

PHAA Conference 2000

**Aboriginal and Torres Strait Islander Health:
Implementation of the Primary Health Care Access
Program (PHCAP) in four remote health zones in
Central Australia in the Northern Territory**

Northern Territory Aboriginal Health Forum

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Introduction

- 1. Barriers and preconditions to Aboriginal and Torres Strait Islander health policy making and the development of primary health care services.**
- 2. Reforms designed to address these problems**
- 3. Improved access to MBS and PBS for Aboriginal and Torres Strait Islander primary health care services**
- 4. The Primary Health Care Access program (PHCAP)**
- 5. Implementation of PHCAP in the NT**

The major barriers to Aboriginal and Torres Strait Islander health policy making and health service delivery:

- 1. Based on extensive community consultation, the 1989 National Aboriginal Health Strategy recommended an Aboriginal community controlled health service for every Indigenous community in Australia**
- 2. By 1994/95, resources for health services to Aboriginal and Torres Strait Islander people still lagged:**
 - ATSIC had only \$52 million dollars for ATSI health**
 - Commonwealth DHAC spent \$18 billion**
 - States and Territories spent \$11 billion**
- 3. Significant underutilisation of MBS/PBS by Aboriginal and Torres Strait Islander people**
- 4. A lack of comprehensive data on expenditure sources and patterns and service utilisation rates for Indigenous Australians.**

Systemic barriers to planning, coordination and cooperation.

- 1. Australian federalism: Separate Commonwealth / State and mainstream / ATSI health systems, compounded by the development of ATSIC as a health funder; lack of coordination between all these programs.**
- 2. Continuing barriers to the emergence of strong indigenous voices about health policy in contrast to the strong representation of State and Territory governments, academic and medical profession opinion on Aboriginal and Torres Strait Islander health.**
- 3. Barriers to intersectoral collaboration at the community level as inadequate resources provided for Indigenous health generated competition rather than collaboration between services**

The community sector and stakeholders campaigned for the following reforms to address these systemic problems:

- 1. Transfer of responsibility for Indigenous health from ATSIC to the then Commonwealth Department of Human Services and Health with increased access to Medicare and PBS funds for Aboriginal and Torres Strait Islander people.**
- 2. Pooled funding arrangements between the Commonwealth and State and Territory governments.**
- 3. The establishment of collaborative regional planning and coordination structures to inform the expansion of primary health care services and advise governments on Aboriginal and Torres Strait Islander health policy issues.**
- 4. Infrastructure support for Aboriginal and Torres Strait Islander primary health care services including the resourcing of peak bodies at the State/Territory and national levels.**

Key outcomes

1. The transfer of administrative responsibility for Aboriginal and Torres Strait Islander health from ATSIC to the then Commonwealth Dept of Human Services and Health: July 1 1995

2. State and Territory Framework Agreements for Aboriginal and Torres Strait Islander Health

"... These Agreements are milestones in inter-agency cooperation and are a foundation for a concerted national effort to address the poor health status of Aboriginal and Torres Strait Islander and Torres Strait islander people" (ANAO 1998 p11).

3. Inter-agency Northern Territory Aboriginal Health Forum (NTAHF) and regional primary health care planning processes established.

- Membership of the NTAHF comprises the Aboriginal Medical Alliance of the NT (AMSANT), the Aboriginal and Torres Strait Islander Commission (ATSIC), the Commonwealth Department of Health and Aged Care (DHAC) and Territory Health Services (THS).**
- The Primary Health Care Access Working Party is a working party of the NTAHF.**
- The Central Australian Health Planning Study (Bartlett and Duncan, 1997) and The Top End Health Planning Study (Bartlett and Duncan, 2000)**

- 4. Funding support for National Aboriginal Community Controlled Health Organisations (NACCHO) and State and Territory affiliates (AMSANT in the NT)**
- 5. The creation of the National Aboriginal and Torres Strait Islander and Torres Strait Islander Health Council to advise the Federal Minister (1996)**
- 6. Improved Commonwealth funding arrangements for Aboriginal and Torres Strait Islander primary health care.**

Key reforms in improving access to MBS and PBS for Aboriginal and Torres Strait Islander people

Research and data

- **The Health Insurance Commission in partnership with stakeholders commissioned the Keys Young report (1997) into Aboriginal and Torres Strait Islander and Torres Strait Islander access to Medicare and the PBS –**
 - **Recommended capitation payments in recognition of lack of access by Indigenous Australians to MBS/PBS**

- **John Deeble et al (1998), 'Expenditures on Health Services for Aboriginal and Torres Strait Islander and Torres Strait Islander People'**
 - **DHAC sponsored research into Commonwealth, total public sector and private sector expenditure on Aboriginal and Torres Strait Islander health.**

 - **In 1995-96, 2.19% of all Australian recurrent health expenditure for Aboriginal and Torres Strait Islander people – only 8% higher per capita than for other Australians, despite a mortality rate three times higher than that of other Australians.**

 - **Across Australia, 55% of health expenditure on Aboriginal and Torres Strait Islander people is for hospital care – this amounts to about \$1,218 per person**

per year on hospital care. This is twice the expenditure on non-Aboriginal and Torres Strait Islander people in hospital (\$604 per person per year).

- For every \$1 that non-Aboriginal and Torres Strait Islander Australians access through Medicare, Aboriginal and Torres Strait Islander Australians receive 27¢. For every \$1 that non-Aboriginal and Torres Strait Islander Australians get from the Pharmaceutical Benefits Scheme (PBS) for essential drugs, Aboriginal and Torres Strait Islander people get 22¢.**

- DHAC (through OATSIH) funds Aboriginal and Torres Strait Islander community controlled primary health care services to a level which goes some way to compensating for the lack of Aboriginal and Torres Strait Islander access to MBS and PBS funds. However, the level of primary health care expenditure for Aboriginal and Torres Strait Islander people is still approximately \$100 per person per year *less than* the national average.**

Health financing reforms

- **July 1 1996 the Commonwealth Government permitted general practitioners working in Aboriginal community controlled health services to bulk bill in addition to being on a salary, later extended to salaried State and Territory medical officers. In both cases additional income is returned to the service.**

- **Aboriginal Coordinated Care Trials**
 - **In the NT, implementation commenced in 1998, trial period lasting to mid-2000**
 - **Two trials at Katherine West and Tiwi**
 - **Flexible funding pool comprising primary health care funds previously administered separately by the Territory and Commonwealth governments**
 - **Additional Commonwealth funds ‘cash out’ MBS and PBS to the local population on a capitation basis**
 - **Local community controlled organisations administer the funds pool to purchase or provide services to their community**
 - **Care coordination: focuses on a whole-of-population approach with individual care plans designed to address priority health problems in the community**
 - **Evaluations show successful implementation of the trial structures, improved community agency and motivation on health, greater emphasis on preventive health and well being, and increased access to services**

- **Note: evidence of population health gains will only be established through longer term monitoring.**
- **1998 the Commonwealth also approved a new program though which Aboriginal and Torres Strait Islander health services in remote areas can access PBS medicines under Section 100 of the National Health Act.**
- **1999 the establishment of the Primary Health Care Access Program (PHCAP)**

Preconditions for the PHCAP

- **Effective, *resourced* health advocacy by the community sector**
- **The collaborative development of coordinating structures and needs-based regional health planning processes between agencies**
- **Development of planning tools such as *health zones*, a definition of core functions of PHC, and population-based minimum standard ratios for AHWs, nurses and doctors used to determine relative need**
- **The ability to work in genuine partnership created through the Coordinated Care Trials and the forums established under the Framework Agreements**
- **Detailed research into health funding**
- **A primary health care literate bureaucracy**

The Primary Health Care Access Program

- **In 1999 the Commonwealth Government agreed to provide additional funding under PHCAP to improve Aboriginal and Torres Strait Islander primary health care in jurisdictions where regional health plans have been developed**
- **The Central Australia region of the Northern Territory is one of the first regions in Australia to have completed its regional plan and received funding under PHCAP.**
- **PHCAP policy parameters and implementation draw on recent Aboriginal health financing research (above) and the partnerships and successes created through the Coordinated Care Trials.**
- **PHCAP funding has been allocated to offset lack of access by Aboriginal and Torres Strait Islander people to MBS funds**
- **It is based on a weighted capitation formula that allows a progressive roll out of up to 4 times the national MBS per capita average (\$350 per person) - two times for increased morbidity and two times for the increased costs of delivering health services in remote areas.**
- **Initial PHCAP funding for community controlled health organisations will be '*mixed mode*' - different to the Coordinated Care Trials in that it will allow a mix of grant funding and access to MBS through bulk billing**
- **Commonwealth PHCAP funding will be provided to communities progressively, in steps, to allow for graduated service expansion and the development of community capacity to undertake management of health services.**

- **In the NT, the new PHCAP funding will be *pooled* with existing Territory resources for community based primary health care and the pooled fund will be managed by zonal community controlled health organisations**
- **This is consistent with THS's (Territory Health Services') recent move to a funder/purchaser/provider model.**
- **Pooled funds may be used to purchase or provide *comprehensive* primary health care services (discussed further below).**
- **THS resources will be progressively pooled, starting with local clinical services and expanding to include regional and population health services over time.**
- **The PHCAP model as articulated in the NT will enable health service reform at the local, regional and Territory levels, better comprehensive primary health care services, and support for Aboriginal and Torres Strait Islander people to take greater responsibility for their own health and local health care services.**

Implementation of the PHCAP in the NT

What the NT Aboriginal Health Forum Partners (AMSANT, ATSIC, DHAC & THS) have agreed so far:

- **Establishment of a dedicated Primary Health Care Access Working Party under the NTAHF**
- **The establishment of a zonal model of comprehensive primary health care service provision for Central Australia**
- **The progressive introduction of a community control model of management for health service zones in Central Australia**
- **Agreement by the funders (DHAC and THS) and partners (AMSANT & ATSIC) to a funds pooling process similar to that in the Coordinated Care Trials**
- **Identification of the initial four zones for the PHCAP consultations and roll out – Anmatjerre, Eastern Arrente, Northern Barkly and Warlpiri – with the other zones to follow in stages**

Key outputs of the Primary Health Care Access Working Party:

- **Development of an ‘Integrated funding model’ to ensure that additional Commonwealth funds for Aboriginal comprehensive primary health care in Central Australia are distributed equitably in the light of the current distribution of resources**
 - **The model establishes a *regional* per capita benchmark by dividing current THS primary health care expenditure**

by the Aboriginal population of Central Australia, and adding the Commonwealth per capita contribution (\$700 initially)

- Despite varying levels of existing THS and Commonwealth expenditure in a particular subregion (zone), additional PHCAP funds will be deployed to ensure that the first zones are at least funded up to the initial regional benchmark**
- The 1997 Central Australian Planning Study has been updated to 2000 to account for additional investment in the intervening period by THS and the Commonwealth**
- Completion of a report on the current estimated Aboriginal population in Central Australia (necessary input to the integrated resource model), in cooperation with the ABS**
- The development of a Communications Strategy to guide the partners' contact teams when undertaking consultations with local Aboriginal communities, in brief:**
 - The partners (AMSANT, ATSIC, OATSIH and THS) will form a contact team for each Health Zone.**
 - The contact team will visit each community to hold information sessions with organisations and community members.**
 - Each community will be asked to nominate 2 (two) community representatives to form a Zone Steering Committee.**
 - The zone steering committee will select a planning consultant to work under the direction of the Zone Steering Committee.**

- **The consultant will develop 2 plans in close consultation with communities:**
 - **A Zone Strategic Plan- This will be a clear plan for all primary health care services in that zone, including existing THS services and new services. The plan will consider all health funding and services, not just the additional funds.**
 - **A Community Control Plan- develop a plan for moving to take greater community responsibility for all primary health services in that zone, at a pace decided locally (training and capacity development to be resourced at community and family levels).**
- **Once the plans have been completed and endorsed by the Zone Steering Committee, they will be sent to the Commonwealth and Territory governments for funding.**
- **Agreement on a definition of comprehensive primary health care for the NT to guide communities and planning consultants on the use of PHCAP funds, being:**
 - **clinical services provided by doctors, nurses and Aboriginal and Torres Strait Islander health workers, such as the treatment of illness and injury, care planning, early intervention and disease prevention.**
 - **support services for clinics such as staff training, management training and systems, and links to specialists, ambulances and hospitals**
 - **special programs like substance misuse, nutrition, emotional and social well being, environmental health, oral health and services for particular groups like women, men, young people and old people.**

- **Policy development and advocacy**
- **The development by THS of a costing study of all own source outlays at line item level for Aboriginal comprehensive primary health care in Central Australia**
 - **This study provides a transparent basis for the allocation of resources, allowing partners, planners and communities to make informed decisions on health care in their zone**
 - **It provides necessary inputs to the integrated resource model and provides a secure basis for additional PHCAP investment in Central Australia**
- **A Commonwealth-commissioned analysis of the THS costing study to inform negotiations between the Commonwealth and THS in finalising the financial arrangements for the PHCAP in Central Australia**
- **Agreements on funding parameters to assist contact teams, steering committees, communities and consultants in the zones when considering priorities when deploying additional PHCAP funds.**

Current priorities for the NT Primary Health Care Access Working Party:

- **Final agreement between the Government of the Northern Territory and the Commonwealth on the financial arrangements underpinning PHCAP in Central Australia**
- **Agreement between the Government of the Northern Territory and the Commonwealth on a Memorandum of Understanding underpinning the funders' arrangements for**

implementing PHCAP in the NT, and seeking AMSANT and ATSIC's advice before signing

- **Tender process to recruit health planning consultants to work with the contact teams, steering committees and communities in developing strategic plans for each zone**
- **Production of a presentation kit to assist contact teams in working with communities and stakeholders in Central Australia and the zones**

Conclusion

- **This presentation has outlined a planning process developing mutual understanding and agreement between the NTAHF partners**
- **The realities of partnership processes are that they are not always easy or fast**
- **These processes are planned around communities making the decisions and progressively taking responsibility for their own health care arrangements**
- **The partners regard PHCAP as an exciting, progressive and ground-breaking opportunity to make long awaited and substantial Indigenous health gains in partnership with the Aboriginal people of the Northern Territory**
- **We are confident that the Aboriginal communities of Central Australia will see:**
 - **Significantly increased resources for local and regional comprehensive primary health care services**
 - **Community controlled health service providers with local management responding to local concerns**
 - **Pooled funding arrangements that are more flexible and streamlined for both funders and services**
 - **The availability of tools that allow communities and individuals to take responsibility for their own health**
 - **A greater focus by communities on long term illness prevention and well being, with long term positive results**