ATTACHMENT B

HEALTH PARTNERSHIPS

1. The Commonwealth is involved in the development of a **National Framework** to coordinate service delivery and identify priorities for funding. There are several components to the national framework including:

(i) a national Aboriginal health advisory body (Aboriginal and Torres Strait Islander Health Council (ATSHC)) to advise the Minister for Health on broader policy issues;

(ii) a Memorandum of Understanding (MOU) with ATSIC to ensure that all primary health and environmental health programs are effectively coordinated; and

(iii) Framework agreements with ATSIC, the States and the community controlled sector to define responsibilities and improve access to health services for Aboriginal and Torres Strait Islander people.

2. **Framework Agreements** have been signed in each State. The Framework agreements set out the responsibilities of the various parties. They are effectively MOU's and do not contain funding obligations. The agreements also contain some commitments and set criteria for judging performance.

3. Under the Framework agreements a **State Forum** was established in each State. The State Forums draw on members from the Commonwealth, ATSIC, States and Community sector organisations. The role of the Forum is:

(i) to decide on key issues about regional planning,

(ii) to contribute to policy and planning development, and

(iii) to evaluate implementation of the Framework Agreement.

4. State Forums have been used to develop **Regional Plans**. The regional plans aim to coordinate service delivery, identify gaps in service delivery and identify needs. Stakeholders involved in the development of the plans include, the Commonwealth, ATSIC, the States, and the community controlled health sector.

5. As regional plans are developed within regions with an emphasis on local input, there is some variation in the definition of need and the indicators used to measure that need. There is also some variation in the geographical basis on which the plans are based. Most contain the following information:

- population demographics;
- location of, and details of, service providers;
- environmental health (including information on condition and adequacy of housing and infrastructure); and
- health status (usually hospital use by diagnostic related group).

6. While the regional plans do not contain funding commitments or guarantees they will be used for planning purposes. However, the use to which they will be put may vary between States and regions.

7. The Commonwealth (OATSIH) has stated that it intends to use regional plans to identify needs and better target funds. At this stage it appears that the regional plans will mainly be used to distribute funds under PHCAP. In 1998-99 this program was less than 5 per cent of OATSIH's total budget.

8. Table B-1 provides a summary of progress on regional plans.

Table B-1 PROGRESS ON AND INFORMATION ABOUT REGIONAL PLANS

State	Regional Plans Completed	Regional Plans Signed Off	Geographical Basis
NSW	Yes	Yes	17 regions based on NSW Department of Health Area Health Service regions.
Vic	No	No	4 Natural geographic regions that generally align with Victorian Department of health regions.
Qld	Yes	Yes	8 ATSIC regions which are further broken down into 36 areas of interest.
WA	Yes	No. The Commonwealth has not yet signed off on the agreement.	5 regions based on WA Department of Health regions with some minor adjustment.
SA	Yes	Yes	8 regions based on the health regions used by SA Department of Human Services. The Northern and Far Western Region (extending from Port Augusta to the Anangu Pitjantjata Lands) was split into 3 sub-regions.
Tas	No	No	Whole of State
ACT	Yes	Yes	Whole of State
NT – Top End	Yes	Yes	10 regions based broadly on language groups
NT – Central	Yes	Yes	12 regions based broadly on language groups

ATTACHMENT C

COORDINATED CARE TRIALS

9. The Coordinated Care Trials tested a new approach to health care financing and delivery aimed at providing better health services to people with chronic and complex care needs. There were both mainstream and Indigenous trials. The Indigenous trials were structured to accommodate the particular service contexts and needs of communities. There were four Indigenous trials run in five locations: Derbal Yerrigan (Perth) and South-West Aboriginal Medical Service (Bunbury); Tiwi Islands; Katherine West; and Wilcannia.

10. Table C-1 shows the key features of each trial. Contextual factors were very important in each of the trials — the model must be adapted to local circumstances.

11. While each trial differed according to its local context, a number of features were shared. Key shared elements of the CCTs are similar to the proposed arrangements under PHCAP. These include:

(i) Funds pooling aimed to provide trial organisations with flexible funding arrangements and the ability to better meet community and individual needs. It transferred the historical funding of existing services such as State health services; MBS/PBS equivalent funding; and hospitals to a single pool managed by community-based trial organisations.

(ii) The Commonwealth contributed MBS/PBS per capita funding equivalent to the average Australian usage to the pool. This was additional funding because the historical use of MBS/PBS services in these areas was less than the average Australian per capita rate; and

(iii) A phase of capacity building in which the ability of a community based organisation to manage and purchase/provide health services is developed.

Table C-1 SUMMARY OF THE INDIGENOUS COORDINATED CARE TRIALS

	Katherine West	Tiwi	Perth/Bunbury	Wilcannia
Target population	Whole of population	Whole of population	Current and potential users of ACHHSs	Whole of population
Fund holder	Katherine West Health Board	Tiwi Health Board	Office of Aboriginal Health, Health Department of WA	Far West Ward Aboriginal Health Service
Funds manager	Katherine West Health Board	Tiwi Health Board	WA-DYHS and WA-SWAMS Trial Monitoring Group	Trial Steering Committee/ Wilcannia Community Working Party.
Timetable	Development phase 12/11/97 —1/7/98 Live phase 1/7/88 — 31/12/9	Development phase 20/2/97 — 5/12/ 97 Live phase 5/12/ 97 — 31/12/99	Development phase 18/3/97 — 17/9/98 Live phase 17/9/98— 31/12/99	Development phase 3/97 —5/2/98. Live phase 5/2/98 — 31/12/99
Key features of trials	• Establishment of KWHB as funds manager • KWHB role expanded during trial to include management of 4 of the 8 local health centres • Establishment of KWHB plus funds pooling created an effective community based decision maker • Considerable effort and resources needed to establish and develop local decision making and funds management capacity • Funds for existing health services were pooled • Medicare and PBS equivalent funding allowed expansion of health services • External factors constrained expenditure for new services • Considerable and on-going negotiations between KWHB and THS re historical funding and basis for ongoing funds pooling.	• THB consolidated through role as funds manager • THB role expanded during trial to include management of local health centres • Considerable effort and resources required to expand and develop local decision making and funds management capacity • Funds for existing community based health services and funds arising from reduced hospitalisation were poled • Medicare/PBS equivalent funding allowed expansion of health services • External factors constrain expenditure for new services • Considerable and ongoing negotiations between THB an THS regarding historical funding and basis for on-going fund pooling	• Trial provided impetus for the establishment of SWAMS as principal provider of primary health services to Indigenous people in Bunbury • Trial consolidated role of DYHS in Perth • Fund pool primarily comprised Medicare/PBS equivalent funding and State 'hospital funding'. • Funds for existing community based health services kept separate from funds pool • Funds held by HDWA with Monitoring group taking on the role of funds manager • Medicare / PBS equivalent funding and inclusion of State funding for historic services (including 'hospital' funding) allowed expansion of health services at both sites.	• Wilcannia Community Working Party took on major decision making role regarding funds expenditure • Inter-agency committees established to advise Community Working Party on funding issues • Funds pool comprised Medicare/PBS equivalent funding and historical funding from existing providers with the latter being conditionally pooled (mostly buy back) • Funds pooled enabled implementation of community initiatives • Significant proportion of Medicare/PBS equivalent funding unexpected.

12. Through the CCTs experience and knowledge was gained concerning the effectiveness of these mechanisms, as well as difficulties faced when implementing them. Information gathered during consultations and from the local evaluations suggests the following benefits of the trials.

- While the CCTs increased the level of resources and overcame difficulties associated with fragmented funding, the administration of funds pooling was extremely complex and demanding.

- Building community capacity is a complex process that is time and resource intensive, but which requires continued investment. As the local evaluation of the Tiwi Trial[1] noted, there is difficulty in accurately anticipating the complexity and costs of capacity building.

- The trials provided an effective mechanism to channel equivalent MBS/PBS funding to communities.

- Funds pooling gave trial organisations flexibility in using the funds which enabled them to respond to community needs and improved service delivery.

- Funds pooling led to more appropriate services in terms of individual and population needs.

- Staff turnover and recruitment difficulties limited services and consumed resources.

13. Concerns raised by the Tiwi CCT local evaluation about the future of such a funding arrangements included the following:

(i) The original historical basis for calculating provision of funds to the pool is likely to be increasingly insufficient as a starting point for State and Commonwealth funding obligations over time. Funds pool managers may face increasing resource demands. It is not clear how funds pooling would develop as services mature and operational budgets begin to fully consume the available funds of the pool.

(ii) Whether historical levels of funding are appropriate with respect to the health service needs of trial populations. While needs surrounding Board arrangements and infrastructure are assessed and resources allocated accordingly, other needs are not. Perhaps there should be a boarder assessment of need.

14. More comprehensive conclusions about the effectiveness of the funding arrangements for the CCTs should become available with the publication of the National Evaluation of the Aboriginal and Torres Strait Islander Coordinated Care Trials (due for

[1] Robinson, G. and Bailie, R., *Tiwi Coordinated Care Trial Final Local Evaluation Report Volumes 1 and 2*, Northern Territory University Centre for Social Research, Darwin, 2000.

release late 2000). However, as the final submission from the National Centre for Epidemiology and Population Health notes, many aspects of the trials can only be evaluated over the long term. John Deeble writes: 'While it can be argued that there are hopeful signs of improvements in capacity and some limited service delivery, it will need at least five years before any impacts can be realistically assessed'[2].

[2] Submission No: 20, National Centre for Epidemiology and Population Health, Page 5.