National Strategy in Aboriginal and Torres Strait Islander Health: A Framework for Health Gain?

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VicHealth Koori Health Research & Community Development Unit
Discussion Paper No. 6
March 2002
ISBN 0 7340 2216 6

ISBN 0 7340 2216 6

First Printed in March 2002

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Copy Editor: Jane Yule
Cover Artwork: Michelle Smith & Kevin Murray
Cover Design: Sue Miller, Social Change Media
Typeset in Garamond 11/12 point
Printed by Melbourne University Design & Print Centre

VICHEALTH KOORI HEALTH RESEARCH AND COMMUNITY DEVELOPMENT UNIT

Discussion Paper Series

The VicHealth Koori Health Research and Community Development Unit (VKHRCDU) was launched in June 1999 and has been developed in partnership with the Victorian Community Controlled Health Organisation, the Victorian Health Promotion Foundation (which funds the Unit) and the University of Melbourne through the Centre for the Study of Health and Society where the Unit is located.

At the core of the Unit's work is a commitment to undertaking, collaborating in and supporting research that directly benefits the Koori community. The work of the Unit spans academic and applied research, community development, and medical education. The combination of these activities is a central and innovative aspect of the Unit's function, as is the identification and use of mechanisms to link research with the improvement of health care practices and policy reform. Overall, these tasks are guided by both an Advisory Committee and a Research Advisory Group.

In relation to the research program, five key areas govern the inquiry undertaken within the Unit. These comprise: historical research into Koori health policy and practice; historical and contemporary research into health research practice, ethics nd capacity building; applied research on the social and cultural experience of Koori health, well-being and health care delivery; health economics research on the factors and processes that impact on the provision and use of Koori health care; and the evaluation of Koori primary health care and related health promotion programs.

The Discussion Paper Series (DPS) is directly linked to this diverse program of research and provides a forum for the Unit's work. The DPS also includes papers by researchers working outside the Unit or in collaboration with VKHRCDU staff. Individual papers aim to summarise current work and debate on key issues in Indigenous health, discuss aspects of Indigenous health research practice and process, or review interim findings of larger research projects. It is assumed that the readership for the series is a broad one, and each paper is closely edited for clarity and accessibility. Additionally, draft papers are 'refereed' so as to ensure a high standard of content.

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NATIONAL STRATEGY IN ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH: A FRAMEWORK FOR HEALTH GAIN?

Ian Anderson

It may seem like stating the obvious, but I want to preface this account by saying that I believe health care reform is a critical component of a whole-of-government strategy that effectively addresses the challenge of Aboriginal and Torres Strait Islander health. This is particularly the case given the demonstrably poorer health status of Aboriginal and Torres Strait Islander people. Despite the extent of this health disadvantage, the Commonwealth did not commence funding Aboriginal health programs until 1968—as a consequence of a constitutional referendum in 1967 that gave the Commonwealth the power to legislate for Aboriginal Australians (Anderson & Sanders 1996). Even then, the Commonwealth Health portfolio did not develop significant program responsibility or demonstrate sustained national leadership in Indigenous health policy until the 1990s.[1]

The significance of this historical failure in the provision of policy leadership is underscored by a comparative analysis of Indigenous health trends in North America and New Zealand. In documenting the relatively poor development of the national approach to developing health care services for Indigenous Australians, Steven Kunitz (1994:6) makes the point that the:

> *different forms of federalism have had important implications both for the way that central and state governments deal with indigenous people and for their health. These differences have tended to be more observable in regard to infectious than to noninfectious diseases, because health services that have been created have been better equipped to deal with infectious conditions. In general where treaties have been signed and where the central government has assumed responsibility for relationship with indigenous people, their general health and welfare are better than where state governments have assumed responsibilities.*

Arguably, within federal health systems central governments can play a strategic role in the development of mechanisms to compensate those, such as Aboriginal and Torres Strait Islander people, for whom existing State government or market-driven health care services are ineffective, difficult to access or otherwise inappropriate.

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1 In 1973 the Aboriginal Health Branch was established in the Commonwealth Department of Health. However, it was the Department of Aboriginal Affairs that carried the lead responsibility for policy development and administering the Commonwealth's Aboriginal health program grants that were provided to community organisations and State and Territory governments. As a result of a perception that administrative arrangements had become increasingly complex and responsibilities were overlapping, the program, and the responsibility for all Commonwealth programs in Aboriginal health, was consolidated within the Department of Aboriginal Affairs in 1984.

Within the structure of the Australian health care system, the Commonwealth Health portfolio plays a lead role in negotiating and strategically developing the nation's health care financing system. This occurs through negotiation with central Commonwealth agencies, such as the Departments of Finance and of Prime Minister and Cabinet, in addition to a complex array of governmental, provider and consumer interests. Without leadership from the Commonwealth Health portfolio in Indigenous health, it is difficult to envision how the link between improved service delivery and the financing of health care could be strategically consolidated. Further, such policy leadership would be a necessary pre-condition to the adoption of a needs-based approach to Indigenous health services development, and the possibility of supporting such services through the development of appropriate and effective linkages with related mainstream components of the health system.

The first attempt to develop a national framework to co-ordinate planning and Indigenous community participation in health policy development occurred through the implementation of the National Aboriginal Health Strategy (NAHS). However, this process had limited success in securing institutional reform within the health sector (CDHHS 1994; Anderson 1997). As a consequence, following the evaluation of the NAHS, the administrative responsibility for the Commonwealth Aboriginal health program was transferred from the Aboriginal and Torres Strait Islander Commission (ATSIC) to the Commonwealth Health portfolio in July 1995. This strategic move subtly transformed the development and implementation of national Aboriginal and Torres Strait Islander health policy and strategy. In particular, there has been a greater focus on the development and utilisation of health portfolio mechanisms, structures and policy levers to achieve Aboriginal health outcomes through improved capacity and performance in the health sector. Other sectors of government—such as housing, environmental and public health infrastructure, and education—that are acknowledged as playing an essential role in achieving outcomes in Indigenous health are drawn into this health-focused framework through a number of formal and informal inter-sectoral structures.

In this paper, I intend to provide a descriptive overview of the strategic framework and priorities that evolved following the transfer of administrative responsibility in 1995 as described above. Although strategy in Aboriginal health continues to be framed by the NAHS, this is done more in the sense of broad principles. Most of the actual specific mechanisms described in the original NAHS were transformed during this period and strategies were also refined within this new context. The 1989 NAHS is currently being reviewed by the National Aboriginal and Torres Strait Islander Health Council (PBS 2001–02), so it likely that there will be further modification and refinement of strategies.

Nevertheless, in the following section I will outline the strategic framework—or the set of institutional structures, providers and mechanisms developed by the Commonwealth Health portfolio as vehicles for reform—in the period following the transfer. After this I will describe the strategic priorities that overlie the development of these structures. It is not my intention to survey comprehensively all of the relevant strategies

in current national policy. Rather, this paper will focus on those priorities related to reforms in health service delivery. Finally, I want to consider some of the key issues and evaluation questions that need to be looked at if we are to draw conclusions about the adequacy of this national strategic framework vis a vis Indigenous health gain.

The Framework Agreements in Aboriginal and Torres Strait Islander health

In the period following the transfer of administrative responsibility in Aboriginal health, priority was given to the development of Aboriginal Health Framework Agreements. These commit signing parties to specific structures and processes in order to implement national strategy in Indigenous health. Signatories to these multi-sectoral agreements include the Commonwealth Minister for Health, State and Territory Health Ministers, Chairperson of the ATSIC, and representatives of Aboriginal Community Controlled Health Organisations (CDHFS 1997). They provide for agreement on:

- the development of national and State/Territory level forums, involving all stakeholders, to provide advice and input to policy and planning processes;
- the introduction of planning processes at the regional level with a focus on improving the capacity and effectiveness of primary health care services, reducing access barriers to mainstream services by making these more appropriate and sensitive to the needs of Indigenous people, and establishing standards and quality assurance processes;
- the necessity of increasing the level of health sector resources allocated to reflect the level of need; and
- the need to give priority to improving data collection and evaluation mechanisms.

As such, the Framework Agreements reflect the view that roles and responsibilities in Indigenous health are not clearly separated between the Commonwealth and the States and Territories. The principle here is that both levels of government are 'jointly responsible for responding to the needs of all Australians [including] Aboriginal and Torres Strait Islander peoples' (CDHFS 1997:222). The Agreements outline a co-ordinating role for the Commonwealth Health portfolio in developing national health policy and a role for the States and Territories in managing, co-ordinating and planning health care services.

Aboriginal Health Framework Agreements were signed in all jurisdictions, most of them in 1996 and the remainder by 1998 (CDHAC 1999), and notionally expired on 30 June 2000. However, in August 1999, the Australian Health Ministers Advisory Council (AHMAC) agreed in principle to extend the Framework Agreements and, so far, new agreements have been signed in the Northern Territory and South Australia with other jurisdictional agreements still being negotiated. Progress in the development of regional plans is at various stages nationally and it is probably too early to make clear evaluative comments about the success of this approach. Aboriginal peak bodies, such as the National Aboriginal Community Controlled Health Organisation (NACCHO), continue to raise concerns about problems in the development of effective and equal partnerships in policy and planning (NACCHO 1999). Developing partnerships between Australian

governments and Aboriginal and Torres Strait Islander community organisations is a central plank in current health strategy, so clearly this issue will require close monitoring and further development.

Achievements under the Framework Agreements include the establishment of regional planning forums in all States and Territories (including the national forum, the Aboriginal and Torres Strait Islander Health Council), and, at the end of 2001, the completion of regional plans covering 96 per cent of the country. To facilitate regional planning, the Commonwealth allocated $6.8 million from the 1999–2000 financial year[2] to priorities identified within these completed regional plans (CDHAC 1999). Another important outcome of the Framework Agreements has been the development of the National Performance Indicators and Targets for Aboriginal and Torres Strait Islander Health, which all Health Ministers agreed to in August 1997 and for which a technical and procedural guide has been produced (CDHAC 1999; CDHAC 2000). To date, two reports have been produced that collate and analyse data against these national indicators (NHIMG 1999 & 2001).

Within the current national policy framework there are domains of policy and strategy development that constitute developmental themes. These are:

- *Developing the infrastructure and resources necessary to achieve comprehensive and effective primary health care for Indigenous peoples;*
- *Addressing some of the specific health issues and risk factors affecting the health status of Indigenous peoples;*
- *Improving the evidence base which underpins the health interventions; and*
- *Improving communication with primary health care services, Aboriginal and Torres Strait Islander peoples and the general population (CDHAC 1999).*

In the following section I will focus on those component strategies that are critical to the development of primary health care capacity, and outline the development of relevant strategies to improve the evidence for health interventions.

Primary health care services

Aboriginal and Torres Strait Islander primary health care services are currently seen to play a pivotal role in strategies for improving Aboriginal and Torres Strait Islander health outcomes. It seems obvious to say that primary health care usually constitutes a person's first point of contact with the health care system, and involves general practitioners, community nurses, community-based allied health professionals, and Aboriginal and Torres Strait health workers. However, it is worth keeping in mind the complexity of the functional definitions of primary health care. For instance, according to the World Health Organization primary health care is

> *... Essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the*

2 This investment was a part of the PHCAP program that is described later in this paper in the section on health financing.

> *community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's overall health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first elements of a continuing health care process (WHO 1978:16).*

The conceptual approach to primary health care advocated by the WHO was consolidated in the National Aboriginal Health Strategy (NAHS Working Party 1989). In broad terms, this functional definition continues to frame Commonwealth approaches to the reform of primary health care services, which are, for instance, defined as:

> *Those health services which involve continuity of care, integration of prevention with sick care, a concern for population as well as individual health, community involvement and the use of appropriate technology. It will encompass those socially organised practices and programs which aim to protect, promote and restore people's health through disease prevention and health promotion (ATSIC & CDHHS).*

Currently Aboriginal and Torres Strait Islander people access an array of distinct types of primary health care service, including: Aboriginal Community Controlled Health Services (ACCHS), State/Territory-funded primary health clinics and mainstream community health services, and private general practice. The Commonwealth Department of Health has argued that if health strategies are to be implemented in a way that takes into account the capacity of Indigenous communities and their priorities and concerns, such strategies will require effective structures and mechanisms for Aboriginal and Torres Strait Islander participation (CDHFS 1997:222–3). There is a broad consensus that Aboriginal community controlled health services build such operational principles into primary health care delivery and, as such, play a critical role in national Indigenous health strategy. However, it is fair to say that there continues to be disagreement between stakeholders about how to provide for, from a national level, an appropriate and effective mix of primary health care services.

Furthermore, there are difficulties in translating agreed principles of effective primary health care delivery into funding models that can be used to develop planning principles. For instance, one operational framework for the WHO model of primary health care identified its core components as:

- *education concerning prevailing health problems and methods of preventing and controlling them;*
- *promotion of food supply and proper nutrition;*
- *an adequate supply of safe water and basic sanitation;*
- *maternal and child health, including family planning, prenatal care, qualified birth attendance, care of newborns, and monitoring child growth;*
- *immunization against the major infectious diseases;*

- *prevention and control of locally endemic (vector borne) diseases;*
- *appropriate treatment of common disease and injuries; and*
- *the provision of essential drugs (Zakus 1998:480).*

To this original list, other commentators have also added:

- *basic oral health care;*
- *mental health care;*
- *care of the physically disabled; and*
- *the use of effective traditional medicines (Zakus 1998:480).*

However, the development of primary health care services needs to be closely attuned to the particular health needs and institutional context for health care delivery. Some components of this WHO operational framework are, therefore, less relevant to Indigenous health in Australia. For instance, the prevention and treatment of locally endemic (vector-borne) diseases is a component of Indigenous primary health care only relevant to particular regions. On the other hand, one could arguably identify chronic illness management as a critical operational element of primary health care service provision in Indigenous health contexts. To a certain extent, the WHO operational model reflects the particular developmental context of the third world. There has been some progress on work that identifies the core components of primary health care service models for Indigenous Australians in remote area contexts (for example, Remote Areas Issue Sub-Committee of the Aboriginal and Torres Strait Islander Health Council 1997). However, to date, not enough attention has been given to the development of operational models of primary health care for Indigenous Australians in rural and urban Australia. It is not possible to build financing models for primary health care services without some clarity on the different operational elements that need to be supported. Such clarity is particularly critical if there is to be effective negotiation between levels of government, within the context of regional planning, in order to co-ordinate the provision of funding to Aboriginal primary health care services.

A program to build primary health care capacity was initiated in the 1999–2000 Commonwealth budget.[3] The Primary Health Care Access Program (PHCAP) provides funding of $78.8 million over four years. Initially, this was to be allocated to areas where regional planning had been completed (which at this time included Central Australia, Queensland and South Australia), in addition to the four former Aboriginal Co-ordinated Care Trial sites (CDHAC 2001a).[4] For the 2001–02 budget an additional $19.7 million each year was allocated to commence in 2003–04, increasing the total recurrent base

3 The PHCAP has three objectives URL: http://www.health.gov.au/oatsih/pubs/phcap.htm (This page last updated by the OATSIH Webmaster 23 November 2001.)

1. increase the availability of appropriate primary health care services where they are currently inadequate;
2. reform the local health system to better meet the needs of Indigenous people; and
3. empower individuals and communities to take greater responsibility for their own health.

4 The Aboriginal Co-ordinated Care Trials are referred to further in the section on health financing reform.

5 By September 2001, all States and Territories had completed their joint regional plans, except Tasmania and the Metro/South-West region of Western Australia.

for the PHCAP to $54.8 million per annum. Again, funding from this program was to be made available in each State/Territory on the completion of regional planning.[5]

A significant parallel development has been the annual service activity and performance indicator reports from the Aboriginal community controlled health services funded by the Commonwealth. The past failure of Commonwealth agencies to reach agreement with the Aboriginal community controlled health sector on service reporting frameworks for ACCHS significantly undermined the development of a national performance measurement framework for these services (Anderson & Brady 1999). Perhaps as a sign of a maturing partnership between governments and the Aboriginal community controlled sector, the current approach to service activity reporting involves the joint collation of service activity data in an annual report produced by the NACCHO and the Office for Aboriginal and Torres Strait Islander Health (OATSIH) in the Commonwealth Department of Health and Aged Care (OATSIH & NACCHO 2001).

Arguably, investing in primary health care capacity is not enough. It is equally important that the service capacities developed through such investment are managed and delivered in a way that maximises the likelihood of health outcomes. Such outcomes may depend on how the different components of primary health care are linked and delivered. Hence, it has been argued that Aboriginal and Torres Strait Islander health outcomes require the development of primary health care services that integrate clinical care, population health and health education/promotion activities at a local and regional level (CDHFS 1997:222–3). In the current strategy, such primary care services are also acknowledged to play a pivotal role in advocating and facilitating local and regional inter-sectoral strategies in health. These services may, for instance, provide advice on the incorporation of health hardware in local housing programs or the development of community environmental health infrastructure (CDHFS 1997). In other words, reform in Indigenous primary health care should aim to provide the range of services required as per health need, and integrate the delivery of such services appropriately in order to reach broader population health goals. Evidence from health services research and evaluation is critical to guide the development of service models.

For these reasons it is important that research policy and strategy in Aboriginal and Torres Strait Islander health has a key focus on developing the evidence base for primary health care services. More recently, some of the evidence specific to Indigenous Australian primary health care was collated in a publication produced by the Office for Aboriginal and Torres Strait Islander Health (CDHAC 2001a). In the delivery of primary health care services to Indigenous Australians, Aboriginal health workers play a key role and are supported by a range of primary health care workers, such as doctors and nurses. An appropriately skilled multi-disciplinary team is ideal to ensure the effectiveness of the primary health service. The critical issues in developing an approach to sustaining the development of such a system of care would entail a focus on the development of more effective strategies in health financing and workforce development.

Health Care Financing

Data that provide a comprehensive analysis of national expenditure in Aboriginal health have only recently become available. Two national expenditure studies, by the Australian Institute of Health and Welfare (AIHW) in collaboration with the National Centre for Epidemiology and Population Health (NCEPH), use 1995–96 and 1998–99 as base years to provide a detailed analysis of health funding provided to Aboriginal and Torres Strait Islanders through both 'mainstream' and specialised programs and from all funding sources—Commonwealth and State/Territory governments and the private sector (Deeble et al. 1998; AIHW 2001). These studies confirm that, despite marked health differentials, expenditure on the health of Aboriginal and Torres Strait Islander people for all services and all sources of funds was similar to that of other Australians at a ratio of 1.22:1 (AIHW 2001:xiv) The second expenditure analysis determined that, when sources of funds are examined, the Commonwealth and State governments contributed a similar amount to Aboriginal and Torres Strait Islander health services, although 50 per cent of the Commonwealth's contribution was paid indirectly through public hospital funding (AIHW 2001:xv). The relatively smaller direct Commonwealth investment is directed through Aboriginal-specific programs, such as the funding provided to the Aboriginal Community Controlled Health Services and specific strategies in diabetes, sexual health, and emotional and social health. In addition, the Commonwealth provides funding for health care through its mainstream Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS). In 1998–99, expenditure through the MBS/PBS accounted for only 7.3 per cent of the total spent on health services for Indigenous people, compared to 23.9 per cent of total expenditures for non-Indigenous Australians (AIHW:xiv). In another study of access by Indigenous Australians to the MBS and PBS, it was reported that Aboriginal and Torres Strait Islander people everywhere encountered significant barriers to the effective utilisation of the resources provided through both these schemes. For instance, between 15–38 per cent of Aboriginal and Torres Strait Islander people were found to have no effective Medicare number or card, and in urban areas between 15–20 per cent of Indigenous people did not have access to current Medicare numbers (Keys Young 1997). According to the second study, if all direct Commonwealth expenditure is considered, the per capita expenditure for and by Indigenous Australians is 78 per cent of that for non-Indigenous Australians

On the other hand, direct expenditure through State and local government programs is relatively higher with respect to Aboriginal and Torres Strait Islanders, at a ratio of 2.19:1. Of all the expenditure on Indigenous people, 72 per cent came through programs administered by State or Territory governments, almost twice the percentage for non-Indigenous people (AIHW:3). This is a consequence of a number of factors: States and Territories provide, in some jurisdictions, Indigenous-specific primary care services; the use of acute care hospital services by Indigenous Australians is relatively higher, reflecting both patterns of morbidity and, in some instances, poorer access to comprehensive primary health care services; and the provision of health services to geographically remote regions is more costly.

As a result of changes in methodology and data availability it is difficult to compare the findings of the first and second expenditure reports, but there are areas where it is possible to identify real increases in funding and service provision. Proportionally, these increases had a net small effect, with the proportion of all Australian health expenditure going to Indigenous people increasing from 2.2 per cent of recurrent expenditure in 1995–96 to 2.6 per cent in 1998–99 (AIHW 2001:16).

These studies point to some significant problems in the ways in which Aboriginal health care is financed. All in all, given the level of morbidity in Indigenous Australian communities, the global level of expenditure would seem to be low. Further, the spread of investment does not appear to provide, as yet, the basis for the development of an effective and efficient comprehensive primary health care for Aboriginal and Torres Strait Islander people.

Since the Commonwealth Health portfolio assumed responsibility for the Aboriginal health program, there has been consistent growth in expenditure provided through the Office for Aboriginal and Torres Strait Islander Health—from $116 million in 1996–97 to an estimated $203.2 million in 2001–02 (Portfolio Budget Statements 2001–02). This growth has been the result of a range of initiatives including: the allocation of new resources to the Aboriginal and Torres Strait Islander primary health care program; specific initiatives in sexual health, diabetes and eye health; and appropriations that provide for collaborative environmental health initiatives with ATSIC. Further, some reforms of existing health financing mechanisms for the MBS and PBS have been developed, such as the provision of 'Section 100' arrangements for pharmaceutical programs in remote communities, or the provision for alternative funding mechanisms so that doctors employed by ACCHS are able to bill Medicare as an additional source of income for services (CDHAC 1999). The Health Insurance Commission is also currently testing innovative approaches to enrolment onto the MBS in some regions (CDHAC 1999). In 2001, new arrangements under section 19(5) of the Health Insurance Act (1973) were made to allow ACCHS, in certain circumstances, to use Medicare to fund the pathology services associated with health-screening activities (personal communication Alison Larkins, OATSIH 2002). The Aboriginal and Torres Strait Islander Coordinated Care Trials were established in order to evaluate whether reform of the financing and administration of primary health care, linked to improved organisational capacity, could improve Aboriginal access to appropriate primary care services. The Aboriginal trails had three key characteristics: coordinated care, funds pooling, and MBS/PBS equivalent funding (CDHAC, 2001c: 15). The evaluation findings warrant a more detailed examination than is possible in this context, Despite this the evaluation authors contend that "The trials demonstrated that the effectiveness of what we currently understand to be good clinical, public health, administrative and financial practice, can be realised if the reform agenda is driven through community organisations that are adequately resourced and supported (CDHAC, 2001c: 27).

A performance audit of the Aboriginal and Torres Strait Islander Health Program recommended that a greater emphasis be placed on the development of needs-based planning mechanisms (ANAO 1998). This hardly seems a revolutionary comment.

However, whilst is may superficially appear to be a fairly straightforward proposition, and significant steps in the reform of health financing arrangements have been made, the reform of health financing in this area requires further development and linkage with the planning processes in order to provide for the comprehensive, needs-based system of primary health care that is required.

Health workforce development

A critical issue in creating effective health care for Indigenous Australians is the development of an appropriate health workforce. It is possible to characterise qualitatively the mix of skills necessary for effective Aboriginal primary health care. Such a mix includes competencies in: cross-cultural practice; chronic illness management; integrated population and clinical care service delivery; the provision of emotional and social health services; and an understanding of the relationship between health care provision, community development and self-determination. There is, of course, a spectrum of workforce development requirements, ranging from the needs of the primary health care workers as employed within ACCHS and other Indigenous-specific programs, and the generic needs of the mainstream Australian primary care health workforce.

National workforce initiatives in Indigenous health have strategically focussed on primary care workers. For example, one such initiative aims to develop regional workforce recruitment services, which have a particular focus on improving recruitment and retention issues in Indigenous-specific primary health care services. In addition, the recent reviews of general practice in Australia highlighted the need to develop the capacity of Indigenous-specific and mainstream general practice (Ministerial Review of General Practice Training 1998: General Practice Strategy Review Group 1998). Professional health colleges and associations have focused on developing their role in Aboriginal health, particularly with regards to health workforce development. For instance, the Royal Australian College of General Practitioners (RAGCP) now has core curricula in Indigenous health for its general practice training program (CDHAC 1999). The RAGCP is also working in collaboration with the Commonwealth Department of Health and Aged Care to increase the number of general practice registrars seeking training placements in ACCHS (CDHAC 1999).

A strategic approach to workforce development in Indigenous health will require a more detailed quantitative understanding of workforce requirements. In particular, this would aid cross-portfolio negotiations on these matters, and could provide the needed additional leverage to align the institutional stakeholders in Aboriginal health workforce development within a shared strategy. In part, the processes of regional planning in Aboriginal health might provide some baseline data to these ends. Further, the agreement by the Australian Health Ministers Advisory Council in October 1998 to support a National Aboriginal and Torres Strait Islander Health Workforce Modelling Project indicates the broad support for strategic action in this priority area (CDHAC 1999).

There is now some longitudinal data available to assess trends in Indigenous participation in health sciences training (Schwabb & Anderson 1998ab), which suggests that trends in the higher education (or university) sector are slightly different from those in the

vocational education and training sector. In the latter, where Aboriginal health workers are mostly trained, outcomes for Indigenous Australians, n parallel with trends in the mainstream vocational education and training sector, continued to grow in the order of 122 per cent during 1995–98 (Schwabb & Anderson 1998a). This is encouraging given that the health care practice provided by Aboriginal health workers is crucial to the delivery of effective primary health care within a community development framework. Nevertheless, it is critical to assess the sustainability of such trends, the comprehensiveness of current access to training for Aboriginal health workers, and whether such training in the vocational education sector provides pathways into higher education for graduates. The AHMAC agreed in 1998 to endorse a National Review of Aboriginal and Torres Strait Islander Health Worker Training, agreeing that 'priority is for the development of a national framework for progressing the development of Aboriginal Health Worker training including mutual recognition arrangements to ensure the mobility and career progression across regions and States and Territories' (CDHAC 1999).

However, according to the trend analysis of outcomes in higher education, there is some doubt about the sustainability of the current growth of Indigenous graduates in health sciences. An overall increase in these fields of study has been slow and has lagged behind other outcomes in Indigenous higher education. For the higher education sector during the years 1995–98, course graduations continued to grow, but the numbers of people commencing new courses in health sciences declined (Schwabb & Anderson 1998b).

Clearly this issue will require further attention in Indigenous health policy. Recently, the Commonwealth provided funding to enable the creation of the Australian Indigenous Doctors Association and the Council for Aboriginal and Torres Strait Islander Nurses. It was recommended that the Commonwealth continue to support the development of professional networks for Indigenous people with health sciences training in the draft Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework which was endorsed by AHMAC on 25 October 2001 and is now undergoing further consultation (CDHAC 2001b).

The findings of the review of Aboriginal health worker training and of the workforce modelling project have fed into the development of this draft framework, which proposes five key objectives in relation to workforce development:

- *Substantially increasing the number of Aboriginal and Torres Strait Islander people working across all the health professions so that there is no longer a racial divide in the health workforce;*
- *Improving the role clarity, regulation and recognition of Aboriginal and Torres Strait Islander health workers as a component of the workforce and support for training of Aboriginal health workers from within the Vocational Education and Training Sector;*
- *Improving the effectiveness of training, recruitment and retention measures targeting non-Indigenous health staff in Aboriginal primary health services;*
- *Addressing the range of workforce groups that have not been significantly addressed by previous strategies that have focussed on Aboriginal health workers and doctors; and*

- *Including clear accountability for government programs to quantify and achieve these objectives, and support for Aboriginal and Torres Strait Islander organisations and people to drive the process (CDHAC 2001b: 2).*

These developments are encouraging, particularly given the findings of the evaluation of the National Aboriginal Health Strategy, which highlighted the failure of the Commonwealth Education portfolio to align Indigenous education strategy with national policy development processes in Indigenous health (DHFS 1994). However, it is still difficult to assess the extent to which the current Commonwealth strategic framework has succeeded in creating sufficiently robust policy linkages with a national Aboriginal education strategy. This issue will require attention if the development of the Aboriginal health workforce is to be sustained beyond discrete workforce initiatives.

Evidence and health policy reform

While the Aboriginal and Torres Strait Islander health disadvantage has been well documented and characterised over the past thirty years, the focus of investigation has only more recently begun to shift towards the type of research agenda that leads to the evaluation of interventions. With a focus on notions of effectiveness and efficiency in health sector reform, and the strategic priority given to the development of Indigenous primary health care capacity, it is clear that some attention should be paid to developing evidence to guide such Indigenous policy reform. However, such knowledge also needs to be developed so that it makes an impact on policy development and health care practice. This has been a particularly critical issue in Indigenous health, where institutional relationships between the research and evaluation sector and Indigenous health community structures have not been conducive to the development of collaborative working relationships.

There are a number of interrelated strategies that will only be flagged at this point. These include strategies to improve the quality of Indigenous data produced from health information systems, and to strengthen the link between research and reform in health policy and practice. Over the last triennium, the National Health and Medical Research Council (NH&MRC) has worked to develop a framework and methodology for priority-driven research in Aboriginal health (NH&MRC 1998). Emphasis has been given to reform in the development of research priorities, and to strategies that build collaborations between the research sector, ACCHS and communities, and those involved in Aboriginal and Torres Strait Islander health policy. The Australian Bureau of Statistics has concurrently been creating a more strategic and integrated approach to the collection of data relevant to Aboriginal health within its health survey program (CDHAC 1999). The development of the National Aboriginal and Torres Strait Islander Health Information Plan, as a strategy in reform of data collected within health information systems, received endorsement from the Australian Health Ministers Advisory Council in 1997 (CDHFS 1997).

These strategies will take time to be consolidated and evaluated. However, clearly the development of evidence to guide action will continue to be a critical element in national Aboriginal and Torres Strait Islander health strategy.

A Framework for Health Gain?

There has been quite a subtle, yet significant, transformation in national Aboriginal and Torres Strait Islander health strategy since the transfer of administrative responsibility in Aboriginal health. In particular, the development of partnerships in policy that builds collaborations between government and the community sector, and between levels of government, has been a key outcome of this period. Given the federal structure of the Australian health system, it is clear that such partnerships need to be maintained and will require ongoing developmental attention. The focus in current national health strategy on health sector reform, and particularly on the development of Indigenous primary care capacity, would seem to be both strategic and defensible given the established link between effective health care and population health gain. However, the evidence base in Indigenous health needs further development in order to focus strategies on providing effective systems of health are delivery in keeping with the demographic, social and historical context of Indigenous communities. A critical element in this approach will be the development of reform in health financing, and the consolidation of an Indigenous health workforce strategy. These policy issues will require some further conceptual and technical development, as I have tried to illustrate in the body of this paper.

Will this strategic framework lead to Indigenous health gain? This, of course, is a complex question to answer, given that the Commonwealth program in Aboriginal health combines direct intervention, through the funding of ACCHS, and indirect intervention, through mechanisms aimed at influencing the allocation of resources and the development of policy in other health jurisdictions and in other sectors (such as education, housing and employment). The issue is further complicated as there is not necessarily a direct relationship between government interventions and change n some of the key determinants of health. In evaluating the focus of this strategic framework we have to rely primarily on evidence (from mostly outside of the Aboriginal context) that identifies the health and non-health sector interventions critical for health gain. Such evidence enables us to identify with greater precision the type of health sector interventions to be developed, and how they should be organised and delivered. It provides a more detailed understanding also of the non-health sector interventions, guiding the development, for example, of programs in housing, education and economic development.

The main issue that needs to be directly tested in this context is the capacity of this framework to enable action within the health system and in key related sectors. Key questions for an evaluator would include whether the regional planning process provides an adequate basis for shifting the allocation of resources into activities and programs that are known to generate health gain. Additionally an evaluator may investigate the extent to which the Commonwealth health sector has been able to align policy in the non-health sectors with known strategies for health gain. To an extent, our ability to make such judgments rests on a well-developed body of evidence that clearly identifies those health sector interventions critical for health gain, and evidence concerning those delivery structures most likely to deliver interventions in

a way that maximises the gain achieved. Evaluating the strategic framework that has been described in this paper would not be a straightforward proposition. Nevertheless, it would be possible to test the strength of the key structural relationships described in this paper using process evaluation methods. Secondly, drawing on evidence from other contexts, and evidence from interventions in Aboriginal health it would be possible to test the relative value of the range of interventions that this structural framework has been designed to produce.

Acknowledgments

This paper was originally the basis for two conference presentations for the Royal Australasian College of Physicians, Annual Scientific Convention, Perth, May 1999, and the Australian International Health Institute Conference: Reform Redesign Revolution, Health Agendas for the 21st Century. A version of this paper was published in the conference proceedings: Galbally, R. & Krupinski J. (eds), Reform Redesign Revolution, Health Agendas for the 21st Century, Australian International Health Institute, The University of Melbourne, Melbourne.

ABBREVIATIONS

ABS	Australian Bureau of Statistics
ACCHS	Aboriginal Community Controlled Health Services
AHMAC	Australian Health Ministers Advisory Council
AIHW	Australian Institute of Health and Welfare
ANAO	Australian National Audit Office
ATSIC	Aboriginal and Torres Strait Islander Commission
CDHAC	Commonwealth Department of Health and Aged Care
CDHFS	Commonwealth Department of Health and Family Services
CDHHS	Commonwealth Department of Health and Human Services
MBS	Medical Benefits Scheme
NACCHO	National Aboriginal Community Controlled Health Organisation
NHIMG	National Health Information Management Group
NH&MRC	National Health and Medical Research Council
PBS	Pharmaceutical Benefits Scheme
PHCAP	Primary Health Care Access Program
RAGCP	Royal Australian College of General Practitioners
WHO	World Health Organization

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