes these difficulties by allowing for a capitation grant and access to Fees for Service (FFS) MBS funding. This reduces the administrative burden, in that patients take their Medicare entitlement with them wherever they go and the

Medicare remuneration goes directly to that practitioner or service. It enhances the flexibility of the PHCAP service's budget to meet increased costs if they generate more patient encounters, which has tended to be the experience. In 2002 Katherine West moved from being funded as a CCT to becoming a PHCAP zone.

It is uncertain whether the weightings in the funding formula for both remoteness and morbidity are sufficient and sophisticated enough to address the inequities in access to primary health services. Both weightings are too blunt in their calculation. For the remoteness weighting there needs to be a greater gradient that recognises the increasing costs of services delivery the further away from urban centres that services operate. Currently there is no weighting in rural areas. This is does not reflect the considerable differences in costs to deliver services in these areas and is therefore not fair to rural Aboriginal people.

The morbidity weighting is based upon a simple single multiplier of two times the national Medicare usage. Within the general population, groups with chronic health needs and worse than average health status have a need for higher than average per capita expenditure on health services. For example:

- Australians over the age of 65 use 2.1 times the national average MBS (DHAC, 2000a).
- Australians with multiple health conditions use higher levels of health funding; for example, around four times the average where two conditions are involved, seven times the average for three conditions and up to twelve times the average for five conditions (DHAC, 2000b).

Aboriginal clients often have multiple chronic health conditions and the morbidity weighting on the PHACP formula should reflect this. Whether this inequity can be addressed only through the flexible Medicare component of the formula will be tested when the services become fully operational. The recent introduction of the Aboriginal and Torres Strait Islander Medicare item announced in the 2004-2005 Commonwealth budget may assist in this matter (DoHA, 2004).

The current PHCAP weighted formula does not address the issue of (vertical) equity of access to services to address discriminatory practice, nor does it consider cultural safety design costs of services. Mooney (2003a) argues that both these factors need to be included if inequity in access to health care for Aboriginal Australians is to be addressed. Vertical equity is defined here as "positive discrimination for the disadvantaged", with the suggestion that this be weighted at a ratio of around 1.2 (Mooney). Based upon research undertaken in South Australia and Western Australia with community groups informed about the current inequities in access to health services, Mooney [2003a, 2003b] argues that there is community support for this type of "positive discrimination".

The issue of cultural safety has been explored extensively in New Zealand (Nursing Council of New Zealand, 2002); however, this concept has been little explored in Australia outside of the nursing profession (Williams, 1999; HoRSCF&CA, 2000). Researchers from Western Australia argue for a weighting to be placed upon funding for service provision in Aboriginal health care to make services accessible to Aboriginal clients (Houston, 2001; Wilkes, Houston, Mooney, 2002). The ACCHOs have argued that there should be additional funding to provide for the costs of maximising community control over health services, including funds to organise meetings, capacity development of board members, and broad consultation; again these costs are higher in remote areas because of increased travel distances and related costs (CAAC, 2002).

The current PHACP weighting of four times the average Medicare usage to account for morbidity and remoteness is well short of the estimates that contemporary research indicates are necessary. Mooney argues for a 5 times weighting without accounting for additional remote area costs (Mooney, 2003a). The Commonwealth Grants Commission has recommended that further research be undertaken to establish the most appropriate measures to inform funding to address access problems (CGC, 2001).

Workforce, regional support services and economies of scale - issues around the corner

The problems involved in attracting an adequate workforce to health services in remote locations are well documented (Australian Medical Workforce Advisory Committee, 2000; KPMG Consulting, 2001b; Johnston & Wilkinson, 2001; DHAC, 2001). There already exist a range of incentives to entice general practitioners (GPs) to these services, including financial incentives, education and promotional campaigns. It is now clear that the recruitment of GPs is one of the principal barriers to the successful implementation

of PHCAP in the remote areas. It may be necessary for the Commonwealth to use a range of non-financial incentives to engineer a more equitable distribution of health workforce across the country. Such measures could include: preferential specialist training places for GPs who have practised for a set period in disadvantaged or under-resourced areas; addressing the gap between specialist and GP incomes; increasing the number of rural and remote bonded scholarships; and limiting the number of Medicare provider numbers available in any given area based upon GP/population ratios (Boffa, 2002; AMSANT, 2003).

AMSANT and others have developed the concept of Regional Primary Health Care Support Services (RPHCSS) as a way of delivering key health service support programs (Boffa & Weeramanthri, 2001). Functions of these services could include in-service education and training, management system development (e.g., financial, human resource policies and procedures), quality assurance systems, IT systems support and program planning and evaluation. Access to these services has been identified as essential for a functional and sustainable comprehensive PHC service (NTAHF, 2001c). The smaller remote area services would particularly benefit, because of the difficulties in achieving economies of scale in developing such services and the increased costs of developing such services in remote settings.

Regional Primary Health Care Support Services in the NT could be funded from already identified, but not currently pooled under PHCAP, regional sources. The NT Department of Health has identified their current regional funding in central Australia is $347 per person in all zones. It needs to be established whether this is consistent across all the Territory and whether these funds would be sufficient to fund these RPHCSS. At this stage the only pooled PHCAP funding is funding identified as primary medical care within the zones. Existing non-pooled comprehensive PHC monies include, for example, the current Commonwealth (non-identified) and Territory (identified but not pooled) contributions to the Central Australian Remote Health Development Service, an in-service training unit.

It is important that mainstream funds such as the Public Health Partnership monies, Divisional funds, and Workforce Agency allocations are considered in this rationalisation of existing funding streams to support the RPHCSS.

Discussion

A key aim of the AMSANT and NACCHO campaign, that led to the implementation of the PHCAP, was to move Aboriginal health funding not only out of the under-resourced funding of ATSIC and into mainstream funding sources, but to secure that funding from the vagaries of the annual program budget bidding process in Cabinet (AMSANT, 1999). AMSANT argues that the allocation for PHCAP, although separate from Medicare, should be considered in the same manner that appropriations for that program are made. Not as special "welfare" programs for Aboriginal disadvantage, but rather as a weighted allocation to address inadequate access to primary health services utilising Medicare usage as its benchmark (Anderson, 2003). Despite the well documented inequities in access to health services by Aboriginal people, all too often funding to address this situation gets caught up in claims that "money is being thrown at the problem" to no effect. Although there have been improvements in some health indicators, most notably Aboriginal birth weights, to date there has not been the opportunity to identify the long-term health improvements that can be gained through access to fully funded comprehensive primary health care services for Aboriginal people. This remains a key goal of the campaign and requires the development of an effective evaluation of the complex contributing determinants as has been proposed through a longitudinal study of Aboriginal PHC services.

Many frustrations exist around the partnership relations that underpin PHCAP through the planning forums and policy councils. Some of this tension is generated from the intergovernmental rivalries embedded in the federal system that are here expressed in both the health and Aboriginal policy arenas. The ACCHOs' frustrations stem from the slow pace of implementation and the perception that there is ongoing resistance by many departmental staff to fully recognise the ultimate aim of having these services under community control. However, funds pooling under PHCAP in the NT is a unique model to overcome the inefficiencies often created in the Australian federal system. It has developed a co-ordinated approach to primary health service planning, integrating the community, Territory and Commonwealth government health sectors. It is fundamental to the success of PHCAP that the Commonwealth must insist upon this aspect of the model. The commitment of states and territories to funds

pooling will rapidly dissipate if the new Commonwealth PHCAP funds are allowed to flow into states that have not agreed to funds pooling or to the type of funding transparency demonstrated by the Northern Territory Government. Without this the PHCAP risks becoming simply another Commonwealth/state bilateral funding program with all the vagrancies of cost shifting and lack of co-ordination of health services to Aboriginal people. If the Commonwealth allows this to occur by not using their fiscal power to make the states and territories commit to funds pooling, they will need to take full and sole responsibility for the adequate funding of Aboriginal PHC services. Aboriginal health cannot continue to be a victim of Australian federalism.

Conclusion

PHCAP should be considered as a means for governments to meet their citizenship obligations to Aboriginal people rather than a welfare issue. It has taken over a decade of dedicated work by many people both within the ACCHOs and in various government departments and other agencies and walks of life to get this far in the implementation of PHCAP. Drawing on the experiences of the ACCHOs in the NT, it should be realised that the establishment of such services represents a massive community health development process. It took many years of community consultation and lobbying of government funding bodies to develop these services (Nathan & Leichleitner, 1983; KWHB, 2003). All partners, but governments in particular, need to ensure that there is a long-term commitment to this process. The basic funding model within PHCAP - of a grant payment plus access to MBS and PBS - is the best possible way to fund comprehensive PHC at the present time. A bipartisan commitment from the major political parties is required to fully realise the potential of this program to address Aboriginal health inequalities. The alternative is to risk yet more empty promises.

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