

‘Unlocking value’: corporate support models and Indigenous primary health care services

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Alister Thorpe is a Gunai (East Gippsland), Yorta Yorta (Northern Victoria), and Gunditjmara (Western Districts) man with many family and connections throughout Victoria. Alister is the Project Officer for the Support Systems for Indigenous Primary Health Care Services Project at Onemda VicHealth Koori Health Unit based at the University of Melbourne. Prior to this project, he worked on the development of a Victorian Aboriginal Child Health Development and Wellbeing Survey, which resulted in some additional content being included in the Victorian section of the ABS National Aboriginal and Torres Strait Islander Social Survey. He also has experience working in several Indigenous community organisations, including the Victorian Aboriginal Health Service (as a research assistant on the Injecting Drug Use Project) and the Aboriginal Housing Board of Victoria. Alister is currently studying for his Masters of Public Health at the Institute for Koori Education (IKE) Deakin University. He has been a Director on the Board for Yappera Childcare Services since July 2009 and has also been a member of the City of Melbourne’s Indigenous Arts Advisory Panel since 2007. Alister has a strong interest in protecting and promoting his Indigenous cultural heritage and working with the Indigenous and mainstream community on improving Indigenous health and wellbeing, in particular the health of Indigenous young people. He is also the proud father of three young children.

Introduction

Effective performance of corporate functions, like governance, general management, human resources and finance is important for optimal performance of any organisation. How to structure these functions to (1) maximise the value obtained from the resources dedicated to them and (2) best support core business (in this case delivery of comprehensive primary health care) has been a challenge for organisations for at least two centuries. For some this challenge has been seen as the challenge of creating organisational structures that ‘unlock the value’ of available resources. As a consequence a number of approaches have been developed (for example, centralised corporate services, decentralised corporate services, matrix models) but in attempting to get the ‘perfect’ organisational structure, some organisations have gone through many (costly) restructures only to find that while some problems are solved, others have been created.

There has been significant effort invested by some in the ACCHSs sector to develop ways of strengthening the corporate function capacity of services through establishing structured models for accessing support in these areas. This is a particularly difficult task given that many of these organisations are small, have access to limited workforce, operate in communities where there are very high-levels of need and very limited resources, and exist in a changing and complicated funding and regulatory environment. Many have experienced rapid growth and have high administrative and reporting loads. Changes to business practices generally, and developments in technology have also increased the complexity of the way organisations operate. This has meant that operating the business side of services now requires skill sets not available in many communities as well as significant resources. Despite this, innovative approaches to improving corporate services through developing joint support models have been developed in ways that ensure the autonomy of individual services.

The need for this study about organised approaches to corporate support in the Aboriginal community controlled health sector was identified by the Cooperative Research Centre for Aboriginal Health in consultation with its stakeholders. This work is part of a larger program of activity aimed at supporting ongoing development of ACCHSs. The project was done in two parts. The first aimed to develop knowledge about the range of corporate functions where ACCHSs might require external support and the factors that influenced the support required. The second part of the project aimed to look at case studies of existing models for organising corporate support services—and this is our focus today. Each part included reviewing literature, consulting with key informants, developing a discussion paper and holding a national roundtable.

Organised corporate support models

ACCHO's have been dealing with the factors impacting on their operational and management functions in varying ways. In the second phase of the project we found that many ACCHO's had carried out significant work to establish and develop support structures for their corporate functions revealing some innovative models.

Our Steering Group identified several of these Aboriginal Health Services or groups of Services with corporate support systems in place and these services were invited to participate as case studies in our project. The intent of the case studies was to identify existing good practice in the provision of corporate support, to identify the issues experienced when establishing and implementing such support as well as to seek information about what else could be done to enhance provision of such support.

Some of the main aspects examined in the case studies included the history of the model and how it was developed, how the model is governed, its underpinning principles and how the model is resourced or funded. We also looked at how each model was structured, including the types of support provided, how it was provided and how support needs were identified. In each case study we also mapped out the relationships of organisations with the support provider. Information was also collected on any evaluation and review strategies integrated into the models along with potential benefits and barriers.

Four models were chosen as case studies. They are described below.

The first is a **regionalised or central support model**, where a number of services agree to work together as a regionalised service. Sometimes in these models corporate support is centralised.

The Katherine West Health Board (KWHB) was selected as a case study for this model. The KWHB was developed as part of a coordinated care trial in 1996, in 1998 its role was as a purchasing body, and in 1999-2001 it transitioned to a service provider. The corporate office, located in Katherine, provides corporate services to seven Community Health Centre's in remote communities. Representatives from the communities sit on the Board and also participate in subcommittees. Corporate support development is integrated into health service development with a planned and incremental approach and a strong commitment to communication.

KWHB has a fairly flat structure to enhance communication between CHCs and corporate functions. Key features of KWHB's model are the ongoing development of IT for communication, knowledge sharing, problem solving and CQI. Many corporate functions are internal, consultants are only used when the right skills are not available locally, demand for support is limited or a skilled local provider is available as a consultant. Capacity building is incorporated in the model through the employment and training of local staff. An administration fee is levied to fund corporate services and evaluation and review is ongoing with KWHB recently undertaking a process for restructuring.

The **provision of corporate support services by a large or peak organisation** is a second model selected as a case study. In this model specialist support is provided either by individuals within the service or by a specialist unit created within a **single** large organisation that has sufficient administrative capacity to provide support to others.

As a peak body for corporate support to Queensland's Indigenous health services the Queensland Aboriginal and Islander Health Council (QAIHC) was chosen for this case study. QAIHC was originally established in 1990 as the Queensland Aboriginal and Islander Health Forum. QAIHC has 26 member services and is governed by a board elected from the membership to represent the different regions across Queensland.

In 2004 QAIHC established a Business Support Unit (now the Sector Development Unit) to provide corporate support to their members. The unit provides direct support from three locations, manages consultant support, facilitates support from other QAICH units, runs a help desk, facilitates statewide training, facilitates specialist networks, organises information sharing (conferences) and has worked with the sector to develop Business Quality Centres.

Members of QAIHC pay an annual 'retainer fee' according to the services required and this is formalised in a written agreement. QAIHC has strategic and business plans and benchmarks the performance of the Sector Development Unit against these. Key performance indicators are around activity and feedback from services. A formal review of the unit is conducted every two to three years.

A third model identified to be included in the case studies was **peer support networks** where a group of organisations (or specific staff within organisations like CEOs or finance workers) form a network to provide support to each other.

Bila Muuji (which means river friends) a CEO network based in Western NSW was chosen as the case study site. CEO's of six rural and remote Aboriginal Medical Services in NSW established Bila Muuji in 1995. The network was setup so the CEO's could meet as a regional forum and share ideas and support each other. Currently there are ten CEO's of services participating in Bila Muuji that meet on a bi-monthly basis.

Bila Muuji identifies and addresses issues of common concern and organises for likely changes in service systems. They work collaboratively on joint initiatives for service development, share skills and expertise and provide one on one and joint peer support. Bila Muuji has recently been incorporated so the group will be able to hold joint funds for future collaborative work. Joint training is also carried out on occasion. Member organisations pay an annual fee that is split into two tiers, one for smaller organisations and one for larger organisations with higher operating budgets.

The final case study model was focused on **auspice arrangements** where a small organisation enters into an auspice arrangement with a larger one. These arrangements are often expected to be temporary.

As an auspice body for several communities the Central Australian Aboriginal Congress (CAAC or Congress) was approached to participate as a case study for this model. The CAAC was established in 1973 and first had an auspice role in 1977. The CAAC's Charter embraces supporting the development of community controlled services. The CAAC currently auspices six services (in nine communities) but since their first arrangement demand has grown rapidly.

Congress has 10 Branches and the Remote Health Branch (RHB) manages auspiced services. The RHB provides direct support to auspiced services and facilitates corporate support from the CAAC Corporate Support Branch. Although the CAAC Board is responsible for auspice service contracts, services also have their own boards which the CAAC Board and CEO work with, however the CAAC Board can over-ride any decisions made by auspiced service boards.

Entering an auspice arrangement may be a funding body requirement—however services often can choose the auspice body. A set administration fee is taken from auspiced services funding to finance the model.

Other models or strategies for the support of corporate functions that we identified included:

- **Organisation-owned shared service provider or service centre** which can be a separate organisation from its member services, but owned and governed by them. This type of service brings together and provides business functions previously performed by the business units within member organisations.
- **Joint outsourcing to the private sector** which is where organisations pool funds to jointly purchase goods or services from the private sector
- **Co-location model** which is where a number of organisations share premises and common resources and facilities
- **Partnerships** which is where individual organisations coordinate relationships with external support providers, peak body organisations, larger services etc on a one to one basis

- **Organisational arrangements with consultants** which is where organisations outsource particular functions, or obtain advice from, consultants.

Diagrams of these models are provided on the following pages.

Advantages and disadvantages of organised corporate support models

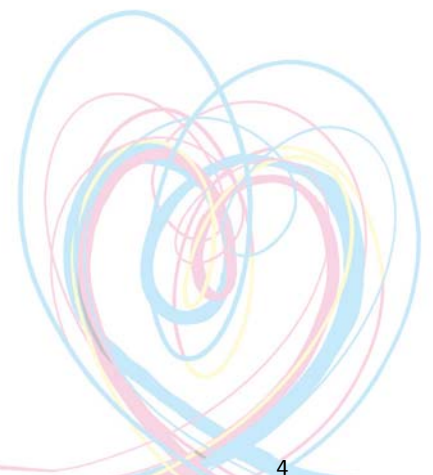
These models of support for corporate functions present a range of potential advantages and benefits to services. Many of the models offer the possibility of economies of scale by maximising the value for each dollar spent by services. By introducing standardised protocols services can reduce duplication of effort for many corporate functions and support the development of consistent business practices across services. They can also facilitate access to high quality, timely specialist advice for services and monitor the quality of the work of contractors. There is also capacity for increased revenue generation and resource pooling and development of joint responses to common issues for a group. Also some aspects of service functioning, such as workforce planning, may be coordinated.

Other benefits include an enhanced capacity for service development and continuous improvement of services through information exchange, joint problem solving, identification of good practices and support in change management. Some models also supported smaller or transitioning organisations and those with difficulties. Generally, participating in an organised corporate support structure enabled services to place their main focus on their 'core business' (service provision).

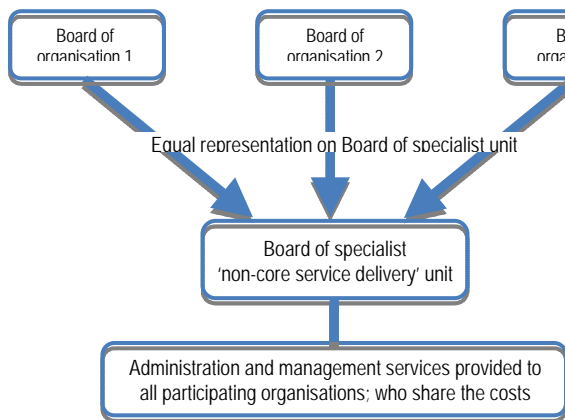
However these potential advantages need to be carefully weighed up against some potential risks and challenges. Organisations or communities participating in a shared service for corporate support need to form an arrangement that ensures equitable benefit to all participants. Joint decisions need to be made around a number of areas including the governance of the model, the decision making process, what functions are to be included and how the model is funded.

The development of new structures for support also requires significant resources (finance and skilled staff) and time to setup and maintain. Without careful setting up by services the involvement in some models can also lead to diminished community and/or organisational ownership of services and could create power-bases with limited representativeness. There is also potential for divisions between different organisations with different agendas.

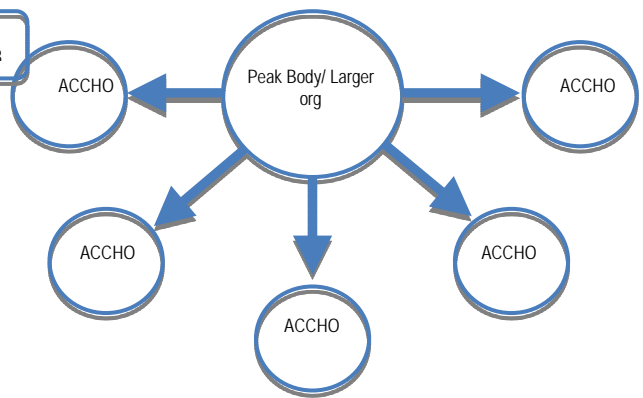
Participants in models must also be aware that the efficiencies and savings created by support models may potentially be seen by some as an opportunity to reduce funding. Ensuring that local capacity is developed is a significant challenge and requires long term planning and strategies. Another risk is the possibility of members opting out of a model, which could impact on the effectiveness of new structures.



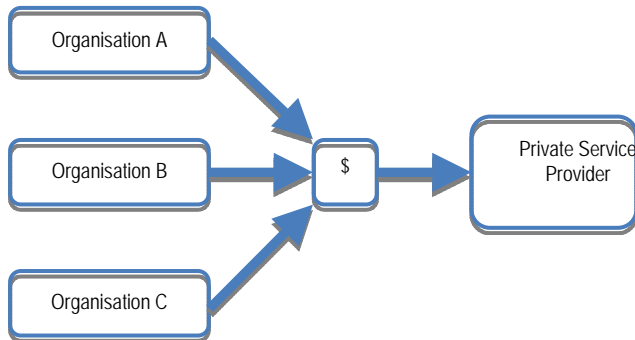
Organisation-owned shared service provider or service centre



Provision of corporate support services by a large or peak organisation



Joint outsourcing to the private sector



Peer support networks

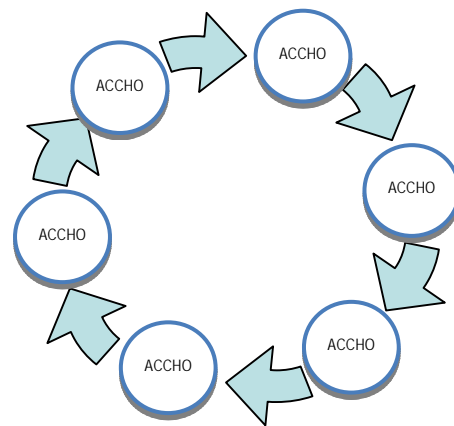
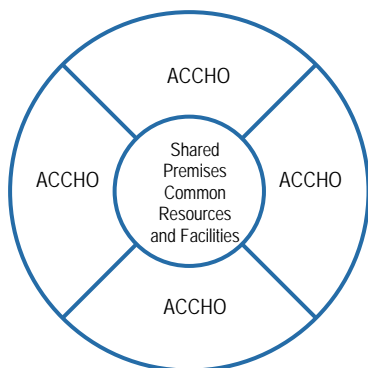
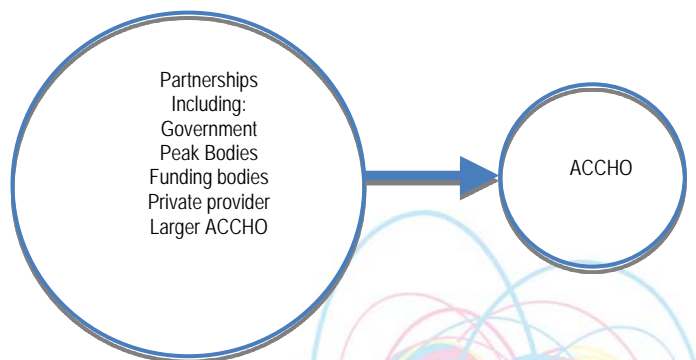


Figure 1 Nine types of organised corporate support structures currently existing amongst ACCHSs

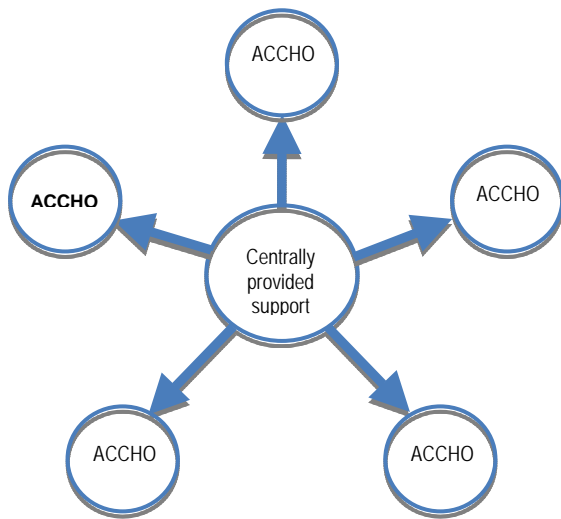
Co-location model



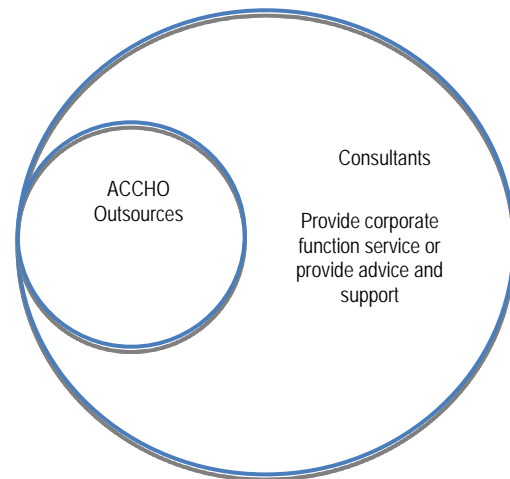
Partnerships



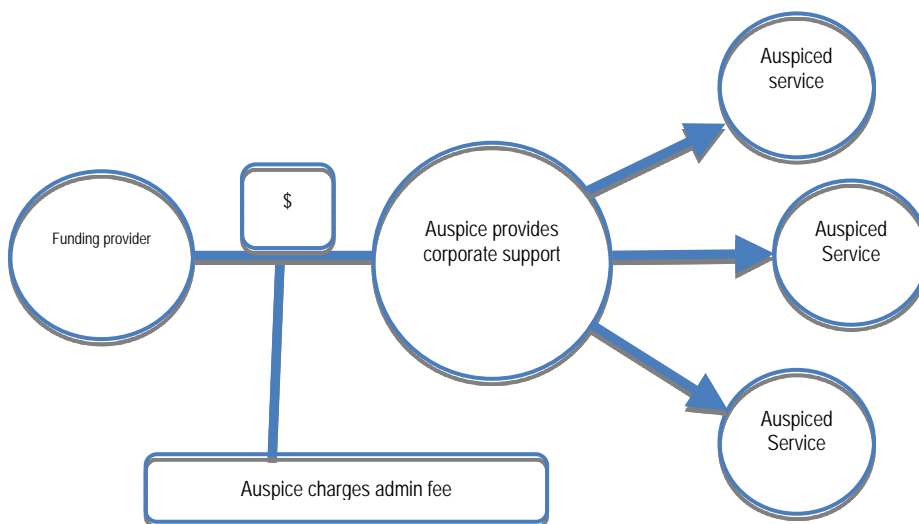
Regionalised or central support



Organisational arrangements with consultants



Auspice arrangements



Key themes and lessons about establishing joint corporate support models

These case studies illustrate some of the significant thinking, work and effort invested in developing a range of joint models for supporting the corporate functions of ACCHSs in Australia over many years. If we look across these models there are a number of key themes that emerge. These include:

- Each model was developed by people working in the sector to address needs they had identified. Strengthening corporate services was seen as a part of supporting effective and sustainable clinical service delivery. Participation in models was generally voluntary.
- Visionary leadership was required to lead development of new ways of thinking and working, particularly in relation to maintaining community control while sharing aspects of corporate functioning.
- Having a good process for establishing a corporate support structure was as important, if not more important than having an existing model that could be applied. This means there is not a 'one size fits all' solution. Involving all potential participants in working through ownership issues, developing the 'rules' and identifying how different needs would be met were all essential parts of this process. Careful

planning, including setting realistic goals consistent stage of development, allowing time to build structures slowly and carefully, allowing time for organisations to change, and undertaking formal and informal review so that the structure remained relevant and accessible in changing times were aspects of this.

- Participating organisations need to make decisions about which corporate functions they consider can be provided externally and which should be provided internally. These are influenced by organisational thinking about the extent to which corporate services should be integrated with core business, the extent to which organisations want to maintain direct control over certain aspects of their service; availability of skills locally; and organisational capacity to train and/or employ relevant staff. Having said this, identifying support needs can be difficult for organisations.
- Where possible, organisations participating in a joint model should be represented in its governance structure and a set of clearly articulated principles to guide joint activity is important.
- Well functioning support models had defined structures underpinning their work. This included formal agreements between participant organisations, mechanisms to ensure effective communication, and formal and informal review processes. However, there was still a big dependence on capacity of individual staff members to build relationships—therefore making models vulnerable to staff turnover.
- Staff providing support need to be highly skilled, flexible (they could identify and work with the needs of different organisations and organise their work to prioritise the needs of others), highly committed; prepared to visit services; be approachable, be able to listen and be non-judgmental, and able to maintain confidentiality.
- A capacity building approach was part of each case study and included direct skills and knowledge transfer as well as assisting organisations create robust internal systems and processes.
- All of the support providers in the case studies generally used a number of mechanisms to achieve their goals, including providing support at combinations of local, community, regional, state/territory and/or national-levels. The main mechanism was through direct support. Other mechanisms included facilitating training, having an help-desk, meeting as a peer support network, developing templates, policies and procedures that could be adapted by organisations, facilitating development of local networks, facilitating upgrades of infrastructure, and facilitating development of regional hubs to take on the role of corporate support. Work was also done through state-wide training and through advocacy at state/territory and national-levels.
- Models were funded in a variety of ways and all required contributions from those accessing support—either through an administration fee, a fee-for-service arrangement, or a membership fee.
- Support providers were accountable to support accessors either through governance arrangements, written agreements and/or through feedback mechanisms.
- Being able to demonstrate benefits that accrue from operation of a corporate support structure was important to maintaining engagement of organisations.

Conclusion

The environment in which Aboriginal community controlled health services work in is characterised by change. In some ways what services are trying to do by working together in support structures could be seen as mitigating some of this risk through collaboration. Collaboration can provide organisations with some degree of flexibility in a flexible environment and can facilitate capacity to maximise the value obtained when opportunities arise. Some of the risks for support structures include: that continuous change means that organisations are often in transition and will require different types of support as they change and develop; limited funds and resources; that the purpose of the support structure can change without associated review of governance and operation; high workloads of staff; and high and increasing levels of demand for corporate support. In addition, when the support provider has an alternate primary role (like advocacy or health service

provision), the support role can overwhelm the other service functions and/or the focus of the organisation can remain on its core business and provide less than adequate support to external organisations.

We are currently using the knowledge gained from this project to develop a decision-making tool to assist services decide their best strategy or model for getting support for their corporate functions.

This project highlights the capacity of the ACCHSs sector to develop innovative solutions to difficult issues while working in a quickly changing environment. Additional resourcing to facilitate ongoing action by the sector in developing appropriate models for supporting corporate services is likely to enable further innovation in this area. Such work should contribute to stronger and more viable health services for Aboriginal communities.

Acknowledgments

We would like to begin by thanking all of the people who participated in this project and who generously contributed their wisdom, knowledge and experience. We would particularly like to thank members of our reference group, workshop participants and case study sites—the latter are Bila Muuji Health Services, Central Australian Aboriginal Congress, Katherine West Health Board and Queensland Aboriginal and Islander Health Services.

