NACCHO
National Aboriginal Community Controlled Health Organisation
Aboriginal health in Aboriginal hands
www.naccho.org.au

Performance Management of the DHAC Primary Health Network program

Submission to

Australian National Audit Office

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About NACCHO

NACCHO is the national peak body for Aboriginal and Torres Strait Islander health in Australia. We represent 145 Aboriginal Community Controlled Health Organisations (ACCHOs) and assist several other community-controlled organisations to improve health outcomes for Aboriginal and Torres Strait Islander people.

Our sector has more than fifty years' collective service. In 1971, Aboriginal people established the first Aboriginal medical service in Redfern, NSW. Mainstream health services were not working and there was an urgent need to provide decent, accessible health services for the medically uninsured Aboriginal population (pre-dating Medicare (1975)). Similar Aboriginal medical services quickly sprung up around the country. In 1974, a national representative body was formed to represent these Aboriginal medical services. That body has grown into what NACCHO is today.

NACCHO liaises with its membership (ACCHOs) and eight state/territory affiliates, governments, and other organisations, to develop policy, provide advice and advocate for better health and wellbeing outcomes for Aboriginal and Torres Strait Islander people. Together we address health issues including service delivery, information and education, research, public health, financing, and programs.

ACCHOs range from large multi-functional services employing several medical practitioners and providing a wide range of services, to small services which rely on Aboriginal health practitioners and/or nurses to provide the bulk of primary health care services. Our 145 members provide services from about 550 clinics. Our sector provides over 3.1 million episodes of care per year for over 410,000 people across Australia; about one million of these episodes of care are delivered in very remote regions.

ACCHOs contribute to improving Aboriginal and Torres Strait Islander health and wellbeing by providing comprehensive primary health care, and by integrating and coordinating care and services. They provide home and site visits; medical, public health and health promotion services; allied health; nursing services; assistance with making appointments and transport; help accessing childcare or dealing with the justice system; drug and alcohol services; and help with income support.

ACCHOs build ongoing relationships to provide continuity of care. This helps chronic conditions to be better managed and provides more opportunities for preventative health care. Through local engagement and a proven service delivery model, our clients 'stick'. Cultural safety in our services is a key factor of our success.

ACCHOs are also closing the employment gap. Collectively, we employ about 7,000 staff – 54 per cent of whom are Aboriginal or Torres Strait Islanders. This makes us the third largest employer of Aboriginal or Torres Strait people in the country.

Enquiries about this submission should be directed to:

NACCHO
Level 5, 2 Constitution Avenue
Canberra City ACT 2601
Telephone: 02 6246 9300
Email: policy@naccho.org.au
Website: naccho.org.au

Acknowledgements

NACCHO welcomes the opportunity to provide this submission to the Australian National Audit Office Performance Review of the Department of Health and Aged Care Primary Health Network (PHN) program. We would be pleased to elaborate further if required.

We support the submissions made by NACCHO Members and Affiliates.

National Agreement on Closing the Gap

At the meeting of National Cabinet in early February 2023, First Ministers agreed to renew their commitment to Closing the Gap by re-signing the National Agreement, first signed in July 2020. The reforms and targets outlined in the National Agreement seek to overcome the inequality experienced by Aboriginal and Torres Strait Islander people and achieve life outcomes equal to all Australians.

This Government's first Closing the Gap Implementation Plan commits to achieving Closing the Gap targets *through implementation of the Priority Reforms*. This represents a shift away from focussing on the Targets, towards the structural changes that the Priority Reforms require, and which are more likely to achieve meaningful outcomes for our people in the long term.

The four Priority Reforms offer a roadmap to meaningfully impact structural drivers of chronic disease for Aboriginal and Torres Strait Islander people:

Priority Reform Area 1 – Formal partnerships and shared decision-making

This Priority Reform commits to building and strengthening structures that empower Aboriginal and Torres Strait Islander people to share decision-making authority with governments to accelerate policy and place-based progress against Closing the Gap.

Priority Reform Area 2 – Building the community-controlled sector

This Priority Reform commits to building Aboriginal and Torres Strait Islander community-controlled sectors to deliver services to support Closing the Gap. In recognition that Aboriginal and Torres Strait Islander community-controlled services are better for Aboriginal and Torres Strait Islander people, achieve better results, employ more Aboriginal and Torres Strait Islander people, and are often preferred over mainstream services.

Priority Reform Area 3 – Transformation of mainstream institutions

This Priority Reform commits to systemic and structural transformation of mainstream government organisations to improve to identify and eliminate racism, embed and practice cultural safety, deliver services in partnership with Aboriginal and Torres Strait Islander people, support truth telling about agencies' history with Aboriginal and Torres Strait Islander people, and engage fully and transparently with Aboriginal and Torres Strait Islander people when programs are being changed.

Priority Reform 4 – Sharing data and information to support decision making

This Priority Reform commits to shared access to location-specific data and information (data sovereignty) to inform local-decision making and support Aboriginal and Torres Strait Islander communities and organisations to support the achievement of the first three Priority Reforms.

Review of Closing the Gap

> 'Too many government agencies are implementing versions of shared decision-making that involve consulting with Aboriginal and Torres Strait Islander people on a pre-determined solution, rather than collaborating on the problem and co-designing a solution.'[1]

In its recent review of the National Agreement on Closing the Gap, the Productivity Commission described government progress implementing the Agreement's Priority Reforms as mostly weak. It found no evidence of systemic change and that Government policy did not reflect the value of the community-controlled sector. The Commission noted that few tangible steps had been taken to increase the proportion of services delivered by ACCOs and that there was a need to improve funding to ACCOs to provide more flexible and longer-term contracts that cover full costs of services and reduce reporting burdens.[2]

PHNs and Aboriginal Community Controlled services

Supporting Aboriginal and Torres Strait Islander people's self-determination and building the capacity of the community-control sector is central to Australian governments' commitment to the National Agreement on Closing the Gap. Funding the Aboriginal Community Controlled Health Organisation (ACCHO) sector to determine, design, and deliver culturally appropriate services will build capacity to improve health outcomes and provide valuable workforce development opportunities for Aboriginal and Torres Strait Islander people.

In a 2018 study of the impact of PHNs on the ACCHO sector, Coombs notes that, *Primary Health Networks control a significant amount of Indigenous-specific health funding, which Aboriginal Community Controlled Health Services have historically relied upon. … The Primary Health Networks promote contestable funding and competitive service markets, destabilising the Indigenous health funding environment. This new funding model does not account for the distinguishing feature of Aboriginal Community Controlled Health Services: self-determination. Additionally, Primary Health Networks possess limited knowledge of Indigenous health contexts and have been resistant to engagement with Aboriginal organisations. All of this limits Indigenous self-determination and threatens Indigenous health.*"[3]

Unfortunately, Coombs assessment of PHNs is as relevant today as it was in 2018. He notes, *…the level of Indigenous Community engagement to the discretion of PHN boards. As a result, ACCHSs have not received significant investment from PHNs, nor have they been consulted in key Indigenous health decision-making processes. Moreover, PHNs do not appear to possess high levels of Indigenous primary health care knowledge or expertise and would do well to engage with and learn from ACCHSs.*

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[1] Ibid.

[2] Productivity Commission 2023, Review of the National Agreement on Closing the Gap, Draft Report, Canberra, July.

[3] Coombs, D. (2018). Primary Health Networks' impact on Aboriginal Community Controlled Health Services. Australian Journal of Public Administration, 77(S1), S37–S46. https://doi.org/10.1111/1467-8500.12357 https://onlinelibrary.wiley.com/doi/full/10.1111/1467-8500.12357 (Accessed 6/12/2023)

Accountability

Initially, PHNs were intended be outcomes focussed and use a co-design methodology to work with the sector, but this is not how they operate in some jurisdictions. Experience from across the ACCHO sector suggests that in some jurisdictions, PHNs are still not prioritising community controlled care and have a poor understanding of the community-controlled sector and how it delivers primary health care.

PHN funding tends to favour large organisations and peak bodies and is predominantly awarded to non-Indigenous organisations. These organisations often deliver services that are not culturally safe, and do not work in partnership with the Aboriginal and Torres Strait Islander community. This draws funding away from ACCHOs and ACCOs which are best placed to deliver services to their communities.

Relationships with ACCHOs

There are significant issues with the way that PHNs work in and with the community controlled sector. Whilst some ACCHOs have good relationships with their PHN, feedback from the sector is overwhelmingly negative. Our member services have indicated that PHNs are largely unwilling to work collaboratively, do not have the skills to engage effectively with the Aboriginal community control sector and have limited awareness of the principles of the National Agreement and the four Priority Reforms. PHNs are for the most part, reluctant to engage with ACCHOs and other external organisations.

NACCHO Affiliates and Members with Memoranda of Understanding with PHNs report reluctance of the PHN to progress MoU objectives. Indeed, some Aboriginal and Torres Strait Islander representatives on PHN advisory groups and Boards have felt that their representation was tokenistic and contentious to the point that they were reconsidering their involvement or withdrawn altogether.

PHN Boards need to be skills based and reflective of the population, and should always include Aboriginal and Torres Strait Islander representation. Feedback from the sector has raised concerns about the objectivity of PHN Board members where they are also key stakeholders.

Funding transparency

Fundamentally, current PHN funding models do not align with the Priority Reforms of the National Agreement. Funding to deliver health services and programs for Aboriginal and Torres Strait Islander communities should be prioritised through the ACCHO sector to reduce fragmentation and ensure a focus on holistic, person-centred care.

Stronger accountability measures are needed which require ongoing, sustainable and embedded engagement and co-design with Aboriginal and Torres Strait Islander communities by PHNs and peak bodies. Accountability measures should also be developed to ensure equitable distribution of funding by such organisations.

Funding currently provided to PHNs and peak bodies should be transitioned to the ACCHO sector in line with Priority Reform 2 and actions recommended under the Primary Health Care 10 Year Plan.[4] Funding the sector directly ensures culturally appropriate prevention and clinical services for individual communities can be designed and developed to meet the specific needs of that community. We know that health care delivered through ACCHOs delivers better health outcomes for Aboriginal and Torres Strait Islander communities.

ACCHOs note the reporting burden associated with funding through PHNs often outweighs the value of the funding. Some services receive funding from as many as 70 different departments, agencies, and organisations, each with unique reporting requirements, often for relatively small funding amounts. ACCHOs are not resourced to manage this level of reporting.

Mechanisms are needed to ensure transparency of PHN funding, both with the public and within the ACCHO sector. Sites like GrantConnect do not reflect the full allocation of funding that goes to PHNs. PHN activity workplans don't disclose the funding they receive for programs.

Performance and Performance Management

Variability in the way PHNs operate suggests that performance and accountability is not being well managed.

The current Guiding Principles document for PHN engagement[5] with ACCHOs, first developed in 2016, is significantly out of date and does not reflect the Priority Reforms of the National Agreement. The document provides no accountability for PHNs to engage with ACCHOs and does not include guidance on how to provide commissioning services for Aboriginal and Torres Strait Islander communities.

It is unclear how PHNs perform against the Guiding Principles or how they are responsible to the Priority Reforms or targets in the National Agreement. There are Key Performance Indicators for PHNs, however none relate to equitable distribution of funding.

This approach does not align with Government commitments to the Priority Reforms of the National Agreement and principles of self-determination for Aboriginal and Torres Strait Islander people.

PHN commissioning burdens

Under Priority Reform 3 of the National Agreement, PHNs commissioning government services are obligated to commit to systematic and structural transformation, to improve accountability and respond to the specific needs of Aboriginal and Torres Strait Islander people.

In practice, when funding is provided to ACCHOs through PHN commissioning arrangements, its value is often diminished. Complex reporting arrangements with often short submission timelines, lack of flexibility in how the funding can be utilised, and instances of funding being tied to programs that are culturally inappropriate for the intended community burden already over-stretched ACCHOs. It leaves them scrambling to find resources to address the unfunded reporting overheads

[4] Primary Health Care 10 Year Plan 2022-2032, Action area C: Close the Gap through a stronger community controlled sector, https://www.health.gov.au/resources/publications/australias-primary-health-care-10-year-plan-2022-2032?language=en

[5] https://www.health.gov.au/sites/default/files/documents/2021/04/primary-health-networks-phn-and-aboriginal-community-controlled-health-organisations-guiding-principles.pdf (Accessed 4/12/2023)

and to undertake resource intensive adaptation of programs to suit local cultural requirements. Importantly, as one Affiliate noted, PHNs have no cultural mandate to commission Aboriginal health programs, including cultural programs.

PHN commissioning approaches often result in significant delays for ACCHO contract renewals. This leads to gaps in funding for salaries between agreements and makes it difficult for ACCHOs to retain staff and provide continuing service. This has a negative impact on outcomes for ACCHOs and for the Aboriginal and Torres Strait Islander communities they support.

The PHN Approach to Market for services to Aboriginal and Torres Strait Islander people is not informed by the ACCHO sector and fails to consider the important role that NACCHO Affiliate organisations play in the Aboriginal and Torres Strait Islander health landscape.

PHN tendering processes are not transparent, and lack accountability and detail on assessment processes. NACCHO understands that historically, Price Waterhouse Coopers prepared a suite of resources to guide PHNs through the commissioning process. These included guidance on how to co-design, how to approach the market etc., however these resources appear to have been abandoned.

In contrast to PHN commissioning practice, ACCHOs report that programs commissioned by community-controlled peak bodies such as NACCHO, understand the needs and challenges of the sector and support flexible local level decision making to optimise service delivery and outcomes for Aboriginal and Torres Strait Islander people and communities.

In October 2021, the House of Representatives Select Committee on Mental Health and Suicide Prevention Final Report recommended that the Australian Government:

- consolidate its funding portfolios to Aboriginal Community Controlled Health Organisations (ACCHOs) within the Department of Health for Aboriginal mental health, suicide prevention, and social and emotional wellbeing, and
- ensure that Commonwealth funding for Aboriginal services is redirected from Primary Health Networks to ACCHOs, where available.

The transition of funding from PHNs to the ACCHO sector is echoed in the Primary Health Care 10 year Plan. The Productivity Commission Review of Closing the Gap draft report also noted that changes to commissioning processes and contracting could ensure that only service providers with the capability to provide culturally safe services are selected.

Data

Affiliates have reported that there is little consistency between PHNs jurisdictionally or nationally, no data sharing or sharing of information. PHNs hold ACCHO data they have collected over many years however, so not use it to inform ongoing work or quality improvement, nor consider how they report it back to the sector or the community.

Program review: Delivery of Aboriginal and Torres Strait Islander mental health and suicide prevention services and the ITC Program

In a recent review of the Indigenous Mental Health and Suicide Prevention (MSHP) and Integrated Team Care (ITC) program, NACCHO made the following observations and recommendations:

- PHN grants often don’t reflect the needs of the targeted audience, and lack flexibility

- PHNs lack consistency across jurisdictions, and nationally, and there is no sharing of data or information.
- PHN grant are often complex and hard to understand. They often don't provide feedback to the applicant.
- PHN grant management is often overbearing for ACCHOs is often overbearing. ACCHOs are overburdened by PHN reporting requirements, noting that the PHN is not subject to the same level of reporting.
- There is a lack of accountability for provision of funding to mainstream services and lack of accountability for mainstream services funded by PHNs to provide culturally safe care.
- There is no systematic approach to grant management. Likelihood of a successful application depends on the relationship between the PHN and the ACCHO.
- Whilst some ACCHOs/Affiliates report good relationships with their PHNs, these relationships are largely personality driven.