

**SUPPLEMENT ARTICLE**

# Primary Health Networks' impact on Aboriginal Community Controlled Health Services

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**Abstract**

The Abbott government's creation of Primary Health Networks in 2015 has substantially affected the way that primary healthcare funding is administered at the Commonwealth level. Primary Health Networks control a significant amount of Indigenous-specific health funding, which Aboriginal Community Controlled Health Services have historically relied upon. These Indigenous sector organisations have been delivering holistic and culturally appropriate healthcare to Aboriginal and Torres Strait Islander people for decades. They are run by and for Aboriginal Communities themselves, enacting Indigenous self-determination at a local level. The Primary Health Networks promote contestable funding and competitive service markets, destabilising the Indigenous health funding environment. This new funding model does not account for the distinguishing feature of Aboriginal Community Controlled Health Services: self-determination. Additionally, Primary Health Networks possess limited knowledge of Indigenous health contexts and have been resistant to engagement with Aboriginal organisations. All of this limits Indigenous self-determination and threatens Indigenous health.

**KEYWORDS**

Aboriginal Community Controlled Health Services, commissioning, Indigenous health policy, Indigenous self-determination, Primary Health Networks

## 1 | INTRODUCTION

In responding to the question: ‘what has happened to the project of Indigenous self-determination?’ this paper examines self-determination in practice with a particular focus on the operations of grassroots Indigenous Community organisations. Reflecting on evidence gathered from interviews with CEOs and senior managers from Aboriginal Community Controlled Health Services (ACCHSs), it considers the nature of power sharing and relations between Aboriginal Communities<sup>1</sup> and the Australian state. Now that the First Nations of this land have once again called on governments to give them a voice in their own affairs, it seems apposite to enquire into the current state of Indigenous self-determination. To appreciate the sentiment and motivations behind the Uluru Statement’s heartfelt plea for substantive institutional change, we must look closely at existing institutions. By understanding what is wrong with contemporary structures we will be more able to understand why change is needed. This paper focuses on one important government funding framework which relies on a purchaser/provider model: the Primary Health Network (PHN). This recent policy initiative exemplifies the way that governments have excluded Indigenous Community organisations and representatives from the decision-making processes that affect Indigenous peoples. In Indigenous health policy, the project of self-determination appears to have been abandoned. When Gough Whitlam adopted self-determination as policy in 1972 his government encouraged Aboriginal people to form corporations for collective action. This new approach to State-Indigenous relations allowed for the creation of an ‘Indigenous sector’, of which ACCHSs are a quintessential part. The continuing Indigenous sector is the most important vestige of the self-determination policy (Rowse, 2002). However, Primary Health Networks disempower and delegitimise Indigenous sector organisations and undermine self-determination in the core area of health. This paper commences by outlining the Primary Health Network’s background and *modus operandi*. Subsequent sections are organised around three prominent themes from the interview data: relationships, knowledge, and resources. Based on interview responses and previous scholarship the paper concludes that government should pursue a more relational mode of engagement with Aboriginal organisations, where power is more equally shared, investment is maintained over the longer-term, and trust is fostered.

## 2 | METHODS AND METHODOLOGY

This analysis is part of a larger research project based on a series of 25 interviews conducted at 20 ACCHSs across New South Wales, including the peak body, the Aboriginal Health and Medical Research Council.<sup>2</sup> Informant voices have been de-identified and are drawn from seven of these interviews (made up of three Indigenous and four non-Indigenous interviewees) all from separate locations. The interviews were conducted in 2017 and 2018 across urban, inner-regional and outer-regional<sup>3</sup> areas of NSW as classified by the Australian Bureau of Statistics. In accordance with a decolonising methodology, following Hart (2010) and Sherwood et al. (2015), Tuhiwai-Smith (1999), this article lets representatives from Aboriginal community-controlled organisations speak for themselves. This methodology is grounded in an ethical commitment to partnering with Indigenous communities in research. Indigenous voices have been consistently excluded from debates about Indigenous issues (Hart, 2010, 5) and non-Indigenous researchers have often put their own careers ahead of the wellbeing of the Indigenous peoples they study (Simonds & Christopher, 2013, 2185). Decolonising methodologies are a response to this silencing and they prioritise Indigenous perspectives because of it. This Indigenous-centred methodology led me to privilege voices from the Indigenous sector.

### 3 | PRIMARY HEALTH NETWORKS

The Abbott government established the Primary Health Network in 2015. This came in response to a review of the PHN's precursor, Medicare Locals, which was an initiative of the Gillard Labor government. The Liberal-National government ordered the review upon taking power in 2013. The then Health Minister, Peter Dutton, stated that one of the review's goals was 'reducing waste and spending on administration and bureaucracy' (Dutton, 2013). This was consistent with Tony Abbott's comments during the 2013 election campaign, where he called for a review 'to try to ensure that we maintain the actual health services that are being provided by Medicare Locals while minimising the bureaucracy associated with them' (Abbott quoted in RMIT and ABC 2016). Abbott's and Dutton's message was that Medicare Locals were bureaucratic and wasteful. This echoed the Coalition election campaign's emphasis on small government and fiscal austerity. In practice, though, PHNs are almost entirely bureaucratic and are only involved in direct service provision as a last resort. Moreover, the cost of winding up Medical Locals has been estimated to be as high as \$200 million (Thompson, 2015).

There are now 31 PHNs across Australia, whereas there were 61 Medicare Locals. However, almost all of the PHNs are either consortia of former Medicare Locals or have a former Medicare local as lead partner (Thompson, 2015). Primary Health Networks function as 'third party payers' (Wade, Smith, Peck, & Freeman, 2006, 3) in the primary healthcare system, offering funding and support to primary healthcare providers. Initially, PHNs were tasked with assessing primary healthcare needs and identifying service gaps (DoH 2015a, 3). More recently they have moved into a commissioning phase, which involves 'co-designing' and purchasing additional services (including Indigenous-specific services) to fill identified service gaps (DoH and PwC 2016, 4). Purchasing has been by open competitive tender processes and contracting (Henderson et al., 2018, 80), but to date it is unclear whether service co-design has occurred and with whom. Even though legally PHNs are independent companies, in a practical sense they are closely aligned with government. They rely on government funding, and work towards government priorities. One of the PHN priority areas is Aboriginal and Torres Strait Islander health (DoH 2015b), a domain in which the ACCHS sector has unequalled expertise, experience and Indigenous cultural knowledge.

### 4 | ABORIGINAL COMMUNITY CONTROLLED HEALTH SERVICES

The ACCHS sector, often referred to as the Aboriginal Medical Services or AMSs, delivers high-quality, comprehensive, and culturally-informed healthcare, and is run for and by Aboriginal and Torres Strait Islander communities (Campbell, Hunt, Scrimgeour, Davey, & Jones, 2017). These Indigenous organisations deliver a range of clinical and allied health services and are also involved in community development and health promotion. ACCHSs provide approximately 50% of all primary health care to Aboriginal and Torres Strait Islander peoples (Panaretto, Wenitong, Button, & Ring, 2014, 649–50) and scholars have argued that ACCHSs are a practical embodiment of Indigenous self-determination (Davis, 2013; Rowse, 2002). This is because they are governed by Community-based boards of directors, elected by members of the health service (Grant, Wronski, Murray, & Couzos, 2008, 8). Aboriginal and Torres Strait Islander people own, run, and oversee their community-controlled health services. ACCHSs are one significant example of Aboriginal self-determination in practice, giving Aboriginal people a say on what their health services do and how.

## 5 | COMMISSIONING

Primary Health Networks take a commissioning approach to the funding and management of Indigenous health services. Commissioning is an umbrella concept that covers a range of public-service activities. These include needs assessment, procurement, purchasing, contracting, service delivery and performance management, all of which are interrelated yet distinct processes (Dickinson, 2014, 15). Sturgess (2018, 165) expresses commissioning's primary function as: 'to design and manage the interface between policy/funding and delivery'. Tasked with improving the efficiency, effectiveness and coordination of services, commissioning organisations, such as PHNs, act as intermediaries between policymakers/funders and service providers. Commissioners are responsible for the strategic design and 'stewardship' of service-provision systems (Sturgess, 2018, 163), gearing their overall functioning towards the efficient achievement of government's strategic objectives. *In theory*, commissioning improves on previous attempts to improve the purchaser-provider relationship because it acknowledges some of the complexities encountered at the service delivery coalface (Sturgess, 2018, 156). However, as Dickinson notes (2015), commissioning's definitional 'fuzziness' has meant that *in practice* the concept has been used 'as a synonym for more contracting out or privatisation'. Theoretically providers are accorded a stakeholder role in commissioning, but commissioners actually follow the familiar governance approach that privileges the demand ('purchaser') side of the purchaser-provider relationship.

The evidence on commissioning's effectiveness is mixed. A recent report written for the Department of Health laments the 'limited evidence that links commissioning with quality improvement or cost containment' (King's Fund et al. 2016, 4). However, some observers are hopeful that commissioning can deliver broad benefits if commissioners' 'softer skills' can be strengthened (Dickinson, 2014, 17). Robinson and colleagues (2016, 10) have argued that the crux of the commissioning task is to accommodate multiple and sometimes divergent values, goals, and practices. In this way, successful commissioners are those who achieve 'a meeting of the minds' amongst diverse stakeholders (Sturgess, 2018, 164). Booth and Boxall (2016, 3–4) contend that fostering reciprocal and trusting relationships between commissioners (e.g. the PHNs) and providers (e.g. ACCHSs) is an indispensable component of successful commissioning. Research on the policies and funding arrangements that apply to ACCHSs also highlights the importance of close and trusting relationships between purchaser and provider. This literature (e.g. Dwyer, Lavoie, O'Donnell, Marlina, & Sullivan, 2011, 43; Lavoie, Boulton, & Dwyer, 2010, 675–6) promotes relational contracting as the best way of funding ACCHSs to maximise Indigenous health gains. Relational contracting involves purchasers and providers working closely together, under flexible long-term contracts, towards the achievement of shared goals. Governments have long known<sup>4</sup> that, when commissioning for complex social services (of which Indigenous-specific comprehensive primary healthcare are a clear example), commissioners should assess how well providers 'understand the human dimensions' of the service contracts for which they are tendering (Sturgess, Argyrous and Rahman 2018, 466). Providers need time to develop this expertise and relational contracting allows for this.

However, based on the testimony of ACCHS representatives, PHN contracting and decision-making processes are more hierarchical than relational. PHNs control both the needs-assessment and funding processes, inevitably compromising the space available for Indigenous self-determination. Under the PHN commissioning model it is ultimately government who 'calls the shots', to use Gingrich's expression (2011). This seems to follow from the Department of Health's vision of commissioning as 'proactive and strategic', where commissioners (i.e. the PHNs), decide what services should be offered, how, and by whom (Smith et al. cited in DoH 2015a, 2). The PHN's power structure and contracting arrangements bind Aboriginal service-providers to the demands of the PHN as purchaser. The PHN is in turn bound to the government which has the final say when determining who and what gets funded

in Indigenous health. The PHN's commissioning hierarchy, and the conflicts (discussed below) that it engenders, supports Dickinson's (2014, 17) contention that 'commissioning is an inherently political (with a small 'p') process'. The PHN's power dynamics also fundamentally undermine the principle of Indigenous self-determination.

## 6 | RELATIONSHIPS

Some ACCHS CEOs and managers are frustrated because PHNs have excluded them from key decision-making forums on Indigenous health. PHN CEOs have the power to control who participates in key discussions around Aboriginal health services. This runs contrary to the Government's own PHN Grant Programme Guidelines, which state: 'PHNs *must* have broad engagement across their region including with ... Aboriginal Medical Services' (DoH 2016a, 7, emphasis added). It also contradicts the principle of 'Aboriginal and Torres Strait Islander Community Control and Engagement' that informs the National Aboriginal and Torres Strait Islander Health Plan 2013–2023<sup>5</sup> (Australian Government 2013, 10), and the associated Implementation Plan (DoH 2015c, 5). Nevertheless, some PHNs have disregarded these nationally established guidelines and strategies, as this informant's statement indicates:

*The Commonwealth actually put out a guideline on how PHNs and AMSs should interact... We had a meeting with the CEO of the PHN and all the AMSs in the region. And I'm quoting the guidelines to him. And he said: 'we didn't have anything to do with putting them together, we don't have to abide by them'. We've asked for Aboriginal representation on the board [of the PHN]. Nup. We asked for an Aboriginal Advisory Committee. Nup. (CEO, outer-regional ACCHS, November 2017)*

One way forward would be to institutionalise the principle of Aboriginal community control in all PHN actions and policies related to Indigenous health but this would be to seriously constrain the purchaser-provider model and suggest it should cede place to a relational contracting approach. Mandating agreements between ACCHSs and PHNs, as the Closing the Gap Steering Committee suggests (Wright & Lewis, 2017, 36), would give ACCHSs more say in how Indigenous health issues are approached by PHNs in their local areas.

In another example of PHNs ignoring Indigenous organisations, an ACCHS CEO alleges that her organisation was not consulted during the needs assessment stage of the commissioning process, and that the PHN's picture of Indigenous communities' healthcare needs is therefore based on incomplete information:

*Well a good example is the current ITC program – so the Integrated Team Care arrangements. [The PHN] gave two thirds of the money to non-Aboriginal organisations and one third to AMSs... It's an Aboriginal-specific program. And we said: 'look, we should be getting more because we see more Aboriginal clients'. [The PHN replied]: 'No you don't'. I said: 'well, where are you getting your stats from? Your stats aren't accurate.' Our stats'd be accurate because we know how many Aboriginal people live in our communities. No sense in using ABS because it's not accurate. You know, our ABS, I think's 823, or something like that, for [our town] ... only. We know there's more than 1000 Aboriginal people that live just in [our town]. (CEO, outer-regional ACCHS, December 2017)*

ACCHSs are frustrated because PHNs decide the level and nature of Aboriginal healthcare need without consulting Aboriginal Community organisations that have access to valuable sources of knowledge and information. This is a clear example of how the PHN, with a mandate from the

Commonwealth, is able to dictate terms to Aboriginal organisations, a clear derogation of the principle of Indigenous self-determination.

The non-binding nature of the PHN and ACCHO Guiding Principles (DoH 2016b) has led to inconsistent PHN engagement with ACCHSs, as the following statement from an ACCHS CEO illustrates:

*PHNs are regularly telling us, well, no they're just guidelines from the Commonwealth and they're right... They're not policy direction that ensures that PHNs are making consistent decisions right across the 31 [PHN] regions in this country. You know, there's some examples where PHNs are working incredibly respectfully and efficiently with Aboriginal organisations and there's many that are not. (CEO, inner-regional ACCHS, July 2017)*

Some ACCHS CEOs have concluded that PHNs have too much flexibility when determining how best to work with ACCHSs. The PHN Grant Programme Guidelines state that PHNs must use Community Advisory Committees but only minimally define their function as: to 'provide community perspective to PHN boards' (DoH 2016a, 8). The lack of clear policy direction is one reason behind the varying levels of respect for Indigenous self-determination across PHN regions.

## 7 | KNOWLEDGE

ACCHS-sector advocates and Indigenous health policy experts have argued that the PHN's ability to improve Indigenous health outcomes is dependent on how well it engages ACCHSs' skills and knowledge (e.g. Couzos, Delaney Thiele, & Page, 2016). It is not clear that the PHN has a coherent strategy for engaging with ACCHSs and concerns have been raised over Indigenous cultural safety. This is because the PHN's competitive tendering processes clear the way for non-Indigenous service providers to enter Indigenous healthcare settings (Russell, 2015, 77). The following excerpt emphasises this concern:

*Who is PHN to say that an organisation is culturally safe or culturally appropriate? ... And who says they're culturally appropriate? And what happened to Aboriginal people's freedom of choice? You know, they're just being ignored, they're not consulted about this... putting a dot art painting on the wall doesn't mean you're culturally appropriate, it's just tokenistic... I just feel that Aboriginal people don't get given... they don't have a say and yet it's their health that we're talking about, you know. At least with us we give them a choice. (CEO, inner-regional ACCHS, July 2017)*

Some ACCHSs feel that the PHNs are not attuned to the culturally-specific health needs and expectations of Aboriginal and Torres Strait Islander peoples. Moreover, this ACCHS CEO feels that Aboriginal peoples' right to self-determination was not respected in the top-down decision-making process that led to the creation of the PHN.

There is a feeling amongst some within the ACCHS sector that PHNs are not familiar with and have not sufficiently engaged with the ACCHS model of care or the Aboriginal definition of health (Cooke quoted in NACCHO 2017; Wright & Lewis, 2017, 33). In response to a question about the differences and similarities between ACCHSs and non-Indigenous health services, a very experienced CEO from an urban ACCHS had this to say:

*No, they don't even... they don't even touch the surface of what we do. I'm on the PHN board. [The] PHN is mainly all doctors and they're fascinated. I did a presentation to them and did a video. They couldn't believe it, what we do. (CEO, urban ACCHS, March 2018)*

This response suggests that PHN board members have limited knowledge of ACCHSs' ways of working, and, that because the majority of PHN board members come from a conventional clinical health background, they do not understand ACCHSs' holistic conceptualisation of Aboriginal Community wellbeing (see AH&MRC 2008, 32). That said, these PHN board members being 'fascinated' by the CEO's presentation indicates that there is potential for these organisations to learn from and work more closely with this ACCHS in the future.

## 8 | RESOURCES

A number of ACCHS managers and CEOs commented on the PHN's lack of investment in their sector. The government's under-funding of the ACCHS sector has attracted persistent criticism from Indigenous health and policy scholars for many years (Alford, 2014; Grant et al., 2008, 19). The following comment came in response to a question about the Indigenous Advancement Strategy (IAS), another recent policy initiative that has been similarly criticised for not engaging with Indigenous Community organisations, underscoring how ACCHSs feel ignored by funding and policy bodies:

*It's the same as the PHN stuff, there was no – they didn't come and talk to us and say 'how many patients you got? What are your occasions of service like? What's your health-outcomes data like?' None of that, so they don't know what we could do, what we could deliver. (CEO, urban ACCHS, January 2018)*

This ACCHS CEO sees value in a process where governments, or intermediaries such as PHNs, could directly approach Aboriginal services with long-standing relationships with their Communities in order to assess the possibility of building upon what is already in place. This did not occur with the PHN in her region.

The following statement from the manager of an urban-based ACCHS eloquently articulates the strongly held view that funding and policy bodies should work with and build on the work of Indigenous Community organisations:

*We've already told them: 'have more dialogue with us'... it's about relationships, it's about understanding the [Indigenous health] space. It's not just contract management ... It's really about making sure that the funding isn't piecemeal. ... We don't want to be set up for failure... So this is the issue: I think the reporting is important and I think the dialogue with our funders is really, really important. It's about having healthy relationships and discussions with our funders around what the challenges are both at an organisational level and at a Community level... It's stepping back and actually sharing the problem rather than administering a contract. (Operations Manager, urban ACCHS, January 2018, emphasis added)*

This manager is urging PHNs to embrace a partnership approach to Indigenous community-controlled organisations. He believes that PHNs need to invest more in the ACCHS sector and that they should share responsibility for Indigenous health outcomes. He also sees a need for PHNs and governments to better understand the challenges faced by ACCHSs and their Communities. However, this would require not just the PHNs but the Australian Government to give up its doctrinaire commitment to contestable funding, an approach that is based on the idea that there should be a competitive service market.

## 9 | CONCLUSION

From the perspective of senior managers in Aboriginal Community Controlled Health Services, the creation of Primary Health Networks has had a negative impact on the delivery of health services to Indigenous communities. ACCHSs now have a new administrative body to which they must appeal for funds. The PHNs do not appear to give substantial weighting to Indigenous self-determination when making decisions about Indigenous health services. The Department of Health's PHN guidelines acknowledge that ACCHSs, as Indigenous Community representatives, make vital and unique contributions to Indigenous healthcare. However, the Department has not institutionalised Aboriginal community control into the PHN funding system. This leaves the level of Indigenous Community engagement to the discretion of PHN boards. As a result, ACCHSs have not received significant investment from PHNs, nor have they been consulted in key Indigenous health decision-making processes. Moreover, PHNs do not appear to possess high levels of Indigenous primary health care knowledge or expertise and would do well to engage with and learn from ACCHSs. Relational contracting is suggested as a way to approach this. This paper has argued that PHNs have had a negative impact on Indigenous self-determination and health services. PHNs offer ACCHSs very few avenues through which to enact self-determination. If, as I would argue, this unequal power dynamic is indicative of the broader relationship between Indigenous Communities and the Australian state, then Indigenous peoples' recent call for substantive institutional reform becomes all the more comprehensible and urgent.

## ENDNOTES

- <sup>1</sup> A note on style: in this paper 'Community', when capitalised, refers to the relevant local Aboriginal community or the broader Aboriginal and Torres Strait Islander community in Australia, depending on the context. This is in line with the definition set out by the Aboriginal Health and Medical Research Council (AHMRC 2008, 6), the state-level peak body that represents the interests of ACCHSs in New South Wales.
- <sup>2</sup> The AH&MRC Ethics Committee has provided ethics approval for the project, allocating it reference number 1225/16.
- <sup>3</sup> The categories 'urban', 'inner-regional' and 'outer regional' used in this paper are based on the Australian Statistical Geography Standard Remoteness Structure used by the Australian Bureau of Statistics <<http://www.abs.gov.au/websitedbs/d3310114.nsf/home/remoteness+structure>>.
- <sup>4</sup> Sturgess, Argyrous and Rahman (2018), in their fascinating study of the contracting modes that governed the transportation of convicts from England to Australia in the 18<sup>th</sup> and 19<sup>th</sup> centuries, found evidence that a relational mode of commissioning, which considered potential service providers' reputation, expertise, and motivation, delivered better human outcomes than transactional commissioning, where the primary consideration was price.
- <sup>5</sup> Thank you to Associate Professor Janet Hunt for reminding me of the contradictions between PHNs' actions and the Commonwealth Government's commitments under the National Aboriginal and Torres Strait Islander Health Plan.

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