Transition to Aboriginal and Torres Strait Islander Community Control of Health in Queensland:
A Draft Strategic Policy Framework
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Acknowledgements

This Draft Strategic Policy Framework has largely been developed from the contributions of participants at the October 2010 Transition to Community Control Policy Development Workshop. Workshop participants included representatives from the Aboriginal and Torres Strait Islander community controlled sector, the Australian Government Department of Health and Ageing, and Queensland Health (District and Corporate office staff).

This Draft Strategic Policy Framework has also been informed by the pre-existing work of: the Apunipima Cape York Health Council, Gurriny Yealamucka Health Service Aboriginal Corporation, the Queensland Aboriginal and Islander Health Council, Queensland Health Cape York Health Service District, Queensland Health Cairns and Hinterland Health Service District, Queensland Health’s Aboriginal and Torres Strait Islander Health Branch, and the Northern Territory Aboriginal Health Forum.

It is recognised that in Queensland’s Aboriginal and Torres Strait Islander community and community controlled health sector there has been a long history of discussion and consultation on greater community involvement in health service delivery, and in some communities there has been agreement on community aspirations for transition to community control.

Appendix 1 shows how the policy has developed from issues through to policy documents.
Introduction

Founded on the basic human right to self-determination, community control of health services refers to the ability of people using health services to determine the nature of those services and to participate in the planning, implementation and evaluation of those services.¹

Purpose

This Draft Strategic Policy Framework outlines the policy directions for the Queensland Government that will enable greater community control over the planning, management and delivery of local Queensland Health services.

It builds on existing local level consultation and documentation and reflects a joint effort among community, government and other health sector stakeholders to provide an enabling policy platform for transition to greater community control in Queensland.

The Draft Strategic Policy Framework recognises that community control of health service delivery can be seen across a continuum of responsibilities and functions - it does not prescribe a single approach to community control, nor is it a new investment strategy, and it does not set a schedule or process for transitioning to greater community control of health services.

The Draft Strategic Policy Framework provides the conceptual parameters under which specific policy implementation work can be progressed in the areas of:

- Community engagement and development
- Comprehensive primary health care
- Consultation and stakeholder engagement
- Industrial relations
- Asset management
- Funding and financial management
- Information management
- Transition ‘readiness’
- Change management
- Risk management
- Monitoring and evaluation

Development

To progress development of a transition to community control policy in Queensland, a Joint Working Group has met regularly. Regular Joint Working Group participants have been:

- The Queensland Aboriginal and Islander Health Council
- Apunipima Cape York Health Council
- Gurriny Yealamucka Health Service Aboriginal Corporation
- General Practice Queensland
- Royal Flying Doctor Service, Queensland
- Australian Department of Health and Ageing
- Queensland Health

The following unions have also been consulted:

- Australian Workers’ Union of Employees, Queensland
- Queensland Public Sector Union
- Queensland Nurses Union
- Australian Council of Unions
The Case for Change

The Policy Context

Aboriginal and Torres Strait Islander participation in and control of health services has been identified at both a state and national level as an important action to improve health outcomes for Aboriginal and Torres Strait Islander people and contribute to “Closing the Gap”.

The National Aboriginal Health Strategy (1989)\(^2\) ‘encouraged’ Aboriginal participation in and control of primary health care services and the Queensland Government’s Queensland Aboriginal and Torres Strait Islander Health Policy (1994)\(^3\) had the goal of empowering Aboriginal and Torres Strait Islander people to develop and manage their own health care services.

In 2003, the Commonwealth Government, Queensland Government and other Australian States and Territories endorsed the *National Strategic Framework for Aboriginal and Torres Strait Islander Health*,\(^4\) which commits to the principle of community control of primary health care services.

In 2008, Statements of Intent were signed by the Queensland and Commonwealth Governments, the State and Federal Opposition, health organisations and unions, recognising that:

> “Crucial to ensuring equal access to health services is ensuring that Aboriginal and Torres Strait Islander peoples are actively involved in the design, delivery and control of these services.”\(^5\)

In 2010, the Queensland Government released *Making Tracks toward closing the gap in health outcomes for Indigenous Queenslanders by 2033 – Policy and Accountability Framework.*\(^6\) At the heart of this policy is trust, respect and community control.

Transition to community control is occurring in the context of National Health Reform. Progressing transition to community control is not dependent on National Health Reform; however, National Health Reform provides a timely opportunity to improve arrangements for the planning and the delivery of health services to Aboriginal and Torres Strait Islander peoples.

Tackling access and equity issues, including improving health outcomes for Aboriginal and Torres Strait Islander Australians, was identified as a priority by the National Health and Hospitals Reform Commission.\(^7\) Subsequent proposed structural changes under the national reforms include Medicare Locals and Local Health and Hospital Networks, which emphasise local governance of service delivery to give local communities and clinicians a greater say in the delivery of local health services.\(^8\)\(^9\)

The Heads of Agreement – National Health Reform, agreed by the Council of Australian Governments in February 2011, commits the Commonwealth, States and Territories to work together on system-wide policy and statewide planning for General Practice and primary health care services. Transition to community control will be one component of this joint work.

Transition to community control is consistent with broader government Aboriginal and Torres Strait Islander reforms, such as Closing the Gap, Cape York Welfare Reforms and the Council of Australian Governments Remote Service Delivery Strategy. In particular, it aligns with the objectives of these reforms, which emphasise improving access to services, better coordinating services, building Aboriginal and Torres Strait Islander governance and leadership capacity, and communities and government working in partnership.
The Evidence Base

Given the poor health status of Aboriginal and Torres Strait Islander people (the gap in life expectancy at birth between Indigenous and non-Indigenous Queenslanders is 10.4 years for males, and 8.9 years for females), governments and health sector stakeholders have to consider how the delivery of health services can be more effective in addressing the health needs of Aboriginal and Torres Strait Islander Queenslanders.

Health status is also affected by a range of other social and economic factors outside the control of the health system, which must be addressed simultaneously to achieve sustained improvement. These social and economic factors include socio-economic status (low income, unemployment, and low employment); environmental factors (substandard housing, sewerage and water quality, and access to affordable, healthy food and adequate food storage facilities); and historical and socio-political factors (forced removal from land and/or family, culturally inappropriate services).

Impact on Health Outcomes

Australian studies have found that Indigenous-specific primary health care services can offer improved communicable disease control (e.g. through vaccination and improved treatment of STIs and scabies); increased screening for cancer (e.g. cervical); early detection and reduced complications of chronic diseases and mental illnesses; improved child and maternal health outcomes; and reduced social and environmental risks, such as alcohol consumption and injury. ‘Indigenous-specific’ encompasses programs delivered through community controlled organisations, government health services and other mainstream health providers. A key feature of the Indigenous-specific primary health care services was the proactive engagement and participation of communities in design and delivery.

Community participation is a founding principle of the World Health Organisation (WHO) 1978 Alma-Ata primary health care declaration. One of the reasons for community participation being important is the idea that people are more likely to use and respond positively to health services where they have been involved in decision making about how these services are delivered.

A 2008 study in the Northern Territory Aboriginal community of Utopia concluded that opportunities for self determination contributed to better than expected health outcomes, including a mortality rate from cardiovascular disease which is 40-50% lower than the Northern Territory average for Indigenous adults.

There is wide acceptance, based on experience in countries like the USA, Canada and New Zealand, that better health outcomes can be achieved for Indigenous peoples where there is access to comprehensive primary health care that includes community participation in priority setting, resource allocation and health service delivery. Canada and the USA have national programs to increase community control through the Health Transfer Program and the Tribal-Self-Governance Program respectively.

Impact on the Health System (access and cost)

There is significant international support for effective primary health care as a critical strategy to improve the equity, efficiency, effectiveness and responsiveness of health systems. Effective primary health care may not reduce total health care costs because of increased access and expanded service utilisation but it can deliver better health outcomes for the investment.
Data suggests that Indigenous Queenslanders are not accessing the appropriate primary health care services to better prevent and manage chronic disease, but are presenting at public hospitals in an advanced state of ill health, where they consume a significantly greater amount of health expenditure due to the complex nature of chronic illness and co-morbidity of chronic disease. Expenditure on inpatient public hospital care for Indigenous Queenslanders is 2.1 times higher than for non-Indigenous Queenslanders; however, expenditure on out of hospital Medicare services for Indigenous Queenslanders is 2 times lower than non-Indigenous Queenslanders.\(^{15}\)

The potential for effective primary health care to reduce the burden on the hospital system can be demonstrated. For example, a Torres Strait trial of Indigenous-specific diabetes care delivered in the primary care setting resulted in a 41% reduction in hospital admissions for diabetes-related conditions, and a Western Australian Indigenous-specific mental health project reduced psychiatric hospital admissions by 58%.\(^{16}\)

A recent Australian study\(^{17}\) that evaluated the impact of delivering health interventions to Aboriginal and Torres Strait Islander populations through community controlled health organisations found high rates of utilisation and adherence to treatment. However, the overall costs of providing services through community controlled health organisations was higher, primarily due to the more comprehensive nature of these services, particularly patient transport.

In summary, there is limited pre-and post-evaluation work to determine the impact of introducing greater community control on service access and provision, health costs and health outcomes more broadly.

It is difficult, given the complex nature of health systems, to attribute gains in health outcomes to any single initiative; however, the research does support that:

- in any population, but specifically disadvantaged populations, investing in and increasing access to comprehensive primary health care is critical for improving health outcomes and reducing the burden on the hospital system
- for Indigenous populations, community involvement in the design and delivery of primary health care services is a key factor in improving access to primary health care
- countries that have taken a systematic approach to increase community control have seen improvements in Indigenous health indicators

As such, it could be anticipated that a policy to increase community control of primary health care services, where communities decide the level of participation and control that best suits their aspirations, would lead to Indigenous Queenslanders accessing more primary health care services, resulting in better prevention, early intervention and management of health conditions, a reduction in potentially preventable hospital admissions and long term health gains.

Developing a robust monitoring and evaluation framework will be an important part of transition to community control in Queensland, and would contribute significantly to the international evidence base for Indigenous health.
Different Aspirations: Different Models

Community control can be considered along a continuum of responsibility for service delivery: with greater control comes greater responsibility.

Along this continuum, different forms of community control exist. They range from minimal control, such as state government-run health services with a community reference group, to a model where an Aboriginal and Torres Strait Islander incorporated organisation, with a community elected board, is the primary health service provider with accountability for decisions made and services provided.

<table>
<thead>
<tr>
<th>Advising</th>
<th>Coordinating/Managing</th>
<th>Purchasing</th>
<th>Delivering</th>
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Adapted from NT Pathways to Community Control

The predominant model of Aboriginal and Torres Strait Islander community control in Australia and Queensland is a community controlled health service/organisation, defined as:18

- an incorporated Aboriginal or Torres Strait Islander organisation;
- initiated by the Aboriginal or Torres Strait Islander community;
- based in an Aboriginal or Torres Strait Islander community;
- governed by an Aboriginal or Torres Strait Islander body which is elected by the local Aboriginal or Torres Strait Islander community; and
- delivering a holistic and culturally appropriate health service to the community that controls it, funded by governments.

Aboriginal and Torres Strait Islander community controlled health organisations in Queensland receive funding from the Commonwealth and Queensland governments for the delivery of primary health care, substance use, social and emotional wellbeing and mental health services for Aboriginal and Torres Strait Islander people.

Aboriginal and Torres Strait Islander community control exist now and functions in a variety of forms, including purchasing and management and delivery of health services. Consistent with the underpinning principle of self-determination, functions should reflect community desire, aspirations and abilities at a point in time, and may change over time.

In addition to Aboriginal and Torres Strait Islander community controlled organisations, other providers including general practitioners, allied health professionals, health care workers and other non-government and government agencies deliver health care to Aboriginal and Torres Strait Islander Queenslanders and will continue work in partnership to deliver services that meet the needs of the local community.
Critical Elements in Achieving Sustainable Health Gains

Experience internationally and in the Northern Territory shows that transitioning to Indigenous community control is not without challenges. Challenges will vary among communities and over time, as will responses to them. Developing a clear policy direction informed by broad stakeholder input will be an important part of managing challenges and supporting transition to community control.

Empowered Citizens

Over the last 30 years, empowerment and community participation have evolved as important strategies for reducing health disparities. All individuals in a community, including the most disenfranchised members, should be able to acquire knowledge of the health system and their rights, opportunities and obligations within that system. Empowering citizens requires government and non-government organisations to effectively and appropriately engage with all members of the community. A significant strategy to promote empowering participation is community control of project funding. 19

Recent observations on the Northern Territory experience indicate that successful transition of health services requires understanding, knowledge and competence in community engagement.

“A key lesson from the COAG Indigenous community coordination trials and the Northern Territory Emergency Response is that engagement with Indigenous Communities is essential to achieve measurable improvements in economic, health and social indicators.” 20

Developing a Community Development and Engagement Framework is a critical component of empowering citizens and of effective transition to community control in Queensland.

Strong Leadership and Good Governance

Strong leadership and robust governance arrangements are important to drive change, mobilise effort, create and sustain partnerships, make decisions, manage potential risk, and provide a point of accountability.

“Getting governance right is gradually being recognised...as fundamental to improving Indigenous well-being and generating sustained socio economic development.” 21

Strong leadership and robust governance structures need to be built and sustained through ongoing capacity and leadership development. 22 For transition to community control to achieve sustainable health gains a focus on leadership and governance needs to occur at the community, organisational and clinical levels.

Competent and Comprehensive Primary Health Care Services

To close the health gap between Aboriginal and Torres Strait Islander and non-Indigenous populations, primary health care services must be delivered in a way that makes sense to Aboriginal and Torres Strait Islander people, is underpinned by best practice, and maximises the potential for health gain.
Addressing the burden of chronic disease in Aboriginal and Torres Strait Islander populations necessitates comprehensive and integrated primary health care, that is, primary health care that has a broad scope, encompassing health promotion, illness prevention, treatment and care of the sick, rehabilitation, community development, and advocacy.\textsuperscript{23}

Managing the resources - funding, infrastructure and workforce - to deliver comprehensive primary health care services (as with any type of health service) is complex and challenging. A health service provider is said to be competent when it can show that it is able to:\textsuperscript{24}

- Prioritise the use of resources to meet the health needs of communities;
- Use and organise resources so that it systematically contributes to health and wellbeing goals and objectives; and
- Maintain sound professional standards and organisational processes.

To this end, the development of a Queensland Aboriginal and Torres Strait Islander Comprehensive Primary Health Care Framework to assist communities to develop local models of comprehensive primary health care service delivery that suits the community and competency standards in the management of primary health care services is critical to support the transition to community control policy.

**Flexible and Stable Funding**

Evidence suggests that adequately resourcing comprehensive primary health care over a long period of time can improve health outcomes for Indigenous populations.\textsuperscript{25}

The limitations of inadequate resources are further compounded by inefficient funding arrangements. Funding arrangements for Indigenous health broadly have been described as “inflexible, cumbersome and inefficient”.\textsuperscript{26} The Aboriginal and Torres Strait Islander Community Controlled health sector specifically is funded in more complex ways, and from more sources, than most other health care organisations.\textsuperscript{27}

To address this, a review of funding arrangements to reduce administrative complexity and allow the flexibility to support comprehensive primary health care delivery that is responsive and appropriate to community need will be an important consideration in transitioning to greater community control.
Strategic Policy Framework

Vision
Transition to Aboriginal and Torres Strait Islander community control contributes to the vision that: Every Queenslander has the same opportunity for health.

Mission
Communities are responsible for their health services at a level that is commensurate with their abilities and aspirations.

Principles of Transfer
1. Transitioning health services to community control is a dynamic and iterative process.
2. Communities and health staff are not disadvantaged through the transition of health services.
3. There is continuity of health care service delivery for communities throughout the process of transfer.
4. Health services provide best practice Comprehensive Primary Health Care, underpinned by rigorous clinical and organisational governance, and delivered through interventions that provide good value for money.
5. Communities and health staff and their unions or nominated representatives are actively engaged and consulted throughout the change process.
6. Changes take account of the rights of traditional owners through Native Title.
7. Public confidence is established and maintained through transparent accountability and reporting processes.

Policy Objectives

<table>
<thead>
<tr>
<th>Self-determination</th>
<th>Aboriginal and Torres Strait Islander people actively participate in the planning, management and delivery of health services in their community.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access</td>
<td>Aboriginal and Torres Strait Islander people access health services at the same rates as non-Aboriginal and Torres Strait Islander people relative to their need.</td>
</tr>
<tr>
<td>Quality</td>
<td>Health services in discrete communities are culturally secure, clinically appropriate and based on best available evidence.</td>
</tr>
<tr>
<td>Equity</td>
<td>Aboriginal and Torres Strait Islander people receive a fair share of health resources regardless of where they live.</td>
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</tbody>
</table>

Transforming Our Businesses
Greater community control can only be actioned and sustained at a local level if the objectives of transition to Aboriginal and Torres Strait Islander community control are embedded at all levels of policy and practices in the planning, funding, purchasing and delivery of health care to Aboriginal and Torres Strait Islander Queenslanders. The breadth of impact and change is extensive, but can be ‘themed’ into three inter-dependent areas where policy negotiation and reform are required.
Outcome Area 1: Health System Planning and Integration

The elements of clinically sound, ‘joined-up’, culturally competent, and community controlled health services.

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Issues</th>
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<tbody>
<tr>
<td>• Communities participate in the planning, management and delivery of health services to a level/degree determined by the community.</td>
<td>• Lack of an agreed evidence-based approach to primary health care models of care.</td>
</tr>
<tr>
<td>• Health services are integrated, flexible and responsive to community need and circumstance.</td>
<td>• Clinical governance.</td>
</tr>
<tr>
<td>• Health workforce is culturally competent, delivering culturally and clinically appropriate care and making culturally appropriate decisions.</td>
<td>• Accreditation and credentialing (clinical, workforce and/or organisation).</td>
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<tr>
<td>• Health services partner to provide optimum models of care.</td>
<td>• Different organisational cultures.</td>
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Policy Directions

<table>
<thead>
<tr>
<th>Strategies (to be progressed in next stage of T2CC policy development)</th>
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<tbody>
<tr>
<td>• Community development approach embedded in service delivery.</td>
</tr>
<tr>
<td>• Comprehensive Primary Health Care as the best practice approach for Indigenous primary health care.</td>
</tr>
<tr>
<td>• Single community health plans, developed with community input and shared by all health providers in a community.</td>
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<tr>
<td>• Accreditation standards for the delivery of comprehensive primary health care (including acute primary care services that can be delivered safely in the community).</td>
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<tr>
<td>• Shared health records.</td>
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<thead>
<tr>
<th>Short term</th>
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<tbody>
<tr>
<td>• Develop a Community Development and Engagement Strategy to support the various models of community control that may emerge.</td>
</tr>
<tr>
<td>• Develop a statement on best practice Comprehensive Primary Health Care for Indigenous health.</td>
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<tr>
<td>• Establish appropriate local and regional clinical governance arrangements, accounting for new structures such as Medical Locals and Local Health and Hospital Networks being established under National Health Reforms.</td>
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<tr>
<td>• Develop local change management programs that are inclusive of all stakeholders.</td>
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<tr>
<td>• Undertake joint health service planning for communities.</td>
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<tr>
<td>• Establish protocols for sharing health records – interim solutions.</td>
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<td>• Review of recruitment, selection, training and performance processes.</td>
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<table>
<thead>
<tr>
<th>Medium term</th>
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<tbody>
<tr>
<td>• Local Community Development Plans.</td>
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<td>• Individual Community Health Plans.</td>
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<td>• Information Management Strategy.</td>
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### Outcome Area 2: Health System Infrastructure

**The physical and non-physical organisational infrastructure required to deliver health services**

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Issues</th>
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</thead>
<tbody>
<tr>
<td>• Sustainable infrastructure is responsive to changing demand and service requirements.</td>
<td>• Different business cultures.</td>
</tr>
<tr>
<td>• Patient information and workforce can move seamlessly between organisations.</td>
<td>• Purchasing power.</td>
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<td>• Optimal use of resources.</td>
<td>• IT infrastructure compatibility, maintenance and support.</td>
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<td></td>
<td>• Organisational governance.</td>
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<td></td>
<td>• Asset ownership and maintenance.</td>
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<td>• Responsibility for future building/ accommodation requirements.</td>
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<td></td>
<td>• Workforce supply – quantity, quality, attraction and retention.</td>
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<td></td>
<td>• Different award rates and terms and conditions.</td>
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<td></td>
<td>• Job security.</td>
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<td>• Providing a career path and structure.</td>
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<td>• Varying role definitions and skill set requirements</td>
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<tr>
<th>Policy Directions</th>
<th>Strategies (to be progressed in next stage of T2CC policy development)</th>
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<tbody>
<tr>
<td>• Agree standards for organisational competence and capability.</td>
<td><strong>Short term</strong></td>
</tr>
<tr>
<td>• Self-sustaining workforce supply.</td>
<td>• Develop a Competence and Clinical Capability Framework including organisational readiness assessment tools, to identify capacity building needs.</td>
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<tr>
<td>• Flexible workforce models supported by mentoring, training and a continuous learning and improvement environment.</td>
<td>• Review existing government processes for procurement of health services.</td>
</tr>
<tr>
<td>• Shared health records.</td>
<td>• Benchmark current workforce across all health service providers.</td>
</tr>
<tr>
<td>• Procurement arrangements that maximise economies of scale for all health service partners.</td>
<td>• Develop an Industrial Relations negotiation framework.</td>
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<tr>
<td>• Increase uptake of Telehealth and Telemedicine MBS Items.</td>
<td>• Identify opportunities to leverage services within the existing Telehealth program.</td>
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<tr>
<td></td>
<td>• Involve communities in the planning and design of local capital works programs.</td>
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<td></td>
<td><strong>Medium term</strong></td>
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<tr>
<td></td>
<td>• Initiate or continue to work towards or meet relevant standards (eg accreditation).</td>
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<tr>
<td></td>
<td>• Shared electronic health records with interoperable IT systems.</td>
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<td></td>
<td>• Health Workforce Strategy.</td>
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<tr>
<td></td>
<td>• Local health infrastructure plans.</td>
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<td></td>
<td>• Site-specific capacity building.</td>
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</table>
## Outcome Area 3: Structural and Funding Reform

### The overarching governance, funding and purchasing of health services

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Health institutions reflect our basic human right to determine our future.</td>
<td>• Siloed funding sources are driving delivery of care rather supporting alternative models of care.</td>
</tr>
<tr>
<td>• Funding reflects health need and supports more holistic models of care.</td>
<td>• Funding for buildings is necessary and appealing to stakeholders but effectiveness is limited in absence of mechanisms to address more complex access issues - hanging out a shingle and expecting people to walk in when they need a service is not enough to ensure adequate service provision. More complex access issues need to be addressed.</td>
</tr>
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</table>

### Policy Directions

#### Strategies (to be progressed in next stage of T2CC policy development)

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Community development approach embedded in health service funding, purchasing and monitoring.</td>
<td>• Need to transition viable services.</td>
</tr>
<tr>
<td>• Community Controlled Health Organisation as single purchaser of health services at a community/regional level.</td>
<td>• Multiple sources (two levels of government and multiple agencies) of inflexible funding.</td>
</tr>
<tr>
<td>• Funding for health services is adequate and stable.</td>
<td>• Input driven performance accountability (eg number staff employed vs. services delivered).</td>
</tr>
<tr>
<td>• Models of care drive funding and infrastructure.</td>
<td></td>
</tr>
<tr>
<td>• Output/outcome driven performance accountability.</td>
<td></td>
</tr>
<tr>
<td>• Maximise uptake of existing MBS and PBS funding programs.</td>
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</tr>
<tr>
<td>• Procurement and accountability requirements allow for local flexibility and community-responsive models of care delivery.</td>
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</table>

### Short term

- Establish a mechanism to support capacity building.
- Undertake finance benchmarking and economic analysis.
- Review funding models to achieve more simplified and flexible arrangements that allow flexible funding packages co-ordinated locally.
- Establish new State or regional governance arrangements.
- Develop a Monitoring and Evaluation Framework.
- Review current health service purchasing models and procurement processes.
- Identify and address any structural barriers to MBS and PBS usage.

### Medium term

- Implement simplified funding arrangements more responsive to health issues/priorities (e.g. per ‘capita’ pooled funding model adjusted for key health markers).
- Statewide Key Indigenous Primary Health Care Performance Indicators (KPI) & single repository for KPI reporting.
A Partnership Approach

A strong partnership between communities, the Queensland Government, the Australian Government, the Aboriginal and Torres Strait Islander Community Controlled Sector, and other non-government health sector stakeholders is critical.

It is equally critical that all stakeholders in transitioning to greater community control place significant importance on establishing trust, cultural security and allowing the process to be a shared journey.

Roles and responsibilities

Stakeholders in transition to greater community control have a collective responsibility to:

- respond to the evidence that Aboriginal and Torres Strait Islander peoples’ participation in the design, delivery and control of health services can deliver health gains
- respond to the evidence that comprehensive primary health care, underpinned by best practice, maximises health gains
- ensure that appropriate community consultation is undertaken and that a community is not disadvantaged in the transition process
- ensure that health staff are consulted and that health staff are not disadvantaged in the transition process
- participate in Transition to Aboriginal and Torres Strait Islander Community Control policy development, planning, implementation and evaluation
- support improved integration of health services within a community, within a region and across the health care continuum
- ensure transparency through timely sharing of information and accountability through regular monitoring, evaluation and reporting

In addition, the Australian and Queensland Governments will commence transition to community control within the framework of government responsibilities under the Council of Australian Government February 2011 Heads of Agreement on National Health Reform:

- The Commonwealth and Queensland Governments have shared policy and funding responsibility for primary health care, including primary health care to Indigenous Australians.
- The Commonwealth Government is responsible for establishing Medicare Locals that will be responsible for coordinating and better integrating primary health care services in their local communities and regions.
- The Queensland Government is responsible for establishing Local Health and Hospital Networks that will be responsible for the day-to-day operation of public hospitals and delivery of public health services.
- The Commonwealth and States and Territories will “work together on system-wide policy and statewide planning for general practice and primary health care services, because it impacts on the efficient delivery of hospital services and other state funded services and because of the need for effective integration across Commonwealth and State funded health care services”.

Specific roles and responsibilities, including the relationships with the to be established Medicare Locals and Local Health and Hospital Networks, will be negotiated through the policy consultation and negotiation process.
Aboriginal and Torres Strait Islander Health Governance

Currently, governance for transition to greater Aboriginal and Torres Strait Islander community control is through the Transition to Community Control Joint Working Group, involving the Community Controlled sector, General Practice Queensland, Queensland Health, the Department of Health and Ageing and others. The current focus of the Joint Working Group is policy development.

Consistent with the principle of self determination at a community level is the need to consider governance structures that support Aboriginal and Torres Strait Islander self determination at a State level, particularly in relation to Indigenous health policy, funding and accountability.

The design of appropriate governance structures for Indigenous health at a State level is an important part of effective transition to Aboriginal and Torres Strait Islander community control in Queensland and is being discussed as part of the broader National Health Reform.

The ongoing structure and purpose of the Joint Working Group will be reviewed as transition to Aboriginal and Torres Strait Islander community control in Queensland moves from policy development to implementation and will take into account any future considerations regarding Aboriginal and Torres Strait Islander health governance within the National Health Reform governance and accountability structures.
Testing and Refining Our Approach

Pilot Sites

In 2006, Queensland Health, the Department of Health and Ageing, local Aboriginal and Torres Strait Islander Community Controlled Organisations and other local non-government health stakeholders were co-signatories to Deeds of Commitment for the transition to community control of services in Cape York and Yarrabah.

In acknowledgement of the existing work done in these sites, and valuing a ‘bottom up’ approach to policy development, the community controlled representatives of these locations are significantly involved in shaping the statewide transition to community control policy.

Measuring Progress

Yarrabah, Kowanyama and Mapoon sites are proposed as the ‘pilot’ communities for transition. Queensland Government approval will be sought to transfer Queensland Health services to Aboriginal and Torres Strait Islander community control in these communities as part of seeking government approval of the broader Transition to Aboriginal and Torres Strait Islander Community Control Policy package.

The process of transitioning to Aboriginal and Torres Strait Islander community control is likely to take at least three to five years, if not longer. Each community starts from a different point and will have different end points and, accordingly, timeframes should be set locally.

Important lessons from other jurisdictions reinforce the need to use common reporting systems and a manageable number of sensitive and consistent indicators.

Given the long lead time between a health intervention and improved health outcome as measured by life expectancy, using outcomes can be a flawed indicator of success for relatively short budget cycles.

If the goal is to measure the effectiveness of health investments, the question being asked needs to be reframed: rather than asking “what health outcome did we get for our primary health care investment”, the question should be “what increases in primary health care activity did we get for our primary health care investment”, and over the cycle of the program there should be a significant increase in primary health care activity – this becomes the success measure. If the increase is appropriate and sustained it would be reasonable to assume gains in health outcomes beyond the life of the program.

It is important to have a comprehensive, long term evaluation of Transition to Community Control, with a potential scope that may include, but not be limited to:

- Community impact – changes in self-governance and wellness, economic benefit
- Health impact – health service utilisation, medium and long term health benefits
- Financial impact – cost effectiveness for the health system (short and long term)
- Health staff impact – changes for health staff
- Policy impact – change to health policy
- Process – effectiveness of process to date, lessons learnt
- “Case studies” – process and impact to date in Cape York and Yarrabah, success stories
Next Steps

It is important that interested stakeholders have the opportunity to comment on this Draft Strategic Policy Framework.

Following public consultation, a more comprehensive policy package and plan (see Appendix 2) will be prepared to support transition to Aboriginal and Torres Strait Islander community control in Queensland.

In addition to a finalised Strategic Policy Framework, the final policy package will include further detail in the areas of:

- Community engagement and development
- Comprehensive primary health care
- Consultation and stakeholder engagement
- Industrial relations
- Asset management
- Funding and financial management
- Information management
- Transition ‘readiness’
- Change Management
- Risk Management
- Monitoring and Evaluation

Queensland Government approval will be sought for the final policy package and to initiate transition in three Communities. The proposed initial sites are Yarrabah, Mapoon and Kowanyama. An important consideration for government, prior to any approval to transition, will be the views of Aboriginal and Torres Strait Islander communities, of other health service providers and peak bodies, and of affected health staff and Union representatives. Government will also consider ‘readiness’ in the sense of capacity and capability in areas such as: community governance, organisational governance, clinical governance, continuity of care, patient safety and industrial relations.

Before transition to Aboriginal and Torres Strait Islander community control can occur in other communities, a period of monitoring and evaluation will be required to demonstrate the effectiveness of the process, and formal Queensland Government approval will be required for any other communities wishing to transition.
Appendix 1: Transition to Aboriginal and Torres Strait Islander Community Control Policy Development Process
## Appendix 2:

### Transition to Aboriginal and Torres Strait Islander Community Control Policy Package

<table>
<thead>
<tr>
<th>Document name</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TzCC Policy and Plan</strong></td>
<td>A collectively owned Queensland policy that translates the Strategic Policy Framework into a more practical guide on policy positions, roles and responsibilities, and transition phases.</td>
</tr>
<tr>
<td><strong>Community Development and Engagement Framework</strong></td>
<td>A guide for building community knowledge and understanding of transition options, establishing community aspirations, and ongoing engagement and capacity development in health.</td>
</tr>
<tr>
<td><strong>Comprehensive Primary Health Care Framework</strong></td>
<td>A collectively owned basis from which to benchmark expansion/enhancement of the local health service system.</td>
</tr>
<tr>
<td><strong>Sector Readiness Assessment Tool</strong></td>
<td>A tool for assessing the readiness of a community controlled organisation to take responsibility for primary health care services.</td>
</tr>
<tr>
<td><strong>Readiness Assessment Tool</strong></td>
<td>A tool for assessing the readiness of Queensland Health to transition health services to a model of greater community control.</td>
</tr>
<tr>
<td><strong>Industrial Relations Negotiation Framework</strong></td>
<td>A Queensland Health guide to negotiating with staff on Industrial relations matters related to transition to community control.</td>
</tr>
<tr>
<td><strong>Stakeholder Engagement &amp; Communication Strategy</strong></td>
<td>A collectively owned strategy for consulting and engaging at a statewide level with community, sector and government stakeholders about the TzCC project.</td>
</tr>
<tr>
<td><strong>Consultation Discussion Paper</strong></td>
<td>A paper to be used in consulting with community and all health service provider staff (Community Controlled, QH, DivGPs, RFDS).</td>
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<tr>
<td><strong>Change Management Strategy</strong></td>
<td>A collectively owned approach to managing change at the local level during transition to community control.</td>
</tr>
<tr>
<td><strong>Information Management Framework</strong></td>
<td>A collectively owned framework for addressing information management issues that may arise during transition at a patient, service provider and community level, including policy and legal context, patient consent and confidentiality, access to patient records, service-level data, community-level data, information technology expectations (soft and hard ware), staff training and education, resourcing, communication.</td>
</tr>
<tr>
<td><strong>Funding and Financial Management Framework</strong></td>
<td>A collectively owned framework that guides local funding and financial management arrangements in TzCC communities.</td>
</tr>
<tr>
<td><strong>Evaluation framework</strong></td>
<td>A collectively owned framework outlining the parameters for evaluating transition to community control from which more specific pieces of evaluation can be commissioned.</td>
</tr>
<tr>
<td><strong>Statewide Risk Management Strategy</strong></td>
<td>A collectively owned strategy to ensure anticipated project risks that have statewide applicability and can only be management a statewide/strategic level are managed for a smooth transition process.</td>
</tr>
</tbody>
</table>
Appendix 3 End Notes


3 Queensland Health 1994, Queensland Aboriginal and Torres Strait Islander Health Policy, Brisbane.

4 National Aboriginal and Torres Strait Islander Health Council (NATSIHC) 2003, National Strategic Framework for Aboriginal and Torres Strait Islander Health: Framework for Action by Governments, Canberra.


14 Department of Health and Aged Care, 2001, Better Health Care Studies in the Successful Delivery of Primary Health Care Services for Aboriginal and Torres Strait Islander Australians, Office for Aboriginal and Torres Strait Islander Health, Department of Health and Aged Care, Canberra.


22. SCRGSP 2009, op. cit.

23. QAIHC 2010, A Blueprint for Aboriginal and Islander Health Reform in Queensland, September 2010.


25. Multiple studies, reviewed in Griew, R 2008, The link between primary health care and health outcomes for Aboriginal and Torres Strait Islander Australians. Report for the Office for Aboriginal and Torres Strait Islander Health, Department of Health and Ageing, Canberra, 2008.
