



# Evaluation of the Pathways to Community Control program

Australian Government Department of Health

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# 1 Executive Summary

## **The evaluation of the Pathways to Community Control program sought to assess the implementation and design of the program and identify improvements**

Over the 2000s, Aboriginal leadership across sectors and growing capability in regional services run by the community-controlled sector prompted planning for the transfer of more primary health care services from the Northern Territory (NT) Government (NTG) to Aboriginal community governance. This resulted in the establishment in 2005 of the Pathways to Community Control agenda and the publication in 2009 of *Pathways to Community Control: An agenda to further promote Aboriginal community control* by the NT Aboriginal Health Forum (NTAHF). This has provided the framework for subsequent work to progress Aboriginal community control, including transitions supported through the Indigenous Australians Health Program (IAHP). These efforts have sought to build upon lessons from previous initiatives including the Coordinated Care Trials in the late 1990s and early 2000s.

With the track record of transition now established and with ongoing commitment to continue the direction, it is timely to evaluate the Pathways to Community Control program (the P2CC program) to assess its performance and identify areas for improvement. The Australian Government Department of Health (the Department) engaged Nous Group (Nous) to conduct an evaluation of the P2CC program. The purpose of the evaluation was to provide the Department and its partners in NTAHF with a clear understanding of how the program is being implemented, an assessment of whether the program's design is fit for purpose, and recommendations for improvement.

## **The evaluation employed a culturally safe methodology drawing on evidence from consultations, documentation and data**

The evaluation aimed to answer two questions:

- How effective has the implementation of the P2CC program been to date and what can we learn from it?
- How appropriate and fit for purpose is the P2CC program's current design?

The evidence base for the evaluation included consultations, documentation and data.

Several measures were implemented to ensure engagement was culturally appropriate, including an evaluation team comprising Aboriginal and non-Aboriginal people with experience engaging with Aboriginal Community Controlled Health Organisations (ACCHOs) across the NT; community facilitators with specialist expertise conducting Aboriginal community consultations; and tailoring of consultation approaches to individual ACCHOs.

## **The evaluation identified overarching findings about the program and specific findings about each transition stage**

All stakeholders support the vision and objective of the program, but this support is eroded by implementation challenges. These include (but are not limited to) perceptions of opaque processes, unclear roles and responsibilities, protracted financial negotiations and other timeframes, a lack of evaluation and knowledge sharing, and few supporting templates and tools. Stakeholders provided consistent feedback about the need for improvement in all aspects of the program.

Findings by transition stage are summarised in Table 1.

**Table 1 | Summary of findings by transition stage**

Stage	Findings
Pre-transition	NTAHF is a strong, tripartite governance body that is committed to the P2CC program. However, NTAHF members' roles and responsibilities could be more clearly defined, as could the relationship of NTAHF processes to other decision-making processes (such as Local Decision Making). The process to identify, select and prioritise transitions could be clearer.
Development	Stakeholders highlighted the importance of genuine and coordinated consultation to understand communities' needs and preferences, and identify governance arrangements and transition pathways that will address them. Related to this, it was suggested that different pathways to community control could be better defined, as could the role of the NT and Australian Governments in the transition process. Unresolved financial negotiations were seen to be a major barrier to transition.
Consolidation	ACCHO Boards benefit from diverse, complementary skillsets. This is commonly achieved through a mix of community directors and independent directors (often from outside the community). Transition managers within both ACCHOs and the NTG play a key role in progressing transitions. Conversely, challenges arise when these roles are not consistently resourced (e.g. due to delays in filling vacancies). Many stakeholders feel there is a lack of practical documents and tools to support transitions. Efforts to address this should be careful not to restrict ACCHO's control of transition processes or impose excessive reporting requirements or bureaucratic processes.
Implementation	Stakeholders identified a number of key enablers for transitions, including: <ul style="list-style-type: none"> <li>• A capable and well-connected CEO</li> <li>• Strong corporate and clinical governance</li> <li>• Workforce transition, attraction and retention</li> <li>• Effective service relationships between ACCHOs and remaining NTG services</li> <li>• Implementation of corporate services including for IT, human resources (HR) and finance.</li> </ul> Conversely, where these enablers are not in place, they can cause major issues and delays.
Evaluation	There has been limited evaluation of transitions or of the P2CC program more broadly. This represents a missed opportunity to develop an evidence base to inform future transitions. In at least one case, an ACCHO developed documents outlining lessons learned from previous transitions to inform future transitions, but this was an exception. While high quality data is available (e.g. the NT Aboriginal Health Key Performance Indicators) it does not appear to have been used to evaluate the outcomes of individual transitions or the P2CC program as a whole.

**The evaluation made recommendations to refresh and recommit to the program, strengthen the core program framework, and improve the transition process and supports**

1. The partners should refresh and recommit to the P2CC program to improve clarity, consistency and transparency in all aspects and promote accountability at all levels.
2. The partners should consider strengthening the authorising environment for the P2CC program through senior-level (in the case of the Australian and NT Governments preferably ministerial level) statements of commitment and endorsement of program guidelines from all partners.

3. The partners should ensure the governance of the P2CC program is led by a group that is sufficiently senior and active to address problems and delays and adapt to emerging issues and events.
4. The partners should improve the rigour of the selection process for the P2CC program through:
  - Proactive planning of the transition pipeline
  - Easily accessible application guidelines and assessment criteria
  - A transparent business case process with approval by the lead governance body
  - Clear communication of the relationship between NTAHF's decision to support a transition and the subsequent Australian Government decision to provide transition funding
  - Clarification of the relationship between the P2CC program and the Local Decision Making process (potentially through discussion with the Department of Chief Minister and Cabinet (CM&C))
  - Ensuring as much as possible of the Australian Government's required information for making funding decisions is captured in the business case.

Improving the selection process in this way could enable the partners to calibrate the number of transitions pursued at any one time based on the level of funding, effort, and time each requires (rather than specifying a set number).

5. The partners should agree on principles and processes that will guide consultation for the P2CC program to ensure:
  - Consistent understanding on the part of partners, communities and other stakeholders about the form and extent of consultation that will occur as a precursor to each transition milestone
  - A feedback loop through which communities are informed of the outcomes of consultation and given the opportunity to respond
  - Engagement of individuals or organisations with appropriate skills, position and authority to conduct consultation processes.
6. The partners should establish a process for undertaking an upfront comprehensive assessment of the costs of transitioning a primary health care service for the P2CC program that:
  - Reflects the stage of development of the organisation taking on the service
  - Articulates all categories of costs of the transition and ongoing operations (including capital) and provides guidelines for how they will be funded
  - Can be tailored to each ACCHO's circumstances, strengths and needs (e.g. governance training for boards)
  - Reflects that government has greater economies of scale than ACCHOs in the provision of primary health care services
  - Enables appropriate resourcing of transition including through transition managers and other roles within the Australian Government, NTG and ACCHO
  - Balances expectations for reporting and accountability with flexibility for individuals involved in transitions to solve problems and achieve outcomes.

The upfront comprehensive assessment would occur as early as possible, ideally as part of the business case.

7. The Australian Government Department of Health should explore possible alternative entry points into the IAHP funding model for primary health care services transitioning to community control.
8. The partners should update key program documents to ensure they:

- Clearly communicate that community governance develops along a continuum (i.e. that there are various levels of community participation rather than a yes/no dichotomy) and that transitions may be staged over time rather than occurring at a single point in time
  - Emphasise that continued service delivery partnership between NT Health and ACCHOs will be essential, whatever the staging of the transition or the governance arrangements selected
  - Articulate who is responsible and/or involved at each point of the transition and include guidelines for when it will occur (including in regard to evaluation)
  - Are accompanied by visual, plain English versions suitable for community stakeholders.
9. The partners should ensure a comprehensive implementation plan is in place for all transitions. This implementation plan would define governance, activities, timeframes, milestones, roles and responsibilities, risks and mitigation strategies, and arrangements for monitoring and communicating progress. The plan would be a living document that is updated over time, as events and challenges inevitably necessitate adaptations.
  10. The partners should promote sharing of transition templates and tools for project management, monitoring and evaluation, and assessment of corporate and clinical capacity. Mechanisms to achieve these could include a standardised toolkit (in an online location accessible to all relevant parties) and a community of practice. These resources could be adapted to each transition. Their use would be optional.
  11. The partners should facilitate appropriate engagement and sharing of client health information between ACCHOs and other health service providers by:
    - Ensuring an effective handover from NTG to the ACCHO
    - Promoting engagement between ACCHOs and secondary and tertiary providers
    - Giving ACCHO's access to NTG client health information systems until their new IT systems are in place and stable and patient records have been transferred
    - Ensuring program documents and implementation plans set clear expectations about what information will be shared, with whom and when.
  12. The partners should further explore the concept of enabling ACCHOs in the NT to access corporate functions externally. As a first step, they could conduct a study to explore different options for shared services and assess their benefits, costs, risks and overall feasibility.
  13. The partners should work in partnership with ACCHOs to manage systemic workforce challenges that threaten the ongoing sustainability of transitioned services, including by maximising employment opportunities for local staff arising out of transitions.

## 2 Introduction

The P2CC program builds on a range of NT and national policy agendas and a long history of Aboriginal community control of primary health care service delivery. The program initially progressed in tandem with regional health service reform and continued when this agenda was halted in 2014. Since the program commenced, six clinics have transitioned to community control. With the track record of transition now established and with ongoing commitment to continue the direction, it is timely to evaluate the program to assess its performance and identify areas for improvement.

### 2.1 The P2CC program builds on strong national and historical foundations

Since the National Aboriginal Health Strategy (NAHS) was published in 1989, three fundamental tenets of the strategy have been at the core of political advocacy and policy discussion.<sup>1</sup> These are:

- A comprehensive model of primary health care, drawing on the two key World Health Organisation declarations regarding health development, those from Alma Ata in 1978<sup>2</sup> and Ottawa in 1986<sup>3</sup>
- Addressing intersectoral factors, including environmental and housing issues and the social determinants of health<sup>4</sup>
- Aboriginal community control of primary health care service delivery.<sup>5</sup>

The effectiveness of Aboriginal community control of primary health care service delivery in improving health and social outcomes has a strong evidence base.<sup>6</sup> Aboriginal community controlled primary health care services have existed in Australia since the Redfern Aboriginal Medical Service opened in 1971. Such services exist in capital cities, many regional centres and some regional and remote areas, but coverage is not complete and much of northern Australia is served by state or territory run primary health care clinics.

Since the mid-1990s and the transfer of portfolio responsibility for direct Aboriginal health funding from Aboriginal and Torres Strait Islander Commission (ATSIC) to the Australian Government Department of Health, there has been a series of initiatives to further the Aboriginal health policy agenda. In the NT, these have included:

- The establishment of NTAHF, which has proven to be a valuable mechanism for maintaining momentum

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<sup>1</sup> Australia National Aboriginal Health Strategy Working Party, A national Aboriginal health strategy, 1989, <https://catalogue.nla.gov.au/Record/668993>

<sup>2</sup> World Health Organisation, Declaration of Alma-Ata, 1978, <https://www.who.int/teams/social-determinants-of-health/declaration-of-alma-ata>

<sup>3</sup> World Health Organisation, The 1st International Conference on Health Promotion Ottawa, 1986, <https://www.who.int/teams/health-promotion/enhanced-wellbeing/first-global-conference>

<sup>4</sup> R Wilkinson, M Marmot, "The Solid Facts", *Commission on Social Determinants of Health*, 2003, [https://www.euro.who.int/\\_data/assets/pdf\\_file/0005/98438/e81384.pdf](https://www.euro.who.int/_data/assets/pdf_file/0005/98438/e81384.pdf); World Health Organisation, "Closing the gap in a generation: health equity through action on the social determinants of health", *Commission on Social Determinants of Health*, 2008, [http://apps.who.int/iris/bitstream/handle/10665/43943/9789241563703\\_eng.pdf;jsessionid=FBEA9902430B9739EF81F66EF9E2B568?sequence=1](http://apps.who.int/iris/bitstream/handle/10665/43943/9789241563703_eng.pdf;jsessionid=FBEA9902430B9739EF81F66EF9E2B568?sequence=1)

<sup>5</sup> National Aboriginal Community Controlled Health Organisation, Our Story, <https://www.naccho.org.au/our-story>; Australian Indigenous Health Info Net, Community Controlled Health Sector, <https://healthinonet.edu.edu.au/learn/health-system/community-controlled-health-sector/>

<sup>6</sup> D Matheson, N Hardie-Boys et al., Evaluation of the Child Health Check Initiative and the Expanding Health Service Delivery Initiative: Final Report, 2011, <https://core.ac.uk/download/pdf/30680988.pdf>



- Coordinated Care Trials in the late 1990s leading to the establishment of important regional community-controlled services in Katherine West and the Tiwi Islands in the NT
- The NT Chronic Disease Prevention Strategy from the early 2000s<sup>7</sup> and the Audit and Best Practice for Chronic Disease (ABCD) clinical improvement strategy led out of the Menzies School of Health Research in the years after.<sup>8</sup>

Over the 2000s, Aboriginal leadership across sectors (public, not-for-profit and Aboriginal community controlled) and growing capability in regional services run by the community-controlled sector prompted planning for the transfer of more primary health care services from the NTG to Aboriginal community governance. This resulted in the establishment in 2005 of the P2CC agenda and the publication in 2009 of *Pathways to Community Control: An agenda to further promote Aboriginal community control* (the P2CC program document) by NTAHF. This has provided the framework for subsequent work to progress Aboriginal community control, including the transitions supported through the IAHP. These efforts have sought to build on lessons from previous initiatives including the Coordinated Care Trials in the late 1990s and early 2000s.

The history of the P2CC agenda is intertwined with that of regionalisation. The *NT Regionalisation of Aboriginal Primary Health Care Guidelines* state that regionalisation aims to:

- “increase the involvement of Aboriginal communities in health decision making” (through regionalised governance models)
- “improve service delivery and outcomes through better coordination and integration of services” (through information sharing, working together and, in some cases, creation of a single regional service provider).<sup>9</sup>

Regionalisation would potentially result in a single ACCHO delivering all primary health care services in each region, referred to as a Health Service Delivery Area (HSDA), replacing or amalgamating smaller ACCHOs and NTG clinics.<sup>10</sup> As such, the P2CC program was initially progressed as part of the regionalisation agenda (as discussed in Section 2.2).

## 2.2 The P2CC program has progressed through three phases

The P2CC program has progressed through three phases since its establishment in 2009.

1. From 2009 to 2011, the program was progressed as part of regionalisation (as noted above).
2. From 2011 to 2014, the program experienced delays as regionalisation lost momentum and was eventually halted (though Yirrkala Clinic was transitioned to community control in 2012).
3. From 2016 to 2021, the program regathered pace, with transitions of five clinics completed and additional transitions underway or upcoming.

A summary of key events in the history of the P2CC program is presented in Table 2. A more detailed timeline of these events is presented in Appendix A.

<sup>7</sup> T Weeramanthri et al., “The Northern Territory Preventable Chronic Disease Strategy - promoting an integrated and life course approach to chronic disease in Australia”, *Australian Health Review*, 2003, <https://www.publish.csiro.au/ah/AH030031>

<sup>8</sup> R Baillie, M Dowden, Audit and Best Practice for Chronic Disease, 2010, <https://www.lowitja.org.au/page/research/research-categories/health-policy-and-systems/monitoring-and-evaluation/completed-projects/ABCD>

<sup>9</sup> NT Regionalisation of Aboriginal Primary Health Care Guidelines: Supporting a Pathway to Regional Aboriginal Community Control, 2011.

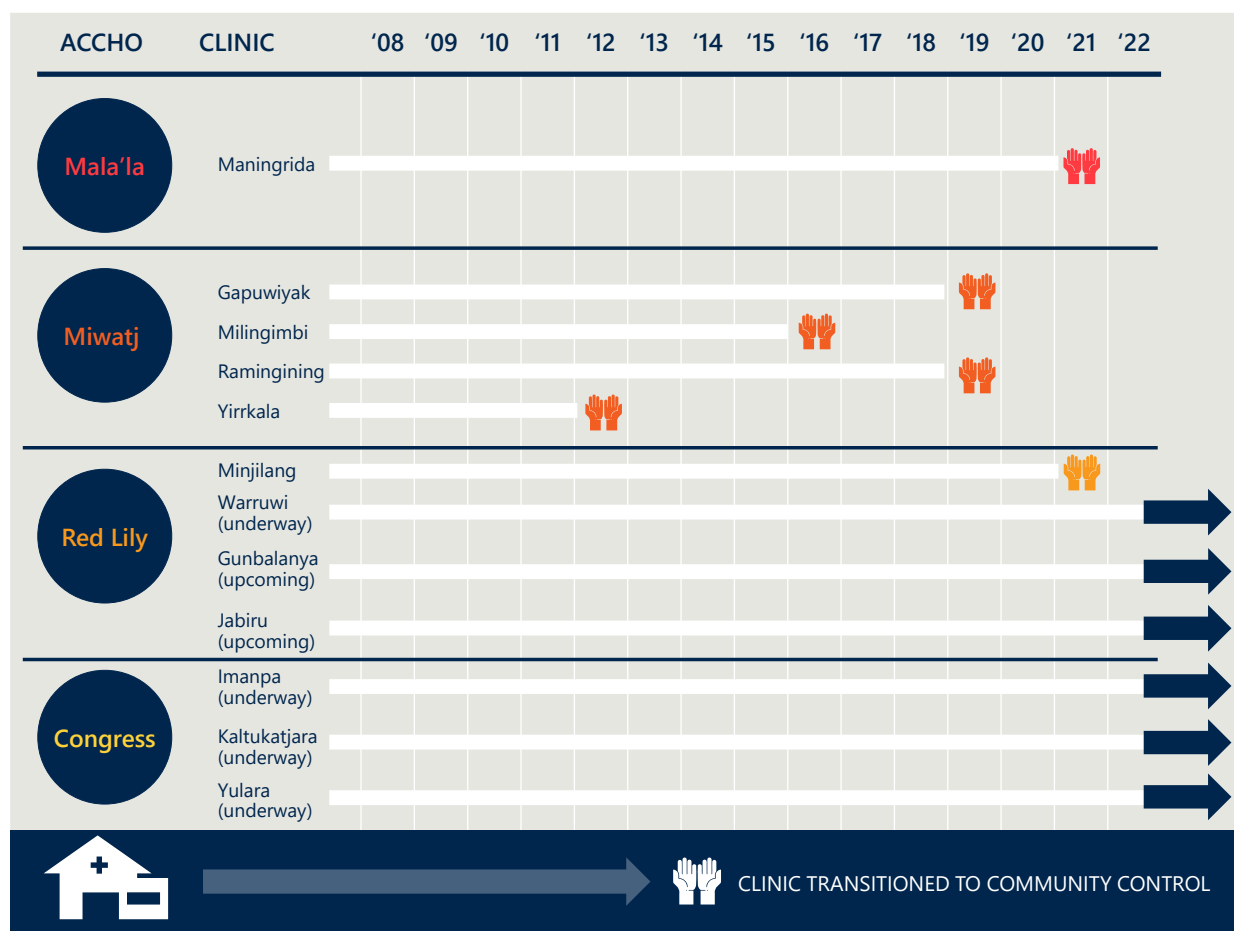
<sup>10</sup> J Dwyer et al., *The Road is Made by Walking: Towards a better primary health care system for Australia’s First Peoples*, 2015, <https://www.lowitja.org.au/content/Document/Lowitja-Publishing/FAR-Summary-Report.pdf>

**Table 2 | Timeline of key events in the history of the P2CC program from 2007 to present<sup>11</sup>**

<p><b>2007-2009:</b> Increased funding for primary health care in the NT</p>	<p>The Northern Territory Emergency Response (NTER) and the Closing the Gap agenda lead to additional funding for primary health care reform and expansion in the NT. This includes the Expanded Health Service Delivery Initiative (EHSDI), which provided funding for regionalisation of primary health care services and their transition to community control, and the Stronger Futures program, which provided additional funding for transition.</p>
<p><b>2008-2009:</b> Establishment of regionalisation governance</p>	<p>NTAHF establishes:</p> <ul style="list-style-type: none"> <li>• The Primary Health Reform Group (PHRG) to lead implementation of its reform agenda</li> <li>• The Reform and Development Unit (RADU) to communicate with the regions and support their engagement with the regionalisation agenda.</li> </ul> <p>PHRG is a subcommittee of NTAHF and oversees RADU, which initially comprises 11 staff.</p>
<p><b>2009-2010:</b> Launch of the P2CC program and regionalisation guidelines</p>	<p>In 2009, NTAHF launches <i>Pathways to Community Control: An agenda to further promote Aboriginal community control in the provision of primary health care services</i>. The following year, it endorses the <i>NT Regionalisation of Aboriginal Primary Health Care Guidelines</i>, a foundational implementation document for the P2CC agenda and the regionalisation process.</p>
<p><b>2009-2011:</b> Regionalisation setbacks and challenges  Final evaluation of EHSDI Capability and capacity framework</p>	<p>Regionalisation experiences a number of setbacks and challenges; for example, a lack of funds pooling or a joint survey of capital assets, misunderstanding and disagreement within communities as to what regionalisation and the P2CC program proposed, and cumulative negative experiences eroding the goodwill of key Aboriginal community members.</p> <p>The evaluation of the EHSDI is positive about NTAHF's achievements and supportive of a continuing partnership structure but identifies a number of issues; for example, the size and complexity of the task relative to the available timeframe and resources.</p> <p>A framework to assess the competence and capability of community governance structures is developed. Response to the framework is mixed, with some associating it with excessive risk intolerance on the part of the Australian and NTGs.</p>
<p><b>2011-2013:</b> Reduced NTAHF activity, changes of government and loss of regionalisation momentum</p>	<p>PHRG ceases to meet in early 2011. No minutes of NTAHF meetings are recorded between mid-2011 and mid-2012. By mid-2012, RADU is reduced to a single officer working in Central Australia and NTAHF enters a period of inactivity. An alternative decision-making body, the Senior Officers Group (SOG), is created but ceases to meet within months of its establishment. There is a loss of corporate memory as key people who had been integral to the regionalisation reform agenda move on.</p> <p>Changes of government at the NT level in 2012 and the Commonwealth level in 2013 lead to financial restrictions, scrutiny of Indigenous affairs, and machinery of government changes to the NT and Australian Government Departments of Health. At around this same time, high-profile challenges experienced by ACCHOs, including three in the NT, negatively affect perceptions of the viability of community control.</p>
<p><b>2012:</b> Transfer of Yirrkala Clinic</p>	<p>Agreement to transfer Yirrkala Clinic from NT Health to Miwatj Health Aboriginal Corporation (Miwatj) is reached in December 2011. Miwatj takes over day-to-day management of the clinic in July 2012. The transfer of operating funds is delayed due to concern about allocation of overhead costs and debate over whether to allocate Australian Government funding directly or via NT Health. The competence and capability framework (referenced above) is applied as a condition of approval to transfer and shows good results.</p>
<p><b>2014:</b> Halting of regionalisation Establishment of IAHP</p>	<p>No funding is allocated to regionalisation in the 2014-15 Australian Government budget. By this point, only three Health Service District Areas (HSDAs) have submitted regionalisation proposals, only one of which has been provisionally endorsed by NTAHF.</p> <p>At this same time, the Australian Government established the IAHP, which aims to increase Aboriginal and Torres Strait Islander people's access to safe and effective essential health services. Funding for the P2CC program originally provided through the NTER and the Stronger Futures program were rolled into the IAHP.</p>
<p><b>2016-present:</b> additional transitions</p>	<p>Five additional transitions are achieved from 2016 to 2021: three to Miwatj Health Aboriginal Corporation (Miwatj), one to Mala'la Health Service Aboriginal Corporation (Mala'la) and one to Red Lily Health Board (Red Lily). Additional transitions are underway or upcoming at Red Lily and Central Australian Aboriginal Congress (Congress).</p>

A timeline of transitions of primary health care services from NT Health to community control through the P2CC program is presented in Table 3. Note that there are many ACCHOs across the NT, many of which were established through processes other than the P2CC program, such as the Coordinated Care Trials (as referenced in Section 2.1). Some of the ACCHOs listed below have had other clinics transition to community control outside of the P2CC program.

**Table 3 | Timeline of transitions of primary health care services to community control**



Further information about the status of transitions at each ACCHO is provided below.

**Mala'la has undertaken a staged approach to transitioning the primary health service in Maningrida**

Mala'la Health Service Aboriginal Corporation (Mala'la) has historically provided a variety of services to the clinic and to the Maningrida community through primary health, aged care and youth services. Services have grown over the last five years resulting in a staged approach to transition. The full transition of the Maningrida clinic to community control was completed in March 2021.

**Miwatj now has six community controlled clinics under management**

Miwatj Health Aboriginal Corporation (Miwatj) is an ACCHO with its administrative base in the town of Nhulunbuy, in North Eastern Arnhem Land. In 2008, Miwatj incorporated two clinics in Galawin'ku:

<sup>11</sup>J Dwyer et al., *The Road Is Made by Walking: Towards a better primary health care system for Australia's First Peoples*, 2015, <https://www.lowitja.org.au/content/Document/Lowitja-Publishing/FAR-Report.pdf>; D Matheson, N Hardie-Boys et al., *Evaluation of the Child Health Check Initiative and the Expanding Health Service Delivery Initiative: Final Report*, 2011, <https://core.ac.uk/download/pdf/30680988.pdf>; Australian Government Department of Health, *Indigenous Australians' Health Programme: Northern Territory Pathways to Community Control Grant Opportunity Guidelines*, 2021.

Nalkanbuy Clinic and Gunyanara Clinic. The transition of Yirrkala and Milingimbi clinics in 2012 and 2016 respectively built the foundation for later transitions in Gapuwiyak and Ramingining, which completed the transition of the sub-region in East Arnhem land.

### **Red Lily is on a journey to transition four health services in West Arnhem**

The Red Lily Health Board Aboriginal Corporation (Red Lily) was incorporated in May 2011. Since then, it has been working to enable the transition of NTG health clinics and services in the four sub-regions of West Arnhem. Minjilang has transitioned and has recently undergone an organisational review to assess its maturity to receive direct funding from the Australian Government. The transition in Waruwi was delayed due to financial negotiations and is now planned for September 2022; the transitions in Jabiru and Gunbalanya have been delayed due to infrastructure negotiations.

### **Congress is in the early stages of transitioning three more clinics to its current portfolio of 14 clinics**

Central Australian Aboriginal Congress (Congress) is the NT's largest ACCHO. It has a longstanding history of delivering primary health services and providing advocacy and support for Aboriginal people over the last 40 years. It is in the early stages of transitioning primary health services in Imanpa, Yulara and Kaltukatjara in Central Australia.

## **2.3 An evaluation of the P2CC program is timely**

Recent policy and strategy settings, including the National Agreement on Closing the Gap, the National Aboriginal and Torres Strait Islander Health Plan 2021-2031, and the NT Health Aboriginal Health Plan 2021-2031, reaffirmed governments' commitment to the three tenets of Aboriginal health strategy. With the track record of transition now established and with the commitment to continue the direction, it is timely to conduct a process evaluation to determine the success and lessons to be learnt regarding preparing for and supporting transition. Further information about the method for the evaluation is presented below.

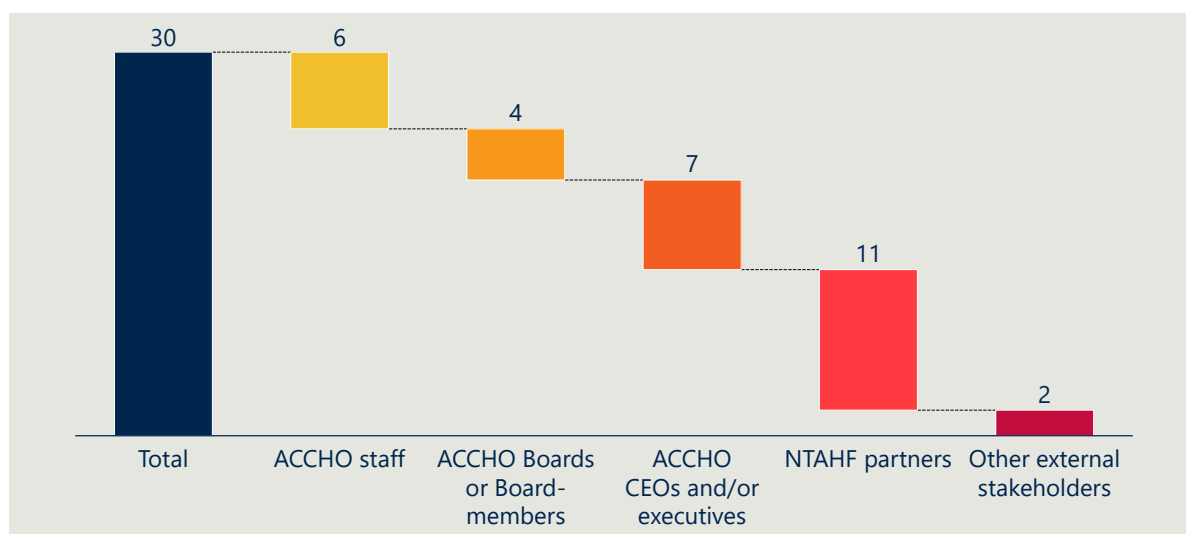
### **The evaluation considered evidence from three sources**

These have included:

- **Documentation** – literature on lessons learned from other jurisdictions (see Appendix B), expert input about good practice (see Appendix C), and program and service documentation
- **Consultation** – 30 interviews and focus groups with a range of stakeholders (see Figure 1)
- **Quantitative data** – financial information.

De-identified quotes have been included throughout the report to demonstrate key themes. These have been taken from transcribed notes and as such may not be verbatim.

Figure 1 | Number of consultations conducted with each stakeholder group



### The evaluation was delivered in a cross-cultural context

The evaluation was delivered, as the P2CC program has been, in a cross-cultural context. This made a culturally effective approach to the evaluation essential. This meant not just working in a way that was safe but effectively drawing out meaning from context and empowering Aboriginal voices. This is important to further the development of the P2CC program so it is the most effective it can be in terms of Aboriginal community preferences, priorities and values.

Several measures were implemented to ensure engagement was culturally appropriate:

- Both the core team and expert advisers comprised Aboriginal and non-Aboriginal people with experience engaging with ACCHOs across the NT
- Two members of the core team were community facilitators with specialist expertise in conducting Aboriginal community consultations
- The consultation approach for each ACCHO was tailored based on an initial briefing with the ACCHO's CEO or Acting CEO.

It had originally been planned that locally based Aboriginal researchers would be employed to co-facilitate consultations conducted with ACCHO Board-members and community-members during visits to communities; however, these visits did not eventuate (as discussed below).

### The evaluation had limitations

The original evaluation plan included site visits to four communities to consult Board-members and community-members and conduct site visits. This was prevented by COVID-19 restrictions and risks. Nous is still in discussion with one ACCHO to visit two communities in which they operate.

The evaluation was a process evaluation and accordingly did not consider the outcomes or impacts of transitions to community control.

## 3 Findings

This section presents evaluation findings, including:

- Overarching findings (see Section 3.1)
- Detailed findings by transition stage (see Section 3.2).

### 3.1 The evaluation identified overarching findings

#### Summary of findings

- All stakeholders support the vision and objective of the program, but implementation challenges erode this support.
- The level of funding, for both the transition process and ongoing operations, is seen to be a major barrier to progress.
- ACCHOs feel unsupported due to what they believe is a lack of evaluation, knowledge sharing and dissemination of supporting tools.
- There has been consistent feedback about the need for greater transparency and consistency in all aspects of the program.
- There is potential to improve the staging of transition processes.

#### **All stakeholders support the vision and objective of the program, but implementation challenges erode this support**

All stakeholders consulted, including ACCHOs, government and external stakeholders, expressed support for the vision and intended outcomes of transitioning health services to community control. Many stakeholders acknowledged the long and rich history of the regionalisation and community control policy reform agenda, and stakeholders were proud of what the program had achieved over the last decade. However, stakeholders' support for the program was eroded by implementation challenges, citing perceptions of opaque processes, protracted financial negotiations and other timeframes, and unclear roles and responsibilities as the main contributing factors.

#### **The level of funding, for both the transition process and ongoing operations, is seen to be a major barrier to progress**

While the transition process is budgeted in the business case stage and funded by the Australian Government, stakeholders believe that this funding does not cover all the costs of transition. Stakeholders identified many gaps in transition funding including infrastructure, staff housing and information technology (IT) costs. New ACCHOs require significant additional support to establish organisational structures, systems and processes and stakeholders believe that this has not been fully recognised. Specific NTG funding is not currently allocated to cover the costs NTG services bear in participating in transitions, which leads to delays as transitions end up competing with other priorities for the NTG staff involved.

The Australian Government Department of Health requires transitions to be cost-neutral in terms of the funding provided through the IAHP for comprehensive primary health care. Stakeholders generally argued that this is unrealistic due to the NTG's economies of scale relative to ACCHOs, particularly with regard to resourcing and corporate services. The ACCHO's IAHP funding may subsequently increase, when it enters the IAHP funding model, but this typically occurs only after ACCHOs commence operation on the existing level of funding.

## ACCHOs feel unsupported due to what they believe is a lack of evaluation, knowledge sharing and dissemination of supporting tools

Many stakeholders argued that a lack of evaluation of transitions, combined with their long timeframe, has hindered knowledge sharing between transitions. The high level of staff turnover in the Australian Government, NTG and ACCHOs, including limited handovers between staff and patchy record keeping of transition documentation by all parties, has also hampered information exchange over time and delayed transition progress.

ACCHOs consistently reported that these factors, in addition to a lack of supporting documents such as project management tools provided to them, has resulted in ACCHOs and their staff feeling like they are starting from scratch with each transition. There is balance to be struck in supporting ACCHOs enough, so they don't have to 'reinvent the wheel' on the basics of transitioning, and ensuring they have the freedom to manage transitions as they choose. New ACCHOs face additional challenges in this area; for example, needing to develop corporate and clinical governance policies, processes and procedures from scratch. Some stakeholders suggested ACCHOs would benefit from greater sharing of policies and procedures or even shared corporate services.

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*"It's hard to toe the line between wanting to have a clear framework but having organisations feeling like they are in control, and they are not being dictated to. Finding that balance is tricky." ACCHO stakeholder*

## There has been consistent feedback about the need for greater transparency and consistency in all aspects of the program

Stakeholders identified a need for greater transparency and consistency in multiple areas of the P2CC program. These included:

- decision-making criteria and processes
- business case requirements and timeframes
- funding and resource requirements and sources
- roles and responsibilities of different parties in the transition process (particularly after approval), and
- arrangements to review and recalibrate the transition over time in response to invariable challenges.

There is an apparent disconnect between the personal and emotional investment of communities and that of other stakeholders in the transition process. Combined with the lack of transparency and consistency described above, and the limited opportunities to participate in the program, this can exacerbate confusion and frustration on the part of communities. ACCHOs and peak bodies described the passion and devotion of communities to the transition process, and the stress and let down when transitions are delayed, and the purpose of the program is lost in bureaucratic processes.

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*"Lots of board members are elderly and want to see this transition in their lifetime...it's the passion and heart of the community – we need to protect this – Non-government stakeholder*

The program could also be better communicated. For example, some stakeholders, including ACCHOs, were unaware of the program in Nous' consultations or unclear on its relationship to related processes such as regionalisation. Stakeholders were unsure what the future pipeline of transitions were for the program or whether there was a plan in place to transition over the remaining health services to community control in the NT.

## There is potential to improve the staging of transition processes

Many stakeholders called for greater emphasis on, and a more structured approach to, the development stage of the transition process. This first stage is essential to understand communities' needs and

preferences and identify which pathways will best address them. At present, this stage is seen to be undermined by several factors. For example, stakeholders reported a lack of trust and consistency in community consultation processes, which was often caused by multiple stakeholders undertaking their own consultation processes, sometimes producing conflicting findings and leading to delays.

Stakeholders also reported an 'all or nothing' conception of the choices to be made, for example, assuming a community wants the entire clinic to transition, when nuanced consultation could identify additional options or more staged transitions. Some stakeholders advocated for conducting transitions and building ACCHO and community capability more gradually over time, rather than transitioning entire services in a single step. However, other stakeholders argued this would lengthen already protracted transition processes. The transitions that have occurred to date have varied in their pace. The right approach is likely to vary depending on community preferences and ACCHO's capabilities.

Many stakeholders believed the ongoing partnership between the NTG and ACCHOs during and after transition could be more clearly communicated. As identified in the founding document for the P2CC program, there is a continuum of community governance and participation that changes over time. However, stakeholders reported that community members may view transition in "all or nothing" terms; for example, expressing concern that the transition means the NTG will leave and the ACCHO will be wholly responsible for all health services in the area.

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*"Government at all levels struggles to work hand in hand [with ACCHOs] so it's either we manage it or you manage it, when often they [ACCHOs] want a hybrid approach – Non-government stakeholder"*

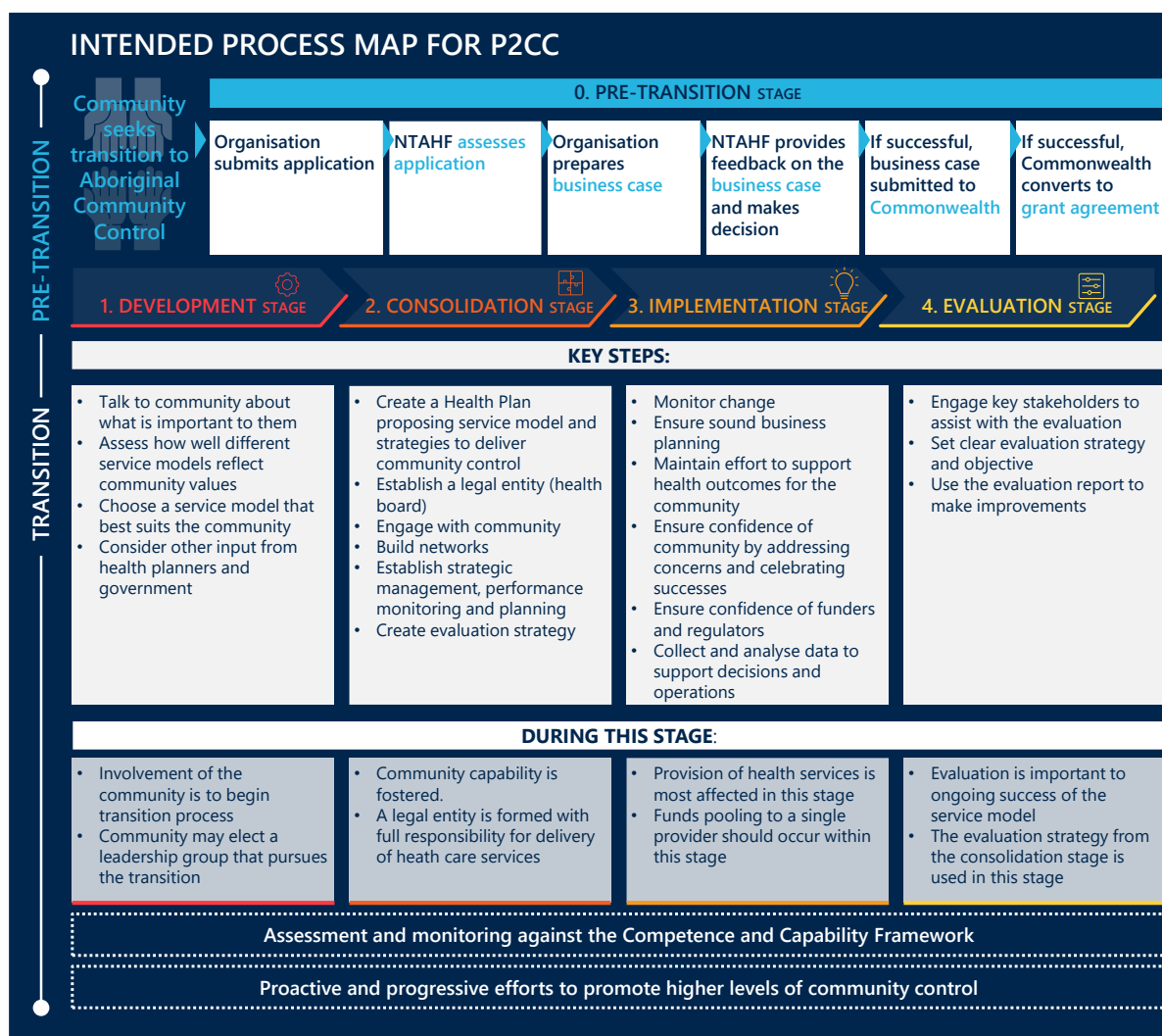
There was also debate as to whether new ACCHOs should be supported to be established under this program at all, given the significant resources and costs involved in doing so. Some stakeholders firmly believed that new clinics should only transition to existing larger ACCHOs so they can draw on resources and help to achieve economies and scale. However, other stakeholders were concerned that this would result in no new ACCHOs being supported to be established at all in future and that this was a disadvantage to communities.

## 3.2 The evaluation also identified findings specific to each transition stage

There are four stages of the transition process outlined in the P2CC program framework as shown in Figure 2 below: development, consolidation, implementation and evaluation (see Appendix D for more detail). For the purpose of this report, a 'pre-transition' stage has been identified which includes the steps in the transition process to identify and select communities to be part of the P2CC program and award funding to transition.



Figure 2 | Intended process map for P2CC program



### 3.2.1 Pre-transition<sup>12</sup>

#### Summary of findings

- NTAHF is generally seen to be a strong, tripartite governance body that is committed to the program.
- NTAHF members' roles and responsibilities could be more clearly defined.
- NTAHF processes overlap with other decision-making processes.
- The NTAHF process to identify, select and prioritise transitions is perceived to be unclear.
- The business case is an important document, but is only the start of negotiations.

<sup>12</sup> The pre-transition stage includes all activities undertaken before the development stage (Figure 2).

## **NTAHF is generally seen to be a strong tripartite governance body that is committed to the program**

Government stakeholders commented on the clear commitment of NTAHF and its diverse membership as a critical enabler of the program. Australian Government stakeholders highlighted the fact that the forum is highly engaged and invested in achieving outcomes. Government stakeholders reported that NTAHF is one of the strongest tripartite forums that the Australian Government works with. Government stakeholders also believed that NTAHF members are well placed to advise on transitions to community control and funding allocations. The Aboriginal Medical Services Alliance NT (AMSANT) is represented on NTAHF. While the AMSANT representatives on NTAHF happen to currently both be from Congress, they wear their 'AMSANT hats' while performing their NTAHF-related responsibilities. However, some stakeholders suggested that wider ACCHO representation at NTAHF could be beneficial.

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*"I think NTAHF is really well placed to advise the Commonwealth on transitions to community control and where the funding should go."*  
Government stakeholder

## **NTAHF members' roles and responsibilities could be more clearly defined**

Australian Government and NTG stakeholders called for greater clarity around the roles and responsibilities of some of NTAHF's key members, particularly the National Indigenous Australians Agency (NIAA), NT Primary Health Network (PHN) and AMSANT.

Stakeholders commented on the fact that NIAA as a key member could play a more significant role in the program, for example, in identifying grant opportunities to assist with funding gaps or coordinate health and community infrastructure. Stakeholders also called for greater clarity of NT PHN's role, which in some cases has assisted transitions by stepping in as a key transition partner and which has the capacity to advocate for the ACCHO and provide funding.

Finally, several stakeholders reported that AMSANT's diverse role needs defining. It has played many different roles throughout the program, including being an advocate for transitions, an auspice body for transitions (including receiving funding on behalf of an ACCHO) and providing varied member support to ACCHOs. Stakeholders raised the challenge of resourcing this diverse range of activities.

## **NTAHF processes overlap with other decision-making processes**

Government, ACCHO and other stakeholders argued that there is a lack of clarity between NTAHF process and other decision-making processes, for example, the subsequent Australian Government Department of Health decision to provide transition funding and the Local Decision Making process, which is run by CM&C and which also discusses transitioning clinics and other health care services. This is a separate process from that of the P2CC program, which has its own criteria. This lack of coordination between processes caused confusion amongst some communities in terms of what is possible regarding local transitions.

## **The NTAHF process to identify, select and prioritise transitions is perceived to be unclear**

Both ACCHO and government stakeholders suggested that there could be a more robust, proactive and transparent process to identify which communities will transition to community control. It is currently not clear who initiates conversations about new transitions. It is also currently not clear how different regions are prioritised. ACCHO and government stakeholders commented on the fact that there is no process to

identify which clinics are in the pipeline and would possibly like to commence transition next and no process to let regions know when an opportunity becomes available to transition.

Government stakeholders highlighted that a positive progression of the program was the creation of a set of criteria to assess the readiness of a region for transition. However, stakeholders noted these criteria were only developed after the Red Lily transition was underway, and they believed previous transitions including the Red Lily transition had not undergone adequate assessment of the readiness of the region to transition. Government stakeholders also noted that since the criteria have been developed, they have not been applied consistently, causing confusion around the selection process. For example, some regions have been subsequently approved for transition without meeting the requirement that the region must have a minimum Aboriginal population of 2,500 people.

Government, ACCHO and other key stakeholders also questioned the guideline that the P2CC program can only focus on transitioning three regions at a time (which might include multiple clinics). Stakeholders noted that this guideline was developed due to the amount of Australian Government funding available at one time for transitions and the Government (both Australian Government and NT) resources available to work on processing transitions at one time. Many stakeholders including ACCHOs, government and non-government stakeholders commented on the slow speed at which transitions were occurring and questioned whether this guideline could be revised if there was a greater commitment to the program in the future.

Research reviewed as part of the literature review commented on the importance of having realistic expectations for how long the transition process can take, with some transitions in Australia taking up to 30 years to fully transition.<sup>13</sup> Efforts in Australia to transfer to community control are generally assumed to be conducted over shorter timeframes (the P2CC framework outlines an indicative 5-year timeframe). However, as this evaluation shows there is a significant variation in the effort and funding needed for different transitions with some quickly transitioning, with others taking a lot longer. Lavoie et al. (2016) commented on the fact that efforts in Australia to transfer to community control under an assumed short time frame are often not realistic and risk creating feelings of failure.<sup>14</sup>

### **The business case is an important document, but is only the start of negotiations**

ACCHOs and government stakeholders agreed that the development of the business case was an essential pre-transition process and that the template was robust. The template requires key areas to be demonstrated, including the proposed model of care for the new clinic(s), evidence of the support for change, demonstrated governance capability, transition risks, expected benefits, and an estimation of costs and milestones associated with the transition process.

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*"How can we do it [identify communities to transition] so it's more rigorous and timely and less bureaucratic - and more transparent in terms of what primary healthcare dollars are being invested by the NTG" – ACCHO stakeholder*

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<sup>13</sup> For example, it took 28 years to successfully transition the Gurriny Yealamucka Health Service (Gurriny) to community control in Yarrabah in Queensland: Jongen, C., Campbell, S., McCalman, J. et al., (2020), Transitioning to Aboriginal community control of primary health care: the process and strategies of one community-controlled health organisation in Queensland. *BMC Fam Pract* 21, 230, . <https://doi.org/10.1186/s12875-020-01300-z>, <<https://bmcprimcare.biomedcentral.com/track/pdf/10.1186/s12875-020-01300-z.pdf>>

<sup>14</sup> Lavoie, 2016, Implementing Indigenous community control in health care: lessons from Canada, 2016, *Australian Health Review*, <https://www.publish.csiro.au/ZO/pdf/AH14101>

The budget detailed in the business case, however, is only an estimated budget for the use of the requested Australian Government funding, based on a series of assumptions. In some cases, preliminary quotes were provided in the business case, with a note that more accurate costs would be provided during the project (e.g., around IT costs). The business case also does not include confirmation of funding availability to obtain or upgrade clinic infrastructure, or estimates of the costs required for staff or contract workers (e.g. allowances). Some business cases highlighted that these costs would be negotiated after the business case stage, with the assumption that either the ACCHO or NTG would fund these activities, despite adequate funding for these activities being essential for a transition to be feasible.

*"I would say going through NTAHF is more of a tick-a-box exercise." – ACCHO stakeholder*

ACCHO and government stakeholders questioned whether NTAHF, in signing off the business case, is undertaking a comprehensive assessment of transitions. Often business case documents are lengthy, and some stakeholders questioned the amount of additional due diligence that NTAHF does, for example to scrutinise budget figures. There is also often significant negotiation (including around funding from NTG) that occurs after the business case phase, in some cases years after the business case is approved in principle. As the final approval for the provision of transition funding sits with the Australian Government Department of Health, some stakeholders argued NTAHF's sign-off could be seen as a provisional sign-off.

*"Yes, NTAHF approves the business case as is – yet we have to work with them [ACCHOs] for months to make it acceptable." – Government stakeholder*

### 3.2.2 Development

#### Summary of findings

- Stakeholders argued that defining different pathways to community control could improve the program.
- Genuine and coordinated community consultation is essential to identifying needs.
- Unresolved financial negotiations are seen to be a major barrier to transition.
- Some stakeholders felt that the roles of the Australian and NT governments in the transition process need to be better defined.

#### Stakeholders argued that defining different pathways to community control could improve the program

A key part of the development stage of the P2CC program process is to evaluate community control service models and assess which service model might be the best model that reflects different community needs. The P2CC program framework document outlines nine different service model examples that sit along a continuum of community participation and control (from being funded and managed solely by the government or alternatively by an Aboriginal Health Service) and identifies a 'partnership matrix' of how the responsibilities between the government and the community might differ under each example. The framework recognises that the "continuum is not sequential"<sup>15</sup> and that the level of community control can change in either direction as preferences change over time. The examples provided are "not meant to limit the range of service models that might be considered, but rather to demonstrate how the mix of capability

<sup>15</sup> Aboriginal Medical Services Alliance Northern Territory, Pathways to Community Control: An agenda to further promote Aboriginal community control in the provision of Primary Health Care Services, 2009, [http://www.amsant.org.au/wp-content/uploads/2019/12/2009\\_Final\\_Pathways-to-Community-Control.pdf](http://www.amsant.org.au/wp-content/uploads/2019/12/2009_Final_Pathways-to-Community-Control.pdf), page 15.

requirements and responsibilities change as a community progresses towards community control".<sup>16</sup> The framework therefore identifies a wide range of different approaches and possibilities to achieving whatever level of community control is desired by each community.

When referencing the P2CC program framework, however, government stakeholders (Australian Government), highlighted the disconnect between identifying the different approaches outlined in the framework, and the operationalisation of different approaches. Stakeholders noted that there is little guidance or structure as to how to execute these pathways. The framework identifies a four-stage process to guide the implementation of particular service models (development, consolidation, implementation, evaluation). However, these four stages provide a broad guide to the overall transition process, rather than a tailored approach based on the different pathway chosen. There is also no acknowledgement in the framework of the significant differences in timeframes and resources needed to execute different pathways.

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*"We just assume we know what they want – that they want to run their own health center, but maybe they want to just work more closely with the people running the health service."*  
Government stakeholder

Another important feature of the P2CC program framework is the requirement for health service providers to be both 'competent and capable' of delivering health services. 'Capability' looks at the extent to which the health service provider can demonstrate that they have an ongoing relationship to the community and that they are serving community needs. 'Competency' looks at the extent to which health service providers can demonstrate their ability to use resources efficiently and diligently to achieve health outcomes. The framework outlines the different capabilities required for each of the nine service model examples provided. However, both ACCHO and government stakeholders reported that they believe there was not enough consideration on assessing the maturity of organisations to transition and their capability and capacity, up to and including Red Lily, and before the transition criteria were established.

One ACCHO, Mala'la, did however opt for a slower staged approach to transition and transferred some programs first, before transferring all clinical services. This helped to demonstrate capability and build the confidence of funders. Mala'la's Maningrida clinic had slowly been transitioning services over to community control years before the full transition. The Board and community decided to initially run programs including men's and mental health programs through what was previously an acute-only NTG clinic. These programs demonstrated Mala'la's clinical and corporate governance ability to funders and also helped to build the confidence of the community who was used to government-run services.

### **Genuine and coordinated community consultation is essential to identifying needs**

ACCHOs and government stakeholders raised the importance of early consultation with the community to ensure community needs are understood. Educating the community about what is involved in the transition of services to community control was also seen as an important part of community engagement, particularly in areas where English is a second language. Some stakeholders reported that there is currently no standard approach to community consultation across transitions. Some ACCHO and government stakeholders commented on the challenges of identifying who speaks for the community within different community contexts. Often there are cultural connections and hierarchies that are difficult to understand for people who are not from that community. Government stakeholders noted the challenges of being confident that they understand what the community really wants.

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*"Who starts the community consultation? How do we know a non-bias and collective process has happened? We are so removed from the local voice."* Government stakeholder

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<sup>16</sup> Aboriginal Medical Services Alliance Northern Territory, Pathways to Community Control: An agenda to further promote Aboriginal community control in the provision of Primary Health Care Services, 2009, [http://www.amsant.org.au/wp-content/uploads/2019/12/2009\\_Final\\_Pathways-to-Community-Control.pdf](http://www.amsant.org.au/wp-content/uploads/2019/12/2009_Final_Pathways-to-Community-Control.pdf), page 10.

Some stakeholders were not always confident with the consultation process and believed that it could be subject to bias, depending on who gathered the feedback. One ACCHO highlighted that an instrumental part of one transition was contracting an independent local organisation to undertake the consultation. Other stakeholders agreed that having someone independent do the consultation who understands the community context and can undertake the consultation in a culturally safe way is important. Stakeholders commented on the fact that it is not always the case that communities want all their health services to be transitioned to community control at once. Understanding exactly what is needed by the community, their preparedness, and how that is best executed is an essential part of the process which many government stakeholders believed is not given enough consideration.

### **Unresolved financial negotiations are seen to be a major barrier to transition**

NTG stakeholders raised the challenge of sourcing additional funding needed to support successful transition (e.g. for infrastructure, building repairs or time spent managing transitions) and reported this can lead to delays. These costs are not included in the Australian Government Department of Health's transition funding. The Australian Government Department of Health has expressed it has been its long-standing position that infrastructure being transferred must be fit for purpose (and infrastructure being leased must include an appropriate maintenance schedule). It will generally not support any requests for capital works funding for at least two years from the date of transition except in urgent or unforeseen circumstances (e.g. natural disasters).

It was noted that the NTG remains the owner of all health centres and associated infrastructure including staff housing, with these being leased to the ACCHO. As such, the NTG retains responsibility for repairs, maintenance and capital works. This means funding for these costs does not need to be included in transition budgets. However, the requirement for infrastructure to be fit-for-purpose means these issues can still cause delays, as is currently occurring in Jabiru and Gunbalanya (e.g. where necessary repairs cannot be made in a timely fashion).

ACCHO stakeholders raised the frustration of costs not being adequately estimated for transition funding (e.g. repairs, cleaning), as well as for ongoing capital costs (e.g. buildings, staff accommodation) and operational costs (e.g. IT, insurance, freight for vehicles, leases). Government stakeholders also commented on the fact that it naturally costs more to establish an entirely new health service such as Red Lily and that these additional seed funding costs were not adequately estimated. ACCHOs reported being consistently surprised that these costs had not been resolved or adequately budgeted for before transition funding had been approved.

Funding to cover the gaps was subsequently sought from the NTG causing major delays. For example, the Red Lily Gunbalanya transition has been delayed until further notice due to ongoing negotiations to rebuild the clinic to ensure it is fit for purpose before Red Lily manages the clinic. Issues around costs and ownership of capital assets have been reported as a longstanding barrier to transitioning health services to community control and the broader regionalisation process.<sup>17</sup>

One ACCHO called for a more standardised approach to the budgeting of health service delivery costs, including a standardised template for costs and a systematic approach for funding negotiation with the NTG (e.g. infrastructure, recurring costs, staff housing). Stakeholders commented on the fact that while

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*"They [NTG] really don't understand what it costs to run a health service." ACCHO stakeholder*

*"Part of the transition is actually negotiating what the money is that's going to actually transition over – but that should all be sorted before." ACCHO stakeholder*

*"The cost for Red Lily providing the same services as NT Health, it's significantly more because of the economies of scale [NT Health has]." - ACCHO stakeholder*

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<sup>17</sup> J Dwyer et al., *The Road is Made by Walking: Towards a better primary health care system for Australia's First Peoples*, 2015, <https://www.lowitja.org.au/content/Document/Lowitja-Publishing/FAR-Summary-Report.pdf>, page 25.

these documents were developed progressively for transitions, they were never officially implemented across the program.

### **Some stakeholders felt that the role of government in the transition process needs to be better defined**

Some ACCHO and government stakeholders called for greater clarity of both the Australian Government and NTG's role, particularly after transition funding is provided. The Australian Government Department of Health's role in assessing and delivering IAHP grants is generally clear. However, the roles and responsibilities of the Australian Government and NTG after the transition funding is awarded is not articulated in any P2CC program documents.

The Australian Government has been more involved in the operational side of some transitions than others. The Darwin-based Australian Government Department of Health team has been an important local resource to support transitions and assist with ongoing negotiations. Australian Government Department of Health representatives are often members of transition Steering Committees, a role they consider essential.

Some NTG stakeholders suggested the Australian Government could be more involved in negotiating ongoing funding outcomes beyond the transition stage. The Australian Government Department of Health has expressed that it is unable to negotiate on the funding provided through the IAHP for comprehensive primary health care (as it must be cost-neutral in the first instance and is based on a formula when the ACCHO enters the IAHP funding model, as stated in Section 3.1). Increased involvement from the Australian Government could nonetheless be valuable, given it is a critical stakeholder for transitions and that successful transitions contribute to overall IAHP program outcomes.

The role of the NTG in providing additional funding, support and resources during the transition is also unclear. Several ACCHOs reported being confused by which NTG department is responsible for funding different parts of the transition – this was specifically in relation to funding that, while not technically part of the transition, is an enabler for it (such as for staff housing). There was also lack of clarity around the ongoing relationship to oversee the operations of the transition and manage transition timelines.

## **3.2.3 Consolidation**

### **Summary of findings**

- ACCHO Boards benefit from diverse, complementary skillsets.
- Transition managers play a key role in progressing transitions.
- Access to Medicare Benefits Schedule (MBS) income is seen as essential to support the transition.
- Many stakeholders feel that there is lack of practical documents and tools to support transitions.
- Flexibility to manage the transitions is valued.

### **ACCHO Boards benefit from diverse, complementary skillsets**

Two ACCHOs raised the importance of having Board members who have the combined skillset to understand the community and also run a business. Several stakeholders highlighted that developing governance capability is an essential part of the transition process, particularly when Board members for some ACCHOs are from a variety of different locations and backgrounds, speak different languages and have different levels of experience. One ACCHO believed governance training for all directors (particularly financial and risk management training) should be mandatory for all transitions and fully funded. A mix of community directors and independent directors (often from outside the community) was common on ACCHO Boards (e.g. Congress, Miwatj) to ensure that the Board had complementary skillsets.

This is consistent with other literature and evaluations<sup>18</sup> about transitions to community control which reported that upskilling board directors in areas such as risk management, business planning, financial expertise and leadership skills is important to ensure that the Board has the right skills to drive the performance of a health service. This was also a key finding of the National Evaluation of the Second Round of Coordinated Care Trials which stressed that education on governance and management approaches was a key enabler for the trials.<sup>19</sup>

### **Transition managers play a key role in progressing transitions**

Most ACCHOs commented on the importance of transition managers in both driving transitions and reporting on transition outcomes to and seeking decisions from steering committees and working groups. Having transition managers both within the ACCHO and the NTG was important. Some ACCHOs emphasised how essential it was to have a transition manager within the NTG to help progress transitions and relay with the transition manager within the ACCHO. Stakeholders highlighted that these NTG transition managers played a critical role in helping to communicate and negotiate with different NTG departments, identifying key stakeholders within government and troubleshooting problems. However, stakeholders raise the challenge of transition managers not consistently being resourced by the NTG and vacancies not being filled quickly which placed significant pressures on transitions.

### **Access to MBS income is seen as essential to support the transition**

ACCHO stakeholders raised the importance of having doctors employed at the clinics as early as possible. This ensures MBS income from seeing patients is available to the clinic (in addition to grant income) and smooths the transition process. Some ACCHOs highlighted the challenge of the MBS funding not initially transferring over to the new ACCHO as a key barrier to transition progress. Some ACCHOs also highlighted the challenge of employing doctors in new ACCHOs, as employing doctors requires adequate staff accommodation, HR support, and sound corporate and clinical governance which takes time and funding to establish.

### **Many stakeholders feel that there is lack of practical documents and tools to support transitions**

ACCHOs (both new and existing) consistently reported a feeling of starting from scratch and needing more guidance when transitioning. While some learnings from previous transitions were documented, these learnings were not always shared proactively with ACCHOs. ACCHO stakeholders were surprised there were not more planning documents (e.g. policy templates, clinical governance templates, timelines, workplans) provided at the outset to help with the transition. Creating these documents without many reference materials was particularly challenging for new health services and used already stretched resources (i.e. Red Lily). One ACCHO mentioned that they were eventually provided with a more comprehensive transition plan template by the NTG, which was very useful in tracking milestones. ACCHOs who transitioned more recently were provided with more helpful documents than those earlier in the process.

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*"No one could really tell me what the process was." ACCHO stakeholder*

*"We were scrambling around making copies of policies and governance frameworks...All of those things could have been ready." ACCHO stakeholder*

The P2CC program framework document, despite being the primary document that defines community control and outlining the potential ways to transition to community control, was not referenced widely

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<sup>18</sup> Jongen, C., Campbell, S., McCalman, J. et al., (2020), Transitioning to Aboriginal community control of primary health care: the process and strategies of one community-controlled health organisation in Queensland. BMC Fam Pract 21, 230, . <https://doi.org/10.1186/s12875-020-01300-z>, <<https://bmcprimcare.biomedcentral.com/track/pdf/10.1186/s12875-020-01300-z.pdf>>

<sup>19</sup> Commonwealth of Australia, (2007), The National Evaluation of the Second Round of Australian Coordinated Care Trials 2007, <<https://apo.org.au/sites/default/files/resource-files/2008-04/apo-nid8664.pdf>>



throughout the ACCHO's transition processes. Many ACCHOs and government stakeholders believed that the P2CC program framework was outdated and needed refreshing. The other documents that were provided (e.g. the competence and capability framework and supporting assessment tool) were not widely used by ACCHOs. Some stakeholders reported that the competence and capability framework was too detailed and more useful for establishing a new ACCHO but not as helpful for an existing ACCHO transitioning services or programs. Dwyer et al., (2015) also reported that the competence and capability framework was not helpful for existing ACCHOs and was perceived by some as an "extension of a generally excessive risk intolerance displayed by both levels of government".<sup>20</sup>

Government stakeholders commented on the fact that while there are common transition considerations for both new and existing ACCHOs, that there is a lot more involved in establishing a new service. They suggested that tailored supporting documents might be needed depending on the maturity of organisations and their transition aspirations.

### **Flexibility to manage the transitions is valued**

A common theme amongst stakeholder consultations was the desire for ACCHOs to be in control of the transition process whilst, at the same time, being adequately supported to transition. One ACCHO raised the challenging balance of the government providing enough guidance and support (e.g. frameworks, tools) while not having to comply with too onerous reporting requirements or bureaucratic processes. It was widely recognised that more support was needed for the establishment of new ACCHOs compared to existing ACCHOs. However, existing ACCHOs nevertheless reported that having basic transition documents provided is helpful to free up precious resources to manage the broader transition process.

## **3.2.4 Implementation**

### **Summary of findings**

- Strong leadership and governance were consistently raised as key enablers of transition implementation.
- Transitioning, attracting and retaining staff requires careful planning.
- Establishing service relationships with ACCHOs and remaining NTG services is essential.
- Implementing corporate services including IT systems is a common challenge across ACCHOs.

### **Strong leadership and governance were consistently raised as key enablers of transition implementation**

Several ACCHOs highlighted the importance of a well-connected and capable CEO in both guiding the transition of services and managing the ongoing service delivery of ACCHOs. Government stakeholders raised the importance of having both strong corporate and clinical governance. Several stakeholders referenced the Gapuwiyak and Ramingining transitions as relatively smooth and timely transitions. They cited strong leadership of the regional director, sound governance structures and the effort to build constructive relationships with ACCHO leadership and the community as key enablers.

*"Success comes from strong leadership." - ACCHO stakeholder*

<sup>20</sup> J Dwyer et al., The Road is Made by Walking: Towards a better primary health care system for Australia's First Peoples, 2015, <https://www.lowitja.org.au/content/Document/Lowitja-Publishing/FAR-Summary-Report.pdf>, page 22.

## Transitioning, attracting and retaining staff requires careful planning

A critical part of transitioning an existing government run clinic to Aboriginal community control is the transition, attraction and retention of staff (including transitioning over to a private enterprise bargaining agreement). While the P2CC program framework identifies that employing capable staff is an important part of the transition workforce, there is no guidance around transitioning, attracting and retaining staff. This was seen as a critical process which several ACCHOs reported could have been better handled. Common issues raised included the lack of communication to staff and change management processes around transition, limited workforce planning and skills mapping prior to transition and insufficient planning around staff entitlements during transition resulting in legal advice being sought.

*“Why are local staff mostly casual? We put local Aboriginal people on permanent contracts so they get access to carers leave, family leave, travel and so on”.- ACCHO stakeholder*

ACCHOs raised the importance of supporting government staff to transition over to new clinics to ease the transition process. Sometimes it was difficult to persuade government staff to transition to the new ACCHO, causing gaps in staffing through transitions. For example, on the day of one clinic’s transition there was a critical shortage of nurses when the government nurses left the clinic. However, this shortage was able to be overcome by drawing on the existing pool of resources that the established ACCHO had in nearby communities. One ACCHO offered secondments to government staff to continue to work at the ACCHO for 12 months after the transition while retaining government employment and benefits. This was a successful strategy to take pressure off workforce issues.

Several ACCHOs reported that staff attraction and retention was a key issue throughout transitions. This was particularly important for new ACCHOs hiring staff for the first time. Having adequate staff housing, permanent contracts, competitive salaries to government salaries, personal leave and travel compensation were noted as essential to attract and retain both corporate and clinical staff, particularly in very remote areas. Government stakeholders note that this challenge was not unique for ACCHOs, with many government-run health services across the NT experiencing workforce issues, particularly in remote areas which has been exasperated by COVID-19. However, it was noted that government-run health services have a much larger pool of resources to draw from to address shortages.

Some ACCHO stakeholders commented on the benefit of employing local staff as soon as possible which encourages other local staff to join. Stakeholders commented on the shortages of nurses and Aboriginal Health Practitioners in many remote areas, however having existing community contacts and relationships was helpful to employing local staff and building the clinic’s workforce. Tailoring employment to support local Aboriginal employees, including desirable working hours and leave for cultural events was also important.

## Establishing service relationships with ACCHOs and remaining NTG services is essential

Several stakeholders noted the importance of establishing strong relationships between the ACCHO and remaining (non-primary health care) NTG services that support the communities, and ensuring services are maintained at the level needed by the community. The transition is high-risk in terms of the continuity of services to the community and so a smooth handover to the ACCHO is important. The transition is also high-risk in terms of the maintenance of engagement with secondary and tertiary providers. Having strong and enduring relationships with NTG services is not only desired but is critical. The NTG can draw on a NT-wide workforce and capability to fill workforce gaps which is not available in the same way for ACCHOs without the relationships with NTG services. Being clear about what is needed and what issues or concerns will be responded to was seen as critical.

Several ACCHOs commented on the fact that transitioning health services did not always feel like a collaborative, partnership process working with the government. Several stakeholders reported that sometimes it felt like some parts of the NT government were in competition with the ACCHO for the delivery of health services, and that transitions sometimes felt like a "hostile takeover". These stakeholders didn't understand why there was an "us vs them" mentality towards some transitions, particularly when government still needed to work closely with ACCHOs, for example, to deliver outreach services from ACCHO clinics and to link ACCHOs with specialists and acute care.

*"Aboriginal Health Services (AHS) in general in the Territory sometimes have a bad name, but now I have gone through a transition, it explains it. It's like NTG is in competition with AHSs" – ACCHO stakeholder*

### **Implementing corporate services including IT systems is a common challenge across ACCHOs**

Several ACCHOs raised the challenge of setting up their own corporate services including transitioning or installing IT and HR systems needed to run a clinic. These challenges were exacerbated when establishing a new ACCHO which had no previous experience in establishing or running IT systems. ACCHOs reported that IT transitions were not adequately planned for or budgeted. Two ACCHOs reported delays in receiving funding to transition over to new IT systems (e.g. Communicare). There were also lengthy negotiations around which IT system was the best to use which delayed some transitions. Not all costs associated with IT were identified in the transition funding and often had to be addressed in the transition implementation (funded by NTG). One ACCHO reported that the discussion about ongoing IT support was only raised after the transition funding was approved and had to be sourced later.

*"It would be really helpful if there was an organisation to provide corporate support for ACCHOs as a generic model where each AACCHO doesn't have to reinvent the wheel every time. – ACCHO stakeholder*

Several ACCHO and government stakeholders suggested that establishing an organisation that managed all the corporate shared services for ACCHOs (e.g. HR, IT, finance) would be helpful. They believed that this would assist ACCHOs, particularly new ACCHOs, achieve economies of scale which, currently, is a major advantage of government run services. However, stakeholders were unclear who would be able to manage such services and noted that while an Aboriginal organisation would be preferable, that it was not one existing ACCHO or AMSANT's role to do so. Larger ACCHOs saw this as less of an issue as they already had corporate services in place.

## **3.2.5 Evaluation**

### **Summary of findings**

- There has been limited evaluation of transitions or of the P2CC program more broadly.
- Some lessons learned about the transition process were developed and shared along the way.
- There has been limited use of data to assess outcomes, but some anecdotal outcomes were reported.
- Measuring short, medium, and long-term outcomes is important to build the evidence base.

## There has been limited evaluation of transitions or of the P2CC program more broadly

Both ACCHOs and government stakeholders noted the limited evaluation that had occurred across transitions generally. The NTG commissioned an evaluation of Miwatj's Milingimbi clinic in 2020 (following its transition in 2016). This evaluation occurred significantly after the recommended evaluation period (which is 2 years after the transition is implemented). One ACCHO reported that there has been no real evaluation process to date for their transitions as they have been so consumed with the transition and there have been limited resources to focus on any formal or ongoing evaluation. None of the ACCHOs consulted as part of this evaluation developed their own evaluation strategies in the consolidation phase as recommended in the P2CC program framework. Many stakeholders were unclear as to who was responsible for evaluation and when it should occur.

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*"[There was] no real evaluation process." – ACCHO stakeholder*

This evaluation report represents the first evaluation undertaken that focuses exclusively on the P2CC program since its formal launch in 2009.<sup>21</sup> However, as this evaluation is a process evaluation rather than an outcomes evaluation, a comprehensive assessment of outcomes of the P2CC program remains as a key gap in building the evidence base for the program and Aboriginal community control more generally. The current limited evaluation of the program represents a missed opportunity for both:

- Process evaluation that could inform continual improvement to individual transitions and the program as a whole
- Outcome evaluation that could identify features of transitions and the program that are associated with greater success.

Both forms of evaluation are critical in developing an evidence base to inform future transitions.

## Some lessons learned about the transition process were developed and shared along the way

While there have been limited formal evaluations of the transition process, some lessons learned about transitions were shared along the way. One ACCHO developed several 'lessons learned' documents for several of its transitions which outlined key issues that occurred across housing, staffing, clinic buildings, IT, leases, legal agreements, and financials. This ACCHO commented on the fact that the lessons from the first transition helped to inform subsequent transitions. Some of these lessons were shared with other ACCHOs looking to transition.

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*"Despite the fact that other transitions happened before, all these hurdles you are having to work out, it's almost as if it has never happened before." – ACCHO stakeholder*

## There has been limited use of data to assess outcomes, but some anecdotal outcomes were reported

There has been limited use of data to evaluate outcomes of individual transitions. While high quality data is available (e.g. the NT Aboriginal Health Key Performance Indicators) it does not appear to have been used to evaluate the outcomes of individual transitions or the P2CC program as a whole. While it is out of scope for this evaluation to assess the change in health outcomes as a result of the P2CC program, many positive outcomes were anecdotally reported throughout this evaluation process. The most common outcomes were improvements in the employment of Aboriginal staff, increased cultural safety and an increase in the number of primary prevention and health promotion activities undertaken.

Several ACCHOs highlighted the significant increase in local employment of Aboriginal and Torres Strait Islander staff, both in terms of the volume of staff, and the different positions in which they were engaged (both in clinical and corporate roles). ACCHOs commented on the fact that this employment had

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<sup>21</sup> Other literature studies the P2CC program and regionalisation reforms such as J Dwyer et al, The Road Is Made by Walking: Towards a better primary health care system for Australia's First Peoples, 2015, <https://www.lowitja.org.au/content/Document/Lowitja-Publishing/FAR-Report.pdf> which is referenced in this report.

important positive flow on effects including increased cultural competency and safety and a recognition by the community that the health service was genuinely controlled by the community.

Many ACCHOs also reported a greater emphasis on primary prevention programs after transitioning to community control. For example, one doctor who worked in the same clinic both before and after transition commented on the dramatic change in approach to primary health care for that clinic. Previously, the clinic was only focused on acute care with little focus on chronic disease. The doctor commented on the benefit of the increase in the diversity of programs (e.g., for women's and men's health) with doctors and nurses allocated to each program. The doctor reported that the clinic was even busier after transition which they believed was a result of being able to investigate issues at the prevention stage.

These anecdotal outcomes align with some of the findings of previous evaluations undertaken regarding the transition of health services to Aboriginal community control across Australia. Evaluations of the three Coordinated Care Trials in the NT (Katherine West, Sunrise and Tiwi Islands), which saw the transfer of health services to Aboriginal community control in the 1990s, documented key benefits of community control including: greater access to health staff and services, enhanced focus on population health, improved cultural safety, and increased employment of Aboriginal and Torres Strait Islander staff.<sup>22</sup> These evaluations were, however, unable to demonstrate the direct benefits of community control in terms of health outcomes.<sup>23</sup> The National Evaluation of the Second round of Coordinated Care Trials<sup>24</sup> also found for trials focused on Aboriginal populations that positive outcomes for participants included increases in access to services, and removal of barriers including access, communication, and discrimination and enhanced cultural safety of services.

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*"You are talking about multi-generational change - not seeing potential outcomes for 20 - 40 years." – Government stakeholder*

*"It's a completely different clinic [since when I previously worked there] ...it was just putting Band-Aids on everything keeping people alive and not dealing with the underlying chronic disease." – Government stakeholder*

### **Measuring short, medium and long-term outcomes is important to build the evidence base**

Stakeholders consulted in this evaluation noted the challenges of measuring changes in long-term health outcomes that often can only be achieved over a timespan of decades. However, outcomes are measurable across different timeframes, and it is important that short term, medium term, and long-term measures are identified and monitored. For example, outcomes such as life expectancy and reductions in type 2 diabetes are measures that will change over long periods of time, however, other measures such as reduced hearing loss or drug and alcohol use are able to be measured over the medium term, and access to services is able to be measured in the short term. Implementing effective evaluation mechanisms to measure these short, medium, and long-term measures is essential to building the evidence base about transitioning health services to Aboriginal community control. The indicators of good practice presented in Appendix A provide an example of an approach to measuring performance when data on outcomes is unavailable (or out of scope).

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<sup>22</sup> J Dwyer et al., The Road Is Made by Walking: Towards a better primary health care system for Australia's First Peoples, 2015, <https://www.lowitja.org.au/content/Document/Lowitja-Publishing/FAR-Report.pdf>

<sup>23</sup> R Bailie, M Dowden, Audit and Best Practice for Chronic Disease, 2010, <https://www.lowitja.org.au/page/research/research-categories/health-policy-and-systems/monitoring-and-evaluation/completed-projects/ABCD>

<sup>24</sup> The Department of Health and Ageing, The National Evaluation of the Second Round of Coordinated Care Trials, 2007, <https://apo.org.au/sites/default/files/resource-files/2008-04/apo-nid8664.pdf>

## 4 Recommendations

This section presents:

- An overarching recommendation for the future of the P2CC program (see Section 4.1)
- A set of recommendations regarding the core P2CC program framework (see Section 4.2)
- A set of recommendations regarding the transition process and supports (see Section 4.3).

For each recommendation, a rationale is provided based on evidence presented throughout the report.

### 4.1 The P2CC program should be refreshed and recommitted to

The P2CC program has endured over almost 15 years despite changes in government and policy at both the NT and Commonwealth levels (see Section 2.2). Recent policy and strategy settings (see Section 2.3) and the consultations conducted for this evaluation (see Section 3.1) reflected continuing support for Aboriginal community control of primary health care.

However, support for the program has been eroded by a range of implementation challenges. Many of these challenges are long-standing; for example, aligning with those identified in the 2011 evaluation of the EHSDI (see Appendix A). Stakeholders provided consistent feedback about the need for improvement in all aspects of the program (see Section 3.1).

This highlights that achieving the vision and intended outcomes of the P2CC program over the long term will require more than incremental improvement. Action is needed to strengthen the fundamental elements of the program.

#### RECOMMENDATION

1

The partners should refresh and recommit to the P2CC program to improve clarity, consistency and transparency in all aspects and promote accountability at all levels.

### 4.2 The program framework should be systematically strengthened

The program framework could be strengthened through:

- Clarification of the authorising environment
- More active governance
- A more planned process to identify potential sites and a more rigorous process to select them
- Agreement of community consultation principles and processes
- Establishment of a process and method for undertaking an upfront comprehensive assessment of the costs of transitioning a primary health care service
- Updating of key program documents.

Each of these improvements is discussed in turn below.

## The authorising environment for the P2CC program should be clarified

The literature review presented in Appendix B highlighted accountability as both critically important and a key challenge in transitioning primary health care services to community control. While the ACCHO must be accountable to government and the community, it is essential that government stakeholders are also accountable to the ACCHO and the community. Achieving this accountability is complicated by the complex mix of funding and regulatory roles between different levels (and agencies) of government and the tripartite arrangements between the Australian Government, NTG and community needed to achieve the transition.

These challenges were evident in the implementation of the P2CC program. The roles and responsibilities of the Australian Government and NTG after transition funding is awarded are not articulated in P2CC program documents. Consistent with this, some stakeholders felt the role of the Australian and NTG agencies involved in the transition process needed to be better defined (see Section 3.2.2).

Some ACCHO stakeholders raised the issue of key NTG personnel such as transition managers not being consistently resourced and vacancies not being quickly filled, leading to delays. This partly reflects a lack of funding for NTG agencies to participate in transition, with the result that transitions compete with other priorities for NTG staff (see Section 3.1).

Clarifying the authoring environment for the program would strengthen accountability at all levels within the Australian and NTGs.

### RECOMMENDATION

2

The partners should consider strengthening the authorising environment for the P2CC program through senior-level (in the case of the Australian and NT Governments preferably ministerial level) statements of commitment and endorsement of program guidelines from all partners.

## Governance should be more actively performed

NTAHF is generally seen to be a strong governance body that is committed to the P2CC program (see Section 3.2.1). However, it is a busy forum that considers many complex issues across the NT health system, which limits the attention it can put on the program, and there are indications it could govern the program more actively. First, at the level of both the overall program and individual transitions, challenges that have emerged have not been expeditiously resolved – some have continued for the life of the program (as noted in Section 4.1 above). Second, ACCHO and government stakeholders questioned whether NTAHF assesses business cases, which are often lengthy documents, as comprehensively as it could. If, given the breadth of NTAHF roles and responsibilities, NTAHF is unable to govern the program as actively as required, it could consider alternative arrangements, such as a separate working group of senior representatives from each partner.

NTAHF cannot be expected to be actively involved in all aspects of each transition. There is a distinction between program-level governance and individual transition-level governance. But they should not be viewed as entirely separate – an important aspect of governance at the program level is the escalation of issues from the transition level; for example, to resolve disputes or trouble shoot challenges.

### RECOMMENDATION

3

The partners should ensure the governance of the P2CC program is led by a group that is sufficiently senior and active to address problems and delays and adapt to emerging issues and events.

## The processes to identify, prioritise and select sites for transition could be improved

Stakeholders raised a number of shortcomings with the process to identify, select and prioritise transitions (see Section 3.2.1); for example:

- The absence of a process to identify which clinics are in the pipeline to transition and notify regions when an opportunity to transition becomes available
- The lack of information about who initiates new transitions and how they are prioritised
- The guideline that only three regions can transition at a time despite the significant variation in time and effort required for different transitions
- The unclear relationship between NTAHF's decision to support a transition and the subsequent Australian Government decision to provide transition funding, and between the P2CC program and the Local Decision Making process.

Development of criteria to assess the readiness of a region for transition was viewed as a positive development, but some noted these criteria had not been applied consistently, leading to confusion.

Stakeholders were unaware of instances in which a business case had been rejected by the Australian Government after NTAHF had endorsed it. The changes made to a business case before the Australian Government converts it to a business case are typically minor. It would be beneficial to more clearly communicate this to stakeholders (e.g. in NTAHF meetings and program documentation). It may also be beneficial to streamline the decision-making process and have as much as possible of the information the Australian Government requires to make funding decisions captured in the business case.

Improving the identification, prioritisation and selection of sites for transition would not necessarily involve establishing a written application or submission process. Such a process may not be culturally appropriate and could be inaccessible to applicants from areas that have merit as potential sites for transition.

### RECOMMENDATION

4

The partners should improve the rigour of the selection process for the P2CC program through:

- Proactive planning of the transition pipeline
- Easily accessible application guidelines and assessment criteria
- A transparent business case process with approval by the lead governance body
- Clear communication of the relationship between NTAHF's decision to support a transition and the subsequent Australian Government decision to provide transition funding
- Clarification of the relationship between the P2CC program and the Local Decision Making process (potentially through discussion with CM&C)
- Ensuring as much as possible of the Australian Government's required information for making funding decisions is captured in the business case.

Improving the selection process in this way could enable the partners to calibrate the number of transitions pursued at any one time based on the level of funding, effort, and time each requires (rather than specifying a set number).

## Consultation principles and processes should be agreed

The evaluation identified a range of issues with the communication and consultation conducted through the P2CC program (see Sections 3.1 and 3.2.2); for example:

- Misunderstanding and confusion with communities as to what transition involves and the relationship of the P2CC program to related processes such as regionalisation



- Underinvestment in understanding communities' needs and preferences and identifying governance arrangements and transition pathways that will address them
- A lack of trust in community consultation processes resulting in multiple parties conducting duplicative and inconsistent processes
- The challenge of identifying who can speak for a community and understanding the hierarchies and connections within it.

Some ACCHO stakeholders emphasised the importance of identifying an independent person or organisation who understands the community and can conduct consultation in a culturally safe way.

## RECOMMENDATION

5

The partners should agree on principles and processes that will guide consultation for the P2CC program to ensure:

- Consistent understanding on the part of partners, communities and other stakeholders about the form and extent of consultation that will occur as a precursor to each transition milestone
- A feedback loop through which communities are informed of the outcomes of consultation and given the opportunity to respond
- Engagement of individuals or organisations with appropriate skills, position, and authority to conduct consultation processes.

### **A process should be established for undertaking an upfront comprehensive assessment of the costs of transitioning a primary health care service**

The funding arrangements for transitions are seen as a major barrier to progress (see Section 3.1), for example:

- ACCHO stakeholders expressed frustration at funding not being adequately estimated for transition costs, ongoing operational and capital costs, or the needs of individual ACCHOs (e.g. funding to establish capability for new ACCHOs).
- Stakeholders generally viewed the Australian Government Department of Health's requirement for transitions to be cost neutral in terms of the funding provided through the IAHP as unrealistic due to the NTG's economies of scale relative to ACCHOs.
- MBS income (if it can be generated) is seen as essential to support service continuity over the transition phase.
- As noted above, ACCHO stakeholders raised the issue of NTG personnel such as transition managers not being consistently resourced and vacancies not being quickly filled, leading to transition delays.

Establishing a process for undertaking an upfront comprehensive assessment of the costs of a transition would help to align stakeholders' expectations regarding funding, thereby reducing ambiguity and disagreement. The process should not be so prescriptive as to prevent ACCHOs and other stakeholders involved in transitions from exercising discretion to resolve issues.

## RECOMMENDATION

6

The partners should establish a process for undertaking an upfront comprehensive assessment of the costs of transitioning a primary health care service for the P2CC program that:

- Reflects the stage of development of the organisation taking on the service
- Articulates all categories of costs of the transition and ongoing operations (including capital) and provides guidelines for how they will be funded

- Can be tailored to each ACCHO's circumstances, strengths and needs (e.g. governance training for boards)
- Reflects that government has greater economies of scale than ACCHOs in the provision of primary health care services
- Enables appropriate resourcing of transition including through transition managers and other roles within the Australian Government, NTG and ACCHO
- Balances expectations for reporting and accountability with flexibility for individuals involved in transitions to solve problems and achieve outcomes.

The upfront comprehensive assessment would occur as early as possible, ideally as part of the business case.

## RECOMMENDATION

7

The Australian Government Department of Health should explore possible alternative entry points into the IAHP funding model for primary health care services transitioning to community control.

### Key program documents should be updated

The P2CC program document, while foundational, is not widely referenced and was viewed by many stakeholders as outdated and in need of refreshing (see Section 3.2.3). Updating the document would provide an opportunity to address several issues:

- Despite the P2CC program document outlining nine different service models along a continuum of community control and recognising that the "continuum is not sequential", there is misunderstanding and disagreement within communities about what transition entails, with some viewing it in "all or nothing" terms (see Section 2.2 and Appendix A).
- There is no acknowledgement in the P2CC program document of the different options for staging transitions and the differences in timeframes and resources required to execute different pathways.
- As noted above, the roles and responsibilities of the Australian and NTGs after transition funding is awarded are not articulated in P2CC program document.

Communication of the complex concepts contained in the P2CC program document would be facilitated through the development of a visual, plain English version specifically targeted at community stakeholders.

## RECOMMENDATION

8

The partners should update key program documents to ensure they:

- Clearly communicate that community governance develops along a continuum (i.e. that there are various levels of community participation rather than a yes/no dichotomy) and that transitions may be staged over time rather than occurring at a single point in time
- Emphasise that continued service delivery partnership between NT Health and ACCHOs will be essential, whatever the staging of the transition or the governance arrangements selected
- Articulate who is responsible and/or involved at each point of the transition and include guidelines for when it will occur (including in regard to evaluation)
- Are accompanied by visual, plain English versions suitable for community stakeholders.

## 4.3 The transition process and supports should be improved

The transition process and supports could be improved through:

- Bringing best practice implementation discipline, templates and tools to every transition
- Maintaining appropriate engagement and sharing of client health information between ACCHOs and other health service providers
- Providing ACCHOs with access to external corporate functions
- Managing systemic workforce challenges in partnership.

Each of these improvements is discussed in turn below.

### **Best practice implementation discipline, templates and tools should be brought to every transition**

ACCHO stakeholders consistently reported they felt like they were starting from scratch with each transition. This was attributed to long transition timeframes, high staff turnover, limited handovers, patchy record keeping, and a lack of supporting documents such as project management tools (see Section 3.2.4). There has also been limited evaluation of transitions (see Section 3.2.5).

There are exceptions to this. For example, Miwatj developed several documents outlining lessons learned from previous transitions to inform future transitions, and the NTG commissioned an evaluation of Miwatj's Milingimbi clinic in 2020 (four years after its transition).

However, in general, these issues have resulted in large variations in implementation approaches across transitions, and the effectiveness of transitions being influenced by the individuals involved. This is a key contributor to the widespread implementation challenges referenced throughout this document.

In addressing this issue, it would be important not to restrict ACCHO's control of transition processes or impose onerous reporting requirements or bureaucratic processes. Transition documents will likely need to be tailored; for example, based on the maturity of the ACCHO and its transition aspirations.

Given the importance of developing both corporate and clinical capability, an assessment tool may be valuable, but this would need to be carefully designed and communicated to ensure it is not perceived as a reflection of excessive risk intolerance on the part of government, as occurred with the competence and capability framework (see Section 2.2 and Appendix A).

#### RECOMMENDATION

9

The partners should ensure a comprehensive implementation plan is in place for all transitions. This implementation plan would define governance, activities, timeframes, milestones, roles and responsibilities, risks and mitigation strategies, and arrangements for monitoring and communicating progress. The plan would be a living document that is updated over time as events and challenges inevitably necessitate adaptations.

#### RECOMMENDATION

10

The partners should promote sharing of transition templates and tools for project management, monitoring and evaluation, and assessment of corporate and clinical capacity. Mechanisms to achieve these could include a standardised toolkit (in an online location accessible to all relevant parties) and a community of practice. These resources could be adapted to each transition. Their use would be optional.

## Appropriate engagement and sharing of client health information between ACCHOs and other health service providers should be maintained

The period in which health services are transitioning from the NTG to community control is high risk for continuity of care. Mitigating this risk requires several elements, including an effective handover from the NTG to the ACCHO, maintaining the ACCHO's engagement with secondary and tertiary providers, and ensuring the ACCHO's access to patient records.

Ensuring access to patient records is a particular challenge given ACCHO's reported issues and delays with transitioning health services to new IT systems. To manage this challenge, ACCHOs should be given access to NTG client health information systems until their new IT systems are in place and stable and patient records have been transferred. In the case of at least one ACCHO, it was reported that NTG staff provided mixed messages about where this was possible.

### RECOMMENDATION

11

The partners should facilitate appropriate engagement and sharing of client health information between ACCHOs and other health service providers by:

- Ensuring an effective handover from NTG to the ACCHO
- Promoting engagement between ACCHOs and secondary and tertiary providers
- Giving ACCHO's access to NTG client health information systems until their new IT systems are in place and stable and patient records have been transferred
- Ensuring program documents and implementation plans set clear expectations about what information will be shared, with whom and when.

## Some ACCHOs would benefit from access to external corporate functions

Several ACCHO and government stakeholders suggested establishing an organisation to provide ACCHOs, particularly those that are smaller and/or establishing, with shared corporate services (e.g. IT, HR, finance). This idea of shared corporate services has a long history in the NT; for example, "Hub Services" (shared services for clinics in a given region) were part of the regionalisation reforms but were not progressed due to a lack of consensus within NTAHF.<sup>25</sup> The idea has also been considered by NTAHF more recently, meeting a similar lack of consensus. This suggests there may be value in further exploring the idea to definitively demonstrate its feasibility or lack thereof.

While stakeholders raised the idea of establishing a standalone organisation, there are other possible approaches; for example, establishing a shared services arrangement between two ACCHOs (one smaller and/or establishing and the other larger and/or established) when the need is identified.

### RECOMMENDATION

12

The partners should further explore the concept of enabling ACCHOs in the NT to access corporate functions externally. As a first step, they could conduct a study to explore different options for shared services and assess their benefits, costs, risks and overall feasibility.

## Systemic workforce challenges should be managed in partnership

Transitioning, attracting and retaining staff were viewed as critical challenges. Stakeholders identified a lack of:

- Guidance or support for managing these challenges

<sup>25</sup> J Dwyer et al., The Road Is Made by Walking: Towards a better primary health care system for Australia's First Peoples, 2015, <https://www.lowitja.org.au/content/Document/Lowitja-Publishing/FAR-Report.pdf>.

- Communication with staff
- Change management processes
- Workforce planning (including in regard to staff entitlements) and skills mapping.

This has contributed to severe workforce pressures.

ACCHO stakeholders identified actions that could be taken at a local level to address workforce challenges; for example, employing local staff as soon as possible, maintaining strong community relationships, and tailoring employment conditions to Aboriginal employees. However, it was also recognised by a range of stakeholders that workforce challenges are systemic across the NT health system (and the NT generally) and have also been exacerbated by COVID. This highlights a need for all stakeholders to work in partnership to address workforce challenges at both the local and systemic levels.

#### RECOMMENDATION

13

The partners should work in partnership with ACCHOs to manage systemic workforce challenges that threaten the ongoing sustainability of transitioned services, including by maximising employment opportunities for local staff arising out of transitions.

# Appendix A Overview of the history of the P2CC program

An overview of key events in the history of the P2CC program is provided below. This is primarily based on:

- J Dwyer et al., The Road Is Made by Walking: Towards a better primary health care system for Australia's First Peoples, 2015, <https://www.lowitja.org.au/content/Document/Lowitja-Publishing/FAR-Report.pdf>
- D Matheson, N Hardie-Boys et al., Evaluation of the Child Health Check Initiative and the Expanding Health Service Delivery Initiative: Final Report, 2011, <https://core.ac.uk/download/pdf/30680988.pdf>

## Establishment of NTAHF (1998)

NTAHF, a formal partnership comprising senior representatives from the Australian Government Department of Health, the NTG Department of Health (NT Health), the Aboriginal Medical Services Alliance (AMSANT) and ATSIC, was established under the NT Framework Agreement on Aboriginal and Torres Strait Islander Health. The Framework Agreement was resigned in 2001 and later extended to 2003. A new Framework Agreement, which excluded ATSIC due to its abolishment in 2005, was signed in 2007 and remained in force until another new Framework Agreement was signed in 2015. NTAHF was subsequently expanded to include the Australian Government Department of the Prime Minister and Cabinet, subsequently the National Indigenous Australians Agency (NIAA), and the NT PHN.<sup>26</sup>

## Increased funding for primary health care reform and expansion (2007-2009)

The Northern Territory Emergency Response (NTER), declared by the Australian Government in 2007, and the Closing the Gap initiative, adopted by the Australian Government in 2008, led to additional funding for primary health care in the NT. The Australian Government committed \$99.7 million over two years from July 2008 to expand and improve health service delivery in remote NT through the Expanded Health Service Delivery Initiative (EHSDI), with measures funded through the EHSDI including the regionalisation of primary health care services and their transition to community control (among others). The Closing the Gap in the NT National Partnership Agreement of July 2009 provided \$713.5 million for the health portfolio over ten years, including to extend the EHSDI as well as for the Stronger Futures program (which included funding to support transition).<sup>27</sup>

## Establishment of Primary Health Reform Group and Reform and Development Unit (2008-2009)

NTAHF established two main bodies to drive implementation of regionalisation (including P2CC): PHRG and RADU.

PHRG was established in 2008 as a subcommittee of NTAHF to lead implementation of NTAHF's reform agenda and manage implementation of the EHSDI.<sup>28</sup>

RADU was established in 2009 to communicate with the regions and support their engagement with the regionalisation agenda. It sat within AMSANT, which was funded through EHSDI for its establishment, and reported to the PHRG.<sup>29</sup> It comprised 11 staff: a manager, five regionalisation coordinators, a

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<sup>26</sup> J Devitt et al., The Northern Territory Aboriginal Health Forum: A historical review, 2015, <https://www.lowitja.org.au/content/Document/Lowitja-Publishing/FAR-NTAHF.pdf>

<sup>27</sup> J Devitt et al., The Northern Territory Aboriginal Health Forum: A historical review, 2015, <https://www.lowitja.org.au/content/Document/Lowitja-Publishing/FAR-NTAHF.pdf>

<sup>28</sup> J Dwyer et al., The Road Is Made by Walking: Towards a better primary health care system for Australia's First Peoples, 2015, <https://www.lowitja.org.au/content/Document/Lowitja-Publishing/FAR-Report.pdf>

<sup>29</sup> J Dwyer et al., The Road Is Made by Walking: Towards a better primary health care system for Australia's First Peoples, 2015, <https://www.lowitja.org.au/content/Document/Lowitja-Publishing/FAR-Report.pdf>

regionalisation support officer, a communications officer, a public health/policy consultant, and an officer (plus a trainee) to provide logistical support.<sup>30</sup> Its key roles included:

- Negotiating the boundaries of HSDAs
- Identifying the strengths, values, preferences and objectives of HSDA residents through community consultation
- Assisting communities to establish governance and leadership arrangements in the form of Regional Steering Committees
- Developing templates and tools to assist regional steering committees and health service providers to engage with the agreed regionalisation process
- Building the corporate, clinical and community competencies and capabilities of regional steering committees and health service providers
- Supporting the development of health plans for each HSDA, including a service plan, a transition plan and a longer-term strategic plan
- Undertaking risk analysis and management.

Local units were established in the Barkly and East Arnhem regions in 2009 and 2011 respectively, playing a similar role to the RADU but specifically for those regions. RADU also presented (in its briefing paper titled *On the Same Track*) a community engagement framework for Aboriginal health, including guiding principles and directions.<sup>31</sup>

### **Establishment of the P2CC agenda (2005-2010)**

Work toward the P2CC agenda commenced in 2005. The P2CC program document was endorsed by NTAHF in 2008 and formally launched in 2009. It outlined NTAHF's collective understanding of community control and potential ways it could be achieved. It also provided an indicative five-year implementation timeframe.<sup>32</sup>

The *NT Regionalisation of Aboriginal Primary Health Care Guidelines*, a foundational implementation document for the P2CC agenda and the regionalisation process, was developed by the PHRG in 2009-2010 and endorsed by NTAHF in 2010. It outlines the regionalisation reforms and describes a four stage process (of development, consolidation, implementation and evaluation) to establish a regional Aboriginal community controlled primary health care service. Only the development stage was described in detail; guidelines for the consolidation stage were developed but never endorsed. Tools for regional steering committees (e.g. consultation report templates) were also included.<sup>33</sup>

### **Setbacks and challenges in regionalisation process (2009-2011)**

From the outset, the regionalisation process experienced setbacks and challenges:

- A funds pooling arrangement, as had existed under the Coordinated Care Trials, was not designed, planned or ultimately established.
- A joint survey of capital assets to be transferred as part of transition was not conducted (with the NT and Australian Governments reportedly conducting separate surveys which were not widely shared).

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<sup>30</sup> D Matheson, N Hardie-Boys et al., Evaluation of the Child Health Check Initiative and the Expanding Health Service Delivery Initiative: Final Report, 2011, <https://core.ac.uk/download/pdf/30680988.pdf>

<sup>31</sup> D Matheson, N Hardie-Boys et al., Evaluation of the Child Health Check Initiative and the Expanding Health Service Delivery Initiative: Final Report, 2011, <https://core.ac.uk/download/pdf/30680988.pdf>

<sup>32</sup> J Dwyer et al., *The Road Is Made by Walking: Towards a better primary health care system for Australia's First Peoples*, 2015, <https://www.lowitja.org.au/content/Document/Lowitja-Publishing/FAR-Report.pdf>

<sup>33</sup> J Dwyer et al., *The Road Is Made by Walking: Towards a better primary health care system for Australia's First Peoples*, 2015, <https://www.lowitja.org.au/content/Document/Lowitja-Publishing/FAR-Report.pdf>

- NTAHF was not well placed to perform the role of implementing regionalisation. “The task was enormous, funding unprecedented and the timeframe tight. Pressure on NTAHF, the partners and key decision makers became intense. Problems and differences emerged.”<sup>34</sup>
- There was misunderstanding and disagreement within communities as to what regionalisation and the P2CC program proposed (e.g. confusion about the existence of a continuum of community control as opposed to a yes/no dichotomy).
- Cumulative negative experiences corroded the goodwill of key Aboriginal community members (e.g. leaders who advocated for reforms were blamed and criticised when they did not materialise).
- The regionalisation guidelines articulated an extensive role for community members in regional steering committees but payment for this investment was ruled out.
- HSDA boundaries and service providers roles within them proved difficult to resolve.
- There was perception within Aboriginal communities that the progress of reform was too slow.<sup>35</sup>

### **Evaluation of the EHSDI (2009-2011)**

Evaluation was built into the EHSDI from the beginning. The final evaluation report, released in 2011, was positive about NTAHF’s achievements and supportive of a continuing partnership structure; however, it identified a number of issues, including but not limited to:

- The size and complexity of the task relative to the available timeframe and resources (e.g. initial under-scoping and under-resourcing meant implementation policy work fell to the PHRG, whose members were already fully employed and becoming overloaded)
- Unclear roles and responsibilities on the part of NTAHF and among its partners
- Inability of NTAHF to resolve emerging disagreements among partners
- The absence of unified, committed leadership in NTAHF
- Emerging ambivalence about regionalisation.<sup>36</sup>

### **Development of competence and capability framework (2011)**

A framework to assess the competence and capability of community governance structures was developed in 2011-2012. However, people who engaged with the assessment process experienced it “not as a supportive step towards community control but, rather, as a process designed to demonstrate local inadequacies and thereby impede progress.”<sup>37</sup> Some viewed it as a manifestation of excessive risk intolerance on the part of both the NT and Australian Governments. The framework was subsequently reshaped and renamed (as the Regional Readiness Assessment Tool).<sup>38</sup>

### **Period of reduced NTAHF activity (2011-2013)**

The final evaluation report recommended regionalisation continue under the auspices of NTAHF but with a new plan and scope, additional resources, and stronger governance and leadership. NTAHF agreed to form a working party to develop a response to the evaluation, but this appears not to have been done.

There are no minutes of NTAHF meetings between mid-2011 and mid-2012. PHRG’s ceased to meet following a meeting in early 2011. There was also a reported souring of essential relationships between the

<sup>34</sup> J Dwyer et al., *The Road Is Made by Walking: Towards a better primary health care system for Australia’s First Peoples*, 2015, <https://www.lowitja.org.au/content/Document/Lowitja-Publishing/FAR-Report.pdf>

<sup>35</sup> J Dwyer et al., *The Road Is Made by Walking: Towards a better primary health care system for Australia’s First Peoples*, 2015, <https://www.lowitja.org.au/content/Document/Lowitja-Publishing/FAR-Report.pdf>

<sup>36</sup> J Dwyer et al., *The Road Is Made by Walking: Towards a better primary health care system for Australia’s First Peoples*, 2015, <https://www.lowitja.org.au/content/Document/Lowitja-Publishing/FAR-Report.pdf>

<sup>37</sup> J Dwyer et al., *The Road Is Made by Walking: Towards a better primary health care system for Australia’s First Peoples*, 2015, <https://www.lowitja.org.au/content/Document/Lowitja-Publishing/FAR-Report.pdf>

<sup>38</sup> J Dwyer et al., *The Road Is Made by Walking: Towards a better primary health care system for Australia’s First Peoples*, 2015, <https://www.lowitja.org.au/content/Document/Lowitja-Publishing/FAR-Report.pdf>



parties, compounded by loss of corporate memory as key people who had been integral to the regionalisation reform agenda moved on.

The Australian Government responded by creating an alternative decision-making body comprising the most senior representatives from each partner. The Senior Officers Group (SOG), originally proposed in late 2011, was intended to take over NTAHF's role in regionalisation (though its formal relationship with NTAHF was ambiguous). The SOG met at least five times but ceased to meet at all within months of its establishment. Following its last meeting in early 2012, several planned meetings were postponed.

By mid-2012, RADU was reduced to a single officer working in Central Australia and NTAHF entered a period of inactivity. The evaluation of the EHSDI identified a number of challenges in RADU's role; for example:

- There was a tension between AMSANT's role as the advocate for the community controlled sector and its responsibilities through RADU for implementation of regionalisation. Some stakeholders were unclear on whether RADU's role was as an advocate for ACCHOs or an independent facilitator. At times, RADU's role brought AMSANT into conflict with its members.
- There were concerns on the part of AMSANT that RADU's role, which had focused on the governance aspects of regionalisation, had expanded to include regional health planning, leading to resourcing challenges. Related to this, there was a perception that RADU lacked resources and capacity in some areas required for its role.

However, the reduction in resourcing for RADU may have reflected a broader loss of momentum that was occurring at this time.

In 2012, a change of government in the NT led to financial restrictions, including freezing of staff numbers and limiting of travel, and a major restructure of the NT Department of Health. In 2013, a change of government at the Commonwealth level brought financial stringency, scrutiny of Indigenous affairs, and machinery of government changes. At around this time, high-profile challenges experienced by ACCHOs, including three in the NT, negatively affected perceptions of the viability of community control. There was insufficient NTG authorisation and support (e.g. Cabinet-level engagement at the Commonwealth level) to enable the parties to maintain the agreed course of action amidst these events.<sup>39</sup>

### **Transfer of Yirrkala Clinic (2012)**

Agreement to transfer Yirrkala Clinic from NT Health to Miwatj was reached in December 2011. Miwatj took over day-to-day management of the clinic in July 2012. The transfer of operating funds was delayed due to concern about allocation of overhead costs and debate over whether to allocate Australian Government funding directly or via NT Health. The competence and capability framework (referenced above as being developed in 2011) was applied as a condition of approval to transfer and showed good results.<sup>40</sup>

### **Halting of regionalisation process (2014)**

The regionalisation process was halted in 2014, with no funding allocated to it in the 2014-15 Australian Government budget. By this point, only three HSDAs (Barkly, East Arnhem and Red Lily) had submitted Final Regionalisation Proposals, only one of which had been provisionally endorsed by NTAHF.<sup>41</sup>

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<sup>39</sup> J Dwyer et al., *The Road Is Made by Walking: Towards a better primary health care system for Australia's First Peoples*, 2015, <https://www.lowitja.org.au/content/Document/Lowitja-Publishing/FAR-Report.pdf>; D Matheson, N Hardie-Boys et al., *Evaluation of the Child Health Check Initiative and the Expanding Health Service Delivery Initiative: Final Report*, 2011, <https://core.ac.uk/download/pdf/30680988.pdf>

<sup>40</sup> J Dwyer et al., *The Road Is Made by Walking: Towards a better primary health care system for Australia's First Peoples*, 2015, <https://www.lowitja.org.au/content/Document/Lowitja-Publishing/FAR-Report.pdf>; D Matheson, N Hardie-Boys et al., *Evaluation of the Child Health Check Initiative and the Expanding Health Service Delivery Initiative: Final Report*, 2011, <https://core.ac.uk/download/pdf/30680988.pdf>

<sup>41</sup> J Dwyer et al., *The Road Is Made by Walking: Towards a better primary health care system for Australia's First Peoples*, 2015, <https://www.lowitja.org.au/content/Document/Lowitja-Publishing/FAR-Report.pdf>

### **Establishment of IAHP (2014)**

At this same time, the Australian Government established the IAHP, which aims to increase Aboriginal and Torres Strait Islander people's access to safe and effective essential health services. Funding for the P2CC program originally provided through the NTER and the Stronger Futures program were rolled into the IAHP.<sup>42</sup>

### **Additional transitions (2016-present)**

Five additional transitions were achieved from 2016 to 2021: three to Miwatj, one to Mala'la and one to Red Lily. Additional transitions are underway or upcoming at Red Lily and Congress.

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<sup>42</sup> Australian Government Department of Health, Indigenous Australians' Health Programme: Northern Territory Pathways to Community Control Grant Opportunity Guidelines, 2021.

## Appendix B Lessons learned from other jurisdictions

The literature reviewed in this document highlighted that despite there being a steady increase in the discourse around First Nations community controlled primary health care models over the last 20 years, there have been few robust evaluations of transitions to community control.

Below summarises high-level themes from several evaluations and reviews of transitions that have taken place in other jurisdictions in Australia and overseas. Overall, the literature reveals that transitioning primary health care to First Nations community control is a long and challenging journey requiring dedicated resources and sufficient time to be successful.

### Transitioning to community control can take a long time

Successfully achieving community control of primary health services is a lengthy and complicated process, in some cases taking up to 30 years. While the transitions for some services have only taken five years, transitions of other services and entire regions to community control can take much longer. For example, it took 28 years to successfully transition the Gurriny Yealamucka Health Service (Gurriny) to community control in Yarrabah in Queensland.<sup>43</sup> This was due to the sustained effort required to demonstrate capability to the community and government and build organisational capacity over time. By 2014, 20 years after the establishment of Apunipima health service in Cape York, the transition to community control of the whole of Cape York's primary health care services had not been fully realised.<sup>44</sup>

In Canada, it took over 20 years to see 89% of eligible communities in the country engaged in the planning or management of transitions to community controlled health services.<sup>45</sup> Jongen et al. (2020) stressed the importance of having realistic expectations for how long the transition process can take. Lavoie et al. (2016) commented on the fact that efforts in Australia to transfer to community control are generally conducted under a short time frame which is often not realistic and risks creating feelings of failure.

### Trust is an essential ingredient to successful community control

In the case of the transition of community control in Cape York through Apunipima, there were concerns as to whether the Cape communities and Apunipima were capable of delivering the necessary health services to a high quality. Dwyer et al. (2015) found that many local people believed hostility to Aboriginal community control, combined with systemic racism, was a major barrier to successful transition, creating deep reluctance to hand over control to an Aboriginal organisation. Government doubts about the capacity and governance of Aboriginal organisations created more barriers and led to increasing levels of micro-management and uncertainty around job security and salaries.<sup>46</sup>

In contrast, trust was established in Yarrabah around 10 years before the transition through strategically growing the capability of Gurriny staff. Yarrabah leaders developed a social and emotional wellbeing program (the Family Wellbeing Program) before the official transition period, which was used to build the skills of the Gurriny workforce. Evaluations demonstrated that the Family Wellbeing program was successful, which built government and community trust and helped to secure future funding for the transition.

### Ongoing engagement with the community requires sustained effort

A critical component of the transition to community control is continual communication and engagement with community members. In the case of Gurriny, community support for the transition was a key enabler

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<sup>43</sup> Jongen, C., Campbell, S., McCalman, J. et al., (2020), Transitioning to Aboriginal community control of primary health care: the process and strategies of one community-controlled health organisation in Queensland. *BMC Fam Pract* 21, 230, . <https://doi.org/10.1186/s12875-020-01300-z>, <https://bmcprimcare.biomedcentral.com/track/pdf/10.1186/s12875-020-01300-z.pdf>

<sup>44</sup> Lavoie, 2016, Implementing Indigenous community control in health care: lessons from Canada, 2016, *Australian Health Review*, <https://www.publish.csiro.au/ZO/pdf/AH14101>

<sup>45</sup> Ibid

<sup>46</sup> Ibid

of success and was obtained through continuous and inclusive engagement with the Yarrabah community including through meetings, events and social media.<sup>47</sup> An overarching finding for the Indigenous Coordinated Care Trials was that community engagement and the delivery of culturally appropriate services facilitated exposure to health assessment and a broader consideration of health issues.<sup>48</sup>

Improvements in community involvement over the course of the trials were associated with increased self determination; health outcomes were diminished when communication with the community did not occur. In the case of the South West Aboriginal Medical Service Aboriginal Corporation (SWAMSAC) Coordinated Care Trial, there was a disconnect between the Board's perception of community engagement (as highly positive) and the community not feeling involved enough (particularly those who were located far away from the trial site)<sup>49</sup>. Increased community involvement by the end of the trial however improved community access to SWAMSAC.<sup>50</sup>

### **Strong organisational leadership and governance are critical enablers of community control**

One of the most important and distinguishing features of ACCHOs in Australia is the establishment of a legal entity including an elected health Board that is accountable to the community. Unlike in Canada where the management and delivery of services is often transferred to pre-existing governance structures, shifting to community control in Australia often requires a new Board to be established (if there isn't already a Board representing the region). This comes with its own challenges including ensuring the Board has representative language groups for health services spanning vast regions. In the case of the Gurriny transformation, Jongen et al. (2020) highlighted that support was provided to help the Board develop the required skills in areas such as risk management, business planning and financial expertise 'to meet the western managerial style of accountability expected by government'.

Dywer et al. (2015) reported that high profile governance failures in Aboriginal organisations in the mid 2000's raised concern about the governance capability of the community control model including around accountability of funding arrangements. Upskilling board directors with management and leadership is a positive way to ensure that the Board has the right skills to drive the performance of the health service. This was also a key finding of the National Evaluation of the Second Round of Coordinated Care Trials which stressed that education on governance and management approaches was a key enabler for the trials.<sup>51</sup>

### **It is important there is accountability on both sides**

The issue of accountability is often raised as a key challenge in the transition of a health service to community control. Lavoie et al. (2016) commented on the challenge presented by the complex mix of funding and regulatory roles between different levels of government in Australia and the tripartite arrangements between the Australian Government, state and the community that are needed to support pathways to community control. Although these agreements are essential to build the foundation of community control, Lavoie et al. (2016) highlighted that issues can arise from no single government holding clear accountability for Aboriginal and Torres Strait Islander health in Australia.

While it is important the health service is accountable to the government and the community, it is essential the government is also accountable to the health service and the community. The mixture of short term and long term funding contracts and complicated funding pools can cause challenges around accountability. While significant funding has been available for many transitions, in some transitions it has

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<sup>47</sup> Jongen, C., Campbell, S., McCalman, J. et al., (2020), Transitioning to Aboriginal community control of primary health care: the process and strategies of one community-controlled health organisation in Queensland. BMC Fam Pract 21, 230, . <https://doi.org/10.1186/s12875-020-01300-z>, <https://bmcprimcare.biomedcentral.com/track/pdf/10.1186/s12875-020-01300-z.pdf>

<sup>48</sup> Commonwealth of Australia, (2007), The National Evaluation of the Second Round of Australian Coordinated Care Trials 2007, <https://apo.org.au/sites/default/files/resource-files/2008-04/apo-nid8664.pdf>

<sup>49</sup> Ibid

<sup>50</sup> Ibid

<sup>51</sup> Ibid

been found that the 'need for adequate resourcing of the change process was insufficiently recognised and accommodated'.<sup>52</sup>

There is also often low understanding of the size and cost of the reform process by both the government and the health service at the outset, particularly when transition timelines are lengthy.<sup>53 54</sup> Onerous reporting requirements and the administrative burden that comes with funding agreements has been raised as a key issue in both Australia and Canada.<sup>55</sup> Clear roles and responsibilities and clear requirements at the beginning of the transition are important.<sup>56</sup>

### **Service delivery at least needs to be maintained**

Many studies have shown that greater levels of community involvement and increased cultural safety in the delivery of primary health care improve health outcomes for the community.<sup>57</sup> The maintenance of service delivery throughout the transition to greater community control is critically important at least in the short term, with improvements to health outcomes able to be developed over the long term. One of the key success factors of the Gurriny transition was that despite workforce supply challenges, Gurriny was able to hire enough staff to provide continuous services during the transition. Help from external consultants to design service delivery models and a clear health plan developed by Gurriny and the existing government run health service were essential components to enabling continuous service provision. Since the transition, considerable outcomes have been achieved, including increased staff numbers, a sustained local Aboriginal workforce and improved performance in chronic illness management.

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<sup>52</sup> Dwyer, J., Martini, A., Brown, C., Tilton, E., Devitt, J., Myott, P. & Pekarsky, B., (2015), *The Road Is Made by Walking: Towards a better primary health care system for Australia's First Peoples – Report*, The Lowitja Institute, Melbourne., *Implementing Indigenous community control in health care: lessons from Canada*.

<sup>53</sup> Ibid

<sup>54</sup> McCalman J, Jongen CS, Campbell S, Fagan R, Pearson K, Andrews S., (2021), *The Barriers and Enablers of Primary Healthcare Service Transition From Government to Community Control in Yarrabah: A Grounded Theory Study*. *Front Public Health*. 2021 Oct 14;9:616742. doi: 10.3389/fpubh.2021.616742. PMID: 34722428; PMCID: PMC8551548. < <https://pubmed.ncbi.nlm.nih.gov/34722428/>>

<sup>55</sup> Dwyer, J., Martini, A., Brown, C., Tilton, E., Devitt, J., Myott, P. & Pekarsky, B., (2015), *The Road Is Made by Walking: Towards a better primary health care system for Australia's First Peoples – Report*, The Lowitja Institute, Melbourne., *Implementing Indigenous community control in health care: lessons from Canada*.

<sup>56</sup> Dwyer, J., Martini, A., Brown, C., Tilton, E., Devitt, J., Myott, P. & Pekarsky, B., (2015), *The Road Is Made by Walking: Towards a better primary health care system for Australia's First Peoples – Report*, The Lowitja Institute, Melbourne., *Implementing Indigenous community control in health care: lessons from Canada*.

<sup>57</sup> Harfield S, Davy C, Kite E, McArthur A, Munn Z, Brown N, Brown A., (2015), *Characteristics of Indigenous primary health care models of service delivery: a scoping review protocol*. *JBI Database System Rev Implement Rep*. ;13(11):43-51. doi: 10.11124/jbisrir-2015-2474. PMID: 26657463, < <https://pubmed.ncbi.nlm.nih.gov/26657463/>>

## Appendix C Good practice

### **Nous' team was supported by an Expert Advisory Group with outstanding expertise and history in Aboriginal health and the transition to community control**

The Expert Advisory Group included:

- **Robert Griew (Chair)**, former Nous Principal, former Secretary of the NT Department of Health and Community Services and former First Assistant Secretary of the Office of Aboriginal and Torres Strait Islander Health in the Australian Government Department of Health
- **Trish Angus PSM**, former head of Aboriginal housing, former head of Aboriginal health and current non-executive director of CareFlight, Venture Housing, Tourism NT and Voyages Indigenous Tourism Australia Board
- **Dr Shane Houston**, director of Cultural Fusion consultancy, former Deputy Vice Chancellor (Indigenous) at the University of Sydney, former head of Aboriginal health in both the NT Department of Health and Community Services and in the WA Health Department and of the National Aboriginal and Islander Health Organisation (predecessor to the NACCHO)
- **Professor Sandra Eades**, Dean of Medicine at Curtin University, former Professor of Indigenous health at the University of Melbourne, at the University of Sydney, at the Baker Heart and Diabetes Institute, at the Sax Institute and at the Telethon Institute for Child Health Research. Sandra is also a current board member of Derbarl Yerrigan Aboriginal Medical Service in Perth WA, where she was also a general practitioner in the 1990s.

This group had input into Nous' evaluation plan and project plan. They met with the Nous team to further how the key evaluation questions would be addressed through consultation, research and analysis throughout the project. They also provided feedback on project deliverables and supported the Nous team to develop findings and recommendations.

### **The Expert Advisory Group considered indicators of good practice at each stage of the transition process**

To develop the indicators of good practice, the Expert Advisory Group considered:

- The key evaluation questions
- The P2CC program documentation provided to Nous
- Work that was going on in the period the P2CC program was being developed, including:
  - Work on the notion of universal core services
  - The NT Preventable Chronic Diseases Strategy of the late 1990s
  - The ABCD project led out of the Menzies School of Health Research.

This sheds light on how the parties who worked together to create the P2CC program envisaged it would achieve better health services for Aboriginal communities in the NT. As such, the indicators also reflect the intended process for transition.

The indicators the Expert Advisory Group developed are presented in Table 4. They are grouped against the four stages of the transition and against three mutually-reinforcing categories: (1) building community control, (2) regionalisation, and (3) building capability of comprehensive primary healthcare.

The indicators of good practice were intended as a starting point to inform how the key evaluation questions would be addressed over the course of the evaluation.

However, they would also provide a starting point for ongoing monitoring and evaluation of the program.

Table 4 | Indicators of good practice

Category	Development	Consolidation	Implementation	Evaluation
Building community control	<ul style="list-style-type: none"> <li>-Provide and improve information for the community members.</li> <li>-Elicit community preferences for service models.</li> <li>-Evaluate options.</li> <li>-Chose a service model.</li> </ul>	<ul style="list-style-type: none"> <li>-Build community capability through:                             <ul style="list-style-type: none"> <li>- A leadership group that is consolidated into an elected health board with accountability to the community or region.</li> <li>-A health plan that is created with support of community leadership.</li> <li>-The establishment of networks and functioning partnerships with stakeholders.</li> <li>-The development of the legal entity's capability to affect strategic management and implement a framework to support the service model.</li> <li>-The agreement of an evaluation strategy to form the basis of the evaluation stage.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>-Monitor changes to ensure the implemented reform meets all appropriate milestones.</li> <li>-Service managers have taken on responsibilities under the service plan and will have sound business plans in place and tied to operational decision making.</li> <li>-Partners maintain effort in support of health outcomes and ensure services meet the requirements of the health plan.</li> <li>-Confidence of the community, funders and stakeholders is maintained.</li> <li>-Communities have mechanisms in place to address concerns and celebrate success.</li> <li>-Data is collected and analysed to support strategic and operational needs.</li> </ul>	<ul style="list-style-type: none"> <li>-Create a judgement regarding the effectiveness and efficiency of the service.</li> <li>- Key stakeholders are engaged as part of the evaluation, giving structure to some of the questions asked by the evaluation.</li> <li>-Set clear business and implementation objectives to be evaluated along with the main service components to establish a logical format.</li> <li>-Use an Evaluation Report to provide a basis to enhance strategic, business or other operational and corporate decisions.</li> <li>-Other indicators of governance strength and function could also be useful here.</li> </ul>
Regionalisation	<ul style="list-style-type: none"> <li>-Have a proposed governance model based on community preferences.</li> <li>-Have a plan for implementing said governance model.</li> <li>-Have a plan for improved coordination and integration of existing services.</li> <li>-Have government endorsement of plans.</li> </ul>	<ul style="list-style-type: none"> <li>-Establish either the Regional Advisory group or Health Board and a governance training plan will be implemented.</li> <li>-Establish a legal entity meeting requirements of competency and capability.</li> <li>-Develop a plan to transition existing services.</li> <li>-Have government endorsement of plans.</li> </ul>	<ul style="list-style-type: none"> <li>-Existing services transition to the new regional service provider.</li> <li>-Implementation and ongoing management of regional health system reform.</li> </ul>	<ul style="list-style-type: none"> <li>-Ongoing monitoring of progress towards regionalisation and also the effectiveness of the current service model inform improvements within the HSDA.</li> </ul>

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Building capability of comprehensive primary healthcare	<ul style="list-style-type: none"> <li>-Assess key performance indicators for comprehensive healthcare against current standard of care within the community.</li> <li>-Establish networks between key local families, business and health providers.</li> <li>-Identify specific health areas of concern, such as substance use, maternal and childhood health, age and disability care and mental, social and emotional health.</li> <li>-Baseline health (&amp; related) service scope in communities, to ensure transition is not set up to fail and development strategies are in place, where needed as part of plan.</li> <li>-Develop education plan to improve health literacy in relation to areas of concern.</li> </ul>	<ul style="list-style-type: none"> <li>-Develop cultural safety policies for clinical situations from consultation with community leadership including cultural orientation for non-Indigenous service providers.</li> <li>-Recruit a qualified Health Services Development Officer or Health Services Manager.</li> <li>-Develop plan for strategic and financial management and governance of healthcare services in relation to service model.</li> <li>-Employ local Aboriginal people to help manage language barriers.</li> </ul>	<ul style="list-style-type: none"> <li>-Recruit further health staff and train those and existing staff to provide core primary health care scope and standards of care.</li> <li>- Ensure avenues for community members to address and advocate for health issues on individual and local levels, along with mechanisms for community feedback.</li> <li>-Ensure avenues to access secondary health services (pharmacy, visiting specialists, diagnostic specialist and pathologists, oral health, etc.)</li> <li>-Standardise regulations for healthcare, particularly in relation to areas of concern within the community, to support preventative healthcare.</li> </ul>	<ul style="list-style-type: none"> <li>-Review healthcare provided against key areas of concern to ensure community needs are met.</li> <li>-Ongoing quality control for provided healthcare.</li> </ul>
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# Appendix D Summary of intended P2CC program process

## INTENDED PROCESS MAP FOR P2CC

