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‘What works’ in partnering to deliver effective Aboriginal health services

The Western New South Wales Primary Health Network experience

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policy issue

This Evidence Brief has been written because early evidence is suggesting that the partnership between the Western New South Wales (NSW) Primary Health Network (PHN) and Aboriginal primary healthcare services in the Western NSW PHN region is proving effective in terms of increased trust and supporting a stronger network of services for local Aboriginal communities. In particular, the structure and governance of services in this PHN region are unique in Australia, and could possibly provide lessons for other PHNs and Aboriginal health programs generally.

This paper outlines and discusses the Western NSW PHN arrangements and how they are supporting and building a stronger platform for the delivery of Aboriginal primary healthcare services in this region.

structure

There are three Parts to the paper:

Part 1: The Australian experience to date on what works generally—the main characteristics of successful Aboriginal health policies and programs aimed at overcoming Indigenous disadvantage.

Part 2: The Western NSW PHN and its approach—a profile of the PHN region and how the PHN has embedded Aboriginal Health as its top healthcare priority, structurally and practically. This is explored with particular reference to the PHN's commissioning and funding of the 'Marrabinya' integrated team care program—how it was established, how it works, and evidence of results so far.

Part 3: Elements of success to date in Western NSW—a brief summary of the main common elements and features associated with the early success of the partnership with Aboriginal primary healthcare services in the Western New South Wales PHN region. This summary is based on information obtained through background research conducted for this Evidence Brief, and telephone interviews with six senior health executives in the region, Aboriginal and non-Aboriginal.

A Western NSW PHN region health profile is available at **Appendix 1**.

Information on methodology—the research conducted and interviews—is at **Appendix 2**.

Summarised observations from the interviews are available at **Appendix 3**. Opinions were especially sought on how Western NSW PHN and Marrabinya aligned with the characteristics of successful programs identified in Part 1, and why Marrabinya is performing well.

part 1 The Australian experience to date on what works generally

understanding Aboriginal health outcomes

Since 2002, the Council of Australian Governments (COAG) has committed to producing regular reports against key indicators of Indigenous disadvantage. This series of reports, released annually, provide a public report card on progress in overcoming Indigenous disadvantage. The reports help governments and others assess the effectiveness of polices and inform the development of new approaches. Despite improvements on a number of measures for the health and wellbeing of Aboriginal and Torres Strait Islander Australians, significant disparities persist between Indigenous and non-Indigenous Australians (1).

Data alone cannot provide a complete understanding of health and wellbeing for Aboriginal and Torres Strait Islander Australians (2). There is a complex range of factors underlying these differences, including: differences in the social determinants of health; differences in behavioural and biomedical risk factors; and the greater difficulty that Indigenous people have in accessing affordable and culturally appropriate health services that are in close proximity (1).

Data also cannot provide a complete understanding of why outcomes improve (or not) and what policies and programs work (or not). Understanding which policies and programs work is critical to achieving improvements in outcomes for Aboriginal and Torres Strait Islander Australians (2).

what the evidence tells us about what works

The evidence available on what policies and programs work in overcoming disadvantage for Indigenous Australians draws from research across a range of sectors, including early childhood and schooling, economic participation, health and safe communities (3). While there is a lack of rigorously evaluated programs in the Indigenous policy area to draw from (2), there are some common themes that should guide any policy and program design.

1. **An openness to working differently**

   Successful policies and programs are underpinned by an openness to working differently with Aboriginal and Torres Strait Islander people. Indigenous people should not be considered ‘one stakeholder among many’, but rather as recognised traditional owners of country (3). It also includes recognising that mainstream approaches are often not the most appropriate or effective approach for healthcare (4).

2. **Genuine engagement**

   It has been identified that it will be difficult to meet the COAG targets for overcoming Indigenous disadvantage without genuine engagement of Indigenous people (5). Article 19 of the *United Nationals Declaration on the Rights of Indigenous Peoples* calls for States to consult and cooperate in good faith with the indigenous peoples concerned through their own representative institutions in order to obtain their free, prior and informed consent before

adopting and implementing legislative or administrative measures that may affect them.' (6)

Aboriginal and Torres Strait Islander Australians must have a genuine say in their own lives and the decisions that affect their peoples and communities (7). Effective engagement has been shown to be achieved when:

- There is an appreciation of Indigenous history, cultures and contemporary social dynamics and the diversity of Indigenous communities.
- It occurs through partnerships with Indigenous organisations within a framework of self-determination and Indigenous control. A commitment to doing projects with, not for, Indigenous people is required.
- There is a commitment to developing long-term sustainable relationships built on trust and integrity. Engagement starts early, involves a deliberate and negotiated process, and is not just information giving or consultation.
- Power inequalities are explicitly addressed, with genuine efforts to share power. A commitment to rectifying structures, relationships and outcomes that are unequal and/or discriminatory is required. Timeframes for deliberation are appropriate. (3,5,8)

3. **Culturally appropriate healthcare**

The negative impacts of ethnocentric health service provision on the health status of Indigenous populations has been long reported globally. It is important that the ability of all systems, services and practitioners to work with the diversity of patients is improved (9). The social and historical context in each place must be understood, recognising the diversity of Aboriginal people within a region as well as contemporary social fluidity (5,9).

In Australia, Aboriginal Community Controlled Health Organisations (ACCHOs) have been central to shifts in leadership and design of Indigenous healthcare delivery. While there are over 170 ACCHOs Australia-wide (10), there is still limited reach and capacity of these services to meet the needs of all Indigenous Australians and so the balance of services is provided by mainstream health services (9).

Despite the lack of an agreed definition of cultural competence, its inclusion in policy and legislation has been deemed an effective strategy towards delivering culturally competent care. There is a limited evidence base from which to draw definitive conclusions about how best to increase levels of cultural competence, however it is clear that cultural awareness training is not enough on its own. Rather, effectively improving cultural competence requires it to be embedded with the healthcare organisational culture, governance, policies and programs. Cultural safety concepts should be incorporated. It also cannot be assumed that a cultural competency program that is successful in one context will work in another; developing and implementing cultural competence programs must be tailored in partnership with and drawing on input from local Indigenous people (9).

4. Comprehensive interventions with adequate resourcing to achieve shared objectives

Interventions have been shown to be effective when:

- Creative collaboration between communities, non-government and government is supported, with aggregated, flexible and sustained funding. These partnerships are maintained through regular, open and frank communication; planning processes that are deliberate yet adaptive; developing a shared understanding of community needs; and staffing to facilitate linkages.
- The underlying social determinants are recognised.
- A 'one size fits all' approach is avoided.
- There is clarity and coherence about responsibilities for all aspects of health services. Shared responsibility and accountability for shared objectives are important. However, an acceptance that different parties will have different roles and responsibilities with resources adequately and transparently aligned with those roles/responsibilities is also required.
- Local capacity is built, e.g., through training of Aboriginal staff and local workforce development, mentoring of staff, and governance systems development. (3,5)

COAG National Indigenous Reform Agreement Service delivery principles

The four themes outlined above are consistent with the COAG National Indigenous Reform Agreement Service delivery principles for programs and services for Indigenous Australians:

- *Priority principle:* Programs and services should contribute to Closing the Gap by meeting the targets endorsed by COAG while being appropriate to local community needs.
- *Indigenous engagement principle:* Engagement with Indigenous men, women and children and communities should be central to the design and delivery of programs and services.
- *Sustainability principle:* Programs and services should be directed and resourced over an adequate period of time to meet the COAG targets.
- *Access principle:* Programs and services should be physically and culturally accessible to Indigenous people recognising the diversity of urban, regional and remote needs.
- *Integration principle:* There should be collaboration between and within Governments at all levels and their agencies to effectively coordinate programs and services.
- *Accountability principle:* Programs and services should have regular and transparent performance monitoring, review and evaluation. (11)

part 2 The Western NSW PHN and its approach

Western New South Wales Primary Health Network

The Western NSW PHN (www.wnswphn.org.au) is one of 31 Primary Health Networks across Australia established by the Australian Government to support and strengthen an integrated high quality primary healthcare system. The Western NSW PHN operates in rural and remote NSW. Its main office is in Dubbo, with other offices in Bathurst, Bourke, Broken Hill and Orange.

The focus of the Western NSW PHN is to increase the efficiency and effectiveness of primary health care, ensuring people receive the right care in the right place at the right time. To achieve this, the PHN works closely with general practice, Aboriginal Community Controlled Health Services (ACCHSs), other health care providers, Local Health Districts, hospitals and the broader community to align services with the health needs of the region. Integral to this are formal partnerships with Aboriginal health organisations and communities such as, variously, Bila Muuji Aboriginal Health Services, Three Rivers Alliance, and Murdi Pakki Regional Assembly.

The Western NSW PHN covers both the Far West and Western NSW Local Health Districts across an area of 433,379 square kilometres, making it the largest PHN in NSW (at 53.5% of the area of NSW) (see Figures 1 and 2).

The region's population is estimated by the Australian Bureau of Statistics (2016) to be 312,670 people, with 17.5% over the age of 65 years (12). About 11.7% of people in the region identify as Aboriginal and Torres Strait Islander, nearly four times the national average, and the highest proportion of any PHN in NSW. Western NSW PHN supports 332 General Practitioners (13) operating from over 100 general practices and Aboriginal health organisations in the region.

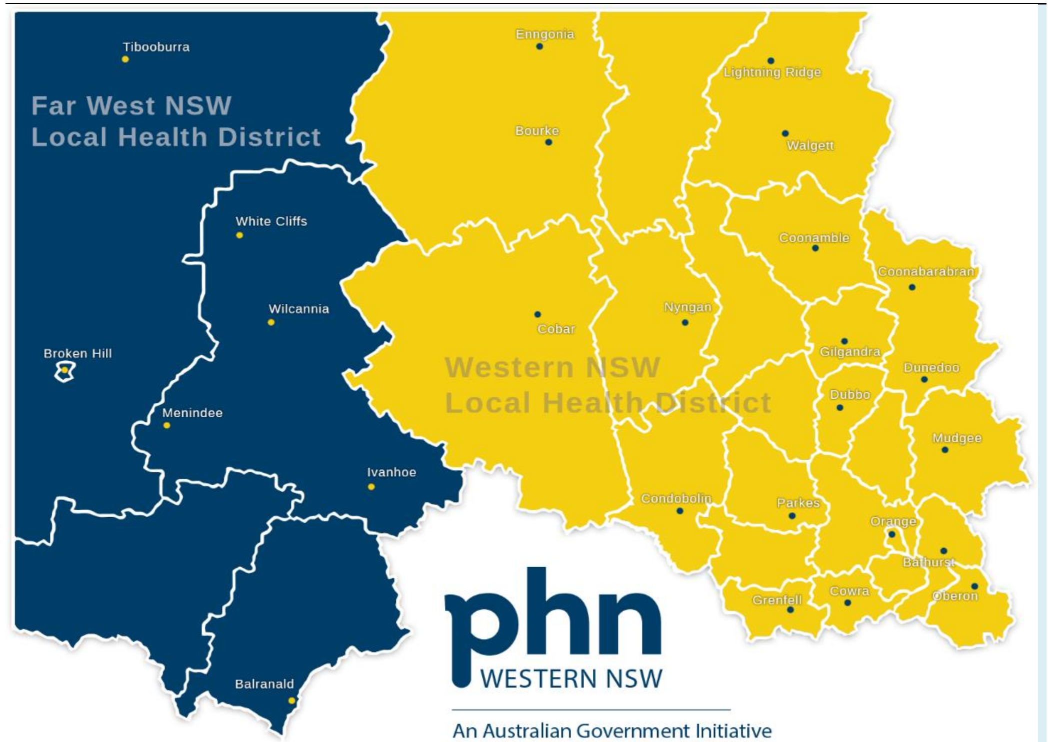

Figure 1: Western NSW PHN region

Figure 2: Western NSW PHN (yellow) within New South Wales

More information on the Western NSW PHN regions and demographics can be found in Appendix 1, 'Western NSW PHN region health profile'.

Western NSW PHN structure in relation to Aboriginal health

The Western NSW PHN, like many PHNs, was established through a consortium of former 'Medicare Locals' organisations (in this case two). But, crucially, the successful Western NSW PHN consortium also included two key Aboriginal health organisations in the region—Maari Ma Health Aboriginal Corporation (www.maarima.com.au) and Bila Muuji Aboriginal Health Services (www.bilamuujihealthservices.org.au). This consortium established the Western Health Alliance Limited (WHAL), a not-for-profit public company limited by guarantee to operate the Western NSW PHN.

The WHAL Board consists of seven Directors and a Chair, working with the Western NSW PHN Chief Executive Officer. Two Board members are Aboriginal Australians.

The Board is advised by five Councils. There are two Clinical Councils, two Community Councils and one Aboriginal Health Council (see Figure 3).

The Aboriginal Health Council was an integral part of the proposed governance of the PHN in the initial January 2015 application to the Australian Government to fund this new PHN.

The inclusion of Maari Ma and Bila Muuji in the PHN, with representatives on its Board, is tangible evidence that, from its inception, the PHN had an authentic and core commitment to Aboriginal health.

The integration of an Aboriginal Health Council into the PHN structure, at the time of establishment of the PHN, is unique in Australia, and is regarded as one of the key drivers of successful healthcare partnerships in the region and partnerships with the various Aboriginal communities themselves.

Each of the five Western NSW PHN Councils has a dedicated Board Liaison Director (a Board member) to support the flow of information and decisions between the Board and Councils. The Aboriginal Health Council's Board Liaison Director is the Chair of the Board, Dr Tim Smyth—a reflection of the importance placed on Aboriginal health in the Western NSW PHN region.

The Aboriginal Health Council supports Western NSW PHN to understand locally relevant Aboriginal Community perspectives in relation to their unique health needs, access to services and service gaps. This Council helps the PHN to develop and promote care pathways (including commissioning frameworks), evaluate outcomes of services, and design new services to meet the needs of Western NSW Aboriginal communities.

The Council also has an important role in strategic planning and developing region-wide funding and program support.

Also highly significant for Aboriginal health services in Western NSW PHN, particularly integrated team care and the way such services are delivered in the region, is that the founding documents for the Western NSW PHN propose that 'solutions to lift Aboriginal Health will be driven through Aboriginal-owned General Practice clinics and services, and through the spread of integrated health, social, and cultural capacity across mainstream General Practice and primary care networks'.

The Western NSW PHN has been guided in its decisions by the Department of Health's *PHN and ACCHO Guiding Principles* (14), which state:

> 'The establishment of PHNs provides an opportunity to build connections across the health system to further improve access for Aboriginal and Torres Strait Islander people to appropriately targeted care that is effective and culturally appropriate. And importantly, to ensure that there is full and ongoing participation by Aboriginal and Torres Strait Islander people and organisations in all levels of decision-making affecting their health needs.
>
> 'There are four key factors for improving quality of life and achieving health equity across all aspects of the social determinants of health:
>
> - connection to culture
> - allowing Aboriginal and Torres Strait Islander people to determine and implement the solutions
> - improving cultural awareness and respect across the wider Australian population, and
> - effective partnerships—Aboriginal and Torres Strait Islander health is everybody's business.'

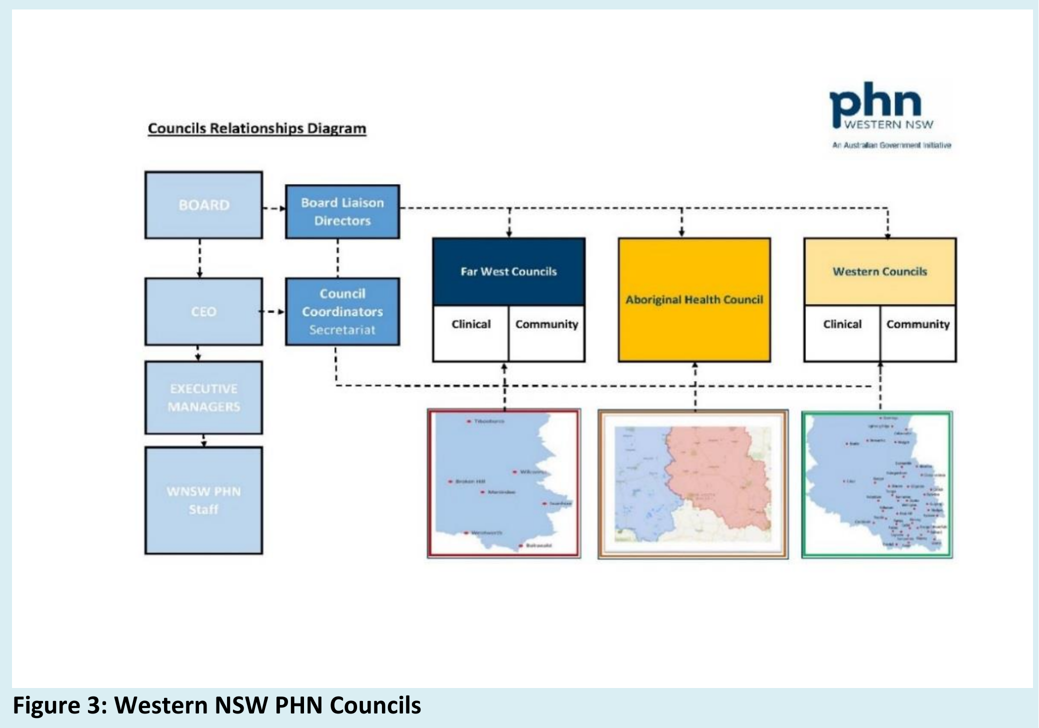

Figure 3: Western NSW PHN Councils

Establishment of the 'Marrabinya' model of care in Western NSW PHN

Integrated Team Care

Marrabinya is a brokerage service for Integrated Team Care (ITC) for Aboriginal people in the Western NSW PHN region.

ITC is a specified chronic disease activity administered by PHNs, with an attached funding stream available through the Indigenous Australians' Health Programme managed by the Australian Government Department of Health (15). The Programme is aligned with the *Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013–2023* (16). PHNs apply for ITC funding under set criteria.

The aims of ITC Activity, as specified by the Department, are to:

- contribute to improving health outcomes for Aboriginal and Torres Strait Islander people with chronic health conditions through better access to coordinated and multidisciplinary care; and
- contribute to closing the gap in life expectancy by improved access to culturally appropriate mainstream primary care services (including but not limited to general practice, allied health and specialists) for Aboriginal and Torres Strait Islander people.

Marrabinya—two key principles

Marrabinya's two major premises/principles follow what was originally envisaged by the PHN as key to improving Aboriginal health in the region, namely solutions driven through:

- Aboriginal-owned General Practice clinics and services; and
- the spread of integrated health, social, and cultural capacity across mainstream General Practice and primary care networks.

The consortium

In line with the two key principles, the Western NSW PHN Board received advice from the Aboriginal Health Council and approved a recommendation from the Western NSW PHN Executive that the service provider for the region's ITC program would be best commissioned using a Single/Most Capable Provider (MCP) Approach to local Aboriginal health services rather than an open public tender. This approach was included in the Western NSW PHN's 2016–17 Integrated Team Care activity work plan provided to the Department of Health, which was approved by the Department in August 2016.

Maari Ma Health Aboriginal Corporation in Broken Hill formed a consortium with the region's other major Aboriginal primary healthcare services organisation, Bila Muuji Aboriginal Health Services Incorporated (based in Dubbo), to prepare and submit a proposal to the PHN.

Maari Ma ('people working together') and Bila Muuji ('river friends') are the two peak Aboriginal health organisations in the region. Both have been operating since 1995. The consortium proposal to operate the ITC program was given the name 'Marrabinya' (a Wiradjuri word meaning 'hand outstretched').

The longstanding experience of the two consortium partners in operating Aboriginal health services in the region was a major strength. The model for Marrabinya was born out of the thinking and design work undertaken by these two organisations, based on their understanding of community and general practice needs.

The proposal included savings through co-locating many Marrabinya staff within various existing Aboriginal Medical Services where possible, sharing office space, administrative support and other workforce assets, and diverting those savings to service provision. Whereas previous models of funding in the region had been predicated on 70% for wages and infrastructure and 30% for services, the model proposed by the consortium was 50% to each.

The consortium's existing strong and longstanding relationships with Aboriginal communities in the region were also a key strength, as was their knowledge of the

role of the PHN through their interactions with the Board and the Aboriginal Health Council.

The PHN Board's approval of the consortium proposal supported Aboriginal control of the service and its funding allocations. As reported in local media, this was 'taking Aboriginal health in Aboriginal hands to a new level' (17).

Because the CEOs of Maari Ma and Bila Muuji were directors on the WHAL Board, they did not participate in the Board's consideration of the consortium proposal and subsequent approval.

ITC commissioning approval

Western NSW PHN forwarded its request for approval of the ITC commissioning to the Department of Health based on the Single/Most Capable Provider model and the strengths outlined above, in its 2016–17 activity work plan. The model of care that was proposed—a single brokerage service for both Aboriginal medical service and mainstream GPs—had not been encountered by the Department previously. The proposed structure and governance—Aboriginal-controlled, including distribution of funds, was unique in Australia. The proposed funding distribution (50% to infrastructure, 50% to services) was also new.

The Board's decision to approve the consortium proposal under a Single/Most Capable Provider approach was the subject of criticism by a number of non-Aboriginal health service providers in the region, and other interested parties. This led to representations to the Commonwealth Department of Health.

The activity work plan was approved after strong representations from the Western NSW PHN Board Chair, CEO and others about the strength of the application in meeting the Department's criteria, particularly the elements of 'Aboriginal health in Aboriginal hands' and working across both Aboriginal and mainstream services.

Services delivered by Marrabinya commenced on 1 November 2016.

How Marrabinya works

Marrabinya delivers ITC services through a brokerage service model with the patient and their referring GP at the centre. The service is available to Aboriginal people accessing both Aboriginal Community Controlled Health Services and mainstream General Practice. The brokerage model permits them the practical benefit of decreasing the overhead costs associated with the ITC program through a more effective sharing of resources (see earlier section), resulting in an increase in the investment in patient services.

Marrabinya can be reached through a central phone number and direct email contact. GP referral is required. Clients need to have in place a current GP Management Plan (item 721 in the Medicare Benefits Schedule), and/or Team Care Arrangements (item 723).

Marrabinya's focus is on supplementary chronic disease services, helping Aboriginal people access and attend assessment, care and other services they require as recommended by their GP. Commonwealth funding is provided on the basis that the ITC services supplement existing funded services. Marrabinya is available to Aboriginal patients of all primary care practices in the region, whether Aboriginal Community Controlled Health Services, local mainstream general practices or other

primary healthcare service providers. Specialists and hospitals can also arrange for referrals to Marrabinya through the Aboriginal patient's primary care provider of choice.

Examples of services provided by Marrabinya include: making specialist appointments, payment of specialist gap fees; paying for diagnostic tests where a fee applies; helping with applications to state government health assistance programs such as EnableNSW (www.enable.health.nsw.gov.au); arranging and paying for transport and/or accommodation to attend health appointments; and purchasing medical aids, including dose administration aids, mobility aids, assisted breathing equipment, and medical footwear—at no cost to the patient.

Walking frames or other aids and appliances can be hired or supplied where these are not available through any other program in a clinically acceptable timeframe, and where the need is documented in the client's care plan.

All support provided is communicated back to the referring GP.

Aboriginal people (including children) in the Western NSW PHN region are eligible for Marrabinya assistance if they have a diagnosed chronic condition, are enrolled for chronic disease management in a general practice or Aboriginal Community Controlled Health Service, have a GP management plan and/or Team Care Arrangements in place, and are referred by their GP.

The chronic diseases prioritised under Marrabinya are:

- Cardiovascular disease
- Diabetes
- Chronic respiratory disease
- Chronic kidney disease
- Cancer.

The way the brokerage service works is broadly as follows:

Step 1 GP completes GP management plan (Medical Benefits Schedule item 721) Care Arrangements (item 723)

Step 2 GP assesses the patient's needs for extra services and refers an eligible pa Marrabinya to arrange/purchase the extra services

Step 3 Marrabinya reviews the referral. If accepted, a local Chronic Care Link Wo assigned to follow up with the patient and referring doctor.

A major avenue of work for other Marrabinya staff is liaising with Aboriginal Medical Service and mainstream GPs throughout the region to increase awareness and use of Marrabinya.

The results so far

Improved access to services

When the program commenced on 1 November 2016, approximately 600 patients were transferred over from previous integrated care programs run by Marathon Health (250 patients) and the Outback Division of General Practice (350). Marrabinya's patient list, based on the number of episodes of care to Aboriginal patients, was 1,184 at the end of March 2017, around double the number of patients who transferred from the previous providers, in just four months of operation.

This result is indicative of early success in fulfilling one of the major aims of the Australian Government's ITC funding round, i.e. improved access to culturally appropriate mainstream primary care services (including but not limited to general practice, allied health and specialists).

Improved health outcomes

It may be two years at the earliest before current data collection activities can provide evidence of a contribution to improved health outcomes for Aboriginal and Torres Strait Islander people with chronic health conditions—the other major aim of the ITC program and funding. Nevertheless, the indications are very good at this early stage. This conclusion has been drawn anecdotally, following comments made by the health executives interviewed for this evidence brief (see next section). Those interviewed were the people most closely involved with Marrabinya and the delivery of Aboriginal healthcare services in the Western NSW PHN region.

Towards cultural safety

In their submission to the Commonwealth Department of Health in early 2015 to operate the new Western NSW PHN, the consortium (for operating the new PHN) highlighted their commitment to building and driving culturally appropriate services for Aboriginal people across the region, including with existing and prospective mainstream and other primary healthcare providers.

Western NSW PHN Aboriginal Health Council discussed and debated how this objective might best be progressed.

As noted in Part 1 of this Evidence Brief, the ideal strategy combination to improve cultural competence is unknown. Interventions designed to improve cultural competence have been evaluated and include reforming health service and systems, improving access to healthcare for Indigenous populations, improving the cultural competence of the health workforce, training and education for health and medical students to be culturally competent practitioners (9). However, programs described in the literature are often occurring in isolation, predominantly in hospital settings, and with a considerable focus on antenatal care/midwifery and cardiovascular conditions (9,18). It is also recognised that internationally validated instruments to measure health service access and use, service quality, perceived discrimination, language barriers and trust of practitioners need to be tailored for Indigenous Australian health services (9).

Even with this evidence, it cannot be assumed that a cultural competency program that is successful in one context will work in another. Program transfer and implementation without cultural-tailoring is ineffective; program success can be place, time and person specific (9).

In 2016, the Aboriginal Health Council recommended that the PHN develop its own comprehensive Cultural Safety Framework. The Framework could then guide all service providers (Aboriginal and other), as well as the PHN's commissioning framework and the PHN itself in building a culturally safe primary healthcare system in Western NSW.

The PHN Board welcomed the recommendation and strongly supported the work undertaken by the Council. The Board provided funding for consultant advice, and additional meetings of the Council to workshop and review the draft Framework.

The Council's development of the Framework was informed by work done previously by Indigenous Allied Health Australia (19).

The Aboriginal Health Council's Cultural Safety Framework was finalised in March 2017 and formally approved by the Western NSW PHN Board at its April 2017 meeting. The Framework sets out a continuum for primary healthcare service providers in the transformation to cultural safety, involving three major steps: Cultural Awareness; Cultural Sensitivity; and Cultural Safety. This progression is to be achieved across the following six Standards:

- **Standard 1 Culturally safe and responsive clinical culture**
  This requires evidence that clinical practice is culturally responsive and supported by culturally based clinical supervision aimed at the continuous improvement and adaptation of clinical practice in services provided to Aboriginal people.
- **Standard 2 Culturally responsive models of care**
  Demonstration that all models of care have been culturally validated and promote a culturally safe service planning and delivery framework for services to Aboriginal people.
- **Standard 3 Culturally safe workplace**
  This requires evidence that workplace practices and workplace design create an environment that supports and responds to the cultural safety of Aboriginal people receiving services, and where all service providers can develop and deliver culturally responsive services.
- **Standard 4 Policy and procedure cultural audit**
  This requires evidence of a continual cultural audit of and cultural adaptation in the use of all policies and procedures where these policies or procedures affect the delivery of primary health care services to Aboriginal people.
- **Standard 5 Cultural community engagement**
  This requires evidence that the appropriate Aboriginal communities are actively involved in consultation, service design and service delivery planning. In addition, evidence of continual proactive dialogue with the appropriate local Aboriginal communities will be required as it relates to the delivery of individual clinical interventions.
- **Standard 6 Cultural workforce planning and management**
  This requires evidence that affirmative action workforce planning and implementation strategies are in place to support and foster the increased participation of Aboriginal people in the health workforce. This includes culturally adaptive supervisions and workplace performance appraisals.

All contracted providers, including mainstream services that provide services to Aboriginal people, will need to work towards meeting the requirements set out in the Framework. In the initial stages, Western NSW PHN expects that contracted providers will demonstrate a commitment to a transformation towards cultural safety, and will subsequently work to meet the six Standards over the following three to five years.

Reinforcing its commitment to the Cultural Safety Framework, the PHN Board has also required the PHN itself to ensure that it meets the six Standards.

The PHN recognises that different providers will be at different stages in achievement of cultural safety, due to considerable variance in history, culture, structure, client profile and local circumstances.

A guide and supporting information and checklists are now being developed by the Aboriginal Health Council. The requirement to work towards meeting the Cultural Safety Standards will be incorporated in all of the PHN's commissioned services contracts from 1 July 2017. A program to guide and support general practices in meeting the standards will be developed in 2017–18.

part 3 Elements of success to date in Western NSW

elements of success

Based on the research conducted for this Brief, and the six interviews, the common elements emerging as the keys to success to date in building the Western NSW PHN's strong partnership in Aboriginal health are as follows.

1. **An idea and a success born of experience**

   Research into the history of the Western NSW PHN and its predecessors showed longstanding experience with Aboriginal health in the region. Many interview comments were made along the lines of 'this is not a 'flash in the pan' and 'the fundamental elements were already there—Maari Ma, Bila Muuji, infrastructure, first-hand and longstanding knowledge of services and local Aboriginal communities'.

   'They [the PHN] *placed great value on our Maari Ma and Bila Muuji collective 40 years of experience in being in the area and delivering services to Aboriginal people'*—Jamie Newman

2. **High level backing**

   There was an absolute commitment from senior managers and the PHN Board to Aboriginal health as the number 1 priority in the region.

   'They also had the support of some long-serving and committed prominent people in Aboriginal Health. Tim Smyth is a former Deputy Director-General of New South Wales Health, and Jamie Newman and I have worked in this area for a long time, as have other prominent Board and Aboriginal Health Council members. With this kind of base it was almost easy to make things come out well.'—Bob Davis

3. **Embedding Aboriginal health in the PHN structure at the start, as part of the set-up at Board, advisory and administrative levels.**

   'The governance structure for Aboriginal health services at Western NSW PHN is very good. They wrote Aboriginal health services organisations and people into the structure right at the start'—Bob Davis

   'Not everyone was immediately happy and trusting, but having these structures in place did a lot to break down barriers'—Tim Smyth

4. **Embedding 'Aboriginal health in Aboriginal hands' at the operational level.**

   'The PHN went for a select tender involving Maari Ma working with Bila Muuji, to ensure that Aboriginal health services were genuinely in Aboriginal hands. This annoyed some

people no end, but really too many Aboriginal dollars were going to non-Aboriginal organisations and people'—Smiley Johnstone

'We were given autonomy to look at all the national guidelines available on delivering Aboriginal healthcare services within PHNs and give our interpretation of how we could work more effectively within the guidelines'—Kim Whiteley

5. **Strength of leadership to see it through, all leaders walking the talk.**

   'Our PHN has 5 Councils, each having a Board Liaison Director who attends and participates in Council meetings as well as sitting on the Board. I am the Aboriginal Health Council Board Liaison Director, which is perhaps a demonstration of the high commitment to Aboriginal health in Western NSW PHN'—Tim Smyth (WHAL Board Chair)

   'Andrew Harvey and Tim Smyth took a lot of flak for the Aboriginal-controlled and managed brokerage model for integrated services. In the end they challenged the Department to officially tell them not to do it'—Smiley Johnstone

6. **The emphasis on partnerships/consortia at all levels to minimise duplication.**

   'The key difference is in the founding document (the application for funding the then-new PHN). It is predicated on Aboriginal and mainstream health services working together'—Andrew Harvey

   'We've sought to empower general practices and Aboriginal Medical Services. They are the providers; we support them'—Jamie Newman

   'Western NSW PHN is a small organisation of 35 people covering a huge geographical area. It is one of many players in healthcare in the region. They **have** *to work in partnership to survive and to see progress'*—Tim Smyth

7. **Being 'smart' with the funds, using currently existing infrastructure to free up funds for services.**

   'The PHN funding concept is brilliant. It allows building of partnerships, it encourages value for money and the sharing of resources, joint planning and avoiding duplication. We are already doing all of this stuff, and it's working well, as the new service is picking up many more people than the old one did'—Smiley Johnstone

   'We thought we could make the funds go further by integrating care and diverting more funds into actual care and less into infrastructure. We already had infrastructure in terms of buildings, computers, transport, and so on'—Jamie Newman

   'We don't necessarily need more money, we just have to make it work better for us'—Jamie Newman

8. **Aboriginal and non-Aboriginal Board and committee members all on the same page in shared dedication to the cause.**

   'The Western NSW PHN has made Aboriginal health a priority in practice, as well as words'—Jamie Newman

   'Why did we use this new method? We were following the philosophy of working with Aboriginal people not for them, doing things with them not to them'—Andrew Harvey

9. **True cultural awareness, and appreciation for differences between local communities.**

   'Cultural safety is really important in increasing access to the services by Aboriginal people'—Andrew Harvey

'The Aboriginal Health Council's Cultural Safety Framework, recently approved by the Board, is a very important document that goes beyond cultural awareness and competency'—Tim Smyth

'There are unwritten understandings and protocols, if you like, in every Aboriginal community. People "just know". Our challenge is to work with this in order to make things happen in the best way'—Smiley Johnstone

10. **A great deal of effort put into communication and face to face liaison with communities and service providers.**

    'A key part of my role is building partnerships and authentic commitments to health partnerships with the local communities…there is a lot of distrust of government programs.'—Kim Whiteley

    'Approaches in the past have been paternal: "Hey look at these services we've got for you". We have had to change that around to us saying to government "Hey listen, this is what works for us, let us have a say in how this is done, and please respect our opinions"'.—Kim Whiteley

11. **A unique patient-centred but GP-practice-led model of care, involving commissioning of supplementary services for chronic diseases—a Health Care Home style of operation.**

    'Marrabinya's model is underpinned by right to choose. It places Aboriginal people in the driver's seat choosing their healthcare provider, mainstream or ACCHO, identifying with their GP the barriers to accessing services, and accessing a brokerage service to address those barriers'—Bob Davis

    'Access to the brokerage program enables patients to access in a timely, cost effective way, the services they required in order to complete their cycle of care. It's a simple model, avoids duplication, is flexible and cost effective, and therefore should be sustainable'—Bob Davis

12. **Combining short term pragmatism with long-term thinking, and appreciating that the current vision may change in the light of experience. This is the beginning of an ever-evolving journey.**

    'We have to increase the numbers accessing the service first, which is well advanced. The next indicator will be an increased number of pathways-to-care as more mainstream general practices and other services get involved. But we have to manage expectations, we cannot change health instantly, we build one thing at a time and let the service evolve. As it evolves, new issues and opportunities will emerge, so we then move on making those things better and using those opportunities, and so on'—Jamie Newman

    'A recent proposed innovation is that the Aboriginal Health Council recognises the importance of the social determinants of Aboriginal health—education, employment, and housing—by expanding its membership to include representatives of these interests'—Tim Smyth

conclusion

The Western NSW PHN has experienced early success with its partnership with Aboriginal primary health services, and the Marrabinya integrated team care program in particular.

This has been due to the building blocks put in place from the very beginning of the PHN, and the PHN's willingness to innovate in order to truly place 'Aboriginal health in Aboriginal hands', at all levels.

Also at all levels, from Board to patient clinics, the PHN has taken heed of and 'walked the talk' with the factors commonly regarded as essential to success in Aboriginal healthcare:

- an openness to working differently;
- genuine engagement;
- culturally appropriate healthcare; and
- comprehensive interventions with adequate resourcing to achieve shared objectives.

Although the Marrabinya scheme is in its infancy, the governance and on-the-ground structures put in place, the shared commitment to success, and the determination to 'see it through' in both the short and long terms, serve as exemplars for PHNs and similar organisations running primary healthcare services for Aboriginal and Torres Strait Islander peoples.

As Western NSW PHN Aboriginal Health Council Chair William (Smiley) Johnstone said in interview, 'We want to show the rest of Australia how to do the business with Aboriginal health'.

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Appendix 1: Western NSW PHN region health profile

HEALTH PROFILE

Area Profile

WE ARE THE LARGEST PHN IN NSW

IN SIZE

OVER 100 GENERAL PRACTICES

332 GPS

2 LOCAL HEALTH DISTRICTS

28 LOCAL GOVERNMENT AREAS

Demographics

OVER 309,000 PEOPLE LIVE IN OUR REGION

17.5% OF OUR POPULATION IS AGED 65 YEARS AND OVER compared to 14.7% nationally

Aboriginal Health

11.7% OF PEOPLE IN OUR REGION IDENTIFY AS ABORIGINAL & TORRES STRAIT ISLANDER COMPARED TO 3% IN NSW

40.7% OF ABORIGINAL PEOPLE OVER 15 YEARS SMOKE DAILY

74.6% OF ABORIGINAL PEOPLE OVER 15 YEARS REPORTED THEIR HEALTH AS BEING EXCELLENT, VERY GOOD OR GOOD, lower than 81.4% of all people in the region

Mental Health

There is a higher prevalence of risk factors in the WNSW PHN region for children 4-15 years developing clinically significant behavioural problems and high or very high distress in adults aged 16 years and over, compared to the NSW Average.

12,443 PATIENTS HAD A MENTAL HEALTH TREATMENT PLAN CREATED BY A GP IN THE LAST YEAR

1,841 PATIENTS ACCESSED ALLIED PSYCHOLOGICAL SERVICES IN THE LAST YEAR

Immunisation

95.6% WNSW PHN LEADS THE COUNTRY in the rate of children under 5 who are fully immunised. The National fully immunised rate is 92.2%

Patient Reported Measures

8 IN 10 PEOPLE IN THE REGION REPORTED THEIR HEALTH AS ★ GOOD, ★★ VERY GOOD OR ★★★ EXCELLENT

92.4% OF 1 YEAR OLD CHILDREN are fully immunised, higher than the national rate of 91.3%

Available at *http://www.wnswphn.org.au/uploads/documents/corporate%20documents/PHN%20Health%20Profile%20A4%20Full%20FINAL.pdf.*

Note: *Population figure updated to 312,670 in 2016 by the Australian Bureau of Statistics.*

Appendix 2: Methodology

Research conducted

Research for this Evidence Brief covered:

- examination of the existing literature on 'what works' in Aboriginal healthcare services
- reading of Department of Health documents such as the *National Aboriginal and Torres Strait Islander Health Plan 2013–2023* and associated *Companion Document* and *Implementation Plan*; and online documents covering the Integrated Team Care (ITC) funding stream under the Indigenous Australians' Health Programme managed by the Department;
- reading of Western NSW PHN's profile documents, funding and workplan documents; and communications materials on Marrabinya, including information sheets and letters to patients, clinicians and other stakeholders;
- examination of Maari Ma and Bila Muuji online documents on Marrabinya and its operation; and
- information gathered from six interviews (see below).

Interview method

Observations on the structure and operation of Aboriginal healthcare services and Marrabinya in the Western NSW PHN region were obtained via telephone interviews conducted in May 2017 with the six senior administrators and managers listed in Table A1.

Table A1: Interviewees—structure and operation of Aboriginal healthcare services and Marrabinya in the Western NSW PHN region

Name	Position held
Mr Andrew Harvey	Chief Executive Officer, Western NSW PHN
Dr Tim Smyth	Board Chair, Western Health Alliance Limited; Liaison Director, Western NSW PHN Aboriginal Health Council
Mr Jamie Newman*	Director, Western Health Alliance Limited; CEO, Orange Aboriginal Medical Service; Chair, Bila Muuji Aboriginal Health Services
Mr Bob Davis*	Director, Western Health Alliance Limited; Chief Executive Officer, Maari Ma Health Corporation
Ms Kim Whiteley*	Western New South Wales Primary Health Network Aboriginal Health Manager
Mr William (Smiley) Johnstone*	Chair, Western New South Wales Primary Health Network Aboriginal Health Council

* Aboriginal man/woman

The interviews were essentially free-ranging discussions, in order to elicit information from interviewees that they wanted to offer, in their own way. Nevertheless, all interviewees were asked to comment on the structure and operation of Aboriginal healthcare services and Marrabinya in the Western NSW PHN region in terms of the four common themes identified in Part 1 that underpin 'what works' generally in Aboriginal and Torres Strait Islander healthcare services:

1. **An openness to working differently**—includes recognising that mainstream approaches are often not the most appropriate or effective.
2. **Genuine engagement**—Aboriginal and Torres Strait Islander peoples have a genuine say in the decisions that affect their communities, and power inequalities are explicitly addressed.
3. **Culturally appropriate healthcare**—recognising that every Indigenous community is different, and embedding cultural competence in partnership with, and with input from, local Indigenous people.
4. **Comprehensive interventions with adequate resourcing to achieve shared objectives**—aggregated, flexible and sustained funding that supports creative collaboration between communities, and government and non-government organisations.

As part of responding to criterion 4, interviewees were asked how they knew that the program was working.

Appendix 3: Interview responses

1. An openness to working differently

Andrew Harvey

- The key difference is in the founding document (the application for funding the then-new PHN). It is predicated on Aboriginal and mainstream health services working together. This is not a requirement as such under the *National Aboriginal and Torres Strait Islander Health Plan 2013–2023* or its *Implementation Plan*.
- The Northern Territory may now have some similar examples, but Western NSW PHN may be the only PHN in Australia with Aboriginal health services built in.
- The Aboriginal Health Council was embedded in the WHAL constitution as an Advisory Council within the new Western NSW PHN, reporting to the Board (WHAL). This was not a requirement of PHNs in offering Aboriginal healthcare services. It has a whole-of-region function, rather than for one Local Health District. This is a unique arrangement in Australia as far as we know.
- Bila Muuji and Maari Ma both date from 1995 in Western Medicare Local and Far Western Medicare Local. Both used to run two different streams of programs (see the funding application documents), with services contracted to Marathon Health and the Outback Division of General Practice, respectively, who also performed a clinical care coordination function.
- We took the decision to recommission these services to offer the Integrated Team Care (ITC) program through a to-be-established Indigenous Health Support Service (IHSS) (since renamed 'Marrabinya').
- Maari Ma joined Bila Muuji as a member and vice versa to form an Aboriginal-led consortium. A selective tender (most capable provider) was offered, inviting Maari Ma and Bila Muuji to tender to provide the services as a consortium. Maari Ma took the lead as the applicant, but in conjunction with Bila Muuji. They elected to run it as a brokerage model, with clinical care coordination led by the patient's GP, whether mainstream or in an Aboriginal Medical Service.
- Our Chronic Care Link Workers (performing functions of what are sometimes called Indigenous Outreach Workers) are part of a new model of care (non-clinical care coordination), a different way within the guidelines. 50% of total funds are to support chronic disease supplementary services, those services being determined/recommended by the GP.
- It is a Health Care Homes style of concept, patient-centred, and GP Practice-led—a brokerage model. We prefer to contract bulk-billers first. 50% of funding employs the Link workers, 50% funds the services.
- There is no cost to patients. All gaps are paid. We try to get bulk-billing services first.
- In summary, the whole model is unique, but within the funding guidelines. The Department had reservations at first as they had not anticipated it. Western NSW PHN are 'change agents' in this regard.
- Bob Davis (Maari Ma) and Jamie Newman (Bila Muuji and Orange Aboriginal Medical Service) are Board Members (WHAL Directors), which gives them a voice at Board level.
- Why did we use this new method? We were following the philosophy of working with Aboriginal people not for them, doing things with them not to them.

Tim Smyth

- We have worked differently and the system is not perfect yet; we will have to see how it develops. But the fundamental ingredients were always there in my view. For example:
  - *Commitment:* Started from a position of strong partnership. Good health outcomes and services for the Aboriginal population was something we all wanted and wanted to do.
  - *Pragmatism:* We wanted to positively acknowledge and recognise the health needs of this population (1 in 8 in Western NSW PHN region). Catering to this population was also crucial to the overall success of the Western NSW PHN.
  - *Strong long-established expertise:* Although new people were brought in with the establishment of the new PHN, there were already strongly-established relationships in the area in this sphere: Tim Smyth, Bob Davis, Jamie Newman, and Christine Corby (at Walgett). They were not starting from scratch.
  - *Proper structure:* Having Bob Davis and Jamie Newman on the Board from the start was the right thing in embedding Aboriginal Health on-the-ground expertise at Board level. They recruited Kim Whiteley as Aboriginal Health Manager, who knows the people in the area, on the ground.
- Not everyone was immediately happy and trusting, but having these structures in place did a lot to break down barriers.
- There have been some suggestions raised of conflict of interest at Board level because of the Marrabinya contract being given to Maari Ma and Bila Muuji working as a consortium. But [Board members] Bob Davis [Maari Ma] and Jamie Newman [Bila Muuji, and Orange Aboriginal Medical Service] withdraw from any discussions or decisions involving those two organisations and any other organisations they are involved with. The Board sees having Bob and Jamie on the Board as an asset.

Jamie Newman

- The Western NSW PHN has made Aboriginal health a priority in practice, as well as words.
- Aboriginal health has always been a priority in terms of the old clinics and support services in the area—infrastructure, buildings, etc.
- It's always been a clinic-based model, so patient records have been duplicated, are in various states of completion, in various different services and clinics, etc.
- We thought we could make the funds go further by integrating care and diverting more funds into actual care and less into infrastructure. We already had infrastructure in terms of buildings, computers, transport, and so on.
- We thought that we, as Aboriginal people, could do it more effectively than the previous providers of services in the two former Medicare Locals (Western and Far Western).
- Hence when the PHN put the new service out to tender, it was a selective tender involving Maari Ma and us at Bila Muuji. Maari Ma took the nominal lead agency role, but working in conjunction with Bila Muuji.
- We doubled the numbers of clients accessing integrated care services from 600 to over 1,100 in a few months. Previously the 600 clients had taken 2.5 years to build.
- Everything was too top-heavy before. It was a 70:30 split: 70% on infrastructure, salaries for administrative jobs, vehicles and so on, and only 30% to delivering the actual health care services/client care on the ground.

- We can't fund everything, and only use the brokerage service when money for a required service cannot be obtained through other types of funding.
- The scheme as it has run so far has far more positives than negatives.
- It has reduced clinical records duplication for a start.

Bob Davis

- With regards to implementing the Marrabinya brokerage model, the majority of stakeholders have been open to working differently—the PHN, suppliers, many of the referring general practices.
- The previous IHSS providers have been critical of the new model, which locates care coordination in the general practice setting. Some general practices report they don't have the capacity to deliver effective care coordination, so there has been some kickback. But overall the model has been accepted, and, importantly, patient feedback on the whole has been positive.
- Patients are open to working differently and exploring options that place them in the driver's seat.
- Jamie Newman and I were on the foundation board of WHAL. The PHN brought Maari Ma and Bila Muuji together in the name of providing Aboriginal medical services. They joined each other for the goodwill and common goal rather than financial or administrative need to do so.
- Bila Muuji changed their constitution to allow Maari Ma to be a formal member of Bila Muuji. Maari Ma probably had better systems in place than Bila Muuji at the start, so the contract from Western NSW PHN is with Maari Ma, but we work in conjunction with Bila Muuji as a partnership.
- The Aboriginal Health Council is a key component of the successful running of the IHSS, and Smiley Johnstone is Chair. He is also a Maari Ma employee.
- The governance structure for Aboriginal health services at Western NSW PHN is very good. They wrote Aboriginal health services organisations and people into the structure right at the start.
- A lot of the infrastructure was already there, there was already a huge commitment to providing much-needed services to a large component of the population (1 in 8).
- They also had the support of some long-serving and committed prominent people in Aboriginal Health. Tim Smyth is a former Deputy Director-General of New South Wales Health, and Jamie Newman and I have worked in this area for a long time, as have other prominent Board and Aboriginal Health Council members. With this kind of base it was almost easy to make things come out well.

Kim Whiteley

- Despite all the work still to be done, and the contributions of many people, both Aboriginal and non-Aboriginal, Marrabinya is all born of a Koori idea. It's our innovation, our implementation, and our evaluation and management.
- The overarching PHN is ensuring and instructing that this all happens. We were given autonomy to look at all the national guidelines available on delivering Aboriginal healthcare services within PHNs and give our interpretation of how we could work more effectively within the guidelines.

- We wanted to innovate, knowing that some things might work and some things might not. We came up with our proposal and the PHN backed it. I can tell you now that organisational backing of a Koori proposal is RARE.
- The funding was in three separate streams and we wanted to put it all into one. In the end it's taxpayers' money, but funders can sometimes more inflexible that we would like about how it is used.

Smiley Johnstone

- With this PHN, Aboriginal health is the number 1 priority and has been from Day 1. This is different to many others in itself.
- Everything I do and we do on the Aboriginal Health Council is for Aboriginal health. We meet quarterly, and we mostly give practical advice to the Board—where the money is, what to spend the money on, and how.
- The genesis of the success of the IHSS (Marrabinya) lies in the DNA of the PHN and its bid for funding to be established out of two previous Medicare Locals, with Aboriginal health at its core with a consortium model of how integrated services were to be delivered to Aboriginal people (i.e. the original consortium of Maari Ma and Bila Muuji).
- The PHN went for a select tender involving Maari Ma working with Bila Muuji, to ensure that Aboriginal health services were genuinely in Aboriginal hands.
- This annoyed some people no end, but really too many Aboriginal dollars were going to non-Aboriginal organisations and people.

2. Genuine engagement

Andrew Harvey

- Genuine engagement is ingrained in our philosophy, especially via the Aboriginal Health Council, plus partnerships with Bila Muuji and Maari Ma, and particularly in mental health.
- Our Practice Support Team liaises with and seeks to cover all GP practices in the PHN region (mainstream and AMS). All practices have increased their numbers of people seen under this program compared with the earlier two programs.

Tim Smyth

- The Aboriginal Health Council has been crucial here. Western NSW PHN is the only PHN to have an Aboriginal Health Council reporting to and advising the Board. Composition was determined through Expressions of Interest. We have a great Chair (William 'Smiley' Johnstone).
- Our PHN has 5 Councils, each having a Board Liaison Director who attends and participates in Council meetings as well as sitting on the Board. I am the Aboriginal Health Council Board Liaison Director, which is perhaps a demonstration of the high commitment to Aboriginal health in Western NSW PHN.
- Tensions: There have been some tensions, e.g. the Commonwealth Government approach to funding, the Prime Minister and Cabinet review of NACCHO, the Department of Health's funding either through Indigenous Health Networks or PHNs. Plus specific program funding. Plus the expectation that PHNs will commission services. Some parties have been confused, concerned, and worried about all the changes, especially those who think they could lose out under the new model (e.g. mental health services).

- Commissioning, as a concept, how it works and why they have to do it, needs to be more widely understood.
- The commissioning of Integrated Team Care directly through Aboriginal organisations (the new IHSS) was a hard one for existing contractors and providers to bear.
- We (WHAL) learned a lesson that commissioning had not only to be transparent, but also communicated well to all parties (e.g. a recent Aboriginal mental health tender, where the PHN had to stop signing off on the successful contractor and go back to communicating with some AMSs who felt, rightly or not, that they had been left 'out of the loop'. They were all subsequently happy with the choice of provider, and how the process was conducted.
- We have also engaged outside the PHN and its region, and have established a good relationship with Minister Ken Wyatt. He is coming to the next meeting of the Aboriginal Health Council.

Jamie Newman

- We've sought to empower general practices and Aboriginal Medical Services. They are the providers; we support them.
- We get great support from the PHN. They apply what they say in practice. It was better to let Aboriginal people run this service.
- They (the PHN) actually listened to us and were respectful. And they delivered on what they promised. They placed great value on our (Maari Ma and Bila Muuji) collective 40 years of experience in being in the area and delivering services to Aboriginal people.

Bob Davis

- The Maari Ma/Bila Muuji alliance demonstrates a genuine effort to collaborate and share power. This alliance is important against the backdrop of an increasingly competitive healthcare environment.
- Organisations will seek out 'natural fit' and mutually beneficial alliances to progress a shared vision. However, in the main, the commissioning process for funds is competitive and therefore not conducive to openness and cooperation.
- Marrabinya's model is based around the GP/patient/multidisciplinary care team. Therefore the care coordination function sits with the patient's general practice
- Our Local Care Link Workers don't provide a clinical care coordination role, they 'Link' patients to the services they require in order to access the planned schedule care outlined in the GP management plan.
- Previous IHSS providers provided clinical care coordination. This in effect 'siloed' care coordination from general practice, and led to fragmented medical records, duplicated effort and in many instances to disempowered patients, and treating GPs feeling 'out of the loop'.
- The brokerage model puts GPs and their patients in the driver's seat. GPs identify the services required and patients choose when, where and how they will access the services. To date, the vast majority of patients have provided feedback that they feel more empowered with regard to the new model because they are the 'keepers' of their own appointments and schedules.

Kim Whiteley

- A key part of my role has been building partnerships and authentic commitments to health partnerships with the local communities.

Smiley Johnstone

- In the old days money was used to grow empires. This PHN can't do that, we don't use the money to fund ourselves, we as Aboriginal people want to engage with local Aboriginal communities and fund appropriate and trusted healthcare services. We do this across the Board. We set benchmarks, measure, mentor, and evaluate.
- Working this way is in our DNA. The Department was wary of what we were doing at first. I don't think they were prepared for it.
- But this PHN is confident in the Aboriginal players. And we want to show the rest of Australia how to do the business with Aboriginal health. The PHN is serious about our success, they are not just paying it lip service.

3. Culturally appropriate healthcare

Andrew Harvey

- Cultural safety is really important in increasing access to the services by Aboriginal people.
- The AHC took an early decision to define four distinct bodies of work:
  - Demographics
  - Mental health
  - Cultural safety
  - Commissioning culturally safe services.
- AHC developed a Cultural Safety Framework, now approved by the Board.
- The Department of Health's *PHN and ACCHO Guiding Principles* are useful context here. So is the *Aboriginal Health Council's 2016–2018 workplan* [internal document].

Tim Smyth

- The Aboriginal Health Council's Cultural Safety Framework, recently approved by the Board, is a very important document that goes beyond cultural awareness and competency.
- It requires all contracted providers to meet the requirements of the Framework, including mainstream services that provide services to Aboriginal people (we have had some pushback from services about that). Also, AMSs can differ a lot. Some cater for mainly non-Aboriginal people. In some towns Aboriginal people prefer to go the mainstream service provider. Getting everyone on a similar page with cultural safety will not necessarily be straightforward.

Jamie Newman

- Some staff from Maari Ma and Bila Muuji are embedded within the AMSs. Sometimes they are NOT Aboriginal. But working within the service itself equips them with cultural sensitivity, knowledge and skills.
- The Aboriginal Health Council and Board have just signed off on a cultural safety framework that all providers and staff have to abide by.
- We at Maari Ma are interested to see how it works in practice, as cultural safety has to come from the community in any given area. The issue of identity, or recognition of belonging to a community, is massive in some places.
- It's tricky to navigate. Even AMSs have to get information on what's 'culturally safe' from the community.

Bob Davis

- Marrabinya's model is underpinned by right to choose. It places Aboriginal people in the driver's seat choosing their healthcare provider, mainstream or ACCHO, identifying, with their GP, the barriers to accessing services and accessing a brokerage service to address those barriers.
- It's a model based on empowerment and strengths. Many patients report that they are relieved to be liberated from the 'hand holding' model delivered by previous providers, which I think is an outdated patronising approach.
- The key is Aboriginal health organisations managing Aboriginal health programs. They were too non-Indigenous before.
- The model is different from previous ones. The previous one was case management. This one is IHSS as a referral point, GPs and their patients to coordinate. Some GPs objected. The originally mandated 70% infrastructure, 30% to services was unsuitable. They changed it to 50:50. The services were more of a priority than the extra cars and buildings. They run on the smell of an oily rag with regard to staff so that more can go into funding services. Aboriginal people are more comfortable with this brokerage model, called 'Marrabinya'.
- Parts of the service are divided into clusters, each with a LCCL (Local Chronic Care Link) worker who brokers and arranges contact with suitable services. They know their areas well, who offers what, who has capacity to provide needed services in time required and at reasonable cost. Some providers are not in the PHN, they may be in Adelaide or Melbourne, etc.

Kim Whiteley

- Engagement with the local communities is very important. There is a lot of distrust of government programs. Approaches in the past have been paternal: 'Hey look at these services we've got for you'.
- We have had to change that around to us saying to government 'Hey listen, this is what works for us, let us have a say in how this is done, and please respect our opinions'.
- Cultural awareness and safety has to be drilled down to patient level, ensuring that cultural protocols are observed.
- We must have authentic use of cultural protocols, and 'fair dinkum' consulting of elders and the community.
- Connections are also a highly valued part of the picture. It's complicated, but do-able.
- The ITC (now the IHSS or 'Marrabinya') evolved under a cultural framework that didn't exist in writing but existed just the same.
- The Aboriginal Health Council and the PHN have now approved a cultural safety framework that provides the tools and principles to cross-check yourself in terms of consultation and other dealings with Aboriginal communities in the PHN area.
- Ultimately one size does not fit all, every community culture is different—so this framework is just a starting point.

Smiley Johnstone

- AMSs aren't in every town. And delivering services across the region is not always straightforward. There are unwritten understandings and protocols, if you like, in every Aboriginal community. People 'just know'.

- Our challenge is to work with this in order to make things happen in the best way.

4. Comprehensive interventions with adequate resourcing to achieve shared objectives

Andrew Harvey

- The Aboriginal population in the PHN is 8.5% according to figures the Commonwealth uses (Census figures, now up to 5 years old), but NSW administrative data show 11.5%. So Western NSW PHN is possibly underfunded.
- Funding is until June 2018. We need to resolve the population underestimate difference. The driver of sustained funding is the *National Aboriginal and Torres Strait Islander Health Plan 2013–2023*. It's the pre-eminent document. This is a long-term journey, always evolving and developing.
- How do we know it's working? There were 600 patients transitioned to the new arrangements last year. Now there are 1,152 patients receiving services under the scheme (29 February 2017). Their aim right now is to provide access to services, get more GPs on board. This increased access will show in improved outcomes overall, but that will take time to show through. It's early days yet, but the indications are good in terms of access to chronic disease care. The services are required to gather outcome and patient satisfaction data to show where they've come from.

Tim Smyth

- Integrated care funding will require evidence of performance. We have the trust and confidence that Aboriginal-led services will deliver. But mainstream services must be equally capable.
- Western NSW PHN is a small organisation of 35 people covering a huge geographical area. It is one of many players in healthcare in the region. They *have* to work in partnership to survive and to see progress.
- A recent proposed innovation is that the Aboriginal Health Council recognises the importance of the social determinants of Aboriginal health (education, employment, housing) by expanding its membership to include representatives of these interests.
- It's not realistic for Kim Whiteley, the Aboriginal Health Manager, to cover Aboriginal health on her own, though the core funding only covers one position. It's everybody's business and responsibility, not just hers. Also, there are only 1.5 people to cover mental health, and 1.0 people to cover drugs and alcohol. The imposing logistics of travel and meeting people across the very large region have to be considered.

Jamie Newman

- Funding is flexible, yes. If we have a surplus in some areas, it can be directed to areas of shortage in the interests of improved patient outcomes. But we don't bite off more than we can chew. We have the authority to move funds and make appropriate decisions around where funds are directed. The PHN has confidence in us making such decisions.
- How do we know if we've done a good job? For a start we have the support of clients, which is the most important thing. This has led to increased participation in healthcare.
- We will measure and monitor for the next 2 years at least and are confident we will get good results, good measured health outcomes, which will build trust in us from government.
- We don't necessarily need more money, we just have to make it work better for us.

- We have to increase the numbers accessing the service first (which is well advanced). The next indicator will be an increased number of pathways-to-care as more mainstream general practices and other services get involved.
- But we have to manage expectations, we cannot change health instantly, we build one thing at a time and let the service evolve. As it evolves, new issues and opportunities will emerge, so we then move on making those things better and using those opportunities, and so on.

Bob Davis

- IHSS forms part of the Commonwealth's Closing the Gap Strategy, and the chronic disease cycle of care is well known and understood.
- Access to the brokerage program enables patients to access in a timely, cost effective way, the services they required in order to complete their cycle of care. It's a simple model, avoids duplication, is flexible and cost effective, and therefore should be sustainable.
- 600 files were transferred from the old arrangements to the new IHSS set-up on 1 November 2016. By the end of February 2017 (3 months) there were about 1,200 clients.

Kim Whiteley

- We have to gather statistics on how we are providing more health services for Aboriginal people.
- Re patient health outcomes, I'd like to see this become a reality with responsibility and commitment to this being shared by both healthcare providers and the community itself.
- The program is being evaluated as it is being implemented, with the first target being to increase the use of the service. The program is an evolving process, so the points of evaluation, the indicators for success may change as we go along too.

Smiley Johnstone

- We've made sure the funding is flexible. I think the Department of Health prefers working with different funding streams for different purposes. They like to prescribe to you what you should do with the money they have passed to you to use.
- We prefer to direct money where it is needed. It might be needed for a certain healthcare purpose in one community, but for something else in the next community. And we knew all along the 50:50 between services and admin was better for us than 30% on services and 70% on admin and infrastructure.
- Andrew Harvey and Tim Smyth took a lot of flak for the Aboriginal-controlled and managed brokerage model for integrated services. In the end they challenged the Department to officially tell them not to do it. Andrew and Tim knew they were fulfilling all the criteria set by the Department. That's the difference between the reality that is set out on paper, and the reality they want or feel most comfortable with.

The PHN funding concept is brilliant. It allows building of partnerships, it encourages value for money and the sharing of resources, joint planning and avoiding duplication. We are already doing all of this stuff, and it's working well, as the new service is picking up many more people than the old one did.