

**COMMONWEALTH GRANTS COMMISSION**  
**INDIGENOUS FUNDING INQUIRY**  
**FINAL SUBMISSION**

**From: Aboriginal Medical Services Alliance Northern  
Territory (AMSANT)**

**Submission No.: IFI/SUB/0058**  
**Date Received: 20/12/2000**

***Why \$400 million per year from  
Medicare needs to be quarantined for  
improving Aboriginal & Torres Strait  
Islander health***

**Report for the Aboriginal Medical Services Alliance of the  
Northern Territory (AMSANT)**

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**Stephen Jan**

**SPHERE, Department of Public Health & Community  
Medicine  
University of Sydney  
NSW 2006**

## **Summary**

The ATSI population experience poorer access to primary health care services than the non-ATSI population. This is evident in the significantly lower levels of Medicare / PBS spending they receive per person. The present Medicare system of funding is not equipped to redress this access problem because it largely about reimbursing existing service providers. It is not about funding new infrastructure. Therefore, those populations or regions that are not well serviced are unlikely to attract much Medicare funding. On the other hand, improving access to primary care services for many indigenous populations would require significant new investment in services and programs. It is recommended therefore that, in the immediate term, some form of dedicated block funding of around \$400 million per year from Medicare be quarantined for this purpose.

## **Introduction**

The question of whether the Aboriginal and Torres Strait islander (ATSI) population are receiving a fair share of health service funding has been the focus of much political debate. Central to this has been the issue of equity i.e. whether by some community standard, resources are being allocated fairly across population groups. However, one aspect of this debate that perhaps has not been as well considered is the issue of efficiency. This means whether funds are being used in such a way as to maximise the return (or health benefit) to the community. In terms of relevance to policy and decision making, it is important that both issues are given due recognition in the debate over how health service funds are to be allocated.

The aim of this report is to incorporate some measures for achieving equity in resource allocation within a framework that will also promote a better use of existing resources.

The outline of this paper is as follows. In the next section, the current situation with respect to health status, funding and service use will be outlined. This will be followed by various funding options aimed not only at achieving an equitable share of resources for indigenous health, but also more appropriate service provision and use. Finally some recommendations will be set out.

## **2. Current situation**

The health status of ATSI Australians very clearly lags well behind that of the non-ATSI population. This disparity has been well documented (and therefore will not be detailed extensively here). Some indicators illustrating this gap in health status are:

- ATSI people have an average life expectancy of 15 to 20 years less than that of Australians in general;
- Infant mortality rates around 3 to 4 times greater than the general population; and
- In some communities diabetes rates are 15 to 20% in comparison to 2 to 3 % in the general Australian population (Abraham et al, 1995).

Despite these vast differences in health status, per capita health care expenditure is not much different between ATSI and non-ATSI populations (8% higher in the former - Deeble, et al, 1998). (This figure includes all government and private spending on health care.)

The story changes somewhat when comparing government expenditure (Commonwealth, state and local). In this case, expenditure per capita is 50% higher on ATSI populations (Deeble, et al, 1998 Deeble, 2000). The reason for this contrast between total expenditure and government expenditure is that private health cover is generally beyond reach for much of the ATSI population.

At present, however, despite significantly poorer health status, ATSI people receive proportionally much less funding through Medicare / PBS than the non-

ATSI population. Deeble et al (1998) estimated that the ATSI population receives around a quarter of the amount of Medicare and PBS funding per capita than rest of the Australian population (\$115 vs \$450). This disparity is to some extent offset by the amount allocated by the Commonwealth to Aboriginal Medical Services (AMSs). When this expenditure on AMSs is added to the amount allocated by Medicare, the difference in per capita expenditure on primary care between the two populations narrows (\$361 vs \$450) but nonetheless, a significant gap remains.

Poor access to primary care has, in turn, contributed to the disproportionately higher levels of spending on hospital services in the ATSI population. This is because individuals who are unable to access primary care are either presenting for treatment at more advanced stages of illness or presenting at hospitals for treatments that could alternatively have been provided at primary care facilities. Neither of these patterns of service use are likely to be the most appropriate in terms of clinical efficacy. Certainly they are unlikely to be particularly cost-effective. In his report to the AMA, Deeble (2000) states that, "ATSI service use is skewed toward high-cost hospital treatment partly because it is the only practical way of providing any but the simplest care in many situations but also because the primary health services are either unavailable or not well used by Indigenous people."

### **3. Addressing issues of access to primary care through equitable Medicare funding**

Against this background, a number of funding options are presented in this section which aim to address the issues of equity and efficiency in resource use.

As indicated earlier, despite the significant difference in health status, the level of total expenditure for ATSI populations is not much different per capita than it is for non-ATSI.

In terms of Medicare/PBS funding, the significant shortfall in funding received by the ATSI populations (even when the amount allocated to AMSs is added)

highlights fundamental and systemic problems of access to primary care services. Furthermore, a large proportion of the ATSI population cannot readily access AMS services. The findings of 1994 ATSI survey indicates that over 60% ATSI population live more than 10 kms from their nearest AMS or Medical aid post and 40% live over 25kms (ABS, 1995).

This suggests that government expenditure has not been sufficient to ensure that ATSI populations have a comparable level of access to primary care health services enjoyed by non-ATSI population.

However, one of the main problems in attempting to redress this through government policy is that, within Medicare, aggregate funding for populations is determined from the ground up. That is, the share of funding received by ATSI vs non-ATSI simply reflects the extent to which respective populations use GP and specialist services. Proposing aggregate funding targets therefore is not consistent with the way Medicare presently operates. Funding through such a system is currently undertaken through what Deeble refers to as a 'demand driven' process. This means that resources are allocated on a 'per service' basis and therefore targets per se are unlikely to be met without systematic measures to improve access and use of services.

The problem is therefore overcoming barriers to access that will enable a better use of primary care services. The existing method of funding under Medicare is not aimed at redressing potential inequities in the distribution of prevailing primary care infrastructure. As it stands, those populations which are better serviced in terms of primary care facilities attract greater levels of Medicare / PBS funding. For example, Double Bay in the Eastern Suburbs of Sydney attracts over \$900 of Medicare funding per person per year compared with less than \$80 for the Aboriginal population serviced by the Nganganawilli Health Service in remote Western Australia (Health Department of Western Australia, 1998). Clearly, this illustrates that funds are not being spent in accordance with health need. It is difficult to see how these patterns of spending could be justified on either equity or efficiency grounds.

This is not necessarily a criticism of Medicare. The current system of Medicare / PBS funding is largely about reimbursing for services delivered by existing providers. It is not equipped to develop primary care infrastructure or capacity nor improving access to existing services (nor is this its aim). In order to tackle these issues, certain levels of Medicare / PBS funding needs to be allocated *outside* the existing funding arrangements. This requires an amount to be quarantined from the MBS and PBS distribution. These funds would be used to improve access to services by addressing some of the constraints on service use experienced by indigenous populations. This is about ensuring that the appropriate infrastructure is in place to allow ATSI people the same opportunity to access primary care services as their non-ATSI counterparts.

The aim of this section is to set out a number of mainly supply-side responses to this problem of access to primary care services. These options will entail different funding options that would enable the establishment of adequate primary care services for ATSI populations.

The starting point for this analysis is the estimates of resource use provided by Deeble et al (1998) and his subsequent analysis of the funding options for Aboriginal health (Deeble, 2000). In the latter study, he examined the possibility of incorporating into a funding formula for all health service spending, weightings for Aboriginality based on differential cost and need.

His analysis suggested a weighting of 1.27 for Aboriginality. This weighting was a composite of a two other weights, one for cost differentials (1.10) and the other for mortality (1.15).

The use of such a weighting has limited applicability in the context of this paper because they do not adequately reflect the additional resource needs of the ATSI population primary health care. In particular, they do not fully reflect the funding requirements associated with the establishment of *new* facilities and programs aimed at improving service access.

The cost weighting of 10% reflects simply the inflation factor associated with providing services to indigenous population as a result of such populations being more likely than the general population to be residing in rural and remote areas and the consequent higher costs of goods and services in those regions. It does not reflect the different resource or service needs of the ATSI population.

The weighting for mortality of 1.15 is based simply on the actual difference in crude death rates between ATSI and non-ATSI populations. It is unclear how this number would then reflect the additional resource needs of the former. For instance, there is no reason to believe that a population with 2 times the number of deaths as another requires 2 times more resources. It may just as likely be the case that they require 4 times or 1.5 times the resources. In effect, such a weighting is purely a function of the measuring scale in which deaths are measured. It does not necessarily bear any cardinal relationship with *resource need*.

Ideally, to properly determine the amount to be allocated to ATSI populations a comprehensive series of micro-level evaluations would be conducted. These would determine, for individual regions, the level of funding required to ensure equal access to primary health care services for ATSI and non-ATSI populations. At each setting, economic evaluation would be undertaken of various options for investing in facilities, infrastructure and programs (factoring in also the costs of maintenance). In general, this entails a 'bottom-up' approach where the amount required in aggregate is determined by adding the amounts required to achieve this aim across all regions.

In the absence of such data, it is nevertheless possible to use the limited information presently available to make global approximations as to the level of aggregate funding required to minimise the disparity in access to primary care services between ATSI and non-ATSI. At the very least, it is possible to identify options which are improvements on the current situation in the absence of information which would allow us to be able to specify precisely the optimal strategy.



There are three resource allocation scenarios presented below beginning with an outline of the current situation and concluding with the recommended option.

Table 1 sets out the existing allocation drawn on 1995-6 figures presented in Deeble et al, 1998. It indicates that per head of population, ATSI people receive about one quarter of the amount of Medicare and PBS funding received by non-ATSI.

**Table 1: Existing allocation through Medicare (Source: Deeble et al, 1998)**

|                                           | <b>ATSI<br/>\$</b> | <b>Non-ATSI<br/>\$</b> |
|-------------------------------------------|--------------------|------------------------|
| Existing Medicare/PBS funding (1995/6)    | 42 mill            | 8,182 mill             |
| Amount per capita                         | 115                | 450                    |
| Ratio of ATSI/Non ATSI per capita funding | 0.26               | 1                      |

Table 2 indicates the effect of equalising the per capita distribution of funding between ATSI and non-ATSI. As indicated, at present, ATSIs attract significantly less Medicare / PBS spending per person than non-ATSIs. These estimates here illustrate the impact on the overall allocation of Medicare funding if the amount allocated to ATSIs were increased to a level where the per capita level of spending was equal to that of non-ATSIs.

In a budget neutral environment, the effect would be to increase the aggregate level of funding to ATSI populations by around \$120 million per year. Such a reallocation would reduce the amount spent on the non-ATSI population by \$7 per person per year from \$450 per year to \$443. This option is presented largely for illustrative purposes. Given the significantly greater health need within the

ATSI population, there is little justification on either equity or efficiency grounds to argue for simply equal per capita expenditure.

**Table 2: Equal funding per capita**

|                                           | <b>ATSI<br/>\$</b> | <b>Non-ATSI<br/>\$</b> |
|-------------------------------------------|--------------------|------------------------|
| Medicare/PBS funding                      | 163 mill           | 8,062 mill             |
| Amount per capita                         | 443                | 443                    |
| Ratio of ATSI/Non ATSI per capita funding | 1                  | 1                      |

Table 3 outlines the recommended resource allocation option. It incorporates an equity weighting of 2.5 for Aboriginality. This weighting is based on that applied to Aboriginality in the NSW Resource Distribution Formula (NSW Health Department, 1996) and thus has some precedent in policy. A similar weighting of 3 for Aboriginality was formerly employed in the Queensland RAF (Queensland Health, 1994). This type of weighting is aimed at achieving vertical equity. It is designed to address the differential needs between the two populations. In effect, it is about closing the gap in disadvantage between the two groups by enabling investment in new services, infrastructure and programs in ATSI populations.

Vertical equity weightings are quite widely used in public policy as a means of addressing differential needs of across populations (Mooney, 1996). For instance, progressive taxation scales used in most Western industrialised nations represent a vertical equity measure designed to effect some form of wealth distribution across households. Within the economics literature this type of weighting has been advocated for use quite extensively within cost-benefit analysis and investment appraisal as a means of achieving equitable patterns of resource allocation (Weisbrod, 1968; Harberger, 1978; Mooney et al, 1995; Williams, 1997; Dolan, et al, 1999). Such weightings therefore in the

context of ATSI health care need to be recognised as legitimate and valid policy levers for achieving the policy objective of equal access to primary care services.

The application of such a weighting would increase the amount of Medicare / PBS funding to ATSI populations by around \$350 million up to \$396 million per year. Again, without increasing overall funding, the reallocation this involves would have a minimal impact on the non-ATSI population.

**Table 3: Equity weighting of 2.5 for Aboriginality**

|                                           | <b>ATSI<br/>\$</b> | <b>Non-ATSI<br/>\$</b> |
|-------------------------------------------|--------------------|------------------------|
| Medicare/PBS funding                      | 396 mill           | 7,829 mill             |
| Amount per capita                         | 1078               | 431                    |
| Ratio of ATSI/Non ATSI per capita funding | 2.5                | 1                      |

The analysis presented thus far has been expressed in 1995-6 dollars. An adjustment for inflation, would increase the \$350 million figure to approximately \$400 million.

### **Conclusion**

On the grounds of allocative efficiency (and equity), it would be difficult to sustain the argument that an additional \$400 million a year to improve facilities and increased infrastructure for primary care for indigenous populations would have better use elsewhere. As indicated above, channelling \$400 million from the funds currently being spent through Medicare / PBS would amount to little more than the loss to each person in the non-ATSI population of a single, short GP consultation per year.

Over the medium and long term it is expected that the increased access to and thus use of primary care services within the ATSI population brought about by

this greater investment will create significant cost savings. These 'downstream' cost savings will result from more appropriate use of primary care services and the health promoting impact this will have. The return on investment of this \$400 million per year will be apparent not only in terms of health gain but also cost savings to the hospital sector. To a large extent this proposal is about shifting the balance of funding to more appropriately meet the needs of ATSI populations as it is about ensuring equity in funding.

***Therefore it is recommended that \$400 million per year of Medicare / PBS funding be quarantined for the purpose of promoting access to primary health care in ATSI populations. This would be channelled into investment in new infrastructure, provision of new services and programs to promote access to existing services.***

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## **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**

#### **Presenters:**

**Pat Anderson (Executive Secretary, Aboriginal Medical  
Services Alliance of the NT)**

**Leonie Young (NT Manager, Commonwealth Department of  
Health and Aged Care)**

**Jenny Cleary (Assistant Secretary, Territory Health Services)**

#### **Authors:**

**John Boffa (Central Australian Aboriginal Congress)**

**Michael Fisher (NT Office, Department of Health and Aged  
Care)**

## 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 ATSIIC 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 through 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 Arrernte, 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**