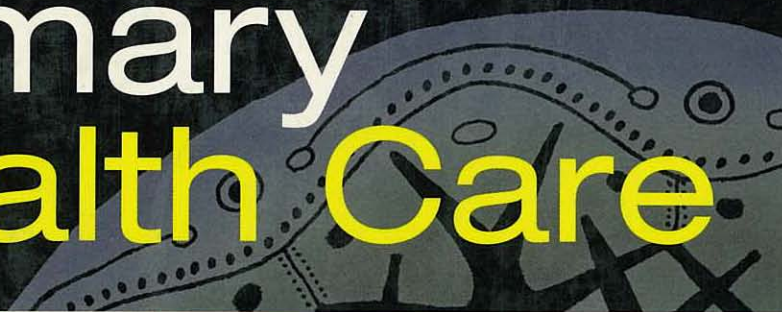


OXFORD

Aboriginal Primary Health Care



An Evidence-based Approach
THIRD EDITION

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Health, Human Rights, and the Policy Process

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We have human rights to things like housing, rights to public health, Medicare, social security, social services and all these so-called international programs that Australia prides itself on signing off on.. [but].. the basic human rights of the individual are constantly left behind when we talk about Aboriginals.

The late Dr Puggy Hunter, 5th National Rural Health Conference Keynote Address, Adelaide, March 1999

Introduction

The health care systems and health status of Aboriginal Australians are shaped by history, and social and political forces that predominantly reflect the values and ideologies of the broader Australian population.¹ Aboriginal peoples and Torres Strait Islanders have by far the worst health status of any identifiable group in Australia, and the poorest access to health systems. Therefore, their potential capacity to benefit from well-targeted interventions is very high. Well-developed health sector policies and strategies can enable these interventions, contribute material resources, support efficiencies, encourage intersectoral collaboration, and stimulate significant innovations that reduce health inequities.

The primary health care sector is the most vital in early detection of diseases and its risk factors, and preventing disease complications, thus minimising the cost of health care provision downstream.² Importantly, and evident internationally, primary health care services can act to mitigate social inequalities. There is strong evidence, however, of substantial shortfalls in resourcing those primary health care services that have been shown to be accessed by Aboriginal peoples. In fact, federal expenditure on universal primary health care-related services is less per-person within the Aboriginal and Torres Strait Islander population than for other Australians, even when their health needs are much greater. The challenge is identifying why this is so, explaining the health policy gaps to rectify this situation, and enabling resourcing so that it is adequate for the primary health care sector to get on with its job.

Australian governments have accepted the need for health policy to be developed according to the priorities of the Aboriginal and Torres Strait Islander population.

This is underwritten in numerous frameworks and agreements federally and in each jurisdiction, but unfortunately often overlooked.

This chapter describes the Australian health policy process at the federal level through the perspective of inequity and human rights, the challenges in developing and implementing policies that may help or hinder the elimination of health disparities between the Aboriginal and Torres Strait Islander population and other Australians, and some ways forward. This chapter should also be read in conjunction with the history of policies affecting the health of Aboriginal peoples (see chapter 1).

Health policy

Health policy is a statement of intention and proposed commitment from statutory bodies. It is a course of action or principle adopted or intended by a government or organisation.³ It is an instrument of governance, the decision that directs public resources in one direction, and not another, as a result of competition between ideas, interests, and ideologies.⁴

Australia's health policy approach for Aboriginal peoples and Torres Strait Islanders has been:

- *to support access to comprehensive primary health care services*
- *to do this in the best way possible, through culturally safe and holistic approaches.*⁵

The Council of Australian Governments (COAG), which is Australia's peak inter-governmental forum and chaired by the prime minister, endorsed Australia's policy for primary health care for Indigenous Australians through its Ministerial Council (the Australian Health Ministers Conference or AHMC). This was in response to incontrovertible evidence that Aboriginal people's and Torres Strait Islanders' access to Australia's health system was much less than other Australians (see chapter 1), in spite of the same access entitlements.

The policy framework for government action to improve the health of the Aboriginal and Torres Strait Islander population is called the National Strategic Framework for Aboriginal and Torres Strait Islander Health (NSFATSIH).⁶ This framework supports Indigenous-specific primary health care services through Aboriginal Community Controlled Health Services (ACCHSs), and at the population level, Indigenous-specific public health strategies. This serves to both enhance Aboriginal people's access to the mainstream health care system and provide needed services that mainstream health care does not (or does not provide well). Supplementing improved access to mainstream programs is part of an enabling strategy to build workforce and health care capacity, and is a key policy platform underpinning Australia's health response to the Aboriginal population's health needs.

COAG committees have also developed policy that optimises Aboriginal people's access to services by influencing the appropriateness of the mainstream health service sector. Some of the policy instruments developed for this purpose include the AHMAC Cultural Respect Framework (2004–09),⁷ Charter of Public Service for a Culturally Diverse Society (1996),⁸ National Public Health Partnership Guidelines,⁹ and the COAG

National Framework of Principles for Delivering Services to Indigenous Australians (2004).¹⁰ Private sector policies include standards for general practice,¹¹ and position statements for the medical profession as a whole.¹² By definition, if an Indigenous-specific health service is an ACCHS, it is intrinsically culturally appropriate¹³ (see chapter 1).

Having both a mainstream and complementary approach to provision of health care to the Aboriginal and Torres Strait Islander population is an important principle in setting the context for public health and primary health care services.¹⁴

Complementary health systems and programs for the Aboriginal and Torres Strait Islander population comprise less than 1% of the total Australian health budget¹⁵ (see chapter 1), and for 2.4% of Australia's population, this could never fully meet needs that are around 3 times higher than those of other Australians. These services therefore cannot *substitute* for the responsibilities of the health sector as a whole—a point that is commonly misunderstood. Thus, the responsiveness of mainstream health services and programs to the needs of the Aboriginal and Torres Strait Islander population is a key policy concern.¹⁶ In population health and primary health care, the mainstream health sector has explicit responsibilities to all Australians and especially to those that are disadvantaged or 'hard to reach'. This equity principle underwrites most population health policy frameworks.

HOW IS HEALTH POLICY DERIVED?

Policy making, for better or worse, is not an organised and systematic process. The policy decisions that are made (or not made) are influenced by many factors, of which only one is the quality and relevance of scientific evidence.¹⁷ It has been argued that 'science can identify solutions to pressing public health problems, but only politics can turn most of these solutions into reality'.¹⁸ It is fairly clear that research evidence should influence policy making,¹⁹ but the relative weighting of its influence over other matters is highly variable.

Health policy tends to be driven more by the values of the dominant society, historical influences, the availability of resources, political ambition, and personal perseverance, than by the scientific evidence.²⁰ Policy makers 'have to get something out of the research if they are to use it'.²¹ They often have to wait for a social environment or opportunity that is receptive to policy change, and this may be serendipitous.²² The evidence must be believed to be relevant to the context, with consensus in understanding and interpretation, and supported from agents of change (such as opinion leaders) and advocacy groups.²³ The evidence-based approach offers the transparency required for patients, health care providers, and the general public to weigh up the pros and cons of various health programs and services based on what is actually known and in the context of their local circumstances.²⁴

In this respect, it is fairly clear why, in the Australian context, health policies to address the known barriers to health care and the excess burden of disease faced by Aboriginal peoples are slow in development, incremental, or even cyclical. Aboriginal people (as a minority) and their advocacy groups do not exert sufficient market forces to induce change (there are no 'votes' in Aboriginal health), the research evidence is

selectively applied and often incorrectly and unfairly disputed, political ambition and the values of mainstream society favours maintaining the status quo, and there is a lack of transparency and partnership in decision making.

Importantly, the public perception of the Aboriginal population as 'undeserving' diminishes pressure for governmental solutions. At the time of the Asian tsunami in 2005, more than 3000 offers of support from a wide range of health care professionals were received by the Australian Government,²⁵ yet ACCHSs across Australia find it hard to fill positions with a substantial workforce shortfall.²⁶

Opportunities to refer research findings to the policy makers' table may be limited, but most significant is that the high turnover of staff in the relevant government departments, and their lack of experience and cross-cultural understanding, ensures that policy lessons from the past are overlooked (see chapter 1). Similarly, federal budget commitments that last only 4 years 'cools all but the most potent of temporary passions'.²⁷ Finally, a policy analysis vacuum is fostered where Aboriginal health services and their representative advocacy bodies remain unsupported in the development of new policy proposals.

While in Aboriginal health more than any other policy context the 'garbage can' model of policy development (where a loose collection of ideas see the light of day when circumstances are right) is most apt,²⁸ there are examples of research evidence having favourably influenced Aboriginal health policy. In 2007, the Pharmaceutical Benefits Scheme (PBS)²⁹ listed a new topical antibiotic for chronic suppurative otitis media—a disease that significantly affects Aboriginal children in remote regions at prevalence levels similar to those of underdeveloped countries (see chapter 8). It took more than 6 years for the National Aboriginal Community Controlled Health Organisation (NACCHO) to gather the evidence necessary for regulatory authorities to make this medicine available, over the potentially ototoxic alternative in use for over 2 decades.³⁰ This involved the conduct of primary research within Aboriginal communities and ACCHSs.³¹ This medicine was already approved in many countries around the world.

Other examples include the provision of free pneumococcal vaccines under Indigenous-specific strategies several years prior to broader free distribution.³² The subsequent reduction in invasive pneumococcal disease in the Aboriginal and Torres Strait Islander population vindicated this policy³³ (see chapter 5). Other examples include the provision of pharmaceuticals to remote area Aboriginal health services in 1999, which resulted in a 350% increase in medicines utilisation by Aboriginal peoples^{34,35} following an independent review³⁶ and intense support for reform from opinion leaders and advocacy groups (see 'Shaping policy options' below).

The lack of a treaty or legislated agreement with the Aboriginal and Torres Strait Islander population (unlike Indigenous peoples of New Zealand, the USA, and Canada) may help also explain the limited impact of research evidence on political will.³⁷ Without such an agreement, the will and obligation of policy makers to negotiate (which is a key influence in the policy process) is diminished.³⁸ In a context where the Aboriginal population is disadvantaged and lacks political clout, and where Aboriginal health and wellbeing is not high on the public, media, or political agendas, the evidence alone

is unlikely to lead to effective Aboriginal health policy or well-resourced Aboriginal health programs.

HEALTH INEQUITY AND POLICY

Aboriginal peoples and Torres Strait Islanders should access services and health care not just at a level enjoyed by other Australians (principal of equality) but at one that reflects their much greater level of health care need (principal of equity). Health inequities put populations who are already socially disadvantaged (through poverty, illiteracy, ethnicity, or other reasons) at further disadvantage with respect to their health³⁹ through institutional or other barriers to health services and programs. Achieving health equity involves eliminating the disparities in health (or its social and environmental determinants) between Aboriginal and non-Aboriginal Australians that are systematically associated with social disadvantage. Removing barriers to health care for those who are already disadvantaged are 'consonant with human rights principles'.^{40,41}

While the burden of disease suggests the Aboriginal and Torres Strait Islander population should be using more health services, in reality, they have less access than other Australians. For example, inequitable access by the Aboriginal population to the following health services has been documented: Medicare Benefits Schedule (MBS),^{42,43} Pharmaceutical Benefits Scheme (PBS),^{44,45} BreastScreen Program,⁴⁶ National Cervical Screening Program (box 2.1), Commonwealth Hearing Services Program,⁴⁷ kidney transplants,⁴⁸ cardiac rehabilitation programs,⁴⁹ National Immunisation Program Schedule,⁵⁰ hospital procedures,^{51,52,53} emergency thrombolysis therapy,⁵⁴ and general practitioner (GP) incentive programs (see chapter 10).^{55,56}

The reasons Aboriginal peoples and Torres Strait Islanders have reduced access to health care are multifaceted. They range from geographic and social barriers, institutional racism, poor policy development, public mistrust and lack of education, to racial discrimination by health providers. 'Hard to reach' populations are often blamed when conventional public health programs fail to improve their health status. Rather, they are often 'locked out' of meaningful participation in more appropriate program design and development.⁵⁷ An example of this is in the range of ways that mainstream programs and their policy instruments preclude Aboriginal women from benefiting from investments to prevent cervical cancer (box 2.1).

While health services alone cannot fully address differential health status,^{58,59} there is international evidence that primary health care is 'equity producing',⁶⁰ contributing to lower mortality and partially mitigating the association between socioeconomic factors (like income inequality) and mortality. Internationally, access to comprehensive primary health care is a significant determinant of lower mortality.⁶¹ In the USA, an increase in primary care resources in areas of high social inequality resulted in greater health improvements (lower mortality) than the same increase of primary care resources in areas of lower social inequalities. An increase of one primary care doctor per 10,000 population prevented 14 deaths per 100,000 population,⁶² and led to a 2.5% reduction in infant mortality and a 3.2% reduction in low birth weight (over the period 1985–95),

independent of income.⁶³ There is good evidence, therefore, that primary health care improvements can lead to improved health outcomes despite the existence of social inequalities.⁶⁴ Evidence has also shown that primary health care is cost-saving to the health system overall (see chapter 5).

Improvements in policy making are vital in order to more equitably distribute funding allocations to culturally appropriate primary health care. Australian expenditure on Aboriginal health services is less than 0.8% of the total federal health budget⁶⁵ with the shortfall in expenditure estimated at \$460 million per annum in 2006 (see also chapter 1).⁶⁶ Australia has available resources to meet this need⁶⁷ especially when measured against the type of spending evident for just one medicine. The cost of atorvastatin alone, a lipid lowering agent, exceeded \$510 million dollars in just one year (2005–06).⁶⁸

The absence of Australian health policy that commits governments to a reduction in social and health inequities has been noted by advocacy groups and the medical profession.^{69,70,71} All public health policy should be assessed for its potential ramifications on disadvantaged populations prior to adoption, an issue which is discussed later under 'Consultation'.

Box 2.1 INEQUITABLE MAINSTREAM POLICIES FOR CERVICAL CANCER PREVENTION AND RAMIFICATIONS FOR ABORIGINAL AUSTRALIAN WOMEN

Health disparity: Aboriginal women's cervical cancer mortality rate is 5 times greater than that of non-Aboriginal women.⁷²

1. National Cervical Screening Program: A \$100 million/annum nationally coordinated response to cervical cancer prevention where states are federally funded to operate cervical cytology registries, monitor screening policy, and work in partnership to promote biennial Pap test screening. States receive a loading for the proportion of Indigenous Australians in their jurisdiction. However:

- cervical cytology registers across Australia do not record Aboriginality and there is currently no system to monitor Pap screening coverage of Aboriginal women;⁷³
- funding agreements with the states do not require reporting of Aboriginal women's Pap smear coverage/participation rate;⁷⁴
- it is not possible to ascertain the proportionate program expenditure reaching Aboriginal women;
- cross-sectional studies indicate significantly lower Pap smear coverage in Aboriginal women than non-Aboriginal women.⁷⁵

2. Practice Incentive Program (PIP) Cervical Screening Incentive: 2001–02 (\$71.9 million to 2004–05), 2005–06 (\$31.6 million), and 2006–07 (additional \$97.2 million for four years) Federal Budget initiative for financial incentives to encourage general practitioners to take Pap smears from unscreened and under-screened women (those who have not received a cervical smear for four years or more and aged 20–69 years). Incentives also reward practices that reach an overall practice screening target. However:

- a significant proportion of ACCHSs were 'locked-out' of the program because of PIP ineligibility;
- independent evaluation showed incentives were not accessible to many ACCHSs and program expenditure was poorly targeted to those it was designed for;⁷⁶
- the evaluation failed to adequately investigate the programs reach to underscreened Aboriginal women;⁷⁷
- the evaluation report findings were withheld from the public;
- Senate Estimates information revealed, in 2004–05, there were only 279 claims under the cervical prevention PIP from Aboriginal medical services across Australia.⁷⁸ Claims from 33 services totalled \$9765 or \$296 each. Services reaching the screening target numbered 16 with payment of \$1666 each.⁷⁹

3. MBS Rebates for Pap smears (e.g. item 10994): Rebate for practice nurses taking Pap smear. However:

- rebates are only accessible to practice nurses and not Aboriginal Health Workers (AHWs);
- there is good evidence that AHWs play an important role in the taking of quality Pap smears in a context of cultural safety;^{80,81}
- AHWs outnumber practice nurses 2:1, and 90% of nurses are non-Indigenous (within ACCHSs).⁸²

Health and human rights

Australia reported to the United Nations General Assembly in 1998 that it had been committed to the Universal Declaration of Human Rights (UDHR) since its inception in 1948. Australia was an active participant in the original eight-member Drafting Committee, and occupied the Presidency of the General Assembly when the Declaration was passed.⁸³

While the UN Declaration and others like it are sometimes criticised as being ineffectual because governments are not subject to penalties for violations,⁸⁴ they do provide a set of aspirations to influence societal values, and ultimately, government policy. Seen in the context of the UDHR, action to reduce and eliminate the excess burden of disease suffered by the Aboriginal and Torres Strait Islander populations should have priority attention because this population has not attained the standards of health enjoyed by other Australians. However, there are significant anomalies in the nature and degree of respect Australians have shown towards the human rights of their own Indigenous population to the present day (table 2.1).

Linking health concepts with 'human rights' is increasingly being used by policy makers and advocacy groups to put increased pressure on governments to take responsibility for the health of their populations.⁸⁵ The challenge is to convert the rhetoric of human rights ideology into health policy that galvanises the health sector's responsiveness to populations that need it most.⁸⁶

There are, however, no examples of human rights instruments having enhanced political commitment towards better health for Indigenous Australians. The Australian

Government's disengagement with UN human rights bodies is well documented,⁸⁷ and non-government organisations (NGOs) are often not aware of or are unable to shadow government submissions to UN treaty bodies. Mechanisms to enable NGOs to formally submit their interpretation of government responses to the UN are in development.⁸⁸ In the meantime, UN instruments may represent a potential lever for improving resource allocation, but are actually more likely to alienate than activate Australian governments in the current political climate of economic rationalism.

International human rights instruments and health

A range of international human rights instruments⁸⁹ have influenced Australian federal legislation (in parentheses) and examples include: the Convention on the Elimination of All Forms of Racial Discrimination (*Racial Discrimination Act 1975*); and the International Covenant on Civil and Political Rights, Convention on the Rights of the Child, Declaration on the Rights of Mentally Retarded Persons, Declaration on the Rights of Disabled Persons, ILO Convention Concerning Discrimination in Respect of Employment and Occupation (*Human Rights and Equal Opportunity Commission Act 1986*).⁹⁰

The right to health was first outlined by Article 25 of the UDHR (table 2.1), followed by Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR, 1966). The ICESCR entered into force in Australia in 1976 and is the principle framework for the universal right to health.⁹¹ These instruments have no force in domestic law and thus their influence on health in Australia has merely been to act as a moral reference. Three instruments are described that have relevance to the health of Aboriginal peoples and Torres Strait Islanders.

INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS (1966)

In the ICESCR, the 'right of everyone to the enjoyment of the highest attainable standard of physical and mental health' (Article 12) was recognised in 1966. The steps required from Australia (as a party to the Covenant) to achieve the full realisation of this right include:

- a the provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child*
- b the improvement of all aspects of environmental and industrial hygiene*
- c the prevention, treatment, and control of epidemic, endemic, occupational, and other diseases*
- d the creation of conditions which would assure to all medical service and medical attention in the event of sickness.*

These steps were clarified in detail in 2000 by the Committee on Economic, Social and Cultural Rights (CESCR) to assist parties' implementation of the Covenant and their reporting obligations.⁹² In particular, the steps are to be 'progressively realised' (Article

2) according to the state's available resources. However, a 'State which is unwilling to use the maximum of its available resources for the realisation of the right to health is in violation of its obligation under Article 12'. Violations include 'insufficient expenditure or misallocation of public resources which results in the non-enjoyment of the right to health by individuals or groups, particularly the vulnerable or marginalised; the failure to monitor the realisation of the right to health at the national level, for example by identifying right to health indicators and benchmarks; the failure to take measures to reduce the inequitable distribution of health facilities, goods and services ... and the failure to reduce infant and maternal mortality rates'.

It is also a core obligation for parties to ensure equitable distribution of all health facilities, goods, and services. The CESCR clarified that 'Indigenous peoples have a right to specific measures that improve their access to health services and care ... States should provide services for Indigenous peoples to design, deliver and control such services so that they may enjoy the highest attainable standard of physical and mental health'. Access to primary health care is identified as a core obligation under the ICESCR.

Australia is obliged to submit reports every 5 years to the CESCR on how these rights are being implemented. The CESCR examines each report and addresses its concerns and recommendations to the state party in the form of 'concluding observations'.⁹³ In 2000, the CESCR's concluding remarks to Australia's Third Report were that:

In spite of existing guarantees pertaining to economic, social and cultural rights in the State party's domestic legislation, the Covenant continues to have no legal status at the federal and state level, thereby impeding the full recognition and applicability of its provisions... The Committee expresses its deep concern that, despite the efforts and achievements of the State party, the Indigenous populations of Australia continue to be at a comparative disadvantage in the enjoyment of economic, social and cultural rights, particularly in the field of employment, housing, health and education.⁹⁴

Although the ICESCR is comprehensive in scope on 'the right to health', reporting on these rights is easily overshadowed by the reporting required on other socioeconomic obligations. This is evident in Australia's Third Report to the CESCR under Article 12 pertaining to Indigenous Australians, which basically comprised the following:

medical services and low-cost pharmaceuticals are available to those who need them, with specific target groups (Aboriginal and Torres Strait Islander peoples, senior citizens and people with a disability) being able to access services which have been specifically tailored to their needs... Indigenous peoples have a statistically lower health status than the rest of the population, and initiatives are being developed and implemented, to reduce specific conditions and diseases which are prevalent among them.⁹⁵

The CESCR recommended that the next Australian report 'provide additional, more detailed information, including statistical data which is disaggregated according to age, sex and minority groups, concerning the right to ... health'.⁹⁶ Moreover, since 1991 the UN has provided guidelines for government reporting on Article 12 of the

ICESCR, which makes it very clear that quantitative data is required on resource allocation to primary health care, health status, and programs developed for population groups whose health situation is significantly worse than the majority.^{97,98}

This data has not appeared. The fourth Australian report for the ICESCR (2007) simply asserts that ‘while Aboriginal and Torres Strait Islander people are the most disadvantaged group within the Australian community, Australian governments are making headway in addressing health disadvantage’, followed by a short list of various government strategies. It states that Indigenous-specific programs ‘are in addition to other social benefits such as *universal health coverage* and income support, which are available to all Australians, and Indigenous programs and services funded by State and Territory governments’. The appended statistical data summarises the usual statistics on Indigenous health inequity but provides no quantitative information on relative expenditure.⁹⁹

INDIGENOUS AND TRIBAL PEOPLES CONVENTION (1989)

The Indigenous and Tribal Peoples Convention was adopted in 1989¹⁰⁰ by the International Labour Organisation (which is a UN agency) and draws on the ICESCR as well as other international human rights instruments. It is most relevant on the importance of community-control in health, but has not been ratified by the Australian Government (although Australia is an ILO member nation). Article 25 of the Convention states that:

Governments shall ensure that adequate health services are made available to the peoples concerned, or shall provide them with resources to allow them to design and deliver such services under their own responsibility and control, so that they may enjoy the highest attainable standard of physical and mental health. Health services shall, to the extent possible, be community-based. These services shall be planned and administered in co-operation with the peoples concerned and take into account their economic, geographic, social and cultural conditions as well as their traditional preventive care, healing practices and medicines.

DRAFT DECLARATION ON THE RIGHTS OF INDIGENOUS PEOPLES

In 1993, the UN General Assembly proclaimed the International Decade of the World’s Indigenous People, starting on 10 December 1994.¹⁰¹ The goal of the decade was to strengthen international cooperation for solving problems faced by Indigenous people in areas including health and to adopt a Declaration on the Rights of Indigenous Peoples. The UN adopted the Second International Decade of the World’s Indigenous People in 2004 and in June 2006 the UN Human Rights Council adopted the Declaration on the Rights of Indigenous Peoples and recommended its adoption by the General Assembly.¹⁰² In this Declaration the most specific reference to health are Articles 23 and 24, which state:

... Indigenous peoples have the right to be actively involved in developing and determining health, housing and other economic and social programmes affecting them and, as far as possible, to administer such programmes through their own institutions.... Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right.

During the last decade the Australian government concentrated effort around *not* adopting the Declaration, with concerns that adoption would undermine Australia's sovereignty and threaten political unity.¹⁴³ In 2006, 30 nations voted in favour and two against the Declaration (Canada and the Russian Federation),¹⁴⁴ while Australia, New Zealand, and the USA were absent. Allegations were made that the Australian Prime Minister lobbied the Canadian Government to vote against the Declaration.¹⁴⁵

World Health Organization

The World Health Organization (WHO) is the public health arm of the UN. Established in 1948, its aim is 'the attainment by all peoples of the highest possible level of health'. The WHO 1978 Alma-Ata (in the USSR, now known as Kazakhstan) Declaration on primary health care was adopted by almost every country in the world. It promoted a definition of primary health care which involved universal, community-based preventive and curative services, with substantial community involvement,¹⁴⁶ which was consistent with the model adopted by ACCHSs that predated the WHO declaration (see chapter 1). The WHO established goals and targets to the year 2000 on a global scale (for example, 5% of gross national product should be spent on health; at least 90% of children should have normal weight for age). However, there were many reasons why government enthusiasm for the initiative waned, the main reason being changes in ideology towards market driven health reforms. Governments now no longer commit to these goals.¹⁴⁷

Instead, the WHO's Millennium Development Goals (MDGs) to the year 2015, to which Australia is a signatory, were agreed in 2000 by 189 countries. These goals are largely directed at developing nations, and have a strong focus on rights to health. Goals include the reduction of child mortality (with indicators including the proportion of children immunised against measles).¹⁴⁸

It has been argued that the Australian and global commitment to these goals may be harnessed for Indigenous Australians to establish a set of Australian Indigenous development goals to 2015 and enhance accountability and transparency. Amalgamating the various parliamentary committees that look at Indigenous affairs into one major joint committee may be necessary.¹⁴⁹ Current Australian Governments, however, are less inclined to use 'targets', citing the need for sound baseline data which it is believed do not exist.^{140,141}

Table 2.1 The Universal Declaration of Human Rights (1948), some examples of Australian violations, and the impact on Aboriginal people's health

Articles of the Declaration	Situation of Aboriginal and Torres Strait Islander population
Article 2: 'Everyone is entitled to all the rights and freedoms set forth in this declaration, without distinction of any kind such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.'	Rights and freedoms for Aboriginal peoples were violated with respect to the Articles in this Declaration.
Article 9: 'No-one shall be subjected to arbitrary arrest, detention, or exile.'	Arbitrary arrests were a finding in the Royal Commission into Aboriginal Deaths in Custody ¹¹² (see chapter 22).
Article 13: 'Everyone has the right to freedom of movement and residence within the borders of each state.'	Freedom of movement was restricted to defined zones such as missions or reserves requiring permits for travel outside them. They were located in geographically isolated regions ('incarcerated for life, even for generations') ¹¹³ up until the 1970s.
Article 12: 'No-one shall be subjected to arbitrary interference with his privacy, family, home, or correspondence, not to attacks upon his honour and reputation. Everyone has the right to the protection of the law against such interference or attacks.'	Vilification and contempt on the basis of race was widely practised and promoted and used to justify policy. Officials in authority over Aboriginals used terms such as 'primitive'; 'children of impulse' ¹¹⁴ and widely acknowledged their 'revolt' over Aboriginal customs. ¹¹⁵ Pejorative stereotypes are promoted to this day with respect to unemployment, alcoholism, disease, and disadvantage apparent in mainstream popular media and espoused by those in positions of authority. ^{116,117}
Article 21: 'Everyone has the right of equal access to public service in his country.'	Access to public service was restricted and strictly controlled in missions and settlements (for example, wage control, inability to vote or receive social service benefits, lower 'Aboriginal' rates of pay, exclusion from control over contracts of purchase or sale, etc.). In addition, state legislation enacted in 1944 and repealed in 1971 enabled 'natives' to apply for 'citizenship' to become honorary whites in effect with all the associated privileges, through 'dissolved tribal and native associations.' ¹¹⁸ Today access to the public health care system is significantly less than other Australians—Medicare, Pharmaceutical Benefits Schedule, Commonwealth Hearing Services Program, National Health Strategies, General Practice Incentives, etc. ^{119,120,121,122}
Article 23: 'Everyone has the right to work, to free choice of employment, to just and favourable conditions of work, and protection against unemployment.'	Access to public service was restricted and strictly controlled in missions and settlements (for example, wage control, inability to vote or receive social service benefits, lower 'Aboriginal' rates of pay, exclusion from control over contracts of purchase or sale, etc.). In addition, state legislation enacted in 1944 and repealed in 1971 enabled 'natives' to apply for 'citizenship' to become honorary whites in effect with all the associated privileges, through 'dissolved tribal and native associations.' ¹¹⁸ Today access to the public health care system is significantly less than other Australians—Medicare, Pharmaceutical Benefits Schedule, Commonwealth Hearing Services Program, National Health Strategies, General Practice Incentives, etc. ^{119,120,121,122}
Article 22: 'Everyone as a member of society has the right to social security and is entitled to realisation ... of the economic, social, and cultural rights indispensable for his dignity and the free development of his personality.'	Assimilation policies were enacted in 1937, 1951, and 1961 ('White Australia Policy'). Forced assimilation and the policy of forced removal of half-caste Aboriginal children was a deliberate policy to breed out Aboriginality with devastating impact on the emotional and social wellbeing of those and current generations and continued through till 1984. ¹²³ Assimilation as policy is still advocated by some in significant positions of authority. ^{124,125,126}
Article 25: 'Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, food, clothing, housing, and medical care and necessary social services ...'	Living standards for Aboriginal peoples and Torres Strait Islanders are far worse than for other Australians, with significant levels of overcrowding, poor nutrition, and poverty. There is inadequate access to primary health care, with high rates of preventable diseases and diseases of poverty as seen in underdeveloped nations (see chapters 2, 7, 8, 9, 11, 12, 15, 17, 18, and 19). Obligations on the 'right to health' ¹²⁷ are not being met.

Articles of the Declaration	Situation of Aboriginal and Torres Strait Islander population
Article 30: 'Nothing in this Declaration be interpreted as implying for any State, group or person any right to engage in activity or to perform any act aimed at destruction of any rights and freedoms.'	Successive Australian Federal Governments have failed to apologise for human rights violations, ¹²⁸ explaining that previous policies were in the 'best interests of the Aboriginal population'. Australia's actions to 'protect' the Aboriginal population in fact caused them serious physical, social, and mental harm. Some state governments have since apologised to Aboriginal peoples for these past violations. ¹²⁹

Steps in the Australian policy process

An influence over health policy requires an understanding of the national policy development and implementation processes in Australia. The process can be described in various ways, but the following is a useful structure:

- setting the policy agenda
- policy analysis in order to frame options
- identifying appropriate policy instruments
- consultation around proposed policy
- coordination between government and agencies sharing interest
- ministerial decisions
- implementation
- evaluation.

This is not to suggest that the policy process is sequential or made up of a discrete series of steps. It clearly isn't,¹³⁰ but using a structure such as the above can help provide examples of where the policy process can help or hinder improvements in Aboriginal people's health.

SETTING THE POLICY AGENDA

Ultimately, government ministers decide whether an issue receives attention. As discussed previously, the range of influences on ministerial decisions is huge, from party political ideologies, to research evidence, to public opinion. Government policy, however, tends to coincide with public opinion, and as the vehicle for public opinion, the media has a significant influence in shaping policy direction. For example, intense media spotlight on incidents of child abuse occurring in Northern Territory Aboriginal communities fostered immediate measures from the COAG in a \$130 million Commonwealth funded package and a joint agency intelligence taskforce in 2006.¹³¹

The NSFATSIH has largely set the health policy agenda to 2013 and is an important blueprint for health sector investments and policy development. The Framework guides government responsiveness to the health of the Aboriginal and Torres Strait Islander population, and in particular commits to supporting 'adequately resourced' ACCHSs. The commitment to develop a methodology to determine the level of resourcing needs

and 'real costs of providing services' is also identified. There are, however, no targets and no mechanism established with Aboriginal representative bodies to explicitly determine the level of adequate resourcing.

There are many gaps in the NSFATSIH, and getting the attention of policy makers to address those gaps is not easy. For example, a national strategy to address acute rheumatic fever is currently lacking¹³³ (see chapter 12), and a move away from disease-based funding was used to justify this. The criticism of 'body-parts' funding for core primary health care was justifiable,¹³³ but a strategic and coordinated response to an endemic health problem like acute rheumatic fever is vital. Absent from the NSFATSIH, state and territory public policy responses to acute rheumatic fever vary considerably and there are gaps in national disease surveillance. Political leaders are now showing some interest in tackling this problem nationally.

The NSFATSIH sets the policy agenda for both Indigenous specific programs (often called 'ghetto funding' because large service gaps are funded through siloed and inadequate allocations – see chapter 1) and for the mainstream health sector to respond to the health needs of Aboriginal peoples and Torres Strait Islanders. However, it is usual for policy makers to treat Aboriginal people's health, and their access and equity issues, merely as afterthoughts to a policy process for broader population health initiatives.

An example is the provision of financial incentives to GPs in order to enhance the cervical screening coverage of women who are underscreened—an initiative driven by mainstream population concerns with no explicit attention to the population of Aboriginal and Torres Strait Islander women (box 2.1). Another example is the pandemic influenza planning agenda costing over \$600 million (to 2006) which neglects attention to Indigenous Australians.¹³⁴ Based on current levels of seasonal influenza (see chapter 5), a pandemic will disproportionately affect Aboriginal peoples and Torres Strait Islanders, but modelling such an impact and apportioning specific strategies have yet to be undertaken.

Use of the political process can generate attention to specific health issues, shift the agenda, and rapidly mobilise policy development. An example is the use of Senate Committees as part of the annual budget cycle to question government expenditure. 'Senate Estimates', as they are called, are an important mechanism for parliamentary scrutiny over the activity of public servants in government departments. The Department of Health and Ageing, for example, is under the scrutiny of the Senate Committee for Community Affairs. All documents received as evidence by the committees become public and the proceedings of public hearings are published in a transcript accessible to all. Public servants are expected to provide factual and technically accurate information to the committees, 'but are not expected to comment on policy—the advocacy and defence of government policies is properly the role of ministers'.¹³⁵

In this example, Senate questioning over the lack of asthma program expenditure for Indigenous Australians, and the revelation that 'coke bottles' were used as substitute spacer devices in remote Aboriginal communities,^{136,137} rapidly mobilised the development of an asthma spacers subsidy scheme for all Aboriginal peoples and Torres Strait Islanders attending Aboriginal health services in 2006.

Community bodies usually lack the resourcing and political influence to shift the political agenda and are vulnerable to reprisals from unsympathetic governments on whom they depend for funding. Public officials can often punish with impunity advocacy groups that lack power, because there is little risk of electoral retaliation from the group or the public.¹³⁸ Literature review has identified the characteristics of interest groups that best exert influence over the policy process (table 2.2).

Table 2.2 Organisational factors that influence the policy process¹³⁹

-
-
- Credible information on available policy options and their likely impacts
 - Recurrent interactions with policy makers (especially using policy entrepreneurs who are able to shape ideas and make them palatable to government)
 - Large and geographically dispersed membership
 - Group cohesion and unified positions on priority issues
 - Organisational resources such as staff size and expertise
 - Campaign funds and political intelligence
 - Strategic position in a policy niche and recognition as a coalition leader.
-

POLICY ANALYSIS

There are usually a number of ways in which a defined problem may be solved, or a proposal translated into policy that can be implemented. Governments may adopt broad policy positions or a set of principles in portfolios, but these do not usually provide enough information for detailed policy development. The public service, political advisers, or external consultants subsequently undertake a more detailed analysis that seeks to explore options and their costs and benefits.

Consequently, 'as with problem definition, shaping options imposes an ethical requirement on analysts to treat the alternatives fairly'.¹⁴⁰ Furthermore, seeking solutions to problems that require new laws, programs, or institutions rather than minor modification of existing programs (incrementalism) is resource intensive and, again, highly dependant on political commitment.

Incrementalism

'Issues that don't lend themselves to simplistic analysis and presentation are unlikely to find an audience.'¹⁴¹ The poor health of the Aboriginal population is the result of a complex intersection of factors for which the health sector alone is not responsible. This tends to perpetuate the incremental approach to health policy whereby Aboriginal interests are satisfied through the announcement of small-scale programs.

Although problematic, incrementalism does have a role. Significant policy innovations were achieved when it was realised that section 19(2) of the *Health Insurance Act 1973* could open up MBS funding for ACCHSs.¹⁴² Minor modifications to the existing MBS in 2004 enabled the introduction of new rebates for adult and child health checks in

the Aboriginal and Torres Strait Islander population.¹⁴³ When drugs needed for health problems faced predominantly by Aboriginal populations were not listed on the PBS, minor changes to approval criteria rectified this problem after lobbying by NACCHO and a coalition of support from other agencies.¹⁴⁴ From 2006, medicines have been provided through the PBS specifically for Aboriginal peoples such as antifungals, antibiotics for chronic suppurative otitis media, antihelminthics, and thiamine.¹⁴⁵ In 2005, minor adjustments to the eligibility criteria for the Commonwealth Hearing Services Program increased the accessibility of hearing rehabilitation services to 6000 Aboriginal Australians (although only 500 have had access so far—see chapter 8).¹⁴⁶

But, absent from the policy makers table are those policy options that demand commitment, such as addressing funding shortfalls in primary health care for Aboriginal peoples to the necessary level estimated by independent analyses (see ‘The way forward in Aboriginal health policy’ later in this chapter).

Other policy ideas may never see the light of day because political consensus is lacking or because the groundwork for implementation is too challenging. An example is the introduction of an incentive to at-risk Aboriginal and Torres Strait Islander families, not unlike the effective US Women Infant and Children (WIC) Program¹⁴⁷ or the UK ‘Healthy Start’ program.¹⁴⁸ Both programs provide voucher schemes for high-risk pregnant women and mothers of young children to access food (see chapter 7 for the evidence supporting a need to address malnutrition in Aboriginal children). Government representatives have not expressed interest in similar Australian schemes,¹⁴⁹ despite support from Aboriginal spokespersons,¹⁵⁰ preferring to offer highly popular ‘baby bonuses’ that provide *all new mothers* with cash benefits. Initiatives that hint at offering Aboriginal mothers something other Australians might not receive, even if to address the higher maternal and infant mortality of Aboriginal women and mothers, lack political appeal. The National Aboriginal and Torres Strait Islander Nutrition Strategy Action Plan (2000–2010)¹⁵¹ provided an agreed policy agenda for increasing food access, but is supported only by discrete small-scale projects unrelated towards addressing the currently high rates of child malnutrition in remote Aboriginal communities (see chapter 7).

Shaping policy options

The challenge for policy ‘entrepreneurs’¹⁵² is to seek policy alternatives that are expressed in such a way that they align with the priorities of political leaders and the public interest, while at the same time making health care accessible to those who most need it. Two examples illustrate this dilemma.

HEALTHY FOR LIFE INITIATIVE

The success of exemplar sites showed ACCHSs that were adequately resourced for maternal and child health programs reduced low birth weight and increased antenatal attendances,¹⁵³ and this helped to secure funding for further maternal and child health programs in the 2005–06 Federal Budget through the Healthy for Life (HFL) program. The HFL program was touted as a substantial innovation to enhance maternal and child health programs in 80 Indigenous specific services.¹⁵⁴ Whilst supplementing maternal

and child health care provision, this policy option was also shaped to align with political priorities towards services accountability.

The HFL program supports a fusion of initiatives including quality assurance mechanisms (requiring audits and the collection of clinical and health systems data), establishment of an external agency (for support, collation and analysis of practice level data nationally), data uploading to a new national data repository, and adult chronic disease support (such as for diabetics and those with cardiovascular disease), in addition to maternal and child health. As such, the contribution of the HFL initiative towards maternal and child health care provision is substantially whittled down. Thus, it might equally be defined as a program to build the data collection capacity of services for their quality enhancement and to make them more accountable to governments (see also chapter 7).

While it is vital to build the capacity of ACCHSs to collect and aggregate practice level data, the concern is that programmatic failure to reduce birth weights and other outcome indicators developed for this program may be deflected towards services rather than to problems with the choice of indicators or uncontrollable factors such as workforce shortages, significant client morbidity, and systems barriers to medicines access (see below). At the national level, appropriate Aboriginal governance over what data is to be collected, and how it is to be used and interpreted, is essential to build Aboriginal capacity and ensure legitimacy. In 2006, the Aboriginal Health and Medical Research Council in New South Wales outlined concerns with the ownership of data emanating from the HFL initiative and the need for submission of analyses for their vetting according to ethical and cultural criteria, prior to any public release.¹⁵⁵

Maternal and child health is a core component of primary health care, and thus HFL funding has been incorporated into the global budgets of services to secure similar benefits to clients as demonstrated by the exemplar sites (note 156). At the same time, health departments are now able to assemble practice level data from participating ACCHSs across Australia to act as quality assurance for the Australian Government (see also chapter 1 and 4).

PHARMACEUTICALS ACCESS IN NON-REMOTE AREAS

Enhancing access to the PBS by Indigenous Australians is supported as a policy agenda by government.¹⁵⁶ The evidence underpinning the policy agenda was the finding that expenditure through the PBS was much lower for Aboriginal and Torres Strait Islander people than other Australians,¹⁵⁷ in spite of a much higher level of illness.

Section 100 of the *National Health Act 1953* allows for the Minister for Health to approve special access arrangements where pharmaceutical benefits cannot be 'conveniently or efficiently supplied' by the usual means. Following lobbying by NACCHO and others through the Australian Pharmaceutical Advisory Council in the mid 1990s, an arrangement was devised that allowed approved Aboriginal health services in remote areas to order and issue medicines directly to patients in a partnership arrangement with community pharmacies that controlled for client co-payments.¹⁵⁸ The implementation of medications under what is called 'S100' for remote area Aboriginal health services was a major breakthrough in medicines access and is regarded as one of the most

important health policy achievements for many years.¹⁵⁹ The S100 scheme commenced only in remote areas in 1999, with 47 ACCHSs and 128 state- and territory-operated Aboriginal health services accessing medications by 2004.¹⁶⁰

As a result of the S100 scheme, medicines expenditure through the PBS increased by 350% in remote areas. In contrast, PBS benefits paid per Indigenous Australian in non-S100 regions (urban and rural) did not change over the same period (1998–2002).¹⁶¹ Moreover, PBS expenditures for Aboriginal people in urban and rural areas is now half that of Aboriginal Australians in remote areas (whereas the reverse is generally true for non-Indigenous Australians). In 2001–02, PBS per capita (Indigenous) spending was \$59.82 in urban and regional areas, but \$110.58 in remote areas.¹⁶² Per-capita PBS spending for Aboriginal people overall is only \$73.23 per person as against \$220.29 per person for other Australians (2001–02).¹⁶³ This conservatively amounts to a \$67 million underspend annually based on the national average (with a significantly higher shortfall if based on need). This underspend has been called the ‘missing millions’.¹⁶⁴

Aboriginal and Torres Strait Islander peoples have reduced access to medicines for a number of reasons. These include: a greater level of poverty than other Australians, the safety-net scheme (which caps pharmaceutical co-payments) being inoperable, more co-morbidity (higher family income spent on medicines), social obligations increasing patient mobility, children not often listed on guardian’s concession cards, prescriptions provided in a culturally alienating setting, lack of timely supply, cultural and literacy issues, lack of supports for continued use of medications, as well as geographic isolation.¹⁶⁵ The geographical limitations of the S100 scheme mean that this program provided improved access to only approximately 36% of Aboriginal and Torres Strait Islander peoples.^{166,167}

Whilst the Federal Government recognised that poor access by Aboriginal peoples to PBS medicines was not just a function of geographical remoteness, progress on what policy approach to take for non-remote areas was stalled for several years. The major policy players in the area (NACCHO, the AMA, and the Pharmacy Guild of Australia) advocated a simple solution: extend the S100 pharmaceutical supply arrangements for Indigenous Australians to those living outside remote areas.¹⁶⁸ While this approach was supported by the peak ministerial advisory body¹⁶⁹ the proposal was unacceptable to policy makers on the grounds that it might undermine patient co-payment principles and the viability of the broader scheme.

Controlling the cost of pharmaceuticals is an important goal for governments, and shifting the cost to the consumer in the form of co-payments is an important strategy to reduce demand.¹⁷⁰ But co-payments can decrease both appropriate and inappropriate use of prescription medicines.^{171,172} If the consumer’s view of and incapacity to meet the cost of the medicine outweigh the perception of benefits, co-payments reduce adherence. In addition, the imposition of ceilings to co-payments (as in the safety net) to protect heavy users or those with low incomes may not be uniformly effective (as shown for the Aboriginal and Torres Strait Islander population).¹⁷³ If there is no co-payment, scripts are more likely to be filled and used.¹⁷⁴

Several international studies have shown that adverse health outcomes from poor access to medicines may well negate any potential health system savings through co-

payments. Some have described this as ‘penny wise and pound foolish’.^{175,176,177,178} A longitudinal cohort study in the USA showed that increasing cost-sharing requirements led to low-income earners leaving their health programs, and skipping buying prescription medicines.¹⁷⁹ A cross-sectional survey from 38 US states investigated differences in drug use between persons residing in states with or without co-payments. It showed that even very small co-payments deterred drug use. Elderly and disabled clients with poor health (self-reported) had a 27% lower annual script use if residing in co-payment states than if residing in non co-payment states.¹⁸⁰ The authors argued that this reduction was unlikely to be limited to trivial and unnecessary drugs. For these reasons, several European countries exempt vulnerable patients from cost-sharing for pharmaceuticals.¹⁸¹

The current position in Australia is therefore that the broader political interest in protecting the integrity of the consumer co-payment principle (even if it is not in danger) outweighs interest in sound equity-generating policy proposals for Aboriginal Australians.

POLICY INSTRUMENTS

The range of instruments available for use by policy makers will define the way in which a policy objective is implemented by government. There are five main types of instruments (box 2.2) providing an alternative to the free market or ‘laissez faire’ health policy approach. These instruments can be used as levers to foster improvements in clinical practice, discourage inappropriate practice, and enhance health outcomes for the community. A number of levers can be used to achieve a single policy objective.

Box 2.2 FIVE MAIN INSTRUMENTS OF GOVERNMENT TO INFLUENCE THE DESIGN AND IMPLEMENTATION OF HEALTH POLICY

- 1 **Education**, for example: Nutritional, health, and anti-smoking strategies in primary and secondary schools, Aboriginal Health Worker training, teaching materials, consumer awareness raising campaigns, clinical practice guidelines.
- 2 **Taxes, subsidies and incentives**, for example: Community store food and freight subsidies, cigarette taxes, consumer subsidies for health hardware (stoves, refrigerators), financial incentives to health providers and consumers, Medicare rebate, subsidies for pharmaceuticals and vaccines, subsidies for health devices (for example, asthma spacers, supplies for diabetes).
- 3 **Regulation and legislation**, for example: Limiting alcohol purchases such as ‘grog free days’, limiting cigarette purchases through age restrictions, immunisation requirements for school-entry, GP standards, bilateral agreements, funding targets.
- 4 **Direct expenditure for services or infrastructure**, for example: Aboriginal Community Controlled Health Services, health workforce, community sport and recreational facilities.
- 5 **Research and development**, for example: disease registers and surveillance, national centres for issue-specific research.

Often, too much emphasis is placed on client education as a policy lever. Information alone may not be enough to result in a desired change of behaviour,¹⁸² nor does it take into account the social and environmental influences on a population's risk for disease. On the other hand, education campaigns for the Aboriginal and Torres Strait Islander population are often neglected. The Federal Government's asthma management program, for example, lacked consumer campaigns for this population despite several mainstream campaigns introduced between 2001–06, and despite greater levels of hospitalisation for asthma.¹⁸³

Health education campaigns and other information sources are most effective when associated with and supported by other strategies, including legislation and incentives. Health provider incentives have played an important role as a lever for improved provision of quality health care in the past few years, with some major successes. For example, the Federal Government invested in financial incentives to encourage GPs to promote and deliver childhood immunisation (General Practice Immunisation Incentive Program), leading to improvements in childhood vaccination coverage in Australia.¹⁸⁴ In the USA, financial incentives have increased coverage rates even when most health providers are aware of the benefits of childhood vaccination.¹⁸⁵

Incentives don't work all the time. In Australia, incentives for improved asthma management were complex and underutilised by GPs.¹⁸⁶ Incentive programs in Australia are almost always designed for the mainstream health sector, which often makes them less accessible to ACCHSs and the Aboriginal and Torres Strait Islander population (see box 2.1). ACCHSs have significantly less access to GP incentive programs and around a third have been excluded from such programs up front because of ineligibility^{187,188} (see also chapter 10).

In the USA, incentives for cervical cancer screening, mammography, and glycated haemoglobin measures tended to reward those who were already close to the performance threshold with little gain in health care quality for the money spent.¹⁸⁹ Incentives have a role but not if there is a common threshold. Reaching incentive thresholds is more difficult in practices with patient populations of low socioeconomic status.¹⁹⁰ This was evident in Australia for asthma¹⁹¹ and cervical cancer prevention incentives where even ACCHSs that were eligible failed to reach thresholds for outcomes payments (box 2.1).

The use of subsidies for pharmaceuticals and asthma spacers as examples were discussed earlier and other policy instrument examples are shown in box 2.2.

CONSULTATION

Aside from producing better policy, engaging with the potential beneficiaries of new health policy is essential in order for the policy to succeed.¹⁹²

In terms of the 'ladder of citizen participation', the vast bulk of health policy affecting the Aboriginal and Torres Strait Islander population is formulated at a level least inclusive of this community. A policy proposal is developed in confidence by government departments, it is announced (usually in the Federal Budget), a workshop or meeting is convened for informational purposes, and compliance from Aboriginal

peoples is then expected.¹⁹³ In some cases, Aboriginal representative bodies may then invest considerable time and effort to reshape these proposals, often with little or no action resulting from this investment.

Budget submissions are often encouraged from NGOs in order to influence government budget processes, but there is rarely open dialogue. The policy development process within government departments is usually invisible to the public and to groups that can best inform on what can ‘make or break’ successful policy.

Consultation may occur through public hearings to elicit formal responses to policy positions from those with an interest in Aboriginal people’s health. Government may undertake public inquiries such as through Senate Committees or the House of Representatives. An example of this is the Standing Committee on Family and Community Affairs inquiry into the health status of Indigenous Australians.¹⁹⁴ Government may conduct referenda, such as that held in 1967 (see chapter 1). Most commonly, however, government departments invite or appoint individual or representative body participation on consultative committees usually after the policy agenda and analysis has been undertaken, and only when advice is being sought on implementation.

How should Aboriginal people and their organisations be represented and consulted in health policy development and in implementation?

National health policy committees now generally include some Aboriginal representation. This appears to be largely an outcome of the funding of national and state/territory peak Aboriginal health organisations (NACCHO and its affiliates), as a consequence of Framework Agreement commitments. The resourcing of peak Aboriginal community controlled health organisations has greatly increased the capacity of Aboriginal peoples to engage in policy development and implementation processes.

Guidelines have been developed to provide advice to policy officers on what constitutes appropriate consultation and representation from Aboriginal peoples and their representative bodies such as ACCHSs.^{195,196} Only the government health departments in New South Wales and Western Australia have implemented these Aboriginal Health Impact Guidelines, which are to be used in the assessment of every new health policy.

Peak bodies from the ACCHSs sector are of the view that Aboriginal input on health matters should be sought through their structures. Their position is that the election of community representatives from the ground up at local, state/territory, and national levels ensures that those nominated by NACCHO and its affiliates speak with a mandate from their constituencies, and are held accountable to represent their views and report back. Dr Puggy Hunter, in May 2001, expressed the NACCHO position this way:

My advice to the Minister was that he can talk to whoever he wants, but at the end of the day, if you want real advice about Aboriginal health issues, then speak to those who have been voted by Aboriginal communities to represent them on health matters ... We’ve been around for a long time, and we’ll probably be around for a lot longer than the bureaucrats and ministers—they come and go.

Government departments, however, sometimes argue that not all Aboriginal communities or individuals are directly represented by the ACCHS sector, as many communities do not have an ACCHS, and some have an ACCHS that may not be accessed by all sections of the community.¹⁹⁷ However, it is entirely another matter as to whether such an argument entitles unelected government officials to determine who should represent those Aboriginal communities.

Moreover, no elected representatives from mainstream politics or from non-Aboriginal health organisations (such as medical organisations) have the support of or speak for all sections of their constituency, and this is not generally questioned. Members of consumer bodies such as the Consumers Health Forum are commonly appointed to represent diverse Australian society, and are rarely challenged on their legitimacy or their personal biases. Therefore, it seems that a greater standard of representation in consultation forums is often demanded from Aboriginal representative groups than mainstream groups.

It is widely acknowledged that policy decisions require 'partnership and ownership and cannot be achieved without consulting with and participation of all relevant groups'.¹⁹⁸ A partnership and collaborative approach to policy making can generate trust, promote sharing of resources and information, and build community capacity. Partnerships rely on interdependence, each partner bringing complementary resources to the relationship, as each cannot achieve alone what can be accomplished together.¹⁹⁹

Some strategies to foster consultation with Aboriginal communities and representative organisations are shown in box 2.3.

Box 2.3 DIRECTIONS TO ASSIST ABORIGINAL COMMUNITY REPRESENTATION IN POLICY FORUMS²⁰⁰

The task of Aboriginal representation in policy forums could be eased through:

- the provision of funding to peak bodies with a clear mandate from the Aboriginal and Torres Strait Islander community to support representation in strategy-development processes, including support for technical advice
 - nomination of one or more alternate representative(s) to allow flexibility in attendance at meetings
 - ongoing efforts by peak bodies to enhance the quality of internal consultation processes
 - ensuring that committees include individuals with appropriate technical or service delivery expertise in Aboriginal and Torres Strait Islander health (best identified through peak body networks)
 - the commissioning of peak bodies (or consortia led by peak bodies) to carry out research and consultation and provide reports that feed into national strategies.
-

COORDINATION

The policy process requires centralised government coordination before submissions are put to Cabinet, so that the government can develop mutually supportive rather than

incompatible policies. For example, for some time the Federal Government supported anti-smoking public health campaigns while subsidising tobacco farmers.²⁰¹ A whole-of-government response to a health issue is vital. All submissions to Federal Cabinet require appraisal by the Department of Finance and Administration, which manages the annual budget cycle and is responsible for sustainable whole-of-government finances. The need to coordinate policy initiatives in the many overlapping areas of responsibilities of the Commonwealth with states and territories adds to the complexity.

The health portfolio competes with other government portfolios for resource allocation. The Department of Families, Community Services and Indigenous Affairs (FACCSIA) is responsible for matters that are not immediately health related, such as employment and housing, and resources these in a single Indigenous budget. The Office of Indigenous Policy Coordination is a part of FACCSIA and aims to achieve coordination and foster cross-portfolio partnerships on matters pertaining to Aboriginal peoples and Torres Strait Islanders. The establishment of the Office is part of new Indigenous Affairs arrangement that promotes a whole-of-government approach to health determinants. At the regional level, this is achieved through Indigenous Coordination Centres (ICCs), which now represent the key point of engagement for Aboriginal communities to use in contributing to whole-of-government health planning and priority setting.

The COAG process also allows for state and territory governments (through bilateral agreements) to coordinate policy and program provision across the whole Indigenous affairs portfolio, and is the main mechanism for governments to support and enable action against socioeconomic health determinants. While important as a mechanism for enhancing jurisdictional coordination on health matters, few health initiatives for Aboriginal peoples and Torres Strait Islanders have been supported financially through COAG.

An example of a whole-of-government approach to health policy is the NSFATSIH and the commitment from all governments towards ACCHSs and the responsibilities of mainstream health to the Aboriginal and Torres Strait Islander population. However, such support on paper fails to translate into action. For example, funded mainstream national breast cancer screening and cervical screening initiatives consistently fail to bridge the gap in services to Aboriginal peoples and Torres Strait Islanders with neither penalties nor reforms (for example, see box 2.1). There is no funded national tobacco control strategy that specifically targets the Aboriginal and Torres Strait Islander population. The National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan²⁰² remains unimplemented except for one project officer and small-scale projects. Addressing unequal access to food supply, especially in remote Australia, has ramifications for the transport and freight industry. Nutritional improvements also depend on intersections with the education sector, exemplified by the 'free school fruit' and other breakfast initiatives for disadvantaged children in the United Kingdom and USA,²⁰³ but there are no such schemes operating in Australia (see also chapter 7). COAG funding to support comprehensive primary health care for Aboriginal peoples and Torres Strait Islanders is also lacking (see 'The way forward in Aboriginal health policy' later in this chapter).

MINISTERIAL DECISIONS

Ministers clearly set the agenda for the public service, but the public service can also set the agenda for ministers in the policy process.

Ministers are responsible for the submissions they bring forward to Cabinet or other Ministerial Forums such as COAG, developed out of the policy process outlined previously. Although ministers are under no obligation to accept the advice put to them by departments, public servants play a key role as policy shapers, and, to a greater or lesser degree (depending on the particular government and minister) tend to drive government policy. There is widespread agreement on the need for guidelines to assist public servants to deal with the dilemmas of health policy development and how it affects Aboriginal peoples, to address their generally limited experience in the delivery of health services, minimise the influence of their personalities and personal biases, and the problems with high departmental staff turnover.²⁰⁴

Ministers may dismiss policy proposals even if fully supported by ministerial advisory bodies, Aboriginal representative bodies and other NGOs, and public servants. The success or otherwise of a policy proposal is therefore subject to the vagaries of political leadership. A leadership that leans towards 'equal' (rather than equitable) treatment of disadvantaged groups, or that is concerned about voter backlash over perceived 'unfair advantage', may be unwilling to support health policies that target the needs of the Aboriginal and Torres Strait Islander population, even when these are based on best evidence. In such an environment, initiatives are likely to be incremental or maintain the status quo.

IMPLEMENTATION

Policy approved by ministers needs to be translated into action. There is some scope for initiative in the translation, subject to resource constraints, but mostly the development and analysis of policy proposals for a specific agenda set the scene for their implementation. Unfortunately, it is usually only at the stage of advising on the implementation of a health policy initiative that the Aboriginal community typically gets an opportunity to provide input (and this is where most of the effort of Aboriginal representative organisations ends up being directed).

Population health policies within the mainstream health sector that fail to reach the Aboriginal and Torres Strait Islander population owe their failure not only to inappropriate program design and choice of policy instruments but also to poor implementation. The failure to incorporate the values and aspirations of Aboriginal peoples in the policy process leading up to implementation means that considerable effort is required to shape preconceived program initiatives so that Aboriginal people benefit from the policy during its roll-out. One example is the GP incentives program previously described where efforts to alter formulae for incentives payments that could be more meaningful to ACCHSs proved too difficult. In the end, a small proportion of program funding was 'carved out' for ACCHSs to use in specific short-term projects,²⁰⁵ but the

flaws inherent in the incentives policy remained. As expected, the incentives program is ongoing, but the short-term project grants have expired.

On the other hand, implementation of some policies are so straightforward, it is a wonder they were not approved earlier. Examples include the PBS reforms that allowed for the listing of medicines predominantly needed by Aboriginal peoples and Torres Strait Islanders because of diseases uncommon in other Australians (see earlier). Through the PBS, remote-area services were immediately able to access these medicines for clients under \$100, and all that was required to implement this policy was a public announcement.

Additional resourcing and enabling strategies may also be required for new policy initiatives. Examples include supports required to enhance the uptake of new MBS rebates such as the adult health check. The lack of an implementation strategy (relying on public announcement alone) to accompany the rebate explains the slow rate of claims. Implementation strategies require interagency initiatives to increase consumer demand for an adult and child health check and mechanisms to approve such claims for health professional development recognition.²⁰⁶

A very common problem in the Australian setting is the 'resource-free' policy—one that involves merely restructuring existing programs, and often applied inappropriately to health policy targeting Aboriginal peoples (as if cost-cutting was necessary in an environment of inadequate expenditure). Examples currently include the National Service Improvement Frameworks for diseases which are national priorities, such as diabetes, asthma, and cardiovascular disease. All these frameworks recognise Aboriginal peoples as disproportionately affected by these diseases, and outline gaps and critical intervention points for the health sector, but none are actually funded (see chapters 14, 10, and 13, respectively). The expectation is that they inform service efficiency within existing resources.

Often policy ends up being resource-free when (contrary to public expectations) funds are not allocated towards service delivery, but are diverted into other activity. An example is the federal 'smoking in pregnancy' budget initiative (2005–06) that was intended to encourage doctors, midwives, and Aboriginal Health Workers to give advice to pregnant women (especially Aboriginal women) about the damage caused by smoking.²⁰⁷ In the roll-out of the program, all funds were expended in literature reviews, guidelines, and research programs.

EVALUATION

Evaluation of health policy is important to assess if the policy worked and if the policy was implemented appropriately. It is vital for accountability in the policy process and to argue for further resourcing.

Clearly, 'an easy way for governments to escape accountability is to deny people the information needed objectively to judge success or failure'.²⁰⁸ One way to do this is to evaluate if the policy initiative targeted disadvantaged groups, but not publicly release

the findings. Senate estimates can be used to source such information, as shown in box 2.1. Another way is by not evaluating if the policy initiative targeted disadvantaged groups, even if the policy initiative was meant for those groups (see also chapter 8 for other examples).

For example, in 2003 the Review of the 4th HIV/AIDS Strategy,²⁰⁹ which specifically targeted Aboriginal peoples and Torres Strait Islanders,²¹⁰ made the following comment:

The Review panel does not have the capacity to explore in detail the impact of the HIV/AIDS strategy on Indigenous Australians health and on the delivery of population health programs in Indigenous communities (page 58).

The National HIV/AIDS strategy is a mainstream population health program *for all* Australians under the bilateral agreements with state and territory governments. The terms of reference of the Review identified that it was to investigate the responsiveness of the strategy to Aboriginal peoples and Torres Strait Islanders. The Government responded with:

The government will refer this recommendation to the new ministerial advisory committee for consideration in the context of developing a new national HIV/AIDS strategy (page 48).²¹¹

The evaluation of this strategy showed how mainstream government programs often fail to meet their responsibilities to Aboriginal peoples and Torres Strait Islanders (despite their being a population target) and how such failures tend to be 'glossed over' or concealed. The approach often taken by state governments is to assume that complementary Indigenous programs (where they exist) are responsible for all health matters that pertain to Aboriginal peoples, when these were never meant to be the sole source of funding. In this instance, the responsiveness of the health system to sexually transmissible infections affecting Aboriginal peoples was left up to the National Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy, which is small-scale yet with a very broad agenda (see chapter 16). Moreover, state governments have legislative responsibilities towards communicable disease control within their populations. What is particularly unfair is that states and territories also receive additional financial loadings for the Aboriginal population in their bilateral funding agreements with the Commonwealth. The result is cost-shifting for services by states onto federal small-scale Indigenous-specific programs and ultimately to the ACCHSs at the end of the funding line. Without an evaluation process to examine these circumstances, it is a lose-lose situation for those services.

The HIV/AIDS strategy is one of the programs where any federal funding is 'broad-banded' under the Public Health Outcome Funding Agreements (PHOFA)—along with breast screening and cervical screening programs, tobacco, and alcohol programs for all Australians.²¹² Being broad-banded means that there are no tied funding agreements and accountabilities with the Federal Government, and no dollar for dollar matching.

Funding goes into consolidated revenue and is expended according to the jurisdictions' priorities, provided there is commitment to and reporting on agreed outcomes. Outcomes measures, however, do not specify (for example) participation targets for Aboriginal women in cervical screening. So, it is not surprising that Aboriginal women's participation rates in screening continue to be below those for other women and remain unchanged from year to year (see chapter 5). Moreover, expenditure reports for the PHOFA do not identify the funds expended for Aboriginal peoples as no stratification of population expenditure is provided.²¹³ (See also chapter 1 for historical examples of the effect of consolidated revenue failing to reach Aboriginal peoples.)

Evaluations of federally funded state/territory government programs are commonly criticised because there appear to be no 'penalties' for failure to meet the needs of Aboriginal peoples. Penalties are, however, paid by services that often have their funding withdrawn if evaluations prove that programs did not deliver expected outcomes. Government may also impose arbitrary indicators of performance for ACCHSs, for example, that are neither consistent, valid, nor feasible and which may distort priorities in implementation.²¹⁴ These include unrealistic expectations that projects should measurably improve health status²¹⁵ or impose premature evaluations that do not allow sufficient lead-time for programs to have had measurable impact. In addition, there is a generally overregulated reporting environment for ACCHSs that contrasts with those for other organisations. ACCHSs, for example, are required to report 6-monthly under the Service Development and Reporting Framework (SDRF) to OATSIH, in addition to annual financial reporting, annual Service Activity Reporting (SAR), and other program-specific initiatives (for example, Healthy for Life). Because funds are usually inadequate, ACCHSs are often also providing reports for various state government grants,²¹⁶ to external agencies, and philanthropic bodies. In some cases, ACCHSs are providing more than 30 reports annually to government bodies. Clearly, there needs to be a rational balance between reasonable accountability in relation to government funding grants and the level of administrative burden imposed by such accountability mechanisms.

Finally, recently developed health performance frameworks (HPF)^{217,218} measure health status to gauge Aboriginal people's health improvements over time, including select health determinants and some health systems. The Aboriginal and Torres Strait Islander HPF that has been agreed to by the Australian Health Ministers' Advisory Council (AHMAC) is an important adjunct to measuring progress with the NSFATSIH, but it is difficult to see how it may be used to promote equitable health service delivery from the mainstream health sector. For example, while the burden of Aboriginal children's hearing loss is a measure in the HPF, Federal Government expenditure towards hearing services provision as a response to this problem is not.²¹⁹

There are no targets whatsoever in the HPF for the responsiveness of health systems. Per capita expenditure on primary health care disaggregated by Indigenous status is identified in the HPF, but targets for the optimal level of expenditure are not. Targets are useful to quantify the expenditure required for health improvements—including in measures such as population to health workforce ratios.

The way forward in Aboriginal health policy

While there is debate over many aspects of Aboriginal health policy, there are some key policy planks for which the evidence is so overwhelming that they are beyond argument. This section summarises some of the key issues in Aboriginal health policy: health determinants; primary health care resourcing; Aboriginal health workforce; and legal options for mandating change. The need to enhance the responsiveness of the mainstream health sector has already been discussed.

ADDRESS HEALTH DETERMINANTS

There have been some gains in the health status of Indigenous Australians, such as reductions in infant mortality from the 1990s (see chapter 3), although significant health disparities persist. In large part, these disparities are directly attributable to the relative and absolute deprivation faced by Aboriginal peoples and Torres Strait Islanders regarding housing, education, employment, social services, and other determinants of health.

The dominance of social and environmental factors in the determination of health status is now widely recognised.^{220,221,222} The principal barrier to addressing these is the fact that most key Aboriginal health determinants (such as public housing, education systems, land tenure, policing and justice systems, essential service provision, industry policy, and exploitation of natural resources, etc) lie in the domain of state/territory and local government responsibility.

In a competitive federal system of government, no one jurisdiction is keen to shoulder responsibility for the cumulative product of neglect.²²³ The cost of bringing health hardware (housing, water, sewerage) to acceptable minimum standards in Aboriginal communities was estimated in 1998 at \$4 billion.²²⁴ A staggering 80% of two- to three-bedroom dwellings in Australia in which 10 or more people live are Indigenous households (from 2.4% of the population).²²⁵ The national housing indicators report for 2003–04 identified a need for 38,377 additional bedrooms in Indigenous households nationally to achieve a standard occupancy benchmark.²²⁶

States and territories, being vulnerable to pressure from property, pastoral, mining, and development interests, tend to lack the will to address inequity if it impinges on these interests.²²⁷ The result is 20 years of what has been described as ‘duck-shoving between the Commonwealth and States in terms of responsibility for Aboriginal people’s health’²²⁸ and a ‘trail of accountability [that] has consistently stopped at State borders’.²²⁹ The House of Representatives report from 2000, noting the ‘enormous unmet need’ in relation to housing and infrastructure, also noted that ‘... were this situation to have developed overnight, a state of national emergency would be declared’.²³⁰

Notwithstanding decades of information, the Federal Government declared (prior to the federal election in 2007) that an ‘emergency’ existed in NT Aboriginal communities following child sex abuse reports, and imposed defence personnel and visiting health teams. Australian and international experience strongly suggests that a dominant Federal Government role is required—through direct community-level funding of Aboriginal

health and infrastructure programs on a large scale and/or watertight accountability mechanisms for state and territory governments linked to funding.^{231,232} The ‘emergency response’ is still evolving, and may or may not deliver the level of resources needed.

Some Federal initiatives are promising. In 2001, Australian housing ministers endorsed a 10-year plan for Indigenous Australians’ housing that focuses on addressing unmet housing needs.²³³ The National Reporting Framework for Indigenous Housing (2003) was developed by all states and territories and the Commonwealth to assist in the assessment of the 10-year plan and comprises 38 performance indicators for national reporting on Indigenous housing.²³⁴ The ICCs established across Australia also aim to assist in the implementation of a range of housing initiatives designed for Aboriginal peoples²³⁵ (see also chapter 11).

In 2003, COAG endorsed and committed steps towards ‘Overcoming Indigenous Disadvantage’ using a framework that identified strategic health determinants and, from those, seven strategic areas for action.²³⁶ These action areas include:

- early childhood development and growth
- early school engagement and performance
- positive childhood and transition to adulthood
- substance use and misuse
- functional and resilient families and communities
- effective environmental health systems
- economic participation and development.

Bilateral agreements with states and territories to deliver various initiatives (not directly linked to the action framework) are underway. Current insights, however, reveal serious concerns about the effectiveness of some of the ‘whole-of-government’ policy initiatives, such as through the COAG trials. For example, a leaked evaluation report on one of the COAG trial communities revealed a failure to provide the agreed level of housing needed: only four houses were built over 3 years—meanwhile 15 others became uninhabitable in an expanding community with 200 babies born in that period.²³⁷

FUND COMPREHENSIVE PRIMARY HEALTH CARE

A key indicator of government commitment to achieving equity in health care is the level of resources applied that are commensurate with health care need. In 2004, analysts commissioned by the Australian Government reported that given excess morbidity, population distribution, and other factors, health care spending for Aboriginal peoples and Torres Strait Islanders should be about 2.2 times higher than that for non-Indigenous (\$5573 versus \$2518 per capita). It was also recommended that funding for Indigenous-specific primary health care services should be of the order of \$1244 per capita.²³⁸ In reality, only \$306 per capita was expended through such services by OATSIH in 2001–02.²³⁹

Expenditure towards ACCHSs does not offset the underspend on primary health care for Aboriginal peoples and Torres Strait Islanders. If spending on ACCHSs, Medicare, pharmaceuticals, dental, aids/appliances, patient transport, related public health activities, and non-admitted hospital services (from all governments) is considered, spending was

only 23% higher for Aboriginal peoples or Torres Strait Islanders compared to non-Indigenous Australians (2001–02).²⁴⁰ Also, these figures did not include spending on other primary care programs that few Aboriginal peoples access such as Divisions of GP (\$132 million per annum, 2003–04)²⁴¹ and the Practice Incentive Program.²⁴²

Moreover, the gap is not closing: during the 4-year period to 2001, growth in health care spending was higher for non-Indigenous Australians (18.8% compared to 16.9%).²⁴³ Economic analysis has estimated the shortfall in expenditure for primary health care services to Aboriginal peoples in 2006 to be of the order of \$460 million per annum and this excludes the cost of additional workforce training needed and health services infrastructure.^{244,245} This is the cost incurred in providing Medicare services to the level required, medicines that are not currently being provided, and dental services and medical consumables including appliances that cannot currently be accessed.²⁴⁶

The underresourcing of Aboriginal primary health care (and ACCHSs particularly) is not helped when politicians misuse financial data. For example, there is repeated reference to per capita health sector spending that is '18% higher' for the Aboriginal and Torres Strait Islander population²⁴⁷ (\$1.18 per person for every dollar spent on non-Indigenous Australians), without qualifying that half of this is hospital spending (often because poor access to primary health care means less early intervention, and emergency departments being used for primary care needs). There are also substantial cost-disabilities relating to remoteness—two-thirds of the total spending on in-hospital care for Indigenous Australians is in remote and outer regional areas (where half the population live).²⁴⁸ Furthermore, a significant proportion of the inpatient expenditure arises from costs associated with kidney dialysis and reflects the burden of kidney disease in Aboriginal communities. That is to say, the additional health expenditure results from costs associated with clinically necessary treatment and not from any kind of largesse on the part of government.

A transparent, needs-based mechanism for funding Aboriginal primary health care is still to be developed. Federal funding of these services continues to be historically based; there is no transparent, needs-based mechanism to allocate funding according to population needs. Research on a resource allocation formula (resources per head with a deflator applied to reflect burden of disease, diseconomies of scale, geographical isolation, etc) was recommended in the National Aboriginal Health Strategy in 1989²⁴⁹ and early work was undertaken on behalf of the National Health and Medical Research Council in 1995.²⁵⁰ OATSIH also attempted funding reform with a limited formula element at a service level when 'rebasin'g Aboriginal health service funding in 1995–96.

The NSFATSIH prioritises a resourcing agenda (see earlier), but according to the NSFATSIH, resources are to be built up progressively to build service capacity. In effect, according to this policy agenda and the position of the Australian Government,^{251,252} Aboriginal health services are not ready to be adequately resourced to meet the health needs of the Aboriginal and Torres Strait Islander population. While this approach has some similarity with the 'progressive realisation' principle in the human rights agenda, this was meant to acknowledge resource constraints in developing countries,²⁵³ not wealthy nations like Australia. The quantum and slow pace of 'progressive realisation'

in Australia is not in keeping with the manifest urgency for action.²⁵⁴ Withholding investment in primary health care capacity because the funded base to build upon is not there creates an unethical 'catch 22' situation.

At an individual health service (rather than regional) level, resource allocation formulae are more problematic. No validated funding models have been developed in the primary care sector that can be based on diagnosis-related groups (unlike case-mix funding in the acute hospital setting). In the Australian context, where patients are not 'enrolled' in a practice, capitation models are hamstrung by arbitrary geographical boundaries, and difficulties in recognising regular versus itinerant clients.

The federal government's Primary Health Care Access Program (PHCAP) has been the most substantial policy initiative in needs-based regional funding of Aboriginal primary health care. The initiative arose from work undertaken by a joint NACCHO and Commonwealth Health Department Aboriginal health financing working group in 1996–97. PHCAP was to progressively replace inadequate historical grant funding with a mechanism to pool state/territory and Commonwealth primary health care resources at a regional level, topped up to an agreed per-capita funding benchmark and based on regional-level planning and partnerships.

While the PHCAP initiative was funded for \$78.8 million for four years from 1999, it required ongoing appropriation of funding through the Cabinet or COAG budget processes for continued roll-out. A handful of regional funds-pooling models were established by mid 2003 but only around \$20 million had been allocated for service delivery—largely because of wrangling between governments over funds-pooling. In spite of concerted effort by the Department to build a case for more substantial investment in the program (see commissioned reviews)²⁵⁵ as well as lobbying by others,²⁵⁶ only \$40 million over four years was approved in the 2005–06 Federal Budget (the second quadrennium).²⁵⁷ As a result, the pooled, capitation-based financing model upon which the program was predicated has been largely abandoned. PHCAP funds are now used for ad-hoc service expansion according to regional and state planning priorities. Additional funding also appears likely to be conditional on Aboriginal health services being able to demonstrate health gain from their improved service delivery (for example, initiatives developed under the Healthy for Life program). (See also chapters 4 and 23.)

In May 2006, the Australian Government released its second whole-of-government Budget in Indigenous Affairs. Of the \$3.3 billion for Indigenous programs, only \$500 million was new funding²⁵⁸ and less than 15% of this was directed to the health care sector in some form. None of the funding was allocated to Aboriginal health services.²⁵⁹ An amount of \$39.5 million was allocated (to 2010–11) for 'brokerage' to urban and regional primary health care services, consistent with the Australian Government's focus on enhancing mainstream services access for Aboriginal peoples and Torres Strait Islanders.²⁶⁰ The premise was that referral agencies can enable Aboriginal peoples to access existing services by brokering the process, although there is a lack of evidence for the effectiveness of this approach.

The lack of inclusion of access to comprehensive primary health care as a pillar in the 'Overcoming Indigenous Disadvantage' COAG framework may be an important

oversight, as this underpins influences across all other identified action areas. Consequently, there is no imperative for COAG to report on progress in this matter.²⁶¹

Aboriginal health investment should take a community development and capacity building approach, and include funding for the development of structures to support community participation and advocacy in health, community-driven needs analysis and program planning, development of funding proposals, training and management support, and so on. Local employment and training should be promoted and measures to keep health funds circulating in communities should be applied.

BUILD AN ABORIGINAL HEALTH WORKFORCE

A national position on Aboriginal health workforce policy was endorsed by AHMAC.²⁶² It identified the need to: increase the number of Aboriginal people working across all the health professions; strengthen the position of Aboriginal health workers (AHWs); improve training, recruitment, and retention of health staff working in Aboriginal primary health care services; and explore the role of other health workforce groups contributing to Aboriginal health.

The Productivity Commission landmark report on health workforce was released in 2006. In relation to Indigenous Australian's health, the Commission noted the AHMAC framework and lent support to widening the scope of practice of AHWs and others providing services to this population. Support was also given to broaden Aboriginal people's and Torres Strait Islanders' participation in health workforce through local training, recognition of prior learning, and on-the-job training and adequate training wages.²⁶³

Increasing the number of Aboriginal people entering health professions is a key policy objective. With a few notable exceptions, the entry of Indigenous Australian students into undergraduate health courses has been disappointing and relates to many factors underlying educational disadvantage, including poverty, remoteness and negative experiences in often underresourced schools. While there is a trend to improved retention of Indigenous Australian students to year 12 (up to 39.5% in 2004) this is only half the retention of non-Indigenous students.²⁶⁴ The problems start at primary school: some 40% of Indigenous Australian students did not meet national year 7 reading benchmark tests in 2001.²⁶⁵

Indigenous Australian registered nurses (RNs) comprised 0.4% of the RN workforce in 2004.²⁶⁶ Anecdotally, the centralisation of nursing education with the transition to university programs in the 1980s had a disproportionate impact on access to nursing by Aboriginal people in regional areas. Indigenous Australian doctors numbers are smaller still—but growing. There were around 90 such doctors in 2007²⁶⁷ (0.2%), up from 35 in 2000.²⁶⁸ There are a range of initiatives through the NSFATSIH and other programs to enhance the recruitment and successful completion of nursing and medicine by Aboriginal people, supported by groups such as the Australian Indigenous Doctors' Association (AIDA)²⁶⁹ and the Council of Aboriginal and Torres Strait Islander Nurses (CATSIN), OATSIH²⁷⁰ and NACCHO. The task is substantial: to achieve numbers pro-

portional to population share, it was estimated that for 2001 the following Indigenous Australian professionals were required: 928 doctors, 149 medical imaging professionals, 161 dentists, 2570 nurses, 275 pharmacists, 119 occupational therapists, 59 optometrists, and 213 physiotherapists.²⁷¹

Recruitment and retention of a general medical workforce to meet the Aboriginal population's needs requires greater support if doctors are to be available in ACCHSs and in rural and remote areas. According to state registration data, there were 299 doctors working in Aboriginal health services in 2004 (0.5% of the total number of doctors working in primary care).²⁷² Conditions of services for health professionals working in Aboriginal health services often compare poorly with other jobs in hospitals and private practice.^{273,274} Competitive conditions of employment and satisfying career options are key policy considerations for those working in Aboriginal health services.

While the history of lay Aboriginal health assistants goes back many decades in the health sector, the development of Aboriginal Health Work as a profession has paralleled that of ACCHSs that have championed AHWs as key members of the health team. National policy documents continue to highlight the importance of the AHW role in addressing Aboriginal people's health issues.^{275,276,277,278}

Policy efforts to improve the training, status, and conditions of employment of AHWs have tended to overlook the fact that there are established Aboriginal primary health care practice roles for AHWs in some areas (particularly northern, central, and Western Australia), while semiskilled liaison and brokering roles have predominated in others (particularly in government health services). Because of this variability, national efforts to 'standardise' training, scope of practice, or conditions of employment have risked diminishing these for skilled Aboriginal primary health care practitioners. The development of national 'competencies' in 1996, which were vaguely worded with clinical skills optional, were a case in point.²⁷⁹ The latest national commitment to improve the lot of AHWs is an important opportunity to get it right.²⁸⁰ The 'Aboriginal and Torres Strait Islander national health workforce strategic framework' commits Australian governments to implementation of new national competency standards and qualifications that 'support comprehensive primary health care practice roles at various levels and distinguish these from other vocational streams currently encompassed by the term 'AHW'.²⁸¹

Statutory registration for AHWs to safeguard standards exists only in the Northern Territory (despite all governments agreeing to examine the issue in 1991²⁸² and again in 2002²⁸³). This leaves AHWs vulnerable to the vagaries of federal and state/territory government training and workforce and financing policies and to pressures for recruitment among training providers. For example, the expansion of funding under the MBS to subsidise AHW services such as wound care and immunisation, although an important initiative, is limited to *registered* AHWs (that is, the Northern Territory only). There is no present indication that other states are planning to introduce registration schemes for AHWs, so the differential distribution of MBS payments may persist for some time. Alternatives to statutory standards mechanisms have been suggested (for example, through professional 'certification'—the strategy used by Physician Assistants in the USA during their establishment phase).²⁸⁴

EXPLORE LEGAL AVENUES

In the absence of political will to deliver resources, legal means can be used to mandate a minimum standard of health hardware. While the legal construct of *terra nullius* was eventually exposed as a 'travesty of fact and a fallacy of law'²⁸⁵ by the High Court, lesser known legal impediments impact on Aboriginal communities, particularly those in remote and rural areas.

The passage of the *Public Health Act 1848* in England was a seminal moment in the history of public health and was able to deliver, in a relatively short period of time, reliable quality drinking water and efficient removal of sewage with a substantial public health impact.²⁸⁶ The direct flow-on benefits included the development of local government with core responsibilities for maintaining a healthy living environment. As noted at the time, 'comfort and convenience can be foundations of concept of dignity and agency, and [that] they are among the structural changes that can give people the sense of power to act, individually or communally, to improve their health'.

A number of legal contortions have seen the application of public health law in Aboriginal communities frustrated—most of them have not been fully tested in the courts. They include the claim that public health laws do not apply, as the Aboriginal community may be on 'non-rateable' Crown land; or that the land is owned and the housing purchased by government departments, which, as agents of the Crown, are not bound by their own laws.

The latter has been taken as far as the Supreme Court in Western Australia in relation to Mardiwah Loop community near Halls Creek. The Shire initiated action against the Minister for Health for failure to apply 1911 *Health Act* standards in constructing makeshift shelters on state-managed land. The Shire lost the case on the basis that the 'Crown did not bind the Crown'.²⁸⁷ The result is legal precedent that health hardware that meets nineteenth-century standards is denied to many Aboriginal communities on the basis that responsible government agencies are exempt from their own public health laws.

The probability that state government liability for such inequities may arise from the Federal *Racial Discrimination Act 1975* has been noted,²⁸⁸ but not tested in the courts. A High Court case (where a local government was successfully sued, in spite of having technically discharged responsibilities, for failure to follow up with the action required to prevent a fire) suggests that a common-law duty-of-care *arises from* statutory obligations regardless of the letter of the law.²⁸⁹ One of the only reviews of the legal responsibilities of government to Aboriginal communities in provision of essential services concludes that a defence based on the Crown not binding the Crown with regard to public health law would be unlikely to survive serious legal challenge.²⁹⁰

The application of public health legislation (and enforcement of any associated common law duty-of-care), as well as remedies available under the *Racial Discrimination Act 1975*, remain an important and largely unexplored means of improving Aboriginal health status by mandating the discharge of government responsibility.

Conclusion

An understanding of the health policy process can assist Aboriginal communities, service providers, politicians and public servants to improve efforts to address inequitable government expenditure. Unlike other comparable developed nations, there has been a general lack of political commitment to improve health outcomes of the Aboriginal and Torres Strait Islander population on the one hand, and lack of clarity with respect to government responsibilities on the other.

There is ample evidence of inadequate public investment in culturally appropriate primary health care that is accessible to Aboriginal peoples and substantial new funding will be required to ensure equity. International evidence suggests that funding comprehensive primary health care to a level that delivers a critical mass of workforce and service capacity is an equity-producing strategy that can help offset the impact of social inequality on the health of Aboriginal peoples and Torres Strait Islanders. Health service expansion can also proceed in parallel with broader social welfare and economic reforms.

While such investment is actually affordable, Australia cannot afford to persist with incremental, piecemeal program responses to glaring unmet health needs. In this way, Aboriginal peoples have their rights to health significantly undermined. There is evidence that according to the universal standards of human rights instruments, health policy directed towards Aboriginal peoples and Torres Strait Islanders is poorly developed, with poor monitoring of the realisation of that right to health at the national level which does not investigate resource allocations to generate health equity, and there are no explicit benchmarks or targets for health improvements.

There appears to be no indication that federal level policy innovations to ensure expenditure is matched to needs (according to the evidence from independent reviews), is forthcoming nor that the situation will change in the near future. Convincing policy makers to account for this evidence and to correct misinformation about the vital importance of comprehensive primary health care services such as ACCHSs remains a major obstacle. The enormous potential in critically appraising the health policy process as it relates to the health of Aboriginal peoples and Torres Strait Islanders, is that it may encourage reflection, debate and lessons for the way forward.

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