The Community Compact

for the Principles and Protocols for the Delivery of External Health Services to Rural and Remote Communities in Western Australia

Version 1

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AHCWA
Aboriginal Health Council of Western Australia

CONTENTS

SECTION ONE

EXECUTIVE SUMMARY

The *Community Compact for the Principles and Protocols for the Delivery of External Health Services to Rural and Remote Communities in Western Australia* (Community Compact) is an outcome of a research project commissioned by the Aboriginal Health Council of Western Australia (AHCWA). Entitled: Rural and Remote Health Service Delivery in Western Australia, the project was initiated to review the level of activity and investment directed at mobile and specialist outreach health services in meeting the access issues and health needs of Aboriginal people in rural and remote areas of Western Australia. Conducted between March to October 2014, the project specifically sought to:

- Detail the service delivery landscape, current and proposed mobile health service delivery models to rural and remote areas, and the key stakeholders involved.
- Identify the extent to which mobile services are meeting some of the critical health needs across rural and regional Western Australia particularly oral, eye, ear and kidney health.
- Examine the barriers and enablers to effective mobile health service delivery in regional and remote areas and the limitations and potential of alternative service models and other strategies.

An extensive stakeholder consultation process was undertaken to inform the project from which emerged the common theme that external services need to see their role as not only directed at specific health issues and needs, but also as facilitating collaboration, coordination and consistency of health service delivery in rural and remote communities. The stakeholder consultation process subsequently resulted in the following outcomes:

- The release of a detailed project report;
- A series of cross sector conversations, following on from the initial stakeholder consultations, over six months involving corporate, government and non-government organisations directly involved with the funding and delivery of mobile and outreach health services; and
- A collaborative and partnership approach across a range of stakeholders with agreement that the development of a Community Compact to support better consultation, coordination, community control and evidence-based decision-making processes in the funding, design and delivery of mobile and outreach health services to rural and remote Western Australia.

'External Health Services' can be defined as a range of clinical and non-clinic based mobile and specialist outreach health services delivered via a range of methods to communities in isolated, regional and remote areas of Western Australia.

INTRODUCTION

In 2014 AHCWA commenced a project that examined the efficacy and issues associated with the delivery of mobile health services to rural and remote Western Australia (WA) and some of the main considerations with current and proposed outreach and mobile service delivery models to these areas.

The project specifically sought to:

- Detail the service delivery landscape, current and proposed mobile health service delivery models to rural and remote areas of WA, and the key stakeholders involved.
- Identify the extent to which mobile services are meeting some of the critical health needs across rural and regional WA particularly oral, eye, ear and kidney health.
- Examine the barriers and enablers to effective mobile health service delivery in regional and remote WA and the limitations and potential of alternative service models and other strategies.

Numerous current and proposed mobile health delivery models seek to address a range of access and equity issues experienced by Aboriginal people living in regional and remote areas of WA. Yet many of these models are hampered by requirements for sealed roads, issues with transporting high level equipment, expensive infrastructure and ongoing operational costs and maintenance needs that often are not funded at the set up stage. Some services are reliant on volunteer and philanthropic efforts.

Even the most 'mobile' of such services are still constrained by seasonal weather conditions, poor roads and large distances that limit their ability to provide regular services. These issues throw into doubt the sustainability of many of these arrangements.

A sustainable service delivery model cannot be dependent on any one key element such that the entire service is placed 'at risk', or significant health needs remain unmet, when a doctor, specialist, or service leaves/is absent or the pool of volunteers cease, or the vehicle breaks down.

It is also important that specialist outreach programs, however comprehensive or 'regular', do not ultimately increase the dependence of rural and remote communities on their services. Rather, they should work to enhance and increase the capacity of rural/remote based health care providers to deal with the health care needs of their communities, and establish a continuity of care by operating in a manner that complements rather than substitutes local or regionally based services.

The Community Compact aims to support better consultation, coordination, community control and evidence-based decision-making processes in the funding, design and delivery of mobile and outreach health services to rural and remote WA. It reflects the collaborative approach, strong intent and strength of commitment across all parties involved.

Terminology

The term 'Aboriginal' is used throughout this document to refer to the original inhabitants of the Australian continent—Aboriginal and Torres Strait Islander peoples. The term is used for the purpose of brevity and in preference to 'Indigenous'. While 'Aboriginal' may be considered as a more specific term to 'Indigenous', it is limited in that it is a generic term that excludes any description of language group, country or nation, and is not the preferred term among all Aboriginal and Torres Strait Islanders.

SECTION TWO

BACKGROUND TO THE PROJECT

There is a great deal of activity and investment ostensibly directed at (and sought for) addressing the health needs and access issues of people living in rural and remote areas of WA – in particular Aboriginal people.

Local, regional and metropolitan based service providers, medical specialists and an array of health professionals, policy makers, funding and investment agencies and research institutes are all working in various ways to overcome critical health disparities and high needs for a range of health services within rural and remote areas.

The Rural and Remote Health Service Delivery in Western Australia review project was commissioned by AHCWA. It was a response to two key questions:

- To what extent is the level of activity and investment directed at meeting the access issues and health needs of Aboriginal people in rural and remote areas achieving those aims? and,

- Are these services and models of service delivery (particularly mobile and specialist outreach services) the most appropriate and optimal way of addressing these issues?

As the peak body of the Aboriginal Community Controlled Health Services (ACCHS) across WA, AHCWA plays an important role in supporting quality clinical practice standards across its members. Achieving excellence in health care service delivery to all areas and communities requires an in-depth understanding of the current state of service delivery and what is required to enhance it.

The review was therefore initiated so as to provide a detailed description and analysis of the current state of mobile and specialist outreach health service delivery in regional and remote areas across WA in relation to critical health needs; and, to identify some of the main considerations for optimizing and enhancing the funding, delivery and effectiveness of these services.

CONTEXT

Across Australia it is estimated that 31% of Australians (7 million people) live outside of major cities. Of these, 4.4 million live in inner regional areas and 2.1 million live in outer regional areas. An estimated half a million people live in remote and very remote areas accounting for 2.3% of the total Australian population. The distribution of populations between remoteness areas varies across states and territories. In Western Australia population growth in regional populations has been very high.

The rural and remote population makes up 28 per cent of WA's population and includes many Aboriginal people. At 30 June 2011 more than 40% of WA's Aboriginal population lived in remote or very remote areas, compared with only 5.4% of the total population.

Many Aboriginal and non-Aboriginal people living in rural and remote communities across WA face a number of barriers in accessing regular primary care services, specialist and hospital care.

Remoteness is a significant factor determining the level of basic health, education and infrastructure services to which people can access. Aboriginal people across regional and remote WA face substantial problems in accessing a variety of health care services for their high level of needs.

Provision of specialist medical care is especially limited for people in these areas with ongoing shortages of a range of specialists relative to demand, and many barriers associated with accessing any services that are provided in larger regional centres.

There are a number of organisations involved in the funding and delivery of mobile and specialist outreach health services to rural and remote WA. These organisations utilise and support a range of service delivery models. Outreach services provided through hub and spoke arrangements, trucks and vans, telehealth, and Fly-In, Fly-Out (FYFO) and Drive-In, Drive-Out (DIDO) teams aim to address some of the unique issues faced by people living in remote communities by providing more equitable access to quality health care services within the local setting. Yet these involve high costs and face a number of issues in providing a regular service.

There is a substantial amount of policy directed at addressing the high level of health needs of Aboriginal people residing in rural and remote areas and the associated service delivery issues. Across the policy spectrum a consistency in language, approach and principles can be identified. These similarities emphasise the importance of reducing duplication, of increasing coordination, of enhancing Aboriginal peoples' access to services and the need for engagement with Aboriginal people, communities and organisations.

Similarly, the particular health strategies and frameworks governing primary care and clinical services in WA repeatedly discuss integration, integrated care, continuity of care and coordination. What is less clear is how these various polices all relate to each other and how they can deliver some consistency in reporting, allocation of funding, and strategic direction across all stakeholders.

PROCESS

From the beginning of the process into reviewing the efficacy and issues associated with the delivery of mobile health services to rural and remote Western Australia, a consultative, evidence-based and outcomes oriented philosophy has been observed by those guiding, undertaking and reviewing the process.

As a result, the collaborative approach, strong intent and strength of commitment by all parties to the process of furthering the project and developing a meaningful result for the work, energy and time that has been contributed, has resulted in a number of important outcomes. These outcomes are:

- A detailed report providing a synthesis of information and research and the outcomes from an extensive consultation process with local and resident health professionals, outreach specialists and mobile health providers, key representatives of Aboriginal community controlled health organisations, state and federally funded health service agencies, the RFDS, not for profit organisations and research institutes and programs.

- A series of conversations held over six months in 2014-2015 hosted by AHCWA with key corporate, government and non-government organisations that are directly involved with the funding and delivery of mobile and outreach health services. The aim of the conversations was to identify ways to optimise the design, delivery and effectiveness of external health services and ensure that those involved undertake appropriate and adequate consultation processes, and support and enhance the work of local organisations and health staff.

- The fostering of a collaborative and partnership approach across a range of stakeholders with agreement that the development of a set of Principles and Protocols was required to guide the decision-making processes, support all organisations involved and ensure some consistency across the sector.

This process has ultimately led to the development of the Community Compact and a request that the Aboriginal Health Council of Western Australia invites key stakeholders to join and abide by the Community Compact.

STAKEHOLDER CONSULTATION

The stakeholder consultation revealed broad consensus among those consulted that many of the existing and proposed models of outreach and mobile health services in rural and remote areas operate in the absence of state or regional wide planning and coordination. Many services were perceived as a current necessity, although not always enhancing primary care and the capacity and skills of local organisations and staff.

The consultations reveal many acknowledge the value and necessity of certain outreach and mobile services (both proposed and existing), however their contribution should extend to supporting existing referral pathways and processes and contribute to the capacity of local staff to recognise and prevent disease and when to refer to a specialist, and to ensure continuity of care.

A common theme was the need for external services to see their role as not only directed at specific health issues and needs, but also facilitating collaboration, coordination and consistency in a region.

The number of outreach services and different agencies associated with their funding was seen as requiring a state wide strategic plan and/or health framework. The consultations highlighted the extent to which many regard the funding and provision of rural and remote health service delivery as ad hoc.

There are gaps in detailed and consistent data collection across the range of external health services meaning there can be no systematic evaluation across all services to create and build an evidence base from which to consider options, ensure investment is directed accordingly, and the right benefits achieved and sustained.

More resources directed to ensuring skills development and staff retention, enhanced primary care capacity and health promotion and prevention strategies, and telehealth (including virtual clinics and training) options for rural and remote based organisations were identified as some of the critical enablers for more sustainable and optimal rural and remote health services and health outcomes.

Key Findings

The following key findings emerged during the Rural and Remote Health Service Delivery in Western Australia review project:

1. *Rural and remote health delivery is currently driven by a disease model that is fuelling a tertiary care approach to many health issues that can and should be addressed more comprehensively at the primary care level.*

2. *Many current and proposed mobile health delivery models are hampered by requirements for sealed roads, issues with transporting high level equipment, expensive infrastructure and ongoing operational costs and maintenance needs that often are not funded at the set up stage. Some services are reliant on volunteer and philanthropic efforts. Even the most 'mobile' services are still constrained by seasonal weather conditions and large distances that limit their ability to provide regular services. These issues throw into doubt the sustainability of many of these arrangements.*

3. *A sustainable service delivery model cannot be dependent on any one key element such that the entire service is placed 'at risk', or significant health needs remain unmet, when a doctor, specialist, or service leaves/is absent or the pool of volunteers cease, or the vehicle breaks down.*

4. *There is a need for more qualitative, quantitative and economic analysis on mobile health services and specialist outreach models to identify the aspects that are working well, the models of service delivery that are more cost effective, and in what ways they are of greater overall benefit than other approaches.*

5. *Models of health care delivery for rural and remote areas require far more planning, collaboration and coordination across all service providers than is currently happening.*

6. *Addressing gaps in Aboriginal health requires the engagement of Aboriginal communities and a commitment to coordinated actions across all governments and sectors to develop and implement strategies and approaches that address the complex, interrelated issues.*

7. *There is a need for more evidence showing mobile service delivery models to be more cost effective, appropriate, sustainable and better able to address rural and remote people's health needs.*

8. *External health service providers should not be introduced or funded at the expense of existing services, unless it has been demonstrated the existing service is unable to meet that particular need of the community. In such instances it was seen as critical that funding only be provided to support a multidisciplinary team approach.*

9. *Any external health service, however comprehensive or 'regular', should not increase the dependence of rural and remote communities on their services. Rather, they should work to enhance and increase the capacity of rural/remote based health care providers to deal with the health care needs of their communities, and establish a continuity of care by operating in a manner that complements rather than substitutes local or regionally based services.*

10. *The need for external health service providers and medical specialists to work in partnership with those best placed to provide appropriate and culturally sensitive primary care, continuity of care and support, and health promotion and disease prevention education to Aboriginal people.*

11. *The increased use of telehealth has the potential to reduce the inequitable access to health services that many people experience, and address the ongoing problem of recruiting and retaining the rural health workforce. It also presents a wealth of opportunities for low cost approaches to training and capacity building local staff.*

12. *Far more planning at a state, regional and local level is required to ensure the broader integration and alignment of all external health services to rural and remote communities' services.*

SECTION THREE

AN INVITATION TO JOIN THE 'COMMUNITY COMPACT'

The Aboriginal Health Council of Western Australia invites the Aboriginal Community Controlled Health Sector, the Government, Opposition and other Political Parties and Representatives of Western Australia, Aboriginal Communities throughout Western Australia, the Western Australian Health Sector, and Businesses, Funding Partners and Philanthropists of Western Australia, to commit to working through the Community Compact together to achieve the following outcomes:

- Meet the health care needs of people living in rural and remote communities.
- Eliminate the barriers to delivering and sustaining mobile and outreach health services within rural and remote communities.
- Provide cost effective access to a range of mobile and outreach health services and specialists and reduce the access issues for many patients in rural and remote communities.
- Ensure mobile health service providers and outreach specialists in regional and remote communities seek to advance primary health care by integrating and collaborating with existing locally based services.
- Focus on the broader determinants of health when addressing the provision of mobile and outreach services in the context of health issues generally in regional and remote communities, including the impact of socio-economic status, living environment, and individual lifestyle behaviours.

SECTION FOUR

THE PRINCIPLES AND PROTOCOLS

Any proposed initiative is to be: evidence based, demonstrably a better approach, and integrated within existing arrangements and services.

Potential providers to undertake early engagement involving consultation and scoping to ensure relevance, identify where or if service aligns with a priority for a region/community, and establish relationships. Respective Regional Plans are to be consulted by any proposed services as a basis to identify service need.

Potential providers must collaborate with local organisation/s and community to co-design a service model/arrangement – before seeking funding.

The service provider must demonstrate how the proposed service can be sustained beyond the initial funding period – unless it is intended to be a time-limited project.

The service provider must include project planning associated with the sustainability of assets and responsibility of costs for any hard infrastructure – especially at the end of a project (or if the infrastructure expires). If the proposed service does not have a focus on delivery of services to Aboriginal people, the service provider should seek appropriate advice elsewhere.

The service provider should demonstrate how the proposed service will add value to existing service delivery.

The service provider needs to demonstrate how the proposed service will support local workforce capacity.

The service provider needs to demonstrate how the proposed service incorporates disease prevention and health promotion strategies.

The proposed service must demonstrate cost efficiencies in the delivery of services to the target population group.

That a pro forma checklist be completed as part of the assessment process for proposed services and that this form is recognised as an intrinsic part of the process for initiating new and externally driven services to regional and remote areas in Western Australia.

The sharing of data between the service provider and the associated local health service is non negotiable and a condition of funding. An agreement must be determined as to how the service provider will share the relevant client information with the local health service system.

Service and partnership agreements from any funding organisation will extend to all the health services and agencies involved, not just with the external service provider.

Any potential service provider must consult:

1. firstly with representatives from each of the local services,
2. then with the relevant Regional Aboriginal Health Planning Forums, and
3. seek final endorsement from an ACCHS CEO reference group and the WACHS CEO/ delegate.

Funding agencies must ensure that this consultation process has been adhered to as a condition of funding.

That the consultation process has involved potential external service providers to firstly engage in the following three stage approval process:

1. with local services and at the same time in a roundtable meeting, (not individually)
2. with the relevant Regional Aboriginal Health Planning Forums (including the WACHS Regional Directors) ,
3. seek a decision from a group representing the sector (suggestion of 7 ACCHS CEOs and WACHS CEO/delegate).

AHCWA to undertake a brokerage role between potential service providers, funding agencies, relevant health services and the sector's decision making group. The brokerage role extends to ensuring any successful contract is being adhered to and adequately evaluated.

SECTION FIVE
PROJECT LEADERSHIP AND MANAGEMENT

AHCWA Senior Management Team Project Reference Group

- Mr Des Martin, Chief Executive Officer
- Ms Patricia Bushby, Operations Manager
- Ms Jenny Sala, Finance and Contracts Manager
- Ms Sharon Bushby, Sector Development Manager
- Mr Andrew Webster, Senior Resources Advisor
- Dr Chantal Ferguson, Public Health Medical Officer

External Health Service Delivery Project Management Team

- Dr Clair Scrine-Bradfield, Project Researcher – SB Consulting
- Mr Graham Lovelock, Project Manager – AHCWA
- Mr Lockie McDonald, Workshop Facilitator, Full Sky

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- Mr John Tunney, WA Director Department of Health
- Dr Viv Manessis, Medical Officer Aboriginal Health Team, Child and Adolescent Community Health
- Ms Melissa Vernon, Executive Director Primary Health and Engagement for the WA Country Health Services
- Ms Linda Waters, Program Manager, Service Planning & Development, WA Country Health Service
- Ms Deborah Gayton, Project Coordinator, Ear, Eye and Oral Health Initiative, WA Country Health Service
- Mr Andrew Heath, Manager, Wheatbelt Aboriginal Health Service
- Ms Jo Wilkie, Grants & Community Development Lotterywest
- Ms Jacquie Thomson, General Manager, Grants & Community Development Lotterywest
- Ms Debra Royle, Manager, Outreach in the Outback, Rural Health West
- Ms Claire Ditri A/Manager, Community Development Pilbara Development Commission
- Ms Emma White, Manager Indigenous community investment, BHP Iron Ore
- Ms Jenny Collard, Executive Director Business and Social Development, Royalties for Regions
- Dr Kirsten Auret, Professor, Deputy Head of School Rural Clinical School of WA
- Dr Stephanie Trust, General Practitioner, Kimberley Aboriginal Medical Services Council
- Ms Trish Barron, Acting Director Diversity and Development, Pilbara Development Commission
- Mr Richard Hancock, Senior Project Officer, Pilbara Development Commission (Karratha)
- Ms Jennifer Elms, Project Officer, WA Country Health Services
- Mr Steve Parkinson, Health Business Executive-WA Government Sales, Telstra Foundation

Who we spoke with and/or contributed

- State Manager WA, The Royal Australasian College of Physicians
- Executive Director, Child and Adolescent Health Services,
- Executive Director, Primary Health and Engagement WA Country Health Service
- Chief Medical Officer, WA Department of Health
- Kimberley Population Health Unit WACHS - Kimberley
- Director Population Health, WACHS - Pilbara
- Aboriginal Health Promotions Officer, WACHS – Pilbara
- A/Manager, Community Dental Services
- Health in Motion Project Team, Murdoch University WA
- Director Corporate Services, Kimberley/Pilbara Medicare Local
- Area Manager – Wheatbelt, Southwest Medicare Local
- Area Manager – South West Coastal, Southwest Medicare Local
- CEO, Ear Science Institute Australia
- Head eHealth, Ear Science Institute Australia
- Manager, The Avant CENTER, Ear Science Institute Australia
- CEO, Western Desert Nganampa Walytja Palyantjaku Tjutaku Aboriginal Corporation
- Dr Michael Watson, Children's Equity
- Dr Angus Turner, Lions Outback Vision
- Renal Project Officer, Mobile Dialysis Truck, Kimberley Aboriginal Medical Services Council Inc.
- CEO, Kimberley Aboriginal Medical Services Council Inc.
- CEO, Derby Aboriginal Health Service
- CEO, Ord Valley Aboriginal Health Service
- CEO, Geraldton Regional Aboriginal Medical Service
- CEO, Wirrika Maya Health Service
- CEO, Mawarnkarra Health Service Aboriginal Corporation
- CEO, Nindilingarri Cultural Health Services
- Practice Manager Support, Aboriginal Health Council of Western Australia
- Public Health Medical Officer, Aboriginal Health Council of Western Australia
- Medical Director, Kimberley Aboriginal Medical Services Council
- Executive Director, Nindilingarri Cultural Health Services
- Project Manager, Spinifex Health Service

- Director of Research, School of Dentistry/Oral Health Centre of Western Australia, UWA
- Winthrop Professor Aboriginal Child Health Research, School of Paediatrics and Child Health, UWA
- Manager, Aboriginal Health Services, Wheatbelt
- Ear Health Project Coordinator, Ngunytju Tjitji Pirni Inc.,
- Chief Investigator, Remote I project, CSIRO.
- Manager Primary Health Care Programs, Royal Flying Doctor Service
- CEO, Rural Health West
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- Dr Harvey Coates (ENT)
- Dr Peter Freidland (ENT)
- Dr Terry McManus (ENT)

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