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Supporting Aboriginal Health Services:

A Program for the Commonwealth Department of Human Services and Health

Ideas for discussion

Ben Bartlett
David Legge

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BEYOND THE MAZE

PROPOSALS FOR MORE EFFECTIVE ADMINISTRATION OF ABORIGINAL HEALTH PROGRAMS

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Beyond the Maze: Proposals for More Effective Administration of Aboriginal Health Programs

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1. INTRODUCTION

Aboriginal Australians are more likely to be sick, injured or disabled and to die prematurely than are non-Aboriginal Australians. Whilst the indicators of Aboriginal child health have been improving slowly, the health status of the adult population (from age 25 onwards) appears to have deteriorated over the last two decades. Aboriginal health indicators are considerably worse than those of comparable 'Fourth World' peoples, in particular, the Maori of New Zealand/Aotearoa and the Native Americans of Canada and the United States.

Who should do what about Aboriginal health is complex and there are real uncertainties and legitimate disagreements about many of the issues. Working through these questions must be a collaborative and multi-layered process. This paper is intended as a contribution to this discussion.

The focus of this paper is on what the Commonwealth Government could do now. We offer an analysis of why Aboriginal health status remains poor, focusing first on the continuing pressures of the colonising process and, second, on the administrative and political failures of the last two decades which have created new obstacles to the development of an effective health service system to address Aboriginal health needs.

We identify two main dynamics in the present administrative arrangements that prevent a more coordinated approach to the issues of Aboriginal health. The first of these is Commonwealth state cost-shifting and buck-passing. A second set of barriers arise from the contradictions between structures recommended by the National Aboriginal Health Service (namely the Council on Aboriginal Health and the tripartite forums) and the structure set up under the Government's Aboriginal and Torres Strait Islander Commission (ATSIC) strategy (in particular the Commission and the regional councils).

We propose a program of initiatives which are directed, first, to rationalising the bureaucratic and planning maze through which Aboriginal health funding is presently administered and, second, towards providing much needed back-up support to the community-controlled sector of Aboriginal health care delivery.

We are grateful to the Central Australian Aboriginal Congress and to the National Centre for Epidemiology and Population Health for their support in the preparation of this paper and to the many people who have contributed ideas and who have commented on earlier drafts. We are grateful to Simon Kneebone for the graphics and to Jenny Braid for assistance with production and distribution.

We hope this paper will stimulate further discussion. We are keen to receive feedback and, if appropriate, to participate in the circulation of further discussion material.

2. PROPOSALS

2.1. National-level policy development

We propose that the Board of Commissioners of ATSIC appoint an **Advisory Board on Aboriginal Health** with strong representation from the community-controlled health services and the regional Aboriginal health planning bodies. We believe that this body should have a strong secretariat, outside the departmental structure of ATSIC. We believe that it would be appropriate for such a body to be funded through ATSIC.

We propose that the **Council on Aboriginal Health** be re-established as a subcommittee of the Australian Health Ministers Advisory Council. As well as Commonwealth and state/territory representatives, the Council should include representation from community-controlled health services and from regional Aboriginal health planning bodies. This might be best mobilised through the proposed ATSIC Advisory Board on Aboriginal Health.

We discuss the rationale for these recommendations in some detail under the heading 'the bureaucratic maze' (page 17 this document).

2.2. Direct funding

We propose that the function of disbursing Commonwealth funds to Aboriginal health services be transferred from the Aboriginal and Torres Strait Islander Commission to the Commonwealth Department of Human Services and Health.

2.3. Regional community-based health planning

We propose that the Commonwealth Department of Human Services and Health support the development of community-based, regional planning structures for Aboriginal health across all ATSIC regions. We envisage that these regional Aboriginal health planning bodies would have a close relationship with Aboriginal community-controlled health services and the ATSIC regional councils. (See Section 5.1 this document.)

2.4. State and territory Aboriginal health development strategies

We propose that the membership of tripartite forums be modified to provide for appropriate representation of regional Aboriginal health planning bodies.

We propose that, where they have not already done so, each tripartite forum undertake a program of research and consultation directed to the development of an Aboriginal health development strategy for their state or territory.

2.5. System support for Aboriginal health service providers

We propose that the Commonwealth Department of Human Services and Health undertake a number of initiatives aimed at providing training, planning, evaluation, research, information and organisational support to the people and agencies delivering health services to Aboriginal people. In particular we propose that the Commonwealth Department of Human Services and Health provide support for:

- the development of regional Aboriginal health training units;
- support to Aboriginal health professional organisations;
- establishing an Aboriginal health care evaluation development program;
- developing a professional literature in Aboriginal health. (See Section 5, this document for more details.)

2.6. Writing Aboriginal health into the Medicare Agreements

We propose that, in the context of re-negotiating the Medicare Agreements[1] the Commonwealth and the states make the following commitments that:

- the states and territories undertake to bring their spending on health services to Aboriginal people (in all ATSIC regions of their state or territory) to at least the level of their spending on health services to non-Aboriginal Australians;
- the Commonwealth undertake to bring its direct expenditure on health services to Aboriginal Australians (in all ATSIC regions of Australia) to at least the level of its spending on health services to non-Aboriginal Australians;
- the Commonwealth undertakes to fund the additional health service expenditure needed to bring the health of Aboriginal Australians to a level comparable to that of non-Aboriginal Australians;
- the Commonwealth, states and territories undertake to shape expenditures on health service development in accordance with Aboriginal health development strategies produced through the tripartite forums;
- the Commonwealth, states and territories undertake to cooperate in developing public, timely and transparent accounts of their revenues and expenditures on Aboriginal health care and agreed data sets describing utilisation and servicing patterns.

We propose that provisions for penalties and bonus payments be included in the Medicare Agreements.

We envisage that the application of penalties would be triggered where states fail to bring their expenditure on health services to Aboriginal people to parity in all regions within an agreed time. We suggest the most appropriate penalties would be proportionate reductions in hospital funding grants.

We envisage that consideration of bonus payments (for Aboriginal health) to state and territory health departments would be triggered by the advice of the tripartite forums to the effect that each state or territory health department was cooperating to the full in developing and implementing their state (or territory) Aboriginal health development strategy and that they (the state administration) needed additional resources as part of furthering the aims of that strategy.

3. PREMATURE DEATH AND AVOIDABLE ILLNESS

Aboriginals and Torres Strait Islanders die younger than other Australians. Assuming present health patterns remain unchanged, Aboriginal (and TSI) children born today can expect to die almost 20 years earlier than non-Aboriginal children. Aboriginal boys would have a 45 per cent chance of living to age 65 (compared with 81 per cent for non-Aboriginals) and Aboriginal girls would have a 54 per cent chance of living to age 65

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[1] The Medicare Agreements are the major Commonwealth state/territory funding agreements. The main focus is state hospital services but they also encompass mental health, health information and health promotion.

(compared with 89 per cent of non-Aboriginal girls) (Australian Institute of Health and Welfare 1994:28).

Age-standardised death rates for Aboriginal males are 2.8 times those of non-Aboriginal males. Age-standardised death rates for Aboriginal females are 3.3 times those of non-Aboriginal females (Australian Institute of Health and Welfare 1994:27). The mortality gap between Aboriginal and non-Aboriginal males is greatest in the 25–54 age group where Aboriginal males have death rates between five and six times that of non-Aboriginal males. Aboriginal females have death rates between six and seven times the non-Aboriginal rates in this same age group. These figures vary across Australia; the gap is greatest in the Northern Territory (Australian Institute of Health and Welfare 1994:28).

Aboriginal infant death rates have declined over the last 25 years (from 60–80 deaths per 1000 live births in 1973–75 to around 20–25 deaths per 1000 live births in 1991). During this time infant death rates for Australia as a whole have declined from 15.7 to 7.1 deaths per 1000 live births (Australian Institute of Health and Welfare 1994:31).

The diseases which account for most Aboriginal deaths include: heart disease, diabetes, hypertension and stroke, injury and poisoning, and respiratory disease. Death rates from respiratory disease among Aboriginal people are seven to eight times greater than for non-Aboriginal people. A higher rate of infection associated with overcrowding and also tobacco use contribute to this excess. Aboriginal people also have a much higher death rate from infectious and parasitic diseases, around 12 to 13 times the rate for Australia as a whole (Australian Institute of Health and Welfare 1994:32). Aboriginal mothers are much more likely to die in childbirth than are non-Aboriginal mothers; their excess risk does not appear to have changed over the last two decades (Australian Institute of Health and Welfare 1994:31).

3.1 The health of children improving, the health of adults deteriorating

Over the last forty years the health of Aboriginal babies and children (as reflected in death rates) has improved but the health of adults has deteriorated.

In the Northern Territory, between 1958 and 1985 death rates between infancy and 25 years improved substantially while death rates from age 35 years onward increased (Australian Institute of Health 1988:111).

In New South Wales, between the periods 1955–64 and 1980–81, death rates of infants and young children declined while death rates from age 15 years and above increased significantly (Australian Institute of Health 1988:112).

Queensland data (regarding death rates in a number of Queensland communities over the period 1972–77 to 1984–90) show an improvement for males under 10 years but a deterioration for adults, particularly for males aged 30–45. An improvement among females is evident up to the age of 25 but from 25–65 their relative health risk has worsened (Ring 1992:19).

3.2 Disease and disability

Some caution is warranted in interpreting declining death rates among children as evidence of improved 'health'. There remain unacceptably high levels of disease and disability among children which are in many cases reflected in adult rather than child death rates (see Thomson 1991; see also Franklin and White 1991).

The excessive burden of diabetes, hypertension and circulatory disease among Aboriginal adults is clearly related to patterns of nutrition and dietary practices established much earlier in life. Likewise, the burdens of respiratory disease and lung cancer among Aboriginal adults may reflect in part the high level of childhood respiratory disease as well as habits of tobacco use acquired in early life.

High rates of kidney disease and rheumatic heart disease among adults in many Aboriginal communities are likely to continue while Aboriginal children continue to suffer from respiratory and skin infections at far higher rates (and more intensely and for longer) than non-Aboriginal children.

Educational disadvantage among Aboriginal adults will continue while Aboriginal children suffer from middle ear disease and consequent deafness at far higher rates than among non-Aboriginal children.

Perhaps the most stark case where adult mortality patterns might be traced back to childhood relates to violence and the harmful consequences of alcohol and drug use. Most Australian children, Aboriginal and non-Aboriginal, grow up in loving and suppportive homes, expecting to fulfill responsible adult roles which are contributory and valued. However, for many Aboriginal young people such futures are remote indeed. The diseases of anger and despair which wrack Aboriginal communities in Australia clearly have many of their roots in childhood.

3.3 Aboriginal health worse than other Fourth World peoples

The health status of Aboriginal Australians is considerably worse than other comparable 'Fourth World' peoples. Kunitz has compared the health experience of indigenous Australians with that of Native American peoples in Canada and the US and with Maoris of New Zealand/Aotearoa (Kunitz 1994).

Table 3.1: Life expectancy at birth of various indigenous and non-indigenous populations—1980s

Country and date	Indigenous Population		Non-Indigenous Population	
	Male	Female	Male	Female
	Indians & Alaskans		Caucasians	
United States, 1980	67.1	75.1	70.7	78.1
	Indians			
Canada, 1982–85	64.0	72.8	72.4	80.1
	Maoris			
New Zealand, 1980–82	63.8	68.5	70.8	77.0
	Aboriginals			
Australia, 1985	54.0	61.6	72.8	79.1

Source: Kunitz (1994:25).

Heart disease is the single largest contributor to the excess mortality of Australian Aboriginals (compared with other indigenous populations which are themselves disadvantaged compared with the corresponding non-indigenous populations) (Kunitz 1994:34). Infant mortality rates are also higher for Australian Aboriginals (around 24 per 1000 live births) than for Canadian Indians (21.8), Maoris (18) and US Indians (9.8) (Kunitz 1994:26).

3.4 Making sense of these data

The data we have cited about Aboriginal health status are aggregate data which obscure significant differences across the country. Nonetheless, the picture they reflect appears to apply fairly widely.

However, simply reciting death rates and listing the disease categories which contribute to those death rates is not very helpful in determining a policy response. There are technologies that are available for preventing and treating many of the diseases contributing to Aboriginal mortality and morbidity. The reasons these are not being applied are not diagnosis-related but are social and political and call for systems of categorisation which can better inform policy-making at the health systems level.

In seeking to reframe, in more locally relevant ways, the patterns of illness that are depicted by morbidity and cause-of-death statistics the Central Australian Aboriginal Congress has explored a three-fold categorisation of health problems (Bartlett and Scrimgeour 1989) including:

- diseases of the physical environment;
- diseases of the social and mental environment;
- diseases associated with nutrition and exercise.

Subsequently, in reviewing mortality patterns in consultation with Aboriginal communities, Weeramanthri and Plummer (1994) have linked these categories more explicitly to the theme of Body, Land and Spirit (Reid 1982) as a way of reconstituting the medical categories in more culturally meaningful terms.

Our purpose in this paper is directed at more appropriate health policies and more effective health planning and program delivery. In this context we find it helpful to categorise Aboriginal morbidity and mortality in terms of injuries and disabilities that reflect:

- the environment of poverty;
- lack of access to basic primary health care services;
- lack of access to a properly coordinated, adequately supported, culturally appropriate health service system;
- the failure of institutional commitment; and
- the sicknesses of anger and despair.

3.4.1 The environment of poverty

A large component of Aboriginal morbidity and mortality reflect the environment of poverty. For example, inadequate household amenities and overcrowding, uncontrolled hazards in the physical environment, lack of transport options and limited choices with respect to nutrition. Continuing preventable morbidity due to this group of causes might be categorised as conditions which reflect the environment of poverty.

3.4.2 Lack of access to basic primary health care services

Some of the health conditions which arise in these circumstances can be prevented or treated through relatively simple technologies. The leading examples of these conditions are respiratory infections, diarrhoea and vaccine-preventable infections in children. The illness burden and death rates from these conditions have been markedly ameliorated through improved access to primary health care services over the last two decades. These improvements reflect the expansion of the community-controlled health services, (of state-run programs in some states and territories and improved access to mainstream primary care services). The significance of these achievements highlights the continuing difficulties under which Aboriginal primary health care services operate, underfunded and lacking the organisational, technical and professional supports that the mainstream health providers take for granted. Continuing preventable morbidity due to the shortfalls in the development of and support to Aboriginal community-controlled health services might be categorised as conditions which reflect lack of access to basic primary health care services.

3.4.3 Lack of access to a properly coordinated, adequately supported, culturally appropriate health service system

The provision of limited primary health care resources makes a basic contribution to health improvement. However, without smooth functional relationships between primary health care agencies and various more-specialised resources, it is hard to develop a more programmatic approach to prevention and to the treatment of more complex conditions. Access to technically effective health care, prevention and treatment, depends upon a health service system: appropriately located with resourced primary care services, smooth consultative links to secondary- and tertiary-level expertise, culturally appropriate styles of service, and a whole range of system back-ups (training, evaluation, research, technology assessment, professional development, etc.).

Kunitz (1994) speculates that the better health status of Native Americans in the United States may be in part because of a more organised approach to health service delivery and a more planned approach to the development of health care resources (facilities, labour force, information, etc.) which is possible within the Indian Health Service. The unitary administrative environment of the Indian Health Service contrasts sharply with the tangle of jurisdictions and departmental mandates through which Aboriginal health development is 'planned' in Australia.

These barriers constitute a category of continuing preventable morbidity which might be described as conditions that reflect lack of access to a properly coordinated, adequately supported, culturally appropriate health service system based on primary health care principles.

3.4.4 The failure of institutional commitment

If the underlying social and environmental circumstances are not changed, there are limits to which technical treatments and preventives, even when delivered through smoothly functioning programs involving a range of different providers, can reduce the burden arising from the diseases of poverty. Changing the social and environmental circumstances that underly Aboriginal ill-health involves a complex mix of interdependent processes: community development, institutional reform, the mobilisation of resources and reconciliation. This kind of movement is taking place, in some states more rapidly than in others. These processes are difficult. There are no direct precedents and no-one can claim to know exactly how they should be approached. However, we believe that one of the basic issues, where different approaches are holding up progress, is what we understand as the 'fundamental resource'.

Where will come the drive to improve Aboriginal health? From the intelligent and strategic 'interventions' of experts and planners? Or from the caring and determination of young people and of elders, of mothers and grandmothers, of fathers and grandfathers in Aboriginal families and communities? Clearly these are not (or should not be) mutually exclusive choices. However, we think that the caring and determination within families and communities needs to be more widely recognised as the most fundamental resource upon which health policies, services and programs should be building. At the very least, health policies, services and programs should not be obstructing and frustrating the efforts of individuals, families and communities to achieve the conditions for better lives and better health.

The development of policies, programs and forms of health practice which support this kind of self-determination in health, calls for technical creativity, a capacity for deep listening, a critical attitude to our own customary ways of doing things and a commitment to self-determination, in particular at the levels of individuals, families and communities. We would categorise the continuing preventable morbidity which occurs while we are waiting for these processes to take effect as diseases of failure of institutional commitment.

3.4.5 The sicknesses of anger and despair

The history of frustrations and disillusionment which flow from repeated manifestations of such institutional failure feed back to further limit the health expectations of Aboriginal people. Perhaps the largest component of preventable ill-health among Aboriginal people is comprised by the health conditions which reflect the anger and despair of people whose lives and family cultures have been deeply influenced by state abductions, police violence, municipal rejection, authoritarian and institutionalised settlements, school failure and now by the failures to deliver upon the promises of reform. Health conditions which might be thus classified as diseases of anger and despair include, at least some proportion of the violence and injury, alcohol and drug damage and nutrition-related diseases which contribute so substantially to the excess Aboriginal morbidity and mortality.

4. CAUSES AND PRINCIPLES

The causes of Aboriginal health disadvantage are complex and there are a lot of different stories which may be told about 'why' and about 'what to do'. In some degree it depends on who is speaking and for what purposes.

In this chapter we discuss in more detail how we understand the present causes of Aboriginal health disadvantage and what we take to be the key principles for finding a way out of it.

4.1 Understanding the persistence of poor Aboriginal health

As we see it there are two main dynamics underlying contemporary Aboriginal health disadvantage. These are:

- the long-term and continuing effects of the processes of colonisation;
- contemporary failures in policy, research and administration.

4.1.2 The continuing health effects of colonisation

The continuing effects of the processes of colonisation are manifest in two ways: first, the colonial legacy, manifest at the personal, family and community levels, and, second, the continuing contemporary pressures of the colonising process.

4.1.2.1 The colonial legacy

There are few Aboriginal families who do not harbour continuing loss and grief from episodes in their personal, family and community histories which were in various ways part of the colonial processes of dispossession, institutionalisation and control. From direct violence, to dispossession of land, forced removals, the taking away of children, to institutionalised dependency, to official neglect in custody; the experience of colonial contact has left many families with disabilities which have profound implications for their life chances and their health chances. These disabilities are not 'just history'; they are part of people's everyday lives, now, in the present.

Despite the continuing presence of this legacy in Aboriginal people's lives the resulting disabilities are often 'invisible' to mainstream health care providers, health researchers and government departments. The languages which are spoken in these institutions do not have the categories for recognising nor speaking about such damage.

4.1.2.2 The continuing pressures of the colonising process

The colonising process did not cease in 1901 (with Federation) or 1967 (citizenship rights) or 1993 (with the Mabo Decision). The continuities into the present of the pressures of the colonising process are manifest in their most obvious forms in contemporary polemics against native title and the proposed Land Acquisition Fund. A less high-profile example which contributes more immediately to ill-health is the municipal neglect of the needs of Aboriginal communities living on the outskirts of country towns in Eastern Australia.

There are more subtle continuities in the ordinary practices of health care institutions and professionals which are perpetuated by not being acknowledged and actively reworked.

Professionals who do not recognise the continuing influence of the colonial legacy on Aboriginal health must base their practice on other explanations. These alternative explanations, which are generally implicit in how they practise, draw in many cases upon cultural stereotypes (e.g., lack of education, exotic cultural beliefs, even genetic difference) to account for the health disadvantages of Aboriginal people. The continuing projection of such stereotypes in institutional and professional practice constitutes one of the most salient continuities between the older faces of colonisation and the contemporary face.

Many health professionals understand the health problems of Aboriginal people primarily in terms of conventional health hazards and risk factors and see themselves as coming in (from outside) with technical expertise in order to help. People who have no frameworks for understanding the embeddedness of Aboriginal health disadvantage in the on-going colonial process have no tools for understanding their own participation in the institutions and cultural traditions through which it is mediated.

Health care providers who are discriminatory, condescending or patronising (no matter how well-intentioned) may be reproducing patterns of practice which recall the missionaries and welfare officers of not-so-long-ago. Such patterns of practice commonly elicit the same kind of resistance that Aboriginal people have shown to previous manifestations of racism. It is too simple to categorise it as simply a lack of cross-cultural skills.

4.1.3 Administrative and policy failure

The legacy and continuing pressures of the colonial process set the long-term context of Aboriginal health. There is a more recent dynamic also which is highlighted by the comparison with Maori and Native Americans. This is the failure in the fields of policy and administration to give effect to repeated commitments to 'do something about Aboriginal health'.

In our view the two major cases of administrative and policy failure are:

- Commonwealth state cost-shifting and buck-passing; political grand-standing combined with administrative neglect; and
- certain divisive effects associated with the Commonwealth's ATSIC strategy, and structural contradictions between the representative principle of ATSIC and the tripartite principle of the NAHS.

4.1.3.1 Commonwealth state and territory relations

Aboriginal health is presently a hostage of Australian federalism. A major plank of Commonwealth policy is the principle of making the states and territories pay their share. This is commonly expressed in terms of their fulfilling their obligations to provide appropriate health care to all citizens. The states and territories are aware of the greater fiscal discretion of the Commonwealth and the political pressure focussed at that level for effective programs to improve Aboriginal health. This awareness appears to have contributed to a reluctance (perhaps more from treasury than from health) to outlay large sums of (state) money on Aboriginal health. The consequence of this stand-off with respect to 'primary' responsibility has been no responsibility.

With the establishment of ATSIC, Commonwealth responsibility has been mediated through an organisation with very little health expertise and inadequate resources. Further, the accountability of ATSIC is ambiguous, in some degree to the Commonwealth Government (although primarily in relation to accounting practices) and in some degree to the Commission (and through it to the wider Aboriginal constituency). Insofar as ATSIC is accountable to its own electorate, the Commonwealth has virtually no focus of authority linked with expertise through which it might discharge a responsibility for Aboriginal health.

4.1.3.2 Contradictions between the ATSIC strategy and the National Aboriginal Health Strategy

The Commonwealth's ATSIC strategy plays a part also in our second instance of policy and administrative failure. This is the implementation of two incompatible strategies for improving Aboriginal health.

In the early 1980s there were two major bureaucratic problems facing Aboriginal health at the national level. The first of these was the competition between the community-controlled organisations and the state and territory departments for Commonwealth money. This competition presented a major barrier to effective coordination of state and community-controlled programs and between community-controlled primary health care agencies and the state-run secondary and tertiary sectors. The second problem was lack of credibility in the eyes of the community-controlled services of the Commonwealth Department of Aboriginal Affairs (DAA) which administered their funds. This lack of credibility was largely due to DAA's lack of professional expertise in health and its inability to provide the support that the newly developing community-controlled services needed. (This was epitomised by its naive approach to performance indicators.)

The National Aboriginal Health Strategy (1989) was, amongst other things, a response to these problems. The National Aboriginal Health Strategy (NAHS) pointed towards a more strategic approach, including the promotion of community development and support for other sectors whose activities impact on Aboriginal health (intersectoral collaboration). The NAHS adopted a tripartitist strategy at both the national and state and territory levels; aiming to get the Commonwealth (DAA and Health), the state and territory health authorities and the representatives of community-controlled services together around the same tables.

At around the same time as the NAHS Working Party was reporting, the Commonwealth was proceeding with the establishment of ATSIC. This was a highly ambiguous strategy. On one hand it was represented as supporting 'self-determination' at the national and regional levels. On the other hand it also had the effect of forcing Aboriginal people to undertake the task of resource allocation including the management of competing demands. Politicians and senior administrators were thereby distanced from these invidious tasks.

The representative principles upon which ATSIC was based conflicted in several respects with the tripartitist principle underlying the NAHS. At the national level two senior bodies were to be created with overlapping responsibilities: the ATSIC Commission and the Council on Aboriginal Health (as recommended in a NAHS). The Council did not have its own secretariat or resources and has not been able to play the coordinating and leadership rôle envisaged in the NAHS. On the other hand ATSIC has not had the expertise to provide effective leadership in the health area.

The NAHS recommended the establishment of tripartite forums at the state and territory level (bringing together the Commonwealth and state interests and the community-controlled health sector). In fact, the representation of a Commonwealth perspective on the tripartite forums (TPFs) has been quite problematic with representatives from the ATSIC structures playing a leading role but representing a politic largely generated through the regional councils. The TPF, as a place where Commonwealth, state and community interests develop a coordinated approach to Aboriginal health, has failed. The main Commonwealth player in health has been virtually absent.

The NAHS placed heavy emphasis on intersectoral collaboration as a necessary strategy for improving Aboriginal health. Intersectoral collaboration involves the health sector working with people in the housing sector, in environmental organisations, in education and in business enterprises to work towards coordinated positions with respect to creating the conditions for better health. Intersectoral collaboration is needed at all levels from national to local. In the context of Aboriginal health, the most important arena in which intersectoral collaboration is needed is at the local community level; building cooperation between land councils, community councils, education associations, housing associations and health organisations.

Rather than facilitating this kind of community-level intersectoral collaboration the ATSIC electoral process has created a new dynamic of competition and intersectoral conflict. In many regions the main organisations in each of the sectors (housing, health, education, legal services, etc.) have constituted the framework around which electoral politics at the regional level has developed. The divisions created by this dynamic has been exacerbated by the fact that most of these organisations are looking to the regional council for funding support.

4.1.4 Impacts on health policy making and health service delivery

We see these two dynamics (the long-term effects associated with the colonising process and the more recent policy and administrative failures) as throwing up a range of barriers to Aboriginal health advancement in the current period including:

- inadequate resourcing of health services for Aboriginal people;
- continuing barriers to planning, coordination and cooperation;
- continuing barriers to the emergence of strong indigenous voices about health policy;
- new barriers to intersectoral collaboration for health development at the community level.

4.1.4.1 Lack of resources

There are no comprehensive data available on expenditure sources and patterns and utilisation and servicing rates. However, early work currently being undertaken in a number of centres around Australia suggests that combined Commonwealth and state/territory expenditure on health services to Aboriginal people remains well below the average per capita expenditure on health services to non-Aboriginal Australians.[2]

It appears that in many regions it may be Commonwealth rather than the states and territories which is accruing the savings from lower rates of service utilisation by Aboriginal people, especially in the medical benefits and pharmaceutical benefits arrangements.

In view of the notorious health gap between Aboriginal people and non-Aboriginal Australians, if this shortfall in expenditure is confirmed it could be construed as serious administrative neglect. The Commonwealth Department of Human Services and Health has shown that it is capable of excellent planning, strategic thinking, and appropriate consultation it a range of other programs. We think that it is time these resources were directed in a more focussed manner towards improving Aboriginal health.

4.1.4.2 Barriers to planning coordination and cooperation

The structural barriers to more effective health planning and coordination are reflected in a divided health system, fragmented into sectors which are working in competing paradigms often in direct competition.

The community-controlled sector is under-funded and unsupported with respect to the development of professional leadership, planning, evaluation and research skills, professional development and information resources.

4.1.4.3 Barriers to the emergence of strong indigenous voices about health policy

There are continuing barriers to the emergence of strong indigenous voices about health policy. This compares sharply with the continuing strong representation of state and territory opinion and academic and medical perspectives.

There is a small number of Aboriginal health leaders whose participation in national policy debate is generally undertaken 'on the side' and completely unresourced.

The failures to support a strong indigenous voice in health policy is reflected most seriously in the continuing confusion, debate and polemic over strategies for overcoming health needs which are (in our terms) the legacy of colonisation and the manifestations of the continuing colonial process. These are issues around which Aboriginal health services have accumulated a great deal of experience which should be the subject of research, reflection and the source of new policies and service strategies.

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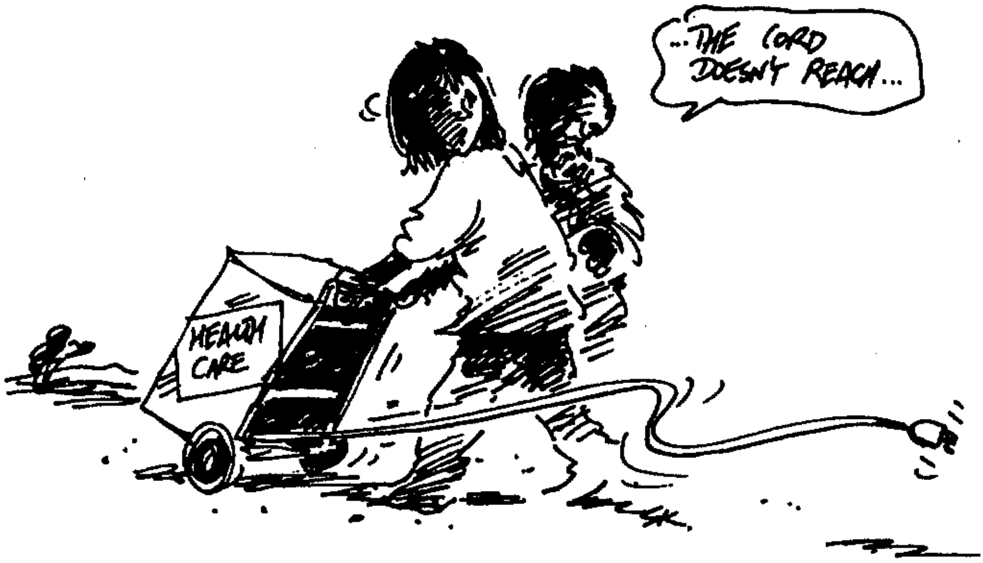
[2] Much of this work is still in train. An exception is Hart, Ring and Runciman (1993).

4.1.4.4 Barriers to intersectoral collaboration at the community level

To these existing barriers a new set of barriers to intersectoral collaboration at the community level have emerged with the advent of the Commonwealth's ATSIC strategy. In many regions the pressures of resource allocation at the regional level plus the increased factionalism associated with the regional electoral processes have thrown up new barriers to intersectoral collaboration for better health at the community level.



4.2 Disagreements and uncertainties

The field of Aboriginal health policy is rent with polemic, people speaking past each other, shouting but not listening. We think that it is important to recognise that there are a lot of issues upon which different opinions may be held in good faith. There are a lot of issues where there is simply not enough information available to make broad generalisations with confidence. We think that it is important to find ways past the polemics to more constructive ways of resolving the disagreements and uncertainties.

In this section we list some of the main issues of disagreement and uncertainty and we acknowledge some of the different positions which are held. We point towards some strategies for resolving the disagreements and uncertainties also. However, action to improve Aboriginal health should not have to wait until all of these disagreements and uncertainties are sorted out. Despite the uncertainties, we think that there is enough firm evidence to point towards practicable initiatives which could be taken now and which we believe could help to remove some of the barriers to Aboriginal health advancement. In the last section of this paper we outline some of the main assumptions upon which our suggested policy initiatives are based.

Some of the key issues of disagreement and uncertainty which have emerged for us in the course of preparing this paper are as follows:

- how to understand and speak about the continuing influence of the historical processes of colonisation;
- how to respond in health policy and health care delivery to the continuing influence of colonisation;

- how to understand the role of social development generally (economic, political, environmental, cultural, etc.) as compared with health service delivery in improving Aboriginal health;
- how to understand the relationship of technical 'interventions' (for example, immunisation or nutrition education) to the processes of community development in improving health;
- how to understand and speak about the impact of the ATSIC strategy, in relation to health care;
- how to understand and speak about the processes of government which have allowed this literally amazing situation to develop and how best to reshape the bureaucratic arrangments;
- how to find out just how much money is spent on health services to Aboriginal people?

4.3 Assumptions and principles

There are lots of disagreements and uncertainties and we need strategies for working through these. However, notwithstanding the disagreements and uncertainties, it is our view that there are assumptions and principles that are sufficiently credible and just, to provide the basis for action now. In this section we summarise these assumptions and principles.

4.3.1 Core resources

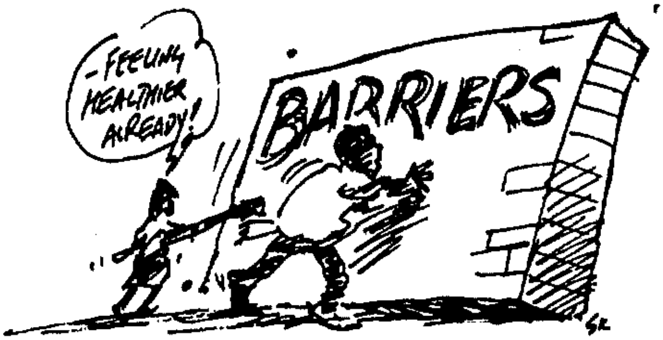
We assume that the core resources upon which Aboriginal health improvement will be based are the caring and determination of Aboriginal people themselves; of young people and of elders, of mothers and grandmothers, of fathers and grandfathers in Aboriginal families and communities. Unless the drive and agency of these people is recognised and placed at the centre of policy making, program design and service delivery, the technical power of the experts will remain relatively ineffectual.

At the very least, health policies, services and programs should not have the effect of obstructing and frustrating the efforts of individuals, families and communities to achieve the conditions for better lives and better health.

4.3.2 Health services can contribute to health development

There is a very wide understanding among Aboriginal leaders and policy makers that the conditions for health are largely created prior to the involvement of the health sector; that the conditions for health are created in the education, housing and cultural sectors and in establishing a firm economic base. We share this understanding.

Unfortunately these insights about the importance of social development generally have contributed in some discussions to an either/or position and a discounting of the importance of health services as 'merely Band-aid services'. Some of this discounting of the role of health care is undoubtedly based on a models of health care practice which incorporate a sharp division between purely technical strategies and the processes



which lead to community development.

To the contrary, we believe that access to the technical resources of medical care and public health are necessary prerequisites for better health and that these can and should be provided for in ways that also contribute to self-determination and community development. These are not alternatives. We believe that appropriate health service policies can contribute to better health through:

- access to technical services and programs;
- support for intersectoral collaboration;
- community development as part of the management and implementation of programs;
- dispersal of health literacy through community participation in program management and delivery.

The Ottawa Charter for health promotion elaborates clearly the role of health services in healthy public policy, creating supportive environments and supporting community action for better health.

4.3.3 Primary health care

The relations between technical interventions and the processes of community development in improving health are highly contentious. The conventional wisdom in health policy circles and health administration either completely ignores the community development side or casts it as something separate from health care.

In our view it should not be seen as a choice between either community development or technical services and programs but primary health care as a vehicle for integrating both. Some writers have taken up the metaphor of *vertical programs* (narrow in brief, focussed on particular outcomes and controlled from above) compared with *horizontal programs* (local, generalist, primary care) and have identified the primary health care model with horizontal (as opposed to vertical program designs). Clearly, there are many different interpretations of the term 'primary health care'. However, as we understand it, the primary health care model is about achieving an integration between horizontal and vertical programs and provides a strong policy model for the development of health services for Aboriginal Australians. The implications of applying a primary health care approach to Aboriginal health include:

- a strong presence of Aboriginal community-controlled health services;
- a range of other services and agencies which constitute the primary health care sector broadly conceived (general practitioners, community health nurses, pharmacists, environmental health officers, etc.);
- strong community and consumer involvement in the management, planning, and delivery of services and programs at the primary health care level, all services and programs, not just those delivered through the community-controlled sector;
- cooperative and respectful relations across the primary health care sector, in particular cooperation between Aboriginal community-controlled health services and other primary health care agencies such as general practitioners, visiting nurses, pharmacies and local government;
- cooperative and respectful relations between primary health care agencies and personnel and more specialised resources such as hospitals, medical specialists and public health specialists;
- a commitment to developing patterns of practice which address the immediate needs of clinical care and of prevention but in ways which also contribute to redressing the underlying conditions (which we have referred to in Sections 3 & 4 above).

4.3.4 Support

In terms of Aboriginal primary health care the core of the system is the community-controlled health service organisations. This is widely acknowledged but has not been fully supported in practice. Funding has been available to pay for the direct service delivery functions of Aboriginal health services (albeit insufficient in relation to the pressures of need) but there has been virtually no funding directed to providing system support to health service organisations and the Aboriginal health professionals and community volunteers who make them work. Among the functions which have not been supported:

- regional planning,
- program planning,
- continuing professional development,
- evaluation skills,
- professional organisations,
- an Aboriginal health literature,
- an Aboriginal community-controlled research capacity.

4.3.5 Intersectoral collaboration at the community level

The representative structures and processes established as part of the ATSIC strategy have strengthened the representation of Aboriginal opinion at the national, state and regional levels. These are important achievements and are being built upon.

However, there have been some negatives from the health point of view. ATSIC regional councils are elected bodies and play an increasing role in disbursing very limited funds across a very wide spectrum of needs.

We believe that the political factionalism associated with electoral processes, combined with the financial stakes for the various community organisations seeking regional council funding, together constitute a significant barrier to intersectoral collaboration at the community level for better health.

Health professionals accept that the conditions for health are shaped prior to the involvements of the health sector. The principle of intersectoral collaboration envisages health personnel conveying to other sectors (housing, education, transport, economic development, etc.) their concerns about the health implications of developments in those sectors and working towards appropriate development strategies. This principle is foundational in terms of modern public health thinking. We think that removing the barriers to such cooperation is of critical importance.

In the recommendations presented in this paper we have sought to remove health service funding from ATSIC disbursement (to reduce the competitive element) while strengthening the planning and consultative role of the regional councils, the tripartite forums and the Commission. We are looking for ways of re-engaging the other sectors of Aboriginal affairs as advocates for health advancement without the implication that the sectors for which they have direct responsibility would be thereby disadvantaged.

4.3.6 Addressing the colonial dimension

The colonial legacy and the continuing pressures of the colonial presence constitute a key dimension of the Aboriginal health problem. The health needs of Aboriginal people are qualitatively different from those of other Australians with similar 'risk factors' by virtue of the colonial dimension.

There are no neat models or precedents for 'anti-colonial health care'. It is complex and difficult but Aboriginal health professionals are exploring different strategies and paths in 92 services around Australia. We do not claim to have solutions but we are sure that denying the presence of the colonial dimension in Aboriginal health statistics is not the right way to go.

There is wide acceptance that the slogan of 'self-determination' points towards political and health care strategies which may facilitate the healing and curb the continuing harm. However, there are different opinions about what this might mean. For example, self-determination at the national or regional levels or at the level of the community, family or individual? One is tempted to say at all levels but there can be contradictions between strategies aiming to realise 'self-determination' at these different levels of scale (Anderson 1994).

We feel that the processes of countering the continuing influences of the colonial presence must involve speaking about these influences, documenting the relations between the local histories of particular families and clans and their subsequent health experience. This is a process begun by the personal histories of the Royal Commission into Aboriginal Deaths in Custody and by the rich material produced by an increasing number of Aboriginal writers (for example, Weller 1986; Morgan 1989; Davis, Muecke, Narogin and Shoemaker 1990).

This process should also involve non-Aboriginal health professionals learning more about the histories of the traditions and institutions in which they practice. To recognise the professional and institutional continuities from the past is not to indict present staff with the brutalities of the past; however, to deny these continuities is to risk perpetuating them (Hunter 1993). Learning to speak about these continuities may help to break them. We see it as an important part of the processes of reconciliation in the health sector.

4.3.7 The bureaucratic maze

We believe that the bureaucratic structures and relationships which have been established over the last five years or so constitute major barriers to Aboriginal health advancement. We have referred to the structures which sustain the cost-shifting and buck-passing between Commonwealth and states. We perceive a lack of accountability on the part of senior bureaucrats and ministers with respect to important policy outcomes (i.e. better health). We have pointed also to the contradictions between the tripartite strategy of the National Aboriginal Health Strategy and the representative strategy of ATSIC, both of which were implemented side by side by the same government.

Notwithstanding the experience of the last two decades we believe that federalism can and must be made to work for Aboriginal people. We have made a number of policy proposals which we hope will contribute to this. We propose that:

- the Medicare Agreements be used as a framework within which the Commonwealth and the states/territories will negotiate fair, binding and complementary funding commitments;
- the administration of Commonwealth funding of Aboriginal health services be transferred to the Commonwealth Department of Human Services and Health with a view to (i) facilitating improved links between Aboriginal health services and the rest of the health system and (ii) removing existing barriers to intersectoral collaboration at the community level;
- the planning work of the tripartite forums be given greater authority by backing them up with sanctions and incentives derived from the Medicare Agreement.

Making the administration of Aboriginal health more effective will require more than administrative change. Our recommendations are also directed at strengthening the planning, monitoring and advocacy capacity of the Aboriginal health movement and of the Aboriginal affairs movement generally in relation to health issues. We intend that our policy proposals would strengthen Aboriginal involvement in health planning, program development and policy-making at the regional, state and territory and national levels through:

- the development of regional planning bodies with close links to the community controlled services and the ATSIC regional councils;
- strengthening the planning role of the tripartite forums;
- re-establishing the Council on Aboriginal Health as a subcommittee of AHMAC so that it may participate more directly in health policy-making and program development at the national level.

We intend that our proposals should also strengthen the accountability of Commonwealth and state/territory health authorities to Aboriginal people by strengthening the monitoring and advocacy role of the Board of Commissioners. We envisage that the proposed Advisory Board on Aboriginal Health would strengthen the relationship between the community-controlled health services and the Board of Commissioners.

5. PROGRAM FUNDING IN SUPPORT OF ABORIGINAL HEALTH

In this section we provide additional detail in outlining some of the priority funding programs which we believe are needed to provide much needed back-up support to the frontline Aboriginal health service delivery agencies.

5.1 Support for regional planning and coordination

Lack of support for regional health planning has been a key barrier to improving Aboriginal health. Funding has been available for organisations which are seen as providing services to particular communities but not to structures which might support regional coordination.

Coordination of health services and programs at a regional level is necessary to facilitate the incorporation of differences into service and program planning. The functions which would be supported by this program include:

- regional planning for service development;
- coordinated program development and support (including support for intersectoral cooperation and support for improved relations between primary, secondary and tertiary services);
- development of appropriate evaluation support;
- improved communication across the region;
- strengthened community involvement in health issues throughout the region;
- stronger constituency for peak bodies (such as NACCHO) and for wider national policy and program development in Aboriginal health.

The funding program would facilitate the establishment of regional forums with appropriate representation from all communities in the region. It would provide funding for secretariat support, meetings, travel and projects. We envisage regional planning bodies as having a close relationship with the relevant ATSIC regional councils.

The program would be implemented through the Commonwealth Department of Human Services and Health in close consultation with the proposed ATSIC Advisory Board on Aboriginal Health.

5.2 The establishment of Aboriginal health regional training units

Specialised training facilities at the regional level are needed to support a range of functions which are integral to comprehensive primary health care. These include:

- continuing education needs, especially for Aboriginal Health Workers;
- orientation programs;
- specific training needs,[3]
- computer training;
- program oriented training (e.g. around particular public health issues);
- management training; and
- training and support in evaluation and planning.

Such units would collaborate with existing educational programs where appropriate. Resources could be made available through regional training units for Aboriginal Health Workers to be involved in exchanges and visits with other Aboriginal health services. The units could develop relationships with national organisations to assist Aboriginal health workers to access higher education and training (e.g. public health training).

5.3 Support for Aboriginal health professional organisations

Aboriginal health personnel lack any national professional organisations and in many places there are no regional organisations either. Their needs are not being heard, understood or addressed.

Likewise NACCHO, the peak body for Aboriginal health services, has virtually no resources. It has no secretariat, and no infrastructure.

The Commonwealth provides national secretariat resources to support a number of professional and other national non-government health bodies through the Community Organisations Support Program (COSP). There is an urgent need for COSP-style support to be extended to Aboriginal health organisations, in particular to NACCHO as the national peak health body of health services.

Aboriginal health workers also need support in terms of resourcing a national health worker organisation with strong regional and state/territory units. Support for the development of such organisations could be made available through the regional health councils with the support of the Office.

Aboriginal managers of primary health care services also have little access to the kind of support that their mainstream colleagues take for granted. Aboriginal management tends to be different from conventional styles; Aboriginal managers tend to operate in an 'open door' style

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[3] Brokerage funds need to be available for the purchase of workshops or 'mentoring' tailored to particular health worker needs at particular times in particular communities.

which is appropriate to their primary lines of accountability, to the community. At present there are few programs available to support professional development for Aboriginal health managers.

5.4 Aboriginal Health evaluation development program

Aboriginal health services are wary of evaluation because the term is so often used to justify unreasonable accountability requirements of funding bodies.

We suggest that the Commonwealth Department of Human Services and Health develop an evaluation development program consisting of (i) grants for small projects, (ii) a scholarship and training scheme, and (iii) best-practice awards.

The funds for the small grants program would be distributed through the regional Aboriginal health councils to Aboriginal health services, for example, to support primary health care workers in documenting their work.

The evaluation scholarships and training scheme would provide grants to applicants approved by appropriate Aboriginal health services or regional Aboriginal health councils. A negotiated training program in health service/program evaluation would be developed and supported through these grants. Finally a system of regional and national awards for best-practice in evaluation of Aboriginal primary health care could be developed. The program should be administered through the Commonwealth Department of Human Services and Health in association with the ATSIC Advisory Board on Health.

5.5 Developing a professional literature in Aboriginal health

One of the resource systems which the mainstream health system depends upon is 'the literature', ranging from books, to articles published in scholarly journals, to shorter practice-oriented pieces published as lift-outs or distributed by commercial organisations.

The professional literature which is organised to support Aboriginal health practitioners is sparse.[4]

The *Aboriginal and Islander Health Worker Journal* is the only publication of its type in Australia. It has limited support at present and is unable to provide full national coverage. The Commonwealth Department of Human Services and Health should consult with the editors of the journal with a view to providing such resources as are needed to broaden its organisational base and its content and to widen its distribution.

The Department should also liaise with mainstream health journals (in particular the *Medical Journal of Australia*, the *Australian Family Physician*, the *Australian Nurses Journal*, *Australian Journal of Public Health* and the *Australian Health Review*) with a view to their publishing material on Aboriginal health which is oriented to meeting the needs of the Aboriginal health workforce. This would require the development of a relationship between the professional associations producing these journals and Aboriginal health personnel.

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[4] A distinction could be made between the professional literature organised to support Aboriginal health practitioners and the literature about Aboriginal health.

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