nous group

Review of the roles and functions of NACCHO and the state/territory Aboriginal and Torres Strait Islander health peak bodies

Department of Health

8 August 2016

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Review Objectives

In 2015, the Commonwealth Department of Health commissioned Nous Group (Nous) to conduct an independent review of the roles and functions of NACCHO and the state/territory Aboriginal and Torres Strait Islander health peak bodies. Nous has been informed by a team of senior Aboriginal and Torres Strait Islander people with extensive experience in the health sector.

The objectives of this Review are to:

1. understand how NACCHO and the state/territory peak bodies contribute to strengthening the organisational capacity of the Aboriginal community controlled health sector and the health system's delivery of quality, culturally appropriate primary health care for the Aboriginal and Torres Strait Islander population and to achieving the CTG targets;
2. understand how current activities of NACCHO and the state/territory peak bodies align with the needs of the Commonwealth government, ACCHOs and the broader health system, and consider the capabilities required to deliver these activities;
3. consider how NACCHO and the state/territory peak bodies function as a national network and the principal issues regarding health system integration with which NACCHO and the state/territory peak bodies could engage;
4. make recommendations to inform the ongoing delivery of required support to ACCHOs. This will include consideration of a nationally consistent suite of supports to provide guidance to the state/territory peak bodies in supporting ACCHOs, including those that may be experiencing operational difficulties;
5. understand how Commonwealth and state/territory government investment interacts to address jurisdictional need; and
6. consider the range of Commonwealth investment that could be made in NACCHO and the state/territory peak bodies, what that range of investment could purchase and where it could be best targeted to achieve best value for money, having regard to factors such as geographical size, Aboriginal and Torres Strait Islander population, and number of ACCHOs in each jurisdiction.

The outcomes and recommendations from the Review will be used to inform:

- an agreed national work programme utilising Commonwealth funding with an associated monitoring framework that will contribute to, and strengthen capacity to, achieve the Closing the Gap targets; and
- how and where the Commonwealth could direct funding so NACCHO and the state/territory peak bodies can contribute most effectively to enabling the health system to deliver high quality, accessible and culturally safe care to Aboriginal and Torres Strait Islander people.

A table that maps the Review objectives to the overall report is provided in 00 on page 53.

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Executive Summary

The Aboriginal community controlled health sector is a critical part of the Australian health system. The sector is the biggest single provider of health care services to Aboriginal and Torres Strait Islander people, with over 250,000 clients and delivering 2.1 million episodes of care in 2012-13. The trusted position that Aboriginal community controlled services occupy for many Indigenous families and communities provides these families, many of whom have complex and chronic conditions, with access to culturally appropriate and high quality comprehensive primary health care. Support for this sector is a key plank in improving health outcomes for Aboriginal and Torres Strait Islanders and in achieving the Closing The Gap targets.

Commonwealth investment in the national and state/territory peak organisations of the sector acknowledges the key role the sector plays in improving the health of Aboriginal and Torres Strait Islanders. At the time of writing, the Commonwealth was funding 141 Aboriginal Community Controlled Health Organisations (ACCHOs) across Australia who deliver a model of comprehensive primary care that is accessible and culturally safe for Aboriginal people. Taken together, ACCHOs are the biggest single service sector for Indigenous people in this country and they perform well in improving health outcomes.

The sector has arisen from deeply held values on self-determination and a distrust of government. It follows that this history impacts on the values, attitudes and behaviours of many people across the sector and widens the front of issues that come into play. Awareness of this history and of the achievements of the sector is important context for governments and mainstream services in seeking to maximise health outcomes. Politics and distrust are realities to deal with as governments interact with the sector, despite the concern of both parties share an interest that the politics not be allowed to distract from the primacy of health care. This Review is important to strengthen the impact and effectiveness of the sector in achieving improvements in Aboriginal and Torres Strait Islander health.

State/territory peaks

The state and territory peaks are diverse organisations that are generally funded by both the Commonwealth and state/territory governments, with the peaks leveraging the different funding sources to increase their effectiveness. They have a key role of providing tailored support to build the capacity of ACCHOs in their jurisdiction to deliver high quality comprehensive primary health care on a sustainable basis. In this role the state/territory peaks are generally seen by the ACHHOs as effective, building a range of capabilities across the sector.

Based on ACCHO feedback to this Review, the state/territory peak bodies provide effective member support services in many areas, particularly in the areas of governance support, financial management support and utilisation of data and IT. ACCHOs would like increased access to support, particularly in the areas of support to deliver better clinical care and preventive health activities, including workforce development and data capability. In building sector capability, one of the key challenges identified by ACCHOs is for the support to be equitable across metro, rural and remote/very remote ACCHOs.

The state/territory peaks also play an important role in representing the sector with state/territory based health services. Based on the range of consultations undertaken, the Review has concluded that the state/territory peaks are effective engagers with mainstream but could further broaden that engagement, particularly by implementing partnerships and collaborative arrangements with Primary Health Networks (PHNs) to strengthen their influence on the mainstream health system.

The Review found a 'patchy' level of collaboration between the Commonwealth and the state/territory governments in relation to their investment in the peaks. While the tripartite partnerships between the Commonwealth and state/territory governments and the state/territory peak bodies have been in place for 20 years, they vary in effectiveness and many are no longer generally considered effective. The Review considers that the Commonwealth, in consultation with the state/territory governments and the state/territory peak, should reconsider the brief for the tripartite forums and either dismantle them or

ensure a clear purpose or need. This might include clear secretariat arrangements, the negotiation and monitoring of a forward plan for the relevant state/territory peak body or joint monitoring of outcomes, given the increased integration of state/territory funding for the peaks. Improved collaboration between the two levels of government is an important precursor to increased effectiveness of the tripartite forums.

Services in difficulty

The Review has found that a change to the way the Commonwealth invests in Services in Difficulty, by placing NACCHO and the state/territory peaks in a more hands on role, is likely to produce more effective outcomes. The state/territory peaks work with ACCHOs to strengthen their capability and as far as possible prevent major problems arising. There are, however, radically different views within the sector about the role of the peaks to intervene with ACCHOs. Some see it as their responsibility, and important to the reputation of the sector as a whole. Others argue that the principle of local community accountability and control is an over-riding consideration that means they should not intervene unless invited. In other cases, there is a conflict of interest (due to familial connections) that precludes involvement.

The Review is strongly of the view that this issue needs to be dealt with within the sector peaks and that it is in the sector's interests for some combination of state/territory peaks and NACCHO to act decisively in these cases. Under a new model proposed by the Review, the Commonwealth would share information about services of concern with NACCHO and the relevant state/territory peak and the state/territory peak would be given the first right of refusal in assisting that peak. Funding currently used by the Commonwealth to bring in administrators or other external assistance could be retained as a pool to fund the agreed way forward.

NACCHO

As the national peak body for the Aboriginal community controlled health sector, NACCHO has a key role in the health system response to improving Aboriginal and Torres Strait Islander health outcomes in order to achieve the Close the Gap targets. While this role is primarily as the voice of the Aboriginal community controlled sector, NACCHO also plays a broader role, in representing and influencing national health policy in relation to the Aboriginal and Torres Strait Islander population.

NACCHO's policy role is in high demand from the Commonwealth and other national players. NACCHO has built productive partnerships with national healthcare organisations and has been instrumental in a number of significant reforms that improve the capacity of services to respond to Aboriginal and Torres Strait Islander health challenges. NACCHO is valued by the sector for the vital role it can play in representing the sector to government and other national players. There is an ongoing need for NACCHO to continue to deliver gains into the future.

The recent period has been a difficult time for NACCHO, which has been without a CEO for most of the Review. Feedback to this Review about the effectiveness of NACCHO has been mixed. NACCHO's engagement with key influential organisations and mechanisms has been seen as 'patchy', with NACCHO absent from some tables where their presence is of considerable importance, both practically and strategically. Sometimes NACCHO's assessment of priorities may differ from mainstream bodies due to a lack of resources to engage. Nonetheless, the Review found that NACCHO suffers reputational damage from this issue that it needs to address. Through a strong ongoing focus on its national role, NACCHO can build its effectiveness in bringing information and evidence to achieve better outcomes.

As a relatively small peak body, NACCHO has struggled at times to attract and retain the high level skills and expertise demanded by its role. The Review has noted the current strategic approach under the new CEO to make better use of the deep expertise that lies across the sector as a whole and to engage fully with key advisory groups to government. The Review encourages the Commonwealth to ensure that its investment supports such flexible use of resources and encourages high level capability within NACCHO.

The National Network

The ACCHO sector is not unique in struggling to address the split of health responsibilities across the health sector in Australia's federal system of government. The existence of separate peak organisations at the state/territory and national levels is the result of history and the way the sector developed. But the separation creates a range of issues for the effectiveness of Commonwealth investment (such as lack of joint ownership of policies and decisions, internal tensions, competition between the peaks) and has for a long time been the focus of a desire for reform.

The effectiveness of the network of peaks would be improved by clarity of roles. Playing to the strengths of each level, the state/territory peaks would be responsible for providing support and assistance to the individual ACCHOs in their jurisdiction and engaging with mainstream at the jurisdictional level while NACCHO would focus exclusively on its national policy role. Adoption of these roles by the peaks themselves as well as by the Commonwealth in its funding agreements would help to improve effectiveness. In addition, the re-branding all the peaks as 'NACCHO' might also assist in helping to unify the network.

This Review strongly recommends that the state/territory peaks and NACCHO work together to create a more effective national network. The Review is equally of the view that reform is unlikely to be successful unless it is driven from within. A number of options exist and it will require a careful process and strong leadership for the sector to be united and working relationships improved. While a number of options are feasible, the Review sees many benefits in NACCHO being governed by a small, skills based Board.

Commonwealth funding agreements

Feedback indicates that current Commonwealth funding arrangements are opaque and hard to navigate for all stakeholders. Funding for the peak bodies has been managed from the Commonwealth's state/territory offices and appears to have been somewhat ad hoc, based largely on history and politics, with funding for specific projects ebbing and flowing. The Review suggests a number of ways in which the funding contracts could be clarified and better targeted, including the Commonwealth more clearly delineating the roles and accountabilities it is funding at state/territory and national levels.

The Commonwealth has a multiplicity of relationships with NACCHO and the state/territory peaks, with the complexity for stakeholders considerably increased by the move of funding for drug and alcohol and social and emotional wellbeing to the Department of Prime Minister and Cabinet. Within the Commonwealth there appears to be a lack of a coherent policy framework to guide relationships and communications. There is a need for clarity on the Commonwealth's objectives in funding the peaks, and following from that a consistent set of steps to translate policy and objectives into funding agreements and reporting requirements.

The Review recommends that the use of a transparent and justifiable funding formula for the state/territory peaks would improve equity. Funding needs to accommodate growth in the number of ACCHOs the peak serves (or respond to a contraction) and ensure that the peak has the ability to service rural and remote ACCHOs. In relation to NACCHO, the Review suggests that Commonwealth investment needs to create incentives for the delivery of expert policy advice and also needs to be matched to the significant demands for engagement from across the Commonwealth Government and other stakeholders.

Given the difficulties that have at times been apparent across the national network, the Review suggests that investment in NACCHO undertaking a national coordination role across the state/territory peaks should not proceed unless there are clear and supported arrangements in place between NACCHO and the state/territory peaks that will enable the delivery of outcomes on behalf of the whole sector. Such arrangements could be by governance changes, or by contractual agreements, or whatever mechanisms for leadership of particular issues are transparently agreed between the state and national bodies.

To enable optimum effectiveness all the peak bodies need to be able to plan in advance, and have stability in funding. Short term funding cycles (three years or less), both at the State and Commonwealth level, inhibit the performance of NACCHO and the state/territory peaks particularly by making recruitment of

staff and longer-term investment problematic. Once the Commonwealth is satisfied that the organisation is well aligned to the needs of the sector and has the capacity to deliver against its funding agreement, greater stability could be introduced through three year rolling funding agreements.

The Review also recommends that performance monitoring be more outcomes based and streamlined to reduce the burden of activity level reporting. For the state/territory peaks performance monitoring could appropriately focus on the satisfaction of the ACCHO stakeholders, measured through a simple regular survey. In relation to NACCHO, the quality of advice delivered is a key indicator. The quality of NACCHO's engagement with other national bodies – both mainstream and Indigenous – could also be measured by a regular survey.

The need for clear and accountable funding arrangements does not diminish the necessity for a strong relationship between NACCHO and the Commonwealth Department of Health which facilitates progress in Aboriginal and Torres Strait Islander health. Throughout the consultations for this Review, the team was made aware of the critical importance of relationships of trust and the need for the sector to feel that the value and history of Aboriginal community control is deeply understood by the Commonwealth, at all levels.

The Review is of the firm belief that a strong working relationship between NACCHO and the Commonwealth is a necessary and critical element in improving the effectiveness of Commonwealth investment in the peak bodies. An effective relationship will be characterised by principles of respect, some shared objectives and mutual understanding of the principled positions of both parties. Optimal results will be produced when the Department demonstrates respect for NACCHO's national role in representing the Aboriginal community controlled health sector and NACCHO accepts that it is not the only voice that will be heard on Aboriginal and Torres Strait Islander health.

In keeping with this perspective it would be sensible for the Department to develop a structured engagement with NACCHO (such as an MOU) in addition to any expert advisory forum it wishes to establish (which could be expected to include NACCHO as well as other expert voices).

A focus of the structured bilateral relationship would be agreed priority issues that the parties will address each year. It might also be a useful forum to help build understanding of government and public service context on the one hand, and awareness of the community control philosophy on the other. A stronger mutual understanding is a key mechanism to improving the health outcomes of Aboriginal and Torres Strait Islander people.

Process of the Review

The Review has been guided by the Review Advisory Forum (RAF) which has representation from the National Aboriginal Community Controlled Health Organisation (NACCHO), each state and territory peak body, and (for the first two RAF meetings only) the Commonwealth Department of Health. The RAF has met four times and considered the overall structure of the Review, the questions to be asked of all stakeholders, and the draft findings. Their input has been a major guide in shaping the Review and its recommendations. Nous has also been guided by a team of Indigenous Advisors who have attended consultations, RAF meetings and provided input to this report.

The Review began its work with the Commonwealth, NACCHO and the state and territory peak bodies with a documentary review of Annual Reports, business and action plans, reporting documents, funding agreements, prior evaluations and the like from government and each organisation to provide background. It then employed a variety of methodologies to gather feedback from NACCHO and each state and territory peak body, ACCHOs, Primary Health Networks and Commonwealth, state and territory health departments and other interested stakeholders.

ACCHOs and Primary Health Networks were invited to participate in online surveys. These surveys asked for respondents' perceptions of the extent to which their jurisdictional peak body and NACCHO are effective in providing member support and representation to mainstream health services; and how effectively the state/territory peak bodies and NACCHO function as a network. Respondents were asked to rate effectiveness of member support on a five point scale with 'Very effective' and the top and 'Very ineffective' at the bottom. They were also asked to nominate areas in which they need further support.

Interviews were conducted with NACCHO and state and territory peak Boards, CEO's and staff, and CEOs of a small group of ACCHOs from each state and territory. Further consultation was undertaken with Commonwealth and state health department officials, Prime Minister and Cabinet Department (federal) and a range of stakeholders who interact with the state peaks and NACCHO.

All stakeholders were also invited to put a submission in to the Review. The submission asked for feedback on the performance of the state and territory peak bodies and NACCHO, and for any other comments. NACCHO and all the state and territory peak bodies provided a submission.

A full list of stakeholders consulted for the Review and membership of the RAF is at Appendix B on page 57. The methodology and results of the survey of ACCHOs and Primary Health Networks is at Appendix D on page 59.

In addition to the overall Review report, Nous was also engaged to provide reports on each state and territory peak body and affiliate, and NACCHO. These reports are to be provided to the Department, and the peak body that is the subject of the report. They are not shared more broadly across the sector.

1 The Aboriginal community controlled sector is a critical part of the Australian health system

The Aboriginal community controlled health sector is the biggest single provider of health care services to Aboriginal and Torres Strait Islander people, with over 250,000 clients and delivering 2.1 million episodes of care in 2012-13[1] and is therefore critical to improving the health outcomes of Aboriginal and Torres Strait Islanders. The trusted position that Aboriginal community controlled services occupy for many Indigenous families and communities provides these families, many of whom have complex and chronic conditions, with access to culturally appropriate and high quality comprehensive primary health care. Support for this sector is a key plank in improving health outcomes for Aboriginal and Torres Strait Islanders and in achieving the Closing The Gap targets.

The community controlled health sector, NACCHO, and the state/territory peak organisations that support it, has arisen from deeply held values of self-determination and a distrust of government. It is in this context that the Review of the roles and functions of NACCHO and the state/territory needs to be considered. Whilst there are capacity issues within the sector, and these can present challenges, NACCHO and the state/territory peaks play an important role in ensuring the sector continues to provide high quality health services to Aboriginal and Torres Strait Islander families. The state/territory peaks also play a key role in representing the sector to government and to the mainstream health system and are often the key source of 'grass roots' advice on matters affecting Aboriginal and Torres Strait Islander health.

This section of the Review report provides context for the role that NACCHO and the state/territory peaks play in the Australian health system.

1.1 Aboriginal community control delivers positive health outcomes

There is good evidence that Aboriginal community controlled health services contribute to health outcomes. ACCHOs deliver high engagement rates for Aboriginal and Torres Strait Islander clients, which mean that health conditions are more likely to be identified earlier, and the clients are more likely to complete treatment. This leads to better health outcomes.

ACCHOs reach people who are uncomfortable in mainstream settings. They provide a culturally safe alternative that provides people with choice over service delivery so that many Indigenous people receive healthcare who otherwise wouldn't. Winnunga Nimmityjah Aboriginal Health Service in the Australia Capital Territory, for example, serves approximately 74% of the Aboriginal and Torres Strait Islander people living in the ACT. In 2014-15 this was over 4,400 clients[2]. One of the key reasons for high levels of engagement with ACCHOs is their practice of employing comparatively high proportions of Aboriginal and Torres Strait Islander staff (54% as at June 2013)[3].

On health outcomes, the Australian Institute of Health and Welfare's 2013 *Healthy for Life* Report Card identifies particular issues for which ACCHOs have performed well in improving health outcomes: in the testing and treatment of Type 2 diabetes and coronary heart disease, and increasing the consistency of antenatal care and raising the average birthweight of Indigenous babies across Australia (which is correlated with a range of other health gains) and increasing the immunisation rates for vulnerable people against the flu. [4]

[1] Aboriginal and Torres Strait Islander Health Performance Framework report 2014: detailed analysis, AIHW http://www.aihw.gov.au/indigenous-australians/health-performance-framework/

[2] http://www.winnunga.org.au/uploads/docs/Winnunga_Annual_Report%202014-15.pdf

[3] *Ibid*.

4 http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129543587

1.2 History and culture are integral

The values, attitudes and behaviours of the Aboriginal community controlled sector are steeped in an historical lack of engagement with Indigenous health from mainstream service systems, the political concept of self-determination, and the direct adoption of the concept of comprehensive primary health care. A brief explanation of each of these is provided below.

Aboriginal community control grew out of historically poor provision of health services to Aboriginal and Torres Strait Islander people

The Aboriginal community controlled health sector goes back to the 1970s. The sector was built because communities did not have access to a quality of healthcare that was responsive to their needs. The sector has grown to develop its own representative bodies and call upon health service providers and governments for effective policy and programs that meet the health needs of Indigenous communities. Great gains in mainstream engagement have been made over the years however the greatest single number of Indigenous people and families continue to seek their primary health care from ACCHOs.

Self-determination is at its core

The values of self-determination are a key plank for the Aboriginal community controlled sector. The politics of self-determination was stimulated significantly by the campaign for the 1967 Constitutional change – which spurred Aboriginal movements and service organisations around health, law and land. These politics inevitably widen the front of issues about which the sector engages with government. These range from core health care and health strategy issues, to issues that relate to the 'social determinants of health', i.e. issues outside health care but impacting on health outcomes.

A degree of ongoing frustration with governments and with the mainstream health system continues within the sector. This is highlighted in the following quote from a Review Advisory Forum member:

> *Regardless of how much work we do it's not being heard and it's not being understood. Aboriginal community control is around the culture, the beliefs, and the values that are enshrined in the service delivery. These are not enshrined in mainstream services, and mainstream services don't have the key to the door into Aboriginal communities.*

The importance of understanding this core concept was recently acknowledged by Prime Minister Malcolm Turnbull in his 2016 Closing the Gap speech where he emphasised Dr Chris Sarra's advice to

> *do things with Aboriginal people, not to Aboriginal people*[5]***.***

The sector is based on the premise that comprehensive primary health care services are most effective

The health needs of Aboriginal and Torres Strait Islander people are often complex, and likely to need a range of interventions. Aboriginal community controlled health services adopt the premise of worldwide thinking about comprehensive primary health care[6]. This thinking positions comprehensive care as the best strategy for addressing the health of disadvantaged populations suffering both excess burdens of infectious disease and emerging 'diseases of transition' (non-communicable chronic diseases).

The effectiveness of these foundations of culture, social issues and comprehensive care is reflected in the following quote from an external stakeholder consulted during this Review:

> *The Aboriginal Community Controlled Health Organisation (ACCHO) model of care, which focuses on the delivery of comprehensive primary health care, is best placed to provide both culturally safe and clinically appropriate health care for Aboriginal and Torres Strait Islander people.*

[5] in Turnbull, M. 'Speech to Parliament on the 2016 Closing the Gap Report' delivered on 10 February, 2016 http://www.malcolmturnbull.com.au/media/speech-to-parliament-on-the-2016-closing-the-gap-report

[6] WHO. 1978. Declaration of Alma-Ata. http://www.who.int/home-page/

1.3 The focus of dialogue must be improving healthcare outcomes

The politics and debate around community control are realities to deal with as Australia strives to improve the health outcomes of its first peoples. The definition of Aboriginal community control has become a subject of discussion as new models of community engagement are successfully developed in parts of Australia. This Review does not take a view on the definition of Aboriginal community control – that is an issue for the sector. This Review does however note that while there are a growing number of different service models that engage effectively with Aboriginal and Torres Strait Islander people, the ACCHOs remain fundamentally important in meeting the health needs of Indigenous Australians.

The politics can be a very real distraction from the primacy of healthcare – for both the sector and governments. Once the history and politics are better understood in context they can become less distracting so that the focus remains firmly on supporting ACCHOs to deliver better health care.

This stance is also reflected in the quote below from an external stakeholder:

> *Notions of community control are valid and should be supported and resourced adequately if true change and a close of the health gap is each to be realised…Politicising these issues is ineffective and will only led to the status quo being maintained.*

1.4 NACCHO and the state/territory peak bodies play key roles for the sector and for the health system

There are over 140 individual ACCHO members incorporating urban, rural, remote and very remote Aboriginal Community Controlled Health Organisations across the country. The role of NACCHO and the state/territory peak bodies in supporting this ACCHO sector can best be understood with reference to the literature about peak bodies. As part of this Review, the review team undertook a literature review of peak organisations across Australia (see Appendix E). The literature gives useful insight into the two overarching roles of peak bodies: the inward-looking role (support to members) and the outward-looking role (representation).

The literature review highlighted that in the Australian context, peak bodies that represent disadvantaged groups play an important role in broader representation of the community or sector in which they operate. Not only do peak bodies therefore represent the organisations which are members, they also ensure the voices of the poor and marginalised are heard within the democratic process[7].

While business and professional bodies have traditionally had the means and access required to represent their interests within the policy process, community development groups have historically not had sufficient resources to meaningfully contribute the views of their sectors in the policymaking process. Funding community based peak bodies offers a method for providing a counter-weight to these groups.[8] Both the 1991 HORSCA review and the 1995 Industry Commission reviews that related to peak bodies found their role to be both valuable and appropriate. For example, the HORSCA report found that "the funding of peak community organisations ensures that the needs and aspirations of significant sections of the community are accessible to Government"[9].

The Australian Institute of Family Studies provides a useful summary of possible barriers to successful Indigenous community managed programs, where peak bodies can be important in facilitating success. Barriers to effective management of programs and services by Indigenous communities can be considered

[7] See Appendix E; Literature Review

[8] Clark, A. & Pisarski, A. (2015) "Peaking over the Horizon", *Parity*, 28 (8), 32-33, p.33

[9] HORSCCA(1991) ' You Have Your Moments: A Report of the Funding of Peak Health and Community Organisations', Canberra, AGPS., p.17

in relation to internal factors, such as the infrastructure and skills gaps that may exist to successfully deliver services, and the external factors, such as the policy environment, quality of relationship with government and commitment of external agencies[10].

This Review will focus on ways that the Commonwealth's investment in the peak bodies for the ACCHO sector can strengthen the impact and effectiveness of the sector and so contribute to improving health outcomes.

Findings:

F1. Community controlled health services play an ongoing critical role in improving the health outcomes of Aboriginal and Torres Strait Islander people.

F2. Awareness and understanding of the history and achievements of the sector is important context for governments and mainstream services in seeking to maximise health outcomes for Aboriginal and Torres Strait Islander people.

F3. NACCHO and the state/territory peak bodies represent community controlled health services, and therefore have a key role to play with the ACCHO sector and in influencing the mainstream health system.

[10] Australia Institute of Family Studies (2015) What works in effective Indigenous community-managed programs and organisations, CFCA Paper, 32

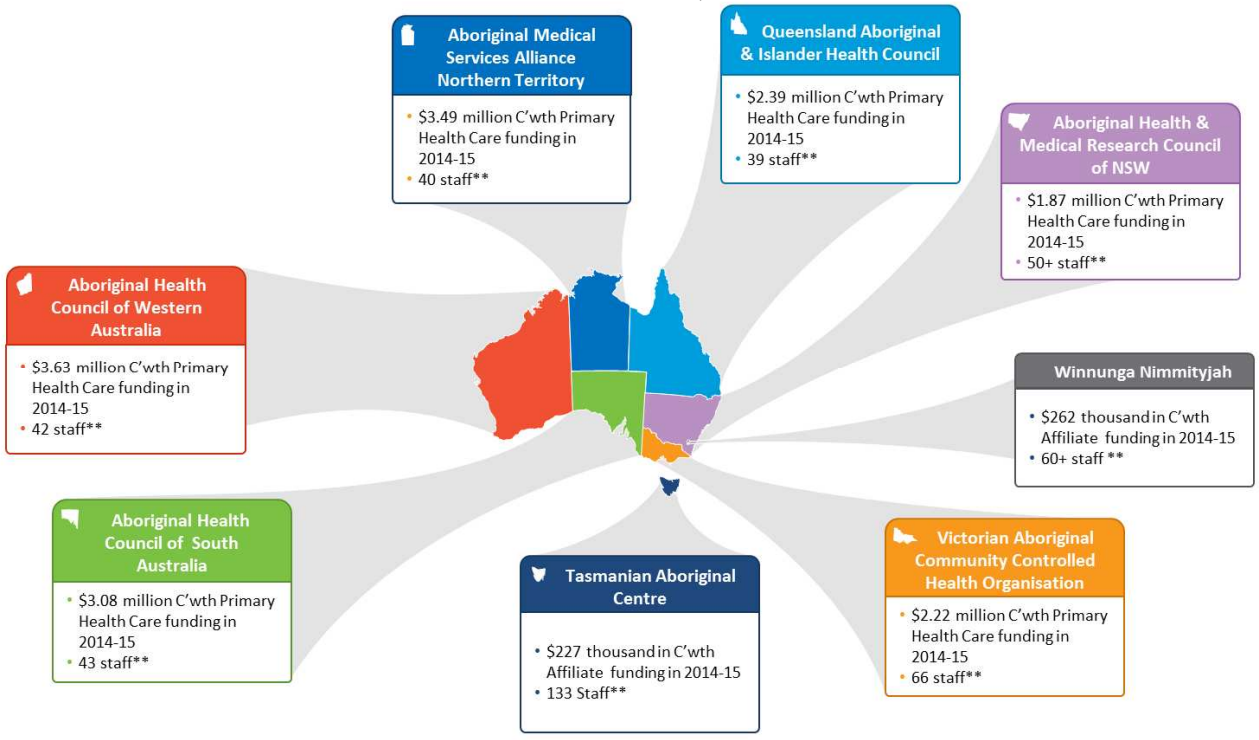
2 The state/territory peaks provide support to ACCHOs and work with mainstream health

This section of the report responds to the Review Objectives that relate to the state/territory peaks[11]. Section 4 deals with these same Review Objectives in relation to NACCHO. Each state and territory has a peak organisation that works with and on behalf of the ACCHO members in that jurisdiction. Six of these peaks are separate organisations that deliver services to a range of community controlled services in that jurisdiction and represent the sector externally. The peak bodies for the ACT and Tasmania are not separate organisations – the peak role is added to the role of an ACCHO in those jurisdictions.

In some cases membership of the state/territory peaks is broader than the membership of NACCHO. This is because some ACCHOs who are members of the state/territory peaks do not qualify as members of NACCHO, based on the definition of community control or of comprehensive primary health services (for example, drug and alcohol providers are also serviced by the state/territory peaks).

These state/territory peaks are diverse organisations and many receive substantial funding from the relevant state/territory as well as the Commonwealth government. Most organisations also receive funding from other sources such as peak bodies, research bodies and not-for-profit organisations and some receive fee-for service income.

Figure 1: Commonwealth funding for each State/Territory State peak body*



*Based on information provided by the Commonwealth Department of Health. Amounts include funds for the PHC Base for Peak Bodies and Programme Specific funds, TAS and ACT are Affiliate funding only and exclude the PHC Base for Service Delivery. All figures are GST exclusive.

**Represents the total number of staff. Funding for some of these positions comes from a range of sources.

[11] The matrix of review objectives refers.

2.1 The activities of the peaks respond to jurisdictional needs

The state/territory peak bodies provide tailored support to build the capacity of ACCHOs in their jurisdiction to deliver high quality comprehensive primary health care on a sustainable basis. To achieve this, ACCHOs need to be able to run a stable organisation that complies with the conditions of their funding agreement, and stay abreast of developments in comprehensive primary health care.

The Review was provided with an external analysis undertaken in February 2014 of over 350 documents relating to the activities of the peak bodies[12]. This external analysis found that all organisations reported activity in the following areas:

- support services for members (e.g. governance, ICT, accreditation)
- support for primary health care (e.g. improving clinical services/CQI, chronic disease planning and care, health promotion)
- policy and advocacy
- workforce development
- education and training
- linkages and coordination

The Commonwealth invests in these areas of activity state across four domains:

1. Improving System-wide clinical and public health initiatives and business systems
2. Improving member organisations' capacity and capability
3. Engagement with Government and key stakeholders
4. Building a skilled and sustainable workforce

The 2014 analysis describes a range of different activities funded for each peak, with broad commonality but also differences, partly as a result of the contracts being managed separately by the state/territory offices of the Commonwealth. The analysis found that many projects and activities appear to be national in scope and implemented across jurisdictions. As an example, most peaks are providing support to members for national eHealth initiatives, for implementing new national workforce initiatives, and for implementing aspects of the Indigenous Chronic Disease Package (ICDP). Peaks also appeared to be acting as a first port of call for members for any assistance relating to management issues (eg ICT and information management, human resources and governance).[13]

In two of the larger, more geographically diverse jurisdictions (Queensland and WA) regional organisations have also been established, with support from state/territory governments. The growth of regional bodies like the Institute of Urban Aboriginal Health (IUAH) in Queensland is a positive move as they are demonstrating they are can develop closer relationships with their ACCHOs in terms of assisting with sound business models and enabling closer future planning based on regional data sources. The work being done by IUAH is also providing leadership to urban ACCHOs in other jurisdictions who are picking up their population data and methodologies. This has led to at least one ACCHO putting clinics closer to those concentrations of community to ensure that the needs of local communities are better addressed. Danila Dilba in Darwin has done this after expert population analysis demonstrated that the majority of community live in Palmerston and the second largest concentration live in the northern suburbs of Darwin - they have now started clinics in both locations.

The Review was also advised that a network of regional CEOs in NSW that operates outside AHMRC (and includes at least one service that is not a member of NACCHO or AHMRC) is proving a very effective mechanism for regional development. Further development at the regional level is likely to have an

[12] Urbis, February 2014, NACCHO and affiliates document review, Department of Health.
[13] *Ibid.*

ongoing positive impact on services at the community level. However it is important that these regional bodies not be interpreted as competition to the state and territory peak bodies, as there is still a need for a centralised presence in each jurisdiction. Rather they add value to the support provided to ACCHOs by being geographically closer and better able to provide regular services.

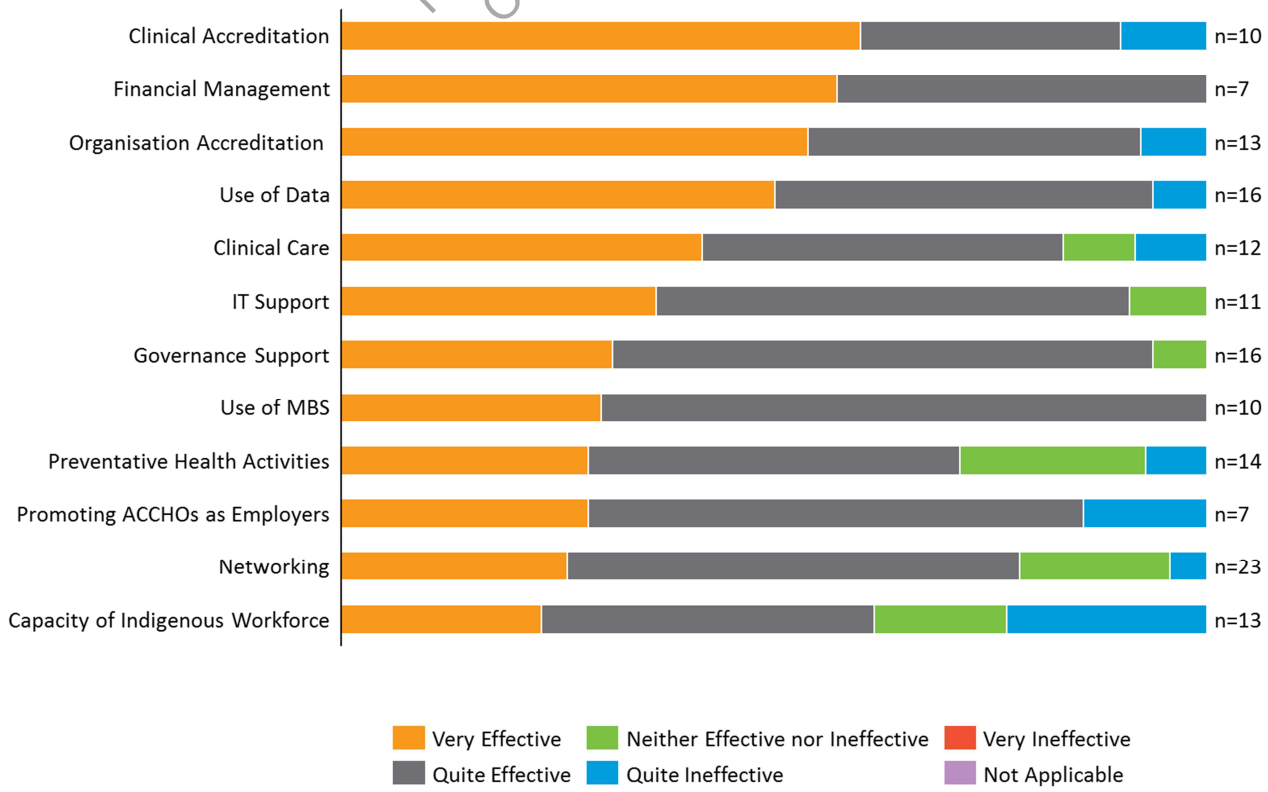
Many of the state peaks do not distinguish between their state and Commonwealth funding and funds are often leveraged to ensure the best value for their members. In addition to their "core" funding, state/territory peaks are also provided with funding for specific additional programmes, for example the Ear Health Coordinator programme or regional grants for the Tackling Indigenous Smoking programme.

2.2 The state/territory peaks are valued for their role in strengthening the state-based ACCHOs

Feedback to the Review from ACCHOs, state and Commonwealth governments and external stakeholders was that the state/territory peak bodies are generally well regarded by the sector and the mainstream system, and play a valuable part in the response to Aboriginal and Torres Strait Islander health.

The Review sent a survey to all ACCHOs asking for feedback on the usefulness of their peak bodies' delivery of accreditation (organisational and clinical), continuous quality improvement, governance support, information systems, networking, use of data, IT support, access to MBS and PBS, financial management, delivery of better clinical care, delivery of preventive health services, capacity of Indigenous workforce and promoting ACCHOs as employers. The feedback gained through the survey can only be regarded as indicative due to a middling response rate, and many surveys being only partially completed.

Figure 1: ACCHO satisfaction with peak body services



In terms of specific services provided by peak bodies, respondents considered governance support, support in utilisation of data, IT support, and improved financial services as being particularly effective. Respondents identified services to support better delivery of clinical care and preventative health activities (including communicable disease) as areas in which they would like further support. Respondents considered services to support the capacity of their Indigenous workforces as particularly in need of development. Almost a quarter (23%) of respondents suggested this service was quite ineffective. Increased support for workforce development was expressed in two ways – the need for more workforce training, and in promoting ACCHOs as employers.

Improvement in capacity to collect and utilise health data was also identified as an area where many ACCHOs need further capability development. This is clearly not the sole responsibility of peak bodies. However, it is a major barrier to both improving health services, and demonstrating the achievements of ACCHOs.

2.3 The state/territory peaks deliver services to a highly diverse and dispersed group of ACCHOs

The survey and consultations raised a number of challenges for peak bodies and the ACCHOs they support.

The first of these is the uneven level of development across ACCHOs, which demands a varied response from state and territory peak bodies. Some ACCHOs are large, competent multi-functional, multi-site organisations. Others are very small and much more marginal. Some stakeholder feedback expressed concern that the gap between these high and lower functioning organisations is increasing over time. Member support and representation from peak bodies is only one aspect needed to support any service, however it is evident that these services need significant support if they are to build their capacity.

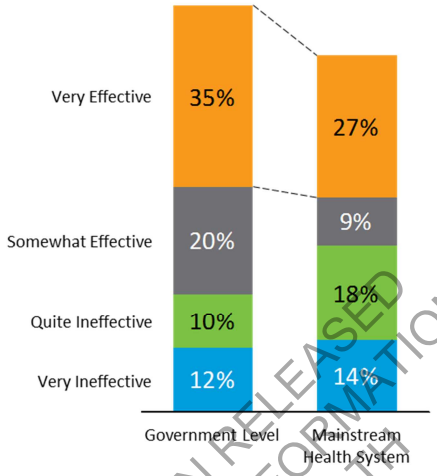
The different member organisations and their various capacities need different types and levels of support at different times. It is not surprising therefore that one of the most common themes in the feedback from ACCHOs was a perceived lack of consistency in the level of support provided for individual ACCHOs. Some ACCHOs felt that their state or territory peak body could be more transparent with the decisions on where to allocate support resources. There was some feedback of a perception of particular services consistently receiving lower levels of support. Some felt that their remoteness meant that they received a lower level of service.

A second challenge is for peak bodies to make sure that ACCHOs are aware of the support services they offer. Some ACCHOs reported that they would like to receive services on particular functions (such as better delivery of clinical care) where their peak body has responsibility to provide member support. However, they were unaware that this service was available. Staffing changes may mean that this information needs to be continually communicated.

2.4 The state/territory peaks play an important role in working with the mainstream

State/territory peak bodies play two key roles in working with the mainstream health system. Firstly, they represent the interests of their members in particular local scenarios, and secondly they speak on behalf of broader Aboriginal and Torres Strait Islander needs at the jurisdictional level. Feedback via the ACCHO survey suggests that members feel they are reasonably effectively represented at the jurisdictional level.

Figure 2: ACCHO satisfaction with peak body representation



For further information on ACCHO satisfaction with individual services provided by state/territory bodies see Appendix D.2 on page 63.

Consultation with the state/territory peak bodies indicates that they are in high demand to participate in a range of committees and initiatives with mainstream health organisations. Almost all the state/territory peaks reported that they do not have the capacity to meet the demand for their input, with many reporting that they are involved in over 40 different streams of engagement on a range of issues. An example of the gains from such engagement is the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) working with Diabetes Australia – Victoria to enable the training and supporting of Aboriginal Health Workers to deliver the 'Road to Good Health diabetes prevention program. While these connections often deliver gains, within current capacity it is difficult to see how the state/territory peaks can put additional resources into this function.

Another area of mainstream relationships is with the Primary Health Networks (PHNs). This will be a vital area in which the state/territory peak bodies need to devote scarce resources. The PHNs are tasked with commissioning services in their local area. This includes some programs targeted to the Indigenous population.

The state/territory peak bodies are particularly concerned with this decision. While the peaks will be able to respond to funding or commissioning rounds managed by the PHNs, they regard this approach as a breach of trust with the sector and an abandonment of the unique role and status of the ACHHOs. They are also concerned with the trend of PHNs setting up Indigenous units to address service delivery targeted to Indigenous population. Their concern is that these units have no accountability to the community, and may result in a diminution of community engagement and control.

The PHN survey demonstrated that formal relationships between the ACCHOs and/or state/territory peaks and PHNs are still at early stages and engagement is uneven across the sector. Some PHNs plan to establish stronger links. It is important that the state/territory peak bodies also prioritise the creation of stronger links.

There is clearly a need for the state/territory peaks to drive engagement with the PHNs in their region – the state peaks can be a key mechanism to ensure effective services are commissioned. An interesting development is AMSANT's level of involvement with their PHN. They are a one third shareholder in the single PHN in the Northern Territory. This gives them significant leverage to influence decisions made, and argue for the benefits of channelling funds to the community controlled sector.

As the above example demonstrates, there are important gains to be made through liaison with mainstream health. The Review is of the view that state/territory peaks need to prioritise collaboration and coordination with state/territory health departments. The challenge of the state/territory peak bodies is to balance their investment in this area of their operations, with their member support functions.

2.5 The environment in which the state/territory peaks operate is increasingly complex

Many stakeholders consulted throughout the Review identified the funding and policy environment as more confused and disrupted than they could remember. They cited the changes associated with the funding cuts, the Indigenous Advancement Strategy, the move of some aspects of comprehensive primary health to Prime Minister and Cabinet, the creation of PHNs and the channelling of Indigenous health funding through the PHNs as examples of disruptive change which called for rapid responses and change management across the sector.

Another issues regularly identified by the state/territory peaks was the somewhat ad hoc nature of Commonwealth investment and the need for a more stable platform to allow the state/territory peaks to tailor their programs of support, with funding currently "coming to an end" in December 2016.

Survey feedback also identified an "increasingly complex and debilitating" funding environment within the Commonwealth, and several bodies presented the need for the social and emotional wellbeing and drug and alcohol funding to return to the Department of Health. There were also comments that reporting requirements may be imposing an unnecessary burden on the sector, as reflected in outputs of the Lowitja Institute's Overburden Project.[14]

All of these factors add to the requirement that the state/territory peaks operate with effective governance arrangements and are able to recruit staff with a high level of capability to meet the demands. Capability is needed across several areas:

- Issues and trends in the delivery of comprehensive primary health care in order to deliver member support
- Health analysis and policy development
- An understanding of government functions and how to effectively influence them
- Good communication skills
- Knowledge of the politics and aspirations of community control

Evidence provided throughout the Review indicated that in most cases the state/territory peaks have a high level of capability for the demands placed on them. In general they have established effective governance boards and have found ways of strengthening their governance using skills based mechanisms (for example the sub-committees used by VACCHO).

[14] Dwyer, J., O'Donnell, K., Lavoie, J., Marlina, U. & Sullivan, P., *The Overburden Report: Contracting for Indigenous Health Services*: *Summary Report*, (CRCAH, Darwin: 2009)

Findings:

F4. The state/territory peak bodies provide effective member support services in many areas, particularly in the areas of governance support, financial management support and utilisation of data and IT.

F5. ACCHOs would like increased access to support, particularly in the areas of support to deliver better clinical care and preventive health activities, including workforce development and data capability.

F6. Demand for state/territory peaks to engage with mainstream health is very high and exceeds their capacity to engage.

F7. State/territory peaks are operating within an increasingly complex and demanding external environment that creates challenges in governance and staffing resources.

Recommendations:

R1. The state/territory peak bodies should keep members well informed of all the member support services they offer. They should also ensure that their member support resourcing decisions are transparent to all members by regularly communicating this and engaging with all ACCHOs in their jurisdiction.

R2. State/territory peaks are encouraged to place a high priority on their engagement with mainstream organisations, particularly PHNs. This could be done through implementing partnerships and collaborative arrangements that strengthen their influence on the mainstream health system.

3 Support for services in difficulty

All the state/territory peaks focus their efforts on assisting the ACCHOs in their jurisdiction to thrive as sustainable organisations delivering high quality care. There is a wide spectrum of circumstances in which ACCHOs need assistance in the running of their organisation. At one end is a need for low level intervention – for example one organisation in Victoria needed an accountant to attend their board meetings, whereas all they could afford is a book keeper. The relevant state/territory peak provided funds and a contact for an accountant to attend. This sort of assistance provided by the peak body prevents more serious problems developing, and has been a regular part of the role of state/territory peak bodies. All of the state/territory peak bodies provide some level of proactive member support services such as on the issue of governance. These services are intended to prevent ACCHOs from getting into difficulty.

At the other end of the spectrum are organisations in need of broadly based intervention to prevent them from failing, potentially leaving the user population without services. Risks to an organisation's financial viability can arise from a number of causes, including being de-funded as a result of incurring serious breaches to their funding agreement. Difficulties can arise because of health practice, financial management, conflicts of interest and legal or governance issues. Advice from the Department of Health indicates that a number of ACCHOs are in serious difficulty at any one time. The more serious end of this continuum is a difficult and contentious area for the sector.

All of the state/ territory peak bodies have some involvement in cases of serious 'service in difficulty'. However, there are radically differing views on the role of state/territory peaks and of NACCHO and on what the state/territory peaks are funded to do in relation to services in difficulty.

Some state/territory peaks are highly active, and have developed procedures which guide their approach. For example, AHCWA has expressed a culture of "not letting anyone fall on their watch" and provides different levels of support to services at risk of liquidity cash-flow or other significant service disruptions. AHCWA has taken this approach to services in difficulty since the financial year of 2010-11 and has assisted at least 5 services since that time, with the Commonwealth providing AHCWA with specific funding to facilitate the role it is playing with a particular service. At one point they provided an acting CEO for a period of six months to assist an ACCHO got back on their feet.

Another model that has been developed is the creation of a separate, but associated, business entity to provide services on a fee for service basis. For example, AH&MRC has a wholly owned subsidiary, AH&MRC Consultants, that provides fee-for-service specialised support products to members on a range of subjects. One of the aims of this is to build a viable model to provide responsive expertise and services. This model has been developed partly in response to what AH&MRC considers the lack of funding from the Commonwealth for this function. This model raises the need for clarity about where member support services end and the consulting arm begins, and what Commonwealth funding is intended to support.

Some state/territory peaks take a view that a single service going "off the rails" is a threat to the whole sector and they proactively intervene with such services. They see this as the whole sector insisting that one family member does not bring the whole family down. A number of these state/territory peaks are proud of having taken some difficult decisions to handle cases that have arisen and to prevent others.

Other state/territory peaks see such intervention as peak body overreach, given the priority they place on the principle of local community control. Moreover, the state/territory peak may have a conflict of interest (such as a board member being related to staff members at the ACCHO in question), or the ACCHO concerned does not want their state/territory peak to become involved. At stake here are two principles: the primacy of local community accountability and control versus the pragmatic shared interest in maintaining the good name of the sector and ensuring that individual service dysfunctions do not prejudice local communities of consumers.

The variability of the capacity or disposition of the state/territory peak bodies to respond to individual cases of services in difficulty suggests that there is a "back-up" role for NACCHO to ensure the provision of a consistent, high quality, response. NACCHO would offer independence, whilst still having knowledge of

the sector. Like the state/territory peaks, however, NACCHO does not appear to have a clearly articulated role in relation to providing assistance to services in difficulty. Some state/territory peaks have viewed NACCHO involvement in these cases as running a high risk of overreach, based on the local control principle. NACCHO has on occasions provided support to services in difficulty, and during consultations, the Commonwealth commented that officials have received useful advice from NACCHO on how to address the issues that arise.

Other feedback suggests that NACCHO does not have all the expertise needed to successfully intervene, depending on whether the nature of the difficulty is financial, governance or in relation to health service quality. There is likely to be a range of expertise required with a need for strong coordination of support.

Cases where the state/territory peak declines involvement, or is blocked locally from becoming involved, create a difficulty for the Commonwealth, as officials must then craft a response without local sector leadership. Consultation with the Commonwealth indicates that a consistent response to services in difficulty is currently a key unmet need for them. There is some confusion over the extent to which the response to services in difficulty is included as a part of the funding agreements between the Commonwealth and the state/territory peak bodies. The Commonwealth reports that they are included, and the state/territory peaks believe that the intensive support to services in serious difficulty (such as the provision of an acting CEO) is not included, and certainly not funded.

Under current ad hoc arrangements, the Commonwealth is often left to pick up the pieces. The sector would be better supported by a clear arrangement through which the state/territory peaks and NACCHO, develop an agreed response to provide services to all services in difficulty. Development of such a model approach is an area where NACCHO could take leadership, working with the state/territory peaks and the Commonwealth.

A range of considerations need to come into development of the model. In the first instance, some state/territory peaks argue that they are not notified by the Commonwealth when a service in their jurisdiction is at risk of, or in breach of, its agreement with the Commonwealth. There needs to be a clear flow of information if the state/territory peaks are to take early action or intervene when required.

The Review believes that the state/territory peak is the preferred vehicle for managing the necessary intervention in a service and that precedence needs to be given to the principle of pragmatic shared interest in maintaining the good name of the sector and ensuring that local communities are not left without services. On this basis, the state/territory peak should be the first port of call. Where conflicts preclude its involvement, or other considerations require broader involvement, there needs to be a clear yet flexible process to follow.

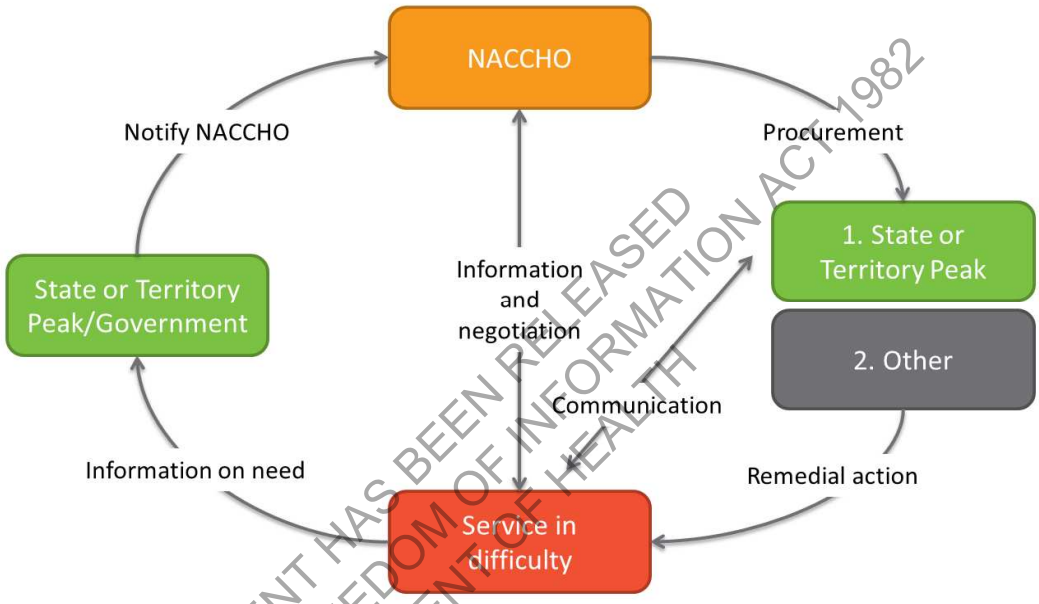
The Review suggests that a potential model for responding to services in difficulty would involve the following steps:

- Information on the need for intervention is received by either the Commonwealth (or state/territory government) and communicated to the relevant state/territory peak and to NACCHO
- NACCHO would function as the 'front door' for cases in which serious intervention is needed. NACCHO would contact the ACCHO and the state/territory peak to discuss the options for which organisation is best placed to deliver the support
- If the state/territory peak is able to support the ACCHO they are the first option to deliver services.
- If the state/territory peak cannot provide that support, NACCHO would have the role of identifying and engaging alternative service providers.
- Where the state/territory peak chooses not to be involved, or does not have the capacity to meet the need, choice of assistance would need to meet the following criteria:
    1. Knowledge of Commonwealth funding requirements

2. Knowledge experience of the community controlled health sector
3. The confidence of both the Commonwealth and the target organisation
4. Skills and ability to provide and implement acceptable solutions.

Such interventions are generally costly, and the state/territory peaks or NACCHO could not be expected to meet such costs from within their budget. They would need to be recompensed at the same levels as commercial operators, which are currently funded directly by the Commonwealth. NACCHO and the state/territory peak could either be funded by the Commonwealth on a case by case basis, or a flexible brokerage fund could be created to avoid the need for the generation of a new contract for each occasion. Figure 2 presents a potential model for a national response to services in difficulty.

Figure 2: Model for a national response to services in difficulty



Finding:

F8. State/territory peaks take different approaches to intervening in services in difficulty. Some take a strong active role and others are uninvolved in some instances for a range of reasons including conflicts of interest and the over-riding principle of local community control and accountability.

Recommendations:

R3. To strengthen the reputation and performance of the sector overall, the peak bodies together should take responsibility for delivering an active and coordinated role in assisting all services in difficulty.

R4. A new model of support for services in difficulty should be developed, with NACCHO playing a leadership role in development of a workable and flexible model and in ensuring support is in place. State/territory peak bodies should have first right of refusal to assist services in difficulty in their jurisdiction.

R5. Funding agreements need to clarify the extent of state/territory peak body and NACCHO responsibility for services in difficulty (within core funding).

R6. A discrete pool of funds should be identified and used by agreement of NACCHO, the relevant state/territory peak and the Commonwealth to provide assistance to services in difficulty on a case-by-case basis.

4 The Commonwealth and State/Territory Governments both invest in NACCHO and the state/territory peaks

The fifth objective for this Review seeks to understand how Commonwealth and state/territory investment interacts to address jurisdictional need.

As outlined in section 3 of this report, all of the state/territory peaks receive funding from state/territory governments as well as the Commonwealth. In theory, state/territory funding is aimed at "prevention" while the Commonwealth funds primary health care. The distinction is not necessarily clear or apparent. Further complexity in funding has been introduced by the split of Commonwealth funding across the Department of Health and the Department of Prime Minister and Cabinet (the latter being in relation to funding for alcohol and other drugs and social and emotional wellbeing).

The state/territory peaks advise that they use their total funds in an integrated manner, to leverage maximum effect by combining funds from different sources to meet the needs that arise. For this reason, their reporting does not always differentiate the sources of funds and the task of reporting to each funder can be time-consuming and arbitrary.

From the point of view of the state/territory peaks the leveraging of funding sources would seem to be effective practice. However there is a real opportunity for the state/territory and the Commonwealth to take a more holistic approach to funding the relevant state/territory peak so as to clarify aims and avoid duplication and gaps. The Review found evidence that there is inconsistency over time and across jurisdictions in how in state/territory and Commonwealth Governments seek to understand how their funding interacts. For example, the Northern Territory tripartite forum is currently used effectively to better align funding arrangements around CQI, and the New South Wales state government have worked closely with the Commonwealth to ensure there greater consultation between the two levels of government in relation to new funding. There are however instances and locations where this is less effective. The effectiveness of the state/territory and Commonwealth interactions and consultation around funding are highly dependent on individuals and/or the government of the day at both the State and Commonwealth level.

4.1 Commonwealth/state/territory peak tripartite mechanisms vary in effectiveness

The tripartite forums draw together the Commonwealth, state/territory governments and the relevant state/territory peak. They have operated since 1996/97 at a jurisdictional level. In some jurisdictions, PHNs are now also engaged as part of this forum[15]. The forum is intended to provide a vehicle for the jurisdictional peaks to provide health policy advice to the Commonwealth and State Governments, and to co-design the response to local health issues. They do not appear to have a role in understanding how the state/territory and Commonwealth funding agreements interact or how the state/territory peaks are performing.

In theory the tripartite agreements and the regular meetings that flow from them give the Commonwealth government a vehicle for influence on the response to Aboriginal and Torres Strait Islander issues at the state and territory level. In practice, most of the forums are not seen as useful or effective mechanisms, although their value varies across jurisdictions. All stakeholders reported that the meetings can lack purpose, and do not result in clear benefits for all parties involved. Often there are new participants at

[15] The Department of Prime Minister and Cabinet are now represented at these meetings.

each forum. Reports suggest that factors that assist them to work well are good knowledge and relationships between participants and good secretariat support.

Secretariat support involves gathering evidence, presenting position papers and formulating policy advice. Some state/territory peak bodies receive specific funding from their state government to provide secretariat support for these partnerships[16]. For other state/territory peaks, the way Commonwealth funding agreements are formulated means that it is difficult to tell if secretariat support services are intended to be included. Some state/territory peaks have commented that the funding received to participate in the partnership is not sufficient to support the policy work that is required for effective engagement in the forum. This was seen as a barrier to the effectiveness of the partnership according to one state/territory peak.

Feedback received during consultations with State and Commonwealth Government representatives have indicated that secretariat support provided by state/territory peaks in some jurisdictions does not adequately support the tri-partite agreement. In these cases this has resulted in ad hoc meeting agendas, low quality papers and inconsistent coordination of agreed actions. The introduction of formal work plans for the partnership in some states is effective in ensuring partnership activities are effective and are directed toward clear outcomes.

It seems likely that the productivity of the tripartite forums would be improved by all parties taking care to send consistent representatives so that meaningful relationships have a chance to develop. The quality of secretariat support is also very important. In the face of feedback from the state and territory peaks that they do not have the resources to provide high quality support, the meetings could be made less frequent. For example, regular meetings could occur twice a year, and more frequent meetings could be arranged to deal with specific issues.

Given the mixed feedback about the tripartite forums there is a need to either dispense with them or encourage them to flourish by re-energising them, and ensuring there is high quality secretariat support and careful attention to agenda-setting. The tripartite forums also need to provide the Commonwealth with an effective mechanism to understand how its investment is interacting with state/territory government investment.

Findings:

F9. The Review found evidence that collaboration between the Commonwealth and State/Territory Governments in relation to their investment in the state/territory peak bodies is patchy. This results in challenges for the peaks in planning and managing their funding.

F10. The effectiveness of the tripartite forums as vehicles for addressing jurisdictional need is mixed.

F11. Improved collaboration between Commonwealth and State/territory governments is an important precursor to the effectiveness of the tripartite forums.

Recommendations:

R7. The Commonwealth, in consultation with the state/territory governments and the relevant peak, should either dispense with or rejuvenate the tripartite forums where they have fallen away as a key joint planning mechanism.

R8. To rejuvenate the tripartite forums the Commonwealth and state governments should agree on a consistent approach (and funding) for secretariat to ensure there are formal work plans and clearer outcome reporting.

[16] Northern Territory, Victoria an South Australia.

5 NACCHO is an influential national voice

As the national peak body for the community controlled health sector, NACCHO has a key role in the health system response to improving Aboriginal and Torres Strait Islander health outcomes in order to achieve the Close the Gap targets. While this role is primarily as the voice of the community controlled sector, NACCHO also plays a broader role, in representing and influencing national health policy in relation to the Aboriginal and Torres Strait Islander population.

NACCHO's strategic direction is focused on three central areas consistent with its constitutional objectives:

1. Shape the national reform of Aboriginal and Torres Strait Islander health;
2. Promote and support high performance and best practice models of culturally appropriate and comprehensive primary health care; and
3. Promote research that will build evidence-informed best practice in Aboriginal and Torres Strait Islander health policy and service delivery.

NACCHO's members are the individual ACCHO services across Australia who conform with its definition of a community controlled health service. Members of NACCHO are all also members of the state/territory peaks, with the state/territory peaks playing a role of vetting individual services for eligibility for NACCHO membership.

NACCHO is governed by a sixteen member Board of Directors made up of one delegate each from ACT and Tasmania, two from the remaining six jurisdictions, a Chairperson and a Deputy Chairperson. NACCHO currently employs 17 full time equivalent staff. Its primary source of funding is the Commonwealth government with specific grant funding to implement projects supplementing NACCHO income from time to time.

5.1 NACCHO has delivered significant benefit to Aboriginal and Torres Strait Islander health

NACCHO is valued for the contributions it has made to improving policy and practices in relation to Aboriginal and Torres Strait Islander health. NACCHO has been instrumental in a number of key developments such as the early access for the Aboriginal community controlled medical services to MBS and PBS, and the development of the culturally resonant Social and Emotional Wellbeing Framework for mental health. There is an ongoing need for NACCHO to continue to deliver gains into the future.

Developing relationships with mainstream health agencies and peak bodies is a key strategic role of NACCHO. NACCHO has put a great deal of energy into projects with national bodies that are aimed at improving the quality of care provided to Aboriginal and Torres Strait Islander clients and these have driven significant gains for the sector.

An example of this is the Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islander People (QUMAX) program which delivers funding to ACCHO's for a range of strategies to overcome a number of barriers to the quality use of medicines. This program grew out of a successful pilot program between NACCHO and the Pharmacy Guild of Australia as part of the fourth Community Pharmacy Agreement between the Pharmacy Guild of Australia and the Australian government. It has been confirmed to run until 2016.

Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islander people (QUMAX)

The QUMAX program was developed by NACCHO and the Pharmacy Guild of Australia in 2006-2007, under the 4th Community Pharmacy Agreement. This program aims to remove barriers to quality use of medicines for Aboriginal and Torres Strait Islander consumers and improve culturally appropriate services through support for ACCHOs and Community Pharmacies.
This program commenced in 2008 with intensive quality use of medicine support in non-remote ACCHOs which included the provision of dose-administration aids, transport support and co-payment relief. Co-payment relief was recognised early as improving access to Pharmaceutical Benefits Scheme (PBS) medicines for Aboriginal and Torres Strait Islander people and was transferred to the Closing the Gap PBS co-payment relief measure. This program has been successful due to a two-way partnership between NACCHO and the Guild in supporting ACCHOs and Community Pharmacies to deliver services and address community needs.

A further example of a partnership that has delivered considerable benefit is the partnership between NACCHO and the Royal Australian College of General Practitioners (RACGP), which was solidified in a memorandum of understanding set to span from 2014-2017. Over the period of the Review, NACCHO has worked with the RACGP to ensure that the College's advice regarding clinical accreditation standards, and standards of clinical practice are mindful of the unique needs of Aboriginal and Torres Strait Islander clients. The RACGP has also partnered with NACCHO throughout the development of the fourth and fifth editions of its high profile Standards for General Practices manual. This publication not only made for improved standards for general practitioners that now take into account considerations of cultural safety and appropriateness for Aboriginal and Torres Strait Islander Australians, but has also enabled individual ACCHOs to access information regarding these standards in a way that takes account of their unique modes of service delivery.

NACCHO has also made considerable efforts to interact with and influence the PHNs. A formal MOU has been put in place between NACCHO and the Australian Hospitals and Healthcare Association (AHHA) which has been acting as the informal peak organisation for the 31 PHNs across Australia. In addition, NACCHO invested considerable effort in preparing the 'Guiding Principles' document to influence the way the PHNs interact with Aboriginal and Torres Strait Islander people. NACCHO expressed considerable disappointment that the Commonwealth had not mandated the Guiding Principles for the PHNs to follow.

NACCHO has a key role in representing the sector and in improving the understanding and benefits of Aboriginal Community Control. In this regard a particular initiative in which the Commonwealth and NACCHO cooperated was the development of the Report Card on "Healthy Futures", documenting the performance of the ACCHO Sector. NACCHO commissioned the Australian Institute of Health and Welfare to develop the analysis and publish the Report Card, with funding provided by the Commonwealth specifically for this purpose (NACCHO submission).

There is scope for further work in building productive relationships with mainstream health agencies and peak bodies. NACCHO reports that there is strong interest for it to be involved in a wide range of Committees and initiatives. They do not currently have capacity to meet this demand. This is unfortunate, as this area of their role offers the potential for excellent benefits for the sector.

NACCHO is uniquely positioned to gather and present high quality information on Aboriginal and Torres Strait Islander health trends and developments. This information can be used to drive the evidence base that will guide the implementation of practices to deliver ongoing health improvements. NACCHO's role in this process is to coordinate the process of transforming data into evidence, and evidence into policy advice. It then has a role to influence the Aboriginal community controlled sector, mainstream health providers and governments to adopt evidence based policy and practices. Finally, there is a need for NACCHO to lead the Aboriginal community controlled sector in issues such as their response to national health reforms, health emergencies, and the adoption of innovations in health practices.

5.2 NACCHO's role in building sector capacity needs to be clarified

Several respondents to the survey of ACCHOs undertaken for this Review commented that they were confused over whether or not the services they received were from their state/territory peak body, or NACCHO. This highlights a particular challenge in understanding how NACCHO contributes to sector capacity: there is a lack of clarity in the roles of NACCHO and the state/territory peaks. There does not appear to be a collective agreement as to whether NACCHO develops capability directly with its members, or by working through the state/territory peaks. The Review believes that NACCHO and the state/territory peaks need clearer roles in relation to development and implementation of nationally consistent resources that build sector capability. Without this clarity, there is potential for NACCHO's support to be duplicative or not as effective as it could be.

This lack of clarity is also mirrored by a lack of clarity in the Funding Agreement between the Commonwealth and NACCHO about what functions NACCHO is being funded to undertake (see Section 8).

In consultations for the Review stakeholders generally agreed on the need for a national role in developing the evidence and materials needed to underpin the provision of member support in fields such as specific health strategies, quality improvement and so on. If this role does not exist, each state/territory peak body needs to undertake the work from within its own resources. This is inefficient, and likely to lead to unequal and possibly lower quality results, as each body may not have the staff and expertise to devote to the task. The materials developed then need to be delivered by people who have local knowledge and understanding.

The state/territory peaks pointed to the example of NACCHO presenting a template ACCHO constitution and Charter of Governance which was distributed directly to ACCHO members and discussed at a national meeting of members and NACCHO. Many of the state/territory peaks felt this was not an effective way to support the members and that it cut across the role and processes that the state/territory peaks had in place with their jurisdictional members.

NACCHO plays a range of roles in strengthening the capacity of the sector. Of particular note is the coordination and facilitation role NACCHO plays in improving members' access to better data – for example through working with the Department to:

- Build a robust evidence base through nKPI reporting.
- Strengthen CQI through the Department's purchase of data analysis software.

5.3 Feedback on NACCHO's recent performance is mixed

The recent period has been a difficult time for NACCHO, which has been without a CEO for most of the Review. Feedback to this Review about the effectiveness of NACCHO has been mixed. NACCHO's engagement with key influential organisations and mechanisms has been seen as 'patchy', with NACCHO absent from some tables where their presence is of considerable importance, both practically and strategically.

It is fair to note that NACCHO would also point out that other sectors' engagement with them has also been patchy at times and that sometimes NACCHO's assessment of priorities may simply differ from mainstream bodies who they have not the resources to entertain. Nonetheless, the Review found that NACCHO suffers reputational damage from this issue that it needs to address.

As a relatively small peak body called on to make a major contribution to one of Australia's most persistent health and social challenges, NACCHO has struggled at times to attract and retain the high level skills and expertise demanded by its role. The Review has noted the current strategic approach to make better use of the deep expertise that lies across the sector as a whole and to engage fully with key

advisory groups to government. The Review encourages the Commonwealth to ensure that its investment supports such flexible use of resources and encourages high level capability within NACCHO.

It is the Review's observation that one individual accepting roles in both bodies not only places an unacceptably high burden on the individual involved but also has a high risk of generating perceptions of a conflict of interest, and is better avoided. It is important that, at least under the current arrangements that govern the relationships of NACCHO and state/territory peak bodies each to their member ACCHOs, NACCHO board members are seen to be independent of the state and territory peak bodies. This will enable that they can focus solely on providing the best possible advice to either NACCHO or their state and territory peak body.

These concerns have functioned to weaken confidence in NACCHO and lessen the authority with which it can represent its members. We note that the new CEO has a work plan that will deliver widespread consultation across the sector on the optimal roles and responsibilities for NACCHO, its governance structure and any related changes to the constitution. After a number of attempts the Review is strongly supportive of this latest effort to ensure that these concerns will be addressed. There is a sense of momentum toward internal reform of the business model, coordination mechanisms and network governance, which the Review sees as very positive.

5.4 NACCHO will deliver the best outcomes through focusing on its national role

As noted above, there is a long standing lack of clarity on NACCHO's role. It has become involved in some projects that are more normally the function of the state/territory peaks, such as improvements to ACCHO governance. This has fuelled tensions within the sector, as this style of project work positions NACCHO as a competitor with the state/territory peaks.

The Review takes the view that NACCHO is best placed to focus on work at the national level which is a more natural fit for its place within the Aboriginal community controlled sector, and where there is a real strategic need for work to be done. Commonwealth investment in NACCHO should reflect this focus.

There are four key areas in which the Aboriginal community controlled health sector needs to be active at the national level:

1. Using information from the sector to create an evidence base in order to drive improvements in the health response:
    - Use the data generated by the Aboriginal community controlled health sector to draw together an evidence base on specific health issues
2. Using that evidence to drive changes within the Aboriginal community controlled sector and in mainstream health practices
3. Developing strong productive relationships across government:
    - Analysing the current response to Aboriginal and Torres Strait Islander health and develop and present policy advice for improvement to government and mainstream
    - Representing the work of the Aboriginal community controlled sector so that future reforms recognise and value its contribution to health improvement for Aboriginal and Torres Strait Islander people
4. Delivering information to the sector:
    - Gathering information from the health sector on improvements and opportunities and deliver them to the state/territory peaks and NACCHO members
    - Customising health promotion and health specific messages so that they are appropriate for the Aboriginal community controlled sector
    - Coordinating the national response to health emergencies.

These roles are the ones where NACCHO is best positioned to ensure delivery of high quality outcomes, using the best resources from across the sector.

There are many on-the-ground activities that are also necessary to drive improvements in Aboriginal and Torres Strait Islander health. The quality of these activities will be strengthened when NACCHO delivers high quality advice across the sector. However, the state/territory peaks are generally best placed to deliver on-the-ground activities.

Findings:

F12. NACCHO has facilitated significant benefits to Aboriginal and Torres Strait Islander health through its policy development and partnerships with mainstream organisations. There is an ongoing need for NACCHO to continue to deliver gains into the future.

F13. NACCHO currently has a strong focus on clarification of roles and strategy which will help to strengthen their influence.

Recommendations:

R9. NACCHO is encouraged to prioritise its national level engagement with mainstream health and research organisations in order to deliver further gains for Aboriginal and Torres Strait Islander health.

R10. The four key objectives for NACCHO as the national peak should be:

1. **Using information from the sector to drive improvements in the health response**
2. **Using that evidence to drive changes within the Aboriginal community controlled sector and in mainstream health practices**
3. **Developing strong productive relationships across government**
4. **Delivering information to the sector.**

R11. NACCHO should be the prime source of national advice to the Commonwealth on the Aboriginal community controlled sector and should encourage the state/territory peak bodies to engage with each other and through NACCHO.

6 The effectiveness of the national network has been limited by the lack of a joined up approach

Australia's federal system, and particularly the split of responsibilities for health services between the states/territories and the Commonwealth, creates challenges for many organisations who operate across this space. NACCHO and the state/territory peaks are not unique in struggling to find effective ways of responding to these challenges.

Although NACCHO and the state/territory peaks share the same membership base, there is no formal affiliation between NACCHO and the 8 state/territory peaks. Each of the peaks – state, territory and national - is a separate organisation. There is currently no over-arching agreement about the relationship between them. The lack of shared policies or joined up governance creates a range of limiting factors on the effectiveness of the peaks.

The separate nature of NACCHO and each of the state/territory peaks is starkly represented by the absence of any joint ownership of policies or decisions across NACCHO and all the state/territory peaks. By way of example, Commonwealth use of the phrase *"NACCHO and its state affiliates"* led one state/territory peak to clarify to the Commonwealth that it is not affiliated with NACCHO – that neither body has control over the other. The state/territory peak pointed out that the only role that the state/territory peak plays is to formally 'vet' the ACHHOs for NACCHO – as the ACCHOs are members of both the state peak and NACCHO. The state/territory peak wrote to the Commonwealth Department of Health to explain this for them:

> *Xx is a jurisdictional peak NOT an affiliate. There are two xx Board Directors on NACCHO but that doesn't tie xx to anything NACCHO does. In summary, xx and NACCHO are aligned, they work together but there is no structural or hierarchical relationship. (NACCHO cannot sign off on something that commits xx).*

6.1 The degree of cooperation and collaboration across the national network has varied over time

Despite the clear structural separation of NACCHO and the state/territory peaks, they have demonstrated at various times over recent history that coordinated collaborative engagement between the state/territory peaks and NACCHO can produce real sector improvement. A particular example that NACCHO and the state/territory peaks identified during a Review Advisory Forum meeting was the Sector Governance Network:

Sector Governance Network (SGN)

In 2012 NACCHO received funding from the Commonwealth Department of Health and Ageing for a governance project in the sector. NACCHO established the Sector Governance Network (SGN) which was comprised of CEOs and chairs of each state/territory peak, supported by an SGN Coordinator. This group developed, unanimously endorsed and implemented National Governance Principles and Guidelines. The state/territory peaks were also involved in supporting their members to implement these governance frameworks.

The state/territory peaks reported that the SGN was a highly effective forum where participants openly shared resources that improved governance standards across member services. The program lasted two years, with the final report being tabled in June 2014 before Commonwealth funding ceased with a change of government.

Following the success of the program, some participants have continued to engage in an informal capacity and utilise the resources that were shared through the Network.

The Review was provided with a number of other examples of instances where the state/territory peaks have contributed expertise in the development of national responses to particular issues, including the documentation of core functions in primary health care, and proposed federal changes to the Australian General Practice Training. The following example demonstrates how this collaboration appears to have worked well:

> *In 2011 AMSANT led the development of the third edition of the core functions of Primary health care policy document which identified key gap areas in early childhood, mental health including alcohol and other drugs, family support and aged and disability services. Following on from this work in the NT, AMSANT is working through NACCHO towards securing agreement on the core functions of primary health care at the national level.*

The state/territory peaks and NACCHO pointed to a number of other examples of successful collaboration – including the Public Health Officers Network, and the policy network. While these have not continued over the recent past, they are being re-energised by a newly appointed CEO and NACCHO and the state/territory peaks are positive about working together more constructively in the future. In a joint submission to the Review, NACCHO and the state/territory peak bodies advised that the NACCHO Board has

> '*endorsed a project to out-source national projects, within the parameters of expertise within the State and Territory Peak Bodies, to ensure an effective and stronger working relationship between all our peak organisations*.'

Feedback from the survey of member ACCHOs indicated that the national network was generally considered to be effective, although the range was broad – i.e. ACCHOs in one jurisdictions rated effectiveness at 50% while in another it was rated as 90%. However, the surveys more clearly indicated a level of confusion about the roles and responsibilities of NACCHO as distinct from the state/territory peaks – in submissions a large number of ACCHOs noted they cannot properly define and separate the roles of these organisations. There were calls for clearer and more defined structures to capture input from state/territory peaks and individual members, to share information, and to represent members.

Feedback from other stakeholders, in submissions and interviews, revealed that the current structure and the lack of a governance model that supports clear roles is widely believed to have scope for improvement.

6.2 The lack of a clear relationship between NACCHO and the state/territory peaks can create confusion and a lack of collaboration

While there are successful examples of cooperative development over past years, the lack of a united voice has at times created tensions that potentially divide the sector as well as creating confusion for stakeholders. Feedback provided to this Review from a range of sources indicates that there is considerable unease within the sector as well as within government about the lack of structured coordinated arrangements. Tensions bubble over at times between the state/territory peaks and NACCHO and the Commonwealth is unsure how best to invest to achieve coordinated sector development.

Unhappiness from the state/territory peaks towards NACCHO has arisen on a regular basis over the years. In 2002 the facilitator of a NACCHO Board workshop concluded:

> *'It seems that there is role confusion and different priorities across the Membership, Affiliates and NACCHO Secretariat'*[17]

Consultation conducted suggests that there is unease about NACCHO'S governance arrangements. Some argue that the leadership of state/territory peaks (especially appointed CEOs) should not be representing their state/territory on the NACCHO Board, as that limits the ability of NACCHO to lead on issues of importance to the sector unless there is consensus among state/territory peaks. Some among those state/territory peaks are concerned about the danger of NACCHO overreach and the loss of local community accountability as the driving

One of the outcomes of poor internal collaboration is that change is not necessarily delivered through the most effective – or cost effective – means. Stakeholders cited the example of a CQI workshop as one where the lack of clearly delineated roles has reduced the effectiveness of sector development.

Poor internal collaboration on Continuous Quality Improvement (CQI)

The Review has heard feedback that there have been instances when NACCHO has not utilised the processes, networks and expertise at the State and Territory level, and instead sought input directly from ACCHOs. An example that was provided on this was a national CQI workshop coordinated by NACCHO and comprised only of attendees from ACCHOs. This is despite state/territory peak bodies have specific skills and expertise in this area - the peak bodies coordinate jurisdictional level network that includes ACCHOs and other members with relevant expertise. The Review has heard that this approach was criticised by state and territory peak bodies who felt that they were being bypassed, and unable to contribute their insights and experiences with a state level perspective.

In other examples, the lack of a jointly owned position among the state/territory peaks has created uncertainty and confusion.

[17] John Mero, Reprot of NACCHO Board Workshop, 2002

Challenges in creating a national position on CQI

The Commonwealth Department of Health commissioned the development of a National CQI Framework for Aboriginal and Torres Strait Islander Health Care. This was envisaged as a two stage program with initial synthesis and analysis of CQI activity and assessment of enablers and barriers to the development of a national network, followed by the development of a national CQI framework.

A consortium comprised of NACCHO, the State/Territory peak bodies, the Menzies School of Health Research, the University of Melbourne, the Australian National University, and the Lowitja Institute won the tender to assess if the first stage of this process would commence, and recommended that it did.

The development of the CQI framework was subsequently commissioned. NACCHO was invited to participate and is noted as a member of the consortium, but it was not involved in this second stage, due to a reported lack of capacity to contribute time and resources to the framework. The state/territory peaks continued to participate and were given funding to support CQI, while NACCHO requested a 'pause' to the process.

There have been barriers to the uptake of CQI including reporting requirements placing a burden on ACCHOs, a feeling that the intention was audit rather than improved outcomes, high staff turnover in some ACCHOs preventing relevant CQI knowledge being shared within and between organisations, and unclear understandings of the capacity needed for CQI data capture. Without a strong and united approach across the sector peaks, these messages have not been conveyed as effectively as they might.

From the evidence collected, the Review has concluded that the lack of joined-up governance across NACCHO and the state/territory peaks has been less than optimal for sector development. Without a clearly delineated relationship between the state/territory peaks and NACCHO, the Commonwealth cannot regard the advice it receives from NACCHO as advice on behalf of the sector. It also cannot rely on the relationship between NACCHO and the state/territory peaks to deliver coordinated sector change. As a result, the Commonwealth has tended at times to engage in 'opinion shopping' across NACCHO and the state/territory peaks in order to understand the views of the sector as a whole. A far more effective approach is for NACCHO to draw on and represent all views from across the sector on any issue of interest to the Department.

6.3 There have been various attempts over the years to reform the governance structure and the way the national network operates. None of these attempts has been successful.

Consideration of different structures and funding arrangements that might deliver a more coordinated and effective sector have arisen at regular intervals over recent history.

In Sept 2001, for example, the Commonwealth introduced the 60/40 funding split of NACCHO's funding (60% direct to NACCHO and 40% to the state/territory peaks to either re-direct to NACCHO or retain.) In response three state/territory peaks (QAIHC, AMSANT and Winnunga) formed a "Consortium" and retained their share, thus effectively withdrawing funding from NACCHO.[18]

The KordaMentha Review in 2005 detailed the ineffectiveness of NACCHO's structure, stating that NACCHO's 'functions and roles… are very broad and not always consistent with the objectives of a 'peak

body…' [and] that this lack of focused direction sits at the foundation of the [governance] issues that NACCHO currently faces.' [19] NACCHO was described as 'too large and impractical,' and 'lack[ing] a clear strategic approach to its role as an advocate… [and] not adequately represent[ing] its members,' leading to 'consultation with NACCHO… resulting in frustration and poor outcomes.' [20]

KordaMentha recommended an alternative governance structure used by many bodies in the federal system. Under this federated model the ACCHOs would be members of the state/territory peaks only, with the state/territory peaks being the members of NACCHO. Under the KordaMentha model the Board of NACCHO would be made up of one Director from each state.

The KordaMentha Review considered that if NACCHO didn't implement this recommendation within "a reasonable period of time (say 3 months)", NACCHO should be declared "ineffective and unworkable" and the Department should commence discussions with NACCHO and the affiliates to incorporate a new peak body structured in accordance with the KordaMentha recommendations.

Given that the individual ACCHOs are the members of NACCHO and must therefore vote on amendments to its constitution, this was a recommendation that government could not actually implement. It was strongly opposed by NACCHO. Structural change that involves constitutional change is unlikely to happen unless it is supported by all the affiliates and NACCHO, as members in one state voting against it could be sufficient to block the change.

The reality of a sector so committed to self-determination as a principle is also that, regardless of whether many in the sector support a particular reform, they will likely oppose such a change if they perceive it being forced on them by government.

Various options have been proposed over time that would attempt to use the Commonwealth's investment to deliver change to the way the national network operates. These options include:

- **Option 1**: Commonwealth to fund NACCHO only and NACCHO fund the state/territory peaks. The Review considers that this approach is untenable and unlikely to diminish tensions without clear governance across the peak body relationships. This arrangement would also remove the relationship between the Commonwealth and the state/territory peaks, which is an important vehicle for the Commonwealth to support the ACCHO sector. It is likely to inhibit reform, and less likely to improve performance at the state level. It also means that NACCHO would be brought more strongly into individual ACCHO capacity building, which this Review argues is not the most effective role for NACCHO.
- **Option 2**: Commonwealth only funds the state/territory peaks who then fund NACCHO for national policy and representation. History indicates that this may lead to the state/territory peaks pulling out and effectively crippling NACCHO. It effectively exacerbates tensions across the sector rather than precipitating reform toward shared ends.
- **Option 3**: The Commonwealth only fund at the ACCHO level and the members then determine funding to the state/territory peaks and NACCHO. The Review considers that this arrangement would not serve the sector well, as there would be no certainty that the ACCHOs would apply the funding in a coordinated and effective way.

It is an independent sector, and it is therefore likely that an imposition of changes to governance may have negative unintended consequences. The Review is resolute in the view that network governance and structural reform is necessary but equally that the sector must arrive at the reform direction itself. Possible avenues for reform are discussed in the following sections.

[19] KordaMentha (2005) 'Review of the National Aboriginal Community Controlled Health Organisation', Perth, p. 8.
[20] Ibid p. 12 – 13.

6.4 Re-branding and a clearer delineation of roles between NACCHO and the peak bodies could help reduce tensions

In consultations for this Review, a number of state/territory peaks and external stakeholders put forward the idea of a re-branding of all the state/territory peaks as NACCHO. Individual state/territory peaks might still keep their current names but be clearly branded as NACCHO. Some of the state/territory peaks felt this might improve the visibility and perceived unity and strength of purpose of the sector – both internally and externally.

Feedback from surveys and submissions demonstrates that there is general confusion about roles and responsibilities of NACCHO and the state/territory peaks– in submissions a large number of ACCHOs note they cannot properly define and separate roles between the organisations.

The lack of clarity means that NACCHO and the state/territory peaks have at points become competitors for the same roles and the relationships that they bring. This undermines the sector, and lessens collaboration across the sector. It also means that roles are duplicated across the organisations, which is not the most efficient use of funds.

In feedback provided to the Review, a number of ACCHOs, state/territory peaks and external stakeholders outlined that the desired role of state/territory peak bodies was to provide support to member organisations, and to conduct representational and policy work at state/territory level.

There was consensus around NACCHO's role being policy and representation at the national level. This role delineation was strongly supported by the members of the RAF.

The Review believes that role clarity is an essential component to a more effective network. We note that the new CEO of NACCHO has commenced a role clarity discussion across state/territory peaks.

6.5 But united governance must remain high priority for the sector

While re-branding and clearer role delineation may make some improvement to how the national network functions, they cannot compensate for united governance of the sector. It remains in the interest of the sector for NACCHO and the state/territory peaks to resolve to create a more workable and influential structure. This Review encourages NACCHO and the state/territory peaks to work together to achieve a structure that is transparent, rigorous and defensible, in the interests of better serving the needs of their members.

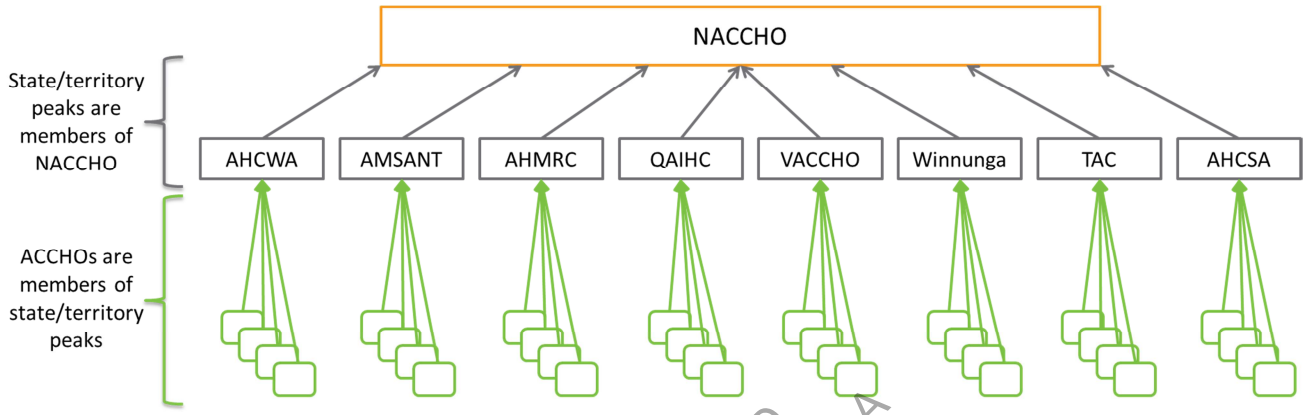
In the course of the Review Advisory Forum discussion, members of the state/territory peaks and NACCHO joined in scenario planning about the future and how the state/territory peaks could position themselves to be a key part of improving Aboriginal and Torres Strait Islander health into the future. Similarly, feedback from Review consultations highlights that the strongest case for any governance change needs to clearly consider plans for future proofing and maintain a direct focus on members' needs. This was also highlighted at a Review Advisory Forum:

> *All of us want NACCHO to be the engine room of excellence – what kind of legacy platforms are we going to leave behind come the years 2030 or 2050? Because here in this room, we all believe our sector is going to grow into a dynamic and competitive one. We need to innovate for national policy and respond to changing needs. Our cultural principles, and our unity, the fact that we need to be seen as one community is so important and I remember this came through very strongly in the last RAF meeting.* [21]

[21] Session facilitation by Review Expert Advisory Kerry Arabena

Many suggestions for new governance arrangements were made to the Review - a number of surveys/submissions suggested that NACCHO be a federation of the state/territory peaks, with ACCHO membership of state/territory peak bodies only, (as proposed by KordaMentha). This federated model is shown in Figure 3 below.

Figure 3: A federated governance model for NACCHO

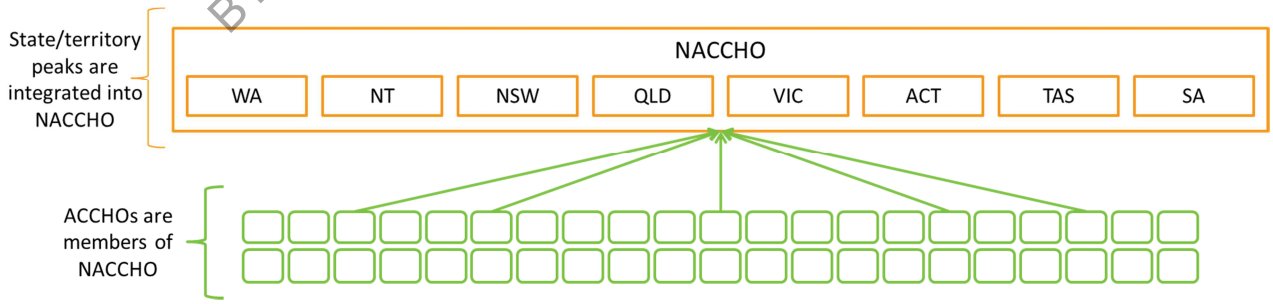


While this model is an improvement on the current state of separation, it is less than optimal from some perspectives. It is essentially a representative model and requires a large representative Board, which can be unwieldy and expensive to manage. It also runs the risk encountered by other such federally structured organisations, that the umbrella national office tends to grow distant from the real membership because its members are the state/territory peaks rather than the individual members whose needs they serve.

An important lens that the literature review (at Appendix E) highlighted is that peak organisations usually provide both outward looking (representation) and inward looking (member support) services, with the balance dependent on the needs of its members. Under the current structure of the ACCHO peaks, these inward and outward functions are compromised for each of the peaks. NACCHO is limited in the support it provides to its members by the role of the state/territory peaks and the state/territory peaks are limited in their outward national representation role by the existence of NACCHO.

The Review is aware that some separate peak organisations that have operated as separate state offices with an "umbrella" national office have moved away from the federated model to a nationally unified model[22]. Reasons for doing this have included the desire to have a stronger national voice to better serve members' interests, to build on and share the strengths developed across the different state/territory peaks, and to reduce duplication and overhead costs. An illustration of the integrated model is at Figure 4.

Figure 4: An integrated governance model for NACCHO



In consultations with stakeholders external to the sector, a number of ideas for an effective NACCHO Board were floated. There was a strong consensus among external stakeholders that NACCHO would be

[22] Leading Age Services Australia is one such example

better served as an effective national body by a smaller and more skills based Board focused on expert guidance to the CEO in relation to influencing national policy, rather than a Board made up of geographically-based representation.

These ideas could lead to the development of an integrated structure, rather than a federated one. Under this integrated model there would be one peak organisation, with national, regional (as required) and state/territory level offices, each with a clear role and mandate and accountable budgets. The Board could be a small (8-9 member) skills-based governance Board, elected by the individual ACCHO members against a matrix of clearly articulated criteria.

Such a major reorganisation of the peak network would not be a simple task and could be expected to take at least 12- 18 months to implement. The ACCHO members would need to be persuaded of the benefits of such a restructure and would be required to vote on constitutional change. They would need to be guided by consistent views across all the state/territory peaks.

These two models are not the only options available to NACCHO and the state/territory peaks. The Harvard governance model[23], which involves the creation of both a community based Board and a governance Board is another option that could be explored.

The literature review on Australian peak bodies undertaken for this Review identifies the following six principles as necessary for an effective peak body (Further detail is provided at Appendix E). An effective peak body is

- representative of and legitimate to the people it supposes to represent
- structured to ensure good governance
- efficient and cost-effective
- autonomous from government
- integrated in policy-making process
- accountable to members and funders.

Whichever direction the peaks decide to pursue, governance reform of the national network needs to be firmly focused on the model that is of greatest benefit to the members that the peaks serve and the population on whose behalf they make representations.

[23] As described in Sullivan, P. (2007) Indigenous Governance: The Harvard Project, Australian Aboriginal Organisations and Cultural Subsidiarity, Desert Knowledge CRC. http://www.nintione.com.au/resource/DKCRC-WP-04-Indigenous-Governance.pdf

Findings:

F14. The lack of joined-up governance across NACCHO and the state/territory peaks has been less than optimal for sector development, with the degree of cooperation and collaboration across the national network varying over time.

F15. For the sector to be effective at all levels, there needs to be clear and transparent network governance, but reform of the governance of the sector will only be successful when the sector itself owns the change.

F16. The effectiveness of NACCHO and the state/territory peaks will be optimised by early agreement on clear definitions of their respective roles. The state/territory peaks should provide support to member organisations and state-related policy and representation. NACCHO should undertake a national policy-related role and engage at a national level with other national bodies.

Recommendations:

R12. NACCHO and the state/territory peaks should place a high priority on continuing the recent initiatives towards working together to clarify roles and improve collaboration across the sector.

R13. The state/territory peaks should consider re-branding as state organisations of NACCHO to enhance the collaboration and unity.

R14. The sector should progress over the next 12-18 months towards a more effective governance model that unifies the sector and strengthens its ability to deliver improved health outcomes for Aboriginal and Torres Strait Islander people.

7 Commonwealth investment in NACCHO and the state/territory peaks could be clarified and better targeted

This section of the report considers the range and targeting of Commonwealth investment to achieve best value for money, responding to the final Review Objective.

Commonwealth investment is delivered and monitored through funding agreements, peak body activity plans and reporting as well as reporting against performance indicators. However the Review found it difficult to identify exactly what functions the Commonwealth funds the state/territory peaks to undertake. The functions described in the funding agreements do not clearly align with those described in their Activity Reports (against which they are required to report). These factors combined to make it difficult to identify activities undertaken, how well these aligned with funding agreements, and if any outcomes were achieved. Funding agreements need to be more specific and meaningful.

In addition to the lack of alignment between funding agreements and reporting arrangements, there is considerable variation in the funding agreements across the different peaks. The reason for this appears to be that the funding agreements are managed at the State level of the Department of Health.

In 2014 the Department of Health's Indigenous Health Division worked with the sector to develop performance indicators that could be included in funding agreements to improve the consistency of reporting and to give a better understanding of activities and outcomes related to this funding. This has been well received by the state and territory peaks, however there is some feedback that in some areas the measures lack the specificity needed to accurately describe work done – for example 'building capacity of members' doesn't necessarily pick up a peak bodies work to stop a service from falling over.

Funding for the peak bodies appears to be based largely on history and politics, with funding for specific projects ebbing and flowing. An external analysis provided to the Review by the Department of Health noted the difficulty in obtaining relevant and consistent financial data across NACCHO and the state/territory peaks because of how this information was reported. A similar internal report identified that:

> *"Traditionally, there has been an ad hoc approach to funding NACCHO and affiliates for peak body activities, with jurisdictions receiving different amounts of funding for different activities".*[24]

Feedback indicates that Commonwealth relationships and funding arrangements are opaque and hard to navigate for all stakeholders. The Commonwealth has a multiplicity of relationships with NACCHO and the state/territory peaks:

- The Canberra office of the Commonwealth Department of Health – various Divisions
- Department of the Prime Minister and Cabinet in relation to social and emotional wellbeing and drug and alcohol issues
- Health State Network Divisions in the State/territory offices of Health in relation to contractual obligations.

Within the Commonwealth there appears to be a lack of a coherent policy framework to guide relationships and communications. There is a need for clarity on the Commonwealth's objectives in funding the peaks, and following from that a consistent set of steps to translate policy and objectives into funding agreements and reporting requirements. Clear functions, structures and expectations will help clarify communication. The policy for communications with the sector needs to clarify and create lines of sight for where the primary relationship lies and what is the appropriate first point of call. Communication

[24] Urbis, Performance Indicators report, p3

between Commonwealth and State governments is also seen to be sporadic and difficult, with no agreed position in relation to funding of the state/territory peaks. There is a significant opportunity for the Commonwealth and states to work together in relation to funding agreements and especially performance monitoring (see Section 0).

7.1 Clarity of funded roles is a key starting point

The Review has found that the current funding agreements do not clearly distinguish the roles that NACCHO and each of the state/territory peaks are funded for and this exacerbates the tensions within the sector, as well as the tendency of the state/territory peaks to compete with each other. Just as the Review recommends that the state peaks and NACCHO need to clearly delineate their roles as an important step in improving the effectiveness of the national network, so the Commonwealth needs to similarly clarify the roles for which it funds NACCHO and the state/territory peaks.

To achieve this clarity it is important that the Commonwealth reach agreement with NACCHO and the state/territory peaks on respective roles, communications, and then clarify its expectations about the outcomes to be achieved.

7.2 A transparent and justifiable funding formula for the state/territory peak bodies would deliver equity

The current approach to determining the level of investment to be made in the state/territory peaks would benefit from a more transparent and equitable approach based on the likely level of need within the jurisdiction. Funding needs to accommodate growth in the number of ACCHOs the peak serves (or respond to a contraction) and ensure that the peak has the ability to service rural and remote ACCHOs. Members of the RAF particularly noted that current funding arrangements do not respond to growth in the number of services.

For these reasons the Review is of the view that a transparent funding formula based on the number of ACCHOs, the population receiving services from the ACCHOs and the geographic challenges would be a more equitable and sustainable way to fund the state/territory peaks. A "base level" of funding for participation in the national network would also ensure that the two jurisdictions where the single ACCHO in the jurisdiction takes on the peak function (ACT and Tasmania) could nevertheless participate in the national network. A simple funding formula for state/territory peaks could be put in place along the following lines:

1 Base funding to operate as part of the community controlled national network, covering
   a. Engagement with mainstream health organisations at the jurisdictional level.
   b. Participation in tri-partite activities (including secretariat services)
   c. Participation in NACCHO activities as appropriate
   d. Provision of expertise to NACCHO as required
2 Funding to strengthen capacity of ACCHOs
   e. A proportion of funding based on the number of member ACCHO's, with a loading for rural and remote services to cover the provision of member support services
   f. A proportion of funding based on the Aboriginal and Torres Strait Islander population receiving services from the ACCHOs.
3 Further funding could be derived from NACCHO for health initiatives and services in difficulty, as agreed.

While this funding formula would provide greater equity, there would need to be a transition period so that funding levels did not result in disruptive cuts to services and staff, or to too rapid an expansion.

7.3 Commonwealth investment in NACCHO should relate to its capacity to deliver

As a relatively small organisation (compared to many of the state/territory peaks), NACCHO has struggled to recruit and retain highly skilled staff in Canberra who can make a significant contribution to national policy and influence national directions. Yet this is a fundamental requirement for a national peak organisation. It has also been at times overwhelmed by the plethora of calls on its staff, who are not necessarily able to prioritise and deliver what is expected.

Commonwealth investment in NACCHO needs to create incentives for the delivery of expert policy advice and also needs to be matched to the significant demands for engagement from the Commonwealth Government.

NACCHO's submission to this Review comments that NACCHO actively engages with all seven Divisions of the Department of Health. They also develop submissions for various Senate Committees and specific enquiries. This absorbs a great deal of time and resources. They comment that their funding is all derived from Indigenous Health Division, and does not acknowledge their involvement across other Divisions.

Managing this broad involvement within resources is a significant challenge. It also poses challenges around prioritisation for NACCHO as there is no coordination of requests from within the Department and no mechanisms by which the Department prioritises its needs. NACCHO has advised that this issue is under active consideration between NACCHO and the Department.

NACCHO's capacity to play this role depends to a large extent on the capability of its staff and the networks of expertise it can draw on to bring influence to bear on Commonwealth policy. NACCHO's capacity to deliver will be enhanced by greater use of expertise that resides across the sector, rather than within NACCHO itself. To facilitate this flexible approach, NACCHO could be provided with brokerage funds to enable it to use the best expertise (either within the sector or externally) to lead national sector development. Each use of brokerage funds would need to be agreed with the Commonwealth in advance.

Similarly, given the importance of NACCHO being able to recruit experienced staff with a high level of skills, the Department may want to consider adjusting the level of funding to NACCHO dependent on the quality of the staff it recruits or seconds from across the sector.

The regular co-development between the Commonwealth and NACCHO of agreed priorities for policy input would give greater clarity to both parties. It would also ensure that the demands on NACCHO for advice are bounded and achievable, dependent on the level of funding provided. If the funding agreement makes it clear that NACCHO is being funded to participate in forums that provide advice to the Commonwealth, then consistent failure to participate in such forums would constitute a breach of the funding agreement.

While investment in NACCHO's role in national policy and representation is a clear priority, this Review has also found that investment in NACCHO has been at times compromised by NACCHO's lack of engagement with the state/territory peaks which has detracted from its inability to implement national programs or present a national voice.

The Review therefore suggests that investment in NACCHO undertaking a national coordination role across the state/territory peaks should not proceed unless there are clear and supported arrangements in place between NACCHO and the state/territory peaks that will enable the delivery of outcomes on behalf of the whole sector. Such arrangements could be by governance changes, or by contractual agreements, or whatever mechanisms for leadership of particular issues are transparently agreed between the state and national bodies.

As discussed earlier, NACCHO could also receive funds as part of a new model for supporting services in difficulty.

7.4 Commonwealth investment will produce better results if funding is stable

To enable optimum effectiveness all the peak bodies need to be able to plan in advance, and have stability in funding. Short term funding cycles (three years or less), both at the State and Commonwealth level, inhibit the performance of NACCHO and the state/territory peaks particularly by making recruitment of staff and longer-term investment problematic. One state peak body identified four ways that short-term funding limits effectiveness:

- limits the ability to plan long term projects and deliver enduring outcomes to close the gap;
- renders project positions less attractive to high performers seeking job security;
- diverts resources to change management, which includes responding to policy changes managing human resources and financial systems; and
- undermines community trust, which requires enduring commitment.

The Western Australian Government commissioned a comprehensive review into its funding of the Aboriginal health sector (Holman Review). The Review was completed in December 2014. It emphasised the importance of funding certainty:

> *"The single most important recommendation of this Review is that in return for a stronger commitment to a results-based performance framework, the WA Government guarantees that the minimum term of a service agreement within the WA health sector is three years with an automatic extension…this guarantee alone, in the Review's opinion, will further lift the level of performance in the Aboriginal health sector to a substantially higher level through certainty of funding…"*[25]

Once the Commonwealth is satisfied that the organisation is well aligned to the needs of the sector and has the capacity to deliver against its funding agreement, greater stability could be introduced through three year rolling funding agreements.

7.5 Measuring performance through outputs and outcomes rather than activities will reduce transaction costs

Perusal of the activity plans established for each peak body indicates a high level of detailed "activity" planning and monitoring rather than a higher level focus on what each peak body needs to achieve. Continual detailed measurement of activities and inputs gives no indication of the effectiveness, usefulness or quality of such activities.

Performance monitoring for the state/territory peaks should relate to the three key roles that these state/territory peaks play: building sector capacity, engaging with their state government, and engaging with the mainstream. Given that each of these roles is also funded by most state/territory governments in some degree, it would make sense for the Commonwealth and the state to jointly approach performance monitoring – thus also reducing the transaction costs on the individual peak body.

The intentional blending of funding to achieve common policy objectives is a sensible strategy. However it renders attributing outputs to specific streams of State and Commonwealth funding more difficult, and also creates duplication in reporting requirements. The Holman Review, commissioned by the WA Government in 2014, noted

[25] Emeritus Professor Holman, D., A Promising Future: WA Aboriginal Health Programs, (Government of Western Australia, Department of Health: December 2014), p81

"Traditional boundaries between health services funded by the Commonwealth and those funded by the State have become blurred, and this is especially so in the Aboriginal health sector"….[26]

"There are many instances, especially in the provision of primary medical services and chronic disease management projects, where service providers disclosed to the Review how State and Commonwealth funds each played a role in enabling the service as a whole to operate"[27]

"Duplication of reporting certainly exists"[28]

The issue of duplication in reporting and means of resolving it are also well canvassed in the *Overburden* report series.[29]

At the outcome level, the performance of the state/territory peak bodies' 'inward' service provision can be monitored by the degree to which the ACCHOs in the jurisdiction receive support and are assisted to meet particular requirements, such as accreditation or improved financial or governance performance. An increasingly well used methodology for assessing client satisfaction is YES surveys (Your Experience of Service). These are short surveys that collect regular data about client experience. Such a survey could be designed for the sector and circulated by state/territory peaks annually. This would give the Commonwealth (and the relevant state) assurance as to the quality of assistance and the equity of support (as discussed in section 3). This would be a relatively low cost means of focusing on outcomes and encouraging more equitable provision of support.

In addition outcome measures can be put in place for the results of capacity building services provided. For many of the proposed measures the peak body does not have sole control over the outcome specified, and this needs to be recognised in how reporting is managed within government. This issue not withstanding, the outcome measures presented below do capture the intention of service delivery and create a clear relationship between services delivered and results with ACCHOs.

Table 1: Proposed outcome measures for ACCHO support activities provided by state/territory peaks

Activities	Outcome measure	Collection mechanism
Governance	• % of members judged to be 'service in difficulty'	Commonwealth
Service in difficulty	• % of members de-funded	Commonwealth
Financial management	• % of members judged to be 'service in difficulty'	Commonwealth
Accreditation	• % of members accredited –organisational	Commonwealth
IT	• YES survey	State/territory peak
Data	• % of members compliant with data reporting requirements	Commonwealth
Improving clinical services	• % members achieving clinical accreditation for three years with no recommendations • YES survey	Commonwealth
Workforce development	• YES survey	State/territory peak
Education and training	• Where applicable: Number of graduates from courses • % of participants graduating	State/territory peak

[26] *Ibid.* p.42
[27] *Ibid*. p.100
[28] *Ibid*. p.101
[29] Dwyer, J., O'Donnell, K., Lavoie, J., Marlina, U. & Sullivan, P., *The Overburden Report: Contracting for Indigenous Health Services*: *Summary Report*, (CRCAH, Darwin: 2009)

A similar outcomes approach could be designed by relevant Commonwealth and state/territory departments (including Prime Minister and Cabinet) to monitor the effectiveness of the engagement of the peak body with mainstream services, and commissioning agencies such as the PHNs. Once again the outcomes are not solely a factor of peak body effort, and this needs to be considered when interpreting results. Table 2 presents proposed output and outcome measures for activities of state/territory peaks.

Table 2: Proposed outcome measures for state/territory peak engagement with government and mainstream

Activity	Outcome measure	Collection mechanism
Representation to mainstream health agencies	◦ Number and value of joint projects with mainstream health agencies ◦ Description of positive changes in practices by mainstream health agencies ◦ Evidence joint programs, receipt of funding and influence with PHNs	State/territory peak
Representation to government	◦ Projects initiated through the tri-partite forums ◦ Policy change in recognition of the needs of Indigenous people	State/territory peak

Performance monitoring of NACCHO as the national peak could similarly focus on outcomes and outputs through a measure of the quality of policy advice provided in relation to agreed priority areas. The quality of NACCHO's engagement with other national bodies – both mainstream and Indigenous – could also be measured by a regular survey.

Findings:

F17. At present there is a lack of clarity and alignment between funding agreements, required activity and reporting. There is also a lack of clarity and visibility on the communications between the Commonwealth and the sector.

Recommendations:

R15. The Commonwealth should develop a clear set of objectives in funding the peaks, and following from that develop a consistent set of steps to translate objectives into funding agreements and reporting requirements.

The Commonwealth funding agreements should direct funding to the state/territory peaks to achieve the following objectives:

a. **strengthen capacity of ACCHOs to deliver sustainable high quality primary health care**
b. **Engage with mainstream health organisations to strengthen their capacity to deliver culturally safe and accessible services to Aboriginal and Torres Strait Islander people.**
c. **Participate in tri-partite activities (including secretariat services) to ensure governments are knowledgeable about Aboriginal and Torres Strait Islander health issues and needs, and participate in co-design for programs to address those needs**
d. **Participate in NACCHO activities in order to facilitate the delivery of health programs within their jurisdiction**
e. **Provide expertise to NACCHO to to identify health trends and contribute the delivery of high quality inputs Commonwealth policy formulation.**

R16. The Commonwealth should develop a clear strategy that clarifies the roles and responsibilities of communicating with NACCHO, peak bodies, and state/territory governments.

R17. The Commonwealth should develop a simple funding formula to determine the precise funding for each peak body comprising:

1 **Base funding to operate as part of the community controlled network, covering**
   - Participation in tri-partite activities (including secretariat services)
   - Participation in NACCHO activities as appropriate
   - Provision of expertise to NACCHO on a range of issues

2 **Funding to strengthen capacity of ACCHOs**
   - Engagement with mainstream health organisations at the jurisdictional level
   - A proportion of funding based on the number of member ACCHO's, with a loading for rural and remote services to cover the provision of member support services
   - A proportion of funding based on the Aboriginal and Torres Strait Islander population receiving services from the ACCHOs

3 **Further funding could be derived from NACCHO for specific health programs (such as ear health) and services in difficulty, as agreed.**

R18. In relation to NACCHO, Commonwealth investment could reflect three separate functions:

1. **Base funding**
   - **Develop an evidence base for trends in Aboriginal and Torres Strait Islander health based on data provided by ACCHOs and the peaks**
   - **Policy development and representation**
   - **Developing relationships and initiatives with mainstream health peaks and organisations**
   - **Facilitation of input to national health programs**
2. **Flexible funding to procure development and implementation of coordinated approaches such as responses to emerging health issues or consistent sector-wide developments, dependent on NACCHO demonstrating it has effective delivery mechanisms in place**
   - **The Commonwealth to fund specific initiatives through separate funding agreements**
3. **Funding to procure responses for services in difficulty, with NACCHO or the Commonwealth to hold funds, and reach agreement to procure services on a case by case basis – with state and territory peaks as first option. This funding should be governed by a discrete funding agreement and specification of procurement protocols**

R19. The Commonwealth and NACCHO should regularly work together to develop agreed priorities for policy input, This would help to ensure that the demands on NACCHO for advice are bounded and achievable, dependent on the level of funding provided.

R20. The Commonwealth should introduce rolling 3-year funding in order to provide greater stability to the peaks. This should only be implemented once the Commonwealth is satisfied that the organisation is well aligned to the needs of the sector and has the capacity to deliver against its funding agreements. Transaction costs would be reduced if the Commonwealth and relevant state/territory developed a joint approach to monitoring the performance of the state/territory peak bodies.

R21. The Commonwealth and the peaks should consider insert moving to short, simple outcomes measures. This needs to be accompanied by an acknowledgement that the peak body is not solely responsible for achievements of the outcomes specified.

8 The relationship between the Commonwealth and NACCHO contributes to the effectiveness of Commonwealth investment

The need for clear and accountable funding arrangements does not diminish the necessity for a strong relationship between NACCHO and the Commonwealth Department of Health which facilitates progress in Aboriginal and Torres Strait Islander health. The improvements to the funding contract discussed in the previous sections are only part of the way forward if the Commonwealth investment in NACCHO and the state/territory peaks is to continue to deliver effective outcomes for Indigenous health in Australia.

Throughout the consultations for this Review the team has been made aware of ongoing challenges to the maintenance of an effective working relationship between the Commonwealth and NACCHO. This has been manifest in a lack of accountability to a clear set of relationship expectations as well as patchy engagement in matters that impact on national Indigenous health policy and Indigenous health.

One of the most frequent criticisms levelled at the Commonwealth by the peak bodies is the perceived high turnover of staff (dubbed the 'passing parade') which makes it difficult for the sector to develop relationships of trust and creates a perception that the value and history of Aboriginal community control is not well understood by the Commonwealth, at all levels.

The experience and history of the sector positions NACCHO to speak strongly and passionately on a variety of issues which can at times be challenging. The Review takes the view that there is some behaviour which public servants have every right to "call out" and take exception to, equally that strong feelings in the sector on particular issues is inevitable and some robustness in communication is to be expected.

The Review is of the firm belief that a strong working relationship between NACCHO and the Commonwealth is a necessary and critical element in improving the effectiveness of Commonwealth investment in the peak bodies. An effective relationship will be characterised by principles of respect, some shared objectives and mutual understanding of the principled positions of both parties. Optimal results will be produced when the Department demonstrates respect for NACCHO's national role in representing the Aboriginal community controlled health sector and NACCHO accepts that it is not the only voice that will be heard on Aboriginal and Torres Strait Islander health.

> *There is a great importance in rekindling relations with the government…We're humble and we want to work in harmony.*

> *It's important to be able to have honest and safe conversations with one another*

The Review advises the Department to demonstrate a positive acceptance that NACCHO is the pre-eminent voice of the single biggest health service provision sector to Indigenous people. An understanding of the meaning, history and sentiment of the concept and realisation of Aboriginal community control is essential knowledge that will underpin mutual respect.

Specific actions the Department could take include improving the knowledge of the background and philosophy of the sector within the Department (and particularly within new staff in the Indigenous Health Division) and raising awareness about the benefits of the model. For example, the Commonwealth's decision to fund a report card on the achievements of the Aboriginal Community Controlled sector[30] is an important signal of the value it places on the sector. The Department could also improve its understanding

[30] AIHW, Aboriginal and Torres Strait Islander health organisations: Online Services Report—key results 2014–15. http://www.aihw.gov.au/publication-detail/?id=60129554783

of the sector by engaging trusted internal advisor/s who have significant experience in dealing with the sector and can guide less experienced staff in handling some of the political issues that arise.

There is also an opportunity for the Department to ensure that the sector has a solid understanding of the assumptions and processes of government. This would be important to ensure that conversations with the Department are not perceived as government policy, for example and in appreciating the way in which the mechanisms of government both constrain and provide opportunity for effective influence.

The Review advises NACCHO to demonstrate its acceptance that the Department operates within a pluralist government system and will engage with a range of voices on Indigenous health. While the Aboriginal community controlled sector has a proud history of contribution and achievement, there are other legitimate voices – both organisations and individuals – with an important perspective. The Review urges NACCHO to be an active participant in any advisory forum established by government in relation to Indigenous health.

The Review urges all involved in the relationship to consider how the prosecution of the range of viewpoints and positions, which all are charged to deliver, can be done in a way that builds long term strength and frankness in these most important relationships. In keeping with this perspective it would be sensible for the Department to develop both a structured engagement with NACCHO as well as an expert advisory forum including NACCHO and other expert voices. A focus of both the structured bilateral relationship and the advisory forum would be an agreed agenda of priority issues that the parties will address each year.

Some state/territory peaks advised the Review that in their experience an effective underlying relationship with a state/territory government, forged over many years, has assisted in resolving many instances of disagreement in a productive and pragmatic manner. The relationship has also assisted in managing community expectations around difficulty policy issues and enhanced the value delivered by the Commonwealth's investment in the sector.

It is the view of the Review team that mutual respect arising from an improved relationship can generate a focus on maximising the impact and quality of advice from the point of view of the Aboriginal community controlled sector. We would urge both parties to talk frankly about what action each could take to improve the relationship.

8.1 An MOU between the Commonwealth and NACCHO would formalise the relationship and help create respect from both sides

In keeping with this perspective it would be sensible for the Department to develop a structured engagement with NACCHO in addition to any expert advisory forum it wishes to establish (which could be expected to include NACCHO as well as other expert voices).

A focus of the structured bilateral relationship would be agreed priority issues that the parties will address each year. It might also be a useful forum to help build understanding of government and public service context on the one hand, and awareness of the community control philosophy on the other. These conversations should take place separately to the set of issues around managing the funding contract - although they might perhaps lead to a decision by the Commonwealth to invest in a piece of work. The MOU should specify:

- Regular formal meetings
- Procedure for setting the agenda and clarity on who is providing information
- Space on the agenda for both parties to raise issues
- Formal minutes taken and circulated
- Work plan that is reported against by both parties
- Procedures for resolving conflicts arising

Findings:

F19. A relationship of mutual respect between the Commonwealth and NACCHO will maximise the impact of the sector on delivering improvements in Aboriginal and Torres Strait Islander health.

F20. The Department of Health can improve the gains from its investment in NACCHO and the peak bodies by strengthening its understanding of Aboriginal community control.

Recommendations:

R21. The Commonwealth and NACCHO should continue to develop a policy of constructive engagement, including setting internal standards for representatives to engage in collaborative approaches that focus on the improvement of the health of Aboriginal and Torres Strait Islander people.

R22. NACCHO and the Commonwealth should create a formal Memorandum of Understanding that describes the mutual expectations and roles of their work together to improve Aboriginal and Torres Strait Islander health.

9 Consolidated Findings and Recommendations

Findings

F1. Community controlled health services play an ongoing critical role in improving the health outcomes of Aboriginal and Torres Strait Islander people.

F2. Awareness and understanding of the history and achievements of the sector is important context for governments and mainstream services in seeking to maximise health outcomes for Aboriginal and Torres Strait Islander people.

F3. NACCHO and the state/territory peak bodies represent community controlled health services, and therefore have a key role to play with the ACCHO sector and in influencing the mainstream health system.

F4. The state/territory peak bodies provide effective member support services in many areas, particularly in the areas of governance support, financial management support and utilisation of data and IT.

F5. ACCHOs would like increased access to support, particularly in the areas of support to deliver better clinical care and preventive health activities, including workforce development and data capability.

F6. Demand for state/territory peaks to engage with mainstream health is very high and exceeds their capacity to engage.

F7. State/territory peaks are operating within an increasingly complex and demanding external environment that creates challenges in governance and staffing resources.

F8. State/territory peaks take different approaches to intervening in services in difficulty. Some take a strong active role and others are uninvolved in some instances for a range of reasons including conflicts of interest and the over-riding principle of local community control and accountability.

F9. The Review found evidence that collaboration between the Commonwealth and State/Territory Governments in relation to their investment in the state/territory peak bodies is patchy. This results in challenges for the peaks in planning and managing their funding.

F10. The effectiveness of the tripartite forums as vehicles for addressing jurisdictional need is mixed.

F11. Improved collaboration between Commonwealth and State/territory governments is an important precursor to the effectiveness of the tripartite forums.

F12. NACCHO has facilitated significant benefits to Aboriginal and Torres Strait Islander health through its policy development and partnerships with mainstream organisations. There is an ongoing need for NACCHO to continue to deliver gains into the future.

F13. NACCHO currently has a strong focus on clarification of roles and strategy which will help to strengthen their influence.

F14. The lack of joined-up governance across NACCHO and the state/territory peaks has been less than optimal for sector development, with the degree of cooperation and collaboration across the national network varying over time.

F15. For the sector to be effective at all levels, there needs to be clear and transparent network governance, but reform of the governance of the sector will only be successful when the sector itself owns the change.

F16. The effectiveness of NACCHO and the state/territory peaks will be optimised by early agreement on clear definitions of their respective roles. The state/territory peaks should provide support to member organisations and state-related policy and representation. NACCHO should undertake a national policy-related role and engage at a national level with other national bodies.

F17. At present there is a lack of clarity and alignment between funding agreements, required activity and reporting. There is also a lack of clarity and visibility on the communications between the Commonwealth and the sector.

F18. The review believes the Commonwealth can improve the effectiveness of its investment by clarifying distinct purposes for its funding to each level of the network.

F19. A relationship of mutual respect between the Commonwealth and NACCHO will maximise the impact of the sector.

F20. The Department of Health can improve the gains from its investment in NACCHO and the peak bodies by strengthening its understanding of Aboriginal community control.

Recommendations

R1. The state/territory peak bodies should keep members well informed of all the member support services they offer. They should also ensure that their member support resourcing decisions are transparent to all members by regularly communicating this and engaging with all ACCHOs in their jurisdiction.

R2. State/territory peaks are encouraged to place a high priority on their engagement with mainstream organisations, particularly PHNs. This could be done through implementing partnerships and collaborative arrangements that strengthen their influence on the mainstream health system.

R3. To strengthen the reputation and performance of the sector overall, the peak bodies together should take responsibility for delivering an active and coordinated role in assisting all services in difficulty.

R4. A new model of support for services in difficulty should be developed, with NACCHO playing a leadership role in development of a workable and flexible model and in ensuring support is in place. State/territory peak bodies should have first right of refusal to assist services in difficulty in their jurisdiction.

R5. Funding agreements need to clarify the extent of state/territory peak body and NACCHO responsibility for services in difficulty (within core funding).

R6. A discrete pool of funds should be identified and used by agreement of NACCHO, the relevant state/territory peak and the Commonwealth to provide assistance to services in difficulty on a case-by-case basis.

R7. The Commonwealth, in consultation with the state/territory governments and the relevant peak, should either dispense with or rejuvenate the tripartite forums where they have fallen away as a key joint planning mechanism.

R8. To rejuvenate the tripartite forums the Commonwealth and state governments should agree on a consistent approach (and funding) for secretariat to ensure there are formal work plans and clearer outcome reporting.

R9. NACCHO is encouraged to prioritise its national level engagement with mainstream health and research organisations in order to deliver further gains for Aboriginal and Torres Strait Islander health.

R10. The four key objectives for NACCHO as the national peak should be:

1. **Using information from the sector to drive improvements in the health response**
2. **Using that evidence to drive changes within the Aboriginal community controlled sector and in mainstream health practices**
3. **Developing strong productive relationships across government**
4. **Delivering information to the sector.**

R11. NACCHO should be the prime source of national advice to the Commonwealth on the Aboriginal community controlled sector and should encourage the state/territory peak bodies to engage with each other and through NACCHO.

R12. NACCHO and the state/territory peaks should place a high priority on continuing the recent initiatives towards working together to clarify roles and improve collaboration across the sector.

R13. The state/territory peaks should consider re-branding as state organisations of NACCHO to enhance the collaboration and unity.

R14. The sector should progress over the next 12-18 months towards a more effective governance model that unifies the sector and strengthens its ability to deliver improved health outcomes for Aboriginal and Torres Strait Islander people.

R15. The Commonwealth should develop a clear set of objectives in funding the peaks, and following from that develop a consistent set of steps to translate objectives into funding agreements and reporting requirements.

The Commonwealth funding agreements should direct funding to the state/territory peaks to achieve the following objectives:

a. **strengthen capacity of ACCHOs to deliver sustainable high quality primary health care**
b. **Engage with mainstream health organisations to strengthen their capacity to deliver culturally safe and accessible services to Aboriginal and Torres Strait Islander people.**
c. **Participate in tri-partite activities (including secretariat services) to ensure governments are knowledgeable about Aboriginal and Torres Strait Islander health issues and needs, and participate in co-design for programs to address those needs**
d. **Participate in NACCHO activities in order to facilitate the delivery of health programs within their jurisdiction**
e. **Provide expertise to NACCHO to to identify health trends and contribute the delivery of high quality inputs Commonwealth policy formulation**

R16. The Commonwealth should develop a clear strategy that clarifies the roles and responsibilities of communicating with NACCHO, peak bodies, and state/territory governments.

R17. The Commonwealth should develop a simple funding formula to determine the precise funding for each peak body comprising:

1 **Base funding to operate as part of the community controlled network, covering**
   - Participation in tri-partite activities (including secretariat services)
   - Participation in NACCHO activities as appropriate
   - Provision of expertise to NACCHO on a range of issues

2 **Funding to strengthen capacity of ACCHOs**
   - Engagement with mainstream health organisations at the jurisdictional level
   - A proportion of funding based on the number of member ACCHO's, with a loading for rural and remote services to cover the provision of member support services
   - A proportion of funding based on the Aboriginal and Torres Strait Islander population receiving services from the ACCHOs

3 **Further funding could be derived from NACCHO for specific health programs (such as ear health) and services in difficulty, as agreed**

R18. In relation to NACCHO, Commonwealth investment could reflect three separate functions:

1 **Base funding**
   - Develop an evidence base for trends in Aboriginal and Torres Strait Islander health based on data provided by ACCHOs and the peaks
   - Policy development and representation
   - Developing relationships and initiatives with mainstream health peaks and organisations
   - Facilitation of input to national health programs

2 **Flexible funding to procure development and implementation of coordinated approaches such as responses to emerging health issues or consistent sector-wide developments, dependent on NACCHO demonstrating it has effective delivery mechanisms in place**
   - **The Commonwealth to fund specific initiatives through separate funding agreements**

3 **Funding to procure responses for services in difficulty, with NACCHO or the Commonwealth to hold funds, and reach agreement to procure services on a case by case basis – with state and territory peaks as first option. This funding should be governed by a discrete funding agreement and specification of procurement protocols**

R19. The Commonwealth and NACCHO should regularly work together to develop agreed priorities for policy input, This would help to ensure that the demands on NACCHO for advice are bounded and achievable, dependent on the level of funding provided.

R20. The Commonwealth should introduce rolling 3-year funding in order to provide greater stability to the peaks. This should only be implemented once the Commonwealth is satisfied that the organisation is well aligned to the needs of the sector and has the capacity to deliver against its funding agreements. Transaction costs would be reduced if the Commonwealth and relevant state/territory developed a joint approach to monitoring the performance of the state/territory peak bodies.

R21. The Commonwealth and the peaks should consider moving to short, simple outcomes measures. This needs to be accompanied by an acknowledgement that the peak body is not solely responsible for achievements of the outcomes specified.

Appendix A Map of Review Objectives to Review Report

Objective		Area of focus	Report Section
1a.Contribution to…	…strengthening the organisational capacity of the sector	State/territory peaks	Section 2
		NACCHO	Section 5
1b. Contribution to…	…strengthening the health system's delivery of quality, culturally appropriate primary health care and to achieving the CTG targets	State/territory peaks	Section 2
		NACCHO	Section 5
2a. How current activities align with needs of…	…Commonwealth government	States/territory peaks	Sections 2,3,4,5
	…ACCHOs		Sections 2,3
	…the broader health system		Sections2, 3, 4,5
2b. Capabilities required to deliver these activities		State/territory peaks	Section 2
		NACCHO	Section 5
3a. Consider how all peaks function as a national network			Section 6
3b The principal issues regarding health system integration with which the peaks should engage			Section 6
4. Make recommendations to inform…	…the ongoing delivery of required support to ACCHOs,		Recommendations
	…including a nationally consistent suite of supports for ACCHOs		Recommendations
	…including services experiencing operational difficulties		Section 3
5. How Commonwealth and state/territory investment interacts to address jurisdictional need			Section 4
6. Range of Commonwealth investment what it could purchase and where it could best be targeted			Section 7

Appendix B Review Advisory Forum members

The Review was assisted by a Review Advisory Forum (RAF) drawn from NACCHO, the state/territory peaks. The Commonwealth Department of Health withdrew membership from the RAF from March, 2016. The members of the RAF throughout the Review are shown below in Table 3. The Commonwealth Department of Health was also on the Advisory forum for the first two RAF meetings. The RAF meetings and the purpose of each meeting are shown below in Table 4.

Table 3: List of Review Advisory Forum members

Organisation	Chair	CEO	Other staff
Aboriginal Health & Medical Research Council (AH&MRC)	• Christine Corby	• Sandra Bailey	• Victoria Jones • John Henry • Jenny Hunt
Aboriginal Health Council South Australia (AHCSA)	• John Singer	• Shane Mohor	• **A**manda Mitchell
Aboriginal Health Council Westerns Australia (AHCWA)	• Des Martin	• Michelle Nelson-Cox	• Cameron Poustie • Shaun Wyn-Jones
Aboriginal Medical Services Alliance Northern Territory (AMSANT)	• Marion Scrymgour • Donna Ah Chee	• John Paterson	• David Cooper
National Aboriginal Community Controlled Health Organisation (NACCHO)	• Matthew Cooke	• Pat Turner (from the 4th RAF meeting only)	• John Gregg • Chris O'Connell • John Rumble
Queensland Aboriginal and Islander Health Council (QAIHC)	• Elizabeth Adams	• Matthew Cooke	• Alastair MacDonald
Tasmanian Aboriginal Centre (TAC)	• David Warrener	• Heather Sculthorpe	
Victorian Aboriginal Community Controlled Health Organisation (VACCHO)	• Marcus Clarke	• Jill Gallagher	• Louise Carey • Noleen Tunney
Winnunga Nimmityjah Aboriginal Health Service (Winnunga)	• Craig Ritchie	• Julie Tongs	
Commonwealth Department of Health (for 1st and 2nd RAF meeting only)	• Allison Killen, First Assistant Secretary • Bridget Carrick, Director • Abbie Alcock		

Table 4: RAF meeting dates and objectives

Date RAF meeting held	Meeting objective/s
30 November 2015	• To establish the Advisory Forum and its role, provide an overview of the project including key components and stakeholders, and seek feedback and advice on the consultation approach
22 February 2016	• To provide an update on the Review
11 April 2016	• To present and discuss emerging themes
13 June 2016	• To present and discuss draft Review findings

Appendix C Review Team Members

Below are lists of the Review Expert Advisors and key members of the Review Team.

Review Expert Advisors

- Prof Ian Anderson
- Prof Kerry Arabena
- Mr Alan Bansemer
- Mr Robert Griew
- A/prof Ted Wilkes

Nous Review Team

- Penny Gregory, Project Director
- Leila Smith, Project Manager (from March 2016)
- Wade Lewis, Project Manager (until March 2016)
- Gill Shaw, Senior Consultant
- Ethan Fogarty, Consultant
- Rowan Gallagher, Consultant
- Lizzy O'Shea, Consultant
- Natalia Beghin, Intern
- Emma Wilson, Project Coordination

Appendix D Methodology and Results

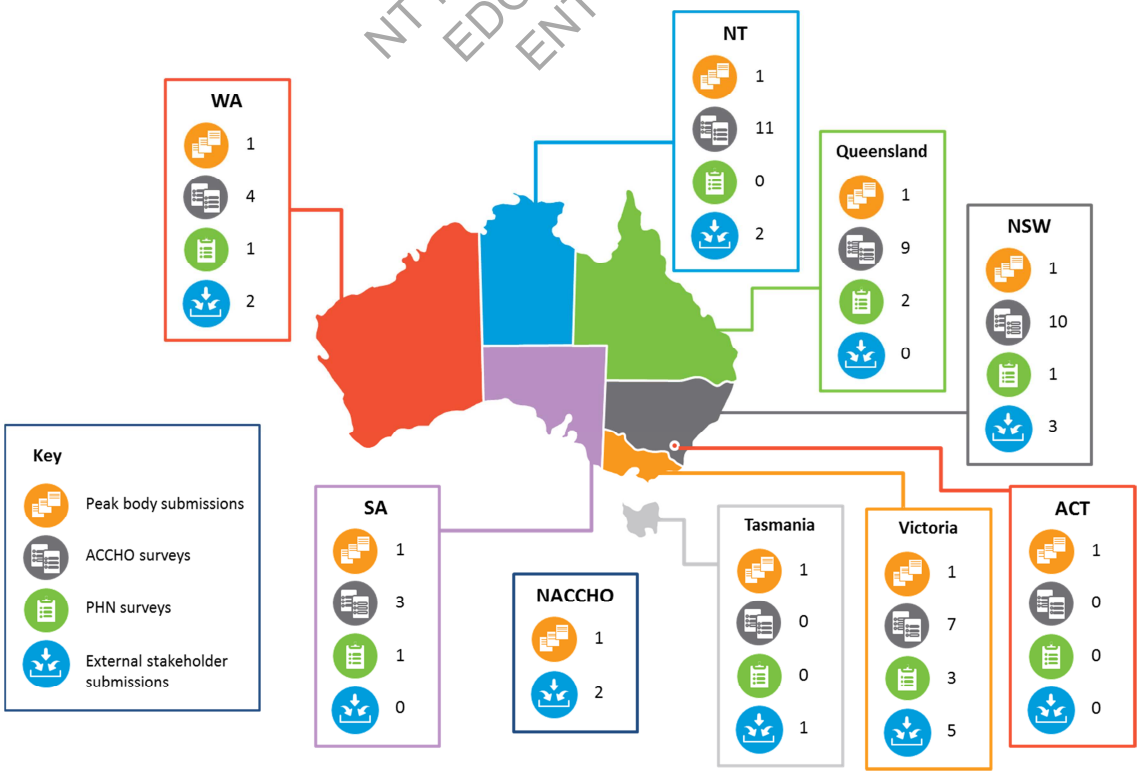
The Review employed a variety of methodologies to gather feedback from NACCHO and each state and territory peak body, ACCHOs, Primary Health Networks and Commonwealth, state and territory health departments and other interested stakeholders.

Interviews were conducted with NACCHO and state/territory peaks peak Boards, CEO's and staff, and CEOs of a small group of ACCHOs from each state and territory. Further consultation was undertaken with Commonwealth and state health department officials, Prime Minister and Cabinet Department (federal) and a range of stakeholders who interact with the state peaks and NACCHO. The list of stakeholders consulted is provided below at Appendix D.1.

All stakeholders were invited to put a submission in to the Review. The submission asked for feedback on the performance of the state/territory peaks and NACCHO, and for any other comments. All the state/territory peaks provided a submission. A separate submission was not provided by NACCHO however NACCHO coordinated a joint submission from all the state/territory peaks and NACCHO. A breakdown of the state/territory peaks and external stakeholder submissions received by jurisdiction is provided below in Figure 5.

ACCHOs and Primary Health Networks were invited to participate in online surveys. These surveys asked for respondents' perceptions of the extent to which their jurisdictional peak body and NACCHO are effective in providing member support and representation to mainstream health services; and how effectively the state/territory peak bodies and NACCHO function as a network. A summary of the ACCHO survey results are provided in Appendix D.2 , and a summary of the PHN Survey results are provided in Appendix D.4.

Figure 5: Submission and survey responses by jurisdiction



D.1 Stakeholders consulted

Below are lists of key stakeholders we approached to participate in this Review.

Table 5: List of stakeholders consulted

Organisation	Name/s	
Aboriginal Health & Medical Research Council (AH&MRC)	• Christine Corby, Chair • Scott Monahan, Board member • Sandra Bailey, CEO	• Jenny Hunt, Public Health Medical Officer • John Hendry
Aboriginal Health Council South Australia (AHCSA)	• John Singer, Chair • Shane Mohor, CEO • Amanda Mitchell, Deputy CEO • Jamie Nyaningu, Board Member • Rameth Thomas, Board Member • Polly Sumner-Dodd, Board Member • Les Kropinyeri, Board Member	• Vicki Holmes, Board Member • Roy Wilson, Board Member • Roderick Day, Board Member • Peter May • Helen Smith
Aboriginal Health Council Westerns Australia (AHCWA)	• Des Martin, CEO • Cameron Poustie, Principal Policy Officer • Shaun Wyn-Jones, Policy officer • Sharon Bushby, RTO Manager	• Andrew Webster, HR Adviser • Jenny Sala, Finance Manager • Patricia Bushby, Regional Manager
Aboriginal Medical Services Alliance Northern Territory (AMSANT)	• John Paterson, Executive Officer	• AMSANT Board
National Aboriginal Community Controlled Health Organisation (NACCHO)	• Matthew Cooke, Chair • Pat Turner, CEO • John Gregg, COO	• Chris O'Connell, former COO • Lisa Briggs, former CEO • Board Directors
Queensland Aboriginal and Islander Health Council (QAIHC)	• Matthew Cooke, CEO • Sandra Gillies, Acting COO	• Mark Walker, Company secretary
Tasmanian Aboriginal Centre (TAC)	• Heather Sculthorpe, CEO • June Sculthorpe , Manager, Policy and Planning	• Maureen Davey
Victorian Aboriginal Community Controlled Health Organisation (VACCHO)	• Jill Gallagher, CEO • Katie Smith • Rohan Francis • Louise Lyons • Nadia • Louise Carey • Noeleen Tunney • Deb Blaber • Graeme Fletcher • Yola Frank-Gray	• Winnie Saulle • Eddie Gibbons • Fiona Scott • Raylene Harradine (Bendigo) • Karen Heap (Ballarat) • Gaye Kelly (DWECH) • Lionel Dukakis (GEGAC) • Rudy Kirby (Mildura) • Jason King (VAHS) • Nava Navaratnam (Ngwala)
Winnunga Nimmityjah Aboriginal Health Service (Winnunga)	• Craig Ritchie, Chair • Shanaye Baxter, Deputy Chair • Alana Harris, Board Member • Lynette Goodwin, Board Member	• Ethel Baxter, Board Member • Julie Tongs, CEO • Jon Stanhope, Executive Adviser

Maari Ma Health Aboriginal Corporation	• Bob Davis, CEO	
Commonwealth Department of Health	• Martin Bowels, Secretary • Wendy Southern, Deputy Secretary • Bobbi Campbell, First Assistant Secretary • Meredith Taylor, Branch Head • Kate Wallace, Branch Head • Tania Rishniw, Branch Head • Carly Partridge, Director • Bridget Carrick • Abbie Alcock • Brian Whitton • Liz Duggan **Regional Service Grants Division South Australia** • Bridget Booth Angelina Taylor Kylie Adams **Regional Service Grants Division Western Australia** • John Tunney • Paul Casey **Regional Service Grants Division Tasmania** • Annabel Thorpe • Michelle McLeod • Sandy Taute	• **Regional Service Grants Division New South Wales /Australian Capital Territory** • Asha Manocha • Jody-Ann Brockelbank • Justine Francke • **Regional Service Grants Division Queensland** • Jade Reading • Daniel Kis • Tim Albers • Brooke Rogers • **Regional Service Grants Division Victoria** • Annabel Thorpe • Terrie Tregenza • Dean Peterson • **Regional Service Grants Division Northern Territory** • *No response*
Commonwealth Department of Prime Minister and Cabinet	• Brendan Gibson, Branch Head • Rachel O'Conner, Branch Head • Kate Brodie, Executive Officer • Danielle Aeuckens, Executive Officer	• Irene Kraus, Executive Officer • Kyla Holmberg, Adviser • Michelle Quee, Adviser • Christian Hall, Adviser
New South Wales Health	• Dr Kerry Chant, Chief Health Officer	• Geri Wilson-Matenga, A/Director, Centre for Aboriginal Health
ACT Health	• Ross O'Donoughue, Manager, Aboriginal and Torres Strait Islander Health Policy Unit	• Denise Ryan
Department of Health and Human Services (Tasmania)	• Carole Owen • Narelle Smith	• Kristy Griffin • Hannah Norris
Queensland Health	• Gregory Richards, A/g Manager, Aboriginal and Torres Strait Islander Health Branch	• Marianna Serghi, Executive Advisor
South Australia Health	• April Lawrie-Smith • Daniel Gallant • Lynne Cowan • Tanya McGregor	• Kurt Towers • Nola Whyman • Robert Zadow
Department of Health, Western Australia	• Linda Waters • Susan Powell • Nicole McCartney	• Gendy King • Matthew Hunt

Department of Health, Northern Territory	• *No response*	
Lowitja Institute	• Pat Anderson, Chair	• Romlie Mokak , CEO
Indigenous Allied Health Association	• Donna Murray, CEO	
Australian Indigenous Doctors' Association	• Craig Dukes, CEO	
Healing Foundation	• Richard Weston, CEO	
Reconciliation Australia	• Justin Mohamed, CEO	
Institute for Urban and Indigenous Health	• Adrian Carson, CEO	
Congress of Aboriginal and Torres Strait Islander Nurses	• Janine Mohamed, CEO	
Australian Institute for Aboriginal and Torres Strait Islander Studies	• Russell Taylor, Principal	
James Cook University	• Sophia Couzos, School of Medicine & Dentistry	
Australian Institute of Health and Welfare	• Fadwa Al-Yaman, Head, Indigenous Policy Unit	• Helen Kehoe • Kathleen Osztrenkovics
NDIA Tasmanian branch	• Sue Ham	• Judy Courtney

D.2 Summary of results from the ACCHO Survey

All Aboriginal Community Controlled Health Organisations were sent a survey to provide feedback on their experiences of member support from state/territory peaks, and their involvement in the broader Aboriginal and Torres Strait Islander health sector. The survey asked questions about the state/territory peaks and NACCHO, as well as the relationships between all of the peak bodies (that is, the peak body network).

There were 45 respondents to the ACCHOs survey (see Figure 6 below for the breakdown by state/territory).

Figure 6: Number of respondents to the ACCHO survey by jurisdiction

D.2.1 Use and effectiveness of member support across states

The survey asked respondents whether they used twelve services provided by the state/territory peak. The twelve services are:

1. Networking
2. Governance Support
3. Use of Data
4. IT Support
5. Use of MBS
6. Financial Management
7. Clinical Care
8. Preventative Health Activities
9. Clinical Accreditation
10. Organisational Accreditation
11. Indigenous Workforce
12. Promoting ACCHOs as employers

Respondents chose either 'Yes' or 'No' to using each service, and the percentage of 'Yes' was recorded in the results. Respondents were asked the effectiveness of the service if they responded 'Yes' to using the service. The effectiveness score is the average on a 5-point scale where 1 is *'Very Ineffective*' and 5 is '*Very Effective'*. This was weighted and presented as a percentage.

Just over a third (38%) of respondents highlighted Use of Data, Clinical Care Delivery, Preventative Health Activities, Capacity of Indigenous Workforce and Promoting ACCHOs as Employers as support services that they would like to utilise, but do not know how to access. See Figure 7.

Figure 7: Services respondents would like to utilise, but do not know how

One quarter (23%) of respondents stated that the support services in Capacity of Indigenous Workforce need development. More detailed results against each of the twelve services are provided below.

1. Networking (relationship building, shared learning, formation of sector responses)

- 92 percent of respondents had taken part in networking opportunities provided by their peak body
- 78 percent of respondents felt that this service was either quite or very effective; 1 respondent reported a negative experience.
- 50 percent of respondents indicated they needed this support service, 50 percent indicated it was not needed

2. Governance Support (Board support and skills development, human resources, facilitation, mediation financial governance, constitutional development and membership management)

- 62 percent of respondents stated they had received governance support from their peak body, whilst 38 percent had not.
- Respondents predominately assessed these services as quite effective.
- 50 percent of respondents indicated they needed this support service, 50 percent indicated it was not needed. One respondent suggested they did not know where to access these services.

3. Use of Data (clinical and administrative data, analysis for internal and external reporting, and CQI and planning)

- 64 percent of respondents had used these services.
- Respondents rated data support services highly when compared to other services; 50 percent indicated it was a very effective service, whilst 43.8 percent considered it quite effective.
- There were a particularly large number of respondents who would like this support, but did not know where to get it from (37.5 percent) in comparison to other support services.

4. IT Support (technical advice, information packages and equipment supporting best practice in clinical management, e-health and administrative IT)

- 42 percent of respondents had used these services.
- Respondents predominately considered these services quite effective.
- 20 percent of respondents indicated that they would like this support, but did not know where to access it.

5. Medicare Benefits Schedule systems support

- 38.5 percent of respondents had used these services.
- This service was rated by all respondents as quite or very effective.
- 13 percent of respondents indicated that they would like this support, but did not know where to access it.

6. Assistance with financial issues (best practice management strategies, connection with mentoring and support, sourcing and applying for funding)

- 26 7 percent of respondents had used these services. Of the services surveyed, this was the least utilised.
- This service was rated by all respondents as quite or very effective.
- 22 percent of respondents indicated that they would like this support, but did not know where to access it.

7. Clinical care delivery (providing updates and relevant information on best practice)

- 46 percent of respondents had used these services.
- 83 percent of respondents considered this service either quite or very effective. One respondent considered this service quite ineffective.
- There were a particularly large number of respondents who would like this support, but did not know where to get it from (36 percent) in comparison to other support services.

8. Preventative health activities (including communicable disease)

- 54 percent of respondents had used these services.
- 72 percent of respondents considered this service quite or very effective. However there were a larger number of respondents who felt this service was neither effective nor ineffective, and who felt it was quite ineffective, in comparison to the other services.
- This service was the least accessible of all the services surveyed. 42 percent of respondents indicated they would like this support, but did not know where to access it.

9. Obtaining and maintaining clinical accreditation (provision of tools, advice and support about accreditation standards and programs)

- 42 percent of respondents had used these services.
- Respondents predominately considered these services very effective.
- 8 percent of respondents indicated they would like this support, but did not know where to access it.

10. Obtaining and maintaining organisational accreditation (provision of tools, advice and support about accreditation standards and programs)

- 54 percent of respondents had used these services.
- Respondents predominately considered these services very effective.
- 9 percent of respondents indicated they would like this support, but did not know where to access it.

11. Capacity of Indigenous Workforce (development priorities, needs analysis and work plans)

- 50 percent of respondents had used these services.

- This service was identified as needing development in comparison to other support services. Whilst 62 percent of respondents indicated the service was either quite or very effective, 23.1 percent stated it was quite ineffective. A further 15 percent stated it was neither effective nor ineffective.
- This service was also identified as the second most inaccessible support service of those surveyed. 39 percent of respondents indicated they would like this support, but did not know where to access it.

12. Promoting ACCHOs as employers

- 35 percent of respondents had used these services.
- Respondents predominately considered these services as quite effective.
- This service was identified as the third most inaccessible support service of those surveyed. 38 percent of respondents indicated they would like this support, but did not know where to access it.

Member support from NACCHO

Do you receive direct member support from NACCHO?

- 44 percent of respondent's received direct member support.

How effective is the member support and services you receive from NACCHO?

- Member support was generally considered either very or somewhat effective. 30 percent considered support to be neither effective nor ineffective.

D.2.2 Representation from state/territory peaks and NACCHO

Respondents were asked the effectiveness of their state/territory peak in representation. The effectiveness score is the average on a 5-point scale where 1 is 'Very Ineffective' and 5 is 'Very Effective.' This section summarises the responses to the effectiveness of the respondent's respective Peak Body in representing the organisation and Indigenous health needs to various government and health bodies by state.

Overall, respondents felt that both NACCHO and their peak bodies were generally better at representing them at the governmental level than in the wider health sector; however they were still generally satisfied with the level of representation provided. See Figure 8 and Figure 9 below.

Figure 8: Respondent satisfaction rates with state/territory peak representation

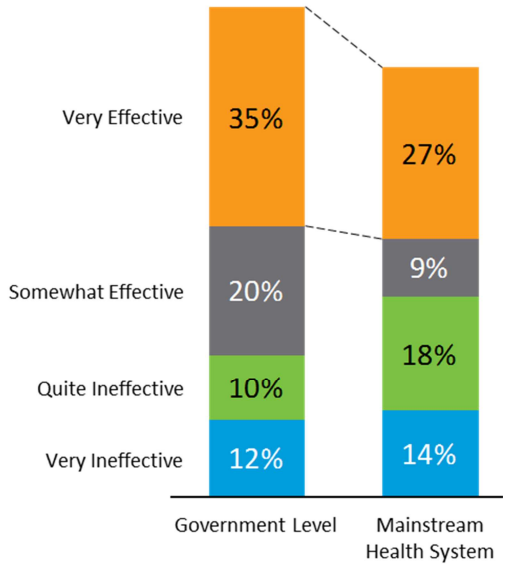
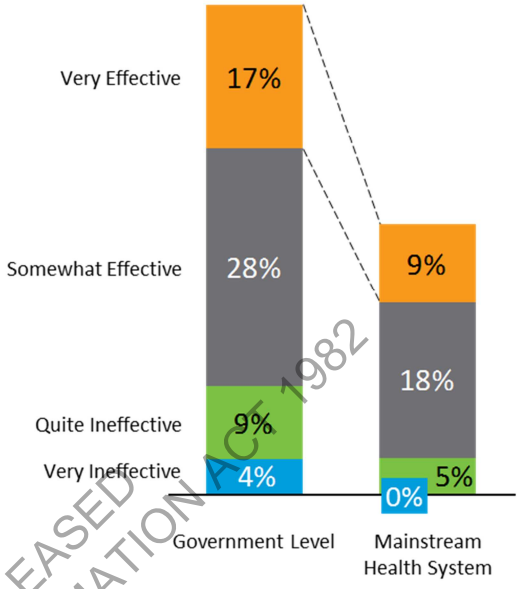


Figure 9: Respondent satisfaction with NACCHO representation



Respondents stated that they are more satisfied with the services provided by their peak bodies than by NACCHO. Just under a third (28 percent) of respondents stated they were very satisfied with their peak bodies, whilst only a tenth (12 percent) of respondents were very satisfied with NACCHO. Further details on the respondents assessments of representation are provided below.

D.2.3 Survey questions and results on representation from state/territory peaks

1. How effective is your peak body (affiliate) in representing your organisation when they engage with the Commonwealth?

- State/territory peaks were considered less effective at representing organisations at the Commonwealth level than at the state/territory level.
- 52 percent of respondents considered their state/territory peak as either very or somewhat effective.

2. How effective is your peak body (affiliate) in representing your organisation when they engage with the State/Territory Government?

- State/territory peaks were considered better at representing organisations at the state/territory level than at the Commonwealth level.
- 58 percent of respondents indicated their state/territory peak as either very or somewhat effective.

3. How effective is your peak body (affiliate) in representing your organisation when they engage with the mainstream health system?

- State/territory peaks were considered less effective at representing surveyed organisations to the mainstream health system.
- Whilst 36 percent of respondents had a positive opinion of their state/territory peak in this regard, 46 percent had either a negative or neutral opinion.

4. How effective is your peak body (affiliate) in representing the health needs of Aboriginal and Torres Strait Islander people to these governments?

- Whilst 62 percent believed their state/territory peak was effective, 21 percent considered their peak body to be quite ineffective.

5. How effective is your peak body (affiliate) in representing the health needs of Aboriginal and Torres Strait Islander people to the mainstream health sector?

- Respondents considered their peak bodies to be less effective at representing Aboriginal and Torres Strait Islander peoples' health needs to the mainstream health sector than to government. 29 percent felt their peak body was either quite or every ineffective.

D.2.4 Survey questions and results on representation from NACCHO

1. How effective is NACCHO in representing your organisation when they engage with the wider health sector?

- 41 percent of respondents considered them neither effective nor ineffective.

2. How effective is NACCHO in representing your organisation when they engage with the Commonwealth?

- 48 percent of respondents considered NACCHO to be either very or somewhat effective, whilst 13 percent considered them quite or very ineffective.

3. How effective is NACCHO in representing the whole community controlled Aboriginal and Torres Strait Islander health sector in their engagement with Commonwealth government?

- 68 percent of respondents considered NACCHO either very or somewhat effective in this area.

4. How effective is NACCHO in representing the whole community controlled Aboriginal and Torres Strait Islander health sector in their engagement with the broader health system?

- NACCHO was considered effective in this area by 57 percent of respondents, slightly less effective here than in their representation to government.

5. How effective is NACCHO in representing the health needs of Aboriginal and Torres Strait Islander people to Commonwealth and State/Territory governments?

- NACCHO was considered either very or somewhat effective by 52 percent of respondents; only 14 percent believed they were quite ineffective.

6. How effective is NACCHO in representing the health needs of Aboriginal and Torres Strait Islander people to the mainstream health sector?'

- NACCHO was considered either very or somewhat effective by 55 percent of respondents; 10 percent believed they were quite ineffective.

D.3 Communication from state/territory peaks and NACCHO

The ACCHO Survey also asked respondents about how frequently they receive contact from their state peak bodies and NACCHO- i.e. less than 3 times a year, monthly, weekly or daily. Contact referred to member meetings, emails and contact with staff from the affiliate.

D.3.1 Survey questions and results on communication from state/territory peaks

1. How often do you have contact with your state/territory peak including through member meetings, emails and contact with staff (affiliate)?

- Results varied across daily, weekly, monthly and less than three times a year. Whilst most respondents had weekly contact, 20 percent had contact less than three times a year.

2. Are you satisfied with the service they provide in these instances? For example - do they follow up on requests for support; do they canvas your organisation's position on issues as they arise?

- Respondents were split between being either very or quite satisfied, and being neither satisfied nor dissatisfied. Only 8 percent of respondents were either quite or very dissatisfied.

D.3.2 Survey questions and results on communication from NACCHO

1. How often do you have contact with NACCHO including through member meetings, emails and contact with staff?

- 47.8 percent of respondents indicated they had contact less than 3 times a year, with 34.8 percent having monthly contact.

2. Are you satisfied with the service they provide? For example - do they follow up on requests for support; do they canvas your organisation's position on issues as they arise?

- Respondents were less satisfied with the service provided by NACCHO than that provided by their relevant state/territory peak. 15.5 percent fewer respondents stated they were very satisfied with NACCHO's services, and an increased 8.5 percent stated they were quite dissatisfied.

D.3.3 State/territory peaks and NACCHO

Results below show the average effectiveness of NACCHO and the state/territory peak bodies (affiliates) at working together as a peak body network to achieve improvements in Indigenous Health.

1. How effective are NACCHO and the state/territory peak bodies (affiliates) at working together as a peak body network to achieve improvements in Aboriginal and Torres Strait Islander health?

- 43.5 percent of respondents considered NACCHO and the state/territory peak bodies to be either very or somewhat effective

D.4 Summary of results from the Primary Health Network Survey

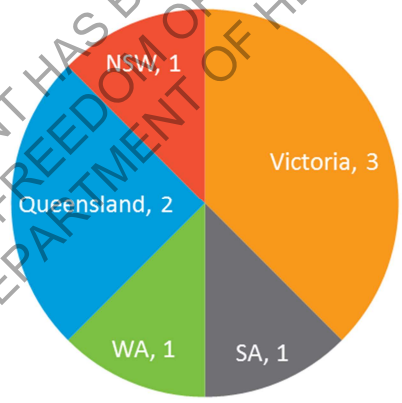
A survey was sent directly to the CEOs of all 31 Primary Health Networks (PHNs). The PHN survey was designed to engage with the CEO's of all PHNs in assessing their experiences with:

- Any ACCHOs in their respective regions
- Their state/territory peak body/affiliates; and
- NACCHO.

The survey also looked at the perceptions of the needs of both the community controlled and mainstream health sectors in improving the services delivered to Aboriginal and Torres Strait Islander people, and outcomes in Aboriginal and Torres Strait Islander health.

There were a total of 8 respondents (See Figure 10 for a breakdown of respondents by state). A written response was provided by PHN Northern Territory, therefore quantitative results were not recorded for this particular PHN. This section provides an overview of the responses to the survey.

Figure 10: Survey respondents by jurisdiction



D.4.1 Key themes from PHN survey results

- PHN's perceptions of Aboriginal community controlled peak bodies in their jurisdictions varied. Half (3) of the respondents expressed negative views of their local peak bodies, describing their roles as unclear and minimal, with one describing their local peak body as negative and unproductive.
- PHNs had limited interaction with their respective peak bodies outside of the tri-partite framework. Just over a third (37 percent) of respondents had any other formal working relationship.
- Just under a third (28 percent) of respondents did not have a clear idea of the role played by NACCHO.

D.4.2 Summary of PHN survey questions and results

1. Where is your PHN based?

- The highest level of representation was from Victoria, with 3 PHNs responding. 2 PHNs responded from Queensland, whilst NSW, SA and WA each had 1 respondent.
- There were no responses from PHNs in either TAS, ACT or NT (NT provided a written submission).

2. Are there particular Aboriginal and Torres Strait Islander health issues that your PHN is focusing on in your jurisdiction?

- 89 percent of respondents indicated that they were focusing on specific issues in their jurisdictions.

3. Do you have any plans for commissioning Aboriginal health related services?

- 78 percent of respondents indicated they did have plans in this area.

4. Do you currently commission any specific Aboriginal and Torres Strait Islander health-related services?

- 67 percent of respondents indicated that they commission specific health-related services.
- Of these services, half were delivered via an ACCHO/Aboriginal Medical Service, and half were delivered by another service provider.

5. What were your reasons for selecting the service provider?

- Respondents highlighted cost effective delivery, local knowledge, a history of past engagement and the local ACCHO being over capacity as reasons for their selection.

6. What role do you think the Aboriginal community controlled peak body in your jurisdiction plays?

- Responses on this were varied. Half of the respondents expressed negative views of their local peak bodies, describing their roles as unclear and minimal, with one describing their local peak body as negative and unproductive.
- Other respondents suggested that the peak body undertakes planning, service linkage, advocacy and sector leadership in their respective jurisdictions.

7. From your organisation's perspective, what do you see as the most effective role for the peak body in your jurisdiction?

- 4 of the 6 responses for this question stated governance support, consultation, collaboration and guiding for ACCHOs.
- Two respondents referred to their answers to question 10, indicating disenfranchisement with their peak bodies.

8. Do you have any formal working relationship (other than the tri-partite framework) with the peak body in your jurisdiction?

- Only 38 percent of respondents had any other formal working relationship, suggesting that most interaction between PHNs and peak bodies is via the tri-partite framework.

9. Do you have plans for any formal working relationship (other than the tri-partite framework) with the state/territory peak body in your jurisdiction?

- 50 percent of respondents indicated that they did have plans in this regard.

10. Are there any ACCHOs in your region?

- 88 percent of respondents stated that there were.

11. Do you have any formal working relationship (other than the tri-partite framework) with any ACCHOs in your jurisdiction?

- 63 percent of respondents indicated they did have formal working relationships.

12. Do you have any plans for a formal working relationship (other than the tri-partite framework) with any ACCHOs in your jurisdiction?

- 88 percent of respondents indicated they did have plans for formal working relationships.

13. What role do you think the National Aboriginal Community Controlled Health Organisation plays on a national level?

- Respondents indicated advocacy, providing training, networking events and policy development and interacting with the community.
- Two respondents indicated that they were unsure.

14. From your organisation's perspective, what do you see as the most effective role for NACCHO?

- Respondents highlighted providing peak body leadership in developing policy, improving cohesion and providing a single point of advocacy to the Commonwealth.
- One respondent indicated they were unsure, whilst another respondent stated that NACCHO had no role in their region.

15. Are there any other comments you wish to make?

- Respondents took the time to highlight the important role of ACCHOs and their state/territory peaks in the community in combatting disadvantage for Aboriginal and Torres Strait Islander Australians.
- One respondent stated that a greater degree of transparency, a better spirit of collaboration and mutual respect is necessary to improve relationships.

Appendix E Literature review on peak bodies

Outline and purpose of section

This section provides a summary of the literature in relation to peak bodies. It is divided into three parts.

The first section begins by outlining differences in the terminology of peak bodies, identifying key differences of interpretation of what a peak body is. Within this, further attention is given to the historical background of community peak bodies and the roles and responsibilities they typically hold.

Secondly, what makes an effective peak body is considered. This section outlines principles often shared by effective peaks, and then considers further what this means in the context of a Federated political system.

Finally, the section focusses on the context of indigenous community managed programs and considers some of the findings within the literature. The section is framed as enablers and barriers to successful operation and considers both the internal and external environment of community managed programs.

What is a peak body?

A peak body or peak organisation is an association made up of industries or groups with allied and shared interests. Peak bodies typically serve as umbrella entities that are able to act as an intermediary between government and the community they represent. The term 'peak body' is used primarily in Australia, and can be known as an advocacy group or trade association elsewhere in the world. Peak bodies may develop from grass roots social movements, or be created by or with government to assist with the consultative process.[31]

Review of the relevant literature demonstrates a variety of interpretations for peak bodies. Differences include the services offered to members, the formalisation of the interaction with Government, and the emphasis on representation of member organisations or the broader sector/community. Three definitions are provided for consideration.

An ARC funded study that was released in September 2003 noted the variation in understanding of the role of peak bodies.[32] As part of the study, individual community peak bodies were invited to define a peak body from their own perspective. Those that responded to the invitation offered definitions that differed in relation to several aspects.

A broad definition arrived at by Melville and Perkins' study is presented in the orange box below. The definition is taken directly from a peak body survey submission.

A peak body is:

"A non-government organisation whose membership consists of smaller organisations of allied interests. The peak body thus offers a strong voice for the specific community sector in the areas of lobbying government, community education and information sharing between member groups and interested parties"

(Melville, 2003)

[31] Bridgman, P. & Davis, G. (2000) *The Australian Policy Handbook*, 2nd Edition, Allen & Unwin: Sydney, p.83

[32] Melville, R. & Perkins, R. (2003) *Changing Roles of Community Sector Peak Bodies in a Neo-Liberal Policy Environment in Australia*, University of Wollongong, NSW.

Limitations in this definition do however exist. Firstly, as is noted by the study itself, the definition does not provide a theoretical basis for the legitimacy of peak bodies in the Australian political process.

South Australia Council of Social Services (SACOSS) also outlines an inaccuracy in language in the above definition. While peak bodies operate as an umbrella organisation for multiple members, members are actually often significantly larger in terms of both operating budget and staff than their representative peak body.[33] Furthermore SACOSS outlines two further limitations of the definition used by Melville. Firstly, the paper notes that the representative roles that peak bodies play for its members are not clearly articulated in the definition. Secondly, while it is not an expectation that all roles that peaks play are outlined in the definition, it is felt that key peak activities, most notably sector development, is not included.

Stickland and Goodes' 2008 review of the Tasmanian health and human services peak bodies provides further definition of peak bodies, in the context of those that should be eligible for funding from the state government.[34] This is included in the grey box below.

Characteristics of a peak body:

1. Membership base is predominately organisations, not individuals
2. Membership base is proportionate to the sector or industry being represented
3. Demonstrates effective mechanisms to represent members' views
4. No direct service delivery to consumers
5. Demonstrates an effective state-wide coverage
6. Demonstrates the capacity to provide input into policy, program and service development.

(Strickland and Goodes, 2008)

Aspects of the definition above clearly align with the definition chosen by Melville in her study. Characteristics 1 to 3 are all either implicit or explicit in the definition provided. Characteristic 4 might be considered overly restrictive given peak bodies could be involved in minimal service delivery, often in the form of pilot trials.[35] Characteristic 5 also does not apply beyond the context of state funding. While characteristic 6 demonstrates a focus on shaping policy that is present in the definition used by Melville.

Finally, the 1995 Industry Commission report on funding for peak bodies and other charitable organisations provides another definition of peak bodies.

A peak body is:
A representative organisation that provides information dissemination services, membership support, coordination, advocacy and representation, and research and policy development services for its members and other interested parties

(Industry Commission, 1995: 181)

[33] SACOSS (2011) "Unique Peaks: the definition , role and contribution of peak organisations in the South Australian Health and Community Services Sector"

[34] Strickland, M. & Goodes, K. (2008) *Review of Tasmanian DHHS-Funded Peak Bodies*, Office for the Common Sector, Department of Health and Human Services, Tasmania.

[35] See TasCOSS (2009) *TasCOSS' Response to the Review of DHHS-funded Peak Bodies*, Tasmanian Council of Social Service, Tasmania.

The 1995 report also outlines that peak bodies differ as they do not provide direct services.[36] The Commission also further considered more detailed taxonomy around peak bodies, considered further in 0.0.0.0 – Classifying peak bodies.

Further consideration on defining a peak body

The definitions considered in the previous section provide a good basis for considering the role of a peak body organisation. However, there are three clear areas that arise in the literature which should be considered further.

1. Is the focus of peak bodies on the provision of services to members or influencing policy through advocacy?
2. Do peak bodies have an inherent role in the democratic process which should inform their definition?
3. Is it a pre-condition that peak bodies represent those that are in some way disadvantaged?

These are discussed in further detail below.

Outward-looking or inward-looking member services

Within the literature discussion occurs as to whether the role of a peak body is inward looking, through the provision of services and sector development to members of that organisation, or outward-looking, through lobbying, advocacy and other work with the aim of influencing policy.[37] While differences are noted within the literature Melville makes the point that inward or outward service delivery should not act as delineation between different peak bodies, and instead represents a balance of the needs of its members. This point was noted by survey respondents themselves. Peak body definitions should therefore not place greater emphasis on either function when defining 'what is a peak body?'. Although respective weight placed by organisations on each function might differ, broadly speaking some emphasis is placed on each by most peak body organisations.

Indeed, Melville's 2003 study found that the emphasis placed by peak bodies on advocacy work to that of delivery of member services. It there appears to exist a comparable division of time between responding to the demands of their constituents through advocacy and lobbying functions, and responding to the expectations of funders to disseminate information to the sector.[38]

Our three definitions differ in relation to the respective emphasis on the outward facing and inward facing nature of peak body services. The Strickland and Goodes definition emphasises the advocacy and research role but does not encompass functions that relate to community or sector development. As a result, arguably the other two definitions present a more well-rounded assessment of 'what is a peak body?'.

Democratic functions of peak bodies

The democratic function of peak bodies and the formalisation of their role within the political process is also considered in defining peak bodies. Some literature sees the formal inclusion of peak bodies in the consultation process as a reflection of the legitimacy of the organisations in representing the views of members. Peak bodies therefore play a role for extra-parliamentary representation for groups that may not be well represented through parliamentary institutions.

Dalton and Lyons considers the democratic merits of peak bodies in two parts. Firstly, the representation of members views with in the policy-making process. And, secondly, the ability to prepare people for

[36] Industry Commission (1995) *Charitable Organisations in Australia*, Report No. 45, AGPS, Melbourne.
[37] Quixley, S. (2006) "What is a Peak Body?: Summary and Analysis of Key Documents, Youth Affairs Network Queensland, Brisbane.
[38] Melville (2003), p.17

involvement in the democratic process. They note that the relative ability to fulfil each function is likely to depend on the size and type of the organisation.[39]

This is supported by others. Sawer outlines five democratic functions that peak bodies play:[40]

1. Recognition of multiple forms of identity mobilised by new social movements
2. Creation of deliberative forums through which policy claims of new constituencies can be crystallised
3. Representation of marginalised and stigmatised groups that are not 'vote winners' and would otherwise lack voice
4. Involvement in policy process of those most affected by government decisions, the groups most reliant on government intervention for quality of life chances
5. Development of communicative or policy capacity or the part of bodies representing the resource-poor sections of the community

Definitions that emphasise the democratic merits of peak bodies therefore differ based on the relative weight placed on legitimacy gained through the process of member representation or through formalisation in the policy process and/or the presence of public funding[41]. Other definitions may place no emphasis on this democratic legitimacy.

Representation of disadvantaged

Consideration of peak bodies should also focus on the broader representative roles that peak bodies play within the Australian democratic process. While there is broad understanding that peak bodies play a representative role for member organisations, generally outlined in the earlier definitions, others imply a broader representation of the community or sector in which it operates.

For instance, the Australian Council of Social Services (ACOSS) places the role of peak bodies in more overtly political terms. Not only do peak bodies therefore represent the organisations which are members, they also ensure the voices of the poor and marginalised are heard within the democratic process.

This is noted as a clear difference to the international context. In their review of the international literature Melville and Perkins finds the representation of non-members and broader groups of disadvantaged or the sector generally as distinct to the Australian system. Thus, in the Australian context, it is argued, advocacy occurs not only for members of the peak organisation, but also for the group of a broader disadvantaged population. While this appears to broadly be the case, further consideration is provided in Section 0.0.0.0 – Classifying peak bodies.

Whereas business and professional bodies have traditionally had the means and access required to represent their interests within the policy/political process, community development groups have historically not had sufficient resources to meaningfully contribute the views of their sectors in the policymaking process. Funding community based peak bodies offers a method for providing a counter-weight to these groups.[42] Consideration is given to this in the section below which provides an overview

[39] Dalton, B. & Lyons, M. (2005) "Representing the Disadvantaged in Australian Politics: the Role of Advocacy Organisations", Democratic Audit of Australia, p.24

[40] Sawer, M. (2002) "Governing for the Mainstream: Implications for Community Representation", Australian Journal of Public Administration, 51(1), 29-49.

[41] Melville, R. (1999) Nonprofit Umbrella Organisations in a Contracting Regime: A comparative review of the Australian, British and American literature and experiences, *International Journal of Not-for-profit Law, 4 (1).*

[42] Clark, A. & Pisarski, A. (2015) "Peaking over the Horizon", *Parity*, 28 (8), 32-33, p.33

of the historical development of community peak bodies with detail on the distinction made between community services peaks and others in more recent times.

For some then, the representation of the disadvantaged represents an inherent part of the function of a peak body.

Historical background of community peak bodies

While government in Australia has provided funding since the 1930s to enable participation of peak bodies in "extra-parliamentary" activities[43], the 1970s saw the support significant increase in new peak bodies as a result of democratic participative reforms.[44] Policy development channels were opened up to the community sector through the establishment of government advisory bodies, consultative committees and commissions of enquiry. Tied to this was the formulation of new policies and practices, and the development of new peak bodies in the community sector. Indeed, during the period between 1970 and 1972, 47,000 organisations that were set up during the period received financial support from the government.[45]

Several reviews of government funding for community sector peak bodies has occurred at both the state and federal level. Two key Federal reviews are discussed in detail here – the 1991 House of Representatives Standing Committee on Community Affairs (HORSCCA) review and the 1995 Australian Industry Commission review of charitable organisations.

The 1991 HORSCCA review evaluated the Federal Government funding for secretariat services for peak bodies. The review focused on the rationale for Federal Government funding, criteria that could be used for such funding and requirements of accountability to the funding department and the organisations' own membership. The review concluded that the funding enabled representative groups to be represented in the policy making process. It also reported that the voice provided in the formulation and implementation of policy to community groups offered a practical and legitimate counterweight to organised private interests. As was stated in the report "the funding of peak community organisations ensures that the needs and aspirations of significant sections of the community are accessible to Government".[46] The committee also found that funding should be limited to the provision of infrastructure required by non-profit organisations, and not available for high-income groups such as occupational groups or professional groups. It was determined that funding should be provided to only organisations that were able to demonstrate they were democratically responsive and representative to their constituency.[47]

The 1995 Industry Commission on charitable organisations also considered the role of peak bodies in the Australian political context. The review adopted a broader lens than the HORSCCA review, outlining the benefits of the charitable sector for Australian society. In general terms, the review found the role of peak bodies to be both valuable and appropriate, and played a significant representative role in Australian politics. More specifically, the review recommended a review of Commonwealth and State government funding arrangements to consider the roles and functions of peak bodies; responsibilities of peak bodies; level, duration and selection criteria for funding; and formal mechanisms for reviewing the

[43] May, J. (1996) "The role of peak bodies in civil society" in Farrer, A. & Inglis, J. (eds.) *Keeping it Together: State and Civil Society in Australia*, Pluto Press: Sydney, p.252.
[44] Goodwin, S. & Phillips, R.(2015) "Policy capacity in the community sector" in Head, B. and Crowley, K. (eds.) *Policy Analysis in Australia*, Policy Press: United Kingdom, p.243.
[45] Graycar, A. & Jamrozik, A. (1993) *How Australians live: social policy in theory and practice*, Macmillan: Melbourne.
[46] HORSCCA(1991) ' You Have Your Moments: A Report of the Funding of Peak Health and Community Organisations', Canberra, AGPS., p.17
[47] HORSCCA (1991), pp.15-16

criteria.[48] Findings and recommendations in relation to the role of peak bodies and the appropriateness of government funding therefore largely mirrored those of the HORSCCA review.

Despite the supportive findings from both the HORSCCA (1991) and Industry Commission (1995) reviews, much of the literature reviewed points to changes that have taken place in government policy in the context of the 1990s, notably the emergence of neo-liberal principles and the effect this has had on the operation of peak bodies. For many, changes in the political context during the 1990s have placed additional constraints and pressures on the operation and perceived legitimacy of peak organisations in the Australian political system.[49] The literature points to the significant reduction in funding between 1990 and 2000. During the ten year period funding to peak bodies reduced from $6.3 million to $3.2 million.[50] These changes have placed additional pressure on both the operation and legitimacy of peak organisations. As is noted by Sawer, their legitimate role as a feature of the extra-parliamentary democratic has been undermined by suggestion "they did not represent broader constituencies and that they distorted grass-roots opinion". The emphasis placed on "governing for the mainstream" by the Howard government is outlined as an example of this shift.[51]

Similarly an increased emphasis on Public Choice Theory, which places an emphasis on the individual as opposed to group interests, also minimises the legitimacy of peaks, with interest groups seen as a distortion of the process for organisational gain.[52] While traditional NGO activity related to good works, for instance, environmental conservation and poverty amelioration, is seen positively, the role NGOs play in public advocacy and policy input is perceived as interfering with the market logic.[53]

The historical background of community sector peak bodies outlines the manner that community sector advocacy is determined by both the institutional arrangements for participation and also partisan politics at the time and the subsequent interpretation of the appropriate role for the community sector.

Classifying peak bodies

An earlier section of this appendix outlined the manner in which Australian peak bodies play a relatively unique role in advocating on behalf of not only their members, but also for the broader sector, including disadvantaged individuals and groups. While widespread in Australia to an extent not seen elsewhere, it would be incorrect to state all peak bodies adopt this role. Further consideration is given to classifying peaks in this section.

The Industry Commission report of 1995 provides a framework for outlining these differences, as it considered four categories of peak that exist at the national level:

- *Social policy peaks* – membership of the peak is made up of organisations, however primarily bodies represent consumers (e.g. Australian Council of Social Services)
- *Service development peaks* – 'trade' organisations for service providers (e.g. ACROD)
- *Consumer peaks* – broad based membership of consumers, with the peak advocating on behalf of consumer (e.g. Councils for the Ageing)
- *Employer/employee peaks* – peak bodies for employees or employers (e.g. Australian Society of Association Executives)

[48] Industry Commission (1995), Recommendation 7.1.

[49] See May (1996), Sawer and Jupp (1996), Sawer (2002) and Melville (1999,2003)

[50] Cheverton, J. (2005) "Past their peak? Governance and the future of peak bodies in Australia", *Australia Journal of Social Issues*, 40 (3), p.2

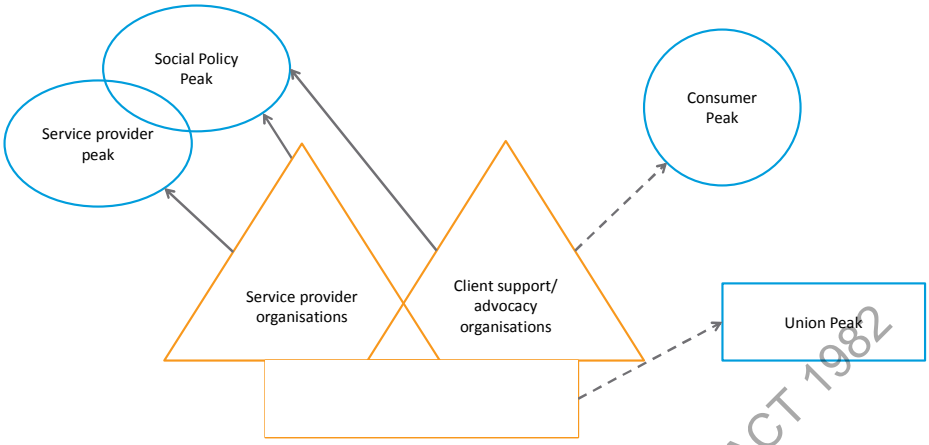
[51] Sawer, M. (2002), p.44.

[52] Self, P. (1996), p.225 in Sawer (2002)

[53] Staples, J. (2007) "NGOs Out in the Cold: Howard Government Policy Towards NGOs", *University of New South Wales Faculty of Law Research Series*, Paper 8., p.8

Figure 11 provides a summary of the relationship between peak classifications and their member organisations.

Figure 11: Taxonomy of Peak Bodies[54]



While it is a useful taxonomy to distinguish between the core features of a peak body organisation, namely its membership and who it supposes to represent, the classifications can become blurred. This is particularly the case for 'mission driven' organisations.[55]

Roles and responsibilities of peak bodies

While variation exists between peak bodies depending on their industry, size and nature, broad understanding of the roles they played is articulated in the literature we have reviewed. Table 6 provides a summary of the roles and responsibilities that are listed within this literature. It should be noted that terminology may differ. These are reflected in the bracketed terms under the primary heading.

Table 6: Summary of Peak Body responsibilities found in literature

Role and/or Responsibility	Literature Source		
	Industry Commission (1995)	Melville & Perkins (2003)	Strickland & Goodes (2008)[56]
Information dissemination	✓	✓	✓
Membership support (Member support)	✓	✓	
Monitoring industry		✓	
Monitoring service delivery		✓	
Coordination (Sector consultation and coordination)	✓	✓	

[54] Taken from SACOSS (2011)

[55] SACOSS (2011), p.4

[56] Note TasCOSS (2009) requested the addition of 'research' and 'education' to Strickland and Goodes (2008) original list.

Role and/or Responsibility	Literature Source		
Networking		✓	
Advocacy/Lobbying (Advocacy and representation)	✓	✓	✓
Research/ policy development (Policy development, advice and responses)		✓	✓
Sector capacity building			✓

The table above provides a valuable summary of the literature. It also supports interpretations that arise in the literature that the primary roles of peak bodies is the effective representation of members through advocacy and lobbying functions and the dissemination of information (often from government) to the sector the peak body represents. That is, peak bodies ideally have both inward facing roles and outward facing roles.

What makes an effective peak body?

Review of the literature related to Australian peak bodies identifies several characteristics that are likely to be held by an effective peak body. These are presented in the list below as principles of an effective peak body.

A peak body is:

- **representative** of and **legitimate** to the people it supposes to represent
- of a structure which ensures **good governance**
- **efficient** and **cost-effective**
- **autonomous** from government
- **integrated** in policy-making process
- **accountable** to members and funders.

These are outlined in greater detail in the sections below.

Representative

As has been noted much of the literature emphasises the representative role that peak bodies play. The mandate that a peak body holds is in relation specifically to represent a particular group of organisations or people. A clear emphasis on the requirement for peak bodies to be representative is found in several reviews at both the State and Federal level. The HORSCCA (1991) and Industry Commission (1995) reviews both outline the centrality of representation to the legitimacy of peak bodies. The 1993 South Australian review also found funding should be restricted for those peaks that could not outline the manner in which they were representative and responsive to their constituencies.[57]

Figure 12 provides an outline of how representation is intended to work within a peak body at a high level.

[57] Hamilton, C. & Barwick, N. (1993) *Scaling the Peaks: a policy framework for the public funding of statewide non-government organisations in the community services,* South Australian Serving Communities Implementation Task Force, Adelaide., p.11

Figure 12: Representation of membership under peak structure[58]

The figure above demonstrates the manner community peak organisations are required to synthesise the experiences that are possessed by their members with expertise available within the peak body itself. In doing so a peak body should offer a unique and distinct perspective on policy. This representation could occur through advocacy, through lobbying or contribution to policy development and research at various stages of the policy process. In this manner, the peak structure offers "a vital feedback link between members and government".[59]

Furthermore, in instances where groups represent not only the members of the peak body but also a broader affected community there is a need for a holistic identity for the organisation. In this sense, community peak bodies in the Australian often play a 'dual role' not typically played by comparable organisations in the international context. These organisations act as both member serving organisations but also serve as advocates for the people that use the services that are provided by their members.

Good Governance

Good governance is a necessary mechanism for ensuring the effectiveness of peak bodies and the representative value of their role. As was noted in the Industry Commission review there is a tendency toward the median constituent on issues of difference unless clear governance processes are in place to ensure broader representation. These processes and activities should also be transparent to organisational members.[60]

Taylor and Warburton consider the need for peak bodies to be 'accountable downwards' with the legitimacy derived from the organisation's membership.[61] This is also best achieved through appropriate and transparent governance structures. These structures both clearly demonstrate how the views of members are identifies by the peak organisations, and how they are represented to government and other external stakeholders.

Diversity of the board represents one such mechanism. This can however be both a benefit and a complication.[62] Diverse boards with conflicting interest might lead to strained and untimely decision

[58] Adapted from SACOSS (2010)

[59] Boris and Mosher-Williams (1998), p.501

[60] Industry Commission (1995), p.197)

[61] Taylor, M. & Warburton, D. (2003) "Legitimacy and the role of the UK third sector organisations in the policy process", *Voluntas: International Journal of Voluntary and Nonprofit organisations*, 14(3), pp..321-338, p.329

[62] Chaskin, R.J. (2003) "Fostering neighbourhood democracy: Legitimacy and accountability within loosely coupled systems", *Nonprofit and Voluntary Sector Quarter*ly, 32 (2), pp.161-189, p.181

making, while boards with uniform interests are likely to fail to represent the diversity that exist within the membership of the peak body itself. There is thus a need to balance the "united corporate view" with accurate reflections of the interests and experiences of their membership.[63] Inclusion of aspects of conflict around a range of interests and recognition of difference in the views of members is important.

Arrangements therefore need to establish and maintain a balance between representing the diversity of their membership and being an effective decision making mechanism. Such mechanisms are likely to avoid concerns on peak bodies being perceived as a 'black box', where it is not clear and transparent as to how membership is represented through the governing body.[64]

Autonomous to Government

The level of autonomy from government a peak body holds is found to be a significant factor in the relative effectiveness of it as a peak organisation.

The 1995 Industry Commission report outlines that a "carrot and stick" approach was perceived as being used against outspoken peak bodies. Due to the large proportion of revenue that is derived from State and Federal Government funding it is sometimes perceived a responsibility exists to the funding party. Forced amalgamations provide another mechanism.[65] Given the extra-parliamentary responsibilities of peak bodies it is therefore important that peaks are provided a level of autonomy to effectively represent their constituency.

The close nature of funding arrangements and reliance can strengthen the influence of government officials on peak body activity. This can be either through direct influence, as noted above, or indirect influence– i.e. subtly shaping the understanding of concerns that they as peak bodies need to respond to.[66]

Sawer outlines the manner in which peaks should be independent of government and reflect their constituency rather than government priorities.[67] Legitimacy should be derived primarily from the membership of the peak organisation. For this reason it is important to ensure that extra-parliamentary institutions reflect the diverse needs of particular groups of people, not the priorities of the government.

Integrated into policy-making cycle

Formal integration into the policy making process is an important determinant of an effective peak body.

Formal integration has implications for both the legitimacy of the peak body and also the effectiveness of it. Strong relationship with government and policy makers (be it at state or Federal level) is important for peak bodies to effectively represent the view of their members.

Accountable

Accountability is an important principle for effective peak bodies. There is broad consensus within the literature that accountability applies to both the funding sources of the organisation, often government, and the membership of the organisation itself (especially where membership fees are paid). There is therefore a need to balance the respective accountabilities to each group of parties to ensure peak bodies can function effectively.

The Industry Commission report found broad agreement between peak bodies consulted that peak bodies are accountable to both their membership and the bodies that fund them.[68] The HORSCCA review

[63] Cheverton (2005), p.434
[64] Cheverton (2005), p.434
[65] Staples (2007), p.9
[66] Dalton & Lyons (2005), p.12.
[67] Sawer, M. (2002)
[68] Industry Commission (1995), p.199

outlines that accountability should apply to both groups, however also note the greatest emphasis should be placed on accountability to the membership. According to HORSCCA it is crucial that peak organisations are accountable to their constituency, with their place in the political process determined by their ability to be accountable to their members. [69]

Appropriate acquittal and outcomes measures and regular reporting arrangements provide one mechanism for ensuring accountability to members. Processes such as these should enable members to assess the peak activities against their expectations of the peak body.

Given there is often not competition for membership from other peak bodies within a sector, and membership revenue makes up typically a small proportion of peak body revenue, mechanisms that encourage the participation and provision of feedback from members is more likely to provide a suitable model for peak body accountability than a market-based approach.

Impediments to peak bodies

The key impediments to effectiveness for peak bodies can also be seen as mirroring the principles noted above.

Melville and Perkins' 2003 study found the following five features as the foremost impediments to peak bodies positively fulfilling their roles:

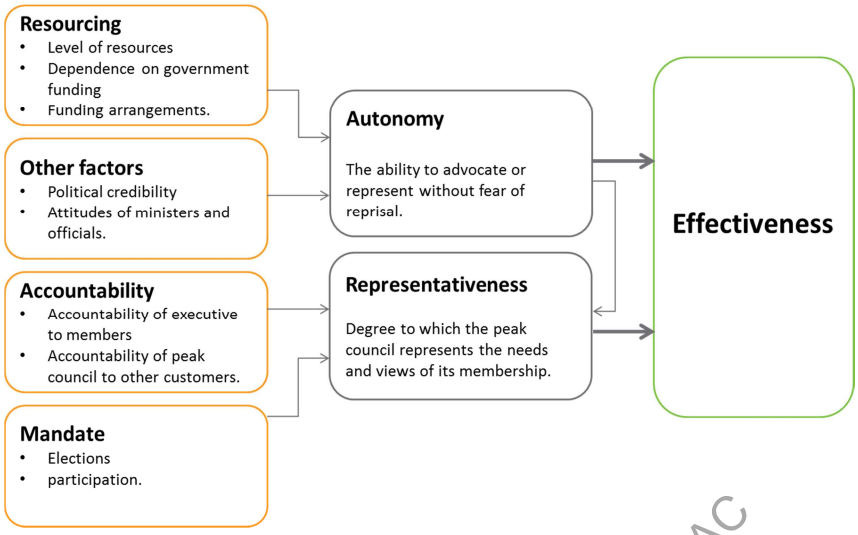
- Changes in government policy
- Reduction of funding
- Demands by members
- Inadequate funding
- Bureaucratic interference

Summary of effective peak principles

The 1995 Industry Commission offers a good framework to consider the principles that have been outlined above. Autonomy and representativeness are presented as the primary factors influencing the effectiveness of peak bodies. Several of the other factors we have outlined in our literature review are considered in parts of the secondary factors that are listed. Figure 13 provides a summary as presented in the Industry Commission report.

[69] HORSCCA (1991), p.44

Figure 13: Factors influencing the effectiveness of peak bodies[70]



This model provides a valuable way of considering the principles that represent an effective peak body. As noted, the framework above also clearly outlines the foremost concerns of peak bodies represented within the literature, their relative autonomy from their government funders, and the efforts to accurately and effectively represent members' views and experiences.[71]

Successful peaks in federated structure

The role of an effective peak body in a federated structure is also an important consideration. Unlike several other comparable countries, significant responsibilities for welfare have historically been retained constitutionally by the Australian state governments. Furthermore, development and expenditure on social policies can also happen at the local government level. With all three levels of government – federal, state and local – involved in policy development and service delivery, consideration of the most appropriate and effective way of representing sector interests at the different levels.[72]

Impetus for the development of peak bodies also differs. While several emerge at the Federal level, more often than not the impetus for peak bodies for newer social movements often emerge at the state level.[73] Given this, coordination across states becomes of significance. Likewise, national structures can often develop out of the legacies of state based peak organisations.

Enablers and barriers to effective Indigenous community managed programs

This section considers the enablers and barriers to effective operation of Indigenous community managed programs.

[70] Adapted from Industry Commission (1995)
[71] See Sawer (2002), Cheverton (2005), Melville (2003)
[72] Graycar & Jamrozik (1993)
[73] Sawer & Yupp (1996)

The Australia Institute of Family Studies (AIFS)[74] provides a summary for the factors for successful operation of these program and also outlines possible barriers to successful Indigenous community managed programs. All barriers and enablers listed derive from the AIFS work unless stated.

Factors that enable effectiveness in community Indigenous managed programs include:

- Facilitating community ownership and control
- Embedding culture
- Employing local indigenous staff
- Harnessing existing community capacity and its leaders
- Implementing good governance
- Establishing trusting partnerships
- Keeping the implementation timelines flexible
- Using community development approaches.

Barriers to effective management of programs and services by Indigenous communities can be considered in relation the internal factors, such as the infrastructure and skills gaps that may exist to successfully deliver services, and the external factors, such as the policy environment, quality of relationship with government and commitment of external agencies. Each is outlined below.

Internal factors:

- Indigenous community organisations lacking sufficient human capital and capacity
- Infrastructure gaps in Indigenous communities
- Social and health problems which reduces social and cultural capital in Indigenous communities
- Programs lack 'whole of community' planning
- Community politics undermining stability of program governance
- Difficulty in securing and retaining experienced professional staff, impacting on leadership and decision-making.

External factors[75]:

- Government services and policies being poorly coordinated and delivered inefficiently, including stop-start funding and/or presence of multiple agencies
- Unworkable and externally imposed and onerous reporting requirements
- Absence of long-term commitment to maintain collaborations by external agencies.

[74] Australia Institute of Family Studies (2015) What works in effective Indigenous community-managed programs and organisations, CFCA Paper, 32

[75] From Hoffman et al. (2012) Achieving highly successful multiple agency collaborations in a cross-cultural environment: Experiences and lessons from Dhimurru Aboriginal Corporation and partners. *Ecological Management and Restoration*, 13(1), 42-50.

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