The Overburden Project
Contracting for Indigenous Health Services

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Background

• 150 Aboriginal Community Controlled Health Services (ACCHS) across Australia (urban, rural, remote)
  • The only sector of the health system that BOTH provides essential CPHC services AND works from a base of fragmented funding contracts
  • Funded in more complex ways and from more sources than most other health care organisations of equivalent size
  • The time & effort for admin and reporting is out of proportion with the funding levels
Project Questions

1. What are the major enablers and barriers to effective PHC delivery in the current frameworks of funding and accountability for PHC services to Aboriginal & Torres Strait Islander people in Australian states & Territories?

2. How could the effectiveness of funding and accountability arrangements be improved, drawing on insights from current Australian practice and international comparisons?
Project Methods

• We collected and analysed three main kinds of data:

1. Government funding program guidelines/policies/contracts in relation to PHC funding for ACCHSs
   Analysed to produce ‘a big picture’ of the policy and program environment in each jurisdiction, to guide interviews and other data collection

2. Interviews with senior staff of health authorities and a national sample of ACCHSs
   Interviews were audio-recorded, transcribed and analysed to identify the main themes emerging from their experiences.

3. Financial reports of a sample of 21 ACCHSs for the financial year 2006–07 to improve our understanding of the complex ways in which these agencies are funded.

• Contract Theory Framework to analyse characteristics of funding, reporting and accountability requirements
## Contract Theory

<table>
<thead>
<tr>
<th>Classical</th>
<th>Relational (alliance)</th>
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<tbody>
<tr>
<td>Separate classical contracts for a basket of PHC services</td>
<td>Engaging with a provider in a long term flexible contract</td>
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<tr>
<td>Short-term, competitive, unstable from year to year</td>
<td>Long term, non-competitive Population based, stable</td>
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<td>High admin costs are compounded with multiple contracts</td>
<td>Lower transaction costs for both; may be partly off-set by relationship building &amp; negotiation costs</td>
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<tr>
<td>Multiple reporting requirements</td>
<td>Reporting requirements can be lower</td>
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<td>Risk lies with the service provider</td>
<td>Risk is shared</td>
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International evidence

- Relational contracting is used when:
  - Service is complex
    - Hard to specify
  - Funder & provider are inter-dependent
    - The risk is shared in reality
  - Long time line is needed
    - For continuity of care or other reasons
  - Competitive market lacking
- Classical contracting doesn’t work as well
Services of a medium-sized ACCHS: $2M; 40 staff; 22 funding lines +MBS/PBS
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Main Findings

1. Fragmented funding is a barrier to integrated PHC

“If I can’t find money in a dental bucket then I’m going to find money in a PHC bucket or a maternal bucket, but it’s all primary health care. So that’s where I think shoe-horning yourself into specific areas – ears or eyes or kids or adults or renal or asthma or whatever it is – actually becomes more problematic. Little amounts of money I think is always hard as opposed to a generic bucket that is PHC which is what we do.”

(ACCHS Manager)
2. Unmanaged complexity and transaction costs cause inefficiency

“It’s a serious problem. It affects the efficiency and effectiveness of the programs offered by the recipient. In one ACCHS, the manager has to manage 27 quarterly reports & financial statements and annual reports. When does she get time to run the organisation? It’s been talked about but it’s not been resolved.”

(Health Authority Director)

“The Commonwealth rolls something out every week, it’s challenging then for us to put things on the ground... It took a year to get the program funding to us for a 3–4 year program, we’ve already lost a year before we even get on the ground.”

(Health Authority Finance Officer)
3. Long-term relationship behaviour enables trust and enhances capacity

“It would be great to have a different relationship with OATSIH or the Commonwealth government where we were viewed as an integral part of the health system, that we are playing an important role in our region. If that was the view that was taken we could have completely different funding arrangements that were based on an annual or three or four year budget, that there was a commitment to the region, that we would have flexibility to move money around without having to go back all the time for every minor thing.”

(ACCHS CEO)

“I think you’ve got to invest in the relationship first.”

(Health Authority Manager)
4. Data for monitoring & performance management are compromised

“We’re the most over-reported and protected sector. You look at divisions of GP, you look at some of those mainstream health organisations and you look at the reporting arrangements that they have versus what Aboriginal organisations have. We have to report on every little thing.” (ACCHS CEO)

“We could do more, some of the stuff we collect doesn’t get utilised as much as we’d like.”

(Health Authority Finance Officer)
5. National priority funding impedes responsiveness to local priorities

“.. we’re never asked our opinion about – in our community – what might be our priority and how might they fund those, which I suspect would be different all over Australia. And so we have these national targets and programs that are developed out of Canberra but we don’t know who they consult to get those ideas from.”

(ACCHS CEO)

“I think from a government’s perspective their priorities and how they allocate money differs from how we identify what our priorities are, because we do it from the community up, they do it from the politicians down.”

(ACCHS CEO)
6. Classical & relational contract paradox

- Contracts are classical, but staff on both sides speak and act as if they are partners in relational contracts.
- So the advantages of classical contracts (e.g., govt retaining power to cease funding) are not achieved.
- But the advantages of relational contracting (e.g., long term commitment to programs on the ground, reduced transaction costs & improved staff retention) are not achieved either.

“There is a reasonable assumption that an ACCHS will receive continual funding but this is not contracted in a way that would make them feel secure.”

(Health Authority Manager)
Conclusions: Good practice principles

1. Long-term contracting for core PHC is the basis for the funder–provider relationship.
2. Core PHC funding allows flexibility for local priority setting, within agreed plans.
3. Data collection and monitoring are simplified and information is shared, based on sound performance and health outcome indicators.
4. Transaction costs and complexity reduced through a single main long-term contract.
5. Risks for both sides are managed and capacity on both sides is enhanced.
Relational Contracts (alliance)

• Alliance contracts: real accountability
  – Funding allocated for longer-term
  – Flexibility for provider to respond to need
  – Meaningful performance measures
  – Real monitoring on both sides
  – Ability to intervene at times of trouble

• Contract managers need to be:
  – More senior
  – More engaged
  – More empowered
Where to from here?

1. Repeat survey of ACCHS annual reports/financial reports for 2007/08 is underway
   - Hope to increase size
   - And to track trends in grants
   - Report by June 2010

2. Doctor of Public Health
How can Relational Contracting improve the capacity of the Aboriginal Primary Health Care (PHC) sector to balance accountability for health outcomes and efficient use of public funds?
2. Action research

- CRC plans to work with the sector and governments to design and trial new approaches

- Evaluate:
  - impact on responsiveness to local needs
  - match of service reporting to endorsed indicators of health gain and effectiveness
  - length of funding and number of reports/$$
  - relationship and compliance indicators (both ways)
  - transaction costs
3. Action?

• National Health and Hospitals Reform Commission recommended radical change to funding
  – Commonwealth takeover of PHC
  – The Overburden Report offers some guidance for design

• Sector action?
  – Develop alternative approach to accountability
  – Address perceived governance problems?
‘Yarn Up’
Any questions?