



# The Road Is Made by Walking:

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

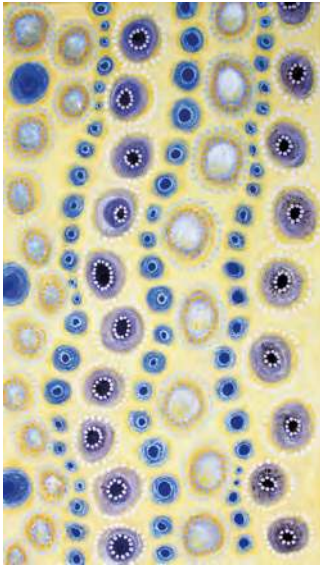
Summary report

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

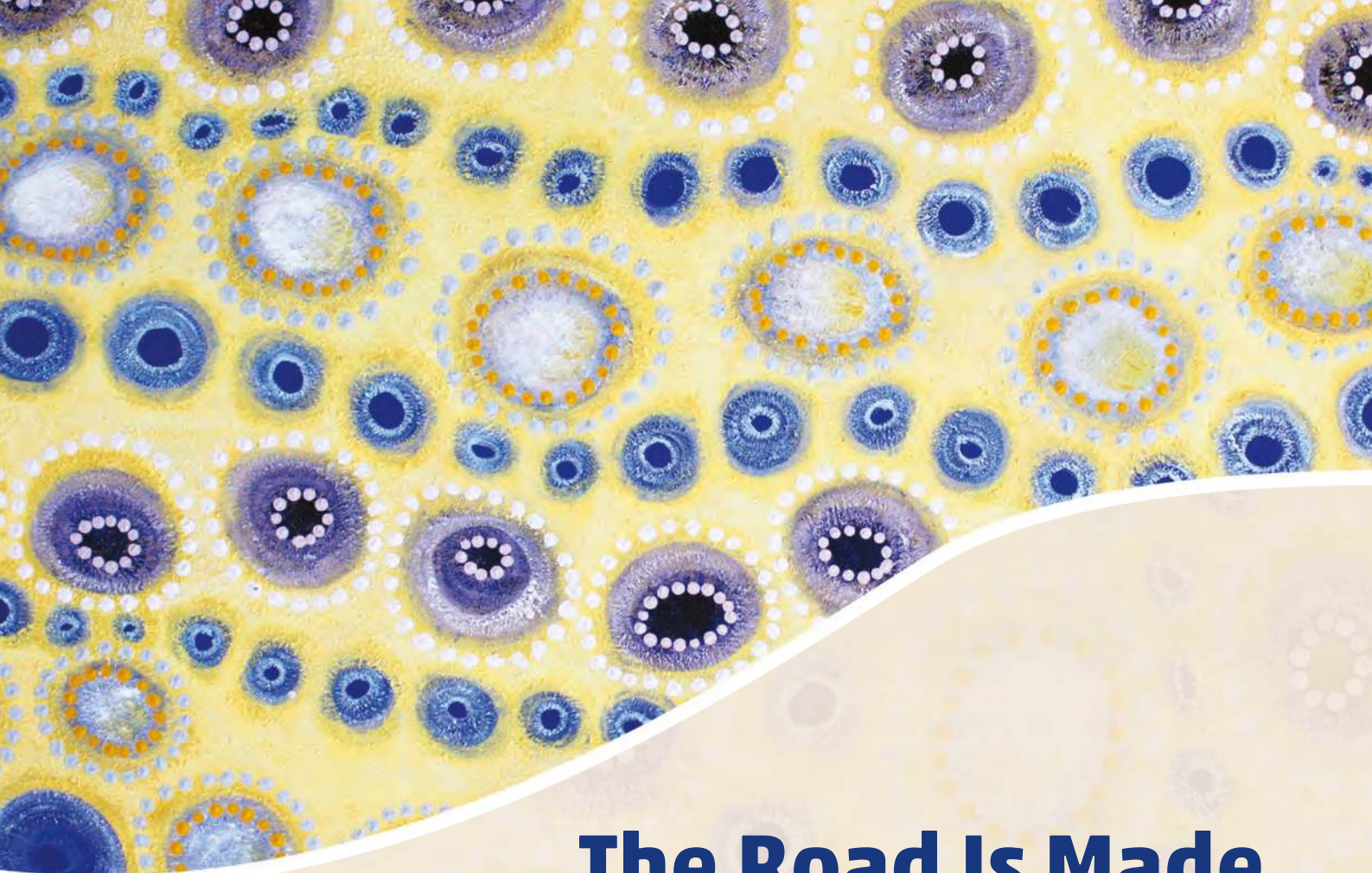
This painting was produced during the 'Manta' (earth) workshops. Karen describes her painting as Walka. Walka is any meaningful mark or pattern and may be an image on a cave wall, on rock or on sand and has cultural and ritual significance. It is used on the body during inma or ceremony. This painting 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  
Torres Strait Islander Health Research



**Flinders**  
UNIVERSITY



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# Contents

<b>Acknowledgments</b> .....	<b>iv</b>
<b>About this report</b> .....	<b>v</b>
<b>Abbreviations</b> .....	<b>vi</b>
<b>Terminology</b> .....	<b>vi</b>
<b>Introduction</b> .....	<b>1</b>
Background.....	1
Study aims and methods.....	1
The case studies .....	2
Case study 1: Pathways and regionalisation in the Northern Territory .....	2
Case study 2: Towards regionalisation in East Arnhem .....	3
Case study 3: Transition to community control in Cape York.....	4
<b>Overall findings and conclusions</b> .....	<b>6</b>
Achievements .....	6
Barriers in the implementation methods.....	6
Authorisation, auspice and control.....	6
Inadequate resources: money, time and capacity.....	6
Working across cultures, in partnership .....	7
Implications for future development.....	7
Regionalisation and the implications for governance and stewardship.....	7
Funding, contracting and accountability .....	8
<b>What needs to be done?</b> .....	<b>10</b>
<b>References</b> .....	<b>12</b>
<b>Author biographies</b> .....	<b>13</b>

# Acknowledgments

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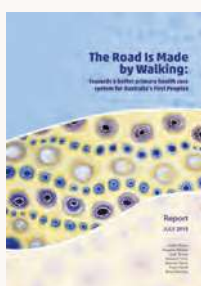
# About this report

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.

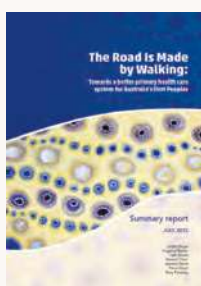
Two brief histories of the project research partner organisations and a case study have also been prepared in order to contribute to the record of development of the broader Aboriginal community controlled health sector in Australia, to give context to the larger research study, and for our partners'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



## Project report:

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

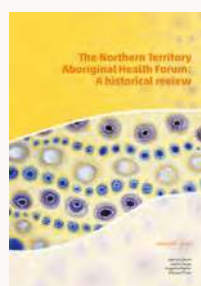
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## Project summary report:

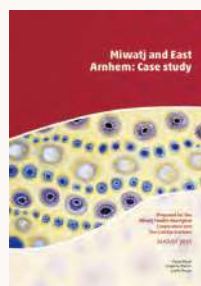
### ***The Road Is Made by Walking: Towards a better primary health care system for Australia's First Peoples – Summary Report***

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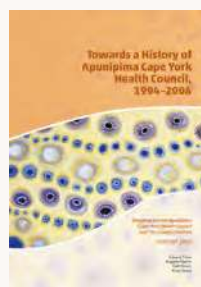
### ***The Northern Territory Aboriginal Health Forum: A historical review***

Jeannie Devitt, Judith Dwyer, Angelita Martini and Edward Tilton  
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### ***Miwatj and East Arnhem: Case study***

Paula Myott, Angelita Martini and Judith Dwyer  
ISBN 978-1-921889-47-9



### ***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

ACCHO	Aboriginal Community Controlled Health Organisation
AMSANT	Aboriginal Medical Services Alliance Northern Territory
ATSIC	Aboriginal and Torres Strait Islander Commission
FAR	Funding, Accountability and Results
FRP	Final Regionalisation Proposal
NGO	non-government organisation
NTAHF	Northern Territory Aboriginal Health Forum
NTH	Northern Territory Department of Health
PHC	primary health care

# 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.



# Introduction

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.

## Background

The provision of PHC to Aboriginal and Torres Strait Islander people is undertaken by the ACCHO sector and the mainstream health system (mainly in general practice). Access is patchy, resulting from the history of development of services and the policy directions and practices of federal and state/territory governments and the mainstream health system. The ACCHO sector in Australia delivers essential health care for communities and individuals, and its role has been endorsed in policy agreements among all Australian governments for many years. The available evidence indicates that ACCHO services are effective. ACCHOs are

funded through a complex array of short- to medium-term contracts, a situation that is recognised as problematic. Health policy aims to ensure better access for Aboriginal and Torres Strait Islander people to PHC, but unresolved issues of stewardship and governance, funding and regulation remain.

The study was informed by a theoretical model of the problems. It suggests that the current regimes of funding and accountability and the planned reforms are shaped by the interaction of two different ways of thinking about the goals and methods for improving Aboriginal and Torres Strait Islander health and health care. The first is based on Aboriginal and Torres Strait Islander concepts and principles for health and self-determination and the second is based on public management methods generally known as New Public Management. These ideas (and the tensions between them) provide a framework for understanding how the reforms progress, or fail to progress, and the implications for future policy and practice.

## Study aims and methods

The study was conducted from September 2011 to December 2014 and aimed to understand the reforms while they proceeded on their own timelines and agendas. 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?

We aimed to provide a coherent description of reforms in PHC for Aboriginal communities in the Northern Territory and 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, one at the level of an Australian jurisdiction (the Northern Territory) and two at the level of regions (East Arnhem in the Northern Territory and Cape York in Queensland). We documented the experiences of each case and analysed the common themes and their implications for future reform work.

The case studies focused on two reforms:

- the regionalisation program outlined in *Pathways to Community Control* (NTAHF 2009) (Case studies 1 and 2): the goal of the Pathways regionalisation program, which was led by the Northern Territory Aboriginal Health Forum (NTAHF) between 2009 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 Cape York Health Council.

The study was developed in accordance with the Lowitja Institute's Facilitated Development Approach. We negotiated endorsement of the study with our research partners and received ethical approval from four ethics committees. We conducted 69 interviews with 55 people involved in the reforms and analysed 242 public and internal documents dealing with the reform processes and structures, financial information and policy considerations. We also engaged in less formal discussions with our research partners as the study progressed, and our notes of those discussions also informed our analysis.

## The case studies

The process of reform in the Northern Territory and Cape York has been difficult and complex, and progress has been slow. However, the work continues and although the reform efforts analysed in this report have been frustrating, many valuable lessons can be learned from the experience.

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

Case study 1 documents the work of the Northern Territory Aboriginal Health Forum to establish a regional community controlled PHC system, as articulated in *Pathways to Community Control* (NTAHF 2009) and subsequent documents. The goal of the Pathways regionalisation program 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.

#### **Background and study goals**

The NTAHF is a formal partnership of the Aboriginal Medical Services Alliance Northern Territory (AMSANT), the Northern Territory Department of Health (NTH) and the Australian Government Department of Health (henceforth the Department of Health) and was established in 1998. Since its inception, the NTAHF has worked consistently on the development of the PHC system for Aboriginal and Torres Strait Islander communities in the Northern Territory, with some notable successes (for details see *The NTAHF and Regionalisation: An Historical Overview* (Devitt et al. 2015), a related paper published as part of this study).

The notion of regionally based PHC services is a longstanding part of the NTAHF's agenda of PHC reform. The partners had an agreed definition and a shared vision for regionalisation 'through 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' (NTAHF 2010:10). The Pathways regionalisation program was funded





by the Department of Health and governed by the NTAHF. Regions were resourced to develop formal proposals for regionalisation.

### **Summary of progress**

In 2010 and 2011 significant elements of the planned reforms were detailed and resourced. Both the Barkly Regional Committee (in 2010) and East Arnhem (in 2012) submitted formal proposals for regional community controlled health services, but neither was formally endorsed to proceed. In 2014–15 regionalisation lost its funding and work ceased. At the time of writing, the partners were working towards recommencing the reforms.

### **Findings**

1. Establishing PHC regions and regional governance was more complex and took longer than planned. There were difficulties both in the central planning and resourcing, and in the process of local communities negotiating agreements to regionalise PHC. The full implications of establishing regions as governance units that function as part of the Northern Territory health system and hold funds for PHC in the region were not fully appreciated.
2. The level of authorisation and commitment required to sustain the reforms over time, and in spite of external changes and difficulties, was not negotiated and secured at the outset. The NTAHF, as a deliberative and collaborative forum, had insufficient authority to drive implementation. The exercise of shared authority and responsibility by the NTAHF partners was always a challenge.
3. Time and resources were inadequate. There were significant gaps in the skills and resources available to the program, and several important elements (such as the design of funds pooling arrangements) were not progressed.
4. Progress was affected by the challenge of working across cultures. Concerns about the capacities of Aboriginal communities and their leaders were not openly

discussed and managed. Turbulence in the health system disrupted some longstanding relationships and exacerbated the problem of trust among the partners.

### **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 East Arnhem Region in the planning and implementation of the Pathways regionalisation program led by the NTAHF between 2009 and 2014.

#### **Background**

East Arnhem has a population of about 10,000 people spread over 33,000 square kilometres, with 10 major remote communities (five of them on islands), many homelands and outstations, and two towns. East Arnhem is culturally rich and linguistically diverse with three major language groupings, and is served by four PHC providers. Miwatj (established 1992) approached the Pathways regionalisation program as a way of pursuing its existing goal of 'one health board to represent all Aboriginal people in the region' (Miwatj 2014). Miwatj is governed by a regionally representative elected board, which includes senior community leaders (Miwatj 2014). It operates from four sites and is funded by the federal and Northern Territory governments through 17 main contracts. Miwatj works closely with two community organisations that support homeland communities.

#### **East Arnhem regionalisation proposal**

The East Arnhem Steering Committee—made up of 14 community representatives, five government representatives and two representatives from AMSANT (the peak body for ACCHOs in the Northern Territory)—commenced work in 2008 and submitted its Final Regionalisation Proposal (FRP) in June 2012. Regional advisory functions were established and a large community consultation process involving 400 community members (Christie et al. 2011) was conducted.

Structures and processes for regional governance were a source of tension throughout the project. Government representatives favoured the development of an overarching regional board, while community leaders decided to adapt the Miwatj Board. The Miwatj constitution was amended to achieve broad representation across the region, including representation of Laynhapuy Homelands Association and Marthakal Homelands Association (which provide services in remote homelands). An 'alliance agreement' to enable coordination of planning, organisation and delivery of care with both homelands associations and NTH services was designed and negotiated, and it provided for an incremental approach to PHC integration.

The proposal was considered by the NTAHF but no definitive response was given. Requests for further development work were made by the Department of Health, but differences on the question of a single ACCHO board for all services in the region and the role of the Miwatj Board were unresolved. No further developments in relation to the FRP occurred during the period of this case study, although Miwatj has continued work on the development of a regional PHC service, including the successful transition of the Yirrkala clinic in 2012, and ongoing work on transition of a second NTH clinic. Advocacy with the NTH and government ministers has continued.

### **Findings**

This case study documents some practical progress, but not success, in implementing the intended reforms. The major findings are:

1. Regionalisation was an existing goal for Miwatj and community leaders, who saw it as both a pathway to better health care and as an expression of self-determination.
2. Problems with acceptance by government of community leaders' decisions were seen by those involved as showing a lack of respect and a failure to understand community structures and processes.

3. Withdrawal of high-level government commitment to community control, and a shift to a focus on 'participation', was seen as an expression of lack of trust in Aboriginal capacity. The impact of several high-profile governance failures or problems in Aboriginal organisations influenced the thinking of politicians and public servants.

### **Case study 3: Transition to Community Control in Cape York**

This case study explains work towards the transition of PHC for Aboriginal communities in Cape York from Queensland Health to Apunipima Cape York Health Council (Apunipima), following the signing of a multi-party Deed of Commitment in 2006.

#### **Background**

Apunipima was established in 1994 with strong support from the Cape York Land Council and the Aboriginal and Torres Strait Islander Commission (ATSIC) Regional Council, and also from government. In 2005 the Cape York Institute recommended that Apunipima take on the delivery of PHC services for Aboriginal communities in Cape York, using existing Queensland Health and new national funding. The tripartite Cape York Regional Health Forum endorsed a plan based on this proposal in 2006, and all parties (Commonwealth and state governments and Apunipima) signed a Deed of Commitment in August 2006, with a target date for full implementation by June 2011.

#### **Early progress followed by loss of momentum**

In 2006 a Transition Planning Unit was established within Apunipima, funded jointly by the Department of Health and Queensland Health, and an extensive round of engagement with local communities was undertaken to seek endorsement. In accordance with the recommendations of the Cape York Institute proposal, Apunipima reduced the size of its board and included members from government health departments and private enterprise (ACYHC 2007:99).





During this time (2006–07) the legitimacy of the Deed of Commitment and Apunipima’s capability were questioned by government agencies. During 2007 and 2008 Apunipima completed several major pieces of work aimed at furthering implementation, including a roadmap for the transition to community control (ACYHC 2007). A report released in 2008 (Eagar & Gordon) recommended funds-pooling for Cape York, combining existing Queensland Health funding with an amount from the Department of Health (approximately \$20 million), to achieve equity in funding per capita. In 2008 Apunipima commenced its first permanent PHC services and in 2009 the Mossman Gorge health service was the first, and to date only, clinic to transition completely.

By 2010 regional planning for transition seemed to have stalled. Ironically, progress on a state-wide transition policy for Queensland, pursued by the state ACCHO peak body (the Queensland Aboriginal and Islander Health Council) since 2006 (QAIHC 2011), seems to have had the effect of delaying progress in Cape York. Work on this initiative continued for several years, but the draft transition policy was not endorsed before major restructuring in Queensland Health and a change of government in Queensland in 2012.

By 2014 Apunipima had achieved significant growth to become a major provider and partner in the delivery of PHC to the Aboriginal communities of Cape York. However, the commitment to full community control of Cape York PHC services had not been realised. In all communities other than Mossman Gorge, a hybrid PHC system operates, with attendant problems in service coordination and pressure on working relationships.

## **Findings**

Significant progress has been made, but several problems prevented the full implementation of the Deed of Commitment. The major problems were:

1. Lack of an authorised collaborative tripartite regional body (i.e. both governments and Apunipima), which left the project without a focus for planning and decision making. An unstable political and health system environment in Queensland, and major concurrent national changes, exacerbated problems with authorisation and implementation.
2. Resources to enable implementation were available only in the first few years. This affected Apunipima’s capacity to maintain engagement among the dispersed communities of Cape York.
3. Hostility to community control among local Queensland Health staff and some of the concerns about the practicalities of transition for staff were seen as evidence of systemic racism.
4. The inherent difficulties of managing and governing a health organisation across a large diverse region made good corporate governance a challenge. Government concerns about Apunipima’s governance added to this problem. Split roles in PHC, with both Queensland Health and Apunipima providing aspects of care in each community, resulted in problems of coordination and working relationships.
5. There was a lack of consideration of the underlying inadequacy of resources for PHC in the region, in spite of available evidence.
6. Funding complexity was not addressed and the reporting burden grew with increased funding.

# Overall findings and conclusions

Although each case study is unique, strong common themes are apparent both in the implementation problems encountered and in the implications for the future development of the PHC system.

## Achievements

Although the policy goals were not achieved, significant progress was made towards the development of a regional PHC system. Community engagement work was undertaken, the rationale for regionalisation of services was consolidated and some health services were transferred to community control. At the jurisdiction level in the Northern Territory, several important technical and policy issues were addressed, including the definition of core PHC services and a framework for the development of regionalisation proposals. Approaches to assessing the readiness of community organisations to undertake regional governance were developed in both jurisdictions (although this matter remains controversial).

## Barriers in the implementation methods

The planned reforms were beset by the following implementation barriers and difficulties.

### Authorisation, auspice and control

There were problems in the authorisation of the reforms in both the Northern Territory and Cape York, with high-level commitments not being matched with secure structures and processes for sharing power and control in order to manage the reforms. The auspice body in the Northern Territory, NTAHF, lacked the executive authority to enable timely binding decisions about the reforms. In Cape York, structures to

auspice and authorise the reforms were unstable or missing.

For governments, the level of organisational and policy change during the period (including changes in elected governments nationally and in the Northern Territory and Queensland, departmental restructures and shifts of individual senior decision makers) had an impact on both their commitment to, and interpretations of, the reforms.

The responsibilities the reforms placed on Aboriginal participants to represent the community, and the associated cultural obligations they took on, were a challenge that was often underestimated by funding agencies. There was also a perception by participants that government did not acknowledge the cultural legitimacy of ACCHOs and their role in shaping the dialogue about community control of the health sector. Although a continuing partnership between governments and the Aboriginal community controlled health sector was an essential requirement, there was a mutual perception of failure to maintain commitments and a sense of significant pressure on established relationships and mutual trust.

**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.**

### Inadequate resources: money, time and capacity

One reason for difficulties 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 itself was insufficiently recognised and provided for.



The complex changes involved in the planned reforms required a range of specialised knowledge and skills—clinical, financial, planning, governance and policy. Although such expertise may have existed, it was not reliably available. There was also a mutual perception of failure to maintain commitment to agreed timelines and processes.

**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.**

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

Working across cultures and in partnerships is difficult but is inescapable in the reform program. The working relationships we studied were often robust and effective, but were also characterised by a mutual lack of trust. This can be attributed to the separate interests of funders and providers, and to the intercultural nature of the relationship and the pervasive and perverse impacts of systemic racism (that is, the ways in which discriminatory effects are built into care systems, with or without intention on the part of those working within them). Although racism was not overtly expressed, it was considered by many participants to be an important underlying influence. Finding good ways to work across cultures remains a significant outstanding challenge, in spite of the fact that there is much skill and experience among some of the people involved.

Many of the strengths, as well as the challenges, are shaped by traditional and contemporary Aboriginal and Torres Strait Islander cultures. These aspects are seen by participants to have been misunderstood and their significance underestimated in the reforms.

The challenge of working across community and government sectors is also a significant one. 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.**

### **Implications for future development**

Our second research question considers what the experience of the reforms tells us about the requirements for the future—the funding and accountability relationships, and the governance and stewardship arrangements that are needed for an effective PHC system for Aboriginal and Torres Strait Islander communities.

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, 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. 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 and Torres Strait Islander communities?

### **Regionalisation and the implications for governance and stewardship**

The development of a regional system of PHC for Aboriginal and Torres Strait Islander communities has implications for the design of the health system as a whole, both at jurisdiction and regional level. Major aspects include the ways that care is structured and coordinated across a region, the allocation of pooled or bundled funding to regions and thence to providers, and the collection and analysis of data to guide regional planning and assess results.

There has been a tendency in Australian health policy debates for regionalisation to be seen as a straightforward restructuring of existing health care arrangements. In contrast, experience in New South Wales with regional structures and funding for public hospitals and health services in the last decades of the twentieth century is a good local example of the benefits of a more systemic approach. NSW Health gave serious attention to regional governance, regional funding allocation, equity in funding on a population basis, fairness for provider agencies within a region, the development of networks of care, and the role of the central health department in a regionalised system.

Importantly, attention is required both to the governance of regions at jurisdictional level and to the structures and methods by which ACCHOs and the mainstream system articulate with each other within each region and at jurisdiction level. This is not a simple matter of defining regional boundaries and asking those within them to work collaboratively.

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 that can only be achieved by governments. The reforms in both jurisdictions clearly offered an opportunity and a need for better systematic integration of ACCHOs in the jurisdictions' public health systems, but this opportunity was not realised.

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. 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. More flexible system design 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. However, while governance concerns clearly influenced government agencies, the matter appears not to have been aired or negotiated in relevant forums.

**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.**

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

Government funders ruled out addressing the question of the overall adequacy of funding levels for PHC for Aboriginal people as part of the reforms despite the strong implication that an adequate funding base is not only required but can also be expected to result in improved health status indicators.

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 needed. 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 a clear explicit intention of the reforms in the Northern Territory (NTAHF 2009:27) and in Cape York (CYRHF 2006:9). However, we found no evidence of substantial work within government on the methods for achieving this change, which would require high-level approvals and significant technical workup.

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 to provide 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.

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.

**Our sixth conclusion is that 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.**



# What needs to be done?

Based on our conclusions, 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 1), almost all of which were explicitly or implicitly included in the reforms we studied.

**Table 1: 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

Although the three case studies gave attention to governance, and implicitly required more attention to stewardship by governments, these matters remained problematic. The 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. Although ongoing 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. We suggest that the funding requirement is substantial but achievable.

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.

The development of a regionalised system of PHC for Aboriginal and Torres Strait Islander communities, under community governance, offers a pathway towards better health care and better health. 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—or recommence—as soon as possible.

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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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