THINK CHANGE

Review of Lower Western Sector Agreement

Updated final report, June 2007

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Submitted to
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with

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Report commissioned by Greater Western Area Health Service and Maari Ma Health Aboriginal Corporation

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Acknowledgments

The Review Team would like to acknowledge the enormous assistance received to undertake this Review. The people of the far west and their organisations were unstintingly generous with their time, trust and honesty. Management in Maari Ma and the Greater Western Area Health Service also opened their books, their records and gave of their time and histories with honesty and engagement. Officials of Health Departments in both Sydney and Canberra made themselves available and were very receptive to both the questions we had and the suggestions and propositions we put to them.

The Review was conducted in two phases. The first phase involved a week long visit to the far west and extensive interviewing, followed by extensive analysis conducted by Robert Griew and Shane Houston. The first write up followed, undertaken by Robert Griew. The first phase was conducted and completed in 2006. In the first phase we were also assisted by Ms Cathy Dyer, then manager of Population Health Planning section in the Remote Cluster of Greater Western Area Health Service, Ms Cath Kennedy, Epidemiologist at Maari Ma and Ms Kate Finlayson who provided support with the design of the first phase.

The second phase of analysis, of results relating to Objective 6: Health outcomes for the Evaluation chapter, was conducted by Robert Griew and Diane Hindmarsh from the Centre for Epidemiology and Research in NSW Health. This led to redrafting of the Evaluation chapter, which was undertaken by Robert Griew. The second phase was completed in July 2007.

We would like especially to pay tribute to the leadership of Mr Richard Weston, Regional Director of Maari Ma Health Aboriginal Corporation and Dr Claire Blizard, CEO of Greater Western Area Health Service.

Finally, we would also like to pay tribute to the Barkandji people of Far West NSW who have a continuing attachment to and responsibility for the land in which the health services covered by the Lower Western Sector Agreement operate.

Robert Griew
Sydney
6 July 2007

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Executive Summary

In 1995, an innovative model of Aboriginal involvement in health care began in the far west of NSW. The local ATSIC Regional Council and its Chair, Smiley Johnstone, commissioned two health consultants – Sue Morey and Jack Best – to consult and advise on the best way for local Aboriginal people to take action to improve their health. These consultants provided a report that, even in retrospect, was unusually frank in its advice not to establish a parallel service structure but to engage with the mainstream Area Health Services.

At the same time a new Far West Area Health Service (FWAHS) was being established and its new CEO, Greg Rochford, set Aboriginal health and primary health care development as his top priorities. Morey and Best's advice was well received not only by Johnstone but also by Rochford, and thus a new approach to Aboriginal engagement in health was formulated.

Over a couple of years a new organisation, the Far West Ward Aboriginal Health Service (FWWAHS) was incorporated and Johnstone took charge. An Agreement was signed between FWAHS and FWWAHS. FWWAHS applied to the Commonwealth Health Department to run one of the new Aboriginal Coordinated Care Trials. These decisions all proved decisive in setting the direction which both these organisations would take.

This Review was commissioned to evaluate the Agreement, through its various iterations, ten years on, and to make recommendations for the future. The Agreement will come to an end at 31 December 2006 and its parties want to know what has been achieved and seek recommendations about any future agreement.

The Agreement provided for Maari Ma Health Aboriginal Corporation (the organisation FWWAHS became in 2000) to provide a contract management service to Greater Western Area Health Service (the organisation that FWAHS became part of in 2004.) Maari Ma provides management for Health Services in the Remote Cluster of GWAHS, outside Broken Hill. In return GWAHS provides various bureau services to Maari Ma and funds for three positions in the management team, including an Aboriginal Health Coordinator for the Remote Cluster.

The Agreement gives the Regional Director of Maari Ma a senior position in the executive team running the GWAHS Remote Cluster. Furthermore, the organisations commit to working together to fashion strategies to improve Aboriginal engagement and employment in health care and to improve the health of Aboriginal people in the region. It also names as partners the Royal Flying Doctor Service and the Sydney University Department of Rural Health in Broken Hill.

This Review included three phases:

- Preliminary review of documents and discussions with the Review Steering Committee;
- Consultation in Broken Hill, Menindee, Dubbo and Sydney; and
- Analysis.

The Review Team has been very grateful for the support of the steering committee, numerous staff of both GWAHS and Maari Ma, and of partner organisations. The Team was also impressed by the willingness of the many individuals to whom it spoke and their responsiveness to seek out additional information and data and their preparedness in many cases to talk to the team again.

While many difficult issues arose the Review Team never felt inhibited from discussing any of them. This is a tribute not only to those individuals themselves but also to the leadership of both organisations; a leadership that is crucial to a successful future.

This Report is broken into four chapters.

1. The health of the people of the Lower Western Sector.

This Chapter describes the difference between this region and NSW as a whole. The people covered by the Agreement live in the most remote and sparsely populated part of NSW, the representation of Aboriginal people is six times the State average and the region is poorer than the rest of the State, with higher unemployment.

The people covered by the Agreement have about 10% more hospital admissions and 15-20% more deaths per head of population. While they have about 10% more births, this is offset by poor birth outcomes. Risk factors for disease are high and, as elsewhere in remote Australia, Aboriginal people are suffering the impact of chronic diseases at a much younger age than non-Aboriginal people.

This is a pattern of illness that requires a specific kind of response: a focus on maternal and child health, on the prevention and management of chronic disease and on the health sector coordinating with other sectors to address underlying social and economic problems.

2. The history of the region and of the Agreement

With the change in personnel over time and given some of the controversy and politics that surrounded the Agreement, it is important to note how deliberate the original parties were in setting it up specifically as they did. The organisational interdependence they sought was a deliberate protection against having to divert too much early effort into running a standalone organisation, allowing a continuing focus on core business. This itself is an interesting model in Aboriginal organisational capacity building but did attract adverse comment from other Aboriginal community controlled organisations.

A number of key issues come from the history.

There have been several changes in the institutional structures surrounding the Agreement over the last ten years: ATSIC no longer exists and the FWWAHS has become Maari Ma Health Aboriginal Corporation, a much more substantial and progressively more complex and competent organisation. Subsequently and amid much local concern, the Greater Western Area Health Service has come into being, moving the administrative centre with which Maari Ma must engage to Dubbo, even allowing for local delegation to Broken Hill.

One of the outcomes of these changes has been increased miscommunication and misunderstanding between the parties to the Agreement. This has reached a point where the relationships needed to administer or develop the Agreement are stymied by this dysfunction. Regardless of any future Agreement this must be addressed. The Review concluded that there is much to be gained from a new

Agreement and the parties are therefore urged, at the most senior level, to use this opportunity to address and improve their relationships.

Encouragingly, the Review Team found a strong willingness by all the key players to do exactly this.

The second issue to arise from the history is the sophistication that has been achieved in health programming, alongside and then through the Agreement. This is partly attributable to the priority put on primary health care by the FWAHS in its early years and partly to the Coordinated Care Trial at Wilcannia. Significant resource growth and thinking has gone into this primary health care strategy for the whole period. Despite its many difficulties the Wilcannia trial prompted creative planning work in the area. This, together with the growing strength of Maari Ma and their role in the Agreement, has retained key professional leaders in the region.

These key professional staff have taken thinking in the area beyond general primary health care thinking and have led other parts of NSW in the implementation of a comprehensive approach to chronic disease. This work has evolved over a number of years but is not formally reflected in the Agreement, the last version of which was signed in 2001, while this work was still underway. It is clear, however, that there is a relationship between the role the Agreement gives Maari Ma in managing the Health Services and the reform effort to implement more comprehensive programming, especially in chronic disease.

The Review also involved lengthy talks about the relationship of the Agreement to wider issues of Aboriginal governance in the region. The Review rejects any analysis that confuses the political debate about Maari Ma's chosen integrationist strategy with questions about the outcomes achieved under the Agreement.

The Review offers a model of governance for consideration, with three domains, interacting but separate. The Agreement needs to be considered for what it is: a management agreement. Wider collaboration among health organisations over health strategy is also important, for example to implement a comprehensive chronic disease strategy. This is a related but separate domain of health governance. The new Centre for Remote Health, established with the new GWAHS in Broken Hill, is a good model for this.

Beyond the scope of health altogether is the domain of Aboriginal governance, through which Aboriginal people articulate aspirations and priorities to which health and other service organisations need to respond. The new Murdi Paaki Regional Assembly, established through the abolition of ATSIC and recognised as a COAG trial site, is a good model for this. GWAHS and Maari Ma need to consider jointly how they will engage at all of these levels.

This model of governance is different to that adopted in much of the rest of NSW and is the cause of some of the criticism the Agreement and Maari Ma have attracted. The Review has not attempted to judge what the right political strategy for Aboriginal organisations is in different places: that is clearly not its role. The Team does conclude however, that within the region for which it was designed the thinking on governance developed by the authors of this Agreement is clear and coherent. The Review Team's conclusion is a plea for pluralism, for different regions to recognise that different strategies will work in different places.

3. Evaluation of performance under the Agreement

Evaluating the performance of the parties in implementing the Agreement was a crucial part of this Review. The leadership of both Maari Ma and GWAHS sought reassurance, as do other key stakeholders in NSW and Commonwealth Health, that the Agreement has achieved its aims. This is partly in order to address the word-of-mouth critique of the 'Maari Ma model' that has continually dogged the Agreement. It is also because of their interest in the possibility of a new and alternative model in the important but vexed area of Aboriginal health. The Review Team did not attempt a comparative analysis of Aboriginal health strategy but did evaluate the specific outcomes achieved under this model.

In order to respond to this imperative the Review undertook an extensive analysis of data at a number of levels. In this first phase of analysis it found that the Agreement had, with one significant exception, been effectively implemented. There have been measurable gains in key indices, including the following.

- Investment by both the Area Health Services and the Commonwealth in primary health care and Aboriginal health, reflected in increased primary health care activity levels.
- Employment of Aboriginal staff in Health Services and development of innovative and appropriate training programs to support this.

- Engagement of Aboriginal health leaders in mainstream health system development and delivery.
- Access by both Aboriginal and non-Aboriginal residents of the region to health services, with some exceptions that require further exploration and action.
- Implementation of new and evidence based program reform initiatives to improve health service response to key priorities, especially chronic disease.

Data analysis to assess health outcomes is always difficult, especially in small populations and when the changing of administrative boundaries mid-course have affected the comparisons of data routinely collected over time. Furthermore, caution should always be exercised before attempting to attribute all of these outcomes to one intervention, in this case the Agreement.

In the second phase of analysis, initiated with support from the Director-General of NSW Health and the Centre for Epidemiology and Research in the Department, a more rigorous evaluation of data relating to the health outcomes achieved under the Agreement was conducted. Data from the midwives collection and mortality and hospitalisations data were compared for the specific LGAs served under the Agreement with Indigenous and non-Indigenous comparator populations in a selected group of similar LGAs in neighbouring parts of NSW. Using a test of significance based on 95% confidence intervals on both the proportions and rates calculated, a number of useful results were able to be added to the first phase analysis.

Significant improvements have been achieved both in access to antenatal care in the first 20 weeks of pregnancy and for vaccine preventable hospitalisations for the Indigenous population covered by the Agreement. Encouraging trends were also identified for premature and low birth weights, with the proportion of premature births for Indigenous women covered by the Agreement appearing now to have fallen below the proportions for non-Indigenous women in both the Agreement area and the comparator group of LGAs. The rate of acute ambulatory care preventable hospitalisations for Indigenous people covered by the Agreement also appears to have been falling, although not so the rate of chronic ambulatory care preventable hospitalisations. These data underpinning these trends lack the explanatory power to allow them to be regarded as significant to the level of the test adopted, but are nonetheless of great interest.

The Review Team concluded that the Agreement has been effectively implemented and has been an essential part of an impressive and encouraging record of health reform in the Remote Cluster over a ten year period.

The one significant failure was to develop Key Performance Indicators (KPIs) under the Agreement that related to the Area Health Service's accountabilities to NSW Health. These could have been relatively easily developed on the basis of the good program development work that was being undertaken and might have put an end to some of the word-of-mouth critique referred to earlier.

4. Key Issues

On the basis of this evaluation the Review recommends that GWAHS and Maari Ma negotiate a new Agreement, continuing the management role of Maari Ma for the Remote Cluster Health Services outside Broken Hill. The team also recommends that a priority under the new Agreement be the development of KPIs that reflect the good program reform work being led by Maari Ma through the clinics and that it also be designed to assist the CEO of GWAHS in meeting her performance agreement with the Director-General of NSW Health.

Beyond this, however, the Review identified a number of key issues to be considered in the development of a new Agreement.

1. Nature of agreement – management or governance?

The Review concluded that the focus of the Agreement on the management service provided by Maari Ma is appropriate but needs to be complemented by a shared strategy for engagement at two other levels. One is the development of the new Centre for Remote Health, encompassing all health service partners in the Remote Cluster. The other is the relationship of the Agreement partners to the Murdi Paaki Regional Assembly as an expression of Aboriginal regional governance.

2. Nature of primary health care strategy

The Review noted and supported the widely held view that primary health care reform has been an appropriately strong focus of the parties to the Agreement, even if it was not reflected in its reporting arrangements. It also found that Maari Ma had moved beyond a general focus on primary health care to a specific focus

on comprehensive chronic disease prevention and management. These are strong points to be reflected more effectively in a new Agreement.

The team also urged, however, that Maari Ma modify its primary health care thinking more comprehensively to integrating the prevention and clinical dimensions of primary health care. This will not only reflect better their chronic disease approach but will reduce some otherwise inevitable tension between Maari Ma's management and the Health Service Managers.

3. Clinical governance support to the Health Service Managers

Related to the need for a more integrationist model of primary health care, Health Service Managers need more direct and accessible clinical governance support. They express this need and it is a priority in modern health system management, for both safety and quality reasons. The Review Team saw nothing but high quality nursing management in the services. The Review is not raising a present safety or quality issue but clinical governance support needs to be more accessible than at present. The Review Team evaluated various options. It recommends that Maari Ma take this role on, as part of its management responsibilities. This would be a strong step to creating a more integrated agenda for primary health care reform. Maari Ma has senior professional staff able to play this role, arguably already at least part funded. Their involvement in the role would in fact provide strong support for Health Service managers in the management of chronic disease.

4. Retrieving an information strategy

Services managed under the Agreement depend on the use of two information support systems, FERRET and Medical Director. They have not been able to make the systems interrelate and this provides significant diseconomies. It also fails to provide an integrated information platform for health service administration or for the reform agenda. Fixing this problem is a priority.

5. Responding to other health priorities

The comprehensive chronic disease strategy now being implemented does provide for the integration of strategies to respond to other health priorities. Nonetheless, it is important that under the new Agreement it is clear how the parties will prioritise and process specific actions to respond to priorities including maternal

and child health, mental health, alcohol and other drugs, disability support and sexual health. This includes articulating the relationship between specialist service response and primary health care delivery.

6. Local management

It is important that the leaders of both GWAHS and Maari Ma are involved in at least setting the parameters for development of the new Agreement. Equally it is necessary for the role of Broken Hill based GWAHS staff and for the parameters of their carriage of local issues to be clear.

There are other local management issues for a new Agreement, including the funding of the staffing base in the Health Services, the application of the contract grant by Maari Ma (especially in light of the need for greater clinical governance) and the remaining level of use and costing of bureau services by Maari Ma.

7. Accountabilities in a next Agreement

Key Performance Indicators reflecting the actual focus of current and projected health service reform are needed for the next version of the Agreement.

8. Workforce issues

Development and recruitment of Aboriginal Health Workers has been a strong result under the Agreement and needs to continue. Additional to this, more concerted thought is needed on general workforce issues, including the development of innovative models to deliver a continuous stable medical and nursing workforce and greater allied health support.

9. Relationships

Finally, the Review Team noted the importance of improving communication, understanding and relationships between the parties and communication about the Agreement to communities and other stakeholders. The team also noted, with great optimism, the willingness to tackle this challenge by all of the key individuals to whom it spoke.

Recommendations

Recommendation 1: That GWAHS review the funding and establishment base for staffing in the Health Services in the Remote Cluster.

Recommendation 2: That Maari Ma review the application of funding for the management positions under the Agreement, considering the priority needs that need to be met by the Health Services Management Team.

Recommendation 3: That the Aboriginal Health Coordinator position in the Maari Ma Regional Office be a member of the Aboriginal Health network for GWAHS.

Recommendation 4: That a new Agreement include explicit Key Performance Indicators related to key health reform objectives agreed between GWAHS and Maari Ma. If it is not possible to agree these prior to a new Agreement being negotiated, that a process, with timelines, be agreed to finalise these within six months of a new Agreement being signed.

Recommendation 5: That partners in the Centre for Remote Health discuss funding needs for ongoing Aboriginal Health Worker Training in the Remote Cluster and seek secure funding for the sustainability of a continuing training program.

Recommendation 6: That the RFDS, GWAHS and Maari Ma meet in the near future to explore the apparent decline in RFDS clinic attendances and what it in fact means.

Recommendation 7: That Maari Ma develop and implement a community education plan to inform its communities of engagement of its analysis of health needs, strategies and activities.

Recommendation 8: That evaluation of performance continue against the measures explored in this chapter be continued and further developed, in cooperation with the NSW Health Centre for Epidemiology and Research, including the measures from the midwives collection and mortality and hospital admissions data and, as longitudinal data become available, of health behaviours from the Health Survey.

Recommendation 9: That GWAHS and Maari Ma negotiate a new Management Agreement for the provision of management services in the Health Services outside Broken Hill, in the Remote Cluster.

Recommendation 10: That the GWAHS Executive consider, under the new Area structure how to maintain Maari Ma's high level of input and engagement with Area direction and to strengthen the reform partnership that has been established within the domain of health service management in the Remote Cluster.

Recommendation 11: That the parties to the Agreement also discuss how to organise their wider engagement, both through the Centre for Remote Health, for a wider health specific partnership in the Cluster, and with Aboriginal governance, through their relationships to the Murdi Paaki Regional Assembly and the COAG trial.

Recommendation 12: That Maari Ma develop a strategy for enhancing their clinical governance and support for Health Service Managers and in doing so adopt a more integrated approach to unifying clinical priorities within their model of primary health care reform.

Recommendation 13: That GWAHS, Maari Ma and RFDS collaborate in an urgent evaluation of the options to provide a unified information system platform to support integrated service delivery.

Recommendation 14: That GWAHS and Maari Ma develop a common strategy for how to address demand for specific action in mental health, alcohol and other drug issues, disability service provision and sexual health, based on the integration of primary health care strategy with other vertical program structures

Recommendation 15: That a priority be placed on further development of maternal and infant health across the sector, building on the AMIHS, and that this emphasis also draw on lessons from the NSW Families First program to build more effective integration of health and other support services for pregnant women and infants.

Recommendation 16: That the GWAHS and Maari Ma senior management meet and agree directions and arrangements within which a new Agreement will be settled and implemented, with clear lines of authority and delegation within their organisations and an agreed default of issues for resolution to themselves for a

transition period.

Recommendation 17: That GWAHS and Maari Ma renegotiate arrangements and costing for bureau services provided to Maari Ma under a new Agreement.

Recommendation 18: That the new Agreement include a commitment to concerted, collaborative work to broaden joint strategy to develop the workforce for the Remote Cluster.

Terms of Reference

This review of the Lower Sector Agreement (Agreement) between what was then the Far West Area Health Service and the Maari Ma Health Aboriginal Corporation, responds to a request from the Maari Ma Health Aboriginal Corporation (Maari Ma) and the Greater West Area Health Service (GWAHS.) The Review is a precursor to the renegotiation of any new Agreement.

Specifically, the Terms of Reference included reviewing the Lower Western Sector Memorandum of Agreement (MoA) between Greater Western Area Health Service and Maari Ma Health Aboriginal Corporation to determine:

- The applicability of the MoA in light both of changed capacity in Maari Ma and new Area structural arrangements.
- How effective and efficient is each element of the MoA, specifically in relation to:
    - Communication between Aboriginal people and the mainstream;
    - Employment and leadership opportunities for Aboriginal people;
    - Involvement of Aboriginal people in the mainstream;
    - Efficiencies achieved through collaboration;
    - Improved service accessibility and appropriateness; and
    - Funding opportunities for both parties.
- Strengths and weaknesses of the MoA and its implementation.
- Scope of a new agreement.
- Critique of alternative models and draw out implications for extending or strengthening the agreement.
- Barriers to reform.

Key deliverables include:

- Stakeholder consultation
- Identification of key issues
- Draft report
- Final report.

Approach

Parameters and emphasis of the project

The Terms of Reference and first Steering Committee meeting guided the Review toward the practical and strategic issues of how best to fashion the relationship between Aboriginal governance and mainstream health service into the future. There were references in both to performance and achievement but these were less emphatic than a pragmatic focus on the future.

However, as the Review began and discussions unfolded with the Agreement's stakeholders it became clear that performance and outcome evaluation would have to assume at least an equal focus to the pragmatic focus on future development of a further agreement. At a basic level Maari Ma's Council and management were concerned as to whether the investment made in working with the mainstream under the Agreement had paid off.

Funders wanted to know that the money and trust they had invested in the Far West model and the Management Agreement was defensible (not least because it, and therefore they, are subject to criticism because of it.) At a higher level, many are also genuinely interested to see if a novel approach with greater integration of mainstream and Aboriginal service leadership may be a direction to encourage, at least as one of a more diverse range of alternatives for Aboriginal health strategy.

It was decided early on, therefore, to modify the focus of the Review to place an equal emphasis on three components:

- An evaluation of the Agreement – what had it achieved?
- Issues needing to be addressed in any model for a future Agreement; and
- The Agreement in its political context and the complex governance challenge for a future Agreement.

The Review Team did not undertake a comparative analysis of achievement under this Agreement, compared to other strategies elsewhere, but did seek to answer the question whether this Agreement had achieved results within its own place and for its target communities.

Despite the short timeframe for the consultation phase of the Review there was a very high level of stakeholder, community and government interest and a large number of informal discussions to complement formal consultation. The stakeholder consultation was open and transparent and stakeholders gave the Review Team permission to challenge preconceptions. At the same time, the Review Team introduced communications tactics during the consultation to begin the bridging of some poor relationships.

The Review Team is confident that stakeholders were given an opportunity to be engaged and that as a result it heard a diversity of views. The Team also believe that, with goodwill and more effective communications, the stakeholders can improve and build on the Agreement and work together more effectively. The Review has clearly identified the primary issues that need to be addressed for a new Agreement to be successful.

The following approach was adopted to fulfil the requirements of the brief.

Desktop research

Documents were provided to the consultancy prior to the stakeholder consultation. These documents assisted the consultancy in identifying the key issues that informed the stakeholder consultation. Additional documents, mainly data and performance information were provided post stakeholder consultation. This data provided for validation of stakeholder comments and perceptions.

Key issues identified through the desktop research which were explored during the stakeholder consultation included:

- Clarifying what the Agreement was actually meant to achieve, was it an accidental or a deliberate strategy? What was the strategy?
- Clarifying that this is not just a review of Maari Ma's performance under the Agreement but of the Agreement as a strategy and, therefore, of both parties' performance.
- The degree of match between various stakeholder perceptions and those of the principals to the Agreement
- Understanding in detail the principles, priorities and performance of the Agreement, including:

- The management structure, strategy and processes established for the remote services in the Lower Western Sector;
- Performance against these, including accountabilities, financial and Human Resource performance, and performance in clinical and service governance;
- Understanding the reason for the plethora of meetings required in the Agreement;
- Outcomes, including:
    i. Aboriginal staffing and training;
    ii. Access to services both within the scope of the Agreement and in referral services;
    iii. Service quality, including implementation of evidence based, best practise models for primary health care through the services covered; and
    iv. Quantifiable results.
- Leadership within a partnership model, the barriers to reform, levels of participation, additional partners/collaborators and their involvement.
- Funding, where it's coming from, whether it is being used efficiently, transparency and accountability.

- Exploring what a new Agreement might look like to stakeholders.

Stakeholder consultation

A list of stakeholders was provided to the Review Team by Maari Ma and GWAHS. Additional stakeholders were also identified during the consultation period. The table at Appendix B lists stakeholders consulted.

An intensive stakeholder consultation period was conducted from Thursday 17th August until Wednesday night of the 23rd August 2006. The stakeholder consultation was conducted primarily in Broken Hill, with constructive visits also to Menindee and Dubbo. Robert Griew facilitated the initial consultation period until he was joined by Professor Shane Houston for the remainder of the stakeholder consultation. The goal was to ensure all who wanted to contribute had in-depth interviews with the team while in the region. Team members also participated in numerous formal and informal 'discussions' with additional stakeholders.

The stakeholder consultation outcomes included:

- Confirmation and/or clarification of the key issues identified through the desktop research.
- Identification of additional key issues.
- An understanding of the context of the Review 'on the ground' and through policy and government settings.
- An insight into the stakeholders, their relationships and how they have interpreted and acted to implement the Agreement.
- An interpretation of the Agreement within an historical, current and possible future context
- Initial and preliminary testing of other possible models for shared governance of the services, including a conceptual framework for a new Management Agreement, and clearer definitions of stakeholders and their relationships and lines of responsibility in such a model.

Analysis of Findings

Following the intensive consultation phase, the emphasis of the Review shifted to analysis. As noted earlier, the Review Team put a specific focus in the analysis phase on assessing the performance of the parties under the Agreement. This was undertaken at a number of levels, from financial and management performance under the most narrow construction of the Agreement to health outcomes for Aboriginal (and non-Aboriginal) people in the Lower Western Sector.

To do this analysis it was necessary to evaluate performance under the Agreement against objectives not specified (or even canvassed) in the Agreement. In this sense the Review Team was conscious that it was engaging in an assessment process that might at first seem unfair, retrospectively applying a performance yardstick. Nonetheless, given the fairly narrow nature of the specific outcomes canvassed in the Agreement, this seemed the only way to make the assessment sought by key stakeholders for the Review.

The Review Team, who have been involved in Aboriginal health for a long time, reflected on this approach with members of the Steering Committee and concluded that this process is generally sound given that good practice in primary

health care and in Aboriginal health has been well described.[1] This may in fact be a generally useful approach in identifying good performance in Aboriginal primary health care.

The analysis phase of the Review canvassed material provided before, during and after the consultation phase. The staff of both GWAHS and Maari Ma were very generous with their time and provided the Review Team with large amounts of material, including answering endless requests for extra data, for which the Team is very grateful. As discussed in the chapter on evaluating performance under the Agreement below, a subsequent phase of more rigorous data analysis was undertaken with support from the Centre for Epidemiology and Research in NSW Health.

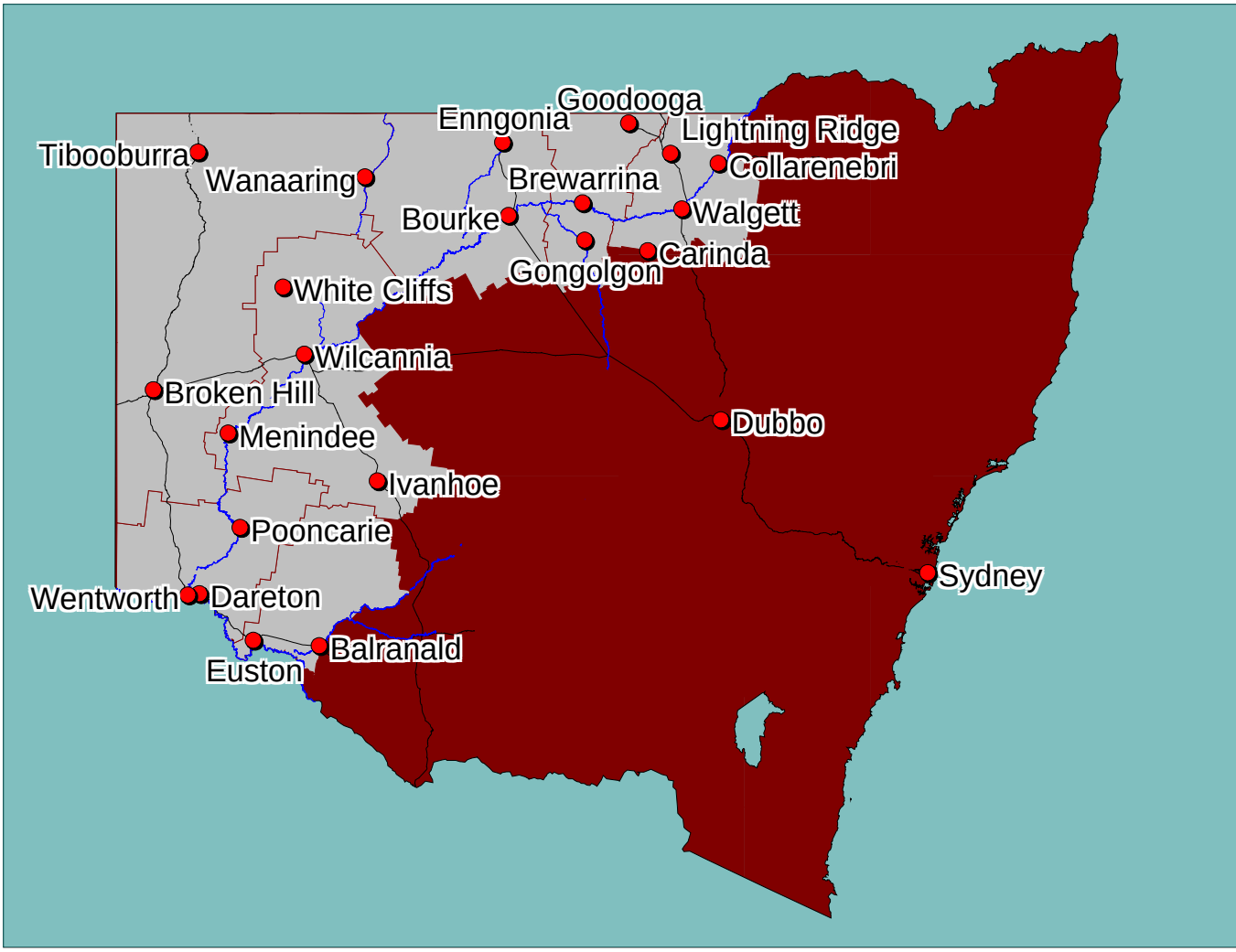
The analysis that took shape is presented under the following headings.

- The people of the Lower Western Sector and their health
- History of the Agreement and the aftermath of change
- Evaluating performance under the Agreement
- Key issues

[1] J Dwyer, K Silburn & G Wilson, National Strategies for Improving Indigenous Health and Health Care http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-oatsih-pubs-reviewphc.htm, last accessed 25 September 2006

The people of the Lower Western Sector and their health

Before it became part of the Greater Western Area Health Service, Far West Area Health Service covered a third of NSW. Its shape approximated an arc lodged in the far west of NSW, stretching eastward with its northern arm. This arc stretched north from its base in the south, Balranald west to Wentworth and the South Australian border, to Ivanhoe and Wilcannia and all communities west and north, and then east to include the cluster of northern river communities as far east as Collarenebri.



Far West Area Health Service

Far West Area Health Service was divided into three sectors for administrative purposes, Broken Hill, the Lower Western Sector, the subject of this Review, and the Upper Western Sector. The Lower Western Sector in fact constituted the western and lower parts of the arc, the most sparse and remote of this larger

region. Within the Lower Western Sector sat the shires of Central Darling, Balranald, Wentworth and the Unincorporated Far West.

57,680 people live across the 303,100 square kilometres of the old Far West Area, a sparse population compared to 6.3 million in 800,725 square kilometres for the whole of NSW. The total population of the Lower Western Sector in 2001 was 13,460, of which 12% (1,566) were Aboriginal people, compared to 2% across NSW. Broken Hill, with its population of 20,279, 5% of whom are Aboriginal, sits within the geography of the Lower Western Sector. [2] Like many other similar towns in rural Australia there is movement between the outlying areas and Broken Hill and a slow but discernible negative net population growth for Broken Hill, comprising inward Aboriginal migration and outward non-Aboriginal migration (about 1% per year since 2001.)

Given the characteristics of the Far West and the Lower Western Sector, compared to the rest of NSW, the purpose of this brief summary is to draw out some of that uniqueness, in terms of health status and health issues. It is only against this understanding that it is possible to evaluate health priority setting, health service performance, reform and strategies, such as the Lower Western Sector Agreement that is the focus of this Review.

[2] Kennedy C, Health in the Murdi Paaki. Broken Hill Centre for Remote Health Research, July 2005, pp5 & 36-67

The first part of the summary information presented comes from C Kennedy, Health in the Murdi Paaki, Broken Hill Centre for Remote Health Research, July 2005. Kennedy has herself used NSW Health and ABS data, mostly from the 2001 Census from referenced sources. The data covers the whole of the old Far West but the demographics of the region mean that they are unlikely to overstate any difference between the Lower Western Sector and the rest of NSW.

Socio-economic status

Using the ABS SEIFA index, the relative socio-economic status of the Far West is poorer than NSW as a whole and for each shire individually. Unemployment rates are higher. In 2001, ABS also reported that income in the Far West was lower than the NSW average and that unemployment was higher. 23% of adults in the Far West have not completed Year 10, compared to 14% of adults across NSW.[3]

Women and babies

The fertility rate for the Far West was 69 per 1,000 15-44 yr old women, higher than NSW (63 per 1,000). 27.2% of births were by Aboriginal women, compared to their population representation of 15.1%. 8% of births in the Far West, however, are under 2500g, compared to 6.4% across NSW and 8% premature, compared to 7.1%. Perinatal and infant mortality are not significantly different.[4]

Acute illness

Admissions to hospital in the Far West are higher than for the rest of NSW. The Standardised Separations Rate for the Far West compared to NSW was 111.7 (95% CI 109-113), with 27% of separations being Aboriginal patients. The level of 'social admissions' in the Far West was lower (17.9% compared to 20.4%) and the level of admission for injury higher (9.1% compared to 7.1%).[5]

Mortality

The mortality rate in the Far West is higher for both men and women than for the whole of NSW. The male Standardised Mortality Rate across six years from 1997-2002 was 119.7 (95%CI 107-132) for the Far West compared to NSW. The equivalent figure for women was 115.9 (95%CI 102-130). Causes of mortality varied with injury and respiratory causes accounting for a higher proportion of deaths than in the rest of NSW (7.2% and 9% respectively) and cancers and circulatory diseases a slightly lower proportion (still 25.8% and 38.7%

[3] ibid, pp7-10
[4] ibid, pp19-20
[5] ibid, pp11-12

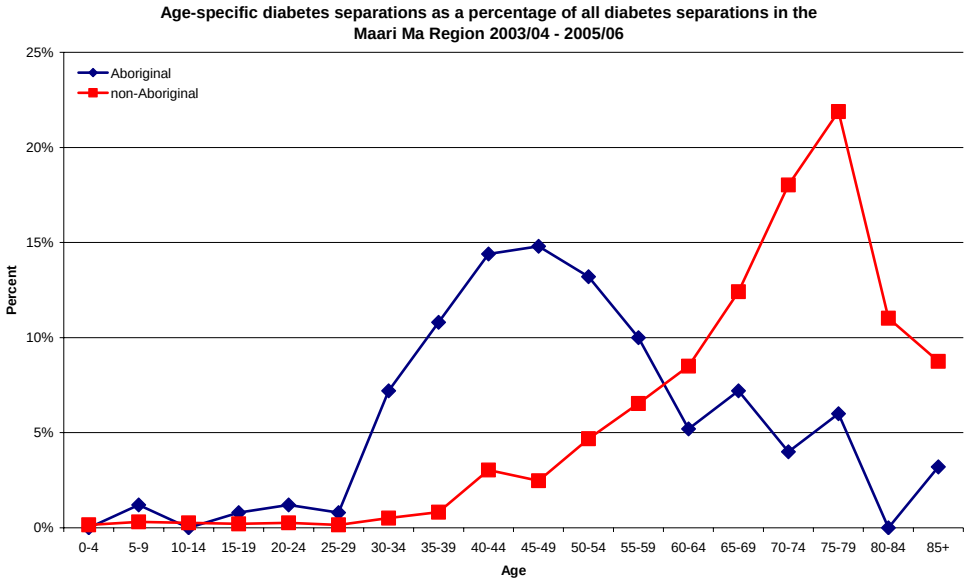
respectively.) Mortality from cancers and circulatory disease was still very high, being a slightly smaller share of a significantly greater death rate.[6]

Overall the Chief Health Officer's Report 2004 highlights that the potentially avoidable deaths rate for very remote NSW is about 400 deaths per 100,000 population, compared to just over 200 per 100,000 for NSW as a whole.[7]

Chronic disease

Chronic disease is not only important in these mortality figures (and of course in the hospitalisation figures cited as well) but onset of disease is much earlier as well. Figures 1 and 2 below demonstrate graphically how much earlier in life Aboriginal people experience incidence of two key diseases in this group accounting for so much of the excess burden of both morbidity and mortality. This data, provided direct by GWAHS was compiled specifically for the Lower Western Sector for the Review.

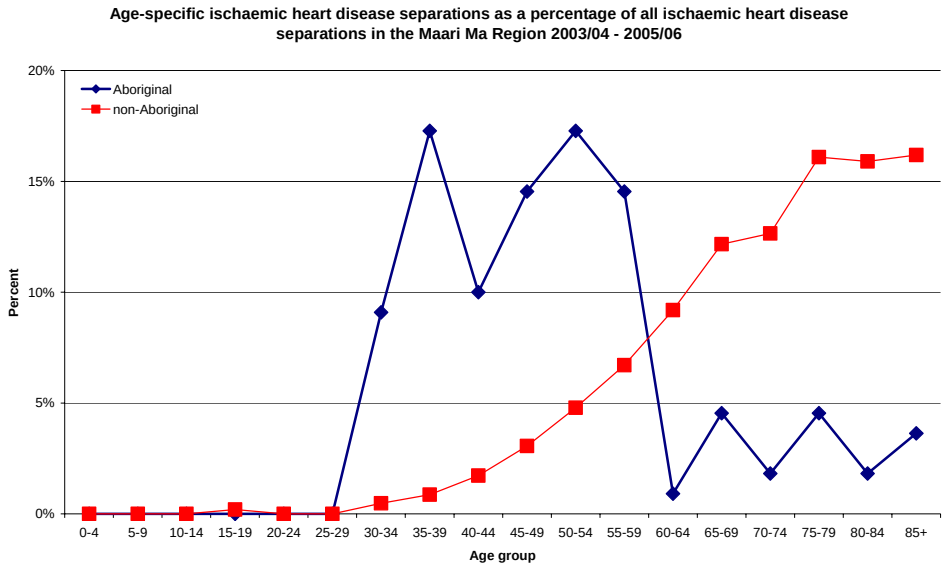
Figure 1



Source: Greater Western Area Health Service - Population Health, Planning & Performance

[6] ibid, pp13-18
[7] ibid, p15

Figure 2



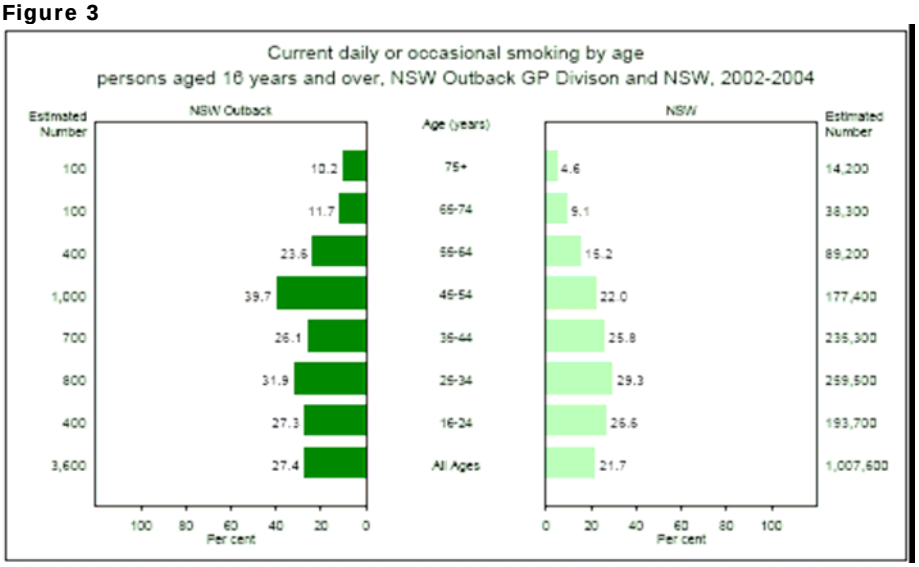
Source: Greater Western Area Health Service - Population Health, Planning & Performance

Risk factors

As already noted, preterm and low birth weight babies are more common than in NSW as a whole, which is itself a key risk factor for early onset chronic disease.

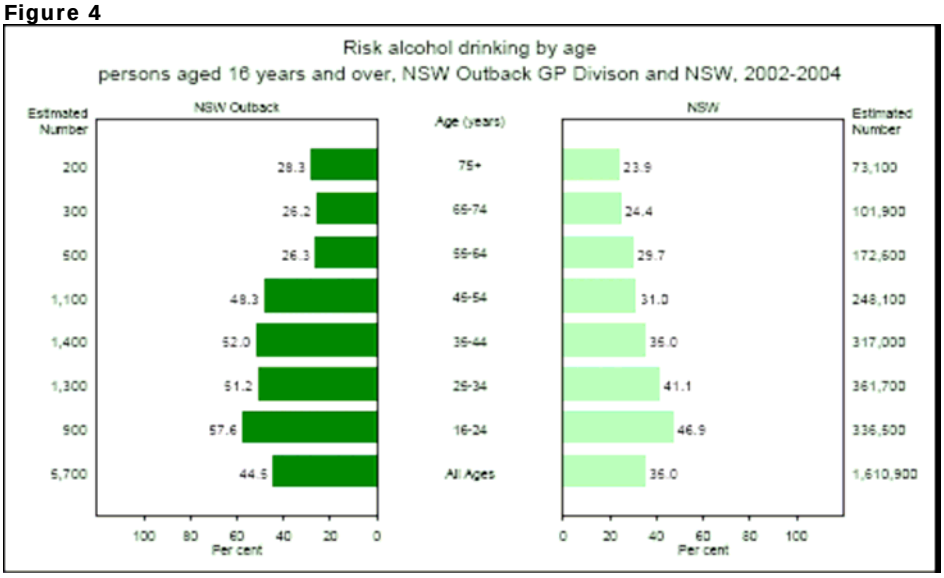
NSW Population Health Survey data, aggregated by Division of General Practice area (NSW Outback Division covering approximately half of the Lower Western Sector) also shows a range of other risk factors for which the Outback is more exposed than the rest of NSW. Figures 3 and 4 show smoking and harmful drinking rates broken down by age group.

Figure 3



Source: NSW Population Health Survey http://www.health.nsw.gov.au/public-health/survey/hsurvey.html, last accessed 6 October 2006

Figure 4



Source: NSW Population Health Survey http://www.health.nsw.gov.au/public-health/survey/hsurvey.html, last accessed 6 October 2006

Data from Well Person's Health Checks conducted by Maari Ma in 2004 and from other sources such as the GWAHS Remote Cluster Mental Health and Alcohol and Other Drugs staff also pointed to significant other risk issues, including depression and alcohol related mental health problems.

In conclusion, the population served by this Agreement has six times higher than State average Aboriginal representation, is poor and remote from services. It has high fertility but is disadvantaged in birth outcomes and, through life, suffers compounding morbidity and mortality. It is the region of NSW where it is easiest to observe the complex pattern of Aboriginal ill-health that has proved so resistant to improvement. This life-course compounds to produce an epidemic of complex chronic disease attacking Aboriginal people tens of years earlier than non-Aboriginal people.

This is a pattern of illness that requires a specific kind of response, a focus on maternal and child health, on the prevention and management of chronic disease and on the health sector playing its part with other sectors to address underlying social and economic problems.[8]

[8] Dwyer J, Silburn K & Wilson G, National Strategies for Improving Indigenous Health and Health Care http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-oatsih-pubs-reviewphc.htm, last accessed 25 September 2006; Weeramanthri T, Morton T, Hendy S, Connors C, Rae C and Ashbridge D, Northern Territory Preventable Chronic Disease Strategy – the Evidence Base, Best Buys and Key Result Areas – Best Practice in Chronic Disease Control, Darwin THS 1999

History of the Agreement and the aftermath of change

A number of people the Review Team consulted about the Management Agreement between Maari Ma and the Far West Area Health Service said it was either an "accidental agreement" or "half an agreement." It was described as "odd" and "inexplicable." While the Agreement certainly is unprecedented in its purpose, contracting in management from an Aboriginal organisation, these descriptors seemed conspicuously vehement.

For this reason prior to any evaluation of their performance, the Review Team went to some effort to clarify with those involved at the time, and through examination of the historical record and literature, what was intended in the Agreement's negotiation. Essentially an examination of why the Agreement took the form it did and what the thinking of the players was in creating it in this form.

1994 to 1996 – The formative period

During 1994-95, the Murdi Paaki ATSIC Regional Council underwent a major planning and community engagement exercise to map the community goals identified for the region. This planning exercise, a requirement of ATSIC Regional Councils, produced a comprehensive regional plan with the primary goal of improving services to Aboriginal people as part of improving people's lives, autonomy, culture, economy and organisations.[9] The principal goal specified in the plan was improving the health standards of the Aboriginal and Torres Strait islander people in the Murdi Paaki region.

Further to the ATSIC Regional Plan, in 1995 a report on health (co authored by Sue Morey and Jack Best) was commissioned and released which put emphasis into increasing Aboriginal control, reach and equity of access to health services for Aboriginal people. This report proved very influential and is still referred to when people consider the new directions and innovations in Aboriginal health policy and management in the Far West.[10] The Murdi Paaki Regional Council was, in turn, instrumental in turning some of the recommendations in that report,

[9] Maari Ma, Concept Paper, Maari Ma: Strategies for Indigenous Health in Far West NSW, 1999, p 12
[10] Morey S and Best J, Health Services for the Aboriginal Communities of the Murdi Paaki Region, May 1995

including the call for an Aboriginal community controlled health service in the region, into a reality.

Even at this early stage the vision in the Far West was unorthodox. The following quote from the Morey Best Report illustrates well the thinking.

> "Many small community controlled organisations have become involved in the provision of health services. In general, there is … little evidence of partnerships between the various health providers or of a team approach to the solution of health problems. Many of the health workers have had little training … and are working isolated from other health professionals. In many instances, divisions in the Aboriginal community have been detrimental to the effectiveness of the services, and in many communities there is a small number of people who have borne a disproportionate amount of work and responsibility for attempting to effect change." (p3)

The Morey Best Report reports on a meeting of key Aboriginal stakeholders that recommended not only seeking funding from the Commonwealth for an Aboriginal Medical Service but also the establishment of a Peak Aboriginal Health Council, "made up of representatives of the Aboriginal people in the Far West Ward of the Murdi Paaki Region, including Dareton, the Royal Flying Doctor Service, Far West Health Service and Remote Health Training Unit."

The instigators of a new Aboriginal health structure in the Far West were from the start conscious of a number of obvious dangers. They did not want to ignore, nor disconnect from either mainstream services or mainstream expertise. They did not want to put all their energy into establishing parallel organisational infrastructure with the risk of organisational frailty and collapse damaging the primacy of their health goals.

And they were conscious also of the tension inherent at that time between ATSIC, with a new emphasis on unrealistic outcome accountabilities for funded services, and the health services still then funded by ATSIC. Dr Ian Anderson and Maggie Brady's CAEPR Discussion Paper in 1995 on this point was widely cited and is

referred to in early Maari Ma documents, showing an impressive sophistication for a fledgling community based organisation.[11]

It is in this context that the innovative arrangements in the Murdi Paaki were created. In 1995, the Far West Ward Aboriginal Health Service (FWWAHS) (now Maari Ma Health Aboriginal Corporation) was set up under the *Aboriginal Councils and Associations Act 1976* in response to the Morey Best Report. It was to service the Broken Hill region in the provision of health care, dental care, medical and health support services. The FWWAHS was governed by the Peak Health Council (PHC), a body of representatives which drew its membership from Aboriginal communities within the Murdi Paaki Regional Council geographical boundaries, similar to the Lower Western Sector of the Far West Area Health Service.

The model was, from the outset, problematic for the Aboriginal Health and Medical Research Council (AH&MRC, the peak body for NSW Aboriginal Medical Services), which saw the model as a retreat from the principles of Aboriginal community control of local, independent health services. The FWWAHS co-located and drew bureau service support from the new Far West Area Health Service (established in 1996) and its Peak Health Council sought minority membership of mainstream health professionals.

The then CEO of the new Area Health Service, Greg Rochford, described this as a "mutual and deliberate strategy of inter-dependence." He and Smiley Johnstone, the first Regional Director of FWWAHS, were conscious that they were both running fragile organisations and needed each other's strengths to succeed. To quote Mr Rochford again, "We needed their relationship with our clients. He was clear he needed our professional expertise. Whose was the bigger need? I was very conscious of our need for this new relationship."

Smiley Johnstone's recollection matches and reinforces Rochford's. "When we got the first grant, $250,000, I didn't hire a bookkeeper. That would have spent the first $50,000 before we got started. I said to Rochford, 'Greg, you've got people who can do that. We want to focus on health business.'" "We grew it up slowly and kept our heads. That was the key."

[11] Anderson I and Brady M, Performance Indicators for Aboriginal Health Services, Discussion Paper 81, Centre for Aboriginal Economic Policy Research, 1995, See also Anderson I and Sanders W, Aboriginal health and institutional reform within Australian federalism, Discussion Paper 117, CAEPR 1996, and Griew R, Sibthorpe B, Anderson I, Eades S and Wilkes T, "On our own terms – Aboriginal health policy in Australia," in Healy J and McKee M (eds), Accessing Health Care, Responding to Diversity, OUP 2003

The strategy of ‘inter-dependence’ was reflected in a close set of personal and professional relationships that developed at this time. Mr Rochford was the first CEO of the new Far West Area Health Service, a strong manager and a reformer. He was clear with his new executive team that Aboriginal health had to be their priority and that to achieve anything in this area they needed to invest in primary health care, reforming the small peripheral hospitals in the outlying communities to run as primary care clinics.

He and his Population Health Director, Dr Hugh Burke, aggressively pursued the relationship with the new FWWAHS and welcomed their pragmatic search for an ‘inter-dependent’ partnership. Rochford, Burke and Johnstone became well known in Canberra and Sydney as they pursued support for the new partnership model they were fashioning out West.

1996 to 1999 – Twin initiatives – Coordinated Care and Service Agreement

Not long after its inception the FWWAHS’ Peak Health Council entered two key agreements. One was to sponsor the proposed Coordinated Care Trial at Wilcannia to support its own priority for primary health care development. The Trial was about integrating funding dollars and health systems in order to better look after people with chronic disease. In the same year the FWWAHS also signed a Service Agreement with the FWAHS which resulted in the FWWAHS providing health management services and having administrative responsibility for the Lower Western Sector.

This second agreement was the precursor to the one that is the subject of this Review. In exchange for FWWAHS management services, the new Area Health Service would provide bureau service support, funding of administrative positions within FWWAHS and membership by the Lower Western Sector General Manager on the Area Health Service executive.

This service agreement became a full Memorandum of Agreement in 1998. The preamble to the Memorandum of Agreement refers to the service agreement as the product of a ‘strategic alliance,’ commencing in 1995 and based on ‘informal relationships.’ The 1998 Agreement was, “expanded to more accurately reflect

the relationships between the two organisations."[12] This Memorandum of Agreement is also referred to as the Management Agreement or just the Agreement. In this Review, henceforth we refer to it as the Agreement.

FWWAHS was also successful in its submission to run the Coordinated Care Trial in Wilcannia. This ran until 31 December 1999, when a transitional phase was commenced, leading in turn to the establishment of a new Commonwealth funded primary health care service from 2002. The Coordinated Care Trial was a very difficult project for all concerned, but especially for the FWWAHS. Significant Commonwealth investment was made in information technology (including in the FERRET primary care management system) and in evaluation (including in elaborate reporting protocols to monitor patient and population flows and establish cost models.)

Under the rules for Coordinated Care Trials, new funding was not available for service expansion but only for infrastructure and evaluation. The processes were exacting and required significant time from local staff and management. When the Trial entered its transitional phase, a new coordinator realised how brittle core services in Wilcannia had become and successfully urged the recruitment of a new manager for Wilcannia Hospital. Margaret-Ann Cook, ex Principal Nurse from the Northern Territory, took the position for a short term but has stayed involved with primary health care development in the region ever since.

1999 – 2000 – Review and consolidation – Maari Ma is created

In 1999, Regional Director, Smiley Johnstone, initiated a review and planning process for the FWWAHS, no longer a new organisation. He reported to the Peak Health Council that, "In a relatively short time, the FWWAHS has moved well beyond the rhetoric of 'glossy' formal agreements."[13] His report was also, however, a blunt and honest appraisal of the challenge and complexity of managing services within the mainstream while staying in touch with their own constituency.

The Vision statement adopted out of the process by FWWAHS includes four points that were clear in their espousal of culture, self-sufficiency and self-determination but maintained the strategy of mainstream engagement. In fact, in the Vision

[12] Agreement Recitals, section 1
[13] Maari Ma Regional Director's Report , 1999

statement of the organisation, the only reference to health service delivery is to mainstream health services. The first two points make the balance clear,

- “Strengthening and preserving our culture in all our lifestyles.
- Improving access to, and accessing, mainstream health service provision.”

Other issues identified included:

- Complexity in reporting arrangements for staff;
- Need to connect effectively with constituency and to maintain community engagement as a continuous priority; and
- Specific health priorities, including:
    - Tackling drugs, alcohol and gambling through harm minimisation
    - Child and sexual abuse targeted through zero tolerance level strategy
    - Information and education around sexually transmitted and communicable diseases
    - Access to dental services for improved oral hygiene
    - Ear, nose, throat and eye early detection strategies
    - Community driven and Aboriginal designed women’s and men’s health strategies
    - Services for people with disabilities
    - Raising awareness of and better coordination of mental health services delivered by mainstream.

Johnstone’s 1999 Report was a strong assertion of his belief that, notwithstanding the challenges, the relationship with the Area Health Service had come a long way and was substantive in its benefits. He and the Peak Health Council were prepared to weather criticism for the benefits they saw in a strategy of mainstream engagement. Current Regional Director Richard Weston still identifies the Board’s strategy in these terms.

> “The first point relates to the Maari Ma Board of Directors’ role in the evolution of the Agreement. The Board has supported Maari Ma's direction since day one. This is important to note given that Maari Ma is an Aboriginal controlled corporation that has evolved in spite of … hostility…”

On the basis of Johnstone's 1999 report and associated planning processes, Maari Ma Health Aboriginal Corporation was born of FWWAHS, with a five year Strategic Plan from 2000-05, and the Agreement was again renegotiated for 2001-05. Looking back the current Regional Director, Richard Weston, identified this period of intense thinking about direction and governance as vital in all that has come since, especially the strength of Board governance.

> "In more recent years (over the last 6 years in fact) the Board has pursued a deliberate focus on implementing effective governance practice into the way it conducts itself as a Board….The focus by the Board on Governance by adopting a contemporary model for Corporate Governance was recognised by MM being named as a finalist (the only one from NSW) in the inaugural Indigenous Governance Awards (2005)."[14]

The history of the Agreement clearly shows that it was not an "accidental agreement" or "half-agreement" as various criticisms claimed. Rather it was a deliberate agreement between two visionary leaders based on clear research and analysis of the preferred priorities of the people of the region, of political structures and approaches that would work and on understandings of the vulnerabilities of two new organisations. It is simply not the case, as is often assumed, that the Agreement reflected a compromise between Smiley Johnstone, wanting more control for his organisation, and Greg Rochford, wanting to give up as little control as possible.

If anything, Rochford was keen to hand over more control to the FWWAHS, conscious as he was of the need to engage Aboriginal people in health service delivery. Johnstone, on the other hand, was keen to preserve focus on improving his people's deal from the mainstream, to build his organisation and to tap the professional expertise he saw in the Area. He was also happy, at least at first, to use the bureau services he was being offered from the Area, rather than have to divert effort to develop duplicate structures, with all the risk he saw in other Aboriginal organisations elsewhere.

Johnstone related this to the imperative of avoiding being too drawn into the politics that, from the outset, surrounded the mainstream strategy. "We always focussed on the business of health service delivery. You have to run the politics too, in a community organisation but I always said to the staff, 'Our core business

[14] Richard Weston, personal communication

is health services.' Frankly it pisses me off when public servants do not show the same discipline."

Other influential Broken Hill stakeholders identified and strongly supported this strategy. Bill O'Neill, ex Chair of FWAHS and ex office bearer on the Barrier Industrial Council described it thus,

> "We knew we needed an influx of Aboriginal people in charge, input from local people, and the steadying influence of the experts to make sure we were going in the right direction." "We started slowly and built up. Lot's of the other Aboriginal health people didn't seem to like what the local ones had come up with but Maari Ma has always been squeaky clean."

In the Review Team's discussion with O'Neill, he also made a strong point about local Broken Hill history, germane to the local acceptance of Aboriginal community involvement in running mainstream health services.

> "You have to understand about this town that it is union. That hospital there was built with lots of union money. We had Medibank before Medibank, you know, the Health Fund. We've still got money from the workers held in trust to help if the hospital needs something. It's the same with this. Having the Aboriginal people stand up and run their own health just made sense to us. Having Maari Ma work with our local health service has helped this town." "There's a lot of racism here in Broken Hill. Don't be in any doubt about that, and half of it is black. But this has been good for our town."

He did not cite the Housewives' Association, although he might have. The Industrial Council for years supported the Association dragging men from pubs before their family's money was squandered. Similarly the Association would pressure shopkeepers not prepared to extend a hand to a family struggling to feed its children. Self determination in health is not a new concept in Broken Hill, nor was it a uniquely Aboriginal construct.[15]

Johnstone also reinforced the development of Maari Ma and the Agreement with wider community change underway.

[15] Hugh Burke, personal communication

> "It's (both Maari Ma and the wider changes) been good for the town. We have Aboriginal people in real jobs, working with the professionals and Far West Board members, our people in uni courses, buying good clothes for their kids, making sure they're going to school. That's all stuff others take for granted but it wasn't there to the same extent for our people in the far west ten or fifteen years ago."

The new decade – Primary Health Care planning and leadership change

In 1999, Barbara Flick, the new, post-Trial Coordinator in Wilcannia, had lobbied successfully for the appointment of Margaret-Ann Cook and the two began an extended planning process for services in Wilcannia. They focussed on Primary Health Care, thinking about the chronic disease lessons from the Trial and considering as well how to generalise reform beyond Wilcannia, to the rest of the sector.

In August 1998 Far West Area Health Service had published a five year Strategic Directions document, emphasising primary health care as the focus for its planning and service delivery. In September 2002, Jill Hardwick wrote a Discussion Paper for the Far West Area Health Service, "Implementation of primary health care in the FWAHS." In it she reviewed the success and failure of primary health care transition projects in Goodooga, Brewarrina, Bourke and Dareton and of an Alcohol Community Development Project. She acknowledged Rochford and Burke's leadership in primary health care development from the founding of FWAHS. She also referred to the 'innovative' management agreement with Maari Ma. She argued, however, for more effort to sustain primary health development across the Area.

The other partners named in the Agreement – the RFDS and the Remote Health Training Unit, now the Sydney University Department of Rural Health, had been in discussion. The outcome was a concerted training effort, targeting Aboriginal health workers, who would participate in a Diploma in Indigenous Primary Health Care, with a clinical focus more akin to Aboriginal Health Workers in the north of the country than those in the rest of NSW. Over the succeeding years some 50 Aboriginal Health Workers would be trained for jobs in both Maari Ma, the Area Health Service and other AMSs.

However, as the century ended, senior personnel changed over too. Rochford and Johnstone both left to senior jobs in Sydney and were replaced by new CEO, Heather Gray, and new Maari Ma Regional Director, Richard Weston, respectively. Through these transition periods there was clearly some loss of momentum, and a shift in the balance and orientation of the Area, to some, albeit unclear, extent. The new Agreement was signed on 1 June 2001. Heather Gray, a new CEO with the range of other Health Service priorities to address, still recalls the Agreement very positively, with only one reserve, an admission on her own part.

> "When the Boards (Maari Ma and FWAHS) used to get together it was pretty special, you know. It was the sort of thing that would give you that back of the neck prickle experience. I think Bill (O'Neill) is probably right. It did change the town … Only one (negative) thing, there were too many meetings prescribed in the Agreement, so we didn't have some we probably should have had."

The Far West Area Health Service was not alone in its focus on primary health care development. In many ways it was in step with a ferment of similar work in the north of the country. In September 1999, Weeramanthri and colleagues published the Northern Territory Preventable Chronic Disease Strategy.[16] This was the first of a number of chronic disease strategies to follow, in Queensland and in NSW, prior to the National Public Health Partnership and finally, in 2005, the Australian Health Ministers' Council.

Over the following couple of years, primary health care continued to be a focus in FWAHS, with senior staff travelling to Queensland to explore the applicability of the Well Person's Health Check and trialling it in a number of communities across the old Area.

The Agreement continued during this period, being reviewed for Maari Ma by Claire Croumbie-Browne in 2003. She found that the Agreement had had a positive impact, including

- Improved communication between Aboriginal people and the FWAHS;
- Enhanced opportunities for Aboriginal people in health services, in leadership and in employment;

[16] Weeramanthri T, Morton T, Hendy S, Connors C, Rae C and Ashbridge D, Northern Territory Preventable Chronic Disease Strategy – the Evidence Base, Best Buys and Key Result Areas – Best Practice in Chronic Disease Control, Darwin THS 1999

- Demonstrating the responsiveness of a smaller organisation to the needs of the health service staff; and
- Efficiencies from the collaboration.

Echoing Johnstone's 1999 appraisal to his Council, Croumbie-Browne also found, however, that there needed to be:

- a communication plan to improve knowledge among staff and stakeholders about the Agreement;
- greater engagement by Peak Health Council staff in the communities;
- indicators to measure changes in Aboriginal service access and Aboriginal employment – the two most measurable objectives; and
- improved clarity regarding the provision of administrative and clinical review process.

The conclusions drawn by Croumbie-Browne are very similar also to a number drawn in this Review. Croumbie-Browne's Review, however, drew no connection between the future of the Agreement and the increasing focus in both Maari Ma and FWAHS on primary health care service development, wellness and chronic disease prevention.

2004 – Area Health re-structure

In 2004, Heather Gray finished her term as CEO of FWAHS. Linda Cutler was appointed the new CEO and then the NSW Health Area structure was reformed and the Far West Area Health Service was abolished. The Greater Western Area Health Service was created in its place, of which the old Far West Area Health Service would be one third and the old Lower Western Sector one sixth. This proved a challenge to the Agreement.

Ironically, in the aftermath of the creation of the new Area structure, focus and progress on chronic disease strategy was coming to a head in Maari Ma. Key personnel, including Cook and Burke, were now working in Maari Ma, adding a focus to health practise reform in the management of the Health Services. In 2005 Maari Ma published its own comprehensive Chronic Disease Strategy and is now participating in the national extension program to the Northern Territory based Audit and Best Practice for Chronic Disease (ABCD(E)) program.[17]

[17] Burke H, Cook MA & Weston R, on behalf of Maari Ma Health Aboriginal Corporation, Maari Ma Chronic Disease Strategy: While prevention is better than cure, control is better than complication,

Maari Ma Regional Director, Richard Weston, sees this strategy as growing directly from the strength of governance from the Maari Ma Board, as well as the professional leadership from his key personnel.

> "The 'Board Level Strategic Direction' sets out Maari Ma's purpose, values\philosophies and future vision (key result areas). This policy was the forerunner to the writing and adoption of the Chronic Disease Strategy. The Board formerly endorsed the Chronic Disease Strategy. The strategy was essentially the operational arm's response to the Board's future vision."[18]

Maari Ma's focus on governance was also evidenced in Weston's decision to hire a Director of Finance in 2003. Maari Ma was becoming a stronger and more independent organisation. It was using less and less of the bureau services that had been an underpinning of the early relationship and were reflected in the 2001 version of the Agreement. From being a fledgling new NGO operating largely dependent on the Area Health Service, Maari Ma had now become a stronger, free standing entity.

Maari Ma's leadership was still committed to a pragmatism and engagement with the mainstream, a strategy that continued to sit well with new Regional Director Richard Weston. Reflecting on the evolution of Maari Ma (and indeed Aboriginal politics), Weston observed,

> "Through the last ten years we have got beyond the idealistic Aboriginal vision of how we can change the world through the force of personality. I have learnt now myself how I have to work with the Health Service Managers, for example, not to judge them for their personalities and their roles, as I might have been inclined to do once. I have found it very exciting, really exciting. It's about taking people out of their comfort zones - all of us, including me and the Aboriginal people."

About him, one of his managers reflected,

Maari Ma, September 2005; Baille R, Dowden M, Si D, O'Donohue L and Kelly A, Audit and Best Practice for Chronic Disease Project Progress Report Menzies School of Health Research CRC for Aboriginal Health 2005

[18] Richard Weston, personal communication

> "Smiley and Richard are each perfect men for their time. Smiley the single minded, aggressive reformer who created a vision and Richard, who is more subtle and a people person, no less a leader but a man who has the capacity to bring people together."

In contrast to the productive and settled period at Maari Ma, the Area went through a difficult transition as FWAHS was combined with two others to form the new Greater Western Area Health Service. In November 2004, the then NSW Health Minister, the Hon Morris Iemma MP, commissioned the Hon Ian Sinclair AC to conduct a Review Group, "to consult far western NSW health and community leaders on health support services in the Greater Western Area Health Service's office at Broken Hill."

The outcome of the Sinclair Review was a set of recommendations largely accepted by the Government, which included:

- a General Manager position in Broken Hill for the Remote Cluster;
- that position having responsibility to manage the Agreement with Maari Ma; and
- the creation of a Centre for Remote Health with all health service players, including the University, in the Remote Cluster.

The only recommendation relevant to this review that the Government did not accept was that the Centre for Remote Health engage on behalf of the Area with the Commonwealth Government on remote health issues. This was not a particularly surprising outcome as a new GWAHS Executive was always going to want to deal direct with funders. However, it does raise an issue, to which this Review will return later about the need now to re-engage the Commonwealth in the Far West.

Notwithstanding this process, relationships between the new administration in Dubbo and a number of Broken Hill players have broken down and remained in a dysfunctional state since the changes and this has been problematic for the operation, evaluation and future of the Agreement. These relationship issues are raised again at the end of the Issues Chapter later in the Report.

Lessons from history

In conclusion, therefore, this exploration of the history of the Agreement makes a number of points clear. First, that the Agreement itself is a quite deliberate part of a wider strategy, specific to the local circumstances of the Murdi Paaki in the middle of last decade and of interest to the wider Aboriginal health world, including to its detractors. Second, the increasing strength and focus of Maari Ma as an organisation has coincided with the reorganisation of the NSW Health Area structure. Third, although the published focus on chronic disease strategy is relatively recent in Maari Ma, there has been a sustained focus on primary health care development and on chronic disease from the foundation of both FWAHS and the Far West Ward Aboriginal Health Service that preceded Maari Ma.

The figure below summarises the features of the Agreement as it was finally enacted by the parties in 2001.

Lower Sector Agreement Far West Area Health Service and Maari Ma Health

Statement of intent, to:

1. improve health status of Aboriginal people in Lower Western Sector;
2. share resources, skills, infrastructure, knowledge, experience and culture to enhance services, remove duplication, achieve best practice and create efficiencies;
3. provide an Aboriginal perspective and Aboriginal terms of reference to management, planning, development and delivery of health services in FWAHS; and
4. build commitment to participation by Aboriginal people in management, planning, development and delivery of health services.

Provisions of the Agreement

1. The Agreement formalises Maari Ma's delivery of Lower Western Sector Management services, Aboriginal health coordination services and Aboriginal participation in setting strategic direction for FWAHS.
2. Additional FWAHS services available to Maari Ma include population health services, mental health, counselling, clinical and medical services.
3. The Agreement is subject to annual funding reviews and obligations against performance criteria.
4. Bureau services are provided by the FWAHS at a cost to Maari Ma.

Framework for operation of Agreement

The Agreement operates on three levels:

1. Area Health service– regular meetings between CEO and Regional Director, Aboriginal health forum meetings, Aboriginal health managers and Area coordinating fora. Discussion to

encompass budget, HR and other management issues and Aboriginal health strategy for Area.

2. Lower Western sector level – management of health services by Maari Ma to NSW Health standards and policies, regular budget meetings, involvement of Maari Ma in consultation meetings and Health Advisory Councils in communities in Lower Western Sector, information collections, funding and marketing.
3. Interagency/organisational level – describes partners and collaborators to the Agreement – RFDS and University Department of Rural Health.

Annexures cover:

1. Definitions and Term
2. Liaison Officers
3. Payment of Funds
4. Services to be provided by Maari Ma
    a. Review, evaluation and monitoring
    b. Consultation
    c. Management of staff
    d. Aboriginal health coordination
    e. Strategic directions
5. Services to be provided by Far West Area Health Service
    a. General and support services
    b. Human resource management
    c. Financial management
    d. IT and fleet management
6. Inspection, termination, dispute resolution, standard provisions
7. Review of Agreement, Review Committee

There is also a 3 Year Plan for the development of the Agreement, focussed on processes of engagement and planning between the FWAHS and Maari Ma.

Evaluation of performance under the Agreement

One of the most commonly posed questions about the Agreement is, “What has it actually achieved?” There are a number of reasons for this. It is now a long time since the Agreement was negotiated in the late 1990s. Many of the players have moved on and not all those now responsible actually understand or recall the original purposes or strategy implicit in the Agreement.

Second, the Agreement itself appears odd to many bureaucrats, at two levels. It is unusual to contract-in service management from an Aboriginal non-government organisation. The Agreement itself also reads oddly to many administrators, with its combination of lofty aims, improving the health of Aboriginal people in Far West, and its detailed focus on management and process (especially on a myriad of meetings it requires.) The unusual nature of the Agreement, and the integrationist strategy adopted by Maari Ma, has also attracted a fairly widespread word-of-mouth commentary (positive and negative) little of which is particularly well-informed about the Agreement itself.

Finally, the restructure of NSW Health Areas has merged the old Far West Area Health Service with the new Greater Western. This merger has drawn attention to the difference between the Aboriginal health strategy in the Far West, of which the Management Agreement was a part, and Aboriginal health strategy in the rest of the State, with which the rest of GWAHS is more similar. Following the merger of old Areas to create GWAHS, disengaged coexistence is less of a viable option in a larger Area that is now the western two thirds of NSW.

As a result of the very factors that make a comprehensive evaluation important, however, the task of assessing success in the Agreement is not simple. The Agreement is clear in its narrow intent: that Maari Ma provides, on contract, a management service for a number of remote Health Services in the Lower Western Sector of the old Far West Area. It also specifies regular meetings and reports consistent with this and a role for Maari Ma’s manager in the old Far West Area executive structure. It does not, however, specify particular Key Performance Indicators (KPIs) nor does it focus attention on the particular health reform objectives to improve Aboriginal health in the Lower Far West. The clearest objective in the Agreement is a commitment to improve Aboriginal employment and visible Aboriginal leadership in health service delivery. Beyond that, little is specified.

Subsequent to the Agreement being signed and implemented, a number of very specific health strategies have been developed. As discussed in the History Chapter, the focus on primary health care reform and chronic disease was coincident with the Agreement and developed alongside it. According to all those involved at the time, the focus under the Agreement fell first on establishing a smooth transition and reassuring communities (both Aboriginal and non-Aboriginal) that services would not suffer under new management. Attention then moved to increasing Aboriginal staffing and training of Aboriginal staff and finally to the opportunity the Agreement provided to implement the health reform agenda that had developed alongside the Agreement.

In order to evaluate achievements and outcomes, therefore, the Review Team decided to read these strategies back to the original Agreement and to evaluate the Agreement as if they had been clear from its inception. This goes further than would be contemplated for most health service agreements in most health services. It involved a degree of retrospectivity that is not in one sense 'fair'. However, without doing this it would not be possible to assess what has been achieved, except at a process level. These process measures are important elements to evaluate but do not by themselves meet the interests of funders and other stakeholders.

In support of this more ambitious evaluation strategy it can be said that the Agreement was in fact part of a quite conscious strategy with which the directions taken subsequently are entirely consistent. Nor are these subsequently adopted objectives at odds with the priorities articulated from the early days, neither for the Far West Ward nor in terms of national priorities.[19] On this basis the Review Team assessed progress under the Agreement against priorities not at the time articulated. A further Agreement should include explicit Key Performance Indicators covering such vital subject matter areas of performance.

Evaluation framework

Given this context the evaluation objective adopted by the Review Team was to test two propositions.

[19] Dwyer J, Silburn K & Wilson G, National Strategies for Improving Indigenous Health and Health Care http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-oatsih-pubs-reviewphc.htm, last accessed 25 September 2006

- First that the parties to the Agreement had fulfilled their obligations under the Agreement and achieved the objectives they set explicitly in it; in essence process measures.
- Second that, during the period of the Agreement's operation, they had at least kept pace with other strategies used across NSW to reform health service delivery and improve health outcomes for Aboriginal people.

To test both of these propositions the Review Team adopted a health performance framework, with tiered levels of evaluation each with its own objective, as has been previously endorsed by Australian Health Ministers.[20] The levels of evaluation related to the two key propositions are illustrated below.

A) Fulfilment of obligations and achievement of explicit objectives:

- Objective1 : Meeting financial and management performance objectives under the Management Agreement.

- Objective 2: Improving Aboriginal employment and training (in both the Area and Maari Ma.)

- Objective 3: Improving Aboriginal (and general community) access to services, provided under the Agreement and by other partners (principally the RFDS) and other specialist services.

- Objective 4: Improving Aboriginal community engagement, Aboriginal participation in service delivery under the Agreement.

B) At least keeping pace with other strategies used across NSW to reform health service delivery and improve health outcomes for Aboriginal people

- Objective 5: Leading Health service development, the reform of health service delivery and development of health programs in order to improve the effectiveness of health services.

- Objective 6: At least ensuring that health outcomes, those measures that provide either a direct measure of health gain or measures of change in

[20] http://www.oipc.gov.au/performance_reporting/sec_group/ar2005/section2_4_1.asp last accessed 25 September 2006

the impact of health service delivery that there is evidence will lead to health gain, improve in keeping with improvements elsewhere in NSW.

The Review Team approached the evaluation task as an evaluation of the performance of both parties under the Agreement. There are some objectives that relate directly to the performance of Maari Ma, for example, in meeting their management obligations. Others, such as increased investment in primary health care or those relating to health service reform are outcomes measuring the commitment of both parties.

Methods

To evaluate performance against these objectives the Review Team accessed a range of data in addition to the extensive interviewing and consultation undertaken. These data were provided from three main sources, Maari Ma, GWAHS and NSW Health. Data sought were those that could assist either by conforming to or throwing doubt on the achievement of objectives.

There were two stages to data gathering and analysis. Most of the information needed was gathered during or immediately after the initial visit to the Far West by the Review Team in August 2006. This first phase allowed the Review Team to draw conclusions about all but the last objective, relating to health outcomes. The data accessed and the propositions tested for the first five levels were as follows.

- Financial and management performance.
    - Net costs of health service for Aboriginal health and primary health care, from FWAHS and GWAHS Annual Reports, to test that investment had indeed increased.
    - Funding attracted by Maari Ma, principally from the Commonwealth (confirmed by the Department of Health and Ageing), to test that the Agreement had met its objective of facilitating Commonwealth investment in health services in the region.
    - Staffing levels in the services covered by the Agreement were accessed, from FWAHS Annual Reports, to test that investment had translated into extra direct service health workforce. Given the expected impact of the Wilcannia Coordinated Care Trial, these data were tabulated separately for Wilcannia and the rest of the communities.

- Non-Admitted Patient Occasions of Service (NAPOOS) from 1994/95 to 2003/04 and Non-Inpatient Register (NIR – a subset of NAPOOS that counts occasions of service provided within the clinic setting) from 2002 to 2005, from FWAHS/GWAHS Annual Reports and GWAHS Population Health Planning section, to test that increased investment had been applied in the services covered by the Agreement and was reflected in increased activity levels. Given the expected impact of the Wilcannia Coordinated Care Trial, these data were tabulated separately for Wilcannia and the rest of the communities.
- Regular management reports provided by Maari Ma to FWAHS and then GWAHS, from GWAHS files, to test that reporting obligations had been met.

- Aboriginal employment and training of Aboriginal health staff.
  - In addition to the information provided by GWAHS and Maari Ma managers, the Review Team accessed information on the proportion of Aboriginal staff in FWAHS from 1999/00 to 2003/04, from FWAHS Annual Reports, and graduation numbers from the Sydney University Department of Rural Health from 2001 to 2007, from the GWAHS Population Health Planning section. This was to test that, under the Agreement Aboriginal people had received improved health training opportunities and had increased in number, as a proportion of FWAHS staff.

- Aboriginal (and general community) access to services.
  - NAPOOS and NIR data allowed the Review Team to test that increased investment and activity in primary health care services had translated into improved access to services for both the Aboriginal and non-Aboriginal communities served under the Agreement.
  - Royal Flying Doctor Service (RFDS) data on medical occasions of service and attendances in total in Ivanhoe, Menindee and Wilcannia from 2001/02 to 2005/06 was also provided to the Review Team by the Broken Hill office of the RFDS, which allowed assessment of whether access to other services had also been enhanced during the time of the Agreement, in which RFDS was also mentioned as a partner.

- Schedules of specialist visits to each community from 2001-2006 was also accessed from GWAHS Population Health Planning section, to test whether specialist service access had improved under the Agreement.

- Aboriginal community engagement.
  - Assessing gains in Aboriginal community engagement was based on in depth interviewing with key informants, a meeting with Maari Ma Aboriginal staff and Board members and a site visit to Menindee, during which the Review Team members interviewed staff, Board, school and community members and visited a service with a historically hostile relationship with the Maari Ma corporation.

2) At least keeping pace with other strategies used across NSW to reform health service delivery and improve health outcomes for Aboriginal people

- Health service development.
  - Assessing health service development strategies was based on review of strategy documents and in depth interviewing with key professional Maari Ma staff. As well, the Review Team talked at length to the Health Service Manager during the site visit to Menindee and to other Health Service Managers at their regular meeting in Broken Hill.

- Health Outcomes

The Agreement has been in place now for 10 years, with a sustained emphasis on primary health care development and, in latter years, improving chronic disease outcomes. Despite this, however, outcomes achieved by health service interventions are notoriously difficult to measure with any degree of reliability, especially in small populations (for methodological reasons) and with very disadvantaged populations (because of the impact of the social determinants of health.)

Populations in remote areas, including the Far West, are also changing at present. For example, for several years until 2006, Broken Hill has had negative population migration of about 1% a year, net of inward Aboriginal migration from

the more remote areas whose Health Services are managed under this Agreement. All of this affects the ease and reliability of analysis.

To assess health outcomes achieved, the Review Team initially identified a number of measures for which it could access data in the limited timeframe for the initial work of the review. These included:

- Health outcomes
    - Changes in Mortality Rates and Years of Life Lost, from the 2002 NSW Burden of Disease Study, to compare these headline measures between the old FWAHS and other Area Health Services.
    - Ambulatory sensitive chronic condition hospitalisations from 1989/90 to 2001/02, from the NSW Chief Health Officer Reports, to compare this measure between the old FWAHS and other Area Health Services.
    - Ambulatory sensitive hospitalisations in Broken Hill Hospital from 2000/01 to 2005/06, from the GWAHS Population Health Planning section, broken down by Aboriginality, to assess trends over this period for which the Review Team was able to access data.
    - Unplanned emergency infant hospitalisations in Broken Hill Hospital from 2000/01 to 2005/06, from the GWAHS Population Health Planning section, broken down by Aboriginality, to assess trends over this period for which the Review Team was able to access data.
    - Five measures used in the Evaluation of the Aboriginal Maternal and Infant Health Strategy (AMIHS) – maternal age less than 20 years, access to antenatal care at less than 20 weeks of gestation, smoking rate during second half of pregnancy, and rate of premature births– to compare achievements in FWAHS compared to NSW as a whole.

The analysis of these data provided insight against a number of measures and with only this material as the basis for the assessment of Objective 6, the first version of the Review was completed during 2006. As previously explained the timing of the Review had been determined by the need for GWAHS and Maari Ma to make a decision by the end of 2006 about whether to enter a new Agreement, given that the existing Agreement was due to expire on 31 December 2006. At the end of 2006, after the Review had been completed and accepted by GWAHS

and Maari Ma, Robert Griew briefed the Director-General and Deputy Director-General / Chief Health Officer of NSW Health about the Review findings.

During the course of this briefing it was agreed that it would be useful to undertake further analysis on the specific question of the achievement of health outcomes. The rest of the Review's findings stood on their own but, in the time available, this aspect of the analysis of results achieved had been partial. The Director-General offered the support of the NSW Health Centre for Epidemiology and Research to attempt a more complete second phase assessment of health outcomes.

Results in this section of the Evaluation of Achievements chapter, therefore, presents two sets of results: those originally produced in 2006 and a second set produced with more rigour in 2007. The first analysis was done by Robert Griew and Shane Houston, the original Review Team. The second was done by Robert Griew and Diane Hindmarsh, a biostatistician in the Centre for Epidemiology and Research, NSW Health. This is the only section of the Review to which additional material has been added since its initial completion.

The aim of this second stage of analysis was to provide a more sophisticated analysis by accessing:

- more complete data;
- more precise data for the Maari Ma Agreement area, for both Indigenous and non-indigenous populations;
- comparator areas that allow for realistic comparison, for both Indigenous and non-indigenous populations; and
- measures to determine if results obtained are significant.

At Appendix C is a detailed methods paper, which describes the second phase analysis of the health outcomes Objective 6 undertaken during 2007. In summary, four kinds of possible data were explored, including health behaviours (from the NSW Health Survey), pregnancy related information (from the midwives collection), along with mortality and discharge data (from administrative data held by the Centre for Epidemiology and Research in NSW Health.) As explained in Appendix C Health Survey data turned out not to be useful. For the other three sets, data were retrieved for the LGAs making up the Maari Ma Agreement area and a combined comparator area, made up of clusters

of LGAs from GWAS, Hunter New England and Greater Southern Areas which were similar in remoteness, Aboriginality and socio-economic status.

Proportions of the number of births were calculated for indicators based on data extracted from the Midwife's Data Collection. 95% confidence intervals were calculated based on the standard error of the proportion. Age standardised rates (with 95% confidence intervals) were calculated using the Australian population in June 2001 as the standard population for indicators involving mortality or hospital separations. All analyses were undertaken separately for Aboriginal and non-Aboriginal populations, as well as overall. Estimates of Aboriginal and non-Aboriginal populations in each area were based on estimates at the local government area level from the ABS.

Two sets of differences were of interest to the Review: differences over time for Indigenous and non-Indigenous Maari Ma populations, and between the Maari Ma and comparator populations for the Indigenous and non-Indigenous populations. The significance of differences was assessed on the basis of the 95% confidence intervals. Thus, the results of interest are those where the confidence intervals are not overlapping, either for Maari Ma populations at different time intervals or between Maari Ma and comparator populations at the same times. These are referred to in the results section for Objective 6 as 'significant differences' or simply 'differences'. As well a number of 'interesting trends' were also identified, which are worthy of comment but are not significant differences (at a 95% confidence level.)

Results

Against each objective in turn, this section presents the results found in the data analysed. Against Objective 6 only results which involve significant differences or interesting trends are presented. Appendix C includes a more complete presentation of the indicators examined.

Objective 1: Financial and management performance

The direct cost in 2005-06 of health care service delivery in the health services across the sector covered by the Agreement was in the order of $10 m ($9.93m Net Cost of Services.)[21] This includes both the costs of primary health care clinics

[21] GWAHS Remote Cluster administration, interview 22.8.06

and three small hospitals, which together provide a combination of aged care, acute and primary care services.

In addition to this, over the life of the Agreement, FWAHS and then GWAHS have provided an annual grant to Maari Ma for the administration unit that administers these services on the Area's behalf.[22]

Maari Ma has also been successful at attracting funding from other sources, both State and Commonwealth, to provide program development and implementation support across the services. As discussed previously, this program work complements the delivery of primary heath care services and has been a strength in Maari Ma's activity, especially over the last few years. The delivery model for these programs rests largely with Maari Ma's Regional Office in Broken Hill with staff visiting services across the Remote Cluster, although some are also located within specific services.

In order to explore further the dynamics of funding and administration, the Review Team did a number of things.

Firstly, it examined Maari Ma's management accountabilities under the Agreement. It examined a sample of Maari Ma's regular reports to the old FWAHS Board and to the GWAHS Remote Cluster General Manager. These have been completed diligently against the information required under clauses 8.1 (a), (b) and (c) of the Annexure to the Agreement.

The one significant failure under the Agreement relates to the requirement under clause 8.1 (d) to,

> "establish mechanisms to facilitate the achievement of performance targets in accordance with the Performance Agreement between the Director-General of the NSW Department of Health and the Far West Area Health Service and submit appropriate reports as are required from time to time by the Department."

There is no evidence of any discussion between FWAHS and Maari Ma about 8.1(d), nor therefore, of any work being done by either party to map Area Health Service accountabilities that might usefully have been reflected in either program

[22] The grant has grown from about $250,000 in 2001-02 to $380,000 in 2006-07

delivery or performance reporting by Maari Ma. The early returns by Maari Ma were focussed on process and budgets and the latter ones were a compelling account of service delivery, with an emphasis on programmatic outcomes, consistent with the history of the Agreement.

If the work had been done to map FWAHS accountabilities and draw out consistent accountabilities for Maari Ma, it is likely these would have converged with the service reform agenda developing within both Maari Ma and FWAHS. For example, when NSW Health issued Aboriginal Chronic Disease Area Health Service Standards in 2004, Maari Ma analysed them and found they met almost all standards in the sector Maari Ma managed.[23]

However, the performance objectives and reporting standards that should have been explicitly developed to map the activity under the Agreement with FWAHS accountabilities were not addressed. This was a joint failing of the parties. Maari Ma was meant to be searching for this discussion. FWAHS could have been expected to have initiated it. In other respects Maari Ma complied with their management and reporting obligations.

Maari Ma was of course established (as the Far West Ward Aboriginal Health Service) in an interdependent relationship with the Far West Area Health Service, in a model deliberately designed to avoid the risk of organisational failure. It is also the case that the provision of bureau services by the Area under the Agreement added further insulation against management failure. The Review Team also noted that the quality of financial data appears to have improved post 2003, when the current accountant took up duty, and are now of a high quality.

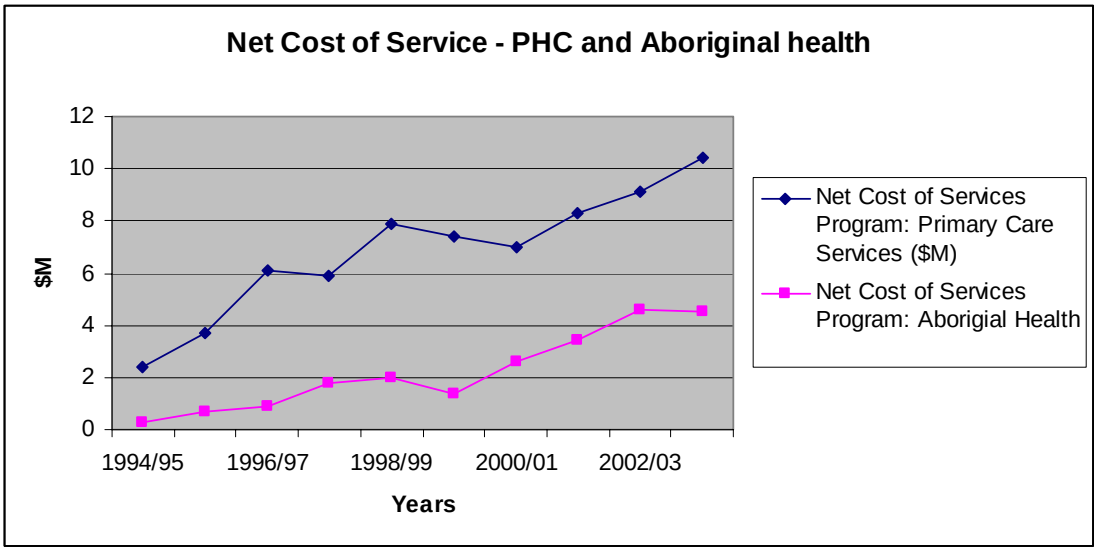
Next the Review Team turned to funding, staffing and activity levels in the Health Services in order to assess the commitment of the Area to funding improved primary health care and Aboriginal health outcomes over the time of the Agreement.

First it extracted Area Health Service funding for both primary health care and Aboriginal health from Annual Reports of FWAHS since 1994-95, and information provided us by the Remote Cluster of GWAHS for 2004-05 and 2005-06.

[23] Maari Ma response to NSW Health Aboriginal chronic disease AHS standards, 2004

Under the old FWAHS, funding designated for Primary Health Care (Program 1.1, 1.2, 2.1 across time) and Aboriginal Health (Programs 1.2 and 2.2 across time) grew steadily and significantly, from $2.4m and $0.3m in 1994-95 to $10.4m and $4.5m in 2003-04 respectively. These program categories do not exactly describe funding in the services and geographic area covered by the Agreement. Primary health care, as described, does not include the three small hospitals for example, and both primary health care and Aboriginal health include the whole of the old Far West Area, including the upper western sector. However, as demonstrated in Figure 5 below, the steady growth does indicate steadily increasing resource commitment, a commitment evidenced in services across the Remote cluster.

Figure 5



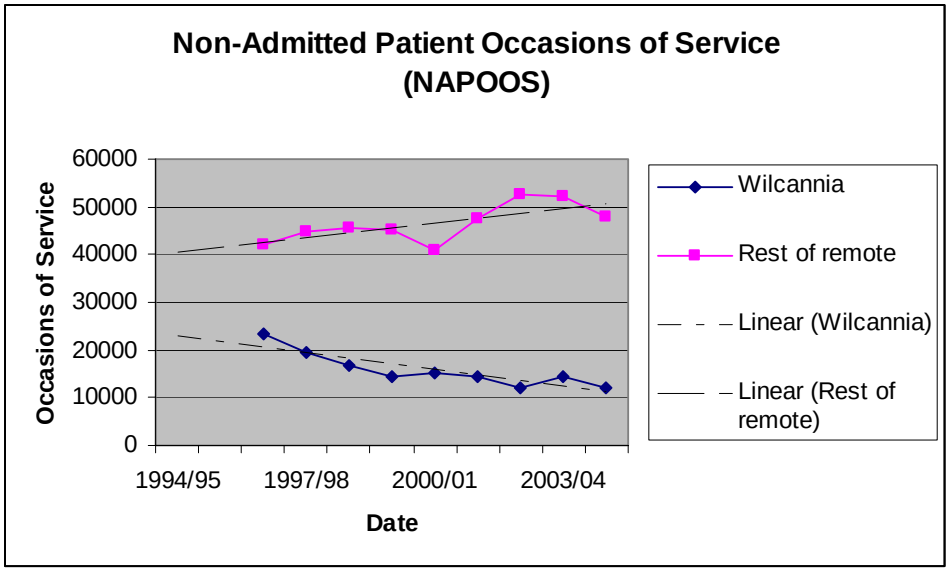
Source: Annual Reports Far West Area Health Service

Under GWAHS, the same programs of expenditure across the whole of the larger Greater Western Area have held ground subsequent to the creation of the new Area. It is not possible to break this down into old Area structures, but the Review Team saw no evidence of any reduction in effort.

From the same Annual Reports the Review Team examined growth in primary health care activity in services covered by the Agreement using Non-Admitted Patient Occasions of Services (NAPOOS) as a measure. This measure provides two useful assurances. First, it identifies any failure of funding to reach service delivery. Second, it provides an indication of any disruption to stable management of core service delivery functions during the period that the Agreement came into effect, when Maari Ma became responsible for the management of the services.

As indicated, the Review Team separated Wilcannia, the site of the Commonwealth funded Coordinated Care Trial (from 1997 until 1999), in case that trial, with its large injection of funds, distorted numbers across the cluster as a whole. The results are shown in Figure 6 below.

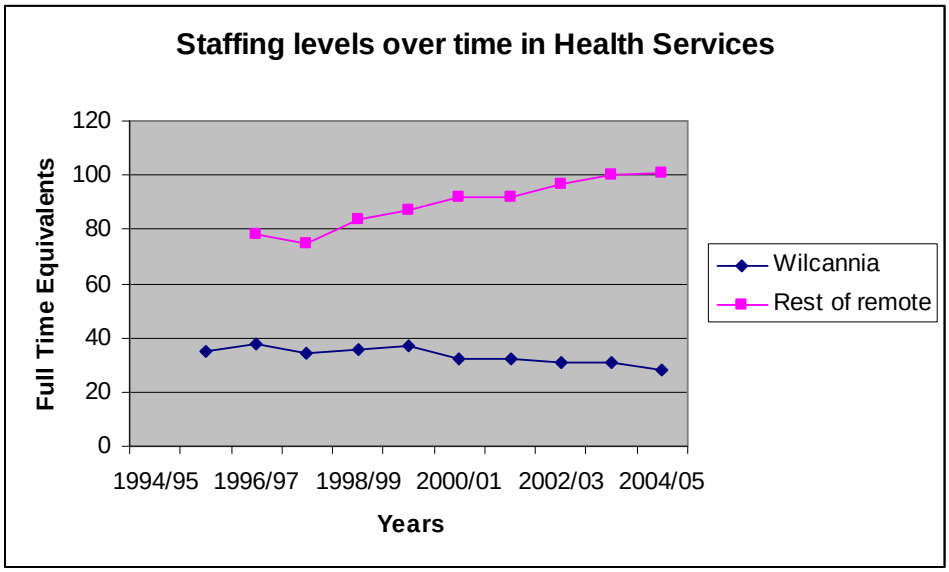
Figure 6



Source: Annual Reports Far West Area Health Service

The Review Team also plotted staff numbers reported in those services, as Full Time Equivalents (FTEs), also using information gleaned from Annual Reports. This is presented in Figure 7 below.

Figure 7



Source: Annual Reports Far West Area Health Service

In Wilcannia, staff numbers peaked with the Coordinated Care Trial and have stabilised at a lower plateau. Activity in Wilcannia, at least measured by NAPOOS, did not increase despite the substantial injection of Commonwealth funds under the Coordinated Care Trial. In fact there would seem to be some evidence in the Figures 6 and 7 to suggest that the trial had a net effect of disrupting service delivery.

Across the rest of the Sector NAPOOS have grown steadily, with the exception of 2001, when they suffered a once-off decline. No-one to whom the Review Team spoke could explain that decline and the growth trend was re-established the following year. Staff numbers steadily increased reflecting greater investment by the Area Health Service.

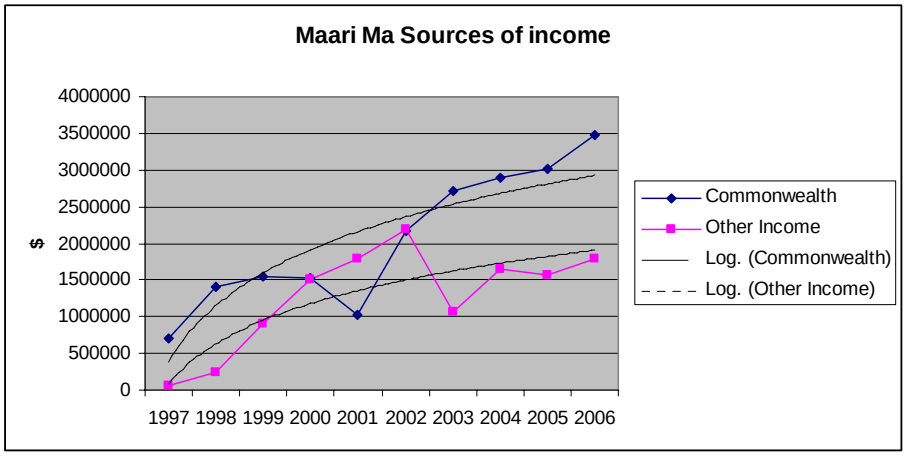
Next the Review Team examined external funding.

Commonwealth Health funds provided to Maari Ma have grown from $0.7m in 1996-97 to $3.5m in 2005-06 ($2.7m in 2006-07.) The largest part of the Commonwealth grant to Maari Ma is for nearly $1.5m for the Aboriginal Medical Service in Broken Hill, which falls outside this Management Agreement. However, the remaining funding ($1.25m in 2006-07) is for programs and staff across the Area, incorporating grants under the Rural Health Services program, Healthy for Life and Aged Care.

Maari Ma's total funding has increased over the same period from $0.8m to $5.3m, with additional grants coming from NSW Health, NSW Department of Community Services, NSW Corrections Health, NSW Premier's Department, NSW Gaming and Racing, Commonwealth Departments of Family and Community Services, OXFAM, Telstra and others.[24] This is presented in Figure 8 below.

[24] Source: Maari Ma administration, follow up to visit; NSW State Office Commonwealth Health and Ageing/ OATSIH, follow up to visit. The quality of Maari Ma bookkeeping has substantially improved since 2003, when the current accountant took up office. For example, accruals prior to this point are possibly not reliably posted to correct years. The trend lines are more reliable in the graph.

Figure 8



Source: Maari Ma finance manager

Objective 2: Aboriginal employment and training outcomes

One of the explicit aims of the Agreement was to improve Aboriginal participation in the health workforce serving the communities it covers. This was seen both as a way of improving the accessibility and cultural safety of services and also as a part of a wider strategy to improve local Aboriginal people's engagement in health.

During the first phase of the Agreement's history increasing Aboriginal employment in the services, and in Maari Ma, was a significant priority. When the Agreement was signed and the new management arrangement came into place staff can remember 6 Aboriginal people who worked in the Health Services in the communities covered by the Agreement. There are now 27, despite the number of Aboriginal people employed in Wilcannia having fallen from 10 to 7 since 2001. In other services the number of Aboriginal staff has increased from 10 in 2001 to the current figure of 21, ie doubling in the last six years.

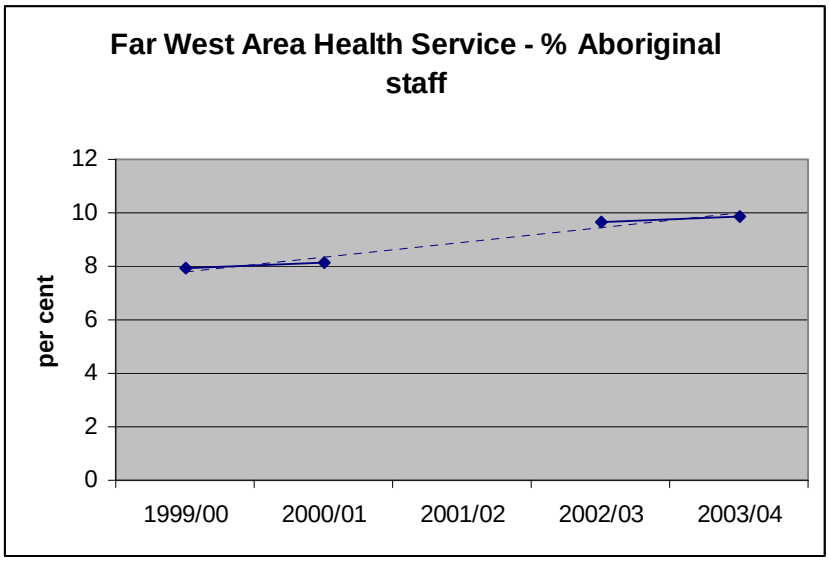
As well, there has been a significant increase in Aboriginal employment through Maari Ma itself, in both the Broken Hill Primary Health Care service and in the Regional Office developing and delivering programs for the Health Services covered by the Agreement.

In 2001 the Far West Area Health Service also launched its Aboriginal Employment Strategy, a comprehensive policy that has seen an increase in the proportion of Area staff who are Aboriginal from under 8% to over 10%.[25] This

[25] FWAHS Annual Report 2003-04

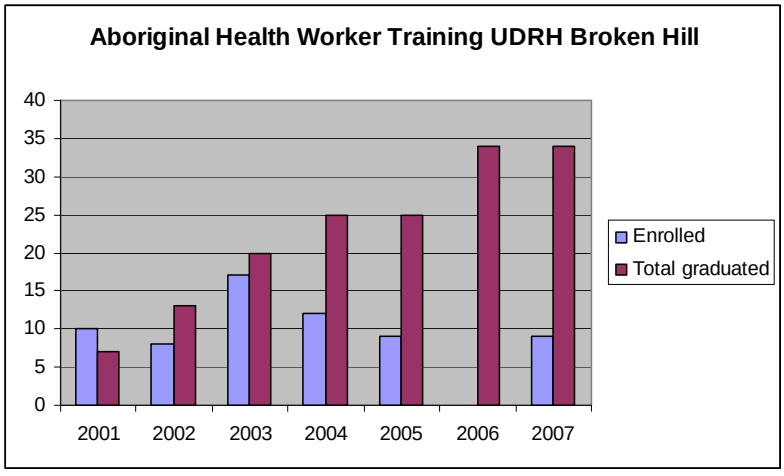
strategy won a NSW Premier's Public Sector Award in 2003. Figure 9, sourced from data in Annual Reports, illustrates the steady gain in Aboriginal employment in the Far West Area Health Service through the Agreement. Most involved in FWAHS at the time cite the relationship and Agreement with Maari Ma as an essential component of this success.

Figure 9



Early on, the parties to the Agreement approached the Broken Hill Rural Health Training Unit, now the Sydney University Department of Rural Health, to develop training for Aboriginal Health Workers. The training developed reflected the aspirations of the parties to train and employ Aboriginal Health Workers with clinical skills, more in the model of northern Australia than in the rest of NSW. This makes best use of the workforce where medical and nursing staff is most difficult to access, where an integrated role for Aboriginal Health Workers in the team is imperative. Figure 10 shows the training provided.

Figure 10



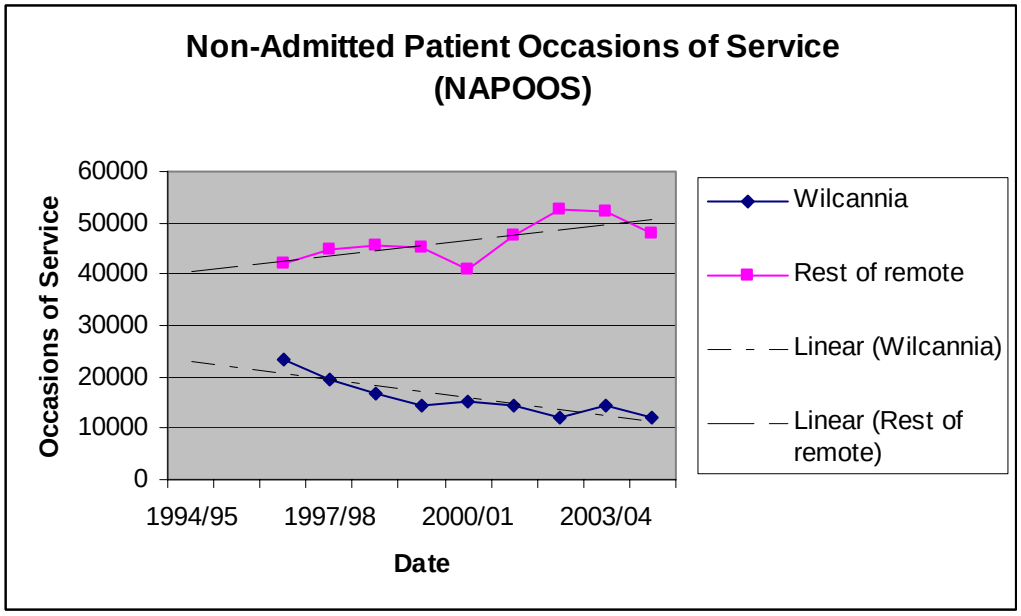
Source: Greater Western Area Health Service Population Health Planning

Since 2002-03, the Commonwealth has funded twelve places for Aboriginal Health Worker trainees under the Structured Training and Employment Program.

Objective 3: Access to services

To assess trends in service access the Review Team analysed a number of measures. First it examined the trends in Non-Admitted Patients Occasions of Service (NAPOOS) in the health service managed under the Agreement. It did this for the years 1996-97 to 2004-05 and found a steady increase, with a dip identified only in 2001 and disruption to service growth around the Wilcannia Coordinated Care Trial. Figure 11 below shows these results.

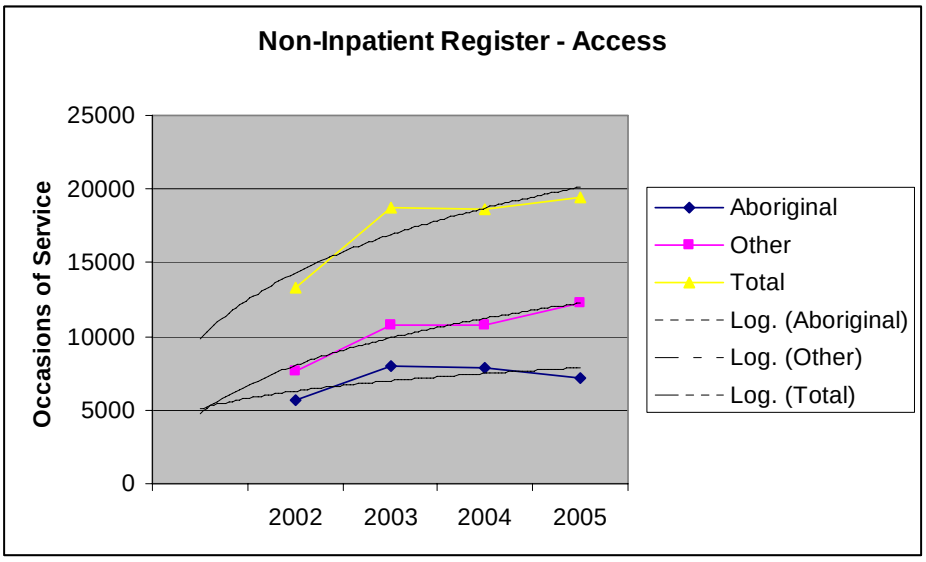
Figure 11



Source: Annual Reports Far West Area Health Service

Non-Inpatient Registered (NIR) occasions of service is another related measure of activity maintained by the health services. These are a subset of NAPOOS, including only non-inpatient services provided within the health service clinic, ie excluding occasions of service provided on outreach and home visits. The Review Team accessed NIR data, broken down into Aboriginal and non-Aboriginal patients for the same period. This data showed a trend increase for both Aboriginal and non-Aboriginal patients, although slightly greater for non-Aboriginal patients. It is presented in Figure 12 below.

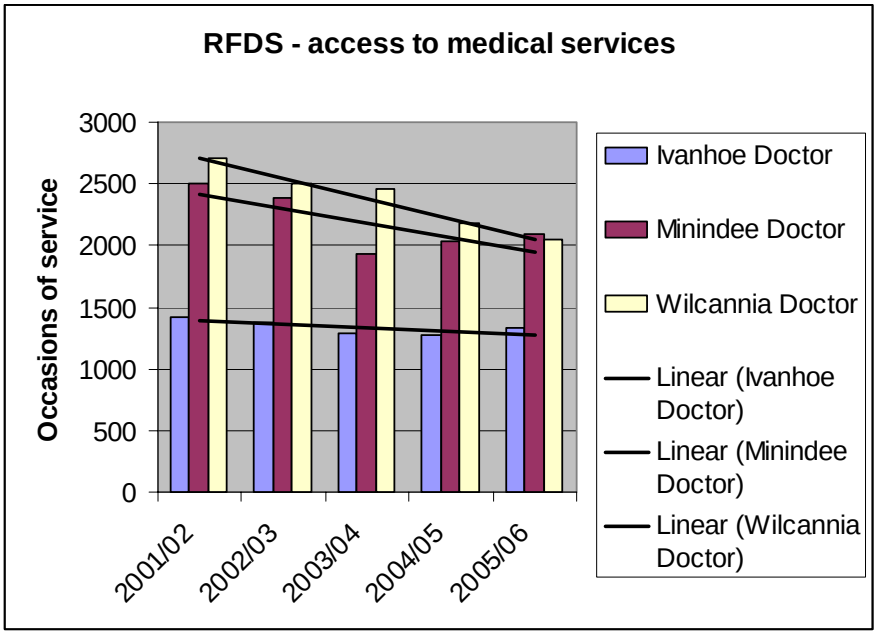
Figure 12



Source: Greater Western Area Health Service Population Health Planning

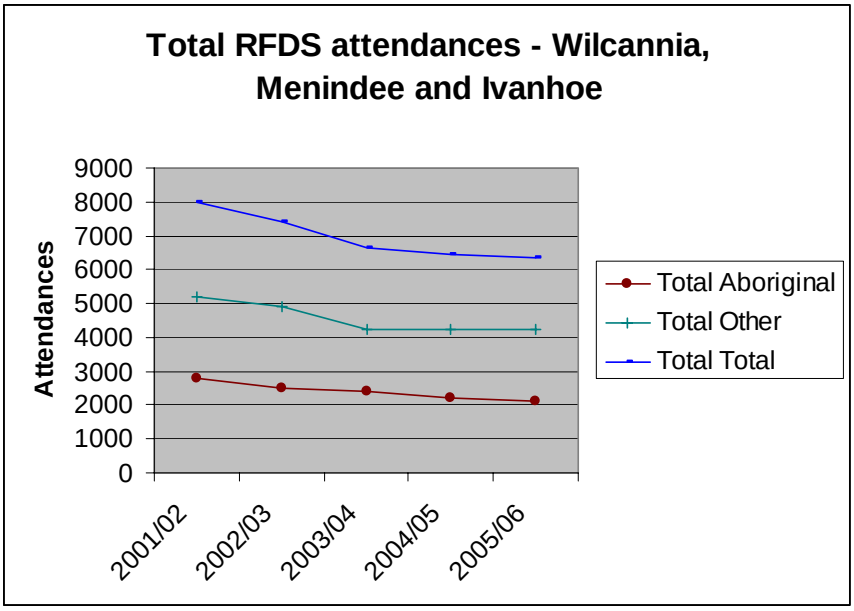
As well, the Review Team examined Royal Flying Doctor Service activity (workload) data for the five years from 2001-02 to 2005-06, in order to examine whether there had been any change in Aboriginal access to services provided by a third party, and partner to the Agreement. It found a marginal decline from 35% to 33% of attendances at RFDS clinics were by Aboriginal people, comprising an increase in Ivanhoe and decreases in Wilcannia and Menindee. Figures 13 and 14 below shows these results. It also shows, however, an overall decline in activity for all communities except Ivanhoe.

Figure 13



Source: RFDS Broken Hill

Figure 14



Source: RFDS Broken Hill

Local GWAHS staff were also able to provide the Review Team with a listing of the specialist services provided by FWAHS/GWAHS, Maari Ma, joint Maari Ma/GWAHS, the local Division of General Practice and RFDS to each community over the six years from 2001 to 2006. With a couple of exceptions where services were not maintained, the pattern is clearly a steady expansion of service provision in key specialties. At Appendix D is the information provided for Wilcannia.

Objective 4: Community engagement

Information was gathered through in depth interviews, meetings and the site visit to Menindee to assess the success of community engagement under the Agreement. This is an objective about which the Review Team received some negative comment, aimed at Maari Ma, from stakeholders outside the far west.

Maari Ma Regional Director Richard Weston pointed out that,

> "Maari Ma has 240 members across the region and we stood up well during a review of our compliance with the Aboriginal Corporations and Associations Act on 2004, by the Registrar for Aboriginal Corporations."

The Review Team saw clear evidence, at a community level, of initiatives to promote and connect each Health Service to its community, making clear in each

case who the local Peak Health Council members were, as well as local Aboriginal staff. Maari Ma staff and management are also demonstrably clear that they work for an Aboriginal community organisation, in their sense of accountability and in their commitment. For example, in one meeting with Aboriginal staff at Maari Ma, one worker made the following statement.

> "I never had a sense of working in a team until this organisation. It's like we're in a boat together. You're not a bird on a biscuit here. We're all working for a direction set by a management team who really care for our people and our organisation … We find other Aboriginal staff (eg in the Area) coming here to revitalise. … I feel more comfortable raising issues here. Working in mainstream, I would just have let things pass but now I raise them up the line because I think the management here want to know and will do something about what I say."

The Review Team saw evidence of some family / language group based conflict around Maari Ma in a couple of places. In Community Working Party Action Plans under the Murdi Paaki Regional Assembly process, the Review Team also saw signs that Maari Ma has work to do to explain its role, strategy and priorities to parts of its community. The alternative strategies advocated in the Community Working Party Action Plans did not include any substantive technical health content that could challenge the work Maari Ma or GWAHS staff are doing, but does bear witness to a level of inchoate opposition, at least in some localities.

Objective 5: Health service development

There are a large number of markers of health service development on which one might focus to assess if a health service is moving in the right direction. In their recent Chronic Disease Strategy Maari Ma make the point that,

> "A great deal of evidence already exists to guide action in a remote region like far western NSW. A comprehensive review of the evidence base was undertaken by the NT Department of Health and Community Services … leading to a set of … key result areas and best buys."[26]

[26] Maari Ma Health Aboriginal Corporation, 2005, Maari Ma Chronic Disease Strategy, p7

The point is well made. The wheel does not need to be reinvented. Following either the epidemiology of the region[27] or a health development perspective[28] will lead to similar priorities. Maari Ma has clearly followed both, identifying its,

> "unremitting commitment to integration – an integrated theoretical framework that encompasses social and medical determinants of health; an integration of client, clinical and public health perspectives … and an integrated approach across the continuum of care between community and hospital services."[29]

Local thinking has developed over the life of the Agreement, tracking contemporary thinking across Australia, from a strong primary health care focus to an approach to disease prevention and management incorporating aspects of maternal and child health, alcohol and other drugs, mental health and the early identification and management of adult chronic disease – especially metabolic syndrome. In a development health perspective such as Maari Ma have adopted, these strategies are not distinct but interrelate across the spectrum from primary to tertiary prevention. Thus, for example, strategies such as antenatal care to improve baby birth weights are regarded as imperative, in part, because they have a primary prevention effect on early onset chronic disease in later years.

The current articulation of this strategy within Maari Ma is recent, with the Chronic Disease Strategy. However, the antecedents have clearly been present for the life of the Agreement. As noted above, in the telling of the history of the Agreement, one of the common points of the narrative is the Coordinated Care Trial, both as an opportunity, with funds, attention and support from the Commonwealth, and as a disappointment. Nonetheless, it also seems clear that the whole experience did create a dynamic that built on the primary health care emphasis led by the then CEO of Far West Area Health Service and his Population Health Director.

In order to assess whether this long term commitment has been matched by action the Review Team examined documents – a report on the compliance of the partners with new NSW Health standards on Aboriginal vascular health, from 2004, the Maari Ma Regional Office Business Plan and the 2006 Wellness Check

[27] Kennedy C, GWAHS, The Health of the Murdi Paaki, 2005
[28] Cf AHMC, 2005, National Chronic Disease Strategy or the approach encapsulated in the new Australian Population Health Development Principal Committee of AHMAC
[29] Maari Ma Health Aboriginal Corporation, 2005, Maari Ma Chronic Disease Strategy, p5

Regional Profile Preliminary Report.[30] It also interviewed staff in the Maari Ma Regional office and Health Service Managers and examined the protocols for the Adult Health Check and care planning. It is clear that the reform effort and program development under the Agreement is consistent with contemporary evidence and practice in these areas and has built on the early impetus toward primary health care reform and is consistent with a contemporary health development approach.

The region covered by the Agreement appears to the Review Team to be in step with best practice across the rest of Australia. Indeed Maari Ma is now the only health service in NSW engaged in a national extension study of the implementation of best practise chronic disease management, the so-called ABCD(E) trial.[31]

Objective 6: Health outcomes

The results from both the initial and subsequent analysis of health outcomes produced results in three areas, pregnancy related indicators and indicators related to mortality and hospitalisations.

Pregnancy related indicators

Results from initial analysis

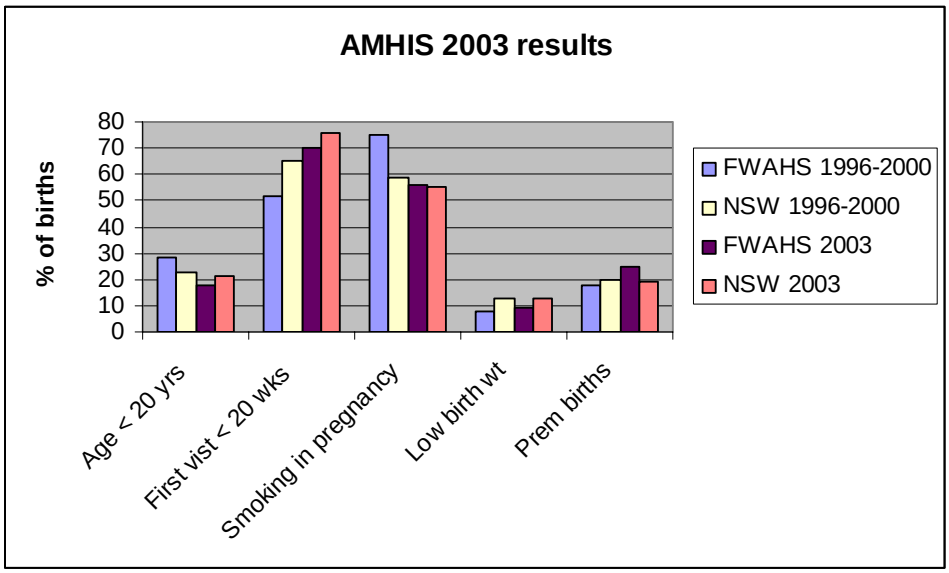
The Review Team examined the outcomes of the Far West's participation in the NSW Aboriginal Maternal and Infant Health Strategy (AMIHS.) AMIHS commenced in 2001 and had a number of aims, including increasing the involvement and trust of Aboriginal women, enhancing primary health care delivery and access to antenatal care and education and to related government services.

Specifically in the Far West AMIHS funded a community midwife and Aboriginal Health Worker position to support pregnant women in Broken Hill and Wilcannia and a Reference Group for women. They worked closely with Maari Ma, with the Aboriginal Medical Service in Broken Hill and with the Wilcannia clinic. There were five target indicators for the program, as indicated in the following table constructed from data in the 2004 Evaluation, to compare results in the Far West

[30] Maari Ma Health Aboriginal Corporation, 2006 Wellness Check Regional Profile Preliminary Report
[31] Baille R, Dowden M, Si D, O'Donohue L and Kelly A, Audit and Best Practice for Chronic Disease Project Progress Report Menzies School of Health Research CRC for Aboriginal Health 2005

with the other sites.[32] A similar service intervention was implemented in Dareton, using Area resources, achieving similar results. Resource constraints have inhibited replication elsewhere.[33] Figure 15 below shows these results.

Figure 15



Source: AMIHS Evaluation 2004

Positive results had been achieved in the Far West: reducing the proportion of births to women below 20 years; increasing the proportion of pregnant women accessing their first antenatal visit prior to 20 weeks of gestation; and in reducing smoking in the second half of pregnancy. The proportion of low birth weight and premature babies, however, had increased in the Far West, while being stable in the other sites. Still the results compare favourably with other sites of the AMIHS.

The reviewers of the AMIHS commented in their review that the failure to reduce smoking rates in pregnancy in most sites should not be over interpreted, probably indicating an increased level of trust in health workers by women who at least admitted to and discussed smoking as a recognised risk in pregnancy. They reported that women they interviewed had acknowledged this.[34] In the Far West, it seems possible that this level of trust in the AMIHS staff, and in health service staff in general, might have gone further to start to influence this significant risk behaviour.

[32] Homer C and Kildea S, Evaluation of the NSW Aboriginal Maternal and Infant Health Strategy, UTS, 2004
[33] Cathy Dyer, personal communication
[34] Homer C and Kildea S, op cit

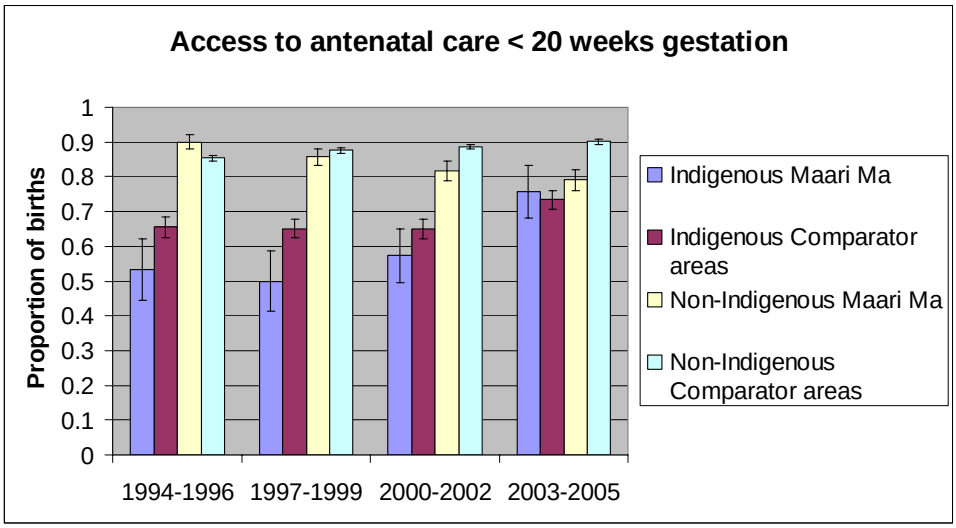
The Review Team was also able to extract data for the proportion of pregnant women accessing first antenatal visit before 20 weeks of gestation, across the whole of the FWAHS for 1996-99. This proportion increased by 9% prior to the AMIHS, a period of increased investment in primary health care during the early years of the Agreement. This would seem to lend extra weight to the hypothesis that AMIHS in the Far West sites was building on improved engagement by primary health care with Aboriginal women. This is a positive sign for one of the aims of the Agreement.

Results from subsequent analysis

Access to antenatal care before 20 weeks of gestation

In Figure 16 below, there were significant improvements for the Indigenous Maari Ma and Comparator populations and for the non-Indigenous comparator population between the first and last periods. There was, however, a significant decrease for the non-Indigenous Maari Ma population.

Figure 16

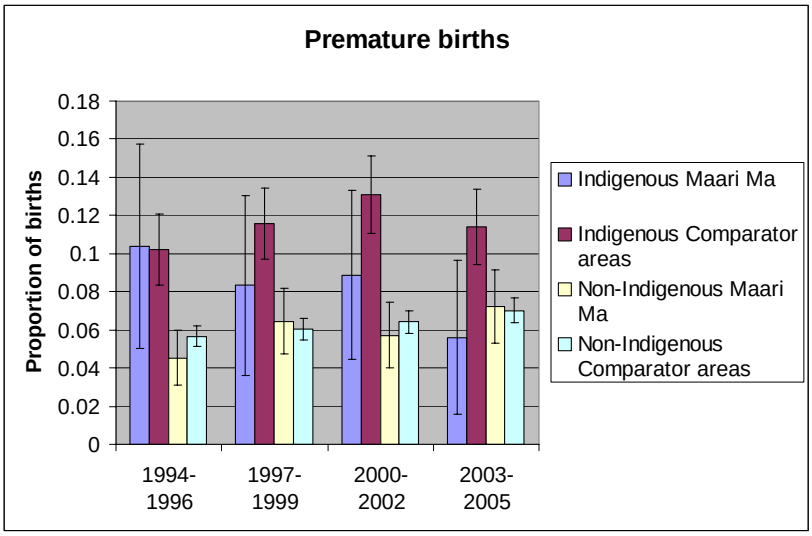


Proportion of premature births

In Figure 17 below there were no significant differences in the proportion of premature births between the Indigenous Maari Ma and comparator areas. However, the graph shows that the proportion of Indigenous women in Maari Ma giving birth prematurely has been trending downward over time, and was similar to the rate for non-Indigenous women in 2003-2005. The non-Indigenous

proportions of premature births, on the other hand, appeared to be increasing, with a significant increase for the non-Indigenous comparator area between the first and last period. The wide confidence intervals, arising from the small numbers in these data, however, meant the data lacked explanatory power to attribute significance.

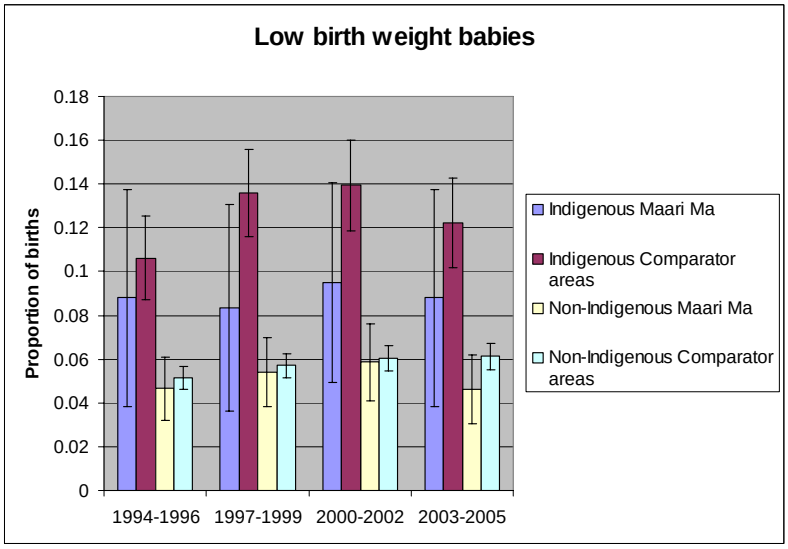
Figure 17



Proportion of low birth weights

In Figure 18 below there were no significant differences evident in the proportion of low birth weight babies, however whereas rates in the Indigenous population for comparator areas has been as high as 14%, rates in the Maari Ma area, for Indigenous births, has remained lower than 10% consistently. This is an interesting trend, even in the face of the data's lack of explanatory power.

Figure 10



In summary, the subsequent analysis conducted during 2007 produced significant differences in relation to access to antenatal care and positive trends, without statistical significance, in the reduction of premature and low birth weight births for Indigenous Maari Ma women. The increase in access to antenatal care was consistent with the AMIHS Evaluation data whereas the apparent decrease in premature and low birth weight births was not. Smoking in the second half of pregnancy was also examined but did not produce either significant or interesting trend data, other than reinforcing the very high levels among both of the Indigenous populations, 65-75%.

Care needs to be taken in comparing AIMHS results with those produced in the subsequent analysis for this Review. The AIMHS Evaluation results were for the whole of the old FWAHS, whereas the subsequent analysis was better targeted on the Maari Ma Agreement LGAs. The time periods covered were also different, with the data accessed for the subsequent analysis being more contemporary, up to 2005.

Mortality related results

Initial analysis

In the years between 1996-98 and 1999-2001, the time of this first burst of activity under the FWAHS, mortality in the old Far West declined by 14%, the greatest decline of any Area in NSW. Similarly over the same period the potential Years of Life Lost in the Far West Area fell by 16% compared to 10% across the State.[35] The Burden of Disease Study was, at the time, being updated by the University of Queensland which might eventually allow for examination of results over the second five year period of interest (2001-206). However, even at mid-2007 this has not been completed and the analysis will not be available by old Area Health Service boundaries, which will make further comparison difficult.[36]

Subsequent analysis

[35] NSW Burden of Disease Study, 2003 http://hoist.health.nsw.gov.au/hoist/report/AHS_reports/index.htm last accessed 22 September 2006

[36] Margo Eyeson-Annan, A/g Director, Centre for Epidemiology and Research, NSW Health, personal communication

A number of mortality related indicators were examined, including all cause mortality, potentially avoidable mortality and smoking related mortality. Results are Attachment C. None showed significant or useful trends or differences.

Hospitalisation related indicators

Initial analysis

Ambulatory care sensitive (ACS) admissions are another measure that is a good proxy for health outcome data. This measures the hospital admission rate for a population or set of conditions (eg acute or chronic illness) that are, at least theoretically, preventable by good quality, well organised ambulatory care.[37] ACS admissions are reported in the regular NSW Chief Health Officer's Report. Given the emphasis on chronic disease in the Far West the Review Team constructed trend tables for ACS admissions for chronic disease for FWAHS and the four old Area Health Services closest to FWAHS.[38] The trends over fifteen years were not, however, definitive. Subsequent years' analysis is available but again only in relation to the new Area structures, at least without further commissioned analysis, not available in the timeframe of this Review.[39]

The Review Team also gathered two lots of ACS related data for Broken Hill Hospital. The first were admissions for ambulatory care sensitive conditions for the 2000-01 to 2004-05 period. The data is affected by significant variance across years but when a three year rolling average is calculated to smooth out that volatility, a sustained downward trend is apparent for both Aboriginal and non-Aboriginal people. These results are presented in Figure 19 below.

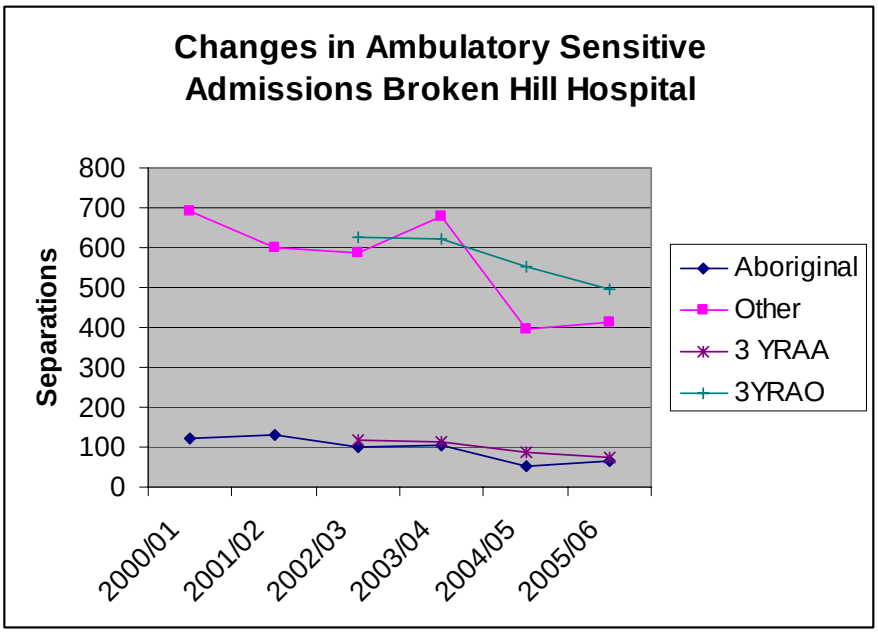
However, there have to be caveats on this data. It includes all admissions to Broken Hill Hospital and the Review Team was not able to access denominator data in the time available. These apparent trends could have been a result of changes in admission numbers or practices. There were also no standard error and, therefore, no confidence intervals calculated for these results.

[37] Stamp, K.M., S.J. Duckett and D.A. Fisher (1998). 'Hospital use for potentially preventable conditions in Aboriginal and Torres Strait Islander and other Australian populations' Australian and New Zealand Journal of Public Health 22(6): 673-84.

[38] http://www.health.nsw.gov.au/public-health/chorep02/toc/list_forahspagelist.htm last accessed 22 September 2006

[39] Margo Eyeson-Annan, personal communication

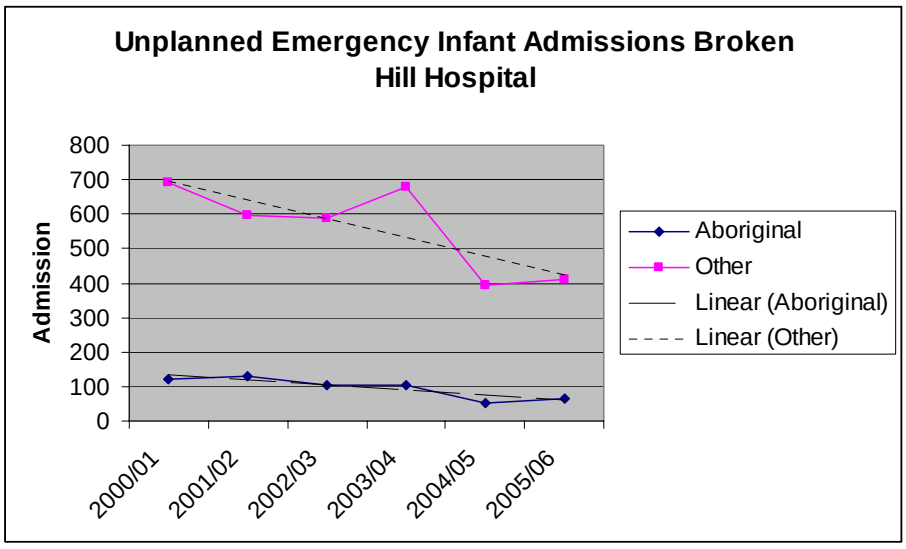
Figure 11



Source: Greater Western Area Health Service Population Health, Planning & Performance

The second measure the Review Team examined was the number of unplanned infant and maternal emergency admissions to Broken Hill Hospital from 2000-01 to 2005-06 broken down for Aboriginal and non-Aboriginal patients. Both showed a significant decline, consistent with good ambulatory practice across the both the city of Broken Hill and outlying communities. These data are presented in Figure 20 below. They also, however, do not take account of any changes in total admissions and are not, therefore, definitive. There were also no standard error and, therefore, no confidence intervals calculated for these results.

Figure 12



Source: Greater Western Area Population Health, Planning & Performance

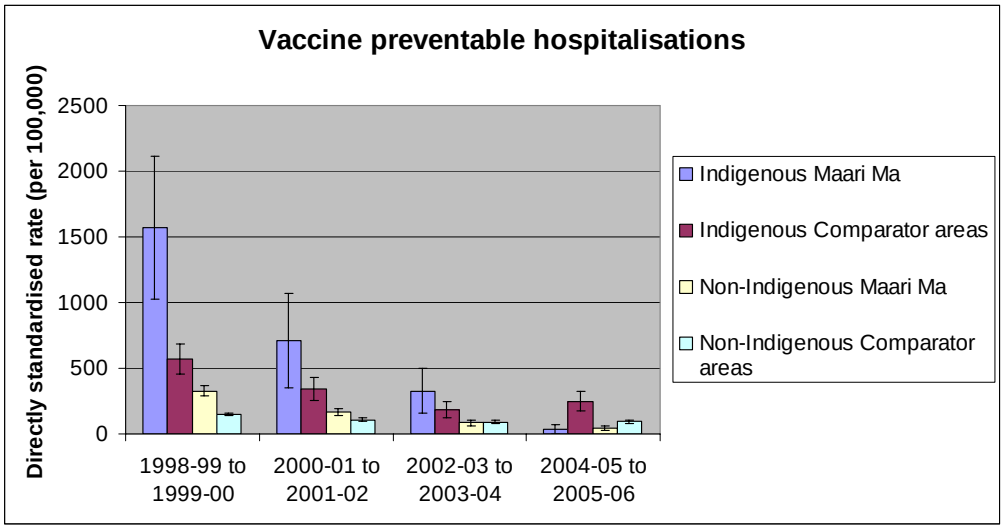
Subsequent analysis

A number of hospitalisation related indicators were examined in the subsequent analysis. All of the results are included in Appendix C. Three produced significant or interesting trend results.

Vaccine preventable hospitalisations

Figure 21 below shows a number of significant differences identified in the rate of vaccine preventable hospitalisations. Most striking was the significant reduction in the rate for the Indigenous Maari Ma population between 1998/99-1999/2000 and the most recent period of time (2004-05 to 2005-06), notwithstanding that the differences in the intervening periods were not significant. The Indigenous comparator population also had a significant reduction between these two times, but not to the same extent. There was also a reduction in vaccine-preventable hospitalisation for the non-Indigenous Maari Ma population. The rate of hospitalisation for Indigenous people in 1004-05 to 2005-06 was not significantly different to the rate for non-Indigenous people, unlike previous periods of time.

Figure 13

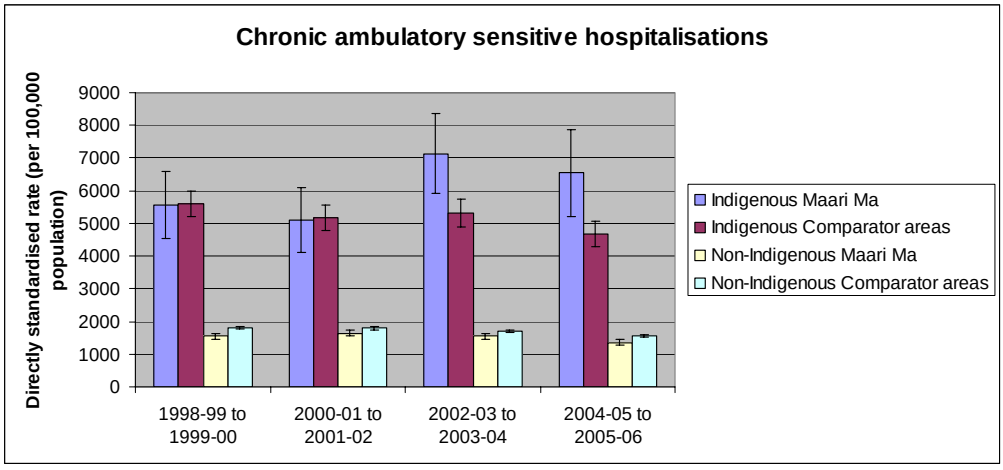


Chronic ambulatory sensitive hospitalisations

Figure 22 below shows that there were significant differences in the data for chronic ambulatory sensitive admissions. The Indigenous Maari Ma population had a higher rate than the Indigenous comparator populations in the last two time periods and the non-Indigenous Maari Ma population had a lower rate than

the non-Indigenous comparator population in the first and the last two time periods.

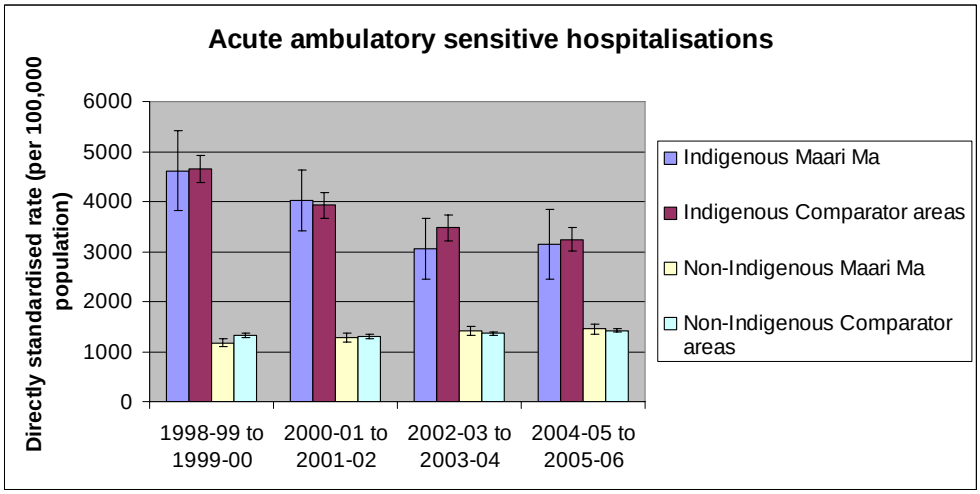
Figure 14



Acute ambulatory sensitive hospitalisations

Figure 23 below shows an encouraging trend for both the Maari Ma and comparator Indigenous populations, however, there were no significant differences identified for acute ambulatory sensitive conditions.

Figure 15



Discussion and conclusions

The Evaluation of results achieved under the Agreement had two components.

- First that the parties to the Agreement had fulfilled their obligations under the Agreement and achieved the objectives they set explicitly in it. The data analysed for Objectives 1 to 4 related to this component.

- Second that, during the period of the Agreement's operation, the Far West had at least kept pace with other strategies used across NSW to reform health service delivery and improve health outcomes for Aboriginal people. The data analysed for Objectives 5 and 6 related to this component.

The analysis for each individual Objective raised a number of important issues, both of interpretation and for any future Agreement.

- **Objective1 : Financial and management performance**

The analysis has limits because the reporting categories in the Annual Reports do not line up with the boundaries of the Agreement and because NAPOOS are only one measure of primary health care activity. However, in general the Review Team concluded that the commitment to growth in primary health care and Aboriginal health has been matched by the sort of increase in activity that we would expect. It is also indicative that the management of the Health Services by Maari Ma did not have any disruptive effect on service delivery.

External funding to a resource-needy, socially deprived area such as the Lower Western Sector presents a dilemma for State Government service departments. The services such funding can purchase are obviously needed and can provide essential supplementation to the services States can afford to provide. It can also, however, provide for service duplication, diffuse priority setting and distort planning for a region and, if the organisation funded is not well run, can lead to other problems as well.

One of the advantages of the Agreement is that it has provided a platform for an integrated service plan overall. Commonwealth funding has either been spent on clearly complementary service, through the AMS in Broken Hill, or delivery of programs through the mainstream services which Maari Ma has been managing. This structure has provided for better integration outcomes than many other parts of the country in which the Commonwealth has invested. Maari Ma has also been a well run organisation and has not suffered the cyclic management crises of some non-government organisations. It has stood out for its commitment to working with the mainstream State health services and not in a separatist model.

On all these bases, the Agreement has provided a basis for integrating external funding into the region in a way that avoids many of the pitfalls often experienced

from a State health service point of view. The Agreement has provided a platform on which both NSW and Commonwealth Governments have invested increasing amounts in Aboriginal and primary health care, and done so in an effective collaboration with Maari Ma.

However, there are still some comments that the Review Team wish to make after their review of management, accountability and funding issues.

The Coordinated Care Trial, contrary to expectations, appears to have triggered a sustained decline in service levels in Wilcannia, albeit against a shifting population denominator. The other Aboriginal Coordinated Care Trials (in Tiwi Islands, Katherine West and Bunbury) have had mixed outcomes, ranging from sustained to transient success. A separate question, especially for the Commonwealth, is whether the lessons of these trials have been learnt? It would be useful as a question in Aboriginal Affairs more generally to avoid expensive pilots and trials that disrupt rather than build strength without adding new capacity.

There is also evidently a vacancy management strategy in place to manage budgets in the services, as there has been for some years. It is presently worth about $0.5m pa, or 5% of local service budget. This seems to be impacting disproportionately on Wilcannia, with a significant number of vacant positions and unstable management over time. This is a common budget management strategy across Australia, given cost escalation in health service delivery. The impact in the Lower Western Sector is, however, not being managed in a transparent and planned way. There needs to be some clear discussion about the issue between GWAHS and Maari Ma.

Recommendation 1: That GWAHS review the funding and establishment base for staffing in the Health Services in the Remote Cluster.

Maari Ma and GWAHS might need to discuss the best use of the three positions funded under the Agreement at Maari Ma, if it is renewed. These positions, responsible for the management of the Health Services, include a senior manager, an operations manager and an Aboriginal Health Coordinator. Maari Ma has acquitted these funds each year and both Health Service and Regional Office staff are very positive about the role of the team. The Aboriginal Health Coordinator position has a wider role than service management and has operated

as a development position with a number of important leaders in Aboriginal health in NSW having occupied the position. However, as discussed later in the Report, there is a deficit in clinical governance within the Agreement. It would seem timely for the parties to review the deployment of these resources.

> **Recommendation 2: That Maari Ma review the application of funding for the management positions under the Agreement, considering the priority needs that need to be met by the Health Services Management Team.**

The Aboriginal Health Coordinator position could also play a useful role in the network of Cluster Aboriginal Health Coordinators being established across GWAHS. This would be a positive step in overcoming some of the relationship tension and mistrust referred to elsewhere in the Report.

> **Recommendation 3: That the Aboriginal Health Coordinator position in the Maari Ma Regional Office be a member of the Aboriginal Health network for GWAHS**.

Finally, as already stated, the Agreement was set up with clear goals, principally local Aboriginal Health Organisation engagement in health service management. However, there were not specific objectives or key performance indicators. There was a requirement, which was not met, that the parties develop a relationship between strategies and reporting under the Agreement to support FWAHS to meet its accountabilities to NSW Health. The Review Team's view is that, had this work been done, it would have picked up activity underway in any case.

However, the original Agreement is weaker and the follow-up work was not done that might have addressed this need. This in part reflected the time and in part that the two managers negotiating the Agreement were conscious that they were both negotiating on behalf of frail organisations at the time. Any new Agreement should be much more specific and reflect agreed health priorities and strategies.

> **Recommendation 4: That a new Agreement include explicit Key Performance Indicators related to key health reform objectives agreed between GWAHS and Maari Ma. If it is not possible to agree these prior to a new Agreement being negotiated, that a process,**

with timelines, be agreed to finalise these within six months of a new Agreement being signed.

- **Objective 2: Aboriginal employment and training**

The data analysed for Objective 2 showed progress in both the training and employment of Aboriginal health staff for both the Area and Maari Ma. There are, however, two issues that arose from the Review Team's discussions and analysis.

Professor David Lyle, Director of the Sydney University Department of Rural Health is, however, concerned that the funding for the Aboriginal Health Worker training program is not secure or adequate. This is an important issue for the partners in the Centre for Remote Health to resolve.

In addition to funding challenges to keep this training going, the model of Aboriginal Health Worker training has also faced a lack of acceptance in the rest of NSW. This relates to a wider disagreement about the role of Aboriginal Health Workers between the north and south of the country, in which NSW has not in general been sympathetic to the alignment of the far west with the greater clinical emphasis of the northern and western parts of the country. Recently, however, Professor Lyle reports that some health service providers from other parts of NSW are showing increased interest in the training developed as a direct result of the Agreement.

Recommendation 5: That partners in the Centre for Remote Health discuss funding needs for ongoing Aboriginal Health Worker Training in the Remote Cluster and seek secure funding for the sustainability of a continuing training program.

- **Objective 3: Access to services**

The Review Team postulated three conclusions from the analysis of data related to access to services. First, in general, service access has improved for most residents for the period of the Agreement. The exceptions to this are service delivery in Wilcannia, which appears to have been impacted by both the Coordinated Care Trial and a vacancy management strategy used as a budget control strategy, and an apparent decline in some RFDS services. Second, non-

Aboriginal residents have not been disadvantaged by Aboriginal management of the health services, a potentially sensitive issue at its outset.

Third, the difference between NAPOOS and NIRs in terms of health service practice may be important. It is commonly accepted that in small remote clinics serving sick populations it is important to maximise staff time spent outside the clinic. This time will most usefully be spent with pregnant women, infants and the chronically ill, undertaking prevention, early intervention and health management tasks. In these communities this will largely amount to health services to Aboriginal families.

In relation specifically to the apparent decline in RFDS service, the Review Team was conscious that this is workload data and the picture may be more complicated, needing to take account also of changing populations in specific communities. Initial comments from RFDS do point to some data issues, including the possible inclusion of specialist visits in early years, then counted out in later years; population effects, eg net outward migration from towns like Wilcannia; and decreasing occasions of service per clinic, possibly as a result of increasing treatment of co-morbidities. Nonetheless, there is an unexpected question raised by these data which is worth noting for further discussion between the service partners.

> **Recommendation 6: That the RFDS, GWAHS and Maari Ma meet in the near future to explore the apparent decline in RFDS clinic attendances and what it in fact means.**

Overall, the Review Team concluded that the Agreement has seen an expansion of access for both Aboriginal and non-Aboriginal people to primary health care and a range of specialist services. This is with the possible exception of the issues in Wilcannia and a question about what is happening with RFDS clinics. Finally the Review Team posed the question whether the mix of service is also changing, with some, likely positive substitution among service types and providers.

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Objective 4: Aboriginal community engagement

One of the constant challenges for any organisation running a health service is to maintain engagement with their constituency, whether conceived as patients, clients, families or community. The people of the far west are conscious that they do not receive equitable access to specialised health services, compared to the rest of NSW, but do rate as high quality those services about which they were asked (eg Emergency Services at Broken Hill Hospital.)[40] Maari Ma's inaugural Regional Director identified in 1999 (also highlighted by Claire Crombie-Browne in her 2003 Review of the Agreement) that maintaining a focus on community engagement is a constant challenge and needs greater focus for Maari Ma. Engaging community is hard of course for all health services. The standard held up for Aboriginal organisations is higher.

It was said a number of times to the Review Team by people outside the far west that Maari Ma is weak in its community engagement. Sometimes this statement appeared to be a coded (or not so coded) political critique of the Peak Health Council model itself, of an Aboriginal organisation deciding to take a different path and build a collaborative approach with the mainstream, rather than establishing standalone services. In the time on the ground that the Review Team was able to spend it was difficult to assess where are the exact contours of strength and weakness in Maari Ma's relationship to their community. However, a couple of comments are able to be made.

Political critique of Maari Ma's model is not relevant to this Review. The aim of the Agreement was simple and specific; to engage Aboriginal people in health service delivery, precisely because the old Far West Area identified that as a weakness of their own service. The Agreement sought to do this at a number of levels.

It has succeeded in putting strong Aboriginal perspectives, articulated by people who speak with confidence from local country and culture, into positions of power within the mainstream health system. That they increasingly speak from a professional, not a lay, perspective does not make their input any less Aboriginal (a point that still strangely seems to need to be made in Australia.) The increased number of Aboriginal staff in both the mainstream and Maari Ma is another part of this strategy and is also a success.

[40] NSW Population Health Survey 2004 Triennial Survey NSW Outback Division http://www.health.nsw.gov.au/public-health/survey/hsurvey.html last accessed 25 September 2006

Asked directly about some of the criticisms directed toward Maari Ma, Sam Jeffries, Chair of the Murdi Paaki Regional Assembly, was very clear about the question of Maari Ma's community engagement and credibility.

> "Don't be deceived. They have credibility in the communities. You have always have your knockers you know, but Maari Ma are 90% credible. They're not just an AMS. It's more than that. The difference between Maari Ma and an AMS is the Agreement with the Area to focus on mainstream Primary Health Care. Maybe that's what doesn't sit right with some of those other Aboriginal organisations. Out here we don't care about those others."

Nonetheless community engagement should be the focus of a communications plan, properly planned and executed, as previously advocated by both Johnstone and Croumbie-Browne.

> **Recommendation 7: That Maari Ma develop and implement a community education plan to inform its communities of engagement of its analysis of health needs, strategies and activities.**

While supporting this recommendation, the Review Team did not conclude that the Agreement has failed in its goal of more effectively giving voice to and engaging the Aboriginal community in health service management.

- **Objective 5: Health service development**

The Review Team's finding is that the Agreement partners are on the right track in terms of their health service reform strategy. A number of comments are, nonetheless, relevant.

These strategies, to date, have been largely add-on activities, undertaken with additional staff effort. The next stage of reform is to increase the extent to which, especially secondary prevention effort, becomes a part of the day to day work of the health Services managed under the Agreement. This is the essence of the NT strategy on which ABCD(E) is based and is the direction to which Maari Ma is now moving.

At a strategic level maternal and child health, mental health and alcohol and other drugs are all areas incorporated within the integrated Maari Ma Chronic Disease Strategy. This makes sense and is consistent with contemporary thought in preventing the scourge of chronic disease in Aboriginal communities. However, each are worthy of more concerted attention on their own terms, for both clinical and political reasons. The Review returns to this in the Issues Chapter.

Finally, an integrationist philosophy such as Maari Ma's requires integrated service delivery. However, clinical governance is not as strong as either service management or primary health care development in Maari Ma. Improving clinical governance of the services is not just worth doing to support a core function of the Health Service Managers (although it would be worth doing just for that reason.) Improving clinical governance of the services is essential to delivering an integrated strategy encompassing disease prevention, early detection and management. The Review also returns to this in the Issues Chapter.

- **Objective 6: Health outcomes**

In summary, there were positive signs in some of these results, and no indication of the Agreement failing to produce health outcomes. The test for this Objective was that the parties to the Agreement were at least achieving outcomes equivalent to other parts of NSW. The data able to be accessed in the time available in the initial review period in 2006 was not conclusive. The further analysis possible during 2007, with access to additional data and assistance from the Centre for Epidemiology and Research, adds to this conclusion although it is also not conclusive.

There was only one set of results based on outcomes from pregnancy-based health indicators that demonstrated significant results. For all but the non-Indigenous Maari Ma population, the populations have achieved improvements in the proportion that access antenatal care in the first half of pregnancy between the first and last periods, with the strongest apparent trend for the Indigenous Maari Ma population. The Review Team followed up the decline in access for the non-Indigenous Maari Ma population with a senior clinician in Broken Hill and was informed that this reflected instability in visiting obstetric services over the period. This disproportionately affected the non-Indigenous population as they preferred specialist obstetric clinic to the midwife clinic.

Although not statistically significant, given the lack of explanatory power in the data, the trends and differences evident in the proportion of premature and low birth weight babies in the Indigenous Maari Ma population were also encouraging. Against both measures a lower proportion of the Indigenous Maari Ma population experienced these outcomes than the Indigenous comparator population and the trend for prematurity appears also to be decreasing and to be lower at the last time period than the non-Indigenous populations. These results are not significant but are nonetheless very interesting and are encouraging.

From the mortality and hospitalisations data there was only one significant difference of great use, which was the marked improvement for both Indigenous and non-Indigenous Maari Ma populations of vaccine preventable admissions over the time period of the Agreement. This probably also explained the decrease in emergency infant admissions seen in the initial analysis.

Although not meeting the test of significance used, there also appears to be a positive trend for both Maari Ma and comparator Indigenous populations in acute ambulatory sensitive admissions. An apparent increase in chronic ambulatory sensitive hospitalisations in the Maari Ma Indigenous population also did not meet the test of significance used but was of interest and warrants further local investigation, in the context of the importance of the Maari Ma chronic disease strategy and in the context of establishing performance indicators for any future Agreement. It is important to stress that the Review Team did not draw any adverse conclusion from the apparent anomaly that, despite the local emphasis on chronic disease, the first improvements from enhanced primary health care would be in vaccine preventable and acute conditions. The challenge of chronic disease is precisely why the local strategy is important.

The more rigorous subsequent analysis undertaken during 2007 did not substantially change the conclusions of the first report. There are some encouraging signs on two fronts. First three key indicators in maternal and child health appear to be demonstrating important signs of improvement, one at the level of significance used. Second, there is a strong result in reducing vaccine preventable hospital admissions and some sign of an improvement in acute ambulatory preventable admissions. These results are consistent with strong investment in primary health care development and with primary health care services achieving improved accessibility and effectiveness.

Conclusion

In conclusion, the Agreement has clearly been a success against five of the levels explored.

- Management and accountability objectives have been met, although greater effort is needed in any new Agreement to the specification of KPIs.
- Aboriginal employment and training of Aboriginal Health Workers has been a success.
- Access to health services by both Aboriginal and non-Aboriginal residents has improved, although there are some questions about what has happened to service levels in Wilcannia and within the RFDS service.
- Aboriginal community engagement in health service delivery has improved, although there is a case for Maari Ma better to communicate its strategy and activities to its communities.
- Health service reform is progressing strongly in the right directions and has been for a long time, although this took some time to develop to its current degree of clarity and some challenges need to be confronted.

Health outcomes are hard to measure and the objective of showing at least comparable gains to other parts of NSW has been met. The analysis undertaken, including the effort it took, would lend support to the need for a strong emphasis on defining performance indicators for any future Agreement.

> **Recommendation 8: That evaluation of performance continue against the measures explored in this chapter be continued and further developed, in cooperation with the NSW Health Centre for Epidemiology and Research, including the measures from the midwives collection and mortality and hospital admissions data and, as longitudinal data become available, of health behaviours from the Health Survey.**

Observing now from a distance and over time, Smiley Johnstone summed up his evaluation with emotional force.

> "If either party walked away now that would be terrible. There would be no vehicle to create anything new in health. People would be terribly dispirited."

Key issues

A number of key issues arose during the Review. If a new Agreement is negotiated, these are issues the Review Team would urge upon the parties for consideration. Some of these are issues that need to be addressed regardless of the future of any Agreement between GWAHS and Maari Ma.

To give more depth and acknowledge the rich input the team was provided by the many people to whom it spoke, a summary of the responses provided during the consultation phase of the Review is at Appendix A.

1. The nature of the Agreement – management or governance?

As explained in the History section of this report, the Agreement between Maari Ma and the FWAHS was quite deliberate in its strategy and reflected both a strategy for creating interdependence and prioritising mainstream service improvement. It is not a wider partnership agreement, aimed at setting health priorities for the region and all health service organisations within it. Nor is it a vehicle for the Area Health Service or Maari Ma to play a role in Aboriginal governance in the Murdi Paaki.

A good part of the comment that has surrounded the Agreement over the years has been a criticism of Maari Ma by more orthodox Aboriginal Medical Services for its political stance on mainstream engagement, or even of forms of Aboriginal governance being developed in the Murdi Paaki, on a wider stage than health. In the Murdi Paaki region, a Regional Assembly has been established that is tasked to articulate community priorities and preferences, with service organisations (both mainstream and Aboriginal) being viewed as responsible to apply professional knowledge to achieve those goals. This is a governance model that also sits awkwardly with more traditional Aboriginal community control of core services as a political strategy. It was, however, embraced as a COAG trial site for NSW.

A number of senior bureaucrats to whom the Review Team spoke were confused about the co-existence of this Murdi Paaki structure with Maari Ma and the Agreement. This is to misunderstand the Aboriginal politics of the area. As explained by Des Jones, the Chair of Maari Ma,

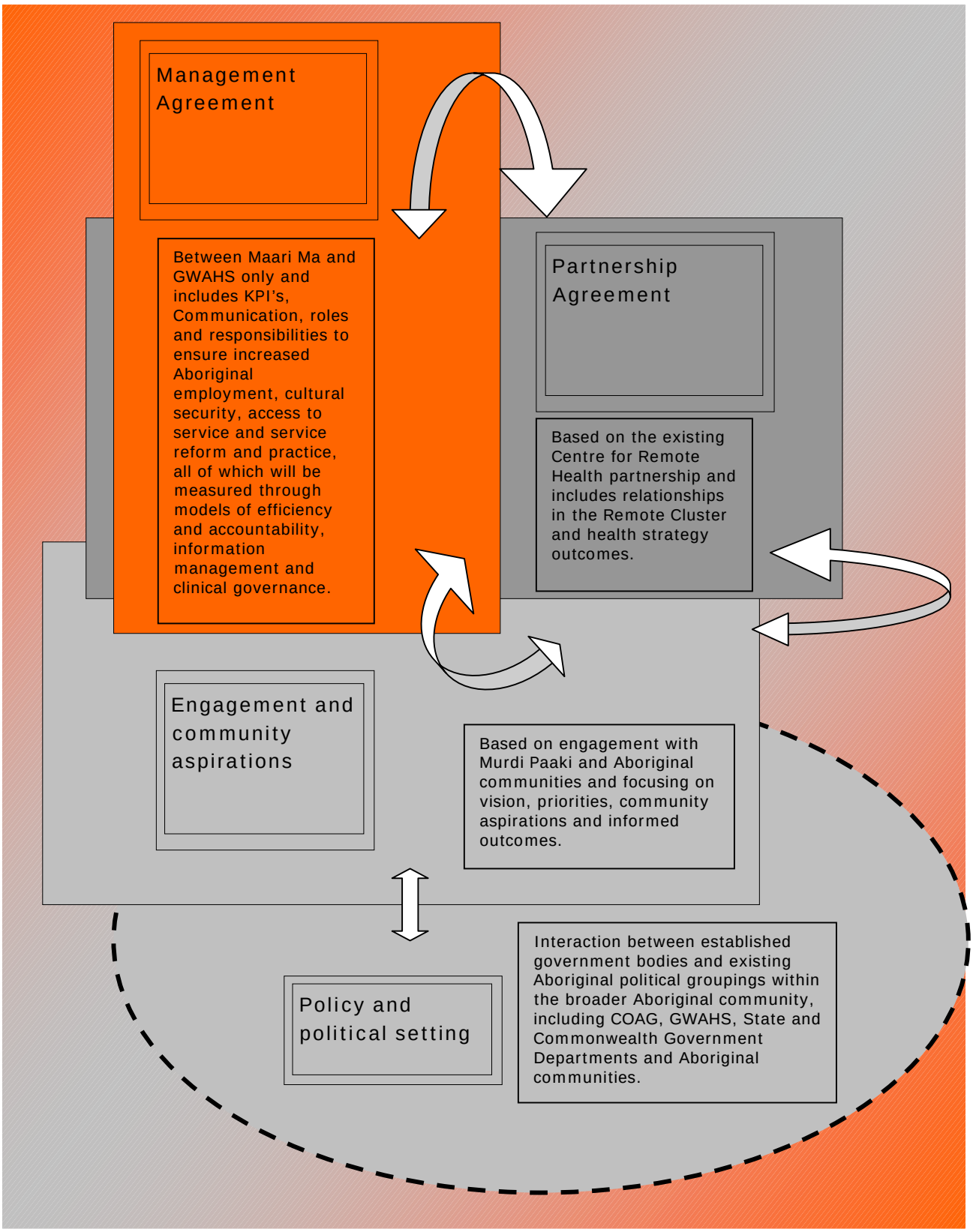
> "What we've done here (with the Murdi Paaki Regional Assembly) is resurrected Aboriginal governance, reified the Aboriginal way. The Assembly is not there to run things or to talk about the cheque book. Maari Ma is there to work with mainstream to deliver the best health service, for the people and to listen to their Assembly. I don't even let (the Peak Health) Council get into the chequebook either. We are there to set strategy. We don't just want to (limit ourselves to) be the best Aboriginal Health Service but (to be) the best health service in NSW."

The Review Team found it useful to separate into three overlapping spaces the relationships that are in play here.

- The Agreement is a management agreement, specific to the provision of a management service for eight health services in specific communities. It could do with more detail and clearer strategy and process in some regards, but it was not intended to be more than a management agreement.
- A second kind of agreement specific to health might be a partnership agreement focussed on setting health priorities and broader health strategies for the sector. Such an agreement would sensibly involve also the RFDS, the University Department of Rural Health and the local Division of General Practice. Such an agreement has a number of attractions, but is in fact very similar to the recent establishment of a virtual Centre for Remote Health, including exactly those parties, and for similar purposes.
- A third level to governance, that extends beyond health but to which health must relate, is the space for discussion by Aboriginal people of their aspirations for the people of the area. This is the purpose of the Murdi Paaki Regional Assembly, in which all parties, including governments through COAG, have invested.

A diagrammatic representation of these three levels might look like the following:

Figure 24: Model of Governance in the Murdi Paaki



The management focus of the Agreement is deceptive in its lack of ambition to take on a governance role. The management role does, however, give Maari Ma significant levers to gain greater influence for its reform objectives in service delivery, including a senior management input within the Area Health Service. This happened both through the presence of senior Maari Ma management inside the Far West Executive and through the direct relationship created between the Health Service Managers in communities and Maari Ma managers. As Margaret-Ann Cook put it,

> "The model (of service reform) has worked through a subtle mixture of influence and control. The Agreement has given (Maari Ma) Council practical leverage over service reform and our chronic disease program development a chance to impact on professional practice in the services."

For a range of reasons, our recommendation is that the parties negotiate a new Management Agreement. This will maintain momentum in the gains made through the Agreements to date, it will provide the greatest leverage for the implementation of service reform now underway and it will provide a good opportunity now to improve it as an agreement.

It is also important, however, that the parties give careful but separate consideration to the other two realms in which they must interact and make agreements. Both the Centre for Remote Health and the Murdi Paaki Regional Assembly provide great opportunities, if engaged with intelligently, to situate the strategies implemented through the Management Agreement to greatest effect.

In both of these other domains it is also important that the Commonwealth Health Department is engaged. It would seem sensible for the parties to the Centre for Remote Health to involve the Commonwealth, as the main funder of Maari Ma, as well as a party to the Murdi Paaki COAG trial. Direct policy negotiation between the Centre or Broken Hill staff of the Area with the Commonwealth has, however, already been rejected by the NSW Government, in response to the Sinclair Review, at the time of the creation of GWAHS. This is another reason for the Executive of GWAHS to be directly involved at this strategic level in the Murdi Paaki and with the Centre for Remote Health.

Recommendation 9: That GWAHS and Maari Ma negotiate a new Management Agreement for the provision of management services in the Health Services outside Broken Hill, in the Remote Cluster.

Recommendation 10: That the GWAHS Executive consider, under the new Area structure how to maintain Maari Ma's high level of input and engagement with Area direction and to strengthen the reform partnership that has been established within the domain of health service management in the Remote Cluster.

Recommendation 11: That the parties to the Agreement also discuss how to organise their wider engagement, both through the Centre for Remote Health, for a wider health specific partnership in the Cluster, and with Aboriginal governance, through their relationships to the Murdi Paaki Regional Assembly and the COAG trial.

2. Nature of primary health care strategy

One of the strengths to which all parties currently point is Maari Ma's leadership in health service reform in the services managed under the Agreement. As discussed this builds on several years of sustained engagement culminating in the Maari Ma Chronic Disease Strategy. The Chronic Disease Strategy is itself an integrated, comprehensive strategy not restricted to primary prevention of disease but to the management of disease through optimally organised clinical management.

This is consistent with best practice, as described at a strategic level in the National Chronic Disease Strategy and programmatically in the ABCD(E) protocols. It is also a move beyond a model of primary health care reform that conceives primary care reform and prevention as somehow distinct from primary clinical care.[41]

The Review Team, however, observed some tension within the parties to the Agreement on this point. Maari Ma Regional Office – led by Margaret-Ann Cook and Hugh Burke – have devised a strong service reform strategy and are rightly

[41] cf Griew R & Weeramanthri T, "Toward and integrationist model of public health" Paper for Nuffield Trust Australian health systems workshop, Canberra 2003

praised for their vision and leadership of this process. They tend to focus their efforts on the clinics in pursuit of this agenda, not the peripheral hospitals, and they are not as engaged in the day-to-day clinical management of the services.

This is a cause of tension for the Health Service Managers, in part because they feel exposed in their clinical governance responsibilities (covered next) and in part because they see an opportunity to pursue the prevention agenda more strongly through their acute clinical responsibilities. This is again one of those understandable tensions. Service reform is difficult and does require shifting emphasis away from where it naturally falls in busy services.

It is common for primary health care reformers to want to neglect the overwhelming day-to-day reality of running remote services. To some extent they need to. However, this is a limited strategy. For a start, credibility with client communities requires constant attention to acute care (reform agendas will lose purchase quickly in the face of a few bad outcomes.) Second, so much of good prevention practice is now understood to come from the proper organisation of clinical management of disease, as the Maari Ma Chronic Disease Strategy itself acknowledges.

An approach to service reform that was itself more integrationist between prevention and clinical agendas would not only overcome some of the tension present in the services, it would also make strategic sense, in terms of the chronic disease agenda itself.

3. Clinical governance support to the Health Service Managers

Related to creating a truly integrated primary health care reform agenda is increasing the level of attention given to clinical governance. Under the Agreement this is formally a responsibility of the Maari Ma management structure. In practice, however, this has always relied on accessing a matrix of clinical governance support, for Maari Ma managed services as for all others within the Area. This matrix included Directors of Medical and Nursing Services for the FWAHS, as well as evolving structures for clinical quality and review. With the new Area structure, similar structures are being put in place for a larger Area.

The problem for the Health Service Managers in the Remote Cluster, outside Broken Hill at least, is that everywhere they might turn for this support is in some

way distant from them. The GWAHS structure is more distant than the FWAHS structure was, and there are less locally accessible managers in place. Maari Ma's strength and focus to date has not been in this kind of support, in part because of the predominant conceptualisation of primary health care that is not clinical enough in its orientation. Some have had the experience of being caught between two reference points, specifically on clinical issues.

> "It's too complicated (managing clinical risk.) If I've got a clinical problem, it's always "operational" as far as GWAHS is concerned, so they don't have to talk to me. Tony and Steve (managers at Maari Ma) are more sympathetic but, if it is clinical, they don't have to talk to me either."

This has to be a priority issue, both to assure clinical standards and to secure the primary health reform agenda. The Review Team wish to make clear that it did not see any sign of poor clinical practice or of clinical exposure. Quite the contrary, the Team saw some excellent local nursing leadership. However modern health systems require more than that. They require systematised quality assurance, clinical review and clinical supervision. To address the issue is necessary. How it is addressed will determine a great deal more than just clinical safety in terms of the future success of a new Agreement. The Review Team is of the view that this is one of the most important decision points for the parties.

There is a range of options to address this clinical governance exposure, including the role being taken on more explicitly by GWAHS or Maari Ma or even, in those services where RFDS visits, the RFDS Chief Medical Officer. For this role to work, however, requires that the clinical leadership provided is consistent and not at odds with the primary health care reform agenda that has started to make health gains in the Remote Cluster. This is related to the imperative that Maari Ma adopt a more integrationist model of primary health care.

The Remote Cluster has an opportunity to push ahead with a chronic disease and primary health care reform agenda as good as the best in the country. This would be a direct outgrowth of the Agreement and a reason for substantial optimism about the future health of the people who are its intended beneficiaries. Probably the most important condition of further success is that there is a unity in the leadership of clinical services and standards, primary health care and reform agendas. This is one of the key lessons of the set of chronic disease agendas from which Maari Ma has developed its Chronic Disease Strategy.

For this reason, the Review Team would suggest that the best option would be for Maari Ma to strengthen its role in this area, and deliver against that aspect of its Agreement responsibilities more proactively. Maari Ma have the personnel to perform this role and arguably at least some of the budget, a point made earlier when management performance was reviewed in the previous Chapter. The organisation would have to agree to place an emphasis on doing so. Awareness of this need is already growing within senior ranks in Maari Ma, as key individuals consider the strengths and weaknesses of their relationship with Health Service Managers.

The Review Team also considered other options for delivering clinical governance support. Not only is the option of Mari Ma 'stepping up' to this challenge the best in terms of reinforcing the wider reform strategy. It is also not apparent to the Team that either GWAHS or RFDS, the other two options, could do this as well for this region. Each could contribute and GWAHS certainly has a role to play in the component of clinical governance that relates to management of critical incidents. However in the wider sense of clinical governance, encompassing the engagement of clinicians and clinical managers in clinical direction setting, reform, priority setting and implementation, Maari Ma is the best placed.

Recommendation 12: That Maari Ma develop a strategy for enhancing their clinical governance and support for Health Service Managers and in doing so adopt a more integrated approach to unifying clinical priorities within their model of primary health care reform.

4. Retrieving an information strategy

Information management has been a serious investment in the Health Services covered by the Agreement. During the Coordinated Care Trial at Wilcannia, the Commonwealth invested substantial amounts of funding in the purchase and set up of FERRET, a primary health care management system that promised great power in supporting good primary care practice. The aim was that this would support a move to information driven, proactive health care, consistent with the chronic disease management emphasis of the Coordinated Care Trials.

A number of problems are reported to have evolved. The RFDS doctors who

service the Health Services in the northern part of the sector use a different system, Medical Director, and say it is better for them in terms of supporting the functions of general practice, eg writing scripts. Weathering some tension with Maari Ma, the doctors refused to move to FERRET, and thus two parallel databases came to exist side by side.

A number of attempts have been made to have Medical Director and FERRET interrelate and share data, so as to support both general medical practice (as determined by the RFDS GPs) and primary health care (as preferred by Maari Ma.) There has been no success in the Lower Western Sector in this endeavour and all involved report that the only consequence of these attempts has been to cause Medical Director to crash. The Health Services under the Agreement have now been directed by Maari Ma only to use FERRET as a recall tool. Maari Ma managers regret this but can see no alternative.

One RFDS GP who now works at the Maari Ma Aboriginal Medical Service in town noted that the AMS Director has now deployed a staff member to manually update databases and to prepare the kind of lists for the GP to guide her practice. She appreciates this and the better practice it leads to but this is of course what FERRET is in fact designed to do. The Director of the AMS noted that, although she can see no alternative from a service effectiveness point of view, the cost in staff time this duplication of systems involves has a material impact on her service.

Everyone agrees with the obvious conclusion that progress is necessary here. If the vision of integrated primary care, with a balanced emphasis on both primary and secondary prevention, is to be pursued as the goal of a future Agreement, then information management is another key supporting strategy. There are a variety of options. The consulting team notes that we are not technically qualified to comment on individual information systems and are making no conclusion about individual products named in this analysis, only that a common strategy is needed, involving all parties.

One possibility that emerged during the consultation phase of the Review is that the Director of Population Health for GWAHS, Trish Strachan, reported being aware that another part of the GWAHS area has attempted to create functional interoperability between Medical Director and FERRET. If this has been achieved it is obviously the most direct path to an information based primary care strategy.

It would also, of course, be a great example of the size and breadth of GWAHS being an asset to the old Far West, in a key success area that has, for nearly ten years eluded a series of people there.

Recommendation 13: That GWAHS, Maari Ma and RFDS collaborate in an urgent evaluation of the options to provide a unified information system platform to support integrated service delivery.

5. Responding to other health priorities

As noted in the Evaluation Chapter, Maari Ma's Chronic Disease Strategy provides a contemporary framework for primary health care development that integrates a number of health priorities related to the prevention and management of chronic disease. Maari Ma has also a track record in addressing many of these issues, including maternal and child health and mental health to cite two examples. From a primary health care point of view, this is the correct approach and the Review Team endorses it.

One of the constant challenges for progressive health care services in remote areas is the question, "On how many fronts can we make progress at once?" The wise counsel implicit in this question is obvious. Just because a problem is real does not mean it will be possible or productive to take on more strategies, if considerable thought does not first go into how to sustain them. Much of what can be done in these specific areas is most usefully done through primary health care services anyway. [42]

Nonetheless the epidemiology supports popular perception that a number of these specific health issues require separate attention. Government policy and funding priorities will also drive attention to specialist service development in some of these areas as well. The four examples brought up with the Review Team during the consultation phase were mental health, alcohol and other drugs, sexual health and disability services. There are some common features about these areas.

- Each is supported by data, although not necessarily in the way popularly expressed. For example, a number of community members raised the

[42] Griew R, Flick B and Deutschman P, with van der Sterren A, Review of Nganampa Health Council, Primary Health Service to the Anangu Pitjatjantjara Homelands, 1999

need for mental health interventions targeting young people, with a specific reference to marijuana induced psychosis. Data provided from GWAHS mental health and drug and alcohol staff, however, pointed to Depression and Alcohol misuse as the main issues, by a large margin, with high Aboriginal morbidity evident.

- In relation to each, primary health care services have a key role to play, and, with Maari Ma involved, each also stands to gain from Aboriginal community leadership. However, in each case also, there are vertical program structures in place across the State that are strong and with which specific arrangements will need to be negotiated if local health services are to play a useful and sustainable role. In the case of disability and ageing service needs, under the NSW Government structure, another Department of state is involved. Recent increases of funding to mental health have been quarantined to specialised mental health programs. In both cases in remote areas, however, primary health care provides the only practical structure through which meaningful activity can be delivered. For example, improving disability support in these communities would, as a starting point, involve improving allied health coverage through the health services.

- All of these health priorities also relate to the delivery of the core chronic disease reform and improving maternal and child health outcomes. For example, people with mental illnesses are at significantly elevated risk from physical chronic disease, as well as often suffering their mental illness on a chronic basis. Sexually transmitted infections are one of the risks to healthy pregnancies that a comprehensive maternal and child health strategy must address.

- All four were also mentioned in early planning documents for Maari Ma, as priorities to be addressed over time. All have received attention, for example in Maari Ma employee, Ms Kate Gooden's, community development work at Wilcannia and in her team's subsequent social health work within the Maari Ma Regional Office.

There are no easy answers as to how to respond to community desires in these and other emerging health needs. In part the answer is for Maari Ma to market more effectively the breadth of its Chronic Disease Strategy, in collaboration with

GWAHS program and population health staff. There is also, however, a case for some concerted program development planning under a new Agreement to establish a basis on which communities served by Agreement managed services can benefit from wider program initiatives in these areas.

These discussions need to agree a method by which Maari Ma's Regional Office capacity and community development skills can be used to complement mainstream program activity and what role the services Maari Ma manages will play. Involving Remote Cluster Population Health staff may also help to clarify their role in health planning and priority setting within the Cluster.

Recommendation 14: That GWAHS and Maari Ma develop a common strategy for how to address demand for specific action in mental health, alcohol and other drug issues, disability service provision and sexual health, based on the integration of primary health care strategy with other vertical program structures

Recommendation 15: That a priority be placed on further development of maternal and infant health across the sector, building on the AMIHS, and that this emphasis also draw on lessons from the NSW Families First program to build more effective integration of health and other support services for pregnant women and infants.

6. Local management

We have already noted that there may be some room for Maari Ma to review how it deploys the resources it receives for its management function under the Agreement, especially in light of the need better to respond to its responsibilities in clinical governance and support. There are also, however, some other priorities in local management that have become unclear and need to be negotiated afresh in a new Agreement.

- The point of engagement between GWAHS and Maari Ma needs to be identified. Two needs must be managed, that drive slightly different imperatives. Maari Ma need to engage at CEO level with GWAHS, and vice versa, as part of understanding each other's motives, the degree of

commonality and moving beyond some of the relationship and communication problems currently undermining progress.

- Maari Ma also need a local point of engagement for both day-to-day matters and strategic issues alike, and that manager (the General Manager of the Remote Cluster) needs to operate with the day-to-day authority of the CEO. The combination of engagement with the GWAHS CEO and delegation to the GM Remote Cluster can give all parties the best of both worlds. Maari Ma and the Agreement can both reflect and deliver against Area wide objectives, while setting the pace as to how this can be achieved in the most remote parts of the State.

- Usage and availability of bureau services to Maari Ma has declined over the course of the Agreement. Maari Ma has become more independent and has developed core corporate management capacity it did not always possess. There is now, however, a lack of clarity about what is being provided and what the charging arrangements will be, in either direction, when staff are placed in either organisation. This can be easily sorted out but requires an open discussion and a transparent arrangement for the future.

Recommendation 16: That the GWAHS and Maari Ma senior management meet and agree directions and arrangements within which a new Agreement will be settled and implemented, with clear lines of authority and delegation within their organisations and an agreed default of issues for resolution to themselves for a transition period.

Recommendation 17: That GWAHS and Maari Ma renegotiate arrangements and costing for bureau services provided to Maari Ma under a new Agreement.

7. Accountabilities in a next Agreement

As noted, there is a lack of specific KPIs in the Agreement, in the 3 Year Plan attached to its 2001 version or in reporting settled subsequently. This is a mutual failure, as the Agreement did specify that the parties would settle performance reporting that responded to the accountabilities of the Area Health CEO to the

Director-General of NSW Health.

In her 2003 Review of the Agreement, Claire Croumbie-Browne recommended the development of two performance indicators – one focussing on Aboriginal access to health services and one relating to Aboriginal employment in health services. These are, in fact, sensible, reasonably robust and achievable measures. The Chapter we have provided on performance evaluation exemplifies how difficult it is to assess outcomes in health services generally and in small population areas in particular. The attention paid by the Far West Ward Aboriginal Health Service in its early days to Ian Anderson and Maggie Brady's seminal work on the dangers of superficial outcomes based reporting will also echo if discussion here is not sophisticated.

All of that said, NSW is a jurisdiction which has invested more than most in attempting to empiricise the discussion about both performance and resource allocation. And, as greater clarity has been achieved about priorities in service reform impetus in the Lower Western Sector, this needs to be reflected explicitly in the Agreement and in Key Performance Indicators under it. These need to relate to the GWAHS CEO's performance obligations to the Director-General of NSW Health. They need to focus attention on both the progress and results of key reform strategies. For example, the work currently underway within Maari Ma on the adaptation of the Northern Territory ABCD framework for chronic disease management and prevention will provide specific sentinel indicators on progress. Recommendation 4 is relevant to this issue.

> **Recommendation 4: That a new Agreement include explicit Key Performance Indicators related to key health reform objectives agreed between GWAHS and Maari Ma. If it is not possible to agree these prior to a new Agreement being negotiated, that a process, with timelines be agreed to finalise these within six months of a new Agreement being signed.**

8. Workforce issues

As noted earlier also, the Agreement has been successful in improving Aboriginal participation in both the Maari Ma and FWAHS/GWAHS workforce. It also stimulated the development of (for NSW) innovative training of Aboriginal Health Workers with clinical skills. We have already recommended that stable funding be

pursued through the University Department of Rural Health.

The workforce needs of the area go further than this however. Workforce is always the sleeping issue in remote health. In common with other remote areas, services in the Remote Cluster face both significant threats and opportunities. In a State that is already the best payer for nurses, we saw little clarity about the specific strategy for attracting and retaining remote nursing staff. There was some discussion we witnessed about Nurse Practitioner roles but this is not, in the experience of the Review Team, sufficient either to retain significant numbers of remote nurses, nor pragmatic in its recognition of the reality of everyday remote nursing.

The medical workforce is dependent on RFDS in several communities. Allied health specialties are lacking, as in all remote areas, and much of the reform agenda in fact depends on good allied health support. NSW is not the strongest jurisdiction in embracing general medicine, paediatrics and surgery as specialist disciplines. Especially the first two will also be important in the tertiary sector's support of good primary health care practice in chronic disease and maternal and child health.

Team based structures for primary health care are much talked about and not hard to theorise. They are, however, very hard to do. The good news is that industrial and professional barriers to innovation are lower in the bush than elsewhere. As noted, there is also some evidence of progress under the Agreement of a useful redistribution of primary health care roles among staff, as staff numbers have grown.

In all of these workforce challenges it is imperative that GWAHS, Maari Ma and other partners note their commitment to concerted effort in workforce development under a new Agreement and establish working processes that are driven by the best and most creative people available over the next, critical couple of years.

> **Recommendation 18: That the new Agreement include a commitment to concerted, collaborative work to broaden joint strategy to develop the workforce for the Remote Cluster.**

9. Relationships

It is now two years since the restructure of Area Health Services and there are a number of factors counting against the Maari Ma / Far West Agreement sitting easily within the new Area structure. GWAHS includes peripheral communities in the least populated part of the State as part of an Area that now covers two thirds of the State. There is a fine line from “innovative” to “odd,” when trying to incorporate idiosyncratic arrangements in one of six regions within such a diverse Area. This is especially the case when an arrangement which may be politically appropriate for the far west is stubbornly at odds with Aboriginal health political and institutional structures in the rest of the State.

The process of Area restructuring had been hard on all involved. The new CEO of the Greater West was also the Administrator whose job it was to rationalise the old Area structures, in an avowedly ‘union’ town. Tiers of management are still being systematically spilled and filled and an inevitable cost in pursuit of the economies of amalgamation is the loss of some of the idiosyncrasy that locals valued under the old arrangement. Even without any misbehaviour (and human nature will always produce some of that) the immediate history of the creation of GWAHS has inevitably created tension and some mistrust on all sides. As it is, there is considerable miscommunication and paranoia about motives and modus operandi on the part of people in both Broken Hill and Dubbo, respectively about each other. As one senior person put it, in describing half of this dynamic,

> “Claire (Blizard, GWAHS CEO) takes too much heat for the way the restructure has been done. She has had to be tough but is motivated by the same things we all are …”

Maari Ma and old FWAHS staff are very connected to their tight community and it is difficult for leaders to make constructive moves to engage with the new GWAHS leadership. On the other hand GWAHS executives are mistaking the subtleties of difference in the position of different Far West people and may be allowing their annoyance at the stubbornness of Broken Hill politics to blind them to opportunities to form relationships that will build their future engagement in the area. The move of key displaced Far West staff to Maari Ma has been good and bad. It has continued to hold very talented people in the area (essential to maintain much of the good work that is happening) but it has also allowed Dubbo

managers to confuse Maari Ma with old Far West employees, not in the interest of either GWAHS or Maari Ma.

The Review Team spoke in depth and honestly to key players on every side and part of this dynamic. People allowed the Team to push them toward reconciliation and we were genuinely impressed with the consonance of values, the commitment to doing better and the readiness of key players to move beyond the current state of miscommunication and mistrust. Regardless of the outcome of this Review process and any future Agreement, this is obviously a key to future progress for Aboriginal people in the Far West. Recommendations 11 and 15 are relevant to this issue.

Recommendation 11: That the parties to the Agreement also discuss how to organise their wider engagement, both through the Centre for Remote Health, for a wider health specific partnership in the Cluster, and with Aboriginal governance, through their relationships to the Murdi Paaki Regional Assembly and the COAG trial.

Recommendation 16: That the GWAHS and Maari Ma senior management meet and agree directions and arrangements within which a new Agreement will be settled and implemented, with clear lines of authority and delegation within their organisations and an agreed default of issues for resolution to themselves for a transition period.

Appendix A - Stakeholder consultation outcomes

The purpose of this section is to outline the stakeholder consultation process and outcomes.

This section is based on meeting notes and observations by consultants taken during stakeholder interviews, workshop sessions, meetings with various organisations and their representatives, and discussions with key stakeholders.

This section does not make any recommendations, not does it provide for detailed analysis. Its purpose is to report on the responses from community members, staff, key personnel in organisations and other stakeholders received during the consultation process.

It must be said that the responses received during the stakeholder consultation were very informative and insightful and they have greatly influenced the findings of the report and its recommendations.

Stakeholders across the board gave us permission to question and challenge them. This helped us enormously and our recommendations would not look the same without the effort and input of stakeholders.

Overview of the Stakeholder Consultation

The purpose of the stakeholder consultation was twofold. With Aboriginal individuals, families and community it was:

- To gauge individual, family and community awareness and perception of the effectiveness of the Agreement in facilitating Aboriginal people's engagement with health services and mainstream structures; and
- To assess community experience of opportunities for Aboriginal employment and leadership in health.

Secondly, in relation to the original and changed structural arrangements that provide a context for the MoA, the purpose of the consultation phase was:

- To assess the effectiveness and efficiency of the partnership arrangements it supports, from both parties directly involved;

- To assess the efficacy of service delivery in terms of health system objectives and evolving population health measures;
- To describe the perception of the arrangements by other health sector stakeholders, both those operating in the Lower Western Sector and in Dubbo, Sydney and Canberra;
- To describe perceptions of the arrangements by all parties, of issues that need to be addressed, of alternative options and of barriers to any desirable reform.

The Review Team worked closely with the Project Steering Committee to define the methodology and implementation plan for the stakeholder consultation, including defining the parameters for information to be gathered.

An agreed understanding about which stakeholders needed to be interviewed was determined by the Steering Committee prior to consultation and by key players in Maari Ma and the GWAHS during the consultation period.

An intensive stakeholder consultation period was conducted from Friday 18th August until Wednesday night of the 23rd August 2006 (actual period was 17 – 24 August which incorporates time for travel). The stakeholder consultation was conducted primarily in Broken Hill, with constructive visits also to Menindee and Dubbo. Robert Griew facilitated the initial consultation period until he was joined by Professor Shane Houston for the remainder of the stakeholder consultation. The facilitators worked very hard to ensure they had in-depth interviews with all targeted stakeholders in the region. They also participated in numerous formal and informal 'discussions' with additional stakeholders and commentator on the Review.

The Review Team constructed the consultation around stakeholder's workplaces and conducted it in such a way as to fit in with daily schedules and constraints. The Team made every effort to meet every stakeholder on their home territory, and when it could not, endeavoured to meet them after hours, or to talk to them on the telephone.

The team ensured that it was not tied to any pre-determined beliefs or dominant interest groups throughout the consultation period. Having two facilitators meant that we could check understandings, challenge beliefs, and cross check issues daily. The Review Team understand where the pressure spots are, and where

certain interests may lie, but feel that in this report it has presented a balanced view of the issues and possible future scenarios.

The Review Team believes consultation is a means not only for receiving information, but for providing it as well. As such, the consultation enhanced stakeholder's understanding of the workplace, the organisation, the Agreement, and the area, and particularly the issues at stake. The Team was able to challenge stakeholders and in doing so felt that all stakeholders were carefully thinking through the issues and offering considered and somewhat innovative responses. Stakeholder's input was therefore invaluable.

The stakeholder consultation included:

- A two hour workshop with Health Service Managers
- Interviews with targeted health sector stakeholders
- One-on-one interviews with staff members from key stakeholder groups
- Small group sessions within workplaces
- Individual informal discussions with various players throughout the consultation period
- A community visit to Menindee for individual, family and community organisation consultation
- Phone interviews with Government Department Heads unable to physically meet for an interview

The stakeholder consultation provided:

- Confirmation and/or clarification of the key issues identified through the desktop research
- Additional identification of key issues
- An understanding of the context of the Review 'on the ground' and through a policy and government setting
- An insight into the stakeholders to the Review, and how they have interpreted the Agreement into their daily service delivery or policy setting
- An understanding of attitudes to the Agreement, and a clear picture of the lines of relationship to the existing Agreement
- An interpretation of the Agreement within an historical, current and possible future context

- Initial and preliminary testing of a possible new model for understanding shared participation in governance of the Area, including a conceptual framework for a new Management Agreement, and clearer definitions of stakeholders and their relationships and lines of responsibility in such a model

Key issues

A Steering Committee meeting was held with the Review Team on 7th August 2006 to clarify client aims and priorities, affirm the objectives of the review, reconsider the project timeline to incorporate the delay in start-up and to organise dates for stakeholder meetings.

These headings reflect the primary understandings desired by the Steering Committee as a result of the consultation, that is:

Steering Committee members framed key questions for consultants to respond to within the context of the Review, including but not limited to:

- What would constitute agreement about the Agreement? What exactly was the Agreement trying to achieve? How is it understood now?
- Has this model of management of mainstream health services by an Aboriginal community organisation worked in practise, how has it worked and has it influenced the actual performance of health services on the ground?
- Does it add value to the system here for Aboriginal people? Is the model the right way to go in terms of Aboriginal representative and community structures in the region? What have been the outcomes for non-Aboriginal population?
- What additional relationships need to be forged? What other values need work?
- If there is to be a new Agreement, how can the original agreement be updated from a purely management framework to reflect changed landscape? What other changes would be suggested?

The key issues identified during the consultation process have been grouped under four headings to reflect the Steering Committee's framing for the consultation:

- Achievement of goals in the Agreement
- Level of awareness
- Health service issues
- Nuts and bolts

A summary of the key issues is included in the following table.

This section does not attribute comments to actual people, except in particular cases where a quote has been provided. Organisations have been named only when it services understanding of the context.

Issue	Feedback
ACHIEVEMENT OF GOALS IN THE AGREEMENT	At high level, most agreed the Agreement addressed fairly well Aboriginal health and access/equity needs, at the same time as settling political/regional aspirations and understandings.
Outcomes	Lack of clarity about what the outcomes are in the Agreement. Suggestion that a new Agreement be outcome driven with a continued focus on accessibility, appropriate Primary Health Care, and evidenced-based best practice in chronic disease.
	Some suggest the Agreement has a lack of priority setting and self-critical reflection.
	A number felt that clarity about the intent of the Agreement has been eroded, leadership and process is confused, and the outcomes are unclear, causing a deal of frustration.
Aboriginal employment and training	Concern expressed about a lack of Aboriginal employees at the Hospitals, other than in Wilcannia, and a lack of Aboriginal employees working in aged care.
	In terms of further cementing relations with partners, some suggested that there should be Aboriginal identified positions at RFDS and UDRH.
	Most were very proud of the numbers of Aboriginal Health Workers trained since the Agreement was signed, however the Aboriginal Health Worker trainees needed further clinical, counselling and health promotion training.
	UDRH is concerned about security of training funding.
Business Plans	Concern that although Business Plans are a part of the Agreement, they are in practice not consciously linked to it, partly because service planning objectives are not spelt out in the Agreement.
Shared information systems	Lack of clarity amongst stakeholders about how to relate Medical Director and FERRET; and concern about the return to the 'paper trail' which means double data entry and therefore increased costs for administration/other staff.

Issue	Feedback
LEVEL OF AWARENESS	
Community Awareness	Strong positive comments from community leaders that the Agreement brought recognition across the community.
	Community members, however, are less likely to know about the Agreement or the role of the GWAHS and Maari Ma. Importantly, however, government officials had most to say in critique of Maari Ma's community engagement, also exhibiting own confusion about Maari Ma's relationship to Murdi Paaki Assembly.
	People identify, however, that the establishment of Maari Ma's Regional Team and the introduction of Health Checks have proved to be good vehicles for raising both staff and community awareness about the Agreement and Maari Ma's role.
	Visibility to hospital staff and management less than other health services. Support for the peripheral hospitals not as strong as clinics.
	Maari Ma felt by clinic staff in Tibooburra to be less well understood because of lower identified Aboriginal population. One question about Tibooburra be shed from the Agreement, while others suggested that if Maari Ma does not have a presence in the north there will be less chance of attracting nurses to those communities.
Perception of partners	Agreement has improved capacity to 'showcase' Far West and attract support to all partners, including RFDS and UDRH.
	Support from local partners for an integrationist model, as opposed to a standalone service model.
	Interesting lack of tolerance of Maari Ma acting like 'other AMSs' – eg writing annoyed letters when frustrated. Raised the question of whether Maari Ma is itself supported rather conditionally by others?
Staff Awareness	Generally agreed that current Agreement is not well understood by GWAHS staff, with the passage of time, ie before restructure as well as after it. Question about depth of Maari Ma staff understanding.
	Nonetheless support for programs including Maari Ma's Health Checks and the new Regional Team in helping clinic staff understand they were part of a team. Maari Ma's chronic disease focus is seen by some as the

Issue	Feedback
	most successful vehicle for bring Health Service Managers into the team.
	Keen awareness by some Health Service Managers that without the Agreement they would have less staff to do the new chronic disease work, which they have come to support.
HEALTH SERVICE ISSUES	
Professional relationships	Medical staff in RFDS want to work more effectively with Maari Ma around issues like chronic disease. Feel that Maari Ma program staff could respect their knowledge and skills better and sometimes blame them for problems they themselves predicted.
	Concern that there needs to be more understanding amongst nursing staff on the role and responsibilities of Maari Ma under the Agreement. Some sense of nursing issues also not being central enough to Maari Ma management, given the importance of the nursing workforce to Maari Ma's role under the Agreement.
Primary Health Care	Very good support for the Primary Health Care agenda in the Agreement. Seen as one of the strong features of the Agreement. Maari Ma identified by most not only as being the best at Primary Health Care, but as being the most obvious body to drive a Primary Health Care model in the region.
	Concern over lack of integration between acute care and primary health care within services, or at least a tension between the acute care role of HSMs and Maari Ma primary care agenda. Frustration by some HSMs that more is not made of opportunities within Acute care work for that agenda.
	Concern that there is a new challenge of new cases/needs being identified through screening, 'secondary wave' concern named by GWAHS and Maari Ma managers.
Clinical governance	Concern that clinical governance processes have not been spelt out, or rather that the matrix of support it is assumed HSMs have is not accessible.
	Partnership Agreement with the Centre for Remote Health suggested as being part of the solution to the issue of clinical governance.

Issue	Feedback
	Other solutions suggested included Maari Ma 'stepping up' to its responsibilities in clinical governance, GWAHS offering enhanced support, or RFDS CMO/GPs playing a role.
Population health planning	Need to develop clinical pathways and strategies around (eg prevention and substance abuse.) It was suggested that Population Health, Planning & Performance could help facilitate and create the intersection at the clinic level of all the vertical programs.
	Suggestion that one model would be to locate all population health activity at Maari Ma for Remote Cluster, with GWAHS taking back clinical service management.
Sexual health programs	Concern by one manager that Maari Ma did not place enough importance on such a program.
Mental Health program	GWAHS mental health managers keen to engage Maari Ma in prevention and primary care agenda but not clear how to do that.
	Concern that mainstream Mental Health programs have no engagement with Aboriginal culture and therefore less service efficiency.
	Criticism of Adult health check that it led to people with identified mental health problems receiving medication and clinic staff monitoring their compliance. "Not our way to take those drugs." (Review Team saw this as a positive in fact.)
	Highlighted need for wider range of adolescent services, ie outside Health.
Other priority areas	Alcohol and other drugs identified as high priority community issue
	Also access to disability and aged care support
Health service relationships	Stronger operational coordination, clinical communication and service delivery on the ground required amongst partners.
	Concern that public health has dissipated in part due to change in Area structure whereby UDRH and others identified as 'outposts' rather than the 'centre' they have always been.

Issue	Feedback
	Concern that GPs and Aboriginal Health Workers need to work together more. Instances cited by Aboriginal Health Workers of not being treated as professionals by GPs, interestingly more than by nurses.
	High levels of concern about how the recent management reform of the Area service coupled with a new Agreement will articulate in terms of how organisations will work together. Expressed as concern that there will not be an adequate level of local delegation within GWAHS for operational requirements.
	Concern that some GP's refuse to do care plan work.

Appendix B – Stakeholders consulted

Stakeholder	Position	Organisation
Heather Gray	Ex CEO	FWAHS
Bill O'Neil	Ex Chair	FWAHS
Michelle Pitt	Director for Nursing and Midwifery Services	GWAHS
Justin Ragenovich	General Manager, Remote Cluster	GWAHS
Cathy Dyer	Population Health, Planning & Performance	GWAHS
Bill Balding	Public Health	GWAHS
Dr Russell Roberts	Director Mental Health	GWAHS
Jenny Coutts	Director Clinical Operations	GWAHS
Linda Williams	Manager, Aboriginal Health	GWAHS
Di Johnson	Maternal and Child Health Coordinator	GWAHS Remote Cluster
Tuana Sanders	A/ Manager for Mental Health and Drugs and Alcohol, Remote & Mitchell Clusters	GWAHS
Peter Miranda	Finance Manager, Remote Cluster	GWAHS
Dr Hugh Burke	Public Health Physician	Maari Ma
Richard Weston	Regional Director	Maari Ma
Justin Files	Social and Emotional Well-Being Coordinator	Maari Ma
Donna Kennedy	Youth Worker	Maari Ma
Nola Whyman	Primary Health Care Manager, Broken Hill	Maari Ma
Chris Eastwood	Director of Finance	Maari Ma
Glenis Barnes	HR Manager	Maari Ma
Steve de Bono	Senior Manager LWS Maari Ma	Maari Ma
Des Jones	Board Chairman	Maari Ma
Cheryl Blore	Menindee member of the Maari Ma Board	Maari Ma

Stakeholder	Position	Organisation
Beth Harrison	Health Service Manager, Balranald Hospital	GWAHS
Trish Algate	Manager, Primary Health Care – South, Dareton	GWAHS
Mary-Anne Flynn	Health Service Manager, Ivanhoe Health Service	GWAHS
Marie Kelly	Health Service Manager, Menindee Health Service	GWAHS
Margot Pollard	Health Service Manager, Tibooburra Health Service	GWAHS
Judy Lamb	Health Service Manager, Wentworth District Hospital and Health Service	GWAHS
Jenny Wressell	Health Service Manager, Wilcannia Health Service	GWAHS
Sophie Covert	Team Leader, Mental Health and Counselling, Dareton	GWAHS
Bernie Kemp	Annual Health Check Worker, Annual Health Check Team	Maari Ma
Margaret-Ann Cook	Manager Primary Health Care, LWS North Team	Maari Ma
Sam Jeffries	Chair	Murdi Paaki Regional Assembly
Leasa Keily	Director	Nyampa Housing Company, Menindee
Clyde Thompson	Executive Director South Eastern Section	RFDS
John Price	Chief Medical Officer	RFDS, Broken Hill
Anne Wakatama	GP	RFDS, AMS Broken Hill
Professor David Lyle	Head, University Department of Rural Health, University of Sydney, Broken Hill	UDRH
Trish Strachan	Director, Population Health, Planning and Performance	GWAHS
Dr Claire Blizard	Chief Executive	GWAHS
John White	Director, Corporate Services	GWAHS
Robyn Kruk	Director-General	NSW Health
Smiley Johnstone	Executive Director	NSW Land Council
Dr Denise Robinson	Chief Health Officer, Deputy Director-General	NSW Health
Vicki Murphy	NSW Manager	DoHA
Greg Rochford	CEO, NSW Ambulance Service, ex CEO, FWAHS	NSW Health

Appendix C – Methods for subsequent evaluation of Objective 6: Health outcomes

The approach taken for the subsequent analysis in 2007 aimed to address the limitations in the 2006 analysis by accessing:

- more complete data;
- more precise data for the Maari Ma Agreement area, for both Indigenous and non-indigenous populations;
- comparator areas that allow for realistic comparison, for both Indigenous and non-indigenous populations; and
- measures to determine if results obtained are significant.

This was achieved by accessing NSW Health's data holdings (HOIST – Health Outcomes Indicator Statistical Toolbox which is a data access, analysis and reporting facility established and operated by the Centre for Epidemiology and Research, Public Health Division, NSW Health Department). Even with these advantages, however, the small population numbers in the area served by the Agreement and the several structural changes during the course of the ten years in question were always identified as a risk to robust conclusions being drawn. This second analysis proceeded through the following stages.

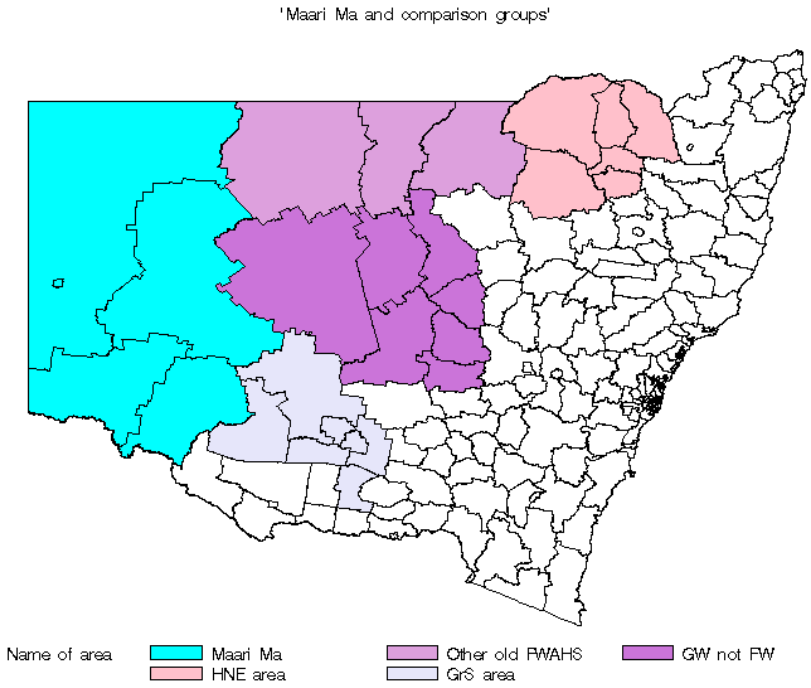
First a number of possible indicators were identified, to ensure that the analysis was not biased toward indicators that might show positive results. Three kinds of indicators were identified. These included health behaviours from the periodic NSW Health Surveys, indicators of antenatal care outcomes from the NSW midwive's data collections and mortality and hospital separations data that would be indicative of effective primary health care.

An initial examination of Health Survey data revealed two limitations with these data. First the only comparisons possible through these data that might shed light on the geographic area in question would be between Divisions of General Practice, and these provided only an inexact match to the area covered by the Agreement. Second, for the Divisions, no time series were available, with data from 2004 being the only time available. Therefore, an analysis of these indicators was not pursued.

The rest of the analysis, therefore, focussed on the midwives data collection and mortality and separations data. These data are held in the Department's HOIST data

warehouse. This analysis was to identify a comparative geographic area for the area covered by the Agreement (for consistency). The best match to the area covered by the Agreement was achieved by compiling the Local Government Areas (LGAs) that comprise the Agreement area. These include the LGAs of Broken Hill, Central Darling, Balranald, Wentworth and the Unincorporated Far West. The characteristics of these LGAs were identified in terms of age distribution, the proportion of their population that is Aboriginal, remoteness (noting the number of LGAs in each group with "very remote" and "outer metropolitan" population LGAs according to the ARIA classification system) and disadvantage (using the ABS Index of Relative Social Disadvantage (IRSD) and the weighted mean education and occupation index (a separate SEIFA index.)

Comparator clusters of LGAs were then identified in other parts of the old Far West Area Health Service, the rest of GWAHS, Greater Southern Area Health Service and the Hunter New England Area Health Service. These in turn were combined to create a comparator population for the Maari Ma Agreement area. The population of the comparator area is larger than the Maari Ma Agreement area, which strengthened the chance of achieving explanatory power. The map below shows the four comparator areas selected.



The table below compares these areas against the measures identified.

Table 1. Summary statistics for LGAs that are part of Maari Ma and the comparison areas

Aspect	Maari Ma	Other old FW	GW non-FW	HNE area	GS area	Total comparator area
# LGAs	5	3	7	6	7	n/a
# with 100% outer regional	1	0	2	2	4	n/a
# with any v remote	2	3	1	0	0	n/a
Average ARIA weighting	5.17					5.49
Range IRSD	864.7–981.6	845.1–930.8	948.2 –971.1	912.0–938.4	901.9–930.9	845.1-971.1
Weighted mean, IRSD	939					955
Range % Aboriginal	6.4 – 39.5	27.4 – 63.2	6.0 – 16.8	1.8 – 21.3	2.4 – 9.6	1.8-63.2
Weighted mean, % Aboriginal	10.0					10.6
Range, Education &Occupation index	905.3–933.6	907.0–964.8	924.3–943.7	912.0–938.4	901.9–931.2	901.9-964.8
Weighted mean, Education &Occupation index	924					930
% Aboriginal residents	10	33.9	10.2	10.8	4.8	10.6
Aboriginal population	3310	4777	5187	5752	2615	18,332
Non-Aboriginal population	29801	9334.	45427	47446	52176	154,385
Total population	33112	14112	50615	53198	54792	172,718
% population <=19	25.9%	28.4%	28.7%	28.0%	30.3%	28.9%
% population 20-64	57.8%	60.8%	56.2%	57.7%	56.0%	57.0%
% population 65+	16.3%	10.8%	15.1%	14.3%	13.7%	14.1%

Population as at 30 June 2005

The total comparator area is more similar to the Maari Ma area than any of the individual clusters of comparator LGAs. On the basis of these comparisons it is possible to conclude that the total comparator area provides a useful and valid comparison to the Maari Ma area. The greater size of the combined total comparator area also provided extra explanatory power than any of the individual areas.

The third stage of the analysis was to extract the data from the HOIST data warehouse for each of the key indicators identified in stage one, in relation of the populations identified in stage two. This was done by the Centre for Epidemiology and Research, NSW Health. Age standardised rates (with 95% confidence intervals) were calculated using the Australian population in June 2001 as the standard population for indicators involving mortality or hospital separations. Proportion of the number of births was calculated for indicators based on data extracted from the Midwife's Data Collection.

Ninety-five percent confidence intervals were calculated based on the standard error of the proportion. All analyses were undertaken separately for Aboriginal and non-Aboriginal populations, as well as overall. Estimates of Aboriginal and non-Aboriginal populations in each area were based on estimates at the local government area level from the ABS, and accessed from HOIST.

Two sets of differences were of interest to the Review: for the Indigenous and non-indigenous Maari Ma populations over time and between the Maari Ma and comparator populations, both Indigenous and non-indigenous. To assess the significance of any differences observed 95% confidence intervals were calculated for all measures to identify those differences that were not likely to have occurred by chance. Thus, the results of interest are those where the confidence intervals are not overlapping, either for Maari Ma populations at different time intervals or between Maari Ma and comparator populations at the same times. These are referred to in the results section for Objective 6 as 'significant differences'. As well a number of 'interesting trends' were also identified, which are worthy of comment but are not supported by significant differences (at a 95% confidence level) in the data.

Results

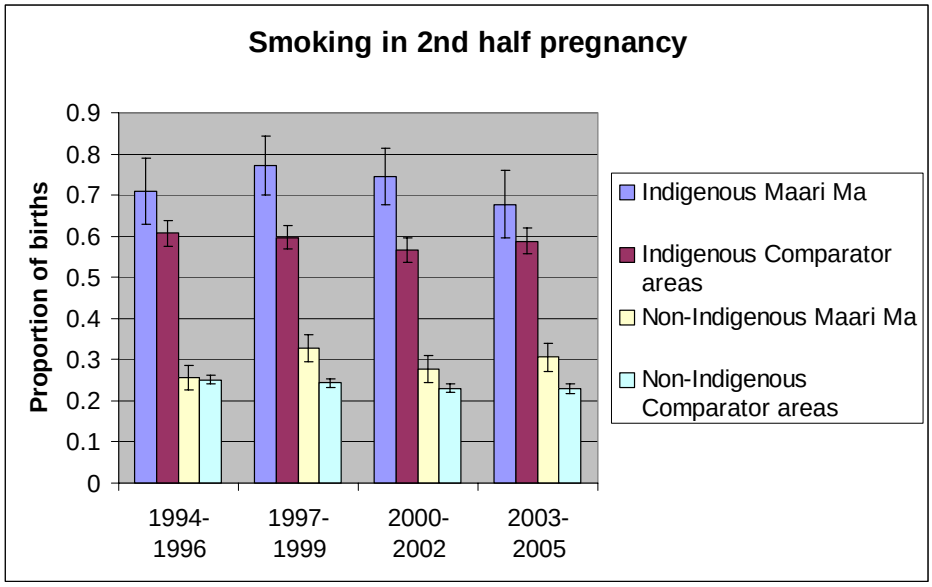
In this section are included, for completeness, the results that lacked either significant differences or interesting trends that have been included in the main body of the Report.

Pregnancy related indicators

Smoking in the second half of pregnancy

In Figure 25 below both the Indigenous and non-Indigenous Maari Ma areas experienced higher smoking rates (or proportions) in the second half of pregnancy than their comparator areas, except for the last period. This was, of course, a difference that pre-dated the Agreement.

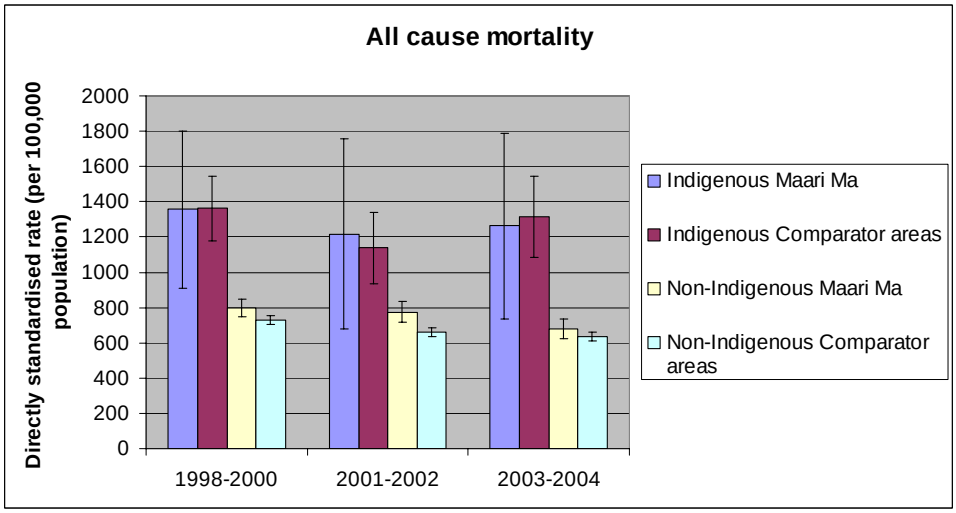
Figure 16



Mortality related indicators

There was only one significant difference in the data covering all cause mortality; the non-Indigenous Maari Ma population had a higher mortality rate the non-Indigenous comparator population in 2001-02. This is not itself a useful result, given that it is the only one, and no other differences were significant. These data are illustrated in Figure 26 below.

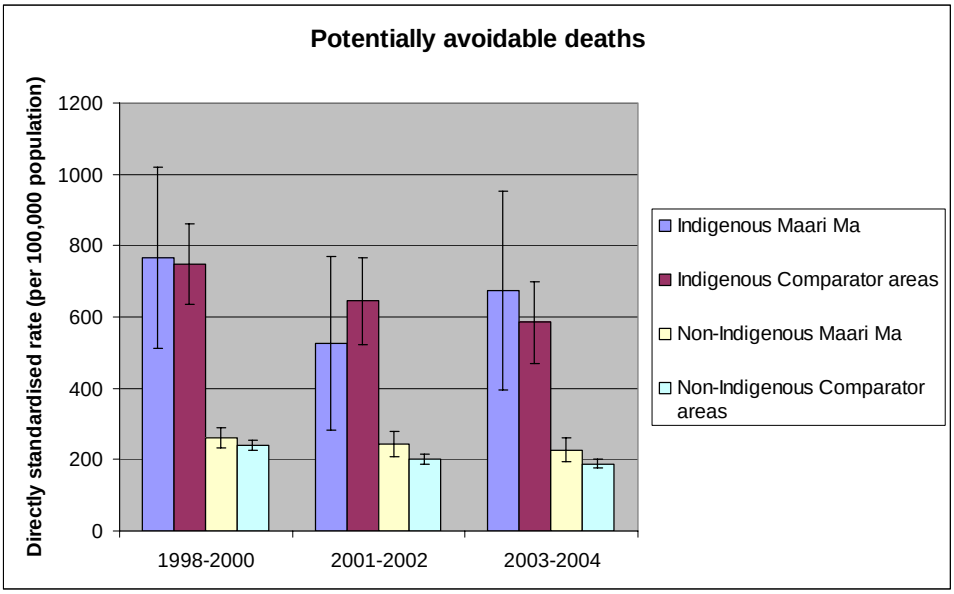
Figure 26



There was only one significant difference in the data covering potentially avoidable mortality; the non-Indigenous comparator population had a lower mortality rate in 2001-02 than the non-Indigenous comparator population in 1998-2000. This is not itself a

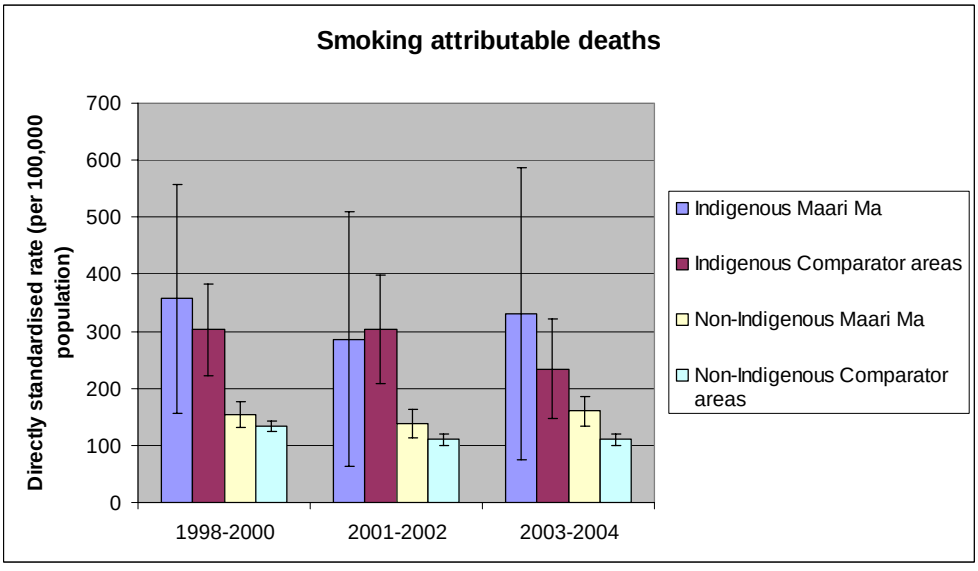
useful result, given that it is the only one, and no other differences were significant. These data are illustrated in Figure 27 below.

Figure 27



There are no significant differences in the data covering smoking attributable deaths, which are illustrated in Figure 28 below.

Figure 28

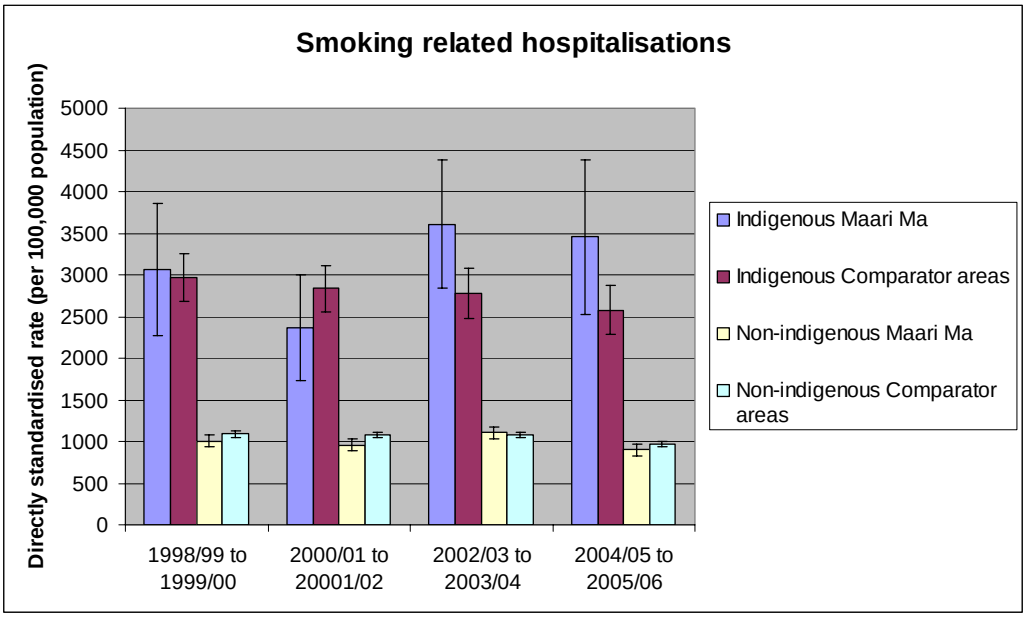


Hospitalisations

Smoking related hospitalisations

Figure 29 below shows that there was only one significant difference in the data covering smoking related hospitalisations, a decline in the non-Indigenous rates for the last time period, although this was marginal, given previous years.

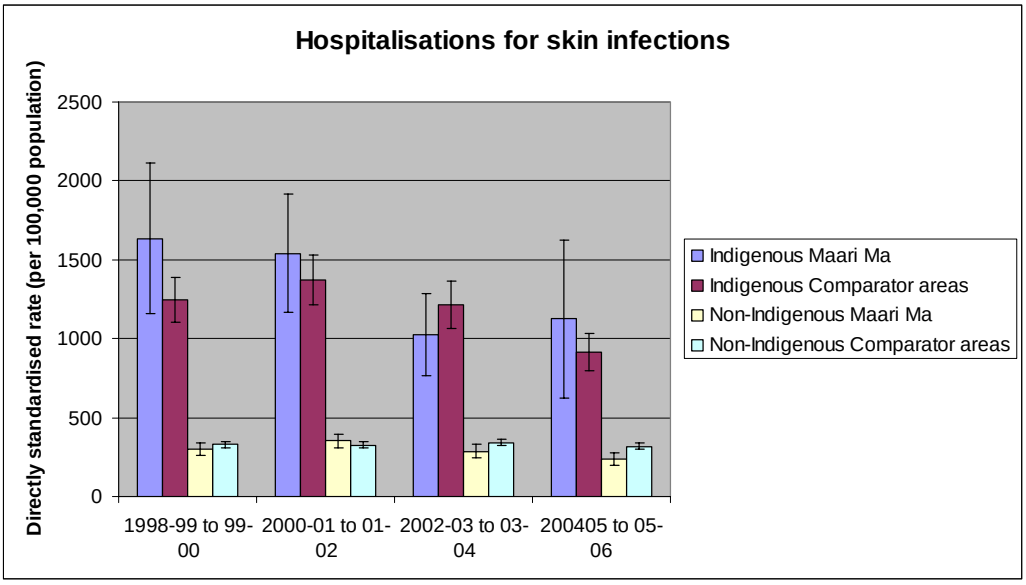
Figure 29



Hospitalisations for skin infections

Figure 30 below shows that there is only one significant difference in the data covering admissions for skin infections. The non-Indigenous Maari Ma population had a lower admission rate than the non-Indigenous population in the comparator area in 2004/05-2005/06. This is not itself a useful result, given that it is the only one, and no other differences were significant. Although not statistically significant, there has been a trend downwards in the rate of hospitalisation of Indigenous people for skin infections in both Maari Ma and the comparator areas.

Figure 30


Hospitalisations for skin infections
Directly standardised rate (per 100,000 population)
2500
2000
1500
1000
500
0
1998-99 to 99-00
2000-01 to 01-02
2002-03 to 03-04
200405 to 05-06
Indigenous Maari Ma
Indigenous Comparator areas
Non-Indigenous Maari Ma
Non-Indigenous Comparator areas

Appendix D – Visiting specialists & other services – example: Wilcannia

2006	2005	2004	2003	2002	2001
GWAHS/NSW Health • Psychiatrist • Mental Health Wkrs • Sexual Health CNC	GWAHS/NSW Health • Psychiatrist • Mental Health Wkrs • Paediatritian • Palliative Care CNC • Sexual Health CNC • Clinical Nse Educators • Dental Therapist	GWAHS/NSW Health • Psychiatrist • Mental Health Wkrs • Paediatritian • Clinical Nse Educators	GWAHS/NSW Health • Psychiatrist • Mental Health Wkrs • Paediatritian • Clinical Nse Educators • Dietitian	GWAHS/NSW Health • Psychiatrist • Mental Health Wkrs • Paediatritian • Clinical Nse Educators Dietitian	GWAHS/NSW Health • Psychiatrist • Mental Health Wkrs • Paediatritian • Dietitian
RFDS • EN & T surgeon • Dentist • Women's Health Nurse • Child & Family Nurse	RFDS • EN & T surgeon • Dentist • Women's Health Nurse • Child & Family Nurse	RFDS • EN & T surgeon • Dentist • Women's Health Nurse • Child & Family Nurse	RFDS • EN & T surgeon • Dentist • Women's Health Nurse • Child & Family Nurse	RFDS • EN & T surgeon • Dentist • Women's Health Nurse • Child & Family Nurse • Dermatologist	RFDS • EN & T surgeon • Dentist • Women's Health Nurse • Child & Family Nurse Dermatologist

Maari Ma • C&F Dietitian • Adult Dietitian • Dental Therapist & A • Audiologist • Audiometrist • Optometrist • Psychiatrist –D & A • IT Specialist • Public Health Phys • Primary Health Coor • Annual Adult Health Check Team	Maari Ma • Adult Dietitian • Audiologist • Optometrist • Psychiatrist –Drug & Alcohol • IT Specialist • Public Health Physician • Primary Health Coor • Annual Adult Health Check Team	Maari Ma • Adult Dietitian • Dental Therapist • Audiologist • IT Specialist • Public Health Physician • Primary Health Coor	Maari Ma • Optometrist • IT Specialist • Podiatrist • Primary Health Coor	Maari Ma • Audiologist • Optometrist • Podiatrist • Primary Health Coor	Maari Ma • Podiatrist • Primary Health Coor
Joint GWAHS/Maari Ma • Endocrinologist • Ophthalmologist • Diabetic CNC • Com Midwife & AHW • Specialist trainers • Smoking Cessation specialists	Joint GWAHS/Maari Ma • Endocrinologist • Ophthalmologist • Diabetic CNC • Com Midwife & AHW • Specialist trainers • Smoking Cessation specialists	Joint GWAHS/Maari Ma • Endocrinologist • Ophthalmologist • Diabetic CNC • Community Midwife & AHW team	Joint GWAHS/Maari Ma • Diabetic CNC • Community Midwife & AHW team	Joint GWAHS/Maari Ma • Diabetic CNC • Community Midwife & AHW team	Joint GWAHS/Maari Ma • Diabetic CNC
Division of GPs • Podiatrist	Division of GPs • Podiatrist	Division of GPs • Podiatrist			

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