NACCHO
National Aboriginal Community Controlled Health Organisation

Core Services and Outcomes Framework*

The Model of Aboriginal and Torres Strait Islander Community Controlled Comprehensive Primary Health Care

What community-controlled comprehensive primary health care offers and why it matters for advancing health and wellbeing of Aboriginal and Torres Strait Islander peoples

For citation

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Acknowledgment of Country

NACCHO acknowledges Aboriginal and Torres Strait Islander peoples as the Traditional Owners of the lands where we live, where we work, and across Australia. NACCHO recognises and pays respect to Elders past, present and emerging across Australia and thanks them for their continuing care and custodianship of land, sea, culture and community.

Acknowledgments

NACCHO acknowledges the financial support of the Australian Government Department of Health for this project.

In a genuine partnership, many individuals and organisations have contributed their time and expertise to the Framework's co-design.

Artwork

The Core Services and Outcomes Framework artwork was created by Kamilaroi artist, Ethan French.

The diagram is a visual representation of the Core Services and Outcomes Framework foundations for community-controlled primary health care. At the centre of the diagram is a meeting place which represents members of the community being the heart of this document. Each ring and section of the diagram represents each component of the Core Services and Outcomes Framework, with culture surrounding the whole diagram and foundations, which is a representation showing that culture is involved in all aspects of the Core Services and Outcomes Framework.

***Framework** (cover): Needs assessment and outcomes will be detailed in phase 2 of this project.

What is the purpose of this document?

BACKGROUND

This document reflects a proud history. The first Aboriginal community controlled primary health care service opened in Sydney in 1971. Within six years, this had grown to ten. As a sector, we have 50 years of collective experience, setting many benchmarks in service delivery, clinical outcomes and population health. There are now more than 140 Aboriginal and Torres Strait Islander Community Controlled Health Services (ACCHSs) in Australia and 450 clinics. Their achievements in promoting and protecting the health and wellbeing of Aboriginal and Torres Strait Islander peoples in the face of significant challenges are incalculable.

The National Aboriginal Community Controlled Health Organisation (NACCHO) is the national peak body representing member services on Aboriginal and Torres Strait Islander health and wellbeing issues. It also has a long history, stretching back to a meeting in Albury in 1974 establishing its predecessor, the National Aboriginal and Islander Health Organisation (NAIHO). In 1997, the Australian Government funded NACCHO to establish a secretariat in Canberra, greatly increasing the capacity of Aboriginal and Torres Strait Islander peoples involved in ACCHSs to participate in national health policy development. There are eight state and territory affiliates working effectively as peak bodies to support member services in their respective jurisdictions.

In 2018 the NACCHO board requested that the organisation work to develop a needs-based funding model for member services. In June 2019, the Department of Health commissioned NACCHO, in partnership with the Royal Australian College of General Practitioners (RACGP), to develop a national Core Services and Outcomes Framework (CSOF) for the Aboriginal and Torres Strait Islander community controlled primary health care sector. NACCHO itself committed significant funds to ensure these projects aligned so that an agreed CSOF developed by the community controlled health sector with stakeholder organisations would inform future decisions about a needs-based funding model.

A **Steering Committee** had oversight of activities undertaken by the **Project Team** led by Dr Dawn Casey. A larger **Expert Advisory Group** provided technical advice and first met in December 2019.

This national **Core Services and Outcomes Framework** reflects this wealth of expertise. It inspires change and readies the sector for the next 50 years. Developing this CSOF in true partnership also reflects the four Priority Reforms set out in the National Agreement for Closing the Gap announced in July 2020.

AIMS

This Framework defines:

1. the model of care for Aboriginal and Torres Strait Islander community controlled health services
2. the expected benefits/outcomes.

WHO WILL USE IT?

There will be three primary users of this Framework:

Aboriginal and Torres Strait Islander community controlled primary health care services and their staff who work every day at the front line to deliver the best care in diverse contexts so that Aboriginal and Torres Strait Islander peoples can live meaningful and productive lives on their own terms. Resources will be developed to inform the many people involved in the sector—including board directors, senior management, clinical staff, administration staff and staff working in health promotion, community empowerment and policy support—to apply the CSOF.

Aboriginal and Torres Strait Islander communities including those who want to understand and reclaim all that is involved in offering, and receiving, a well-planned, long-term and comprehensive primary health care service, and who see health care as a human right so that individuals in the community can lead strong, self-determining and healthy lives. Resources will be developed in various formats to ensure communities attain health as a human right and can realise the benefits of comprehensive primary health care for health equity.

Policy makers who seek a clearer understanding of the benefits to be realised through needs-based, fully-funded Aboriginal and Torres Strait Islander community controlled comprehensive primary health care. Whether working in the sector itself or in government or stakeholder organisations, policy makers need to recognise that investment in community controlled comprehensive primary health care is the most efficient and reliable means to close the gap in Aboriginal and Torres Strait Islander health outcomes.

This document acknowledges that terms such as AMS, ACCHO, ACCO and ACCHS are used interchangeably. In this Framework the acronym ACCHS is used as a standard term to refer to the type of organisation from which a community receives Aboriginal and Torres Strait Islander community-controlled comprehensive primary health care.

How to read this document

What is the purpose of this document?

Read this section to understand why the NACCHO board co-funded the production of this Framework with the Indigenous Health Division of the Australian Government Department of Health. The Framework defines the model of comprehensive primary health care for Aboriginal and Torres Strait Islander community controlled health services and the expected benefits and outcomes. The NACCHO board will use the Framework to advocate effectively for the funds the sector requires to deliver better health and wellbeing for Aboriginal and Torres Strait Islander peoples.

Our value proposition

Read this section to learn about where we have come from, where we are going, and why this matters. This section also references Australia's new National Partnership between Aboriginal and Torres Strait Islander Peoples and the 2020 National Agreement for Closing the Gap. By reading this section, you will better understand the history and philosophy of the sector. The 2020 National Agreement for Closing the Gap requires NACCHO affiliates and ACCHSs to be equal permanent partners with governments in decisions about health and wellbeing.

Key terms and concepts for the model

Read this section to learn what terms have been selected for this Framework and why they make sense on the ground to Aboriginal and Torres Strait Islander peoples for self-determination and health gain.

Principles

Read this section to learn about the four **Framework Principles**. These explain how self-determination achieves better health. This section also presents the seven **Operating Principles** for core services in the Framework. The Framework is seen as a sound, member-owned resource articulating requirements for community controlled comprehensive primary health care throughout Australia. Although government will decide whether the Framework can be used as part of a funding model, NACCHO will argue persuasively for this to be the case.

How the model works

Read this section for an overview of the model's components, and how it is designed to link to other parts of the health system and local place-based services. A diagram provides a visual representation of the model. Technical resources to assist in assessing needs and defining and measuring outcomes will be provided in the future.

Domains in detail

Read this section for detailed descriptions of each of the four domains by which core services have been organised.

Our value

Our value

Fundamental to this Framework is the moral imperative to work **for**, **with** and **in response to** the needs of the local community. Aboriginal and Torres Strait Islander community controlled primary health care has always reflected an unswerving commitment to the collective – the community – as well as to the individuals within it (Otim et al. 2015; Gomersall et al. 2017; Closing the Gap campaign 2019). ACCHSs first arose in the early 1970s in response to the failure of the health system to meet the needs of Aboriginal and Torres Strait Islander peoples and their aspirations for self-determination. Since the first Aboriginal Medical Service in Redfern in 1971, the number of ACCHSs has expanded and there are now over 140 ACCHSs around Australia.

As described here, ACCHSs have developed a comprehensive model of primary health care that is consistent with, yet predates, the definition of primary health care outlined in the Declaration of Alma Ata (WHO 1978). ACCHSs were the first organisations to offer comprehensive primary health care in Australia and are acknowledged in multiple forums and in research as the best example in recent times.

Cultural determinants of health are anchored in Aboriginal and Torres Strait Islander ways of knowing, being and doing; these encompass a holistic understanding of health and wellbeing (Lowitja 2020; Lovett et al. 2020). Culture is central to this understanding and shapes relationships across self, country, kin, community and spirituality. As the health system becomes more complex, the role of community controlled primary health care as an act of self-determination becomes even more critical.

PRIMARY HEALTH CARE IS A PARTICIPATORY COMMUNITY ASSET

To reduce health inequity, primary health care is planned and delivered with the active participation of the community it serves, and is highly aware of the social, economic, historical and political determinants of health (Sanders et al. 2019). Responsiveness to community need and inclusiveness in action are immutable characteristics of primary health care.

To meet the needs of Aboriginal and Torres Strait Islander peoples, primary health care must be 'comprehensive'. By contrast, 'selective' primary health care can deliver only part of the promise of primary health care. In 'selective' care, priorities are determined from outside the community (Magnussen et al. 2004). Resources for 'selective' care generally arrive through 'vertical funding', the means by which governments or funding agencies typically pursue a specific focus. Vertical funding risks distorting comprehensive approaches on the ground—the services people need may not be those made available by vertical funding. In addition, these 'vertical' approaches are inconsistent with the holistic Aboriginal and Torres Strait Islander concept of health defined by the National Aboriginal Health Strategy (1989).

COMMUNITY CONTROL WORKS

The expression of culture and its highest attainment through self-determination are central and unique to Aboriginal and Torres Strait Islander community controlled comprehensive primary health care. Governments around the world struggle to achieve health for all as a human right (PAHO 2019). For Aboriginal and Torres Strait Islander peoples in Australia, community control over core services and outcomes provides the clearest means to do so.

COMMUNITY CONTROLLED PRIMARY HEALTH CARE AS AN INVESTMENT IN COMMUNITY HEALTH

Our sector provides a 'double benefit' for governments investing in community controlled comprehensive primary health care. Strong cultural authority throughout an organisation ensures culturally safe services. In addition, the sector provides fulfilling roles and diverse careers for high numbers of Aboriginal and Torres Strait Islander people. ACCHSs aspire to be employers of choice for Aboriginal people, Torres Strait Islanders and non-Indigenous people. Nationally, this sector is the second largest employer of Aboriginal and Torres Strait Islander individuals.

RESPONSIVE ORGANISATIONAL ARRANGEMENTS, ECONOMIES OF SCALE AND INFRASTRUCTURE

Because of the diverse range of community contexts and capacities across Australia, responsiveness is key. A variety of structural arrangements currently exist: regionalised structures such as Miwatj or Central Australia Aboriginal Congress; hub and spoke such as Kimberley Aboriginal Medical Services in the Kutjungka region; and single-site structures such as Yarrabah with outreach. Regional networks and health bodies under community controlled governance are in place to support coordination and maximise impact.

For many decades, the sector has exhibited a responsiveness to community need and a focus on economies of scale wherever possible. However, both long-standing and relatively new ACCHSs are impeded in their provision of services by limited capital infrastructure. This includes not only clinic spaces especially for outreach, but also, in regional and remote settings, on-site staff housing owned by the ACCHS. These are serious yet remediable barriers to high-quality services. Unaddressed, these limitations in physical buildings and clinic amenity will detract from the full impact of comprehensive primary health care. Emerging technological solutions to achieve more effective health services with lower costs, such as telehealth, make it imperative that accreditation standards for clinics and administrative offices are met and maintained. Improvements in physical and technical infrastructure reinforces the pride communities have in their local ACCHS.

THE WIDEST POSSIBLE LENS ON COMMUNITY HEALTH AND WELLBEING

Primordial prevention comprises actions that inhibit the emergence and entrenched establishment of environmental, economic, social and behavioural conditions known to increase the risk of disease. This includes food security, housing, economic prosperity, general education and literacy.

Primary prevention moves towards an individual focus to limit the incidence of disease and disability. It does so by eliminating or reducing factors that undermine health and promoting factors protective of health. Examples of primary prevention include programs to discourage the uptake of smoking, encourage immunisation, and increase opportunities for healthy eating. Primary prevention targets whole populations, including healthy individuals.

Secondary prevention aims to prevent the progression of disease through early detection and/or intervention. Secondary prevention also identifies individuals through screening to detect those with early disease.

Tertiary prevention aims to reduce the consequences of established disease. This means a diagnosis has been made and disease-treatment plans are explained, negotiated and organised. Other examples of tertiary prevention include self-management programs for people with diabetes, or rehabilitation programs for those recovering from accident or illness.

VALUE FOR MONEY

Primary health care for Aboriginal and Torres Strait Islander peoples takes place in challenging circumstances. Evidence shows that community controlled care is highly cost effective: primary, secondary and tertiary prevention are intertwined and directed in accordance with community need and prioritisation (Deloitte 2016). One major study concluded that: '... up to fifty percent more health gain or benefit can be achieved if health programs are delivered to the Aboriginal population via ACCHSs, compared to if the same programs are delivered via mainstream primary care services' (Voss et al. 2010).

Revenue sources for ACCHSs are diverse; they include block grants from the Department of Health, Medicare billings, targeted funding (for specific programs or disease management), jurisdictional grants and contracts. Through the latter, ACCHSs may obtain funds for services identified as critical to community health and wellbeing, where there is an unmet need or no other culturally safe provider—for example, National Disability Insurance Scheme (NDIS) coordination, dedicated services for mental health, aged care, prison health services, out-of-home care for children and family preservation programs. By seeking separate funding to deliver these services, the sector reinforces the holistic nature of Aboriginal and Torres Strait Islander health and wellbeing, connecting health and social services.

Irrespective of funding source, primary healthcare as a system ensures the sector is primed to respond comprehensively to priority health needs and to embrace new technologies and methods. Investing in community control, including better training, employment and retention, youth leadership and capacity building across every domain, brings intergenerational benefit. This spectrum of care treats diseases and manages chronic illness at the first level of presentation for individuals, but also incorporates areas such as environmental health, pharmaceuticals, counselling, preventive medicine, health education and promotion, rehabilitative services, antenatal and postnatal care, maternal and child care, approaches to address socio-somatic illness, and wrap-around services provided in a holistic, culturally safe and person-centred way.

ACHIEVING EXCELLENCE THROUGH CONTINUOUS QUALITY IMPROVEMENT

ACCHSs undertake Continuous Quality Improvement (CQI) to support and improve the quality of their services. CQI is a process of designing continuous cycles of change, guided by teams and using data to identify areas for action, develop and test strategies, and implement service improvement (NACCHO 2018).

Accreditation of clinical services through Australian General Practice Accreditation Limited (AGPAL) or similar organisations has been longstanding and should be maintained. Accreditation of population-health programs and community empowerment is less well standardised. On their own initiative ACCHSs have sought accreditation through the International Organisation for Standardization (ISO). Standards for ACCHSs are broader and extend beyond those for mainstream primary care.

CQI is most effective when embedded in the core business of providing health care. A whole-of-organisation approach ensures that CQI is visible in governance, operational leadership, clinical services, community programs, and partnerships. Community consultation and participation distinguishes CQI undertaken by ACCHSs (CREATE 2020).

While ACCHSs are not primary agents in dealing with the wide range of social determinants of health, CQI can be adapted to ensure each organisation monitors and mobilises action on social determinants in partnership with other agencies. This approach to accountability and working together using data helps to ensure that other parties do not neglect their responsibilities in addressing social determinants.

KNOWING THE COMMUNITY AND ITS STRENGTHS

Primary health care is a holistic approach incorporating body, mind, spirit, land, environment, custom and socio-economic status. Aboriginal and Torres Strait Islander concepts of health care are culturally constructed; they encompass essential, integrated care based on practical, scientifically sound and socially acceptable procedures and technology. This care is accessible to community members as close as possible to where they live and enables their full participation, mobilising the principles of self-reliance and self-determination. Providing this calibre of primary health care requires an intimate knowledge of the community and its health priorities. The community itself decides how best to approach health issues, including the balance between promotive, preventative, curative and rehabilitative services.

COLLABORATION AND SUPPORT BY THE SECTOR FOR THE SECTOR

In each state and territory, there is an affiliate network funded through NACCHO to support ACCHSs. These collaborative networks promote learning, the sharing of expertise and development of a cohesive national approach to health policy and programs for Aboriginal and Torres Strait Islander peoples. While this Framework does not detail the functions or outcomes required for NACCHO, its affiliates or regional community controlled health networks, their roles in supporting every ACCHS to improve service reach, performance and impact are critical, implicit in this Framework and similarly require resourcing.

ACCHSs are an integral part of the architecture of the Australian health system

They must be:

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

Boards of ACCHSs must comprise a majority of Aboriginal or Torres Strait Islander people elected by Aboriginal and Torres Strait Islander community members only.

By definition, organisations controlled by government to any extent are excluded.

By definition, organisations that adopt a vertical approach to health, inconsistent with the holistic definition set out in the National Aboriginal Health Strategy, are excluded.

This Framework presents the core services and outcomes for community controlled comprehensive primary health care that will enable delivery of integrated, effective and culturally safe services. These services are designed in response to the health needs and priorities with service configurations identified and valued by the community.

Key terms and concepts for the Model

Key terms and concepts for the Model in this Framework

MODEL OF ABORIGINAL AND TORRES STRAIT ISLANDER COMMUNITY CONTROLLED COMPREHENSIVE PRIMARY HEALTH CARE

Aboriginal and Torres Strait Islander community controlled comprehensive primary health care services are unique. Each is **controlled** by the community receiving the service. **Cultural authority** is guaranteed as each service is governed by a community-elected board. The local community identifies need and demands that its service 'delivers care our way'.

This Model is an act of **self-determination**. Self-determination cannot be achieved through any other model. It is true to the universal principles of primary health care articulated in the 1978 Declaration of Alma-Ata which stated that 'people have the right and duty to participate individually and collectively in the planning and implementation of their health care'.

There are four domains covering functional areas and activities necessary to respond to community health needs as determined by a community-elected board. Health is broader than physical health or the absence of disease for individuals. For Aboriginal and Torres Strait Islander peoples, health is intrinsically connected to land, sea, language and culture and to community and interpersonal relationships. These four domains describe functional areas in detail so that each area is easy to find and not forgotten.

To be categorised as an Aboriginal and Torres Strait Islander community controlled comprehensive primary health care service, all functions described in each domain must be pursued.

All four domains must be in place and linked to improve health and wellbeing. Each domain has been conceptualised to permit a clear description of service activity that can be systematically costed in any future needs-based funding model. These core services that individuals and communities can expect from their community controlled comprehensive primary health care service are presented as the WHAT. Each ACCHS decides HOW its core services are to be offered.

This term refers to the policies, pathways and other resources within each ACCHS designed to communicate the specifics of service delivery to users and staff. Service delivery models document operational requirements such as who first sees a person presenting to a specific service, how referrals and follow-up work, which staff are employed or how people with a chronic disease have their care plans co-designed and implemented. Cultural safety is operationalised in these service models through daily action. Service delivery models are not prescribed in this Framework. Instead, the Framework enables flexibility in 'models of care for service delivery' according to community and board decisions.

ACCHSs are an anti-racist structure.

Participant at CSOF Expert Advisory Group virtual meeting, July 2020

'Community control' is not just a term—it is a 48-year-old model forged at Redfern in 1971—and now exercised in 144 local Aboriginal and Torres Strait Islander communities across the country.

Donnella Mills, NACCHO Keynote Address at the CATSINaM National Professional Development Conference, Sydney, 26 September 2019

To call yourself a comprehensive primary health care service, you need to be more than a 'sick care service'. You also need to be public health advocates to garner action on poverty and overcrowding. You must invest in communities, develop leaders and reclaim community empowerment. You must look to act on social determinants of health as well.

Participant at CSOF Expert Advisory Group meeting, Sydney, December 2019

You can do all the work you like with a psychologist and psychology strategies on an individual level; if you send people back into an environment where there is no community engagement and no commitment on everyone's part to say look, this is what we're going to do as a group, it's not going to work.

Practitioner interview quoted in Freeman et al. 2019

Principles

Framework principles

In the Australian health system, only Aboriginal and Torres Strait Islander community controlled primary health care organisations have community-elected boards accountable to specific communities, to funders and to each other. As institutions of self-determination, these services attend to all matters affecting health and wellbeing--from transformative community empowerment through to individual health treatments and continuity of care. By delivering the largest benefits in primary health care, ACCHSs represent value-for-money overall and reduce inefficiency from avoidable hospitalisations (Vos et al. 2010). Integration and coordination functions also ensure effective and efficient secondary referrals, admissions when required, and handover of responsibility for client management back to primary health care. Person-centred approaches are widely recognised as the foundation for safe, high-quality health care—approaches that are respectful of, and responsive to, the preferences, needs and values of individual clients in their family and community context. The transition of one remote health care service from government management to community control increased utilisation of the service by 408 per cent; accelerated immunisation rates; reduced the proportion of babies born with low birth weights to less than 10 per cent; and increased employment of qualified Aboriginal and Torres Strait Islander people (Myott et al. 2015).

Health inequities are the result of the circumstances in which people are born, grow up, live, work, and age, circumstances that in turn are shaped by asymmetries in the distribution of money, power and resources. These circumstances are unique in Australia for Aboriginal and Torres Strait Islander peoples because of the history of colonisation and the continuing unreconciled effect of this history manifest in institutional racism and structural disempowerment. Social relations and asymmetries of power affect the exercise of people's rights, including the right to health (Closing the Gap campaign 2019). Primary health care has a unique responsibility to recognise and act on social, cultural, historic and economic determinants of health (Labonté and Packer 2017). As stated in the National Aboriginal Health Strategy in 1989, Aboriginal and Torres Strait Islander communities across Australia have known for a long time that primary health care described in the 1978 Alma-Ata Declaration is the preferred mechanism for achieving health gain (Sanders et al. 2019). Vigilance is required to avoid an excessive reliance on individual clinical services or biomedically-dominated models of care. Aboriginal and Torres Strait Islander community controlled comprehensive primary health care combines the benefits of culturally safe clinical care, an increasing emphasis on prevention and effective partnership action on social determinants. Eleven per cent of the Aboriginal and Torres Strait Islander health gap is due to individual behavioural risk factors; 15 per cent due to the interaction of behavioural risk factors with social and environmental determinants; 31 per cent to social determinants; and 43 per cent to other factors such as access to health services (AIHW 2014).

Comprehensive primary health care must include 'illness care' to ensure those needing individualised attention receive treatment through qualified multidisciplinary teams with the necessary skills and team mix. 'Illness care' at the front line encompasses early intervention and access to health staff with expertise in effective counselling and support. Because in Australia a substantial component of illness care is provided in primary care, this country's health-care system is one of the most cost-effective for dollar spent in the world (Schneider et al. 2017). In contrast, health systems such as in the United State of America where people can self-refer directly to disease-specific physicians, surgeons or others who by training have a narrow scope of practice are highly inefficient and unsustainable. In Australia, non-GP medical specialists ('partialists' in one disease, body system or age group) are seen only after a team-based GP referral is made. This Framework recognises that community controlled primary health care accelerates health improvement by increasing access (geographic, cultural and financial) both to high-quality generalist services achieving continuity of care at the 'front line' and, through coordination, across the rest of the health system, building confidence in mainstream health institutions. This delivers cost-effectiveness with public monies (see Vos et al. 2010; Campbell et al. 2018).

This Model ensures that all decisions, strategies and improvements are led by Aboriginal and Torres Strait Islander people. ACCHSs are highly visible in Aboriginal and Torres Strait Islander communities and hold a unique, respected place in Australia's history of self-determination (Sullivan 2011). Endorsement of this Model should not disadvantage any current ACCHS in their efforts to provide comprehensive primary health care nor inadvertently further inequity. Consistently high standards are achieved through accreditation, CQI, benchmarking and other performance-improving methods. By adhering through this Model to the principles of the Alma-Ata Declaration (WHO 1978), ACCHSs ensure that health and wellbeing are improved through collective public health action as well as individual clinical approaches. As specified in the Ottawa Charter (1986), ACCHSs ensure that prevention is as important as treatment. Health promotion is in the hands of the people themselves rather than external experts who have little community connection or understanding. Through employment, engagement, empowerment and social action, ACCHSs are a proven mechanism for Aboriginal and Torres Strait Islander people to take responsibility over their health matters (NACCHO 2009).

Operating principles

The board sets strategy, and then oversees management and operations in delivering against the strategy. Health is a complex sector. Governance of health services is a matter of life or death and a critical responsibility. Governance is conceptualised in two ways: first, governance as it relates to the structures of community control that are unique to the Model and, second, the corporate-support services required in every health service to secure standards and ensure that these are implemented in a community controlled safe environment. Governance also ensures place-based solutions. ACCHSs work in very diverse service landscapes. In a well-resourced urban environment, there may be a range of options to ensure delivery of core services; services may be brought in from service partners including access on site to non-GP medical specialists employed through the state by the Local Health Network. In another type of location, additional primary mental health or alcohol and other drugs (AOD) supports may be limited by a lack of services to partner with. Similarly, remote ACCHSs may have few options for partnership and so will need to find resources and approaches to provide the full range of core services themselves.

Resourcing of core services cannot be confined to service positions only. A suite of infrastructure is required including funding for 'support functions': electronic clinical information and management systems, technology (for example, telehealth), physical infrastructure, transport, business services, cyber-security, insurance, legal advice, accreditation, professional and career development. Other 'support functions' include technical and coordination expertise for policy development and implementation, quality improvement, financial and human resource management, needs assessment, evaluation and research. The Model also includes 'enabling functions' such as processes for community control, engagement and participation (AMSANT 2011). Capital assets including well-equipped clinics and staff accommodation will be required.

Governance guarantees service quality and impact

Service delivery models of care are set by the board

Infrastructure enables and supports

Service delivery models of care promote and safeguard integrated, person-centred care

While this Model and the scope of core services required will be universal, the disciplinary mix of staff and programs operating the Model rests with the community-elected board. The board is accountable for responding to priorities in the community, balancing service configurations and staff mix, policies, and strategic outcomes. Management and staff will develop and implement responsive 'models of care for service delivery', integrating cultural, clinical and non-clinical aspects. These models of care recognise that individuals and families coming to the service also have their own priorities, preoccupations, health goals and solutions. These should be acknowledged, respected and negotiated in partnership when staff work with individuals, families and groups (Jennings et al. 2018).

This principle affirms that the organisational management of core services is overseen by the community-elected board. Further, whenever different staff are responsible for different aspects of care, or linkages are required to weave an effective 'client journey' between different health organisations or mainstream hospitals, the Model ensures that all necessary coordination, information exchange and handover is part of the core service and experienced seamlessly from the client's perspective. Use of CQI and 'systems approaches' including policies and procedures, incident reporting, case management and service evaluation are required.

ACCHSs demonstrate consistently high rates of sustained employment of Aboriginal and Torres Strait Islander people in a range of meaningful, satisfying job opportunities bringing community benefit. ACCHSs commit to 'train our own', recognising potential and supporting health-career pathways (Lowitja 2020). As community members, Aboriginal and Torres Strait Islander staff are co-designers of the services and programs they and their families engage with and benefit from. Their community engagement is genuine, effective and strengths-based (Askew et al. 2020). Work teams will typically comprise a mix of Aboriginal, Torres Strait Islander and non-Indigenous people. All will be appreciated, respected and supported in the Model to provide the highest standards of service.

Social determinants of health will be embedded in the upcoming National Aboriginal and Torres Strait Islander Health Plan 2021–2031 including housing, education, employment and food security. Community controlled organisations understand these determinants better than government or non-government organisations. Responsibility for action on social determinants of health lies beyond primary health care; however, the necessary intersectoral action is often facilitated by primary health care services. In addition, the very presence of a successful community controlled comprehensive primary health care service is a shining light for opportunity and meaningful work, achievement of results, social accountability and self-determination. Aboriginal and Torres Strait Islander community controlled comprehensive primary health care has responded to confront institutional racism. Dispossession, interruption of culture and intergenerational trauma have significantly impacted the health and wellbeing of Aboriginal and Torres Strait Islander peoples.

Service delivery models of care will be evidence-based and increasingly welcome knowledge and evidence produced by Aboriginal and Torres Strait Islander scholars in partnership with Aboriginal and Torres Strait Islander communities and services

Aboriginal and Torres Strait Islander staff will flourish in ACCHSs as work environments placing high value on their skill sets, their connections within communities and their knowledge of culture

Social determinants of health may not always be within the direct sphere of control of ACCHSs but will always be within their sphere of interest and concern

Since their inception, ACCHSs have embraced evidence-based practices and have become vital partners in health and medical research. Yet previous research has not always delivered positive outcomes for Aboriginal and Torres Strait Islander communities. Data democracy and expectations of Aboriginal and Torres Strait Islander peoples regarding data sovereignty are changing. Threats to health data use and misuse include cloud-based data storage and access. Community-led research is incubated by ACCHSs who also prioritise local research capacity building. Health service design, delivery and improvement will become an even stronger focus for innovative partnerships across Aboriginal and Torres Strait Islander communities, boards, Aboriginal and Torres Strait Islander academics and their research organisations (Beks et al. 2019). Accelerated implementation of proven research findings into daily practice—also known as 'research transfer'—augments quality of care and achievement of the best possible outcomes.

How the model works

People

Culture

Leadership and cultural authority

Needs assessment* and outcomes*

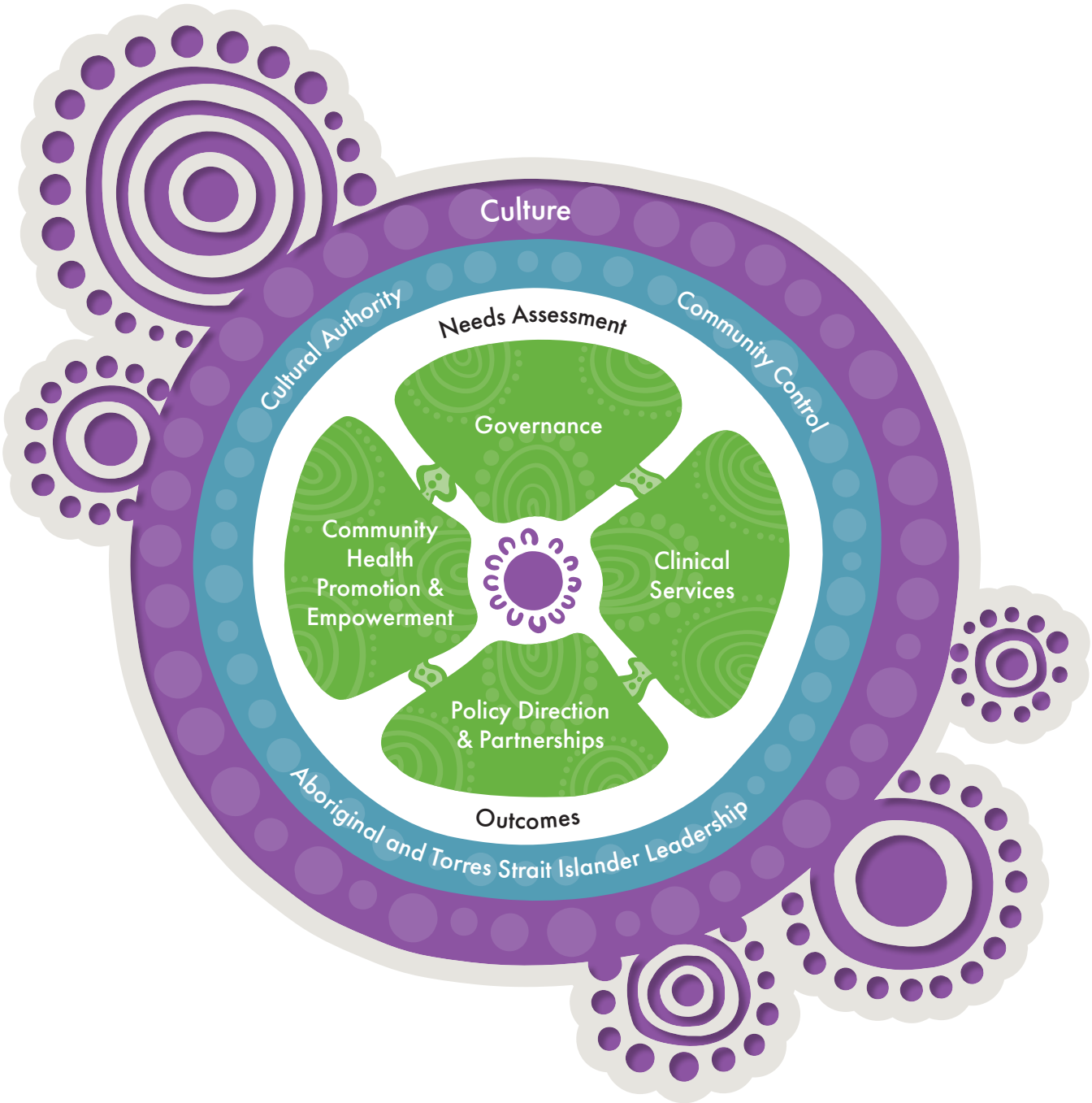
Domains for core services

*To be described in further detail in future documents

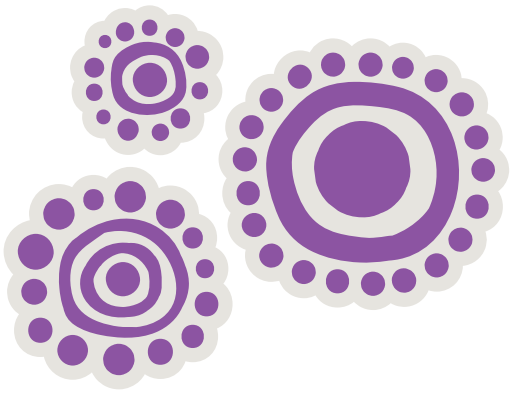
How the ‘model’ works

This visualisation has been developed to convey the components of the MODEL OF NEEDS-BASED COMMUNITY-CONTROLLED COMPREHENSIVE PRIMARY HEALTH CARE that is the foundation for this Core Services and Outcomes Framework. Each component is explained in the following pages.

Figure 1: Model of needs-based community controlled comprehensive primary health care



People



People surround the Model because the Model serves people—and people engaged through community control ensure the Model succeeds in improving health and wellbeing.

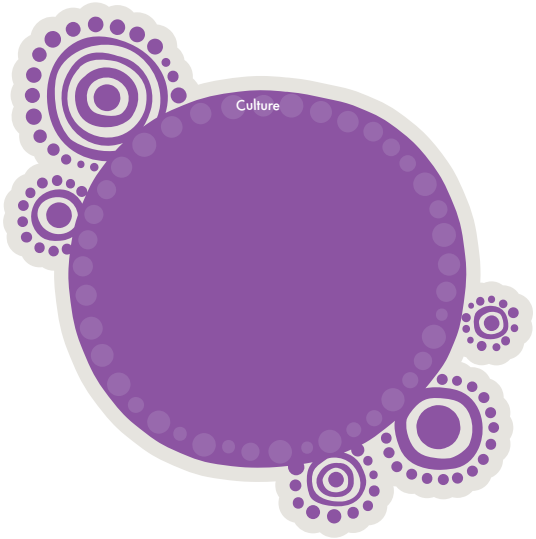
As a member of their community, every Aboriginal and Torres Strait Islander person should expect core services as an individual according to their life course and clinical and cultural needs. This is consistent with person-centred care espoused both by NACCHO and by all peak medical colleges and organisations for health professionals responsible for standards of professional practice. It is also consistent with the expectations of the Australian Government, relevant bodies such as the Australian Commission on Safety and Quality in Health Care, and accreditation requirements.

As self-determining social entities, Aboriginal and Torres Strait Islander communities should expect to have access to more from their community controlled comprehensive primary health care than individual clinical services confined to biomedical perspectives. In this Model, every community sees and benefits from public health action and health promotion programs co-designed by the community. These include effective strategies undertaken through primary health care on the range of social determinants of health, planned according to population health needs and reflecting the preferences of the community. Each community has deep and untapped strengths unique to its history and culture. These are extraordinary foundations for effective community re-empowerment and nation building.

Employment and progressive credentialing to perform varied functions ensures Aboriginal and Torres Strait Islander people who want to stay in their communities have access to highly complex, satisfying jobs. This Model also encourages workforce capacity building to reduce reliance on non-Indigenous short-term staff who are unfamiliar with the community, its culture, networks and strengths.

> **Local Aboriginal and Torres Strait Islander people in local communities are the foundation of Aboriginal and Torres Strait Islander community controlled organisations.**
>
> *QAIHC 2018*

Culture

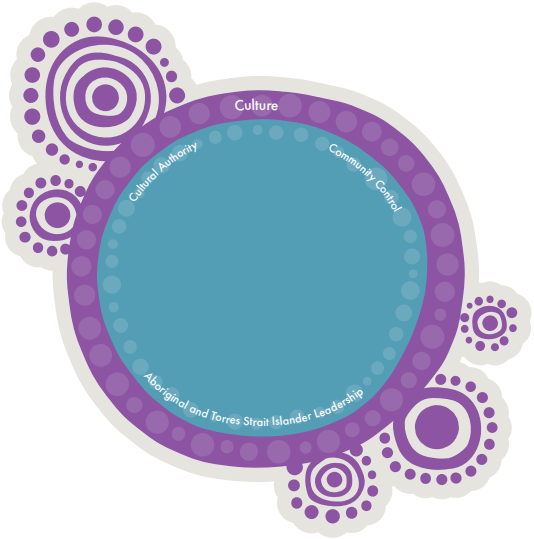


From inception, the CSOF Steering Committee affirmed the importance of culture in every aspect of the community controlled primary health care sector. Culture is embedded in all aspects of care offered by Aboriginal and Torres Strait Islander health services and everything they do (Hardfield et al. 2018). Depicted in Figure 1 as the outermost solid rim, culture keeps communities strong and healthy. To ensure culture is expressed in all components of the Model, culture surrounds it. Culture is highly correlated with empowerment, community health and other social outcomes such as employment and education (Cairney et al. 2017). A strong cultural ethos ensures a strengths-based approach, sustained incorporation of Aboriginal and Torres Strait Islander knowledges and accountability to past, present and future generations. The imminent *National Aboriginal and Torres Strait Islander Health Plan 2021–2031* will embed the cultural determinants of health to achieve its vision that Aboriginal and Torres Strait Islander peoples enjoy long and healthy lives. Culture emerged as crucial through the consultations held by the Implementation Plan Advisory Group (My Life My Lead report 2017). To foster cultural wellbeing, governments should value in the health context Aboriginal and Torres Strait Islander peoples' language, knowledge and beliefs, kinship, cultural expression and exchange, country and caring for country.

These vital insights about culture are exercised through Aboriginal and Torres Strait Islander governance structures, in other words, through community control. Cultural safety is inherent in the Model. Cultural safety is the 'outcome of education that enables safe services to be defined by those who receive the service. Unsafe cultural practice is any action which diminishes, demeans or disempowers the cultural identity and wellbeing of an individual' (NATSIHWA 2013). As defined in the Australian Health Practitioner Regulation Agency Strategy (AHPRA 2020), cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families and communities. Culturally safe practice is the visible result of ongoing critical reflection about knowledge, skills, attitudes, behaviours and power differentials by health practitioners themselves as they strive to deliver safe, accessible and responsive health care, free of racism (AHPRA 2020). For non-Indigenous people joining an ACCHS, these deep cultural dimensions of Aboriginal and Torres Strait Islander health and wellbeing may not be immediately comprehensible. Effective orientation is required. The Model acts as a buttress against paternalistic attitudes or the re-emergence of colonising practices or institutionalised racism in health organisations that are not community controlled.

While it is true that cultural safety and authority flows from the very nature of Aboriginal and Torres Strait Islander community control through the governing board and community consultations and engagement, the Model ensures that cultural safety is embedded and integrated operationally throughout the organisation and its daily operations. How this is done looks different for different ACCHSs, but the need for operational integration is universal. Recognising and formalising the roles of Aboriginal and Torres Strait Islander staff in an integrated cultural-safety framework further embeds this characteristic. From a work health and safety perspective, the workplace must be safe for everyone and welcome diversity. Cultural safety in service delivery is, however, paramount.

Leadership and cultural authority



The assertion of **Aboriginal and Torres Strait Islander leadership**, past, present and emerging, at every level and in every activity of a community controlled organisation is conveyed in the next rim of the diagram. The twin concepts of 'cultural authority' and 'community control' are also depicted. These are asserted through sound governance, community-elected boards, meaningful community consulation, scrutiny of all aspects of the service by Elders and others in the community vested with cultural knowledge and expertise, and recalibration of any aspect of service design and delivery that might push up against culture. The Model also recognises youth perspectives and develops young people's leadership.

Community control accelerates the attainment of health and wellbeing for Aboriginal and Torres Strait Islander peoples in two ways: firstly, the assignment of authority to select, design, manage and be accountable for community-based health care increases health impact, and secondly, the lived experience of genuine individual and community empowerment leads to more equitable power relations in Australian society (Campbell et al. 2007; Thorpe et al. 2016; Coffin et al. 2017). In Canada, Chandler and Lalonde (1998) documented how the highly variable rates of youth suicide among British Columbia's First Nations were clearly associated with scores against six markers of 'cultural continuity': self-government, land tenure, control over education, health and other public services, and success in marshaling resources needed to construct cultural facilities within the community. The greater the community control, the lower the youth suicide rate. This pattern has also been observed in Queensland (Gibson et al. 2021).

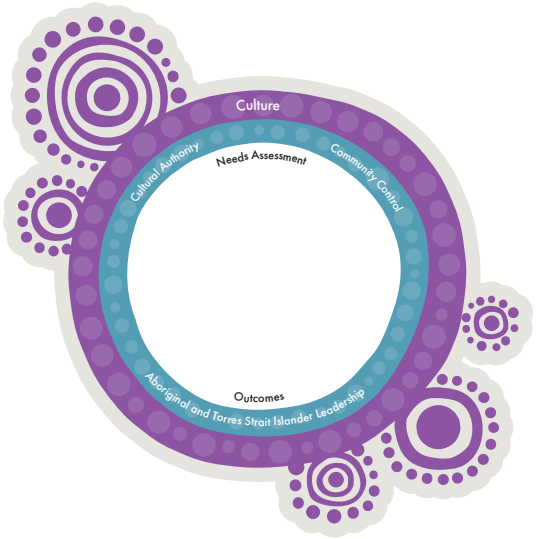
Similarly, in community controlled primary health care in Australia, the community itself makes decisions and gives direction about health care priorities and responsive service delivery through an elected community governing board. This is a unique and distinguishing feature of the sector. Cultural authority over all aspects of service provision cannot be guaranteed in any other way. Community governance and community control are only present in this Model. By definition, government-managed or privately-owned primary health care clinics have different organisational structures, are not community controlled and therefore cannot guarantee through transparent governance that the interests of the Aboriginal and Torres Strait Islander peoples they serve will be placed above their own institutional imperatives. In these situations, efforts through consumer advisory groups or other mechanisms are needed to enhance cultural safety as described in the six actions specific to Aboriginal and Torres Strait Islander people in the second edition of the National Safety and Quality Health Service Standards (NSQHSS) (ACSQHC 2017). However, the distinct quality of community control and the value-add for access and impact is absent in these models. A growing focus on 'consumer-led' models across all levels of the Australian health care system simply mirrors this feature of the Model, namely that Aboriginal and Torres Strait Islander governance of ACCHSs is the most visible application of 'consumer-led' health care in the country.

This Model ensures the four habits of high-performing health care organisations can be achieved through Aboriginal and Torres Strait Islander governance: These common habits are:

1. specification and planning
2. infrastructure design
3. measurement and oversight
4. perpetual learning for all, ensuring health knowledge is a public good and not the property of individual clinicians.

Each ACCHS reflects its local community's conceptualisations of cultural values, philosophies and spirituality. One better known example is kanyini, a Pitjantjatjara word conveying the principle of connectedness through caring and responsibility. These connections 'hold' a community together, build resilience and the deep strength essential for a vibrant society and healthy people (Peiris et al. 2012). Finally, this 'rim' visualises the oversight of linkages across domains in the Model that must be in place to improve Aboriginal and Torres Strait Islander health and wellbeing.

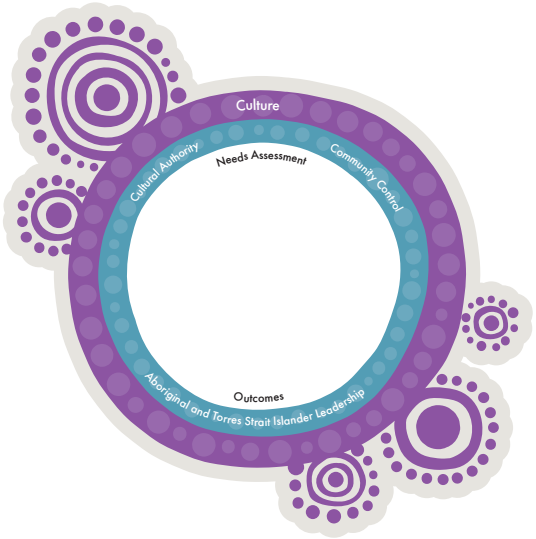
Needs assessment



The next inner rim references the technical function of **needs assessment** combined with board, management and staff knowledge of community needs, priorities and strengths. Needs assessment has both technical and social dimensions. Population-based approaches including deep knowledge of local community health issues will be incorporated in needs assessment.

Needs assessment will be detailed in Phase 2 of this project.

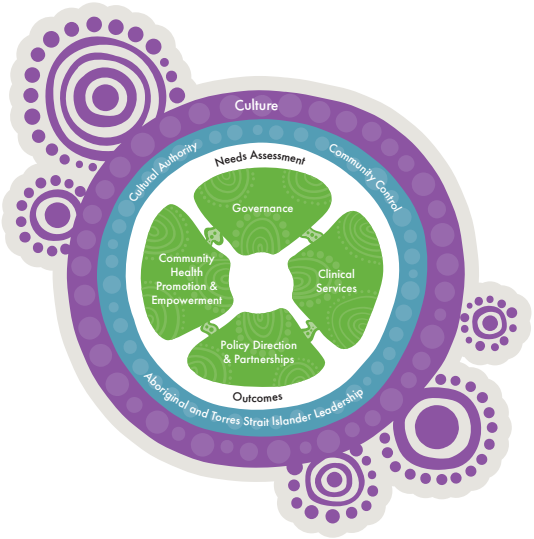
Outcomes



Also depicted in this rim is accountability for a set of agreed **outcomes** and for improving health and wellbeing in effective, efficient and sustainable ways. Value-based health care achieves value for the individual, value to the employed workforce, population health outcomes and cost-benefit. Research by the World Bank demonstrates significant improvements in health-care performance in developing countries when communities receive quantitative performance data and themselves monitor service standards (Bjorkman et al. 2017). These reinforcing benefits of community controlled primary health care are needed more than ever. Strategic investment in primary health care leads to less spending on more costly consequences such as preventable hospitalisations (Ma and Ward 2020). Outcomes will mirror the National Agreement on Closing the Gap signed in September 2020 and the upcoming *National Aboriginal and Torres Strait Islander Health Plan 2021–2031* being developed by the Implementation Plan Advisory Group.

Outcomes will be detailed in Phase 2 of this project.

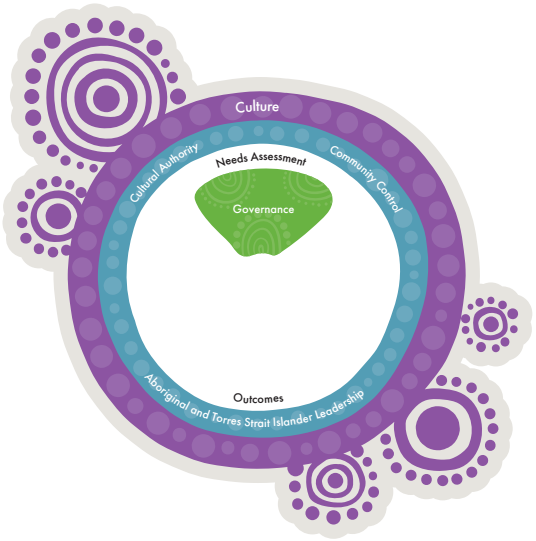
Domains for core services



These outside rims hold together four integrated domains coloured in green. These four domains organise service functions so that each function is easy to find and not forgotten. Each domain has been conceptualised to permit a clear description of service activity that can be systematically costed in any future needs-based funding model. This shows how core services conceptualised in four integrated domains achieve full realisation of this Model and improve health. These core services that individuals and communities can expect from their community controlled comprehensive primary health care service are presented as the WHAT. Each ACCHS then decides how these core services are to be offered (the HOW). 'How' is not prescribed in this Framework because flexibility in the local context is paramount. By designing its own 'service delivery models' responsive to context, each ACCHS ensures right care, right time, right place, right team. Organisational needs assessments or capability assessments can systematically check where the ACCHS is positioned to address community needs and identify areas for improvement. All other features of the Model need to be in place. ACCHSs do not work in a vacuum, unsupported or isolated. Their respective state or territory affiliates are a ready source of technical support, coordination of clinical or health promotion programs, policy input or evaluation expertise whenever required. NACCHO responds to national needs and capacity gaps. NACCHO and affiliate support is readily provided. As shown in the following pages, each domain is further strengthened by Continuous Quality Improvement. Each requires workforce and infrastructure. In this Model, CQI is not confined to clinical issues as it may have been in the past. CQI resources give capacity to the sector to improve all aspects of organisational performance including governance, clinical practices, partnerships and population health impact. Community-led research and evaluation also features in this Model, ensuring Aboriginal and Torres Strait Islander people lead research for change.

Domains in detail

Governance



This domain supports the role of a governing body elected by members of an Aboriginal or Torres Strait Islander community as guarantor of community control in setting strategic direction of the organisation and overseeing service performance, culture and impact. This section articulates what is required for community control to function well.

Through their unique corporate structure, ACCHSs '... are an expression of self-determination that aim to improve health and wellbeing and mitigate the processes of ongoing colonisation' (Freeman et al. 2019). Governance is about people, power and authority; it is as much about relationships and values as it is about formal structures, management and corporate technicalities (Smith and Hunt 2008). Exercise of community control and cultural authority occurs through governance structures that perform well. To be community controlled, every ACCHS must have a registered membership base which elects the board, ensuring community-engagement mechanisms are inherent to its structure. Each ACCHS constitution specifies membership criteria, admission to membership and eligibility to vote for board directors. Without fully functioning community control, Aboriginal and Torres Strait Islander leadership and cultural authority can be sidelined.

Other differences between community control and mainstream control are mitigated through the Model. Mainstream control is everywhere. The mainstream has access to considerable institutional resources and social capital. An obvious difference is that Aboriginal and Torres Strait Islander people are more likely to be impoverished. It is usually far less easy for an Aboriginal or Torres Strait Islander board member to self-fund the travel or incidentals associated with the responsibilities of board membership. Similarly, consultations reveal a resolute commitment to fund youth leadership development and succession planning for ACCHSs. This requires specific resourcing. At a deeper level, colonisation is a root cause of the present circumstances including the health outcomes of many Aboriginal and Torres Strait Islander people. Taking an intergenerational perspective, ACCHS boards will have a view to ongoing community capacity building and building talent in emerging leaders, young people and staff.

Succession planning and the upskilling Aboriginal and Torres Strait Islander young people will help ensure they develop as successful leaders ready for board roles.

The board sets strategy, and then oversees management and operations in delivering against the strategy. This is why the functional areas in this domain are presented in two sections. It is best practice to distinguish board strategic advice from the daily operations of the service. Each ACCHS is enabled through this Model to tailor their governance arrangements to community preference and risk. The Model recognises governance as 'core'. Governance also requires resources. Adequate resources for effective governance enable the day-by-day responsibilities of board work but also investment in the capacities of community-elected board members and succession planning, equipping emerging leaders for future roles. As shown below, the costs of board meetings as well as community meetings, professional development and other strategies to build organisational capacity in the board and senior management must be funded. Infrastructure and resources for governance and service performance are also needed to produce community reports and demonstrate accountability. Corporate accreditation focuses on organisational systems, policies and procedures as a backbone for all service delivery. Clinical accreditation gives independent assurance to the community, users, funders and partner organisations that the ACCHS has systems in place to deliver high-quality care (SAHMRI 2020). Ultimately, quality and safety are the responsibility of the board; it must satisfy itself that the highest standards of care are being achieved consistently in challenging circumstances. ACCHSs workforce development achieves strategic goals for Aboriginal and Torres Strait Islander career pathways, lifelong learning and positive community impact (AHMAC 2017; Bailey et al. 2020).

BOARD GOVERNANCE AND STRATEGIC DIRECTION

G1 G2 G3

G1 Aboriginal and Torres Strait Islander leadership through the board

- Assert Aboriginal and Torres Strait Islander community control in all strategic, business and operational aspects of primary health care in the community
- Ensure up-to-date registers of community members eligible to vote for board directors
- Ensure majority of directors are elected Aboriginal and Torres Strait Islander people
- Strengthen board skills for sound governance under the *Corporations Act 2001*, *Corporations (Aboriginal and Torres Strait Islander) Act 2006* (CATSI Act) or other legislation under which the ACCHS is incorporated
- Register with the Australian Charities and Non-Profit Commission
- Provide strategic direction and decide on ACCHS strategies, priorities and objectives
- Set and monitor the strategic direction of the service to improve health and wellbeing of the community
- Review and approve budgets, internal compliance and control systems, risk assessments, policies, procedures, and codes of conduct
- Appoint, support and oversee performance of the CEO and plan for succession
- Ensure that the service's financial results are appropriately and accurately reported in a timely manner in accordance with constitutional and regulatory requirements
- Ensure that the organisation's affairs are conducted with transparency and accountability
- Provide stable leadership, build capacity for current and future directors, involve young Aboriginal and Torres Strait Islander people and plan leadership succession
- Adapt service priorities in response to community direction
- Direct cultural safety throughout the organisation and its programs
- Undertake periodic reviews of board performance and community perceptions

G2 Strategic service development

- Ensure high-value services and programs are delivered to the community, checking that these are valued by the community, individuals using the services and staff
- Ensure capacity to conduct or commission regular health needs assessments including both community perspectives and priorities and data on health needs and social determinants of health
- Identify, measure, interpret and monitor community needs through a cultural lens
- Oversee risk management processes across the organisation
- Lead and participate in strategic, business and operational planning
- Support CQI systems, data collection and support, reporting and service improvement
- Monitor staff morale and high-performing multidisciplinary teams in the workplace
- Ensure compliance with occupational health and safety standards
- Negotiate necessary support from the affiliate body when required, and receive it
- Ensure accreditation of the whole service as well as clinical accreditation

G3 Cultural authority and safety

- Ensure organisation-wide cultural safety policy, including regular monitoring of its implementation
- Include cultural competence as part of staff-performance appraisal processes and all program evaluations
- Include cultural issues in all critical incident investigations
- Design and comply with processes designed by the community—e.g. through consultations with local Elders and Traditional Owners—to gain insight and advice on cultural matters affecting services
- Encourage an organisation-wide focus on trauma-informed, healing-focused care

- Acknowledge and incorporate communication and language issues (e.g. in community-facing written materials, access to interpreters on- or off-staff)
- Implement accessible and appropriate client and community feedback mechanisms
- Employ, retain and train local Aboriginal and Torres Strait Islander people and value their role and advice
- Ensure cultural orientation for all incoming staff and monitor cultural safety

MANAGEMENT FUNCTIONS OVERSEEN BY THE BOARD

G4 G5 G6

G4 Integrated corporate support

- Manage money, resources, physical facilities, organisational culture, vehicle fleet, equipment and consumables
- Ensure sound administrative, legal and other services
- Equip multidisciplinary and multicultural teams to work together, recognising that team members will usually come from a mix of backgrounds: Aboriginal, Torres Strait and non-Indigenous
- Use information technology to improve impact and cost-effectiveness of all core services—e.g. electronic clinical records system, incident reporting, document management, tracking and archiving
- Modernise digital health and telehealth facilities, purchase required bandwidth
- Ensure systems are in place to monitor and replenish consumables, medical supplies, equipment in clinic(s)

G5 Organisation-wide commitment to provision of integrated person-centred care

- Develop, support and reinforce multidisciplinary teams to break down 'silos' in service delivery and meet clients' needs holistically—e.g. including adequate time/resources to integrate case-management across health-care disciplines
- Build workforce capacity and competency to deliver integrated care (training in teamwork, addressing power-differentials in the multidisciplinary team)
- Design and implement administrative and financial systems to support integrated care (e.g. managing/reporting on multiple funding streams)
- Ensure efficient information sharing across the team (e.g. common access to Client Information Systems, My Health record and adaptations of systems to support an integrated approach)
- Ensure opportunities for improvement in corporate, clinical and logistic activities are always identified and used to close priority gaps and attain agreed targets and indicators
- Scan and address infrastructure needs (whether co-location, stand-alone or outreach)
- Consider health needs of transitional clients, those who are homeless or visiting from other communities
- Maximise appropriate integration with services managed outside the organisation through implementation of memorandums of understanding (MOUs), referral pathways, case conferencing, etc.
- Measure change and report service-integration effectiveness

G6 Human resources (HR) and staffing

- Prioritise recruitment, training, support and retention of Aboriginal and Torres Strait Islander staff at all levels
- Support the development of Aboriginal and Torres Strait Islander managers and leader throughout the organisation
- Set and achieve targets for Aboriginal and Torres Strait Islander staff levels and seniority
- Ensure workplace culture is strengths-based and non-discriminatory

- Meet all legislative work health and safety requirements and all other relevant industrial relations requirements (such as those in the Fair Work Act 2009) including workforce safety especially in rural and remote areas
- Develop staff, train staff and educate staff
- Remunerate staff commensurate with their qualifications, skills and value to communities and the sector
- Support workforce and human resources through management best practice to maximise staff wellbeing, work satisfaction and retention including:
  - Recruitment
  - Salary, entitlements and working conditions
  - Orientation
  - Staff development including senior management training to optimise management practice and, for non-Indigenous staff, cultural safety
  - In-service
  - Mandatory training
  - Performance review including but not limited to cultural competence
  - Consumer feedback

INFRASTRUCTURE, WORKFORCE AND CONTINUOUS QUALITY IMPROVEMENT

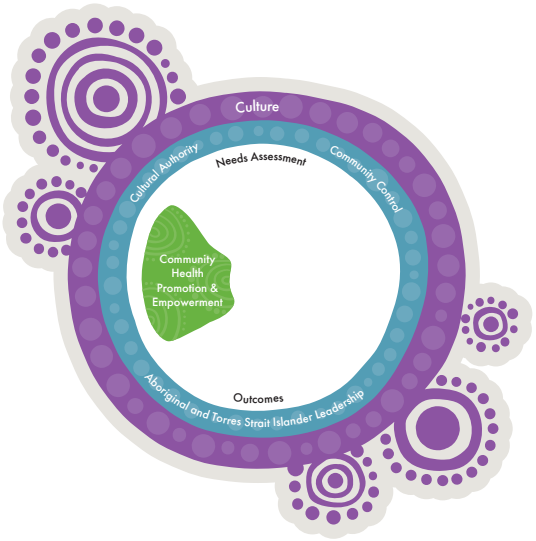
Infrastructure requirements for governance and, in turn, operational performance and service effectiveness include adequate resources for all the above functions including budgets for board training, remuneration, travel and meetings; all corporate infrastructure and service support functions including human resources (HR); minor repairs and maintenance to physical infrastructure; vehicle fleet, leasing or purchasing arrangements and insurances. The 'overburden' of administrative requirements disproportionate to accountability requirements has been recognised for some time (Dywer et al. 2009). Removing unnecessary reporting will release and redirect more resources to service delivery.

The absence of any or all necessary infrastructure is rate-limiting for high quality services. Inadequate infrastructure impedes health impact. Governance also ensures sufficient physical infrastructure to deliver all domains. In remote and some regional settings, essential physical infrastructure includes provision of on-site staff accommodation, satellite phone systems, a generator, and fuel and emergency supplies systems including generators. In settings where the ACCHS is the sole 24/7 service provider, additional infrastructure is required to ensure high-quality, safe care for the community and staff. Provision of emergency services is a specific function of the Model. Accordingly, ambulance bays, ambulance fit-outs and emergency rooms must be resourced when required.

Strengthening capacity for community-controlled governance needs a focus on local leadership including emerging youth leaders, Elders and Traditional Owners. Developing Aboriginal and Torres Strait Islander executive leaders and senior managers supports workforce requirements for this domain.

CQI will be applied at board level to improve the board's own performance and support the development of the organisation as a whole. ACCHSs must be lawful, efficient, prudent and ethical. Board directors must act in the interests of the ACCHS. CQI can be utilised to address issues and challenges anywhere in the organisation; however, CQI for the board will focus on director skills, performance and strategic achievements or more procedural matters such as conflict of interest registers, adherence to board charters and 'rule books' or skills mix. Boards can also focus on cultural safety throughout the organisation, adherence to service models as endorsed by the board, community feedback and satisfaction, quality and reception of annual reports, community engagement in priority setting, or quality of partnerships as a few examples. Boards can initiate risk registers, policy audits, financial enquiries and restructures. The Office of State Revenue, Queensland (OSR) data portal is a source of data for organisational capacity assessments well-suited to CQI projects. More complex CQI projects can examine longitudinal change and health-improvement indicators. Across the sector CQI will elevate standards for all, sharing best-practice examples in non-threatening forums such as the annual NACCHO conference.

Community health promotion and empowerment



This domain presents core services for community empowerment including health promotion and preventive programs organised and delivered by community controlled primary health care.

Comprehensive primary health care differs from 'primary care' because it is equally committed to community development, effectively promoting health beyond the confines of the clinical service and advocating for action on determinants of health lying outside the immediate health system. Community health promotion and empowerment benefits the community as a whole, as well as individuals and families within it. Community co-design occurs when the community itself has control. Healing and resilience are achieved through consistent strengths-based approaches. Effective health promotion reduces the burden of disease through primordial prevention (addressing the 'causes of the causes') and primary prevention (intervening to reduce risk factors before disease occurs) (Brown and Kritharides 2017). Primordial prevention tackles how society is structured and power asserted. This is also known as the political economy of health. Clinical needs and population health are integrated to complement and amplify each other through Aboriginal and Torres Strait Islander community controlled comprehensive primary health care.

There is no expectation that primary care, by itself, plans and delivers effective community health promotion. Primary care is too narrow to support empowerment and legitimately strengthen self-determination (Freeman et al. 2019). This is why comprehensive primary health care is needed for Aboriginal and Torres Strait Islander health and wellbeing. Supporting the creation and maintenance of physical, social and cultural conditions that promote health has always been at the heart of community controlled comprehensive primary health care. This includes identification of health threats and mobilising action to address these threats through leadership and collaboration with other organisations. A compelling illustration of this is the sector's mobilisation of resources, relationships and networks in confronting the COVID-19 global pandemic in 2020 (Crooks et al. 2020; Findlay and Wenitong 2020; McCalman et al. 2021). This response demonstrates the population impact of ACCHSs in protecting communities through effective health promotion and public-health planning.

Core services in this domain discover, use and enhance community strengths. They enhance and improve positive factors in the community that support health and wellbeing. Negative factors in the community that act to diminish health and wellbeing are minimised, mitigated and effectively addressed, often through partnerships and policy advice. Programs that are community-led and multifaceted are likely to be more successful. Specific programs in Aboriginal and Torres Strait Islander health promotion have been effective in changing individual risk factors and disease progression. Some target individual behaviours in relation to physical activity, healthier eating and smoking, while others tackle structural barriers to better health including food security. There is an ever-increasing volume of literature and evidence showing the success of Aboriginal and Torres Strait Islander-led health promotion (Kickett-Tucker et al. 2017).

It is acknowledged that the Australian Government classifies many of the core services in this domain as 'population health activities'. Because of the effects of colonisation, health promotion must be designed, led and evaluated by Aboriginal and Torres Strait Islander peoples to avoid the risk of continued assimilation (Freeman et al. 2019).

This domain includes core services to support community action, supportive environments and activities to orientate the broader health system towards prevention and early intervention as recommended in the Ottawa Charter. Health information, education, skills development and resource production are also envisaged within 'core services'. Through its board, the community might decide to prioritise tertiary prevention to arrest progress of chronic diseases and support self-management through large-group community-based programs.

A focus on community health ensures social determinants of health are visible and action taken to address them. Social determinants as a category refers to the significant health inequities between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians. The structural disadvantages experienced by Aboriginal and Torres Strait Islander peoples are shaped by the broader social and economic conditions in which they live. These social and economic determinants for Aboriginal and Torres Strait Islander people include connection to family, community, country and culture; educational attainment; employment and income; housing; institutional and interpersonal racism; interaction with government systems including criminal justice systems; and environmental conditions affecting the adoption of health behaviours.

Environmental health is a science-based, action-oriented technical practice that addresses disease risk arising from environmental conditions. There are twelve categories of environmental determinants including water quality, public amenities such as parks and ovals, waste management, chemical hazards, housing and home maintenance (McMullen et al 2016). Aboriginal and Torres Strait Islander environmental health combines deep cultural knowledge of how things work in local communities with broad knowledge of disease transmission, environmental vectors and risk. Environmental conditions in many communities are the result of dispossession and entrenched poverty, resulting in Aboriginal and Torres Strait Islander peoples not sharing the health outcomes that non-Indigenous people now enjoy (Tardrew et al. 2001). Evidence is compelling for environmental determinants. Skin-related diseases and viral conditions such as influenza are associated with crowding. Ear infections are associated with crowding, lack of functioning facilities for washing people, contaminated bedding and poor sewage outflow. In mainstream Australia, such disease transmission routes have been addressed. Sustained progress in addressing the social and environmental determinants of health has permanently reduced the rates of preventable infectious diseases for non-Indigenous populations. By contrast, standards for housing occupancy, maintenance and repair programs, public amenity and community infrastructure have largely been taken out of Aboriginal and Torres Strait Islander control (O'Connor 2021). In some communities, permanent positions in the Aboriginal environmental health workforce are no longer available or supported to provide holistic and culturally responsive environmental health services. Because of the scope of environmental health and its scientific basis, supervision by credentialed experts in environmental health is required to ensure preventable diseases rates are reduced effectively.

Cultural and social determinants of health have been acknowledged as foundational in the imminent *National Aboriginal and Torres Strait Islander Health Plan 2021–2031*. This domain ensures that ACCHSs have the resources to identify these cultural and social requirements for population health.

Foundations for a healthy life

Cultural determinants	Social determinants
Country and caring for country	Racism
Knowledge and beliefs	Early childhood development
Language	Education
Self-determination	Employment and income
Kinship	Housing
Cultural expression	Environment and infrastructure
	Interaction with government systems and services
	Law and justice
	Alcohol, tobacco and other drug dependency

Community health promotion and empowerment (cont.)

Despite the impact of colonisation, Aboriginal and Torres Strait Islander peoples sustain a strong level of cultural knowledge: for example, in kinship responsibilities, finding and preparing foods, honouring special places and preserving cultural stories. Researchers have identified six cultural domains—(1) country and caring for country (2) knowledge and beliefs (3) language (4) self-determination (5) family and kinship, and (6) cultural expression—that are significantly and positively associated with physical health, social and emotional wellbeing, and a reduction in risk-taking behaviours (Bourke et al. 2018). The six concepts are deeply entwined. As shown by Yawuru-led research, Aboriginal cultural expression leads to better health which leads to even stronger culture (Yap and Yu 2017).

While social issues such as poverty, housing, education and food supply may not be within the control of primary health care, these are matters of concern. How health promotion is prioritised, co-designed and delivered on the ground is decided by the community through community controlled primary health care.

Funding of this domain ensures the Model maximises sustained responses to social determinants through partnership. For example, one community may need specific social-support programs, or an ACCHS may need to facilitate access to legal services for client/s. The required action depends on local need and is determined by the board. If the board decides that no other community organisation is resourced to offer culturally safe health-related programs or services, then the ACCHS can secure funds to provide or contract that program or service.

Cultural promotion across ACCHSs differs depending on the situation in communities. What is important is that cultural protocols are respected, that health promotion affirms community strengths, and that Aboriginal and Torres Strait Islander people decide and direct the focus. This Model therefore becomes an asset available to and directed by the community to rebuild and re-empower itself (Ah Chee 2019). Population-based approaches that re-empower communities act synergistically with clinical interventions (Olayiwola et al. 2018; Shahzad et al. 2019). Community empowerment through effective community development and control achieves and reinforces self-determination.

Every ACCHS will advocate for programs and services to address social determinants and 'join the dots' at the local level; ACCHSs have greater ability to perceive problems and mobilise partnerships than other types of service. Aboriginal and Torres Strait Islander worldviews—especially of health, wellbeing and connections to country, sea, language, ancestors and culture—will be articulated, refreshed and used in service planning, program design and evaluation. There is a growing body of research, an evidence base, relating to Aboriginal and Torres Strait Islander health promotion to inform this domain. ACCHSs cannot be held accountable for action on social determinants of health without adequate infrastructure and resources for health promotion. Infrastructure is required to ensure genuine, sustained and valued community engagement.

CE1 Individual and family health promotion

- Empower individuals and families to self-manage their health through individual and collective family actions
- Use family-based programs when family action supports individual health outcomes
- Increase individual health literacy and health knowledge
- Offer health promotion programs to individuals and families such as
  - Social and emotional wellbeing initiatives
  - Youth health
  - Mental health and suicide prevention
  - Sexual and reproductive health programs
  - Alcohol and Other Drug use and misuse
  - Cultural activities to strengthen cultural connections
  - Language renewal and revitalisation
  - Mental health (general)
  - Men's shed and other men's health promotion
  - Risk-factors knowledge and self-management
  - Promotional activities aimed at a full range of issues including wellbeing, chronic disease, environmental health, child and maternal health, women's health, healthy aging, advanced care planning and end-of-life education, eye health, gambling and child-protection behaviours

- Integrate vertical health promotion programs to individuals and families such as
  - Tackling Indigenous Smoking
  - Ear health promotion
  - Oral (dental) health promotion
  - Skin health programs such as No Germs on Me
  - Food security and healthy eating
  - Home programs such as Living Skills
  - Community programs addressing priorities using cultural approaches such as Deadly Choices
  - Violence (lateral, family, domestic, social)

CE2 Community development

- Design and implement community events to advance community empowerment, health and wellbeing
- Strengthen community networks, relationships and problem-solving to improve health and wellbeing
- Integrate health promotion in strategic community-development initiatives
- Share health knowledge with the community
- Respond to community-identified gaps in health understanding, access or outcomes
- Create healthy community environments
- Support community action to promote health
- Develop and reinforce acquisition of health skills and health-promoting behaviours in the community
- Support informed decision-making by community councils and other decision-making bodies
- Work strategically to bring new resources to the community that are supported by the community
- Orientate clinical services to social and cultural determinants of health
- Nurture community agency and re-empowerment
- Involve and expand community participation in health issues
- Report back to the community on progress as agreed, elicit feedback and continuously improve activities
- Target age groups or other groups within the community as required for effective health promotion
- Work respectfully across cultures
- Work as required in Aboriginal or Torres Strait Islander language
- Translate resources as per community need and provide in accessible formats
- Support community strategies to address transgenerational trauma

CE3 Cultural determinants and cultural affirmation

- Monitor and support cultural determinants that enhance health and wellbeing in the community
  - Culture is strong, contemporary and health promoting
  - Cultural connection and cultural programs are accessible, affordable and appropriate as determined by cultural bosses and Elders
- Offer directly or contract from local enterprises effective cultural therapeutic programs and other cultural interventions to improve health and wellbeing
- Ensure community controlled primary health care is true to local Aboriginal and Torres Strait Islander culture
- Strengthen capacity of Aboriginal and Torres Strait Islander staff to lead community development and health promotion activities

CE4 Early childhood development, positive wellbeing and nurturing families

- Scan current community programs and take proactive steps through partnership or direct service provision, if required, to ensure the community's children develop physically, mentally, spiritually and culturally
- Ensure family-centred service models and programs
- Establish trusted relationships with mothers and fathers through ante- and postnatal programs and family programs
- Promote continuity of care beyond confinement
- Ensure infancy and childhood are enriched and developmental milestones achieved as a strong foundation for a child's future life course
- Support school readiness and respond through service provision and/or policy direction and partnerships as required
- Ensure children are ready to learn (hearing, language acquisition, curiosity, attention, social skills, relationships)

CE5 Mental health, and social and emotional wellbeing (SEWB)

- Integrate social and emotional wellbeing throughout primary health care
- Strengthen community and culture as foundations for social and emotional wellbeing
- Promote wellness in the community and strengthen positive structural, social, cultural and individual determinants of mental health
- Reduce stigma and eliminate discrimination against those with problems in mental health and psychological wellbeing
- Deliver integrated, multidisciplinary SEWB services and innovate as appropriate in response to local needs; these services can include social and cultural support, linking when required to individual therapeutic services and clinical support
- Integrate trauma-informed models in community development as required
- Diminish reliance on the non-Indigenous workforce in setting directions for health promotion/community development

CE6 Economic benefits

- Use health-service programs and positions to offer fulfilling, meaningful and stable employment and careers to members of the local community
- Increase high-level roles filled by Aboriginal and Torres Strait Islander staff
- Nurture career aspirations in the community and offer meaningful career paths
- Prioritise local Aboriginal and Torres Strait Islander businesses and enterprises
- Offer best-practice terms and conditions for Aboriginal and Torres Strait Islander employees that ensure high rates of retention, job satisfaction and family prosperity

CE7 Environmental health

- Assess the burden of preventable illness in the community due to environmental conditions
- Respond to environmental threats and mobilise communities
- Inform community decisions about environmental determinants with data and technical expertise
- Organise environmental health education and sustained family-centred support for behavioural change in the home to reduce disease transmission
- Ensure environmental health workforce is supervised by credentialed experts in environmental health to reduce preventable disease rates

CE8 Other social determinants of health

- Identify those determinants within control of the ACCHS, those within its sphere of interest and those within its sphere of concern
- Ensure social circumstances affecting the health and wellbeing of individuals and families are understood and incorporated in service-delivery models—e.g. transgenerational trauma, violence and homelessness
- Monitor and mobilise action on the social determinants of health:
  - Housing: All houses are healthy, safe and ready for climate change.
  - Law and justice: Populations as a whole experience better justice and individuals have access to legal services, support and services to reduce imprisonment and minimise recidivism such as justice reinvestment.
  - Education: Children are equipped for their futures as envisaged by the community.
  - Income and poverty: assist clients to access income support (such as Servcies Australia) and other community support services.
  - Food security: All Aboriginal and Torres Strait Islander peoples have physical, social and economic access at all times to sufficient, safe and nutritious food that meets their dietary needs/food preferences for an active and healthy life.
  - Home modifications: For people with disability, chronic disease or frailty are promptly completed.
  - Persons with disabilities: Have ready access to the programs and resources they require.
  - Retail policies: Such as alcohol restrictions and other actions reflect community decisions and influence the way outside industries operate.
  - Racism: is acknowledged and addressed.

- Recognise and communicate the intergenerational consequences of social determinants of health including epigenetics
- Obtain and analyse health-outcome data showing preventable health gaps and inequities due to social determinants
- Identify those whose circumstances impede access to primary health care including the prison population; secure stable funding for service provision
- Contribute submissions to enquiries and commissions, work with other organisations and individuals who share values and goals for social justice, and appear as witnesses when required to communicate the health dimensions of social issues pertaining to or affecting Aboriginal and Torres Strait Islander peoples
- Support other organisations in obtaining resources, or obtain resources directly, to fill gaps to address social determinants—e.g. employment of a Youth Justice Health Officer
- Strengthen climate resiliency and identify and mitigate climate-change risks that will affect community health and wellbeing

CE9 Health protection

- Implement evidence-based health protection and communicable disease control programs including culturally-safe contact tracing
- Develop shared service models compliant with respective jurisdictional legislation and public-health requirements
- Mobilise resources and pivot responsively in situations including pandemics such as COVID 19, natural threats including cyclones, floods or bushfires, and other disasters
- Work with the community using strengths-based approaches and proactive-response planning to identify chains of command, decision-making and accountability
- Monitor on-the-ground capacity and key public-health infrastructure maintained by government under statutory requirements

INFRASTRUCTURE, WORKFORCE AND CONTINUOUS QUALITY IMPROVEMENT

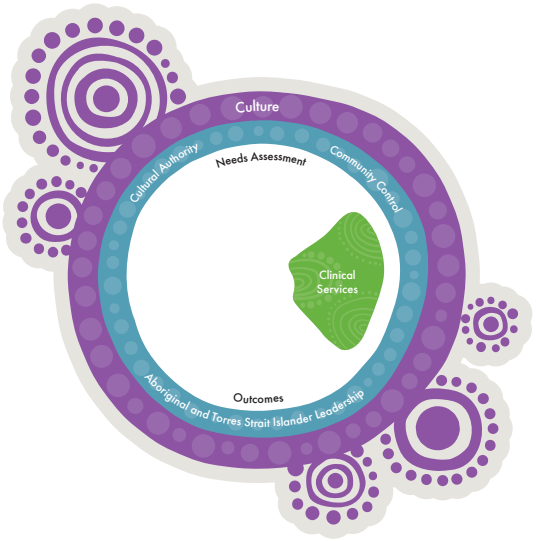
Fully resourcing this domain ensures sustained health improvement according to the principles of the Ottawa Charter (note the cross-over with other domains). Integration will ensure seamless experiences for the community across health promotion and clinical teams highlighting the expertise of Aboriginal and Torres Strait Islander staff.

These functions must be funded in a way that reflects local Aboriginal and Torres Strait Islander worldviews and belief systems as well as local perceptions of what a healthy community would look like. Resources must be available to ensure health promotion is directed by Aboriginal and Torres Strait Islander people, sustained over time sufficient to deliver an intergenerational impact, and resilient against counter-cultural forces.

The local community is an invaluable source of staff and expertise for this domain. Workforce development will reduce reliance on temporary non-Indigenous staff.

CQI is everyone's business. As a method to improve performance, CQI will be as applicable in this domain as in the other three. Issues in community development, community engagement and health promotion can be addressed through team-based, data-driven and collaborative CQI (see Percival et al. 2016 as an example).

Clinical services: evidence-based and responding to life-course needs



This domain presents a way of understanding and managing the complete range of clinical services under a community controlled Core Services and Outcomes Framework.

Clinical services span diagnosis, investigation and evidence-based treatment of illnesses, injuries and diseases affecting people and inhibiting their quality of life whether acute, short-term, long-term or lifelong. These clinical services cover all body systems including mental health, cardiovascular, renal, respiratory and others. Comprehensive primary health care must deliver clinical services that are evidence-based and respond to life-course needs. This care must be person-centred. The earliest intervention can also assist in reducing the perpetuation of multigenerational issues. Multidisciplinary clinical teams focus on individual needs but, in primary health care, their efforts are planned and coordinated closely with health promotion and community development. This integrated approach as possible in comprehensive primary health care achieves significant health gain. Integration between primary, secondary and tertiary levels of the health system must also be deliberately coordinated to ensure the client experiences 'holistic' care. ACCHSs play a central role in facilitating access for clients to health care outside the expertise of the ACCHS itself. As shown in mainstream Australia (Einarsdóttir et al. 2011), Canadian First Nations (Lavoie et al. 2019; Lavoie et al. 2021) and for children in the Northern Territory (Zhao et al. 2013), continuity of care in 'front-line' primary health care reduces hospitalisation rates for common and complex chronic conditions. Hospital-based post-discharge initiatives to prevent re-admission are not always as effective (Quilty et al. 2019). By integrating care across clinical and population health in response to community need and direction, Aboriginal and Torres Strait Islander community controlled comprehensive primary health care increases the focus of clinical services on prevention, holistic person-centred care, healing and wrap-around services.

Importantly, this Model incorporates united, person-centred and team-based care. This must be more than simply accessing a shared electronic clinical record. Strategies must be in place to integrate visiting service providers, contracted clinicians and staff in a common service model, focused on the client and their family and optimising their outcomes. This will likely require more frequent case-management meetings, handover and planning sessions than in conventional general practices or other community settings. Resolute unity in focusing on the benefits for clients, their own self-determination and community outcomes is achieved only by investing time and resources in strengthening multidisciplinary team-based care. This investment also reinforces a 'holistic' approach, ensuring that the generalists in the primary health care team balance the 'partialists' who typically visit the service on a sessional basis to focus on one disease, body part or program.

ACCHSs ensure their own services are culturally appropriate, physically accessible, financially affordable and provide the necessary supports with language and health literacy. In the twenty-first century, comprehensive primary health care teams are multidisciplinary. To achieve the best outcomes for clients, ACCHSs may prioritise on-site access to allied and non-GP medical specialist care, point-of-care pathology, other on-site tests and investigations such as audiology or spirometry, non-dispensing pharmacist services (for example, medication reviews) and dispensing medications in certain circumstances and always facilitating connections with social services as required.

If the complexity of the client's clinical presentation or progress under treatment exceeds the expertise of the primary health care team, referral is required to an external professional. In Australia's health care system, GPs are medical specialists with a comprehensive scope of practice (RACGP 2017). When the primary health care team identifies an appropriate external professional such as a paediatrician, nephrologist or otolaryngologist (ear, nose and throat specialist) for specific treatment, referral pathways must be seamless and reliable. Some ACCHSs will themselves employ allied health staff such as physiotherapists, psychologists or speech pathologists as part of their multidisciplinary service models. Pharmacists, social workers, diabetes educators or clinical psychologists may be permanent members of the multidisciplinary primary health care team.

In this domain, the Framework describes the core services but not their disciplinary composition as this will depend on community priorities, size and location. The board makes these decisions, considering needs, priorities, service models and local circumstances. Deciding the required models of care for service delivery requires community control, an appreciation of local circumstances and data about gaps and needs. Furthermore, this Model commits to multidisciplinary team care within each service, giving prominence and recognition to the expertise of Aboriginal and Torres Strait Islander Health Practitioners and Health Workers (AHPs and AHWs). Client enrolment with one ACCHS enhances continuity of care.

This 'whole-of-person' approach to integration, consistent with the Aboriginal and Torres Strait Islander definition of 'health', ensures that the client's history is communicated to each referred professional, that the client does not need to repeat their story unnecessarily or repeatedly, and that the client's health outcomes are significantly improved through this referral. Reasons for referral are entirely predicated on the client's clinical need and the scope of the primary health care team. Recommendations for client care are integrated within this whole-of-person approach. Clinical consultations are generally longer in ACCHSs than in mainstream primary care. Family meetings may be needed. Care coordinators facilitate access to necessary services, navigating a complex and disjointed health system that can be unfamiliar to and unsafe for Aboriginal and Torres Strait Islander peoples. Staff use and value accurate and relevant clinical documentation in shared clinical information systems. Relationships with other social services such as police, education and community services enable an ACCHS to be aware of non-medical pressures and events that have an impact on individuals and communities. It must also be recognised that Aboriginal and Torres Strait Islander peoples are disproportionately more likely to be experiencing trauma. Any person with a disability needs to be assessed, referred and services coordinated to optimise wellbeing.

This approach also ensures efficiency in delivering vertical programs. These are disease-specific initiatives or short-term programs confined to pre-defined target groups (age, risk factors, disease or condition). In general, vertical programs fragment the horizontal integration of holistic care that best responds to the needs of the whole person. Vertical programs tend to be more transactional in nature whereas this Model is relationship-based. Efficient integration of vertical programs to maximise outcomes is more likely when the vertical program is introduced into a strong primary care foundation. Integration within the operational models of ACCHSs ensures that Aboriginal and Torres Strait Islander peoples experience a 'holistic', culturally safe and cohesive health-care journey. This is particularly important when mental health and biomedical programs must be integrated under one provider. One-stop-shop mental health approaches poorly integrated with other services have been criticised (Higgins and Collard 2019). Having more than three organisational providers disrupts health care, resulting in poorer outcomes (Haggerty et al. 2003). Global health research has shown that targeted vertical-funding strategies undermine efforts to strengthen the health system. Vertical programs cannot be delivered effectively and efficiently unless there is a highly functional primary health care foundation (Assefa et al. 2018).

Telehealth brings new potential for expanded access, and its implementation was accelerated during Australia's response to the COVID-19 global pandemic. NACCHO's general principles include the importance of having a prior existing relationship with the client; the importance of face-to-face consultations where it is safe to do so, and the need for appropriate client end support especially when telehealth consultations are offered by medical specialists unfamiliar to the client. Telehealth is not a substitute for face-to-face continuity of care but can enhance clinical delivery to support longitudinal, person-centred primary health care, associated with better outcomes.

Clinical services are typically focused on the individual, while recognising the context in which that individual lives, works and thrives. An overly biomedical emphasis in clinical services must always be counterbalanced; the holistic focus of Aboriginal and Torres Strait Islander worldviews and the imperative to re-empower Aboriginal and Torres Strait Islander peoples must be affirmed. Group and family-based clinical interventions are often used in ACCHS. This responsiveness is a characteristic of any primary health care system that functions well and is adequately resourced. To maximise health improvement, an evidence-based approach brings the best of Western evidence-based health care to community controlled primary health care. 'Bush medicine' and traditional healers have always held a central place in Aboriginal and Torres Strait Islander healing systems and are now being recognised by governments and Western health systems for their expertise and knowledge.

Clinical services: evidence-based and responding to life-course needs (cont.)

Aboriginal and Torres Strait Islander peoples should expect core services that adopt a holistic, person-centred approach to:

- correct diagnosis, investigation and an evidence-based course of treatment
- clinical preventive services including effective links to externally managed screening programs: e.g. mammographic screening for women; risk-based screening (e.g. for sexually transmitted infections [STIs]) and age-based screening (e.g. for cardiovascular disease), as specified in NACCHO-endorsed guidelines (NACCHO/RACGP 2018)
- age-based and risk-factor screening by identifying target groups and increasing access and achieving high participation rates for externally-managed screening programs (e.g. mammography)
- early diagnosis and early intervention
- rehabilitation and recovery
- secondary and tertiary prevention through effective chronic-disease management, recognising multimorbidity and clinical complexity whenever required
- integration, wrap-around service delivery and referral within and outside the primary health care team as determined by service models such as:
  - allied health workers employed in the team whether for the short-term (physiotherapy for a chest infection or ankle injury) or longer-term (chronic back pain, arthritis compromising mobility or diabetic foot care)
  - clinical psychologists employed in the team for mental health
  - non-GP medical specialist and allied health referrals from the primary health care team:
    - on staff (internal referral)
    - on site (external referral but consultations occur in the ACCHS)
    - off-site (external referral and services accessible through transport or other arrangements)
  - reviews of medication by a team pharmacist
- handover of responsibility for direct client care between health services
- implementation of recommendations from referred specialists
- re-integration of care plans from different health professionals (e.g. allied health, screening conducted outside primary health care such as diabetic retinopathy screening or mammography)
- promotion of self-management and self-care
- optimisation of medication access and use, including client and practitioner level medication-related activities (i.e. promoting optimal prescribing by prescribers) and, where required, dispensing and administration of medications
- client advocacy in the broader health system.

Effective relational health care allows people to make informed decisions themselves for their health. In the context of continuing colonisation in Australia, it is imperative that paternalistic, patronising or disempowering approaches to service provision for Aboriginal and Torres Strait Islander peoples are avoided. True person-centred care in this Model moves from individual to family to community and avoids being overly biomedical.

Transitions from primary health care to hospital, or to another external health professional, take a lot of time due to many factors. The health conditions highly prevalent in Aboriginal and Torres Strait Islander peoples are typically complex, compounded by lower rates of participation in formal education with consequences for health literacy. The capacity of an individual or family to self-navigate a Western health system or self-care must be assessed and the appropriate supports put in place.

This complexity of clinical presentations and treatment pathways (the client journey) may require novel service models and innovation to ensure clinical outcomes are achieved efficiently, effectively and equitably in a culturally safe way. These service models would be submitted to, then reviewed and endorsed by the board.

Systems to support effective clinical services must be in place. Their daily reliable functioning will make or break service delivery. Infrastructure for clinical service delivery links to infrastructure for the domain of governance and effective service performance.

Life-course approach

A life-course approach has long been viewed as critical in building the foundations for an extended and healthy life (Griew et al. 2007; Weeramanthri et al. 1999). The current Implementation Plan of the Aboriginal and Torres Strait Islander Health Plan 2013–2023 was initially released in 2015. It offered a life-course frame for comprehensive primary health care:

- Maternal health and parenting
- Childhood and early development
- Adolescent and youth health
- Healthy adults
- Healthy aging.

Clinical services must be available to meet the needs of clients according to their life-course needs. As emphasised earlier in this document, the Model requires that boards each decide how to meet these life-course needs in their ACCHS; this includes making decisions on optimal clinical staffing and models of care and on protocols and pathways for service delivery including resources to support complex client journeys.

In the AMSANT resource (2011), clinical functions comprised services delivered to individual clients and/or families, in both clinic and home/community settings, including treatment, prevention and early detection, rehabilitation and recovery, and clinical support systems. Emphasis was placed on supporting self-care and self-management, particularly in cases of chronic disease including mental health. Demand for acute care from communities with unchecked rates of sickness can be high. Service demand is also higher when people have complex lives and challenging circumstances compounded by poverty and dispossession. AMSANT's 2011 resource affirms the importance of having adequate staff to allow the consultation time needed to deliver quality outcomes and ensure that resources are allocated for both clinical and non-clinical prevention work. Over-reliance on single-disease/system specialists can be frustrating if the primary-health-care foundations are not in place for handover and follow-up. The sector has led innovation in technological systems to facilitate handover such as MAPPA and PIRS. This is another reason for full funding of comprehensive community controlled primary health care. An adequate funding model will also ensure that core clinical services can address any unmet community need for dental treatment and dental hygiene.

This Framework recognises the important of early childhood development for life long health. The first 2000 days lay critical foundations. This Framework also advances the concept of the 'life course' in considering and organising requirements in core services. For example, a young Aboriginal male adult may not have any chronic diseases but he is likely to be at risk. He might present to the local clinic only for an acute reason such as a football injury. Adopting an opportunistic approach during that consultation enlarges his relationship with the ACCHS. His initial contact progresses to regular proactive engagement: screening for conditions such as pre-diabetes, syphilis and other STIs, mini-mental health assessments and checking of his cultural connections. If his relationship with the service is characterised by high trust and confidence, he will benefit from this 'holistic' approach, reducing his health risks at a pace he determines, and increasing his chance of a long and healthy life. Initial opportunistic engagement leading to active participation in annual health checks matched to age will provide the earliest possible attention to risk factors or pre-disease.

As another example, a woman aged 55 years who presents for a health check annually and preparation of a GP Management Plan for her early-stage renal disease will benefit from this systematic approach to her health. She should also be comfortable to discuss with a trusted team member any concerns about her family members who may be unwell such as grandchildren who don't seem to be keeping up at school or a sister with a sore hip. A male cultural boss with early dementia will be diagnosed in a timely way when there is continuity of care and longstanding knowledge of his typical demeanour and daily activities.

To ensure this document is readable, some repetitions have been avoided in each sub-domain listed below. For example, Alcohol and Other Drugs of Dependency (AOD) services must be available whenever required; however, because AOD early intervention has the greatest positive impact when targeted and delivered for adolescents and young people, AOD is listed in that life course and not others. Similarly, sexual and reproductive health is lifelong but explicitly stated only in the key age groups. Generally, the order in which core services are presented reflects their frequency in provision. It should also be noted that clinical preventive services dominate for infants and children but continue based on risk through adulthood and older age in accordance with the evidence of benefit.

CS1 Maternal health and parenting

- Preconception counselling
- Antenatal shared care offered by appropriate multidisciplinary teams and coordinated with referral services including midwifery group practice, GP obstetricians, Aboriginal and Torres Strait Islander midwives and Aboriginal Health Practitioners
- Other options to support continuity of antenatal care and safe delivery that integrate with ACCHS service models
- Smoking cessation support during pregnancy
- Healthy eating, alcohol and other drug use
- Pregnancy care plan by risk (e.g. 'low', 'high') including health education such as the risks of alcohol during pregnancy, antenatal iodine, folate and iron supplementation, STI and gestational diabetes screening and treatment
- Dental checks and dental treatment where required
- Special case pregnancies e.g. mothers with rheumatic heart disease
- Episodic clinical care unrelated to pregnancy
- Integrated treatment pathways for every diagnosis adjusted for pregnancy including referral if required and individual follow-up according to evidence
- Postnatal reviews and support, including mother's mental health, contraception and breastfeeding
- Parenting support and skills programs if not available in the community
- Integration of above services within the continuity of primary health care

CS2 Childhood and early development (0–12 years)

- Proactive child health checks from birth at recommended schedules particularly in the first 2000 days graduating to comprehensive annual multidisciplinary health assessments from school age to assess developmental delay promptly, asymptomatic physical conditions such as ear disease, social functioning, attainment of milestones and emotional wellbeing
- Coordinated referral to environmental health services to reduce environmental disease transmission
- Foundations for social and emotional wellbeing and cultural connection
- Dental checks, preventive methods and dental treatment provided either directly or through effective referral off-site including, where recommended, provision of fluoride varnish from eruption of first tooth or fissure sealants
- Immunisation/vaccination according to the National Immunisation Program
- Episodic care e.g. acute cough, fever, gastroenteritis, acute ear disease
- Integrated treatment pathways including referral if required and individual follow-up according to evidence
- Coordinated resolution of curable conditions through sustained disease management—e.g. a daily ear toilet for a child with a chronic ear infection or managing a child with anemia
- Disability assessment, referral and service coordination
- Service coordination for all who require this support—e.g. organising attendance at specialist clinics or the correct sequence of tests before specialist review
- Intensive case management for children and families with multiple, complex clinical and social needs

CS3 Adolescent and youth health (13–24 years)

- Integrated treatment pathways for every diagnosis including referral if required and individual follow-up according to evidence
- Sexual, reproductive and STI screening services
- Contraceptive advice including implants and access to medical termination therapy
- Comprehensive multidisciplinary health assessments including social and emotional wellbeing at least annually
- Mental health early intervention and support
- Episodic care—e.g. for headache, injury, respiratory infections
- Chronic disease care plans—e.g. for young people with rheumatic heart disease
- Sustained disease management—e.g. 28-day penicillin injections for those with acute rheumatic fever
- Disability assessment, referral and service coordination
- Individual treatment for alcohol and other substance misuse and dependencies (AOD)

- Smoking prevention and smoking cessation interventions
- Dental checks by a dentist and dental treatment where required
- Annual/other immunisations as per the National Immunisation Program
- Service coordination—e.g. organising attendance at specialist clinics or the correct sequence of tests before specialist review
- Intensive case management for adolescents with multiple, complex clinical and social needs

CS4 Healthy adults (25+ years)

- Episodic care—e.g. for headache, injury, respiratory infections
- Comprehensive multidisciplinary health assessments including social and emotional wellbeing at least annually
- Integrated treatment pathways for every diagnosis including referral if required and individual follow-up according to evidence
- Clinical preventive services based on risk—e.g. cervical screening
- Early clinical intervention for risk factors and early disease including lifestyle medicine to reverse the trajectory of pre-diabetes and reduce kidney disease and renal failure
- Disability assessment, referral and service coordination
- Annual/other immunisations
- Individual treatment for alcohol and other substance misuse and dependencies (AOD)
- Smoking prevention and smoking cessation interventions
- Service coordination—e.g. organising attendance at specialist clinics or the correct sequence of tests before specialist review
- Chronic disease care plans and their implementation
- Intensive case management for adults with multiple, complex clinical and social needs—e.g. very complex renal disease, mental illness, substance use disorders, HIV, tuberculosis or leprosy case management
- Medication reviews and other quality use of medicines activities
- On-staff allied health
- Dental checks by a dentist and dental treatment where required

CS5 Healthy aging of older adults and meeting the needs of frail elderly

- Episodic care—e.g. for headache, joint pain, mobility, infections
- Comprehensive multidisciplinary health assessments including social and emotional wellbeing at least annually
- Integrated treatment pathways for every diagnosis including referral if required and individual follow-up according to evidence
- Clinical preventive services based on risk—e.g. falls prevention
- Annual/other immunisations
- Service coordination—e.g. organising attendance at specialist clinics or the correct sequence of tests before specialist review
- Individual treatment for alcohol and other substance misuse and dependencies (AOD)
- Smoking prevention and smoking cessation interventions
- Sexual and reproductive services
- Chronic disease care plans and their implementation
- Intensive case management for older people with multiple, complex clinical and social needs
- Medication reviews and other quality use of medicines activities
- Dental checks by a dentist and dental treatment where required
- Health assessments to access social and welfare programs
- Palliative care
- Proactive support for needs of carers
- Trans-disciplinary aged care services
- Assessment of the cultural safety of domiciliary services
- Medical/other visits to those in residential aged care facilities

INFRASTRUCTURE, WORKFORCE AND CONTINUOUS QUALITY IMPROVEMENT

Resources and infrastructure are required to:

- maintain all clinical support systems necessary for highly productive, integrated multidisciplinary teamwork
- produce and make available evidence-based guidelines and protocols
- achieve failsafe systems for handover, pathology ordering, on-referral to non-GP medical specialists and return to care
- ensure access to all necessary medicines without economic barriers for clients including procurement, stock management which may be in or in partnership with community pharmacies
- ensure systems are in place for referrals and follow-up, bookings, hospital admissions and supports including travel assistance
- articulate explicit models of service delivery to ensure consistent, high-quality clinical services for the community
- recruit staff incorporating the Australian Health Practitioner Regulation Agency scope of practice and credentialing to ensure the right team is in place for community need
- manage staff overtime and workplace arrangements
- adopt zero tolerance for data disclosures, and non-compliance with codes of conduct and privacy policies
- improve post-hospitalisation care and receipt of discharge summaries
- mitigate risks from short-term locums and high staff turnover—e.g. ensure test results are actioned
- advocate for the health of individual clients and secure the social-service interventions and supports necessary for the client's health and wellbeing
- adopt evidence-based technology such as point of care testing on site
- test ordering, spirometry, audiology, etc.
- enable multidisciplinary team meetings, case conferencing and coordination of care
- ensure safe and quality use of medicine
- transport clients to other off-site appointments such as non-GP medical specialist appointments

In certain contexts, essential functions also include:

- ensuring access to emergency care during business hours
- ensuring access to emergency care outside business hours
- providing for the safe, timely dispensing of medicines
- supporting access to bush medicine and traditional healers.

As for the other domains, workforce is critical for responsive life-course and evidence-based services. While recognising workforce shortages and costs (Russell et al. 2017; Zhao et al. 2019), ACCHSs are preferred employers for many health professionals (Lai et al. 2018; Jongen et al. 2019; Wright et al. 2019). Without workforce, services cannot be delivered sustainably, efficiently and effectively.

CQI in relation to clinical service delivery has been highly visible in the Aboriginal and Torres Strait Islander primary health care sector for many decades. There are different levels of maturity in the sector; increasing maturity requires resources. To address significant clinical issues effectively, CQI must be collaborative, non-threatening, open to all team members and enabled through practical tools to support local systems assessment and data gathering. Senior management support for system-wide change is also required.

Policy direction and partnerships

Article 23 of the Unites Nations Declaration of the Rights of Indigenous Peoples (UNDRIP) states: *Indigenous peoples have the right to determine and develop priorities and strategies for exercising their right to development. In particular, indigenous peoples have the right to be actively involved in developing and determining health, housing and other economic and social programs affecting them and, as far as possible, to administer such programs through their own institutions.* This domain explains how policy action and partnerships beyond direct design and delivery of services and programs are required to give effect to this right.

ACCHSs are heavily involved in policy and partnerships. Through active participation in committees, working groups, taskforces and consultation, these largely undocumented and under-recognised contributions improve many aspects of the Australian health care system. Leadership in decisions affecting health must come from the people whose lives and futures are at stake. They are experts in their own right. ACCHSs must be influential in setting policy direction whenever policy affects Aboriginal and Torres Strait Islander peoples and their health and wellbeing. As experts in Aboriginal and Torres Strait Islander health and wellbeing, ACCHSs willingly share their much-needed knowledge and insight with others. ACCHSs persuasively influence the work of others, as an equal partner in co-design and shared decision-making (Davis 2013). This includes effective engagement to lead policy and shape legislation (State of Queensland and QAIHC 2021).

AMSANT (2011) identified a range of advocacy functions including:

- advocacy for the health of individual clients
- advocacy for effective strategies to address determinants of health which lie outside the direct responsibility of health departments
- promoting system-wide change that is conducive to better health and wellbeing for Aboriginal and Torres Strait Islander peoples.

Policy influence as envisaged in this Model is strategic, sustained and long-term. These efforts will be vindicated by improvements in health and wellbeing achieved for Aboriginal and Torres Strait Islander peoples.

Comprehensive primary health care develops partnerships to alleviate social, historical, economic and environmental determinants of health and wellbeing so that individual behavioural programs and clinical services have maximum impact. Each community is unique in its lived experience of these social determinants and its assessment of the necessary solutions. The Australian Government includes establishing and strengthening partnerships and collaborations as part of the current contracting structure. Its continued inclusion as a core service is acknowledged in the Model. For example, effective ways of working are required with mainstream organisations including non-government organisations providing services for Aboriginal and Torres Strait Islander peoples ('secondary' 'tertiary' or 'quaternary' care hospitals, for example). A cultural-determinants approach must seek to balance the structural inequality evident across the entire health system. Mainstream change requires a bureaucracy that is aware of its own limitations and upholds the importance of Aboriginal and Torres Strait Islander culture (Lowitja 2020). Growing commitment to co-design will increase the demands on ACCHSs to support community participation and release staff for genuine co-design with external organisations.

Effective and strategic partnerships utilising 'systems thinking' and a place-based focus benefit the community. These partnerships and collaborative activities should be based on an astute assessment by the board of these potential benefits as well as risks, costs and ethics. ACCHSs will have high visibility in implementation of the National Agreement for Closing the Gap and the four Priority Reforms (July 2020). Health is identified for a three-year Sector Strengthening Plan. Under the Jurisdictional Implementation Plans required by the National Agreement for Closing the Gap, six new place-based partnerships will also be established across Australia by 2024. These place-based partnerships will encompass the Australian Government, relevant states or territories, local government and agreed communities. Locations will be considered by

the Joint Council by July 2021. While not all locations will have an ACCHS, those that do will require their ACCHS to be effective, articulate and ready to contribute to high-powered collaborations focused on community benefit. Partnerships with ACCHSs ensure that sustained, effective action on social determinants is well-planned, implemented and accountable. ACCHSs bring extensive networks and local community knowledge to every partnership. ACCHSs frequently support mainstream health agencies and hospitals that deliver services and programs to Aboriginal and Torres Strait Islander people to reduce racism, promote cultural awareness and achieve significant and enduring change towards cultural safety. These collaborations occur in this domain.

This domain also illustrates the need for effective links through core services of each ACCHS to their respective state or territory affiliate. Affiliates do not provide services directly to Aboriginal and Torres Strait Islander people. Their role is to enable, support and develop ACCHSs in their jurisdiction to do so. Affiliates function to support and share best practice across their networks as specified in their strategic plans. Affiliates also drive change. For example, QAIHC funded the first hospital institutional research in partnership with the (then) Queensland Anti-Discrimination Commission (now Queensland Health Rights Commission) (Marrie 2017). To further accelerate system-level change, NACCHO works to promote the sector at the national level. In this Model, each ACCHS obtains the support it requires from its respective affiliate whether through out-sourcing, network participation, regionalisation or communities of practice.

This domain also includes research and evaluation. Business as usual and current research approaches are no longer options for Aboriginal and Torres Strait Islander peoples seeking to accelerate improvement in their health and wellbeing (Cheer et al. 2020). Through its successive Cooperative Research Centres (CRCs), the Lowitja Institute developed a research philosophy known as the Facilitated Development Approach (FDA) (Arabena and Moodie 2011). Each CRC worked with its partners in the Aboriginal and Torres Strait Islander health sector to identify areas where research could make a real difference, then commissioned that research. Using the FDA, Aboriginal and Torres Strait Islander voices had strong input at each step of the research process (Aranena and Moodie 2011; Ewen et al. 2019). This also supports effective knowledge translation.

PP1 Policy direction and strategic influence

- Articulate and effect change to address determinants of health which lie beyond the direct responsibility of the health system
- Articulate and achieve change in social determinants of health identified by the community such as housing, environmental health, employment and education
- Consider the potential of every organisation visible in the community (whether mainstream of other community controlled organisation) to work effectively together to achieve changes that improve health and wellbeing
- Invite partnership with a range of organisations with capacity and resources to contribute to health improvement in the community such as Local Health Networks (LHNs) (also known as Hospital and Health Services [HSS] in Queensland and Local Health Districts in New South Wales), Primary Health Networks (PHNs) and Royal Flying Doctor Services as examples
- Promote system-wide change more conducive to better health and wellbeing for the community
- Promote evidence-based public policy grounded in Aboriginal and Torres Strait Islander perspectives
- Provide a comprehensive holistic platform in primary health care for vertical, externally initiated, short-term programs
- Participate in relevant forums, consultations, working groups and committees to improve cultural safety in other health services
- Maintain a visible media presence to accelerate policy change
- Obtain data to assess cultural safety of local services

PP2 Partnerships

- Initiate, maintain and expand strategic networks and partnerships to achieve and accelerate health in the community
- Participate as an equal stakeholder in joint planning with government and other organisations at the local level and, as required, at national and state/territory levels
- Assess health needs and articulate social determinants of health effectively and persuasively, especially when health data show that current housing, education, employment, food access, childrens safety or other social determinants compromise health

- Monitor progress, support achievement and challenge any slippage in accountabilities for agreed collaboration through partnership in addressing key determinants of health
- Negotiate and implement instruments for partnerships such as MOUs based on two-way understanding and respect, building trust and together achieving desired outcomes
- Agree to and deliver mechanisms, measures and indicators for joint accountability in partnership agreements
- Work with other organisations on appropriate enforcement of legislation and regulations including environmental health, housing standards and utilities
- Partner and work with other ACCHSs and contribute to affiliate and national networks including peak body meetings, conferences and forums contributing to better service standards and more effective services
- Partner with the affiliate and NACCHO as specified to build capacity and improve service as agreed in sector-support arrangements
- Promote the involvement of CEOs, youth leaders and senior staff in forums and dialogues and assert influential thought leadership ('be at the table')
- Mitigate all forms of racism including institutional racism affecting the community
- Share expertise in order to improve cultural safety of other services
- Drive effective working relationships that achieve results with Primary Health Networks and other accountable organisations in the primary health care system
- Reach out to non-health organisations influential in local health outcomes such as shire employees, local hospital employees, teachers and police to offer effective cultural awareness training and promote partnerships
- Obtain all necessary support and technical advice from the state/territory affiliate

PP3 Community-led research and evaluation

- Promote community-led research through self-determination and grow local capacity from entry-level research skills to academic leadership
- Design, conduct and publish community-led research and evaluation
- Analyse own data to demonstrate achievements, document progress and improvement, consistent with Priority Reform 4 of the National Agreement on Closing the Gap
- Negotiate priority research questions with external research institutions and funding bodies, negotiate MOUs or other written agreements to protect community interests and specify data-sharing requirements including public disclosure and permissions
- Generate and answer own research/evaluation questions
- Acquire locally generated data from diverse sources to plan better services, improve performance and save money
- Invite collaborations with academic institutions to pursue community-led, high-priority research and evaluation
- Initiate, join and collaborate with ACCHS Centres of Excellence to set own research agendas and establish research committees and other structures to enhance community-led research and evaluation
- Conduct and collaborate in research in an ethical manner that embeds the dignity, rights and welfare of Aboriginal and Torres Strait Islander people and communities
- Translate research evidence into practice

INFRASTRUCTURE, WORKFORCE AND CONTINUOUS QUALITY IMPROVEMENT

These functions must be funded in a way that guarantees they can be strategic, sustained and long-term. Discussions have already identified the need for every CEO to be supported by a policy officer. Resources must be available for developing, retaining and deploying expertise in policy issues, retaining critical expertise and sharing strategic lessons. Resources are also needed for staff time, backfill, debriefing from policy meetings, travel and incidentals including library fees, journal subscriptions and conferences.

Policy impact and partnerships will be enhanced through systematically applied CQI. Boards will identify priorities for CQI in this domain, as for others. Resources will be needed to ensure valid and reliable methods are used, including credible measures for partnership quality.

Acronyms

ACCHO	Aboriginal Community Controlled Health Organisation
ACCHS	Aboriginal and Torres Strait Islander Community Controlled Health Service
ACCHSs	Aboriginal and Torres Strait Islander Community Controlled Health Services
ACCO	Aboriginal Community Controlled Organisation
ACNC	Australian Charities and Not-for-profits Commission
ACSQHC	Australian Commission on Quality and Safety in Health Care
AGPAL	Australian General Practice Accreditation Limited
AHCSA	Aboriginal Health Council of South Australia
AHCWA	Aboriginal Health Council of Western Australia
AHMAC	Australian Health Ministers' Advisory Council
AHMRC	Aboriginal Health and Medical Research Council
AHP	Aboriginal Health Practitioner
AHPRA	Australian Health Practitioner Regulation Agency
AHW	Aboriginal Health Worker
AIATSIS	Australian Institute of Aboriginal and Torres Strait Islander Studies
AIHP	American Institute of the History of Pharmacy
AIHW	Australian Institute of Health and Welfare
AMS	Aboriginal Medical Service
AMSANT	Aboriginal Medical Services Alliance Northern Territory
AOD	alcohol and other drugs
CATSI Act	Corporations (Aboriginal and Torres Strait Islander) Act 2006
CATSINaM	Congress of Aboriginal and Torres Strait Islander Nurses and Midwives
COAG	Council of Australian Governments
CEO	Chief Executive Officer
CQI	Continuous Quality Improvement
CSOF	Core Services and Outcomes Framework
CVD	cardiovascular disease
ENT	ear, nose and throat
et al.	et alia (Latin for 'and others')

FDA	Facilitated Development Approach (Lowitja Institute)
GP	General Practitioner
HR	human resources
IPAG	Implementation Plan Advisory Group (for National Aboriginal and Torres Strait Islander Health Plan 2013–2023)
ISO	International Standards Organization
Lowitja	Lowitja Institute (National Institute for Aboriginal and Torres Strait Islander Health Research)
MAPPA	online platform: Mapping Health Services Closer to Home
Model	Model of Community Controlled Comprehensive Primary Health Care
MOU	Memorandum of Understanding
NACCHO	National Aboriginal Community Controlled Health Organisation
NATSIHWA	National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners
NDIS	National Disability Insurance Scheme
NIP	National Immunisation Program
NSQHSS	National Safety and Quality Health Service Standards
OOHC	out of home care for children
OSR	Office of State Revenue
PAHO	Pan American Health Organization
PHN	Primary Health Network
PIRS	Patient Information Recall System
QAIHC	Queensland Aboriginal and Islander Health Council
RACGP	Royal Australian College of General Practitioners
SAHMRI	South Australian Health and Medical Research Institute
SEWB	social and emotional wellbeing
STI	sexually transmitted infection
WH&S	work health and safety

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... health done 'our way' is unique. It is a holistic system grounded in truth, lived realities, our culture, law and country. ...You can bring these ingredients together, utilise changing structures and relationships to design the culturally informed health models and work programs our people need. It is the way that we deliver our work from the ground up that informs the best policy and legislation. We have to seize this moment.

June Oscar, speech at AMSANT conference, August 2019