Independent Governance Review of the *Health Services Act 2016*

Date: 16 May 2022

Introduction

The Aboriginal Health Council of Western Australia (AHCWA) is the peak body for 24 Aboriginal Community Controlled Health Services (ACCHS) in Western Australia. WA ACCHS are located across geographically diverse metropolitan, regional and remote locations. They deliver the most effective model of comprehensive primary health care for Aboriginal people[1], and are in a unique position to identify and respond to the local cultural and health issues of Aboriginal people and their communities across WA. AHCWA exists to support and act on behalf of its 24 Member ACCHS, actively representing and responding to their individual and collective needs.

AHCWA welcomes the opportunity to provide a submission to the Independent Governance Review of the *Health Services Act 2016* (the Review) to ensure the needs of Aboriginal people and their communities are reflected in health system governance. Given the experience of the ACCHS sector working alongside the WA public health system in various regions across the State, the sector is in a unique position to comment on the governance of the WA health system and its impacts on local level decision-making and patient outcomes.

There are sections of the Review's terms of reference that are out of scope for AHCWA, as some of the issues relate to the experiences of internal stakeholders. Thus, AHCWA's submission to the Review will focus on interactions between the ACCHS sector and the public health system. It is important to note that many aspects of the relationship between the ACCHS sector and the WA public health system have strengthened over time, and that relationships differ by region. With the intention of providing feedback that can further strengthen system governance and accountability, this submission will focus on those areas where further improvement is required.

The system's ability to manage, plan and implement key health reforms and workforce requirements

Implementation of policy priorities and health reforms

The WA Government has committed to a number of key policies and strategic frameworks that guide how healthcare should be delivered to the Western Australian Aboriginal community. Implementing these key policies and strategies is vital to ensuring optimal health and wellbeing of Aboriginal people and their communities. To properly implement health policies and reforms, it is crucial that each Health Service Provider (HSP), and health services within their jurisdiction, are accountable for adopting the commitments made in key health reforms. This is consistent with the *Health Services Act 2016*, which has as one of its objectives: 'to coordinate the provision of an integrated system of health services and health policies in the WA health system'[2]. However, it is the ACCHS sector's experience that the devolved governance model can sometimes act as a barrier to the timely and comprehensive implementation of policies and reforms. This may be in part because of a lack of awareness about what implementing those policies requires, a lack of appropriately robust accountability mechanisms,

[1] Throughout this submission, AHCWA uses the term 'Aboriginal' to respectfully refer to all Aboriginal and Torres Strait Islander people across Western Australia.

[2] https://www.legislation.wa.gov.au/legislation/prod/filestore.nsf/FileURL/mrdoc_29646.pdf/$FILE/Health%20Services%20Act%202016%20-%20%5B00-e0-06%5D.pdf?OpenElement (pg. 2)

or inadequate resourcing to allow HSPs to both implement changes and continue to deliver their core services.

As a framework for any policy, program or service that impacts Aboriginal people, it is essential that the entire public health system is familiar with, and that the governance structure reflects the requirements of, the National Agreement on Closing the Gap (National Agreement)[3], with a particular focus required on the four Priority Reforms.

Priority Reform One of the National Agreement outlines the need for more 'formal partnerships and shared decision-making' (pg. 5). As per WA's Closing the Gap Jurisdictional Implementation Plan (WA Jurisdictional Implementation Plan)[4], the WA Government has committed to 'build and strengthen structures for Aboriginal representation in decision-making' and 'strongly involve Aboriginal people in service design' (pg. 21-22). Priority Reform Two focuses on 'building the community-controlled sector' (pg. 8). This directly relates to government funding and commissioning practices, as it requires an increase in 'the amount of government funding for Aboriginal programs and services going through Aboriginal and Torres Strait Islander community-controlled organisations' (ACCOs) (pg. 18). Under Priority Reform Three, all parties have committed to 'systemic and structural transformation of mainstream government organisations to improve accountability and respond to the needs of Aboriginal and Torres Strait Islander people' (p. 11). This includes (among other things) the need to increase Aboriginal employment, increase Aboriginal representation in governance positions, and identify and eliminate racism (p. 19). Priority Reform Four emphasises the importance of Aboriginal peoples' access to 'relevant data and information', specifically at the regional level (pg. 20). The WA Jurisdictional Implementation Plan highlights that this priority reform area acknowledges the historical lack of information sharing by governments, which 'must change in order to further empower Aboriginal people to make and participate in decisions about their futures' (pg. 33).

AHCWA suggests that renewed efforts are required from all stakeholders within the WA public health system to fully implement key policy reforms, including the National Agreement, the WA Jurisdictional Implementation Plan, the Sustainable Health Review (SHR)[5] and the Aboriginal Empowerment Strategy[6]. There are various commitments to implement actions from these plans and strategies in partnership with the ACCHS sector and local Aboriginal communities, a number of which could be prioritised in the short- to medium-term.

- While AHCWA has had many opportunities to meet with SHR Recommendation Leads, and actively participates in many SHR activities, we have had limited success with influencing the actual implementation of SHR Recommendations. This is despite the fact that the SHR report recognises ACCHS as 'leaders in Aboriginal primary health care'[7].
- Moreover, one of the aims of the SHR is to shift the WA Health system from an acute, hospital-based system, to a focus on preventative health and 'community-based care'[8]. However, there remains a greater funding emphasis on acute care and hospital services, rather than community preventative care. The SHR report notes that 'only [an estimated] 1.6 per cent of total health expenditure in WA is spent on prevention activities each year', which is almost half

[3] https://www.closingthegap.gov.au/sites/default/files/2021-05/ctg-national-agreement_apr-21.pdf
[4] https://www.wa.gov.au/system/files/2021-09/Implementation%20Plan%20-%20CtG_1.pdf
[5] https://ww2.health.wa.gov.au/~/media/Files/Corporate/general-documents/Sustainable-Health-Review/Final-report/sustainable-health-review-final-report.pdf
[6] https://www.wa.gov.au/system/files/2021-09/Aboriginal-Empowerment-Stategy-POLICY%20GUIDE.pdf
[7] https://ww2.health.wa.gov.au/~/media/Files/Corporate/general-documents/Sustainable-Health-Review/Final-report/sustainable-health-review-final-report.pdf (pg.11)
[8] Ibid. (pg. 39)

the OECD average expenditure (2.8 per cent)[9]. Notwithstanding the need to ensure hospitals are adequately resourced, primary healthcare providers delivering community-based care are imperative in minimising emergency department admissions[10], and ultimately reducing long-term overall healthcare spending. (AHCWA acknowledges that primary health care funding is in many respects a Commonwealth responsibility, but still considers that the State has an important role to play in increasing preventive health measures and services.) This is supported by SHR Recommendation 1, which details the need to increase the total health expenditure on prevention to 'at least 5%' by July 2029[11]. Given the WA Government's recent budget surpluses[12], and projected surpluses in subsequent years, there is ample capacity to undertake expenditure aimed at supporting the tertiary/secondary health system, while also investing in primary and preventative health care.

- Furthermore, SHR Recommendation 17[13] provides an opportunity to progress the transition of funding for Aboriginal community services from mainstream organisations to ACCHS (and, in some cases, ACCOs), consistent with Priority Reform Two of the National Agreement. This is consistent with commitments made in the Aboriginal Empowerment Strategy and the WA Jurisdictional Implementation Plan.
- There are also opportunities to further build the capacity of the ACCHS sector through the transitioning of government-run primary health clinics to Aboriginal Community Control[14]. As indicated in the Closing the Gap Health Sector Strengthening Plan, transitioning government-run clinics to Aboriginal Community Control would provide better health outcomes for Aboriginal peoples and deliver 'a fourfold cost benefit compared to the mainstream service in remote areas'[15]. While it is imperative that the transitioning of services is driven by community, and Aboriginal services work in partnership with the State to progress these actions, WA Health could be proactive in considering what services could be transitioned and what is required from government to ensure the successful transition and longevity of the services.

It is paramount that the implementation of key health reforms includes short- and medium-term deliverables (with a higher level of ambition), and that both the identification and progression of policy reforms are made in partnership with the ACCHS sector. The sector expects there to be greater accountability across the WA health system in implementing these reforms, to ensure the WA Government is able to deliver against the reform commitments it has made regarding Aboriginal health. This will ensure the objectives of the *Health Service Act 2016* are achieved, which includes aiming to 'identify and respond to opportunities to reduce inequities in health status in the Western Australian community' and 'provide access to safe, high quality, evidence-based health services'[16].

Serious challenges also remain regarding the cultural security of public health services. Addressing systemic racism will be essential to WA Government efforts to meet the commitments it has made

[9] Ibid. (pg. 47)
[10] https://ww2.health.wa.gov.au/~/media/Files/Corporate/general-documents/Sustainable-Health-Review/Final-report/sustainable-health-review-final-report.pdf (pg. 26)
[11] Ibid. (pg. 46)
[12] https://www.ourstatebudget.wa.gov.au/2022-23/budget-papers/bp3/2022-23-wa-state-budget-bp3.pdf (pg. 1)
[13] 'Implement a new funding and commissioning model for the WA health system from July 2021 focused on quality and value for the patient and community, supporting new models of care and joint commissioning' (pg. 17): https://ww2.health.wa.gov.au/~/media/Files/Corporate/general-documents/Sustainable-Health-Review/Final-report/sustainable-health-review-final-report.pdf
[14] https://coalitionofpeaks.org.au/wp-content/uploads/2021/12/Health-Sector-Strengthening-Plan.pdf (pg. 11)
[15] Ibid. (pg. 11)
[16] https://www.legislation.wa.gov.au/legislation/prod/filestore.nsf/FileURL/mrdoc_29646.pdf/$FILE/Health%20Services%20Act%202016%20-%20%5B00-e0-06%5D.pdf?OpenElement (pg. 2)

under Priority Reform Three of the National Agreement. In addition to the National Agreement, the WA Aboriginal Health and Wellbeing Framework[17] provides a valuable guide to implementing broader system change. Strategic direction 4.3 of the Framework is 'a culturally respectful and non-discriminatory health system', with the strategic outcome for this direction stating: 'WA Health recognises racism as a key social determinant of health for Aboriginal people. Health care, whether government or community provided, is to be free of racism and discrimination' (pg. 13). As the Framework notes, 'racism and discrimination experienced by Aboriginal people in the delivery of health services contributes to low levels of access, engagement and compliance with treatment' (pg. 13). The following paragraph from the evaluation of the first five years of the Framework illustrates that this remains a key challenge:

> Several respondents reported that changes in personnel within their organisations had often stalled or slowed progress being made over the last five years. This situation was especially apparent when changes occurred at senior levels and the people in these positions understood and championed Aboriginal health or that the organisation simply abandoned the implementation of the Framework to the Director of Aboriginal Health within that service. Systemic racism, although reducing, was still felt to be present in some parts of the system. It was described as often being subtle and hard to pin down – but nevertheless still present. One respondent noted that there are no current measures of the degree of cultural bias in place across the system and that this makes it difficult to measure progress and identify what actions or strategies for the system are required next.[18]

AHCWA also continues to receive feedback about the persistence of systemic racism. To address this, broader changes are required to the public system's culture, driven by a clear strategy which is understood and actioned by all levels of the workforce. This is an area where AHCWA considers that further monitoring and review is required to ensure existing plans and strategies are being implemented. Among other things, this could entail the introduction of relevant KPIs for particular institutions and senior leadership. Consistent and public championing of the need to address systemic racism must come from all senior staff in the health system.

Workforce requirements

AHCWA welcomes the inclusion of the health workforce in the terms of reference, and considers that further improvements could be made regarding workforce planning and sharing (although it is acknowledged that some of the challenges related to the health workforce are due to factors beyond the control of the WA Government). Similar to the points made above, AHCWA considers it crucial that workforce policies and planning continue to reflect key health policies and reforms, including the commitment to 3.2% Aboriginal employment in the WA Health system, as per the WA Health Aboriginal Workforce Strategy 2014–2024[19] (which is slightly lower than the national health workforce target of 3.43% by 2031[20]). It is imperative that the Aboriginal 'health workforce continues to grow to support the health needs of Aboriginal and Torres Strait Islander people, whether they are accessing community-controlled or mainstream health services'[21]. The improvement in Aboriginal employment

[17] https://ww2.health.wa.gov.au/~/media/Files/Corporate/general-documents/Aboriginal-health/PDF/12853_WA_Aboriginal_Health_and_Wellbeing_Framework.pdf
[18] https://ww2.health.wa.gov.au/~/media/Files/Corporate/general-documents/Aboriginal-health/PDF/14054-aboriginal-framework-evaluation.pdf (pg. 34)
[19] https://ww2.health.wa.gov.au/~/media/Files/Corporate/general-documents/Aboriginal-health/PDF/workforce_strategy.pdf (pg. 4)
[20] https://www.health.gov.au/sites/default/files/documents/2022/03/national-aboriginal-and-torres-strait-islander-health-workforce-strategic-framework-and-implementation-plan-2021-2031.pdf (pg. 9)
[21] Australia's Primary Health Care 10 Year Plan 2022-2032: australia-s-primary-health-care-10-year-plan-2022-2032-future-focused-primary-health-care-australia-s-primary-health-care-10-year-plan-2022-2032.pdf (pg. 36)

across the WA health system in recent years is welcome[22], as a larger Aboriginal workforce will help to improve cultural safety.

While individual HSPs may have their own Aboriginal health strategies and cultural safety frameworks, there also needs to be some general oversight to ensure appropriate cultural safety standards are met and that HSP policies reflect whole-of-government policies and commitments. There is also a need for greater engagement with the ACCHS sector regarding workforce planning. The development of partnerships with the ACCHS sector to 'assist in Aboriginal workforce planning and information sharing', is consistent with the Implementation Guide for the WA Aboriginal Health and Wellbeing Framework 2015 –2030[23].

Finally, there is an opportunity for HSPs and the ACCHS sector to work collaboratively to ensure Aboriginal Health Practitioners (AHPs) are appropriately integrated into the WA Health system (a project currently being delivered as part of the SHR program). HSPs must provide appropriate and regular cultural safety training to all employees to ensure a culturally safe environment for AHPs during their introduction to the public system. This will assist in mitigating any resistance from the current health workforce. Additionally, workforce education regarding the role of AHPs will need to be undertaken to address current gaps in the understanding of the AHP role. Furthermore, the introduction of AHPs into the public health system must not compromise the supply of AHPs in the ACCHS sector. Since there is an existing shortage of AHPs across the state, there must be appropriate investment from the WA Government in the continual building of the AHP workforce, and the Aboriginal health workforce more generally.

System-wide governance reflects local level needs and decision-making

Aboriginal Representation on HSP Boards and Consumer Groups

AHCWA acknowledges the rationale for a devolved governance model that seeks to prioritise local level decision-making[24]. Local level decision-making can ensure programs are tailored to communities within a particular geographic area that has specific health needs. Thus, appropriate representation on boards and committees is necessary to advocate for local community needs. This is consistent with the Implementation Guide for the WA Aboriginal Health and Wellbeing Framework 2015–2030, which recommends 'Aboriginal representation on boards (e.g. Health Service Boards)' and 'Aboriginal participation in regional health planning processes'[25]. This requires that the WA Government continues to ensure there is Aboriginal representation on HSP boards and committees, as well as other advisory groups. It also requires mechanisms to ensure that the issues raised by Aboriginal Community Advisory Groups are taken seriously and addressed.

Regional Aboriginal Health Planning Forums are another important institution in Aboriginal health, providing opportunities for region-specific stakeholders to participate in regional health planning processes and ensure decision-making reflects local priorities. The Forums bring together ACCHS and government stakeholders, and can be utilised to drive health service partnerships and improve

[22] https://ww2.health.wa.gov.au/~/media/Files/Corporate/general-documents/Aboriginal-health/PDF/14054-aboriginal-framework-evaluation.pdf (pg. 27)
[23] https://www.healthywa.wa.gov.au/~/media/Files/Corporate/general-documents/Aboriginal-health/PDF/13283-implementation-guide-final.pdf (pg. 38)
[24] https://ww2.health.wa.gov.au/~/media/Files/Corporate/general-documents/Health-Reform/Fact-Sheet---The-Health-Services-Act-2016---Snapshot.pdf
[25] https://www.healthywa.wa.gov.au/~/media/Files/Corporate/general-documents/Aboriginal-health/PDF/13283-implementation-guide-final.pdf (pg. 40)

community health outcomes. The Forums also grant the opportunity for local level governance in the development, planning and resource allocation for Aboriginal health.

Inconsistent communication, data and resource sharing between HSPs and the ACCHS sector

There have been instances of limited communication and data sharing between HSPs and primary healthcare providers such as ACCHS. This has effects on patient journey and the quality of care. Some cases where there has been fragmented service delivery due to limited resource sharing and communication across institutions have resulted in:

- The physician's lack of access to a current patient's record, and inadequate discharge planning for the local primary healthcare provider to follow up on patient outcomes.
- Country patients missing metropolitan hospital/specialist appointments due to appointment letters not reaching the patient (for example, because there may not be PO boxes in remote communities).
- Patient's lack of understanding of how to fill out a Patient Assisted Travel Scheme (PATS) form, past issues with PATS not accommodating family support, and transport issues from the airport to metropolitan accommodation, and from the accommodation to the hospital/specialist location.

Thus, there is a need to have better communication between HSPs and primary healthcare providers through adequate patient data sharing (with patient consent), to enable responsive management of patient flows, while ensuring increased delivery of care in community settings, where appropriate.

Better sharing of data aligns with Priority Reform Four of the National Agreement. Better shared care also complements SHR Recommendation 11a, which details the need to 'improve timely access to outpatient services […] out of hospital settings in partnership with primary care [providers]' (pg. 76), and Recommendation 12, which notes the need to 'improve coordination and access for country patients by establishing formal links between regions and metropolitan health service providers' (pg. 79). All of which encompasses one of the functions of HSPs enshrined in the *Health Services Act 2016*, which requires that HSPs 'cooperate with other providers of health services, including providers of primary health care, in planning for, and providing, health services'[26]. Despite some HSPs making efforts to strengthen communication with primary healthcare providers to improve out-patient care, there remain inconsistencies regarding how each HSP operates. Strengthening collaboration across HSPs and with non-HSP healthcare providers will ensure a more integrated health system across WA.

Genuine partnership and engagement in decision-making

Consistent with Priority Reform One and Two of the National Agreement, it is crucial that any system-wide health policies, programs or services affecting Aboriginal communities, are designed *by* or *in partnership* with ACCHS and Aboriginal communities. Partnership with the ACCHS sector in system-wide governance ensures that local governance structures are respected, and that Aboriginal local knowledge is valued and incorporated in broader system operations.

AHCWA is informed that funding allocation at a regional level does not always reflect local community needs. For example, AHCWA received feedback from Members about funding being allocated for a particular service where there is already an existing provider offering a similar service, resulting in the duplication of work; or an external party is funded to provide a service for a short-term period, resulting

[26] https://www.legislation.wa.gov.au/legislation/prod/filestore.nsf/FileURL/mrdoc_29646.pdf/$FILE/Health%20Services%20Act%202016%20-%20%5B00-e0-06%5D.pdf?OpenElement (pg. 29)

in the constant change in healthcare staff and inconsistency in service availability for the community, which in turn leads to mistrust about the longevity and usefulness of future healthcare teams.

Thus, it is crucial to ensure public health governance in each region reflects and builds on existing governance structures and local/regional needs. This opportunity for partnership and engagement with Aboriginal stakeholders in designing and planning programs and services, and creating 'opportunities for Aboriginal people to participate in governance arrangements and decision-making' is consistent with the Implementation Guide for the WA Aboriginal Health and Wellbeing Framework 2015–2030[27]. AHCWA recommends that health service planning be led by local stakeholders and based on local community needs assessments, ensuring services reflect the specific needs (including cultural needs) of a local community.

The system's ability to respond to emergency situations

In this section, the COVID-19 pandemic will be used as a case study to discuss the system's ability to respond to emergency situations.

Partnership and co-design opportunities for primary healthcare services in emergency planning and management

ACCHS are best placed to provide their communities with culturally secure care and many Aboriginal people have sought COVID-related support from their local ACCHS. Despite this, there have been many instances in the latest phase of the pandemic in which WA Government stakeholders did not adequately engage with the ACCHS sector. This has resulted in reduced capacity for all parties to manage challenges related to the spread of COVID-19. Whilst there have been differences across the state, the following are some key examples:

- The ACCHS sector has highlighted that the COVID Care at Home program is not fit-for-purpose for many Aboriginal people. The sector noted that the program's phone-based system delivered by a provider unknown to the community would be unable to support many Aboriginal people's health, social and cultural needs. There were concerns that the Care at Home program posed a cultural and medical safety risk to Aboriginal communities, as there was no indication that the operators received WA-specific cultural awareness training, and they had limited knowledge of patient histories, medication needs and care plans. Furthermore, the program's 'opt-in' nature, internet-based registration and phone-based service model disadvantaged people who do not have access to phones or internet services, are not digitally literate, or who have low literacy more generally. The limited opportunities to partner in the delivery of COVID-related services resulted in the issues outlined immediately above, as well as a duplication of services. Since the ACCHS sector understands local needs and has established relationships with community members, the sector has been providing COVID-19 ambulatory services to communities, as many Aboriginal people preferred receiving support from their local ACCHS. This additional work was initially un-funded.
- Furthermore, the ACCHS' involvement in local pandemic planning and management has been inconsistent at a regional level. This is exemplified in some of the various COVID-19 planning committees having regional ACCHS membership, and some did not. This limits the capacity to address critical issues affecting local communities, and undermines the effectiveness of the overall health response.

[27] https://www.healthywa.wa.gov.au/~/media/Files/Corporate/general-documents/Aboriginal-health/PDF/13283-implementation-guide-final.pdf (pg. 29-30)

Delayed response in pandemic planning, management and service delivery

In response to certain COVID-related issues, the system's response has not been timely, and has resulted in the ACCHS sector bridging this gap to provide the culturally appropriate COVID-19 services required. Given the constantly changing environment that the pandemic presents, the sector acknowledges that it is not possible to provide immediate responses in all situations. However, it has been noted that current system governance can create challenges in responding quickly. For example, in the initial 2020 wave of the pandemic, the ACCHS sector was unable to secure funding in a timely manner, and relied on philanthropic funding to purchase PPE for frontline staff.

Whilst AHCWA acknowledges that COVID-19 has created unprecedented challenges, it is imperative that emergency responses allow for local level decision-making. AHCWA recommends future emergency response settings include a more appropriate framework or mechanism to ensure flexibility, a greater emphasis on local decision-making and resource allocation, as well as timely responses in the provision of services to local communities.

Limited understanding of Government roles and responsibilities from the perspective of the primary healthcare services and consumers

During the COVID-19 pandemic, there has been a lack of clarity regarding the roles and responsibilities of government agencies and other stakeholders in emergency planning and management. The following are some examples:

- In the initial stages of the 2022 wave, the 13COVID phone line had a problematic consumer interface. Before the recent changes in menu options, there were difficulties navigating the phone-line menu options to get to the desired outcome. For instance, despite promotional materials detailing that RAT registration could be made over the phone, there was no specific menu option to complete this for an extended period of time.
- Similarly, for those that required emergency food and accommodation support, reaching the Department of Communities was difficult in the early weeks of the 2022 outbreak. It became evident that to gain welfare assistance, a patient had to navigate through the State Health Incident Coordination Centre before receiving assistance from the State Welfare Incident Coordination Centre. This complex system slowed response times, and impacted patient satisfaction and healthcare providers' management of patient demand and flows. The ACCHS sector had to assist patients with service navigation, until after weeks of advocacy a more streamlined process was implemented.
- Generally, responsibility for the care of certain cohorts has been unclear, such as those without permanent or adequate accommodation. In addition, there was a lack of clarity regarding the level of support that would be provided to meet welfare needs, with different government staff giving different messages, and messages changing (sometimes abruptly) over time.

Resource sharing and communication between HSPs and the ACCHS sector

In the initial stages of the 2022 COVID wave, communication with the ACCHS sector was poor in some parts of the state. There were instances of ACCHS receiving information regarding COVID positive cases via non-government stakeholders or the media. The inconsistencies in data sharing across the regions, with some regions having access to timely and pertinent information and some not receiving such information, made it difficult to promptly respond to emerging issues. This was largely due to COVID-related data being held within a centralised system, requiring ACCHS to frequently rely on regional Public Health Units for access to patient-related data (with inconsistent data sharing across regions, depending on the willingness of particular Public Health Units to share this information).

In some regions, the limited communication and data sharing between HSPs and the ACCHS sector was a missed opportunity to manage patient demand and share responsibility for the pandemic response. Upon completion of a COVID-19 test, there was no upload of results onto the patient's My Health Record (if tests were done through public COVID-19 testing sites), nor was the option of notifying the client's doctor made available to the person receiving the PCR test (unless the test was completed under a GP referral). If PCR intake forms requested the person's Medicare details, the result could have been uploaded to their My Health Record (if consent was given) and this may have acted as a source of information that would have been useful for primary healthcare providers assisting with patient care. Similarly, in the initial stages of the COVID Care at Home program, there was a lack of information sharing with the ACCHS about their COVID positive patients. Since there was no requirement to notify GPs/ACCHS of cases, it was difficult for the sector to determine whether patients with chronic diseases were provided appropriate care.

As noted, the WA Government has committed to partnering and sharing decision-making with Aboriginal people and communities under Priority Reform One of the National Agreement. The COVID-19 pandemic is an example of an emergency situation that will disproportionately impact Aboriginal people, requiring a genuine and robust partnership response. Thus, the pandemic has highlighted the need for more 'inclusive systems of governance'[28] that support the ACCHS sector in responding to needs at a local level. The ACCHS sector's efforts have aided the system's ability to respond to the pandemic – to ensure the sustainability of the ACCHS sector's activity in emergency and pandemic responses, greater levels of shared decision-making, resource sharing and genuine partnerships are required. This aligns with the Aboriginal Empowerment Strategy, which notes that decision-making must reflect local level needs, and incorporate culturally-informed solutions. It also points to the need for 'place-based engagement'[29], which is essential to the effective management of any critical situation, and would ensure healthcare delivery meets the needs of all WA communities.

[28] https://researchonline.nd.edu.au/cgi/viewcontent.cgi?article=1002&context=nulungu_reports (pg. 11)
[29] https://www.wa.gov.au/system/files/2021-09/Aboriginal-Empowerment-Stategy-POLICY%20GUIDE.pdf (pg. 29)