Strategies for narrowing the gap

The Review required advice on the strategy and relevant timeframes required to achieve appropriate levels of comprehensive and effective health care for Aboriginal and Torres Strait Islander people. This part commences with a consideration of the requirements for an adequate well-managed service delivery system on the ground, and then addresses the broader issues of national leadership, supportive policy, workforce capacity, information and healthy public policy.

The experience of the last 30 years (since the initiation of Aboriginal Community Controlled Health Services), and particularly the period since the mid-1990s, means that decisions about how to improve health care for Indigenous Australians can now be made with a degree of confidence. There are some important limiting factors that mean a developmental approach is required, and expenditure growth should be carefully scaled to enable capacity to develop. It is also essential, while taking a national perspective, to ensure that regional and local variations in health problems, health system capacity, cost structures, workforce supply and community capacity are recognised. All strategies will need to be tailored to local and regional conditions, within the framework of national goals and policies.

4.1 Care delivery models

This section defines comprehensive primary health care, explains some of the necessary conditions for effective CPHC and proposes the development of a delivery system model for Indigenous-specific services funded by OATSIH (with variations for location and other factors). This section is focused primarily on Indigenous-specific agencies, but the role of mainstream agencies in Indigenous health care delivery is also addressed.

4.1.1 Definition and scope of comprehensive primary health care

The established OATSIH definition of comprehensive primary health care (CPHC) is sound and consistent with the WHO definition described in the Alma-Ata declaration (WHO 1978). Its taxonomy of four key elements specifies a platform of services:

- clinical care—treatment of acute illness and injury, emergency care and management of chronic conditions (including mental illness);
- population health programs—antenatal services, immunisation, screening programs for early detection of disease, and specific health promotion programs (e.g. physical activity, nutrition, oral health, prevention of substance misuse);
- facilitation of access to secondary and tertiary care—referral, support for referred patients, development and maintenance of links with a range of health services (such as medical specialists and referral hospitals) and related community services (aged care, disability); and
- client/community assistance and advocacy—identification of factors contributing to illness or risk, working with individuals and communities to develop strategies to reduce risk or harm, including for health risk factors and health determinants that lie outside the direct ambit of the health system (OATSIH 2003c; NATSIHC 2003; Shannon & Longbottom 2004).

If the goal of comprehensive primary health care for Indigenous Australians is to be achieved, a necessary next step is to develop better specification of the basic platform of services and capabilities that must be achieved at various levels (e.g. for given population sizes and travel distances).
Detailed specification of services is a task that is beyond the scope of this paper, and should be tackled by a multi-disciplinary group with strong clinical and community input. However, the following is a draft list of the key elements.

Table 3: Elements of comprehensive primary health care

<table>
<thead>
<tr>
<th>Health services</th>
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</thead>
<tbody>
<tr>
<td>Clinical services – with access to emergency care 7 days/24 hours (local or remote)</td>
</tr>
<tr>
<td>Antenatal care</td>
</tr>
<tr>
<td>Immunisation</td>
</tr>
<tr>
<td>Care of 0–5 yr olds, and support for effective parenting</td>
</tr>
<tr>
<td>STI services</td>
</tr>
<tr>
<td>Primary medical care</td>
</tr>
<tr>
<td>Screening where there is an appropriate method and good evidence of outcomes</td>
</tr>
<tr>
<td>Access to specialist care and referral to secondary and tertiary services</td>
</tr>
<tr>
<td>Secondary prevention of chronic disease</td>
</tr>
<tr>
<td>Care coordination for people with complex and chronic conditions</td>
</tr>
<tr>
<td>Mental health services and programs to enhance social and emotional wellbeing</td>
</tr>
<tr>
<td>Specific vertical programs (nutrition, substance abuse)</td>
</tr>
</tbody>
</table>

Support

| Standard treatment protocols for common conditions, based on evidence              |
| Data collection, evaluation, monitoring                                         |
| Ongoing staff development, including health worker training                      |
| Intersectoral collaboration (focused on known opportunities for health gain)     |
| Programs to enhance the capacity of Indigenous families and individuals to take responsibility for their own health |

Standards

| Competent and expert care                                                        |
| Well-led and managed (sound policies and procedures, practice guidelines and manuals) |
| High quality                                                                      |
| Universal access                                                                 |

Source: Based on personal communication with Dr Paul Torzillo (2 September 2003)

4.1.2 Chronic disease care: a ‘best buy’ requiring a base of CPHC

The modelling carried out by Beaver and Zhao (2004) assessed the ‘best buys’ for reducing the burden of illness for nine preventable chronic conditions. They found that Clinical Primary Health Care (new cases) and Clinical Primary Health Care (existing cases) were the most effective interventions for the purposes of saving health care resources. Health promotion was the third priority for eight of the nine diseases (malnutrition is the exception). Prevention was more effective than hospital care in terms of saving resources (Beaver & Zhao 2004, p. 21). Health promotion and prevention become more effective in saving resources in the longer-term (20 years), but are still less cost-saving than clinical primary health care (Beaver & Zhao 2004, p. 21).

These findings illustrate the potential for enhancing the cost-effectiveness of intervention through evidence-based planning and care delivery. However, effective delivery of these most effective interventions requires a platform of comprehensive primary health care. Good clinical care for new and existing cases can only
be reliably provided from a base of competent general primary health care, readily accessible to patients and responsive to their broad health concerns. ‘Best buys’ are part of effective primary health care, not a substitute for it.

*The existing OATSIH definition of comprehensive primary health care is a sound basis on which to build further specification of the basic platform of services, and service system models, which are needed to improve access to health care and health outcomes for Indigenous Australians. It is possible to identify some services that provide a clear and strong return on investment, but (with some minor exceptions) they can only be effectively provided from a base of comprehensive primary health care.*

### 4.2 The primary health care delivery system

Effective primary health care is a seemingly non-controversial goal in most health systems, but is nevertheless difficult to achieve. Perhaps one of the reasons for this is that the primary health care system is at the bottom of the pyramid, characterised by small-scale provider organisations (or small groups of practitioners), providing services that lack the glamour of tertiary care and operating far from the centres of power. Strong policy support from the centre needs to be informed by an understanding of some of the dilemmas primary care providers face. This section attempts to outline some of the conditions required for effective primary health care, and the key elements of the service system.

#### 4.2.1 Requirements for effective primary health care

Reference to the mainstream Australian system for models of comprehensive primary health care is not particularly helpful, because the mainstream system is itself plagued by discontinuities, jurisdictional boundary problems, and great tension between the goal of integrating care for patients on the one hand and the goal of targeting services through tight specification of eligibility and service types on the other. In this respect, Indigenous programs are less conflicted and contested by competing interests and there is perhaps more freedom to develop a coherent system. The major tensions that the system must balance are explained below.

**Achieving both integration of care and effective targeting**

There is much rhetoric about the need for integrated care, and a significant body of experience in finding methods for delivering it (‘horizontal programs’). But there is also evidence to support the pursuit of specific health goals and the use of targeted programs to achieve health gain in relation to specific health problems (‘vertical programs’). These potentially conflicting goals or methods are both important, and need to be managed together.

As in all organised human endeavour, there is a need in health care to enable specialisation (i.e. break the system up into manageable components of care and manageable organisational arrangements) on the one hand, and then to find ways of coordinating the pieces to make a coherent whole on the other (Mintzberg 1991). In the case of Indigenous primary health care (and this is also true in the mainstream), the most effective approach is for primary health care organisations or practitioners to fulfill the integrating function, presenting a ‘seamless’ point of entry to the whole system and acting as the anchor point for individuals, coordinating access to care and working with clients to ensure that the inputs of all the other players are managed coherently.

If this anchor point and integrating function are working, vertical programs, delivered either by the primary health care service itself or in close collaboration, can be tightly specified and targeted; and population-level key performance indicators can be collected and monitored, with a minimum of discontinuity for the patient. Secondary prevention for chronic illness can be achieved with both specialised skill and generalised
management of care for the individual. Finally, the needs of the seriously ill can be met in a coordinated way.

For this approach to managing both integration and targeting to work, some prerequisites must be in place.

- The implications of new, targeted programs for primary health care providers (increased workload; new data collection and information technology [IT] needs; facility and equipment requirements; need to develop new partnerships) must be recognised in the development of policy and funding programs (e.g. Centre for Remote Health 2003).

- The work of establishing effective links with primary care providers must be included in the remit of targeted programs that sit outside core primary health care activities (e.g. breast cancer screening), and both the process of development and the resourcing levels must take this into account.

**Community governance/localism and national/state/territory programs**

The second significant tension that must be managed is the potential conflict between the desire of local communities and agencies to determine local priorities and the policy goals of national or state/territory programs that seek to improve outcomes at population level.

Both of these goals are vital: inability to respond to local issues can be a serious barrier to implementing local solutions for health gain, and can compromise effective local management of resources and services. On the other hand, it is equally vital that the primary health care system has the capacity to support the delivery of national programs in areas where there is strong evidence of both significant need and the effectiveness of an intervention or program method.

These potentially conflicting goals can be reconciled. For example, the Northern Territory Preventable Chronic Disease Strategy has been implemented in both mainstream and Indigenous health care organisations, with considerable success (Weeramanthri *et al.*, 2003). Focused on five diseases, the Strategy has succeeded in achieving interim outcomes. Preliminary analysis against a baseline of 21 indicators shows a trend in:

- improvement of birth weights;
- sustained high levels of immunisation;
- a slowing in the rate of growth of renal dialysis treatments;
- a decline in the number of diabetic amputations in the Top End;
- some improvements to the food supply;
- a relatively stable per capita alcohol consumption; and
- a continuing decline in adult smoking prevalence, though slower than in the rest of the country and still with very high levels in the Indigenous community (Territory Health Service 2001).

A careful process of development and negotiation of this program is seen as essential to its success.

For this sort of success to be generalised, the following are required.

- Effective use of planning and negotiation forums (such as the Partnership Forums - see section 4.4.1) to enable participation by all parties in the development of national/regional priorities, to identify potential conflicts between local and national priorities, and establish arrangements to enable local variation.

- Agreed methods of framing requirements and negotiating local implementation so that programs can be targeted to real local priorities, local agencies can plan for engagement and if necessary be resourced to deliver their component, and so that there is joint ownership of program outcomes.
For comprehensive primary health care to be effectively implemented, the decision-making and management processes of the delivery system (at all levels) must be designed to support the primary care level. This in turn requires that the inevitable tensions between integrated care and targeted programs, and between local and national priority-setting, be acknowledged, recognised as legitimate challenges for all parties, and carefully managed through robust, durable and mutually respectful negotiation processes.

4.2.2 Service system models

Good system design in this field must recognise and accommodate diversity while ensuring that universal access to a common platform of services is available. While there will be variation in levels of funding, capacity and volumes of services delivered across the Indigenous-specific sector, it would be useful to establish standards and benchmarks against which service development could be planned and progress towards the goal of universal access could be monitored. While the following discussion is focused on Indigenous-specific agencies as the cornerstone of the model, we would emphasise that achieving CPHC requires a network of services, Indigenous and mainstream. Differences between remote, rural and urban models are noted as they arise.

The Primary Health Care Access Program (PHCAP) program has established benchmarks for relative funding effort and absolute levels of funding for primary health care on the basis of population size, remoteness and current capacity to utilise Medicare. We propose that a flexible service system model also be developed, based on a regional approach. A core platform of primary health care services to be provided at regional and local levels for given population sizes would be specified, and could be used as a template to guide funding decisions and service development.

The historical development and local autonomy of ACCHSs must be respected, while at the same time recognising that sustainability and effective health care delivery arrangements are essential. The success of any new approach will depend on strategies that focus on health care delivery and the goal of health gain, rather than on re-organising existing organisations to fit a model. While the forms and structures of existing organisations may need to change over time (particularly where small size is a strong limiting factor on effectiveness), this should be achieved as part of a program of growth and development in health care delivery, by negotiation and in stages. The regional template should not specify a requirement for a single regional board of governance. Rather it should allow for a mix of organisational arrangements, including the following:

- Local ACCHSs linked at regional level through consultation and negotiation forums, and shared support services (finance, human resources [HR], IT, data collection, clinical and management protocols).
- Regional ACCHSs with local clinics and programs (e.g. Nganampa Health Council SA, Katherine West NT, Central Australian Aboriginal Congress NT).
- A regional primary health care network including Indigenous-specific and mainstream organisations, that work together on health programs for Indigenous people to ensure that the necessary services are available in the region.
- Arrangements whereby community-based agencies contract with government or private sector agencies for care delivery, and act as purchasers rather than managers of service delivery.

The service system model should enable funding for necessary support services at regional and local level. A regional network of local ACCHSs could establish and jointly manage a regional support capacity, to provide shared services such as financial reporting, human resource and industrial relations expertise, staff development, information systems support, data processing, and supply management, where they are not
achievable at local level. Clinical support services could also be provided by this mechanism, including diagnostic services, evaluation of care and analysis of evidence both of effective methods and local and regional progress against indicators and targets.

The service system model would need to be flexible enough to support cross-portfolio sharing or pooling of resources, such as a single facility housing all health, community and education agencies in small communities.

It is also important that regional boundaries are determined on the basis of the needs of health care delivery, recognising mainstream health regions where appropriate. Consistency with local government and Aboriginal and Torres Strait Islander Commission (ATSIC) boundaries is also strongly desirable.

In building a stronger and more capable comprehensive primary health care system, it will be essential to take a developmental approach, with an agreed growth path. In some under-serviced areas, it will not be practical to develop an Indigenous-specific agency, or at least, not immediately. For these cases, the service system model could also specify good practice in providing Indigenous services from within mainstream organisations, such as is currently happening in Central Australia under PHCAP. The National Strategic Framework for Aboriginal and Torres Strait Islander Health requires that these services should be provided in partnerships among Indigenous-specific and mainstream agencies, in ways that maximise community decision making, influence and control (NATSIHC 2003).

It may be helpful to describe stages of development, with a cluster of characteristics of each level (e.g. from Stage 1 where there is no Indigenous-specific service through to Stage 4 where there is a good Indigenous primary care service with effective links into other services, strong regional structures, etc.).

The establishment of an agreed model for the Indigenous-specific service system, combined with specification of the basic platform of services that constitute CPHC, has the potential to deliver several benefits. These measures will provide a guide for decision making in relation to funding and support, support progress towards the goal of equity of access to care, assist the development of best practice in clinical care and the use of effective interventions, and support stronger governance and management.

4.2.3 Care coordination for people with chronic conditions

The significant burden of chronic disease in Indigenous communities means that care coordination is of central importance, and arrangements that are known to be supportive of care coordination should be designed into the primary health care system.

There are three important system design elements. Firstly, the role of the primary care provider as the coordinator of the patient’s care must be endorsed. Secondly, funding methods that enable the primary care provider to perform this function (possibly including some element of capitation) are needed. Thirdly, capacity to link medical records would facilitate the effective transfer of needed information between care providers. Each of these elements raises issues of privacy and choice, which need to be resolved with Indigenous communities and individuals.

The development of the Oacis system in South Australia (which currently provides an integrated medical record for patients with kidney disease across metropolitan Adelaide) provides a model for a clinically appropriate, well-designed use of record linkage to improve care (HealthConnect Program Office 2003). Privacy issues have been addressed, and technical requirements are understood. While such a system may seem a long way in the future particularly for remote services, these agencies have proven their willingness and capacity to use sophisticated solutions to the problems of distance and isolation, with many ACCHSs routinely using population registers. For example, Nganampa has established a population register that includes information on daily clinical contacts as well as specialised medical databases. This is used to plan...
and implement strategic health interventions, and provide activity reports to staff, communities and funding bodies. Nganampa has also established a chronic disease register to improve the management of clients with a chronic illness (Shannon & Longbottom 2004). It seems that there is support for this kind of system among some communities who understand the privacy issues involved, and see them as acceptable in the context of potential health gain (e.g. for antenatal care and immunisation programs).

Given the importance of complex chronic illness in the Indigenous population, systems and processes that enable strong coordination of care are needed. They will require collaborative development and informed agreement by communities, with particular sensitivity to any concerns about privacy and autonomy. There are some early signs of informed and considered acceptance among Indigenous communities.

4.2.4 Indigenous-specific agencies in urban areas

The extent to which Indigenous-specific agencies are best placed to deliver all elements of comprehensive primary health care will vary with location, including remoteness but also local conditions (such as distance from and relationships with other agencies). Other factors include the relative roles of private general practice and the full range of public and private sector care providers, and their readiness to provide appropriate care.

The basic definition of CPHC describes services that should be available to urban Indigenous Australians, whose poor health status indicates poor access to existing health care agencies. But there are more options for Indigenous people in relation to access to care; and for Indigenous-specific agencies in relation to working collaboratively with others, and these should be taken up where they can deliver health benefit.

While concern to allocate the maximum possible amount of funding to remote and rural people is recognised, this should not mean continuing disadvantage for urban Indigenous people. They should be able to use an Indigenous-specific primary health care service if they need to do so. A need based on reluctance to use mainstream services (for whatever reason) is a valid need in circumstances where such reluctance will result in lack of access to health care. The challenge to enhance the acceptability of mainstream services lies primarily with the mainstream, and secondarily, with the ACCHSs (whose roles include advocacy and advice to the mainstream).

The application of service system models and the basic platform of CPHC will be different in urban areas. The same access principles should apply. The challenge to make mainstream services more acceptable and accessible to Indigenous Australians lies primarily with the mainstream (see section 4.3).

4.2.5 Services for non-Indigenous Australians in remote areas

Expansion of the network of primary health care in remote areas could provide an opportunity to resolve the question of access to Indigenous-specific services for non-Indigenous people in areas where the ACCHS is the only local service. This issue is generally satisfactorily resolved in practice, and codifying the arrangement in policy would strengthen the basis for good practice. The funding method could be based on either MBS/PBS or a component of per capita funding, or a combination of the two.

4.2.6 Mainstream service delivery

This discussion of the primary health care system has focused largely on Indigenous-specific agencies, because this is the sector that has Indigenous health as its primary goal, and which can be designed and adapted to respond as closely as possible to Indigenous health care needs. However, the mainstream system also plays a vital role. On any given day, at least as many Indigenous Australians attend private GPs as ACCHSs across Australia, and Indigenous people rely on the mainstream secondary and tertiary systems.
There is growing awareness at all levels in the mainstream health system of the fact that Indigenous health care is everyone’s responsibility, but that awareness and willingness is yet to be converted to active engagement throughout the mainstream system. There is some tendency to regard Indigenous health care as the responsibility of the ACCHS sector, and in the secondary and tertiary sectors, as a primary health care issue.

Acceptance of responsibility throughout the system needs to be embedded into the full range of policy and governance instruments, from Health Service Agreements to statements of objectives in Articles of Association or incorporation, and the strategic plans of agencies. Continuing national, professional, management and peak body leadership is needed.

The role of mainstream services is to provide easy access to quality care for Indigenous patients. This requires policy commitment; understanding of the health care needs of Indigenous patients, and the particular barriers to access that they encounter; the engagement of clinicians in ensuring that clinical practice is appropriate; and the supportive role of Aboriginal Liaison Officers and local ACCHSs.

It also requires debunking of the myth that Indigenous-specific funding is more than adequate to meet needs. This myth underlies an attitude or belief in some mainstream providers that the health care funding pie has been definitively cut on racial lines, and that mainstream resources are really for the care of non-Indigenous people.

For the providers of health care, better ascertaining and recording of Indigenous status is an immediate practical issue, often needed for effective care delivery as well as for better understanding and reporting of Indigenous health status and health care use in the long term.

The Divisions of General Practice have an important role to play in enhancing the capacity of general practice in Australia to provide effective primary health care for Indigenous Australians. The recent review of the role of Divisions of General Practice (Department of Health and Ageing 2003a) notes the variable relationships between them and ACCHSs, and the variable level of engagement in relevant activities by the divisions (Department of Health and Ageing 2003a, pp. 45–47). The report acknowledges the fact that for some Divisions of General Practice, the absolute numbers and the proportions of potential Indigenous patients who might use general practice care in the area are very low, but notes that ‘it is essential that all Divisions undertake activities that improve the health of Indigenous Australians’ (Department of Health and Ageing 2003a, p. 46). In four relevant recommendations, it urges that the Australian Government fund a consortium to identify models of best practice for Divisions of General Practice and ACCHSs in working together; that a common performance indicator be introduced by the Australian Government to measure effective engagement between the two sectors; and that guidelines for culturally safe practice in general practice be developed.

The Government has supported the Commonwealth Grants Commission’s view that appropriate strategies to address lack of responsiveness by mainstream agencies include involving Indigenous Australians in the design and delivery of mainstream services; and improving the relationship between mainstream and Indigenous-specific programs (Commonwealth of Australia 2002, p. 15).

*The mainstream health system’s commitment to enhancing Indigenous health and health care needs to be strengthened, and embedded in policy, service agreements, strategic plans, objectives, performance agreements and other instruments. A strategy and resources are needed to support this work, and to support mainstream clinicians in their endeavours to enhance the effectiveness of the care they provide to Indigenous patients.*
4.3 Governance and structure of Indigenous health organisations

There appears to be significant variation in the organisational effectiveness of Indigenous health services. Some are relatively well-funded, well-staffed, well-governed and managed, able to provide a comprehensive range of primary health care services, and supported by useful data about their communities, client base and service outputs. In three significant field studies (Department of Health and Aged Care 2001b; Shannon et al. 2002; Shannon & Longbottom 2004) the critical success factors for comprehensive primary health care and the Indigenous-specific health service sector have been examined. The factors identified are generally consistent with the principles of good health care management and practice applying in the mainstream:

- adequate secure resourcing;
- reasonable access for the population to be served;
- interventions based on good evidence of efficacy;
- effective collaboration by the range of providers needed for comprehensive care;
- capacity for innovation based on evidence;
- priority-setting that reflects community perceptions of needs; and
- acceptability to the community.

The differences lie in the particular styles of comprehensive primary health care (with a greater range of services being provided by single agencies serving Indigenous communities, as compared to agencies of similar size in the mainstream); and in the way that the principle of community engagement is expressed.

There are some outstanding examples of success. Detailed case studies of Nganampa Health Council SA and Townsville Aboriginal and Islander Health Service QLD (Shannon & Longbottom 2004) reveal that, with the current level of investment and current system influences, these services have been able to develop into effective primary health care services.

‘Their development has taken a long time and sustained effort over many years. They have demonstrated that they have good systems in place to manage their resources on a daily basis and have strategic approaches to manage longer term issues. Both services have intermediate outcomes that should, in time, lead to improvements in health outcomes’ (Shannon & Longbottom 2004, p. 121).

The authors include a cautionary note about the potential for health gains to be undermined by the impact of social and economic disadvantage in these communities.

The Australian Government funds a range of Indigenous health agencies, mostly to provide primary health care services, and many also receive state/territory funding. The majority of these agencies are ACCHSs which are defined by the National Aboriginal Community Controlled Health Organisation, the peak body for ACCHSs, as

‘… primary health care services initiated and managed by local Aboriginal communities to deliver holistic and culturally appropriate care to people within their community. Their board members are elected from the local Aboriginal community.’ (NACCHO 2003, p. 2)

NACCHO is strongly committed to this model of community control (for reasons including the history of the sector’s development in an environment of mainstream neglect). The services provided by these agencies include:
• the diagnosis, treatment and management of illness and disease;

• population health programs such as screening and immunisation; liaison with secondary and tertiary health services; and

• advocacy and support roles.

In 2000–01, 129 Indigenous-specific primary health care organisations were funded by the Australian Government and they provided 1.3 million episodes of care, as well as undertaking related activities such as training (Department of Health and Ageing data 2003d).

A significant proportion of Australian Government-funded primary health care services (43% or 56 services) receive less than $500,000 per year with only 17 services receiving over $2 million per annum and able to offer a broad range of primary health care services. This funding is often from multiple sources each requiring different and specific reporting formats. The higher burden of disease experienced by Indigenous people impacts on staff workloads and coupled with relatively low funding levels, generally limits the capacity of these services to provide early detection and prevention programs. However, there are a number of high capacity agencies that are providing a good base of clinical care, and early detection and prevention programs, which are having an impact. The roles agencies play vary by location, with ACCHSs providing virtually all primary health care in some remote areas, often including 24-hour emergency care. State/territory-funded Indigenous-specific and mainstream services provide such care in other remote areas (e.g. some parts of the Northern Territory, and in Cape York).

Service capacity often reflects historic arrangements, and agencies are not currently funded fully on the basis of community need. It should be noted that the Government has considered and rejected the option of reallocating existing funding for Indigenous health services more evenly (Commonwealth of Australia 2002, p. 25) in light of the Commonwealth Grants Commission finding that there was no evidence of funding in excess of needs in any location (Commonwealth Grants Commission 2001, p. 144).

4.3.1 Effective Governance in Indigenous agencies

There are many examples of good governance practice in the field of Indigenous health, and there are also areas where improvement is required.

The extent of effective governance and leadership in ACCHSs around the country, and the development of appropriate governance styles and conventions, needs to be acknowledged. Most services meet accountability requirements, and over time, board members and staff have developed impressive skills and expertise in managing ‘interculturally’ (i.e. between traditional informal Indigenous ways, obligations and relationships, and the formal legal structures of incorporated organisations). For example, the Katherine West Health Board, which was established in 1997 to manage a coordinated care trial, has extended its role to become a community-controlled service provider, delivering a range of services (and purchasing others) in one of the most remote communities in Australia. Initially, Territory Health Services provided technical support to the Board so that members gained the skills and expertise to govern a service with complex arrangements. The Board now has the capacity to assess and plan for the whole of the region’s health needs and has made a significant improvement in the provision of health services for its service population (Department of Health and Aged Care 2001b; KPMG 2001).

The contributions made by clinicians and managers with the drive and technical competence needed to build successful organisations, especially those who have sustained their commitment over many years, have been vital but largely unrecognised. Shannon et al. (2002, p. 64) found that leadership (by Indigenous and non-Indigenous people) was a key factor in the success of the projects they examined: ‘Strong and
sustained leadership by a skilled individual was key to a number of projects but was not acknowledged despite the evidence’ (Shannon et al. 2002).

However, the incidence of governance problems in ACCHSs is of concern with 24 of 184 (13%) community-managed organisations delivering health and substance use services experiencing difficulty in July 2003 (OATSIH unpublished 2003h). Causes of these problems include the following.

1. Small size of organisations, that must nevertheless shoulder the full burden of corporate accountability, often without access to critical resources and skills such as accountancy services, HR expertise, adequate IT and timely legal advice, and without an adequate asset base, or secure ongoing funding.
2. Arising from the above, weakness or poor development of guidelines, policies and procedures that might otherwise strengthen and protect ongoing management functions, particularly for small organisations or organisations that have grown rapidly without implementing a robust management system.
3. The intensity of demand for the time, energy and influence of key leaders in communities, with leadership skills being stretched too thin in communities that are under high levels of stress.
4. The shortage of Indigenous health and management professionals with management skills and experience; and difficulties of recruiting and retaining skilled staff (Indigenous or not), exacerbated by lack of security of tenure for staff employed on ‘soft’ funding.
5. The challenge of creating and sustaining effective corporate governance in the ‘intercultural’ space occupied by Indigenous organisations (Martin 2003), and the difficulties of managing the tensions between formal governance structures and methods and the informal structures and relationships within communities, including strong family groupings.
6. The complexities of administering different reporting requirements from different funding sources, and the burden of constant submission writing for renewal/expansion of funding sources with the need to ‘invent innovation’ to meet funding guidelines.
7. Difficulties in developing and maintaining effective linkages with other agencies whose contributions to care are necessary.

This list is similar to one that might be produced in relation to service failure in mainstream health services, particularly in smaller organisations and rural areas.

**Community control as a governance model**

The principle of community control is one of the key features of Indigenous-specific agencies and one of the cornerstones of the development of these services (Shannon et al. 2002). It is based on the political goal of self-determination (Griew et al. 2003; Anderson 1994), and the practical goals of improving community capacity and tailoring services to meet needs in ways that will be accepted by Indigenous people. It essentially requires that ownership and governance of the health agency are vested in the local Indigenous community, generally through the mechanism of a local Indigenous board of governance and an Indigenous CEO. This arrangement aims to enable the local community to decide on its priorities, policies, management structure, staffing and service profile, within funding guidelines.

Community control emerged with the founding of the first Aboriginal Medical Service in Redfern NSW in 1971, and has been closely held and valued within the sector and more broadly by
Indigenous communities. It was accepted as a fundamental part of the National Aboriginal Health Strategy (NAHSWP 1989) and is endorsed in the National Strategic Framework for Aboriginal and Torres Strait Islander Health (NATSIHC 2003). The principle of community control has similarities to the traditional and still common governance structures of some public hospitals, community health centres and other mainstream health agencies (including the substantial non-government sector).

While the concept of ‘cultural appropriateness’ is generally endorsed in relevant government policies, government agencies and policy analysts also express concern that good corporate governance may be compromised in Indigenous organisations precisely because of adaptations of generally accepted governance principles. Areas of concern include weaknesses in the separation between board and management roles; and in the application of conventions for avoidance of conflict of interest, for example through strong demarcation between the roles and interests of recipients and providers of services (Martin 2003). We note that these issues also give rise to governance problems in mainstream agencies.

Shannon et al. (2002), in their assessment of achievements, developed a typology of forms and methods of community control and community participation. They describe a broad continuum of engagement with Aboriginal and Torres Strait Islander communities, with five levels—community-controlled, community-initiated, community-grounded, community-adopted and community-oriented projects (Shannon et al. 2002, p. 12).

The key issue from a health system perspective is quality health care supported by good governance and effective management.

The Commonwealth Grants Commission has endorsed the importance of ‘working partnership arrangements and effective community control of services’ (Commonwealth Grants Commission 2001, p. 133) and the Government has endorsed the importance of community engagement in its response to the Commonwealth Grants Commission report (Commonwealth of Australia 2002). This policy position is supported by the findings of Shannon et al. (2002), which reiterate the widespread though hard won general support in Aboriginal and Torres Strait Islander health policy for the participation of Aboriginal and Torres Strait Islander people and organisations in primary health care. The successful projects they reviewed demonstrated

‘...the value of diversity at a local level within a national framework that provided consistency in policy direction. The success of a range of models of community participation reflected the importance of engagement of the community, rather than the necessity of one prescriptive model’ (Shannon et al. 2002, p. 66).

They also stress the need for diversity, to ‘reflect the diversity inherent in Aboriginal and Torres Strait Islander communities’, shaped within the broad strategic directions that might ensure equity in access to care.

We propose two policy principles and a number of practical areas for action to enhance the effectiveness of governance in Indigenous organisations. Firstly, future funding should be provided at levels that enable agencies to achieve critical mass for good governance and effective service delivery. A regional approach to governance structures, with local arrangements for service delivery, is the most practical method of
achieving this goal given small, dispersed populations. Alignment of regional boundaries, and the size of regions, should be based on the design requirements for effective health care delivery. Arrangements to accommodate existing small agencies will be required.

Secondly, the principle of Indigenous governance of Indigenous-specific services should remain strong, and the forms and types of organisations that are accommodated by this principle should continue to develop, in accordance with Indigenous community needs and the needs of ACCHSs. At the same time, the validity of other forms of engagement for specific services and purposes (such as partnership arrangements and Indigenous services and committees within mainstream agencies) should be recognised.

Practical strategies to enhance governance capacity are also required. The key requirements (in place or underway in some areas) include the following.

- Access to key areas of technical management know-how and capacity, either in-house or through other means, including accounting and financial management, information systems, human resource management and industrial relations, and legal and other support for compliance with applicable standards and regulations.
- Development of governance, leadership and management skills through effective learning programs and methods, and identification of the essential skills and experience required of board members. Resources are required to enable trialling and evaluation of a range of approaches to support emerging and current Indigenous leaders in health care (including both formal teaching and alternative approaches such as mentoring, coaching and learning sets).
- Support for the development, testing and evaluation of policies and procedures to guide boards, managers and staff in the fulfilment of governance and management requirements.
- Alignment of funding programs, accountability and reporting requirements to enhance security of funding, reduce the burden of reporting and submission-writing, and encourage focus on meaningful indicators of throughput and impact of service delivery.
- Infrastructure for quality improvement activities, including clinical protocols (see Couzos & Murray (2005) and the CARPA manual [CARPA 1997]), good IT and data systems, benchmarking, and a user-friendly evidence base.

Case study: factors supporting effective governance

Nganampa Health Council (NHC) has worked hard to achieve good governance. NHC was established in 1983 and took over management of the health service from the South Australian government in 1985. The administrative centre for the health service is at Umuwa and there are six major clinics and three health worker stations. NHC receives approximately $9 million dollars per year from a range of sources.

The governing body (the Council) has 20 members, including the Director (who is an Anangu person), Anangu Health mayatjas (managers), an elected representative from three health worker stations, three elected representatives of the Women’s Council, four elected general representatives from the Anangu Pitjantjatjara Lands, two elected Anangu Health Worker representatives and the Chairman of Anangu Pitjantjatjara.

The Council meets every four to six weeks. The NHC committee is provided with technical, clinical and financial advice. The Health Services Director presents options and potential consequences in decision making and problem solving, the Medical Director provides advice on medical and clinical
matters and the finance manager provides financial planning advice. A principle of 'twinning' has been established, by which Anangu and non-Anangu managers work together in complementary roles. NHC also has processes to obtain input from other staff (including having representatives on the NHC and through getting reports from staff at meetings).

The NHC has overseen the development of very effective models of primary health care (see section 3.7) that are demonstrated by measurable impacts and improved health outcomes over time.

Source: Shannon & Longbottom 2004

While the principle of community control is well established and clearly supported in public policy, achieving good governance is a continuing challenge for Indigenous-specific agencies, as it is in the mainstream. We propose the development of a robust framework for the Indigenous-specific service system, including the specification of a basic platform of services, combined with action in accordance with the principles and strategies outlined above, to support continuing development of good governance.

4.3.2 Governance in the mainstream

Attention to Indigenous health at the governance level of mainstream health care organisations (public and private hospitals, regional health services, divisions of general practice, community health, mental health, disability services and many others) is patchy. Indigenous community representatives, and Indigenous health professionals can make a significant contribution in this area, and some States (notably South Australia and New South Wales) have incorporated Aboriginal Health Advisory Committees into the governance arrangements for mainstream health agencies. However, there is no consistent approach to engaging Indigenous people in mainstream health care planning and management.

There are some outstanding examples of initiatives taken by health care agencies to ensure better access for Indigenous people, and to enhance the relevance and effectiveness of their services. For example, in recognition of a failure to engage with Aboriginal and Torres Strait Islander communities in a strategic planning process, the Parks Community Health Service in South Australia undertook work to build relationships with local Aboriginal and Torres Strait Islander people that, over time, resulted in the establishment of an Aboriginal Health Committee. This committee developed strategies that would be effective and acceptable to the local community and was successful in securing funding for a team of Aboriginal Health Workers.

The Aboriginal Health Team has developed joint services and programs with other Aboriginal and community organisations. This work has also involved examining how mainstream agencies can validate different cultures in their policies, practices and processes. A key impact is an increase in the number of Aboriginal and Torres Strait Islander people using mainstream services at the Parks Community Health Centre (Tesoriero 1995). Such efforts seem to depend on a combination of motivation by clinical and management leaders in the organisation, a critical mass of demand or use, and the availability of resources.

There is also evidence that research bodies, both government (NHMRC and others) and non-government (such as the national foundations for various illnesses or organs), are instituting policies and procedures to ensure that the research agenda is relevant to Indigenous Australians, and that research on health care delivery and health system design addresses their concerns and supports the development of tailored interventions to meet their needs.

The learned colleges of the health professions, peak bodies such as the AMA and the organisations that support general practice (including the divisions and their peak bodies) are also increasingly attending to their responsibilities for Indigenous health. However, practice on the ground by divisions, as evidenced by
vigorous participation in partnerships and initiatives with Indigenous health organisations, remains very variable (Commonwealth of Australia 2003, p. 47).

Attention to the needs of Indigenous communities by mainstream health care providers and other mainstream agencies is patchy, and the governance levels of these organisations bear responsibility for ensuring that Indigenous Australians enjoy equitable access to needed services. Measures to formalise and consolidate that responsibility are required.

4.3.3 Capacity of government agencies

Martin (2003) suggests that it is not only Indigenous capacity that needs to be built, but that capacity of government and its agencies is often a major limiting factor in addressing disadvantage. Policies, procedures, funding program ‘rules’ and the conduct of relationships are seen as insufficiently responsive to the challenges of health care delivery and to the realities of Indigenous communities.

Government departments and their officers as well as Indigenous organisations, communities and their representatives need the skills for strategic engagement in relationships for planning, funding and accountability. The middle-level officers of government departments, who function as the major interface with health care providers, need content knowledge and management skills. Health care provider organisations express frustration about rapid staff turnover, asymmetric timelines (i.e. a perception that deadlines only apply to the less powerful) and the length of the chain-of-command in government departments. At the same time, providers acknowledge the support they receive from Department of Health and Ageing and state/territory department staff, and the commitment of many staff to improving Indigenous health.

While there is much good practice and constructive engagement, we would suggest that the effectiveness of public administration of Indigenous health could be improved through careful examination of current strengths and weaknesses (e.g. through organised constructive feedback on performance) and use of the results to revise operating procedures, program guidelines and staff training programs.

4.4 National system development for Indigenous health

Since the National Aboriginal Health Strategy (NAHSWP 1989), and the transfer of responsibility for Indigenous health to the Australian Government health portfolio in 1994–95, a slow but steady development of supportive policy platforms and national implementation plans is evident. The evaluation of the NAHS (ATSIC 1994), and its conclusion that implementation of the 1989 strategy had substantially failed, led to recognition that achieving coordinated action was a very difficult challenge, one which required concerted and sustained effort.

4.4.1 National leadership and coordination

Since 1995–96 the Australian Government (both alone and in concert with states and territories) has progressively implemented strategic reforms aimed at enhancing the health care system for Indigenous Australians at the national level. The National Strategic Framework for Aboriginal and Torres Strait Islander Health (NATSIC 2003) provides a consistent strategic direction, and was endorsed by all Australian governments in 2003. National coordination is now addressed through NATSIHC and SCATSIH; and the Framework Agreements reinforce the strategic direction in each state/territory jurisdiction. Information and data improvement are being addressed through the NSFATSIH, SCATSIH, NAGATSIIH, the ABS and the AIHW; and the Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework (SCATSIH 2002) provides guidance for all relevant parties. With the exception of AIHW and the ABS, all of these initiatives or bodies, and many more, are less than seven years old.
The picture at the state/territory level is complementary, with the development of new forums, advisory bodies and methods of engagement with the Indigenous community. The Framework Agreements negotiated during the latter half of the 1990s established commitment from all jurisdictions to:

- develop national and state/territory level forums;
- introduce regional planning;
- increase allocation of health sector resources to reflect the level of need; and
- place a priority on improvement in data collection and evaluation (Anderson et al. 2002).

Continuing national leadership is essential to maximising the performance of the health system for Indigenous health. The leading and coordinating role of the Australian Government is clearly accepted, but the roles of states and territories in funding and coordinating major parts of the health system mean that coordination between the levels of government is a critical challenge. Elaborate arrangements to achieve coordination between levels of government and with Indigenous organisations and community representatives will continue to be needed, and will continue to require financial and human resources to maintain. Creativity is required to ensure that coordination is achieved where it adds value, and that the ‘policy disconnect’ noted by Indigenous organisations is avoided.

Many of the necessary elements of national coordination for Indigenous health have been consolidated over the last ten years.

- The National Aboriginal and Torres Strait Islander Health Council was established by the Minister in 1996 and restructured in March 1999 following a review of its operation. The Council has played a key role in linking the development of national Aboriginal and Torres Strait Islander health policy and strategy with local and regional developments. It is charged with bringing together the Framework Agreement partners as well as a range of other people with expertise to provide national policy advice.

- State and Territory Health Forums were established in each state and territory under the Framework Agreements to decide on key issues in regional planning, to contribute to policy development and to evaluate the implementation of the Framework Agreements. The Forums include representatives from the Australian Government, state and territory governments and the Torres Strait, ATSIC (the Torres Strait Regional Authority in the Torres Strait) and the Aboriginal and Torres Strait Islander community-controlled health sector. The Forums have achieved varying levels of success to date.

- The Standing Committee on Aboriginal and Torres Strait Islander Health (SCATSIH) provides advice to the Australian Health Ministers’ Advisory Council on matters of Indigenous health.

- The National Public Health Partnership is a mainstream inter-governmental working arrangement to plan and coordinate public health activities, provide a more strategic and systematic approach to addressing health priorities and provide a vehicle to assess and implement major initiatives, new directions and best practice in population health. It has adopted a policy requirement that attention to Indigenous health be included in all mainstream public health initiatives (National Public Health Partnership 2002, p. 2).

- The Joint Advisory Group on General Practice and Population Health, which is made up of four nominees of the National Public Health Partnership (NPHP), and four nominees of the General Practice Partnership Advisory Council (GPPAC), also includes a nominee of NACCHO to improve the link with Indigenous community-based primary health care services (OATSIH 2003b).

NACCHO and its state/territory affiliates provide leadership in the field and act as advocates for the interests of their members.
These policy and strategy platforms demonstrate political and institutional will and promote coordination in action on Indigenous health. As Shannon & Longbottom (2004) found from case studies, one of the clear contributors to success in Indigenous health care delivery was political commitment, and the location of projects within a supportive policy framework. For example, Queensland Health’s Indigenous Workforce Management Strategy—sponsored by the Director-General—provided the necessary authority and policy commitment to make Indigenous recruitment an acceptable performance indicator at district level, and to ensure workforce change. The Western Australian Aboriginal Identification Project (Young 2001) is another example of the influence of national strategies, in this case in response to recommendations of the Aboriginal and Torres Strait Islander Health Information Plan as endorsed by the Australian Health Ministers’ Advisory Council.

Impact of supportive policy on effective care: Katherine West

The Katherine West Coordinated Care Trial (CCT) demonstrates the benefit of a supportive policy environment. Katherine West used the opportunity afforded by the CCT to explore new funding and structural options, with a resulting improvement in health services. Having established its policy ‘niche’, the Katherine West CCT has been influential in the development of arrangements for PHCAP, which potentially allow models of coordinated care to be extended and modified, bringing additional primary care resources and a new approach to funding. Shannon & Longbottom (2004) concluded that the continued development of a policy framework for Aboriginal and Torres Strait Islander health was an imperative. The building of broad consensus in policy direction, and a commitment to coordination and integration is crucial to effective progress, and the experience of the Katherine West CCT is an exemplar of this effect.

While national coordination and negotiation arrangements are vital, continuing leadership and commitment are required to ensure that they are focused on achieving results on the ground, and that their work bears fruit. The current arrangements are necessarily complex, but we would recommend that these structures remain in place to guide and support the development of additional capacity and enhanced effectiveness in the provision of Indigenous health care and healthy public policy.

4.4.2 Existing portfolio allocation should be maintained

The location of responsibility for health within the Australian Government Department of Health and Ageing is virtually universally supported within the health sector, including by Indigenous health organisations. The reasons for this support include the greatly enhanced ability to bring public health and medical expertise to bear, the emerging evidence of effectiveness, and the record of achievement over the last eight years in the allocation of increased funding from within the health budget to Indigenous health. The benefits of location within the health portfolio also include an enhanced ability to benchmark spending and strategies in Indigenous health with mainstream standards and approaches; and greater engagement of the mainstream health system, state/territory health authorities, training institutions and learned professional colleges than would otherwise be the case. Responsibility for Indigenous health should remain with the mainstream health portfolio.

A long-term strategic policy framework with appropriate resource commitments is seen as essential to support and sustain further achievements in Aboriginal and Torres Strait Islander health and to enable further capacity building, enhanced sustainability of programs and improved health outcomes. The location of responsibility for health within the Australian Government Department of Health and Ageing is virtually universally supported within the health sector, including by Indigenous health organisations.
4.5 Workforce development

A competent workforce of adequate size is critical if both mainstream and Indigenous-specific health services are to be effective. Currently, the capacity of the workforce is a key limiting factor in the provision of health services to Indigenous Australians, in rural, remote and urban areas.

The workforce required to provide comprehensive primary health care to Indigenous Australians includes a diverse mix of health care providers (general practitioners, Aboriginal health workers, nurses, allied health, mental health and public health personnel) and a range of skilled professionals to manage and administer complex services (including health service managers, accountants, human resources personnel, data managers and IT providers).

4.5.1 Current workforce issues

To deliver effective services, whether through Aboriginal community-controlled health services or through mainstream agencies, the workforce needs to be highly skilled (both clinically and in the provision of culturally appropriate services), and available. There are currently a number of limitations with respect to both skill and availability of the workforce that need urgent and sustained attention. These include the low capacity of mainstream agencies to provide culturally appropriate and evidence-based care to Indigenous people who often have co-morbidities and complex care needs (Department of Health and Aged Care 2001a); the limited number of appropriately skilled personnel in rural and remote areas; and the limited number of Indigenous health care professionals. In 2001 only 0.9% of health care providers were Indigenous (3742 people)\(^6\); and of these, 853 (23%) were employed as Aboriginal Health Workers (AIHW 2003a, p. 18). Excluding this category, the proportion is a tiny 0.7%—this number would need to be increased almost four-fold to reflect Indigenous representation in the population as a whole (2.4%).

The following table provides an overview of the percentage of Indigenous people participating in selected categories of the health workforce in 2001.

<table>
<thead>
<tr>
<th>Worker category</th>
<th>Total number</th>
<th>Total Indigenous</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical staff (including general practitioners, specialists, medical administrators, trainees)</td>
<td>46 804</td>
<td>151</td>
<td>0.3</td>
</tr>
<tr>
<td>Nurses (including registered and enrolled nurses and nursing assistants)</td>
<td>244 419</td>
<td>1 916</td>
<td>0.8</td>
</tr>
<tr>
<td>AHW (Indigenous health worker)</td>
<td>915</td>
<td>853</td>
<td>93.2</td>
</tr>
<tr>
<td>Dentists and dental workers</td>
<td>25 052</td>
<td>155</td>
<td>0.6</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>12 046</td>
<td>10</td>
<td>0.1</td>
</tr>
<tr>
<td>Allied health professionals</td>
<td>38 645</td>
<td>133</td>
<td>0.3</td>
</tr>
<tr>
<td>Complementary therapies</td>
<td>6 926</td>
<td>24</td>
<td>0.3</td>
</tr>
<tr>
<td>Environmental health officer</td>
<td>3 302</td>
<td>114</td>
<td>3.5</td>
</tr>
</tbody>
</table>

Source: AIHW 2003a, p. 85-86

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\(^6\) Health care providers include medical, medical imaging, dental, nursing, pharmacy, allied health, complementary therapies and other personnel.
There are fewer total health and community services workers in remote areas than in major cities (1498 health workers per 100 000 population in very remote Australia compared to 3005 in major cities; and 796 community services workers per 100 000 population in very remote Australia compared to 1008 in major cities) and high rates of staff turnover in these areas (AIHW 2003a, p. xiv). Rapidly growing areas on the outskirts of major cities also experience low relative numbers of health and community service workers. However, some progress has been made in recent years, as evidenced in the 2001 census results:

- 44 general practitioners identified as Indigenous, 50% more than in 1996;
- 61 Indigenous medical administrators in 2001, almost three times the number in 1996; and
- 921 registered nurses identified as Indigenous, 33% more than in 1996 (694).

4.5.2 Current initiatives

It is imperative to address workforce issues if the capacity of both mainstream and Aboriginal community-controlled health services is to be increased. A coordinated effort by Australian Government and state/territory governments is required to address the training, supply, recruitment and retention of appropriately skilled health professionals, health service managers and health policy officers to work in both mainstream and Indigenous services (Standing Committee on Aboriginal and Torres Strait Islander Health 2002).

All Australian governments endorsed the Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework in 2002, which provides a consistent approach to Indigenous primary health care workforce development. This work is progressed through the AHMAC Aboriginal and Torres Strait Islander Health Workforce Working Group. The key objectives of the health workforce strategy are:

- increasing the numbers of Indigenous people working in all health professions;
- improving the clarity of roles, regulations, recognition, training and support provided to Aboriginal and Torres Strait Islander Health Workers;
- addressing the development needs of other professionals, both health care providers and managers, contributing to Aboriginal and Torres Strait Islander health;
- improving the training, recruitment and retention of both Indigenous and non-Indigenous staff working in Aboriginal and Torres Strait Islander primary health services; and
- making governments accountable for achieving these objectives and supporting Indigenous people to drive the process.

Health professionals


Several initiatives which aim to improve workforce capacity are underway. The Puggy Hunter Memorial Scholarships Scheme, which provides scholarships to Indigenous students in health careers, was established in 2002. AIDA and the Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN) continue to increase their capacity and provide a higher level of assistance and support to their members, especially medical and nursing students.

The Indigenous Nursing Education Working Group (established by OATSIH in 2000) has formulated recommendations to increase the participation of Aboriginal and Torres Strait Islander people in the nursing workforce and to increase the competence of the nursing workforce to deliver culturally appropriate care to Indigenous Australians (Indigenous Nursing Education Working Group 2002). Recommendations address
recruitment and retention of Indigenous nurses, curriculum development and implementation, advanced nursing practice and post graduate education, articulation between Aboriginal Health Worker courses and university study, establishment of partnerships between Aboriginal and Torres Strait Islander communities and universities, and monitoring and accountability. The working group is pursuing the implementation of its recommendations with universities, nursing registration boards and others, with a focus on developing a consistent approach to the education of nurses about Aboriginal and Torres Strait Islander health and culture.

It is generally recognised that as a group ACCHSs experience ongoing shortages in their workforce. A recruitment and retention package for health professionals employed by ACCHSs is required, including individual retention payments (similar to the Rural and Remote GP Program) weighted towards remote and rural services, and recognising the additional difficulties of retaining staff in non-urban areas. Rural health workforce agencies assist ACCHSs, among others, in GP staff recruitment and retention, and this service could well be extended to other health professions.

OATSIH intends to provide a mechanism for strengthening salary supplementation for doctors, nurses and allied health workers employed by Australian Government-funded, Indigenous-specific agencies, especially in rural and remote areas. A key element in attracting medical staff to work in Indigenous primary health care is to ensure that service in Aboriginal and Torres Strait Islander communities contributes materially to a doctor’s career. Currently, leaving the proximity of the major teaching hospitals in the larger cities can have a negative effect on the chance of a doctor being accepted for specialty training or advancement. OATSIH proposes to work with the colleges to ensure that service to Indigenous communities is recognised for these purposes.

Aboriginal Health Workers (AHWs) play a key role in facilitating access to the health system for Aboriginal and Torres Strait Islander people, and there is a need to enhance their skills, raise their professional status and establish the potential for their training to articulate to tertiary sector training and health careers. Community Health Services Training Australia (CSHTA), a national industry training advisory board, is developing revised AHW competencies, aimed at strengthening their role and capacity, with completion expected in 2005. Negotiations to establish AHW associations in each state and territory are taking place, with the first association already established in South Australia.

An implementation package is required to support the new national AHW competencies currently under development, drawing on the lessons learned from the under-utilisation of the 1996 AHW national competencies. This will require the development of standard learning resources, a comprehensive competence assessment strategy, support for ACCHSs for ongoing training and associated salary costs, articulation into the tertiary sector and support for community-controlled Registered Training Organisations. Consistency of application of national competencies across Australian Government and state/territory-funded primary health care agencies is also necessary.

Some important steps in ensuring that mainstream health professionals are trained in Aboriginal and Torres Strait Islander issues have been taken. The Committee of Deans of Australian Medical Schools has made an explicit commitment to increasing enrolments and retention of Indigenous students, and has completed a draft Indigenous studies curriculum, intended to be a standard component of all medical degrees. The Royal Australian College of General Practitioners and some GP divisions are also active in workforce training and development. The Australian Nursing Council also recently endorsed a recommendation that all state and territory nursing registration boards incorporate Indigenous studies in nursing curricula. A Masters of Applied Epidemiology (Indigenous Health) course is operating at the Australian National University (National Centre for Epidemiology and Population Health). OATSIH has funded nursing courses with a
focus on Indigenous health at Deakin and Sydney universities. The Queensland General Practice Alliance has been funded to assist GPs in providing accessible services to Indigenous clients. There does not seem to be similar progress in some other important professions, including dentistry and allied health.

OATSIH intends to pursue a coordinated package of initiatives designed to increase the number of Aboriginal and Torres Strait Islander people working in the health professions. This includes improved retention and support services for Aboriginal and Torres Strait Islander students in tertiary health courses, student incentives, cadetships and scholarships, incentives for innovative course design, on-campus support mechanisms and support for professional associations. Professional associations are key vehicles in providing the close personal support that has been shown to be effective in improving Aboriginal and Torres Strait Islander graduation rates. OATSIH will continue to work closely with the Australian Indigenous Doctors’ Association, the Congress of Aboriginal and Torres Strait Islander Nurses and the proposed national Aboriginal Health Worker association. OATSIH will also work with the GP Education and Training program to ensure that 10% of all GP registrar training places are identified as Indigenous health training places.

Given the significance of the undersupply of health professionals, it would make sense for governments to invest in further strategies to increase the participation of Indigenous young people in health professional education (Objective 1 in the Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework). This is clearly a long-term investment, and an inter-departmental responsibility, and should be sustained for at least 10 to 15 years. The strategies for Objective 2 (roles, regulation and recognition of Aboriginal Health Workers) and the other objectives in the Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework would provide a quicker return, and could be pursued more vigorously with a significant investment.

Management and other support staff

The need for professional development for management and other staff should also be addressed. Areas such as IT, planning, accounting, evaluation and general management are in need of attention.

A health management training course jointly funded by the New South Wales Government, the Department of Employment and Workplace Relations (DEWR) and OATSIH, managed by the Australian College of Health Service Executives and delivered by the University of New England, assists Indigenous managers and aspiring managers to undertake mainstream health management qualifications. It is proposed that this program will be developed nationally as a multi-site program of health management studies, with additional funding support to be sought from state and territory governments and DEWR. This initiative would focus on assisting Indigenous managers or aspiring managers with a track record in health or related sectors to attain recognised mainstream qualifications.

Good human resource practice is also important, and funding to enhance HR management skills (in areas of recruitment, retention, performance management, staff development, job design) for organisations providing health care to Indigenous people could also be allocated.

Management and leadership development for Indigenous managers and board members provides an important opportunity to improve governance and the retention and performance of staff. A small number of strategies should be trialled and evaluated, and the successful ones should be made available at regional, state/territory and national level. Indigenous organisations have a key role as settings for learning, and as the carriers of experience and technical knowledge.

The establishment of stronger regional networks or regional services may also assist in the management of workforce problems. Health professionals and managers are often attracted to diversity and development
opportunities in their jobs, and the potential to work across a regional network may assist with staff recruitment and retention.

4.5.3 Good human resource management practice is also needed

While overall supply of health professionals and skilled support workers is a critical issue, it is also true that agencies can act to improve their ability to attract and retain good staff. Nganampa Health Council, for example, has acted consistently and over a long period of time to enhance its management of staff, provide needed on-the-job training (as well as being a registered provider of training), and provide a supportive working environment for staff (Shannon & Longbottom 2004). Nganampa still experiences staffing difficulties, but they would be more severe without good HR practice.

**Good human resource practice improves recruitment and retention**

An analysis of existing human resource management within a number of effective Indigenous primary health care services has suggested key requirements for effective recruitment and retention strategies (Shannon & Longbottom 2004; Department of Health and Aged Care 2001b). These include:

- the leadership and cultural knowledge of Indigenous management and staff;
- a clear philosophy and mission statement that recognises the value of skilled committed staff and is relevant to their work;
- a well-defined organisational structure with clear roles and responsibilities, and the necessary mix of staff and skills to support an organisation of its size;
- managerial and administrative expertise and a dedicated financial manager;
- a dedicated human resources manager;
- critical mass of staff and resources;
- annual reports produced every year, providing a comprehensive overview of the organisation’s work including financial statements;
- clear policies and procedures, reviewed and updated as required;
- an ongoing program of review and evaluation;
- regular clinical staff meetings (3–4 times per year) to review goals and strategies;
- a recruitment strategy that involves bringing short-listed applicants to visit communities and understand the environment in which they would be working;
- an intense orientation process that includes a focus on cultural issues, the local service delivery context and practical issues (e.g. four-wheel drive training course);
- probation arrangements and active performance management;
- terms and conditions for staff that reflect an understanding of the demands placed upon them and the personal and professional isolation that can be felt working in remote communities. For example, a one-week break every 12 weeks, in which staff are required to leave the remote setting; an open phone policy, which encourages staff to seek advice and de-brief on difficult issues;
staff supported in their roles by skilled technical advisors and visiting specialists;
• staff supported by key local community people with specialised knowledge;
• a professional development program which staff are encouraged to undertake and which is related to service activities;
• secure recurrent funding for staff training programs;
• career advancement possibilities within the organisation;
• a high value placed upon the role of the Aboriginal Health Workers as a critical component of the primary health care system;
• a comprehensive accredited Aboriginal Health Worker training program;
• long-serving staff who carry corporate memory; and
• adequate salaries.

The availability of a skilled workforce is a major limiting factor on the capacity of the health system to provide effective health care to Indigenous Australians. The Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework (SCATSIH 2002) sets out specific objectives and methods of pursuing them, and provides a policy framework for addressing workforce shortages. Strong investment in workforce development will be important as part of an overall strategy to enhance Indigenous access to effective primary health care. Good human resource management practice also contributes to agencies’ ability to attract and retain good staff.

4.6 Information and data

Good information and data is required to support planning, evidence-based practice, quality improvement and for monitoring and reporting on changes over time. To be most useful, this data should be accurate, consistent, tracked over time and freely available to all who want to use it, especially Indigenous communities and health services.

4.6.1 The National Strategic Framework for Aboriginal and Torres Strait Islander Health: goals and strategies

To support the collection, collation and publication of accurate comprehensive data, capacity building at the local, state/territory and national levels is required. Priorities have been specified in the National Strategic Framework for Aboriginal and Torres Strait Islander Health. In relation to improving data availability and quality the National Strategic Framework for Aboriginal and Torres Strait Islander Health makes the following recommendations:

• Continuing implementation of the National Aboriginal and Torres Strait Islander Health Information Plan;
• Developing consistent environmental health audit tools and environmental health indicators for Indigenous communities;
• Linking data collection activities at all levels of government between health services, housing agencies and other community and welfare programs to facilitate a cross-sectoral approach and support preventative and environmental health activities;
• Conducting representative surveys where there are important information gaps (such as oral health);
• Improving the quality, collection and management of health workforce data in both mainstream and
Aboriginal community-controlled health services.

In relation to the development of data, information management and utilisation at the service level, the
National Strategic Framework for Aboriginal and Torres Strait Islander Health specifies:
• development of minimum data sets useful for planning at local, regional and state/national levels;
• development of a framework that clarifies the nature and purpose of existing data and identifies and
addresses gaps; and
• investment in information technology and staff skills to enable establishment of improved data systems
in primary health care services, including computerised patient records for use as care planning tools,
and improved resources for evaluation and analysis of health system data.

Further, the National Strategic Framework for Aboriginal and Torres Strait Islander Health recommends that
to improve data quality and availability, continuing oversight of data issues by the National Advisory Group
for Aboriginal and Torres Strait Islander Health Information and Health is needed. It is essential to make
sure that Indigenous people are involved in developing data collections so that they are appropriate to their
needs. It is also vital to ensure that:
• the ABS standard for Aboriginal and Torres Strait Islander identification is used in all data collections;
• training and support to health care staff for collecting data about Aboriginal and Torres Strait Islander
status at all collection points is provided;
• the employment of Indigenous people by organisations involved in data collection, analysis and
research is encouraged;
• the ABS survey and census collection program is maintained;
• mainstream data collections include adequate samples of Aboriginal and Torres Strait Islander peoples; and
• annual reporting of the Aboriginal and Torres Strait Islander National Performance Indicators is
maintained.

These goals and activities need to be adequately resourced. Activity to address both the national- and
agency-level information needs is underway, and is described below.

4.6.2 Information for clinical, management and accountability needs

The data required for national collections of health status, and for monitoring at the national level are often
different from the data required for management, evaluation, and quality improvement at the agency level.
This information is vital to the effectiveness of care and for accountability, and will also require resourcing.

A Service Development and Reporting Framework for OATSIH-funded services is being developed. This
work is intended to make reporting easy for service providers, and to enable them to use the information
they collect for continuous quality improvement and evaluation. Compliance with reporting will be built
into accountability requirements under the single funding agreements.

It is critical that data collection for reporting is not over-burdensome for agencies (Sibthorpe et al. 2003, p.
2), can be incorporated into daily practice, and produces information that is meaningful for communicating
with communities. This means that routine data collection is necessarily limited in scope. To complement
routine datasets, it may be useful to establish nationally coordinated sentinel sites for comprehensive data
collection on specific issues or activities. Establishing sentinel sites would also enable piloting of data collection methods and refinement of data. The Cooperative Research Centre in Aboriginal Health and other research groups have the needed capacity to support this work.

4.6.3 Information for health system performance measurement

Growing demands for health care, rising costs, limited resources and evidence of wide variations in health care practice have prompted interest across the world in the measurement and improvement of health system performance.

Indicators of long-term health outcome (such as increased life expectancy at birth) are too distant in time from the factors that impact on health to be useful for policy makers and others in their endeavours to measure the success of programs and interventions. Focusing only on the longer-term outcomes can create the perception that nothing is changing and engender a sense of hopelessness, when in fact there may be good evidence that gains are being achieved (SCRGSP 2003).

Performance indicators should enable measurement of health system functions and should provide answers to questions about relationships between different elements of the system (e.g. between health financing, and the level and distribution of health services) (Murray & Frenk 2000). Good data collection is clearly critical if performance indicators are to be meaningful.

Interim National Aboriginal and Torres Strait Islander Health Performance Indicators, which were intended to enable governments to report on progress towards improving Indigenous health, were endorsed by AHMAC in 1997. These indicators covered mortality and morbidity, access to and impact of health services, workforce development, health risk factors, intersectoral issues, community development, and quality of service provision and were reported on in 1998, 1999 and 2000 (ABS & AIHW 2003). A refined set of 56 indicators and a draft framework were developed by the Cooperative Research Centre for Aboriginal and Tropical Health in consultation with the AIHW, OATSIH, SCATSIH, NHIMG and NACCHO and endorsed in 2000 (ABS & AIHW 2003). These indicators pertain to government inputs, social equity, access to health services, risk markers and outcomes for people (Burns et al. 2002). However, data for reporting against indicators were either not available or of poor quality in many jurisdictions and all jurisdictions have agreed to continue reporting and to attempt to make improvements to enable complete coverage in the future (ABS & AIHW 2003). SCATSIH has prioritised 15 indicators (see Table 5) and is overseeing a scoping project to identify the improvements that are needed to enable reporting against them.
Table 5: Priority indicators from the current National Performance Indicators for Aboriginal and Torres Strait Islander Health

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Impacts</th>
<th>Inputs and processes</th>
<th>Management of key conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life expectancy at birth</td>
<td>Pap smear rates</td>
<td>Government expenditure</td>
<td></td>
</tr>
<tr>
<td>Infant mortality rate</td>
<td>Childhood immunisation</td>
<td>Indigenous workforce</td>
<td></td>
</tr>
<tr>
<td>Low birth weight babies</td>
<td>Smoking prevalence</td>
<td>Access to health care</td>
<td></td>
</tr>
<tr>
<td>Child hearing loss</td>
<td>Alcohol consumption</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vaccine-preventable disease rates</td>
<td>Age-specific death rates and ratios</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overweight and obesity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexually transmitted infection rates</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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</tbody>
</table>

In May 2003, SCATSIH agreed to oversee the development of a national Aboriginal and Torres Strait Islander Health Performance Framework (ATSIHPF) to support the implementation of the National Strategic Framework for Aboriginal and Torres Strait Islander Health, consistent with the mainstream National Health Performance Framework (Australian National Health Performance Committee 2001). This Framework includes three levels: health status and outcomes, determinants of health and health system performance. Equity is intended to be built into each level. The health system performance level has nine dimensions (effective, appropriate, efficient, responsive, accessible, safe, continuous, capable and sustainable). OATSIH is currently undertaking work to define each of the dimensions of health system performance from Aboriginal and Torres Strait Islander perspectives as well as to map existing indicators that may be useful.

Both the National Aboriginal and Torres Strait Islander Health Performance Framework and the Service Development and Reporting Framework should be supported. It is essential that indicators of primary health care performance are harmonised across the two frameworks, using common data definitions (where relevant) and ensuring that processes of collection, processing, collating and analysing data are synergistic.

Investment in improved data collection by primary health care providers is essential, but needs to be focused and streamlined. As much as possible, routine data collection in primary health care organisations should be a by-product of administrative and clinical processes. Routine comprehensive collection on some key indicators should be complemented by sentinel site surveys and research. The Aboriginal and Torres Strait Islander Health Performance Framework project is expected to deliver valid indicators of impacts and outcomes.
The work by AIHW, ABS, OATSIH, state/territory health authorities and health care providers over recent years to improve data collection, including the identification of Indigenous status, provides a strong foundation, but further effort is required. We conclude that the elements of an effective performance monitoring system are in place or in progress, as a result of focused effort over several years, and results should be forthcoming within a reasonable timeframe.

4.7 Working with other sectors: healthy public policy

Governments and health systems are often criticised for failing to work effectively with other sectors, and thereby failing to take advantage of opportunities to enhance the health impacts (or reduce the health risks and consequences) of policies and programs in other portfolios of government and in industry generally.

The goal of intersectoral collaboration is pursued vigorously in rhetoric, but is in fact a real struggle to achieve. There are many good reasons for this—health is not the goal of living, but a resource for living, and not every decision can be based on health considerations. Lack of attention to health goals by other portfolios is also an inevitable downside of the necessary structuring of the work of government into functional portfolio areas.

However, effective intersectoral collaboration can strongly enhance the effectiveness of health expenditure. Beaver and Zhao estimate that it might be possible to increase the benefits of primary health care by 35% when other sectors, and the community, are highly engaged (Beaver & Zhao 2004, p. 34). There is evidence of consistent effort by Indigenous organisations to take advantage of this potential leverage. For example, service activity reports show that approximately 80% of Australian Government-funded Aboriginal and Torres Strait Islander primary health care agencies have undertaken some school-based activity; approximately 75% have provided support for public housing issues (OATSIH & NACCHO, 2003); while 20% have organised store-based dietary interventions (Keys Young 1997). The Keys Young report notes that capacity to do this appears to be linked to funding—better-funded services are more likely to be proactive.

The critical factors for success seem to be a combination of:

- an important health issue at stake;
- a practical method, with a strong cost–benefit case, of enhancing health impact (or minimising health risk) within another system; and
- leadership at the key pivot point, which may be local, regional, state/territory or national.

The best approach to enhancing the effectiveness of intersectoral collaboration may be to establish the conditions that enable opportunities to be exploited, rather than attempting to set up machinery that requires reporting about collaboration (such as a mandatory health impact statement), which does not have a proud record of success. Very different approaches might be needed at local versus national level, and while uncertainty about effectiveness remains, experimentation should continue. The following conditions might enable opportunistic gains in this respect:

- Recognition of the legitimacy of primary health care providers working with key local services such as schools and councils, to identify health hazards that can be addressed locally;
- Strengthening of information systems through which local and regional patterns of health problems can be identified and analysed;
- Support for local and regional coordinating mechanisms, such as standing cross-portfolio forums, which build relationships and create opportunities for collaboration;
- Development of mechanisms to enable primary health care providers to generate quick responses to maintenance/environmental issues that directly impact on health, such as leaking sewage drains.
The current program of Shared Responsibility Agreements under the aegis of COAG (Office of Aboriginal and Torres Strait Islander Affairs 2003) are a potentially important move to enhance the capacity of government to work across portfolios and the Australian Government/state/territory divide, and with Indigenous communities. Careful evaluation of this initiative will provide valuable insight into the factors that drive success as well as those which impede it.

Analysis of models from Canada (for early childhood policy and services) (Budgell 2002), the UK ('joined-up government', again often focused on support for families with young children) and the USA could also offer useful insights (Eades 2004).

It is important that work on intersectoral collaboration be focused at ‘the pointy end’—that is, be driven by substantive opportunities rather than simply general principles. As noted earlier, there is an ever present risk of wasting time and resources on enterprises with little chance of success.

It would be useful to select a small number of key intersectoral issues, in collaboration with Indigenous organisations, for follow-through. Examination of the non-health determinants of key Indigenous health problems indicates that the following issues may be high priority:

- Family and community violence and abuse
- Support for early childhood development and effective parenting
- Improving educational opportunities for disadvantaged children (both health and social disadvantage)
- Trauma and injury prevention
- Alcohol and substance use
- Environmental risk factors (local and regional).

The following principles should apply.

- Clinical and public health expertise should be made available for working with other sectors, as this is the ‘value add’ the health system can offer.
- ACCHSs and other primary care agencies/services should be recognised as a strong source of knowledge about local and cultural issues, and should be resourced to participate in intersectoral work. At the same time, the reality that they cannot alone be responsible for outcomes on issues outside their control must be recognised.
- Engagement with industry should be based on local issues and specific evidence for effective methods.
- ATSIC and ATSIS are important partners for interactions between Indigenous communities and other Indigenous programs.

We suggest that approaches to intersectoral collaboration should be pitched at two levels. Firstly, Indigenous primary health care organisations should be resourced to pursue local opportunities to address health risk factors and preventable illness through working with other sectors on practical programs with a health component, and the legitimacy of their roles as advocates should be recognised. Secondly, at the national level, a short list of key issues should be identified and proposed to government for endorsement as a required focus for cross-portfolio action by the relevant departments. We would strongly urge that this list include a focus on early childhood development and health, for two reasons: this area is critically important for the future of Indigenous communities; and there is good evidence regarding a range of cost-effective interventions (Eades 2004).
5 Measuring improvements and required investment

The fundamental question that this paper addresses is whether increased (that is more equitable) investment in comprehensive primary health care for Indigenous Australians will result in a measurable improvement in health and wellbeing, and if so, how best should that investment be deployed. Our assessment is that there is now sufficient knowledge about how to invest additional funding for health gain that a planned progressive increase in investment is warranted. This part addresses the impacts and outcomes that might be achieved, the required level of Australian Government investment, and the funding methods and programs required. A short conclusion completes the paper.

5.1 Measuring the impact of adequate investment

It will be important, as part of a program of increased investment in primary health care for Indigenous Australians, that a manageable number of sensitive indicators of health outcomes and impacts are chosen and consistently monitored over time. People can then focus on ensuring that data collection and data quality activities provide the information needed to support sound monitoring. However, indicators are just artefacts that stand as signposts towards the goal of equitable health outcomes and cannot be allowed to displace the goal itself (as those who have focused on surgical waiting lists in various states have inevitably learned).

The lead times between increased investment in effective programs and improved health outcomes as measured by life expectancy are long. If the goal is to ensure that investment in health care is effective, it is more useful to monitor intermediate indicators of outcome and impact, because these indicators are more sensitive and results can be assessed in a shorter timeframe.

Only sustained effort will bring results

‘Current Indigenous mortality rates are at a level last seen for all Australians back in the early 1950s. For overall life expectancy, the corresponding reference point is the early 1920s. Given these excessive time lags in the profile of mortality, even if the pace of mortality change that has occurred among the total Australian population were to now apply to the Indigenous population, it would still take another 40 years before the Indigenous infant mortality rate reached the current level observed for the total population. Moreover, unless program efforts aimed at improving health outcomes for Indigenous Australians are dramatically enhanced, with commensurate effects, it will take another seven decades before the expectation of life at birth among Indigenous Australians reaches the level currently recorded for the total population. Clearly, the timetable for Indigenous mortality improvement is long term, and this adds further weight to the opportunity cost argument that there is an imbalance between health expenditure on Indigenous Australians and their needs’ (Kinfu & Taylor 2002, p. v).

The release of Overcoming Indigenous Disadvantage: key indicators 2003 by COAG has established a new framework for developing useful indicators. The chosen goals and indicators are rightly focused on enabling effective monitoring of progress towards equitable outcomes for Indigenous Australians. However, the COAG framework is not specific enough to measure health system performance, and the indicators require further development and interpretation to be useful at this level (SCRGSP 2003, p. XXII).

The Aboriginal and Torres Strait Islander Health Performance Framework being developed by SCATSH will include measures that reflect program logic for the whole health system from inputs through to outcomes and will distinguish between short-, medium- and long-term measurement of health system activity.
The ATSIHPF recognises that headline indicators such as mortality and life expectancy are significantly influenced by factors outside the control of the health system. Therefore, while health system performance will be measured against factors that are attributable to the health system, other determinants of health will also be measured to enable monitoring of progress across the whole spectrum of factors that influence health outcomes.

Health outcomes will be measured in relation to prevalence of disease and functional impairment, life expectancy, wellbeing and mortality. Determinants of health such as socioeconomic and environmental status, community capacity, health behaviours (e.g. smoking and excess alcohol consumption) and individual factors (e.g. blood pressure, cholesterol levels) will also be included. The ATSIHPF will measure health system performance in relation to nine domains of health system activity and overarching principles of quality and equity. One of the objectives of the Aboriginal and Torres Strait Islander Health Performance Framework is to include performance measures that recognise that comprehensive primary health care systems and appropriate secondary and tertiary health care are being developed, but have not yet been achieved.

Long- and short-term targets for improved Indigenous health and improved access to health care should be established on the basis of the Aboriginal and Torres Strait Islander Health Performance Framework and the Service Development and Reporting Framework, both currently under development.

5.2 Required level of Australian Government investment

This section examines current funding levels and patterns of use, and the estimated levels of spending required to enable equitable access to comprehensive primary health care, and to maximise health gain.

5.2.1 Current funding levels and patterns

The current level of spending on Indigenous health care is inadequate to meet the health needs of the population. Recent expert analysis of total spending and Indigenous health-care needs relative to non-Indigenous Australians (see below) shows clearly that less than half of the required funding is currently available. Within this total level of spending, there is also a mismatch of type of investment, with low spending on primary health care offset by higher use of hospital care (at approximately twice the rate of non-Indigenous Australians), which is neither good for health nor an efficient use of health resources.

Total expenditure on health services for Aboriginal and Torres Strait Islander Australians is estimated at $1245 million in 1998–99. This was equivalent to $3065 per person, compared with the $2518 per person estimated to have been spent for non-Indigenous Australians. This equates to $1.22 being spent per Indigenous Australian for every $1 spent per non-Indigenous person (AIHW 2001).

There are three major distinctions in types of health expenditure that must be understood in this field—mainstream versus Indigenous-specific, Australian Government versus other (state/territory, non-government and private), and primary health care versus secondary and tertiary care. Mainstream funding programs are major source of total health expenditure on Indigenous Australians, but if only primary health care expenditure is considered, mainstream Australian Government primary health care programs (MBS and PBS) provide less than half of the total.

The vast majority of total expenditure on Aboriginal and Torres Strait Islander Australians in 1998–99 (90%) was through mainstream Australian Government and state/territory health services, with inpatient hospital care making up the largest single component (36.4%, compared to 21.8% for non-Indigenous Australians). Only about 13% of total health expenditure on Indigenous Australians arises from use of mainstream Australian Government funding programs (including MBS and PBS), compared to 37% for non-Indigenous Australians (AIHW 2001). See Table 6 below for further details.
Table 6: Estimated health expenditure per Indigenous and non-Indigenous person 1998–99

<table>
<thead>
<tr>
<th>Through state/territory programs</th>
<th>Per person Indigenous ($)</th>
<th>Per person non-Indigenous ($)</th>
<th>Ratio Indigenous/non-Indigenous</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted patient expenditure</td>
<td>1 115</td>
<td>548</td>
<td>2.04</td>
</tr>
<tr>
<td>Other through state/territory program expenditure</td>
<td>1 090</td>
<td>372</td>
<td>2.93</td>
</tr>
<tr>
<td>Total through state/territory programs</td>
<td>2 205</td>
<td>920</td>
<td>2.40</td>
</tr>
<tr>
<td>Through Australian Government programs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indigenous-specific programs</td>
<td>298</td>
<td>1</td>
<td>..</td>
</tr>
<tr>
<td>MBS/PBS</td>
<td>224</td>
<td>601</td>
<td>0.37</td>
</tr>
<tr>
<td>Other Australian Government programs</td>
<td>169</td>
<td>336</td>
<td>0.50</td>
</tr>
<tr>
<td>Total through Australian Government programs</td>
<td>691</td>
<td>937</td>
<td>0.74</td>
</tr>
<tr>
<td>Through local government programs</td>
<td>20</td>
<td>11</td>
<td>1.78</td>
</tr>
<tr>
<td>Services through private sector programs</td>
<td>148</td>
<td>650</td>
<td>0.23</td>
</tr>
<tr>
<td>Total recurrent expenditure</td>
<td>3 065</td>
<td>2 518</td>
<td>1.22</td>
</tr>
</tbody>
</table>

Source: AIHW (2001, p. 4)

Setting aside state/territory and private expenditure, the largest avenue of delivery of *Australian Government funding* is through Indigenous-specific programs (43%), at a level of around $300 per person (AIHW 2001).

MBS and PBS spending has increased in recent years in response to changes designed to make medical and pharmaceutical services more accessible to Indigenous Australians, but is still less than half the equivalent spending on non-Indigenous Australians, without adjustment for need or remoteness. This is partly compensated for by grant funding through OATSIH, but the total level is still inequitable in comparison to non-Indigenous Australians, and inadequate to maximise health impacts and outcomes.

Adjustments for need and remoteness add significantly to total costs. Given the poorer health of Indigenous Australians, equitable access to health care would result in higher than average use. The additional cost of delivering services in remote areas, and other characteristics such as high proportions of patients who primarily speak languages other than English and lack literacy skills, mean that higher unit costs of care are also incurred.

5.2.2 Estimating needed funding levels

There is no simple answer to the question of how much funding will deliver the required level of access to effective care. The economic modelling that has been done in recent years (Econtech 2004; Commonwealth Grants Commission 2001; Mooney *et al*. 1998; McDermott & Beaver 1996; Beaver *et al*. 1996; McDermott 1995) has variously allowed for burden of illness, remoteness, costs of treating people with little or no English, and the costs of infrastructure. Estimates range from 2.2 to 7.3 times the average per capita resources required by the non-Indigenous population. OATSIH has analysed the modelling work, noting that some of the studies use data from specific populations, such as Indigenous people living in the NT. When figures are adjusted to take into account the Indigenous population on a national basis, and including allowance for remoteness and burden of illness, they fall between 3 and 6 times the national average per
capita expenditure (OATSIH 2003e). The Commonwealth Grants Commission concluded that ‘at least 2 times’ average per capita expenditure was required given adjustment for poorer health status and greater reliance on the public system; and that this number would need to be multiplied by a factor of up to 2 to allow for the impact of greater costs in remote areas.

Econtech (2004), in a paper commissioned for the Review, estimates the required level of total health funding on a population needs basis (i.e. adjusting for the poorer health status of Indigenous people) at approximately 2.21 times the spending on non-Indigenous health care. There was no adjustment made for the additional costs of remoteness or for culturally appropriate services.

The Econtech paper also estimates the cost of bringing funding for Indigenous-specific services to the level currently provided to a set of eight ‘best practice’ Indigenous health services (2 very remote, 1 remote, 2 rural and 3 urban). Agencies were selected for the Econtech modelling on the basis of location (i.e. a mix of urban, rural, remote) and mode of service delivery (i.e. a mix of hub and spoke model, town-based service with outreach services and stand-alone service). In all cases agencies selected were high capacity sites demonstrating current best practice in the delivery of effective health primary health care services for Indigenous Australians.

The costing study indicates that, to extend the current level of care provided by these agencies to all Indigenous Australians, an average funding level of $890 per person is required (ranging from $2789 per person in very remote to $399 in urban areas). This is compared to the 1998–99 average per capita level of OATSIH funding of $295 per capita. The total cost of this level of funding is $409 million. The authors note the limitations of this method, including the lack of allowance for unmet need, for variations in the availability of alternative services or for inadequate staffing in some key areas (including specialists and allied health professionals). If an allowance is made for the cost of achieving adequate staffing in remote areas, the costs rise to $944 per capita or $432 million. They also note that this is modelling for the provision of ‘best practice’ in one component of the care system, Indigenous-specific services, rather than for a comprehensive care system. That is, the figures do not include mainstream programs such as Medicare, which would need to be considered as part of an integrated system. The authors also assume no increase above the current ‘best practice’ levels in any location, that is, no allowance is made for unmet need in the areas served by the chosen agencies.

The OATSIH analysis (OATSIH 2003e) concluded that the lower resource estimates emerge from modelling of the costs of a minimum level of health services. The higher estimates relate to the cost of providing additional services, to address health inequities and to provide culturally appropriate programs.

Health gain from additional resources is not a straight-line ‘dose response’ relationship. In a situation where there is inadequate primary health care to enable effective interventions to be provided to those who need them in a comprehensive, coordinated way, there is an outcomes curve. Too much money will give rise to diminishing returns, too little may not enable the system to reach the tipping point where health gain begins to be seen. This view is supported by the modelling undertaken by Beaver and Zhao (2004), and the strongly positive saving:cost ratios from optimal investment for the nine conditions, particularly arising from Clinical PHC (new cases) and Clinical PHC (existing cases) (Beaver & Zhao 2004, p. 21).

We conclude that total health spending on Indigenous populations would need to be increased to a level between 3 and 6 times the current national average per capita expenditure to achieve equitable access to effective care. It is beyond the scope of this paper to estimate the budget implications of applying this modelling to OATSIH and other funding programs.
5.3 Funding methods, programs and timelines

This section addresses the Primary Health Care Access Program (PHCAP) as a funding framework to resource comprehensive primary health care, then turns to funding formulae. We discuss the need for certainty and longer-term funding cycles; the need for a phased development program; and the need for effective accountability mechanisms. Our proposals are summarised in the final section.

There has been much progress in recent years towards making existing funding programs more effective, including the gradual implementation of PHCAP; improvements in the accessibility of MBS and PBS (addressed in section 3.3); growing understanding of the costs of service delivery; and increased funding for infrastructure, training and other development needs through OATSIH. Much has been learnt about how additional investments might best be deployed.

5.3.1 PHCAP provides a framework and a method

The Primary Health Care Access Program is a program of health system reform being implemented in partnership between the Australian Government, each state or territory government, the ACCHS sector and ATSIC (OATSIH 2003c). PHCAP has three objectives:

• to increase the availability of primary health care services in areas where they are inadequate;
• to reform the local health system so that it meets the needs of Indigenous Australians; and
• to empower people to take better care of their own health.

A formal agreement will be established between the Australian Government and each state and territory, via a memorandum of understanding (MOU), committing them to jointly fund improved comprehensive primary health care to better meet the needs of Indigenous Australians. Each MOU will include a commitment to:

• a range of potential models for service delivery with a preference for community-controlled models;
• joint funding arrangements that include maintenance of existing effort and an increase in resources in line with the arrangements in the Framework Agreements;
• financial transparency;
• potential funds pooling and other joint service arrangements; and
• re-investment of savings made in the acute sector from increased investment in primary health care (OATSIH 2003c).

The process is careful and complex. Funds are only allocated through PHCAP in states/territories where joint regional plans specified under the Framework Agreements have been completed. Only a few sites in each state/territory are being developed under this arrangement and many of these sites have a cap of 2000 on the population size that can be covered (as there were not sufficient funds to extend the program to the whole population). This has caused considerable debate and meant that implementation processes were more complicated than they might have been. It is intended that different implementation arrangements will be made in each state/territory, but implementation must ensure a joint approach to the roll-out of PHCAP and include strategic planning in the relevant local area. Local-level planning will include:

• identification of needs, priorities and gaps in both mainstream and Indigenous services;
• how services can be improved and expanded to form an effective and integrated local area health system; and
• governance and fund-holding arrangements.
The maximum level of funding to be allocated by the Australian Government under PHCAP is determined with reference to benchmarks that take into account the poorer health of Indigenous Australians and the increased cost of providing services in remote areas. The mix of funds will vary with the capacity to use Medicare (OATSIH 2003b). The basic benchmark is 2 times the average per capita use of MBS with an additional loading for remoteness (up to 4 times per capita use of MBS). The funding, which is assessed against the benchmark, includes funds currently utilised through the MBS, funds currently allocated for primary healthcare services and other funding. A total of $78.8 million over four years was allocated in the 1999–2000 Australian Government budget, and a further $19.7 million/year to be allocated from 2003–04 was committed in the 2001–02 budget, taking the total recurrent base to $54.7 million per annum (OATSIH 2003c).

Local-level planning provides opportunities to fill service gaps, improve links in the system (to improve care coordination and reduce duplication) and provide arrangements for greater community involvement (OATSIH 2003c). The case study below demonstrates the use of PHCAP to bring mainstream and Indigenous-specific services into partnership, with a net increase in the resources available to the local Indigenous community.

PHCAP sites include the four former Aboriginal Coordinated Care Trial sites, five sites in South Australia, seven sites in the Northern Territory and five in Queensland. A recent appraisal of the implementation of PHCAP strongly supports the program, identifying that the conceptual foundation, operational framework, long-term commitment and use of planning processes as a way of engaging communities and service providers are excellent aspects of the program (Mandala Consulting 2003). However, there is some concern in the field that the Program is ‘too bureaucratic’ and the machinery for approving expenditure under PHCAP is unnecessarily complex; that the ‘rules’ seem changeable; and that significant delays are being experienced as a result. Recommendations for improvement include simplifying the program, allowing greater flexibility to respond to different operating circumstances and expediting progress (Mandala Consulting 2003).7

Case study: PHCAP and the mainstream in Northern Adelaide

The strategic planning process undertaken in the Northern Metropolitan Region of Adelaide achieved a whole-of-system approach by engaging Indigenous community members and bringing them together with both Indigenous-specific and mainstream service providers.

The key to the success of the working relationships was a common vision to create a united Aboriginal Health Team. The mechanism was an MOU between two community-controlled health services and a mainstream community health service, which identifies clear service improvement outcomes. The planning identified service gaps for Indigenous people and proposed integrated mainstream and Indigenous-specific strategies to close the gaps.

Major achievements of the planning process were greater collaboration and coordination of programs and services on the ground and a significant increase in the commitment of the mainstream agencies to Indigenous health.

7 The Department of Health and Ageing is currently reviewing PHCAP and seeking to simplify arrangements for PHCAP implementation.
For example, during the course of the planning process the State Government increased their annual recurrent financial contribution by $747,800 with a commitment to an additional $519,000 in one-off funds for specific initiatives such as capital works and program development.

Additional Australian Government funds made available through PHCAP (including access to MBS and PBS) are supporting increased access to GPs, nurses and Aboriginal Health Workers, child and youth services, men’s health, nutrition and diabetes programs. In addition, both Governments have made substantial commitments to upgrade and refurbish clinic facilities at the two health sites, which provide a ‘shop-front’ for delivery of a range of jointly funded services.

The CPHC approach provides for multidisciplinary health assessments and referrals to relevant allied health professionals, specialists, clinics and social services such as food banks and financial counselling (which now provide outreach sessions to both sites). Other actions include the development of culturally appropriate protocols with the major hospital in the region, and arrangements for referrals to local GPs.

Institutional racism is also being addressed, through revision of relevant policies and procedures, input to student training and cultural awareness training to achieve behaviour change in mainstream workers. This strong reform approach includes strategies to improve services for Indigenous people in the major public hospital in the region, as well as mental health services, GPs and prisons (including exit planning).

The planning process has given community members a greater understanding of the services in the region and an understanding of how PHCAP has the potential to improve them. A ‘Leadership Group’ has been formed to provide advice and oversee the planning, development and implementation of health and human services (both mainstream and Aboriginal-specific) for Aboriginal people in the region. This will ensure continuing involvement of the community in setting directions for the region and will maintain a coordinated approach to Aboriginal affairs by Aboriginal people for Aboriginal people in the region.

Case study provided by OATSIH 2003.

The National Strategic Framework for Aboriginal and Torres Strait Islander Health and the agreed regional health funding benchmarks established under PHCAP provide a useful basis on which to plan funding growth. The contributions made to primary health care funding by the Australian Government and state/territory governments vary in each jurisdiction. Figure 5 below compares these contributions with the PHCAP regional health funding benchmarks. These benchmarks are based on the ‘basic’ PHCAP model adjusted for regional cost variations. This gives an indication of the minimum level of resources required jointly between the Australian Government and state/territory governments to enable the development of effective primary health care services for Indigenous Australians.

In every jurisdiction, the Australian Government is providing well below the benchmark of what is provided for non-Indigenous Australians, largely because of under-utilisation of MBS and PBS programs. By contrast, in every state and territory with the exception of South Australia, the states and territories are funding at or above the benchmark. To assist in improving access to MBS funding, it would be helpful to allow primary health care providers to negotiate options including a choice between billing and partial cashing out the MBS aliquot for their populations.
Given the progress made under the PHCAP arrangements, and the investment in consultation, planning and negotiation forums, PHCAP offers the most practical and potentially most effective approach to a funding rollout. The key requirements to make this work include the following:

- increased investment, which will not only enable service development, but also give the parties to the enterprise a strong motivation to make it work;
- continuation of development of effective multi-party forums for planning and negotiation;
- continuation of the principle that funding increases are for additional services, not substitution; and
- engagement of mainstream providers as part of the system of care for Indigenous Australians.

Success for any partnership or alliance project, in the commercial world, in government and in the health care system, requires careful attention and considerable investment in relationship-building, including the development of trust and mutual understanding of business or policy imperatives and organisational cultures (Spekman & Isabella 2000). The PHCAP project faces all of these challenges, with the additional element of intercultural communication. No-one should be surprised that progress is initially slow, or that the road is rocky. The benefits are seen when mature alliance partners are able to work together to a level not previously possible and achieve mutually beneficial outcomes.

The Katherine West CCT has demonstrated the potential benefits of strategic use of increased resources. The pooling of an Australian Government allocation based on modelled per-capita PBS/MBS expenditure, and the Northern Territory Government’s budget for the purchase of health services and administrative costs was backed up by an administrative contribution from OATSIH. The trial tested a potentially sustainable alternative method for funding primary health care that drew
on Australian Government medical and pharmaceutical benefits, capitating and adjusting for relative need. While the method was debated, the testing of a new approach and commitment of increased funding has been successful in both health gain and good governance in a community control model (Shannon et al. 2002, pp. 55–56).

We recommend that the rollout of PHCAP continue and be accelerated using additional funding. PHCAP provides a framework for ensuring sound planning and allocation of funding, for collaboration between mainstream and Indigenous providers, and for managing the partnering relationships among key stakeholders, including governments, that are a necessary part of this endeavour. We considered the option of revising or rebadging the PHCAP program, because of the negative feelings in some areas about delays, and because of the inevitable wear and tear in partnership programs. We concluded that there is more to be gained by persisting, and not wasting the existing progress and learning.

5.3.2 Funding formulae and phasing

A range of funding approaches is required, both for different agencies and for different operations within agencies. A mixed model could involve tailored combinations of:

- a base grant for infrastructure (management, support services, training, IT, data collection and reporting) and for a base line service capacity (clinical management);
- capitation-based grant funding for a specified platform of primary health care services for the defined catchment population (which could in remote areas include non-Indigenous people);
- simple grant or fee-for-service arrangements (with low transaction costs) for services to additional patients (visitors, etc.);
- negotiated grants for specific additional services (i.e. for participation in ‘vertical’ programs, such as the Eye Health Program);
- capital and equipment funding, based on business plans.

Funds pooling is one method that has much to offer under the PHCAP umbrella, but it is not the only way to bring Australian Government and state/territory funding together, and should remain as one of a range of approaches. It may be particularly relevant in remote areas where there is only one provider, but joint funding of agencies may also be appropriate in other areas.

The need for improved funding is urgent, but the gap between current and needed levels (between 3 and 6 times the current OATSIH funding) is so large as to be unbreachable in the short term. A staged long-term program of growth in funding would be required to enable sustained growth in capacity, while also ensuring that the most effective interventions and service models are used. ‘Front-loading’ of investments in workforce development, governance capacity-building, data, information and other infrastructure for quality would enhance the effectiveness of funded service delivery and smooth the budgetary requirement.

5.3.3 Funding certainty

The literature review and over 100 case studies initially nominated for consideration by Shannon et al. (2002) (only 10 met their selection criteria for inclusion) demonstrated the ‘stop–start’ nature of past Aboriginal and Torres Strait Islander health policy and the short funding cycles that programs endured.
There has been a repeated search for innovation which results in a high turnover of projects and recycling of ideas, rather than utilising the not insignificant knowledge currently available and properly evaluating its effectiveness. The combination of rigorous evaluation, with realistic performance indicators, and extended cycles of funding would contribute to greater organisational stability and enable capacity building to occur.” (Shannon et al. 2002, p. 66)

One of the clear requirements for improved performance in Indigenous primary health care is to move the balance of core and project-specific funding, so that higher proportions of total budgets are predictable. Reliance on ‘soft funding’ is a serious impediment to recruitment and retention of staff, and to strategic planning and development of services and organisations. Effective accountability must be assured, but ‘stop-start’ funding is not the best way (Shannon et al. 2002, p. 56).

The Australian Government (OATSIH) is aware of this problem, and much of its budget is allocated to service providers in a predictable way. However, OATSIH is not the only funder, and further progress towards reliable funding levels is needed.

Funding for ongoing primary care services needs to be made more certain, so that agencies can consolidate their focus on quality and effectiveness.

5.3.4 Accountability in a developmental framework

Accountability requirements should reward effectiveness, and enable the sharing of lessons learned. ACCHS organisations point out that their funding is more closely monitored than any other health sector. However, it is still important that funding and reporting requirements are designed so as to focus on the achievement of outputs rather than accurate accounting for inputs. It is equally important that the real costs of infrastructure and development are recognised, and that use of this portion of funding is monitored in appropriate terms (that is, in terms of capacity building rather than health service volume outputs) over an extended timeframe. The international development field may provide useful examples of methods for ensuring accountability while promoting sustainability and capacity-building.

The development of OATSIH within the Australian Department of Health and Ageing and its state and territory counterparts, and the evolution of community-controlled health organisations provide the basis for an increasingly comprehensive accountability framework for Indigenous health. However, Shannon et al. (2002) note that accountability regimes seem not to contribute to achievement in Aboriginal and Torres Strait Islander health practice, perhaps because responsibility for the projects they studied was diffused over a range of funders and other stakeholders. In most cases, financial accountability was to the funding agency, and requirements in this regard were clear. They also found increasing use of performance indicators to measure outcomes, and a growing focus on evidence-based approaches. However, staff were less likely to represent themselves as strategically accountable for their outcomes within a specific policy framework. Too many different accountability requirements in the pursuit of diverse policy and program objectives do not provide a good basis for coherent organisational strategy.

These findings and observations reflect dilemmas outlined earlier in this paper, that is, the challenge of balancing local agendas and community accountabilities with state/territory or national priorities, performance and accountability requirements. The diffusion noted by Shannon et al. (2002) is a significant challenge that needs to be managed collaboratively among the major stakeholders, including the funded agencies. The ongoing importance of the partnership forums and regional planning is highlighted by this dilemma. The need for sophisticated thinking about accountability measures is also brought into focus, and current work on the Aboriginal and Torres Strait Islander Health Performance Framework (outlined
in section 4.6), will potentially provide one of the key technical requirements to enable accountability measures to be harmonised across jurisdictions and levels.

Shannon et al. (2002, p. 59) concluded that ‘accountability, evaluation and funding reform were all possible, most usefully tied together in one package and necessarily related to processes of defining accountabilities to communities as well as funders’.

Reconciling community-level and system-level accountability

Programs in the Shannon et al. (2002) study with superior evaluation and accountability strategies had a more plausible story to tell about results. They showed that it was possible not only to reconcile accountability with community ownership but also that accountability constructed around very specific outcomes for community was the most powerful. Both the Fixing Housing for Better Health and the Katherine West Coordinated Care Trial were exemplars. They had strong lessons for both funders and service providers in Indigenous health (Shannon et al. 2002, p. 59).

Conclusion

The weight of the evidence we have considered in the course of preparing this paper has convinced us that the groundwork has been done and there is a clear pathway for government to fulfill its commitment to addressing Indigenous health disadvantage.

Summary of conclusions

- Government commitment to overcoming Indigenous disadvantage requires that policy and funding decisions be based on two criteria: the potential to provide equitable access to effective health care; and the potential for improvement in Indigenous health.
- Good progress has been made in recent years in the development of the service delivery system and system infrastructure, both mainstream and Indigenous-specific.
- Current access to and investment in Indigenous primary health care is too low, but the existing level is producing some positive health impacts and outcomes.
- Investment in comprehensive primary health care should be increased to a level between 3 and 6 times the national average per capita expenditure.
- Funding should be allocated through both Indigenous-specific and mainstream funding programs, and to both Indigenous-specific and mainstream providers.
- The principle of community control of planning, management and delivery of Indigenous primary health care services should be maintained, in accordance with the National Strategic Framework. Community participation in partnerships and other forms of collaboration with mainstream health care agencies is also needed.
- The Primary Health Care Access Program should continue to be used as the major vehicle for additional funding and for the development of effective partnerships and plans.
- Urban Indigenous-specific agencies should continue to be supported, in light of the needs of urban Indigenous people and in recognition of the roles these agencies play in developing the capacity of the mainstream health system.
• Indigenous health care should continue to be funded and administered as part of the health portfolio.

• The full potential of the mainstream health system to contribute to redressing Indigenous health disadvantage has not yet been realised, although there is increasing awareness of the need and commitment to contributing.

• Outcomes and impacts of increased funding should be monitored through the Aboriginal and Torres Strait Islander National Performance Framework currently under development. Sustained focus on a small number of valid indicators, focused on those conditions and targets that are sensitive to improvements in primary health care, and supported by robust data collection and analysis, are needed.
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