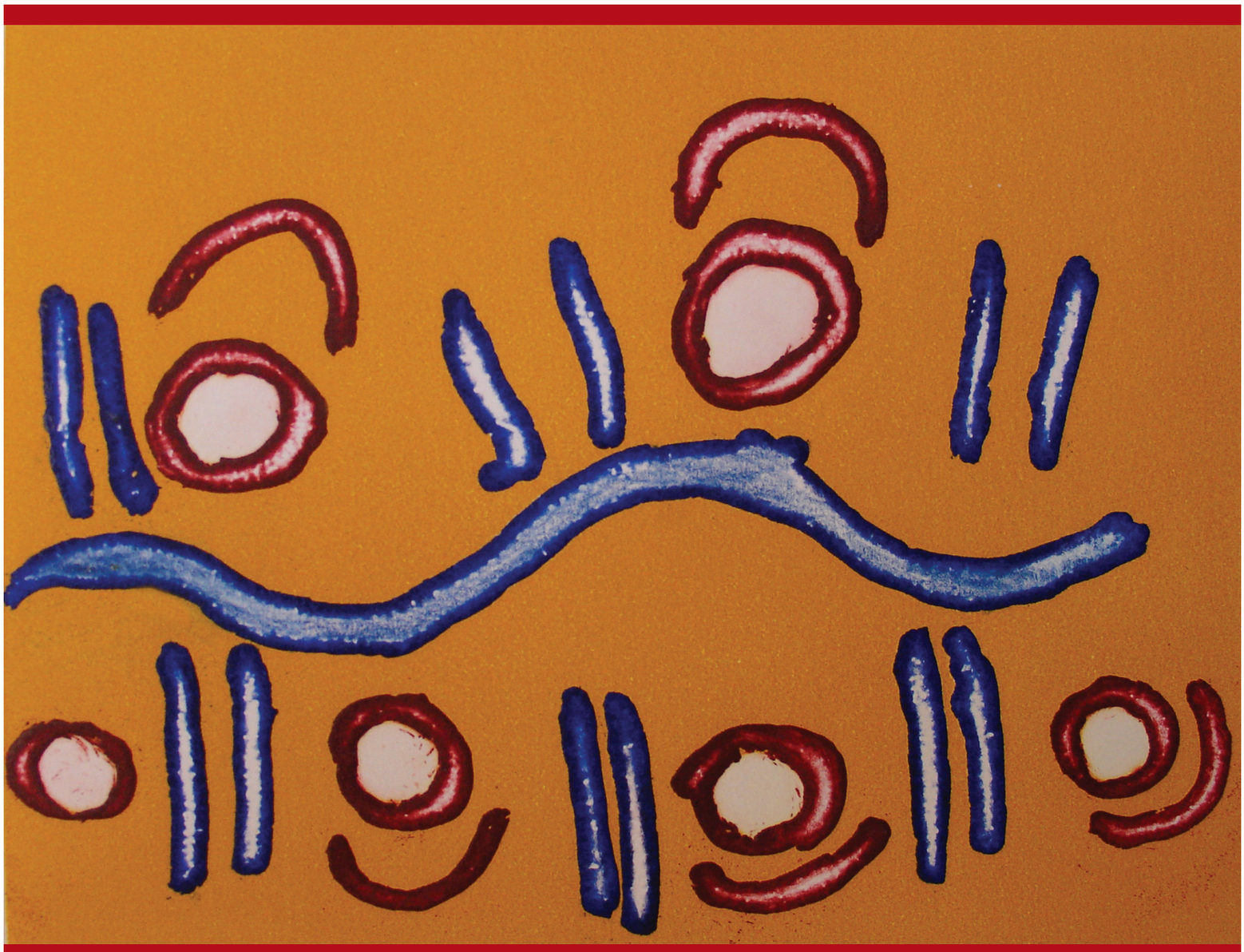
NORTHERN TERRITORY
Aboriginal Health Forum



Pathways to Community Control

An agenda to further promote Aboriginal community control in the provision of Primary Health Care Services

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Northern Territory Government

ABORIGINAL MEDICAL SERVICES ALLIANCE NORTHERN TERRITORY
AMSANT

Australian Government
Department of Health and Ageing

The Fire and Water Suite
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(Walpiri - Ancient Symbols of Bushfires, Waterholes, Lightening, Rain and Desert Soaks)

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Executive Summary

The primary purpose of this document is to create a framework that supports Aboriginal communities' control in the planning, development and management of primary health care and community care services in a manner that is both commensurate with their capabilities and aspirations and consistent with the objective of efficient, effective and equitable health systems functioning.

Northern Territory Aboriginal Health Forum (the Forum) partners believe that greater levels of community involvement brings benefits both to the process of health and family service delivery and to the health of those that are engaged. Benefits potentially on offer to Aboriginal Territorians include a more responsive health and family services system, improved quality and cultural security of services and improved levels of family and community functioning; all contributing to improved levels of health and wellbeing.

Within this framework community control refers to the principle that Aboriginal communities have the right to participate in decision making that affects their health and wellbeing. It also refers to the organisational model of Aboriginal community controlled health services that has existed for more than 30 years. Parties have agreed that community controlled governance of health services is the optimal expression of the right of Aboriginal people to participate in decision making.

The framework seeks to example how the progressive extension of the right to participate can be reflected in organisational arrangements within the health sector. The framework reflects that not all communities will have the same aspiration or capability to manage the planning, development and delivery of primary health and family services at the same point in time.

However this framework does contemplate a progressive movement to greater levels of community participation including movement to the community controlled health service model. The framework explores the key partnership responsibilities under the different examples and subsequently outlines some of the key capabilities and level of functioning required of each party under that model. This partnership between communities and the health system is critical to achieving an efficient, effective and equitable level of health system functioning.

The framework creates a policy space in which community and organisational development can occur and connect; and in which partnership between community and public sector can grow. The activity within this space is not static as the objectives of either community or government can change. Hence this framework thinks about this policy space as dynamic and capable of responding to the changing circumstances.

This framework makes explicit a commitment to strengthen levels of community and systems functioning in support of greater community participation and control. In doing so the Forum partners remain mindful of the need for:

- consistency and continuity of service capacity and arrangements;
- quality and coverage of services;
- management of risk; and
- fairness.

The Forum partners agree that the management of primary health care services is a function that requires specialised skills and knowledge and that organisational arrangements structured under this framework should reflect a specific competence and experience in an organisation primarily dedicated to the purpose of primary health care service delivery.

This framework contemplates a four-stage process through which community participation and control could be encouraged. These stages are as listed:

1. Development
2. Consolidation
3. Implementation
4. Evaluation

Introduction

The Forum is the principal partnership mechanism created by the NT Framework Agreement on Aboriginal and Torres Strait Islander Health. The Forum has agreed that the objectives of the Framework Agreement would be well served by further strengthening at a local level the engagement of Aboriginal communities in the functional planning, development, delivery and monitoring of health services. The key principles drawing the parties together on this issue are:

- Aboriginal community participation is a key element of sustainable, viable, effective and efficient delivery of primary health;
- a shared commitment to the development of a strategy to secure greater levels of Aboriginal community control in the delivery of primary health care in the NT;
- a shared commitment to foster an effective partnership between governments, communities and providers that ensures best practice governance of services and optimal health gain; and
- a shared commitment to personal and community development as an integral contributor to improved levels of community participation and control.

This framework seeks to support Aboriginal communities and public sector agencies in their efforts to incrementally realise these shared principles.

Purpose

In this paper the concept of community refers to Aboriginal people living in a particular place and/or belonging to a particular cultural group. Whilst this notion of community focuses on populations or groups this paper includes concepts and responsibilities that may fall to families and/or individuals within communities.

The primary purpose of this framework from a policy perspective is to increase the level of community participation and control in the health and family services sector in the NT. The Forum partners recognise that the level and nature of community participation will vary depending on a range of factors. However partners believe that community control brings both benefits to the process and to the health of those that are engaged.

> *'Put another way, community engagement has the potential to improve the quality of the service supplied, but it can also improve the opportunities and capacities of those who rely on services, so lessening their need for them'*[1].

The Forum partners agree that one model does not fit all needs. In the development of this framework, community participation is meant to reflect the level of engagement each community seeks to exert over the planning, development and management of primary health care services. Broadly speaking a community's decisions about participation seeks to influence singularly or in combination four major goals:

- identifying and/or defining issues/problems;
- identifying and/or developing solutions;
- managing and/or delivering solutions; and
- monitoring and evaluating services.

This framework identifies community participation as our policy goal. This implies that as community aspirations and capabilities expand governments should be ready to engage with communities to realise these aspirations in a manner consistent with the need to ensure a functioning health system. The framework recognises that successful implementation requires that both the community and government need to have the necessary skills and insights for the partnership journey.

1 Rogers B and Robinson E (2004) Active Citizenship Centre Report – The benefits of community engagement a review of the evidence, IPPR

Community control requires communities and their organisations to possess both the understanding of and the ability to apply the knowledge and competence on which sound engagement is built. It also depends on the capability of government organisations and structures to understand and find new ways of working that respond to community's calls for greater levels of engagement.

Experience in the NT tells us that this understanding already exists in many places. Success may require the Forum partners to both commit to finding ways of building or releasing existing capacity for community engagement in current service providers as well as new efforts to build capability where it does not exist.

In summary this Agenda recognises:

- community participation can take different forms and will not always be static;
- the community controlled health service model as providing the greatest level of community participation in health service delivery;
- knowledge, skill, competence, motivation and opportunity are required for communities, organisations and individuals to engage effectively in discussions, decision-making, governance and service delivery;
- both communities and public sector organisations may have greater potential and capacity to engage effectively than is currently recognised;
- a range of barriers operating within communities and organisations (and in the interaction between them) may constrain capability, suggesting that releasing capacity, may be as important as building it; and
- the Forum partners are committed to releasing untapped potential and building new capabilities in support of community participation and control.

Describing the Continuum of Community Participation and Control of Primary Health Care Services

The Forum partners recognise that across the Territory the extent of community participation and control varies significantly. In some communities health services are managed and provided by the Department of Health and Families (DHF). In these communities the level of community participation is comparatively, more narrow. In other locations, communities contract the provision of services from external providers and here increased community participation is exercised through decisions about what services are to be provided; who should provide them; and whether the services are provided in a satisfactory manner.

Yet in other communities, community controlled Aboriginal health services provide health care, and here community participation is comparatively more encompassing and is what has historically been defined by Aboriginal people as community control. The Forum partners recognise that community participation and control is a reflection of where community and government preferences and capabilities lie at any particular time.

This framework provides a policy platform that creates space for community and governments to pursue organisational and community development that may contribute to changes to the nature of local community participation and control of health and family services.

This framework recognises that the circumstances of communities and their health services can change and that this change may involve either greater or lesser community participation or control. In order to ensure Aboriginal people continue to receive core health and family services the Forum partners remain committed to a strong partnership that accommodates unexpected or problematic change.

This framework describes some of the critical responsibilities and capability required in both community and governments in a number of service models. The use of these examples is not meant to limit the range of service models that might be considered but rather to demonstrate how the mix of capability requirements and responsibilities change as a community progresses towards community control.

The fact that this framework describes both sides of this pathway is important. The Forum experience suggests that success is built through effective partnerships. This partnership environment is described in Figure 1 (next page).

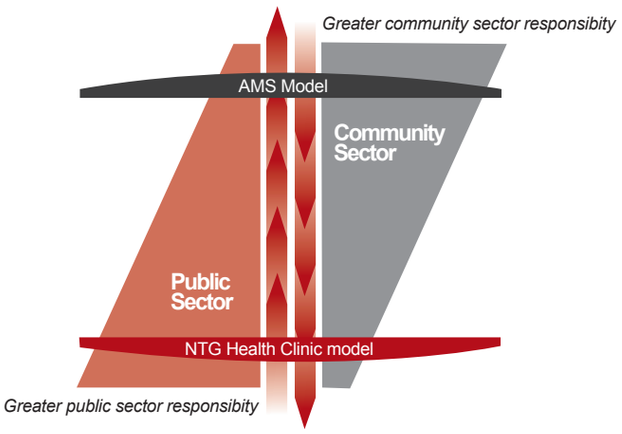

Figure 1. The Continuum of Community Participation and Control

The continuum of community participation and control is easily described towards the extremes either by the primary health care centres that are funded and managed by the Department solely or alternatively by the existence of independent community controlled Aboriginal Health Services. The level of responsibility held on the one hand by the public sector and on the other by the community sector changes as communities move along this continuum.

This continuum recognises existing structures but contemplates both different models between, and new models outside the current service models described above. These new models might for example include regional health service models based on aggregated PHCAP zones.

The Forum partners are conscious that the continuum is a two-way environment, communities may in response to changing circumstances move along the continuum in both directions. The Forum partners agree that there are a number of possible service delivery models. Some of the factors defining the viability and suitability of service models include:

- community preferences;
- community capability;
- need;
- demographics and geography;
- organisational strength;
- leadership;
- funding;
- workforce; and
- public policy settings.

Governments and communities will need to take these matters among others into account in decision making about how and when development or changes in service models are proposed.

Partnership Matrix

This section describes the critical changes to the distribution of responsibilities between the public sector and community sector under a number of service model examples. Importantly at no time is responsibility vested in one sector alone. The provision of health and family services is a responsibility shared between governments, NGOs, communities, families and individuals. As circumstances and service models change the responsibilities of sectors also changes. Table 1 (below) demonstrates this changing partnership matrix as the choice of model changes.

Table 1. Describing Distribution of Responsibilities

Service Model	Public Responsibilities	Community Responsibilities
NTG Primary Health Care Centres	Competent core and other priority primary health services on demand or delivered through program structure. Provides services and model behaviours that are culturally secure. Is broadly aware of community interests and concerns.	Community and families promote the timely and appropriate use of health and family services including compliance with treatment. Community and family within the limits of their capability, take responsibility for their own health.
Proactive NTG Primary Health Care Centres	Provides competent core and other priority primary health and family services on demand or through structured programmes. Provides services and models behaviours that are culturally secure. Engages in data development, management and reporting. Proactively interprets with community local health data, needs and community preferences to identify priorities and plan activities.	In addition to the above: Supports community and family engagement with health and family services information about their community and their families needs; actively engages in consultation processes around health and family service issues.
Proactive NTG Primary Health Care Centres with advisory structure	In addition to the responsibilities of Proactive NTG PHC Centre: Works with a formal advisory committee comprised of community members to whom information is regularly provided and whose views are activity sought and considered; and Actively engages in good data development and management and reporting.	In addition to the proactive PHC Centre: Community establishes an Aboriginal health advisory group that acts as an effective link with the PHC Centre to collect, interpret and convey community values, views and priorities; and Responds to information and promotes health and family wellbeing in the community and families.

Service Model	Public Responsibilities	Community Responsibilities
Proactive NTG Primary Health Care Centres with shared care or management arrangements	In addition to the responsibilities of Proactive NTG PHC Centre with advisory structures: Shares the health and community care and/or management responsibilities with structured and viable community controlled organisations. Provides relevant information to the community and service partner in a timely manner.	An appropriate community based legal entity is in place with a local operating governance structure or committee and compliant governance and regulatory framework. Through a legal entity provides competent partial or whole programme centred services that form part of the suite of core services or regional priorities offered through the NTG PHC Centre e.g. provides part of the ante natal care services to pregnant women, or provides all health service to older people. The governing committee produces and maintains an appropriate strategic and annual business plan for the programmes it is in control of. Competent staff are engaged to manage and provide services. Appropriate organisational structures, processes and controls are in place and working effectively to manage resources, accountabilities and services. Provides relevant information to the community and service partner in a timely manner.
Aboriginal Community Controlled fund holder purchasing PHC Centres from a competent provider	In the event that the NTG is the provider. Under the terms of the service agreement with the fund holder: Provides competent culturally secure core and other priority primary health and family services according to the service agreement Proactively interprets in consultation with communities and fund holder local health data, needs and community preferences; Reports to the fund holder on activity and complies with the contract; and In conjunction with the fund holder provides relevant information to the community.	An appropriate community based legal entity is in place with a local operating governance structure or committee and compliant governance and regulatory framework. Appropriate organisational structures, processes and controls are in place and working effectively to manage resources, and accountabilities and purchase services. Funds are applied via service agreement with a single service provider. The legal entity monitors provider performance against the service agreement. Supports community and family engagement with health and family services information about their community and their families needs; actively engages in consultation processes around health and family service issues.

Service Model	Public Responsibilities	Community Responsibilities
Auspice model with advisory structure	In addition to the responsibilities of Aboriginal community controlled primary health care service provider operating under fundholder model: Works with a formal advisory committee comprised of community members to whom information is regularly provided and whose views are activity sought and considered. Actively engages in good data development and management and reporting.	In addition to the Aboriginal community controlled primary health care service provider operating under auspice model: Community establishes an Aboriginal Health Advisory Group that acts as an effective link with the auspice organisation to collect, interpret and convey community values, views and priorities. Responds to information and promotes health and community wellbeing in the community and families.
Community controlled primary health care service	Responds appropriately and within capacity to requests for information and support from the service provider. Meets contractual obligations if any. Maintains an engagement with the service to promote, protect and maintain the health and wellbeing of Territorians.	Provides competent core and other priority primary health services on demand or through a programme structure. Produces a strategic and annual business plan. Provides services and models behaviours that are culturally secure. Is broadly aware of community interests and concerns. Meets contractual obligations to funder and obligations to the corporate regulator
Proactive community controlled health service	Responds appropriately and within capacity to requests for information and support from the service provider. Meets contractual obligations if any. Maintains an engagement with the service to promote project and maintain the health and wellbeing of Territorians.	Provides competent core and other priority primary health services on demand or through a programme structure. Provides services and models behaviours that are culturally secure. Proactively interprets in consultation with the community local health data, needs and community preferences to identify priorities and plan and evaluate activities. Meets contractual obligations to funder and obligations to corporate regulator.
Regional community controlled health service	Responds appropriately and with capacity to requests for information and support from the service provider. Meets contractual obligations if any. Maintains an engagement with the service to promote projects and maintain the health and wellbeing of Territorians.	Provides competent culturally secure core and other priority primary health services on demand or through a programme structure. Proactively manages services on a regional basis in consultation with individual communities. Proactively interprets in consultation with communities within the region health data, needs and community preferences to identify priorities, plan and evaluates activities. Meets contractual obligations to funder and obligations to the corporate regulator.

The Forum partners agree that sustainable health gain is predicated on competent and capable service models. Together the service models offered above provide a sense of the evolving nature of community participation and control and of the need for structured development of skills, knowledge and the capability to successfully operate, whichever model is applied.

This continuum is not sequential. Communities are not required to step through each in order to progress. It is also possible that new hybrid models may emerge. In some cases the level of community participation and control may change dramatically in either direction as level of functioning changes.

The Pathways to Community Control are described as a continuum because circumstance or preference may change over time. Issues that might trigger change in the model of service delivery in a community or region might include:

- sustained and demonstrated enhancement of community capabilities and competence;
- sustainable improvements in the organisational competence of a service provider;
- health and family service demand;
- public policy changes;
- erosion of a community or organisation's competence or capability;
- change created by economies of scale or diseconomies of small scale; and
- treatment of identified service or management of risk in organisations.

Being Competent and Capable

Viable and sustainable community control of health services depends on two key processes. Firstly, the health service provider must be competent in organising, managing and delivering health and family services. Secondly they must also be able to inform and work with the community including responding to the community's priorities and values.

The efficient and effective provision of services is reliant upon the capability of health service providers to apply the available resources to the achievement of agreed health and wellbeing goals. Capability refers firstly to the extent to which service providers are able to demonstrate that they have engaged communities in determining the values including for example fairness, cultural responsiveness and the markers against which service provision is to be judged. Secondly whether providers can translate community priorities and values into management and operational decision making.

Being Capable

In summary service providers are contributing to the capability of communities where they can demonsrate they have:

- *structureed a functioning ongoing relationship with the community that enables a clear articulatoin of and engagement with the community's strengths, preferences, values and objectives; and*
- *applied their technical and professional skills in a manner that serves these strengths, preferences, values and objectives efficiently and effectively.*

Communities and governments will be interested in whether service providers can competently manage the functional elements of a health service. Competency refers to fundamental knowledge, ability, or expertise in a specific subject area or skill set, in this case skills necessary to manage a primary care health service.

Being Competent

In summary competence exists where service providers can demonstrate their ability to:

- *prioritise resource use to meet the health needs of communities;*
- *use and organise resources in a manner that systematically contributes to health and wellbeing goals and objectives; and*
- *maintain sound professional standards and organisational processes.*

Bringing capability and competence together in a system (see Diagram 1 below) provides both communities and governments with confidence that resources will be well managed; that the community's culture, priorities and preferences will be taken into account; and that progress towards health goals can be monitored against agreed values and standards.

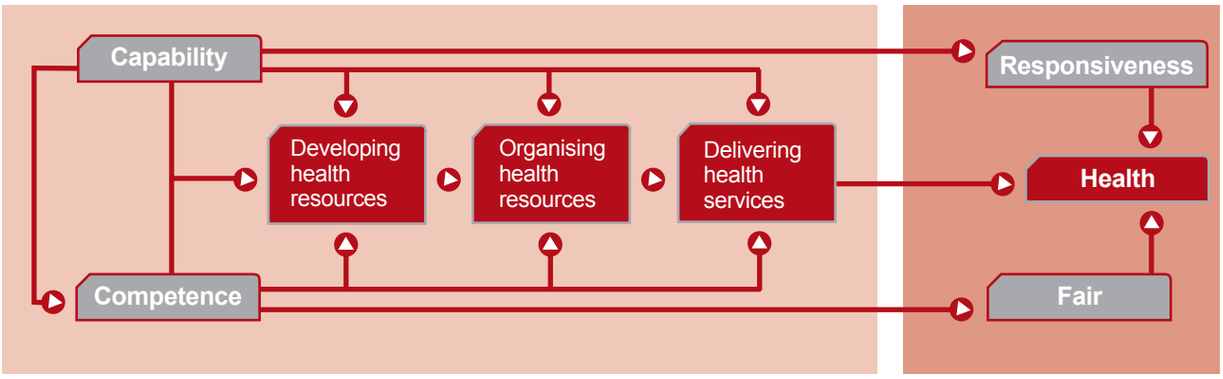

Diagram 1. Health System

In this framework the objective is to combine both capability and competence so that we can create and sustain functioning service provision and greater health gain.

Importantly under this framework public sector providers share a responsibility to optimise competence and capability. This means that where the public sector continues to manage services they must have deliberate strategies and processes in place to contribute to competent and capable service delivery. This is a responsibility that falls also to the community sector.

Communities may express an aspiration about the sort of health service model they believe is required in their community or region. In some cases communities may seek to negotiate a greater role in the planning, delivery and management of health and wellbeing services than currently is the case. Similarly, other communities may express the view that no change is required.

Where these aspirations seek a new model of service provision this framework contemplates that service providers must possess and demonstrate the necessary competencies and capabilities prior to full transition to the new model. Changes to the health service arrangements should be underpinned by a structured transition plan that includes specific attention and support for the development of the necessary competencies and capabilities.

Table 2 (next page) describes the sentinel capabilities and competencies that fall to either the public or community sector under the same set of models used earlier. Where providers meet these requirements the Forum partners believe that service providers will have achieved a level of functioning that justifies the transition to, or continued support for that service model. Again these models are not meant to be the only models that might be used but they stand rather as a guide to the changing nature of key competencies and hence example the sort of development necessary to support transition.

Table 2. Demonstrating a Functioning Health Service

Service Model	Public Sector Functioning	Community and Community Sector Functioning
NTG Primary Health Care Centres	Staff have generalised knowledge of the community's circumstances and culture. Service providers engage competently with individual clients and provide services effectively around the individual patient's needs. Health goals and objectives are output based. Resources are organised around individual need. Competent staff are engaged to manage and provide services. Appropriate organisational structures and processes are in place and working effectively. Generally external parties govern staffing and other programme decisions. Evaluation of performance is undertaken externally and client and community satisfaction is structured broadly around generic complaints management processes. Data collation and analysis is ad hoc focused around specific external requirements.	Individual and community health capability generally low. Community and individual demand for health care is generally episodic Individuals generally present with high levels of undiagnosed disease.
Proactive NTG Primary Health Care Centres	Service providers engage competently with individual clients, provide core services consistently. Staff provides culturally secure services and have generalised knowledge of the community's circumstances and priorities. Engages in programme specific consultation with community. Local data and experience is proactively used to design and support a suite of population health services, for example HSAK and GAA. Consumption of resources is driven generally by personal health service patterns but explicitly includes priority population health considerations. Health goals and objectives are substantially output based but include a range of outcome measures related to population health goals and objectives. Local resource management relates primarily to utilisation of staffing resources to achieve personal and population health service coverage. Local data and evaluation influences resource management and planning decisions.	Some individuals, families or sub groups within the community provide advice on specific programme issues. Demand for episodic health care continues, but there is an appropriate level of community enrolment in population health programmes. Individual and community health and wellbeing capabilities are present but are generally unorganised.

Service Model	Public Sector Functioning	Community and Community Sector Functioning
Proactive NTG Primary Health Care Centres with shared care or management arrangements	In addition to the responsibilities of Proactive NTG PHC Centre: • competent and formal service partnership structures exist for specific programmes, for example ante natal care, women's and men's health care. • the responsibility for elements of specific programmes is shared with external providers either from the community or another acceptable partner according to agreed protocols.	In addition to the responsibilities of Proactive NTG PHC Centre: • where established, the community partners provide elements of shared programmes according to agreed protocols.
Proactive NTG Primary Health Care Centres with advisory structures	In addition to the responsibilities of Proactive NTG PHC Centre: Has a formal advisory structure that enjoys a competent and honest partnership with the PHC Centre and which: • enjoys the confidence of the community. • Is provided relevant information in a timely manner from which they can form advice. • carries influence in the strategic decisions of the PHC Centre; and • reflects the community's preferences.	In addition to the responsibilities above: • formal advisory structure competently uses information and cultural social projects to formulate advice; and • advisory structure monitors the service provider's compliance with advice and is able to effectively advocate on behalf of community interests.
Aboriginal Community Controlled fund holder purchasing PHC Centres from a competent provider	In addition to the qualities of functioning described for a proactive NTG PHC Centre: • delivers services in accordance with volume, quality and price standards set under the terms of the contract appropriately. • responds appropriately to the advice of the community; and • in conjunction with the fund holder responds to community consultation.	An appropriate community based legal entity is in place with an effective local governance structure that is compliant with governance and regulatory frameworks. Within the scope of the community's preferences and objectives fulfils any obligations associated with the contract for services. Contributes competently to an effective monitoring regime of the performance and cultural security of the providers service and is able to advocate on behalf of community interests effectively.
Auspice model with advisory structure	Monitors the health and wellbeing of Aboriginal Territorians and either: • advises community and provider of events that warrant their attention and/or intervenes as appropriate to protect public health and wellbeing; and • fulfil any responsibilities identified under the contract.	An appropriate community based legal entity is in place with an effective local governance structure that is compliant with governance and regulatory frameworks. Within the scope of the communities preferences and objectives fulfils any obligations created under the contract for services. Contributes to an effective monitoring regime of the performance and cultural security of the providers service and is able to advocate on behalf of community interests effectively.

Service Model	Public Sector Functioning	Community and Community Sector Functioning
Aboriginal Community Controlled fund holder purchasing PHC Centres from a competent provider	In addition to the qualities of functioning described for a proactive NTG PHC Centre: • delivers services in accordance with volume, quality and price standards set under the terms of the contract appropriately. • responds appropriately to the advice of the community; and • in conjunction with the fund holder responds to community consultation.	An appropriate community based legal entity is in place with an effective local governance structure that is compliant with governance and regulatory frameworks. Within the scope of the community's preferences and objectives fulfils any obligations associated with the contract for services. Contributes competently to an effective monitoring regime of the performance and cultural security of the providers service and is able to advocate on behalf of community interests effectively.
Auspice model with advisory structure	Monitors the health and wellbeing of Aboriginal Territorians and either: • advises community and provider of events that warrant their attention and/or intervenes as appropriate to protect public health and wellbeing; and • fulfil any responsibilities identified under the contract.	An appropriate community based legal entity is in place with an effective local governance structure that is compliant with governance and regulatory frameworks. Within the scope of the communities preferences and objectives fulfils any obligations created under the contract for services. Contributes to an effective monitoring regime of the performance and cultural security of the providers service and is able to advocate on behalf of community interests effectively.
Community controlled primary health care service	Efficient and effective funding and accountability mechanisms and processes are in place and operating well. Funding Agreements offer clear guidance of service performance outcomes and timelines. Appropriate mechanisms for the referral, treatment and discharge of clients to and from secondary and tertiary acute and other services exist.	An appropriate community based legal entity is in place with an effective local governance structure or committee that is compliant with governance and regulatory frameworks. The governing committee produces and maintains appropriate strategic and annual business plans. Competent staff are engaged to manage and provide services. Appropriate organisational structures, processes and controls are in place and working effectively. Service providers engage effectively with individual clients and provides services in response to individual patient's needs. Health goals and objectives are output based. Resources are organised around individual service needs. Staff have generalised knowledge of the community's circumstances and culture. Performance evaluation is undertaken externally and client and community satisfaction is structured broadly around generic complaints management processes.

Service Model	Public Sector Functioning	Community and Community Sector Functioning
Regional community controlled health service	Efficient and effective funding and accountability mechanisms and processes are in place and operating well. Funding Agreements offer clear guidance of service performance outcomes and timelines. Appropriate mechanisms for the referral, treatment and discharge of clients to and from secondary and tertiary acute and other services exist.	An appropriate regionally based legal entity is in place with an effective governance structure or committee is compliant with governance and regulatory frameworks The governing committee is representative of the region it serves and produces, maintains and monitors its strategic and business plans and operational guidelines. Competent staff are engaged to manage and provide services. Appropriate organisational structures, process and controls are in place and working effectively to manage resources, accountabilities and services. Service providers engage effectively with individual clients, provide core services and priority populations health services consistently. Staff provide culturally secure services and have specialist knowledge of the community's circumstances and priorities including at a regional and sub regional level. Engages in programme specific consultation with community. Local data and experience is proactively used to design and support service provision and resource allocation including population health services for example HSAK, GAA and disease control Health goals and objectives are substantially output based but include a range of outcome measures related to population health goals and objectives. Consumption of resources is driven generally by both personal health service patterns and priority population health considerations. Local management of staffing and other resources to achieve personal and population health service coverage according to agreed regional standards. Data and evaluation is proactively used to influence resource allocation, management and planning decisions at a regional level.

Building Community and System Functioning

"Capacity-development, like sustainable development, encompasses a wide range of aspects, including the human, technological, organisational, financial, scientific, cultural and institutional…capacity-building is the process and means through which Governments and local communities develop the necessary skills and expertise to manage…"[2]

In addition to outlining the levels of competence and capability necessary for sustainable service delivery and governance this framework commits the Forum partners to a proactive and progressive effort to promote higher levels of community functioning. Such efforts will assist Aboriginal communities to assume greater levels of responsibility in the NT partnership to improve Aboriginal health. Contributions to improved levels of community functioning will also contribute to other community development needs.

The Forum and its members have already undertaken a number of projects that seeks to build the capacity of communities and the health service system to evolve to greater levels of community participation and control. These include:

- regional planning
- service and finance benchmarking
- auspicing arrangements for services; and
- Health Service Development Officers

Whilst these efforts are worthwhile a more systematic approach that builds on past experience is required if we are to secure greater community participation and control.

Community Side

On the community side, capability building will not always be about skilling the community to run and/or provide health service; service organisations will employ experienced and qualified staff to fulfil that role. However the capabilities of communities and Boards of Management are threshold issues within this framework.

These structures must be able to serve the community's interests, stay connected with the community's preferences and values and discharge strategic corporate responsibilities effectively.

2 UN Commission on Sustainable Development (1996, p. 2).

Capability building within the various forms of community participation contemplated by the framework may require development in a number of key areas including:

- *knowledge building:* the capacity to grow skills, utilise research and development and foster learning;
- *supporting information:* the capacity to collect, access and utilise quality information;
- *leadership:* the capacity to develop shared directions and influence what happens in the provision of services;
- *authority:* giving the community the authority to move along this pathway;
- *responsibility:* the capacity to accept responsibility for improving health status;
- *network building:* the capacity to form partnerships and alliances; and
- *governance:* the capability to achieve effective strategic management and corporate performance including risk management.

Public Sector Side

Much of the organisational infrastructure necessary to discharge service responsibilities exist in the public sector. However, there are a number of areas critical to the objectives of this framework where the public sector has increasingly recognised the need for improvement. These have been in:

- community engagement: how to scope, define, implement and evaluate community engagement strategies and community values and preferences; and
- cultural security of services: ensuring that clients do not suffer less favourable outcomes because of cultural differences between Aboriginal people and service providers.

Similarly increasing levels of community participation will place demands on current service providers particularly in respect of:

- skilling staff to appropriately respond to the scope of engagement sought by communities; and
- building systems that ensure the cultural security of services offered.

Taking Action – Transitioning

In adopting a framework to build community and systems functioning in support of greater community participation and control both communities and governments will be concerned with:

- consistency and continuity of service capacity and arrangements;
- quality and coverage of services;
- management of risk;
- fairness, and
- responsiveness

This framework contemplates a four-stage process in which community aspirations to adopt a particular services model could be framed:

1. Development
2. Consolidation
3. Implementation
4. Evaluation

1. Development Stage

In the development stage service provision will be largely unaffected. However, parallel efforts that involve the community as a whole are undertaken that:

Improve information: health and family services information is presented to the community that encourages an active discussion of health issues, and builds capacity for communities to make informed decisions abut their priorities for health.

Elicit community preferences: the objective is to establish the qualities and characteristics the community believes are important to the choice of service model. The community could consider the question 'What are the values and preferences that we believe are important to the decision about a service model?'

Evaluate the options: in this element the community, based on their preferences and priorities review all of the potential service models and makes some decisions about how well or not the models reflect their values and preferences.

Choosing a model: having weighed up the options the community should discuss the results and may then be in a position to decide which model suits them. At this stage the community may elect to create a leadership group that pursues the reform sought by community. In some cases such leadership groups have visited other communities to look at different service models that are in operation in order to help them decide which model might best suit them.

Beyond the community there are considerations taken by health planners (such as the Forum) and by governments that will impact on the nature and pace of reform. Such considerations include:

- equity;
- relative need of a community compared to others;
- cost;
- consistency and continuity of service capacity and organisational arrangements;

- quality and coverage of services; and
- management of risk.

An indicative time frame for the development stage is 12 to 18 months.

2. Consolidation Stage

In the consolidation stage work begins to build the capability of communities, the leadership group and the services providers to accommodate the proposed reform. During the consolidation stage the provision of health services may not be affected except for a growing exchange of views and information. This exchange however may contribute in itself to an improvement to current provision of services. By the end of this stage a legal entity would have been formed so that the leadership group is consolidated into an elected health board that has greater accountability to the community or region through open Annual General Meetings.

Leadership: the leadership group meets regularly, and provides direction for the staff or community members working to build reform. This leadership group can help the community demonstrate its capability to grow skills, utilise research and development and foster learning, and provide direction to and clearly articulate community needs and aspirations. It may also help build the capacity to develop shared directions and influence what happens in the provision of services. The group might also consider the employment of a Health Service Development Officer (HSDO) to assist in the various elements outlined in this stage.

Create a Health Plan: with the support of the community the leadership group could construct a health plan for the community or region. Health plans could at a minimum set out demographics; an overview of the determinants of health; information about the current health status; details of current service provision including an analysis of any gaps; the proposed model and the leadership groups strategies to deliver core services; community control and cultural security and other service development and management issues.

Associated with this is the need for the leadership group to have a firm view of how they are going to implement the transition.

Community Engagement: essential to successful reform is the ability of the leadership group to demonstrate effective community engagement with the reform and appropriate levels of community confidence in the process. As part of this, the development of a fully constituted legal entity with broad consultation with the community or region is essential to ensure that the leadership group is accountable and formalised to a fully functioning health board.

Builds Networks: the leadership group and others should take the time to build networks and form functioning partnerships and alliances with relevant stakeholders. The Forum partners believe this is an important feature of successful community growth and development. These networks can help clarify potential funding available to support the reform process and example successful initiatives in other locations.

Governance: the incorporated legal entity demonstrates the capability to achieve effective strategic management and corporate performance including risk management; puts in place the corporate framework necessary to support the identified service models; demonstrates financial expertise in terms of a clear capacity to meet all funding compliance requirements; prepares an annual business plan from the health plan with clearly identified performance indicators.

Evaluation Strategy: partners in the reform should agree an evaluation strategy that serves to show progress against the objectives of the reform. Such an agreement could provide the basis for the evaluation stage.

An indicative time frame for completion of the consolidation stage is 12 to 24 months. The Forum will regularly monitor the progress.

3. Implementation Stage

The implementation stage is commenced when the necessary transitional arrangements are in place and when the Health Board or Health Services Committee has assumed full management responsibility for the delivery of primary health care services on an initial basis. Funds pooling to a single provider should occur within this stage. The provision of health and family services will be most affected during the implementation stage and accordingly the Forum and governments will be interested in monitoring change and minimising risk.

Monitoring Change: the stakeholders will be interested to ensure that the implementation of reform is meeting all appropriate milestones. Governments and the Forum will be concerned to ensure that any risk to services for the community is minimised and that sustainable corporate, service and other engagement arrangements are operating well.

Business Planning: having taken on the appropriate responsibilities under the service model, service managers will need to ensure that sound business planning is in place and tied to operational decision making.

Effort Maintained and Commitments Met: partners maintain effort in support of health outcomes for the community. Service outputs for the community required by the health plan are being satisfactorily met under the new arrangement.

Confidence of Community: the community continues to have confidence in the model and related decisions and is able to offer the necessary advice through well-established mechanisms to address concerns or celebrate successes.

Confidence of Funders: the new arrangements continue to maintain and build the confidence of funders.

Confidence of Corporate Regulators: where the model involves an independent corporate entity the continuing confidence of the corporate regulator is essential.

Data Collection: appropriate and sound data collection, collation and analysis are occurring both to support operational and strategic needs.

An indicative time frame for completion of the implementation stage is 12 to 24 months.

4. Evaluation Stage

Evaluation of the performance of service models is important to the ongoing success of any service programme. Evaluation means making a judgment about the services effectiveness (i.e. have the original objectives been met) and efficiency (i.e. how well resources are being used). It entails looking at outcomes as well as at activities; at relevance as well as numbers; at what could have been done as well as what was done. The evaluation strategy outlined during the consolidation stage could form the basis for action here.

Stakeholder Engagement: the engagement of key stakeholders (funders, community networks and leadership) is important to sound evaluation. Stakeholders can help frame some of the questions to be addressed by the evaluation. These discussions might also assist in marshalling the resources (perhaps cash and in-kind contributions) to conduct the evaluation.

Setting clear Objectives and Logic: evaluation strategies should set out the main service components and the related implementation or business objectives to be evaluated so that a logical format and expectation is established.

Use of Evaluation Report: evaluations should provide a basis to enhance the strategic, business or other operational and corporate decisions.

The evaluation stage should commence no sooner than two years after the commencement of the implementation stage or no more than 12 to 18 months after the implementation stage is finalised.

Conclusion

Aboriginal and Torres Strait Islander communities have long associated the importance of community control to the achievement of health and wellbeing goals.

Research suggests that the development of greater levels of community and family functioning that is cognisant of cultural values and process[3] may contribute to better health and wellbeing. This framework seeks to build the necessary and ongoing partnership between health and wellbeing stakeholders in the NT, service and culture, that delivers a conscious and deliberate effort to support community engagement in, and control over health and wellbeing. Encouraging this engagement stakeholders anticipate greater levels of community functioning and greater levels of health and wellbeing.

3 Chandler and Lalonde, Cultural Continuity as a Hedge Against Suicide in Canada's First Nations,