
ACHIEVEMENTS IN Aboriginal and Torres Strait Islander HEALTH

SUMMARY REPORT

Cooperative Research Centre for Aboriginal and Tropical Health
on behalf of the
Standing Committee on Aboriginal and Torres Strait Islander Health

Achievements in Aboriginal and Torres Strait Islander Health

Summary Report

Cindy Shannon

John Wakerman

Peter Hill

Tony Barnes

Robert Griew

with assistance from

Ann Ritchie

November 2003

Cooperative Research Centre for Aboriginal and Tropical Health

on behalf of the

Standing Committee on Aboriginal and Torres Strait Islander Health

© Commonwealth of Australia 2004

ISBN 0 642 82448 7

This work is copyright. Apart from any use as permitted under the Copyright Act 1968, no part may be reproduced by any process without prior written permission from the Commonwealth available from the Department of Communications, Information Technology and the Arts. Requests and inquiries concerning reproduction and rights should be addressed to the Commonwealth Copyright Administration, Intellectual Property Branch, Department of Communications, Information Technology and the Arts, GPO Box 2154, Canberra ACT 2601 or posted at <http://www.dcita.gov.au/cca>.

Publication Approval number 3439 (JN 8450)

Publications Production Unit
Australian Government Department of Health and Ageing

CONTENTS

Abbreviations	iv
Acknowledgements	v
Executive summary	1
Background	3
Study design	3
Results	5
Phase 1	5
Literature review	5
Definition of 'achievement' and factors contributing to success	7
Phase 2	7
Phase 3	8
Discussion	9
Policy framework for <i>Achievements in Aboriginal Health</i>	9
1. Model of health	9
2. Community factors	11
3. Funding and evaluation	12
4. Implementation factors	13
5. Other factors	16
Policy implications	17
Model of health	17
Community factors	17
Funding and evaluation factors	18
Implementation factors	18
Conclusion	19
Bibliography	23
Appendices	
1: Project team	25
2: Project nomination list by jurisdiction	26
3: Case study summaries	30
1. The Western Australian Aboriginal Identification Project	30
2. Fixing Housing for Better Health	30
3. The Indigenous Employment Policy	31
4. Koori Maternity Services Program	32
5. NSW Aboriginal Vascular Health Program	32
6. Queensland Health <i>Indigenous Workforce Management Strategy 1999 – 2002</i>	33
7. The Western Australia Swimming Pools in Remote Aboriginal Communities Project	34
8. Katherine West Coordinated Care Trial	35
9. The Nutrition Policy for Remote Retail Stores in Queensland	36
10. Healthy Jarjums Project	37

Abbreviations

AH&MRC	Aboriginal Health and Medical Research Council
AHMAC	Australian Health Ministers' Advisory Council
ATSIC	Aboriginal and Torres Strait Island Commission
CCT	Coordinated Care Trial
CDEP	Community Development and Employment Project
CRCATH	Cooperative Research Centre for Aboriginal and Tropical Health (now the Cooperative Research Centre for Aboriginal Health)
DATSIP	Department of Aboriginal and Torres Strait Islander Policy
DOH	Department of Health
EEO	equal employment opportunity
HAHU	Heads of Aboriginal Health Units (now replaced by the Standing Committee on Aboriginal and Torres Strait Islander Health)
Hib	<i>Haemophilus influenzae</i> type B
IEP	Indigenous Employment Policy
KWCCT	Katherine West Coordinated Care Trial
KWHB	Katherine West Health Board
MBS	Medical Benefits Scheme
NACCHO	National Aboriginal Community Controlled Health Organisation
NAIDOC	National Aboriginal and Islander Day of Observance Committee
OATSIH	Office for Aboriginal and Torres Strait Islander Health
PBS	Pharmaceutical Benefits Scheme
SCATSIH	Standing Committee on Aboriginal and Torres Strait Islander Health
STD	sexually transmitted disease
STEP	Structured Training and Employment Projects
UPK	Unwankara Palyanyku Kanyintjaku (<i>Strategy for wellbeing</i>) the public health arm of Nganampa Health Council
VACCHO	Victorian Aboriginal Community Controlled Health Organisation

Acknowledgements

The authors would like to acknowledge the contributions made by a number of people:

- Project assistants—Condy Canuto, Michael Meehan and Emily Farrell from the Indigenous Health Division at the University of Queensland for their contribution to the development of the framework in Phase 1 of the project and assistance in collecting and analysing data during Phase 2;
- Dr David Thomas of the Cooperative Research Centre for Aboriginal and Tropical Health for assistance with editing sections of the report.
- Key informants during Phase 1 for their time and input into the development of the framework for further data collection;
- Nominated officers in each of the jurisdictions for their cooperation in submitting information to the project team and assisting with additional data requests as required;
- Professors Ian Anderson and Dennis Gray for their expert advice and input at various stages of the implementation of the project;
- Susan Jones, Jack Quinane, Rose Marimon and Kate Gilbert from the Office for Aboriginal and Torres Strait Islander Health for their ongoing support and advice to the project management team, and particularly Helen Evans for her advice and comments; and
- Rus Nasir from the secretariat for Standing Committee on Aboriginal and Torres Strait Islander Health for his assistance in the timely dissemination of materials to its members.

Neil Thomson, Jane Burns, Janette Brooks, Sam Burrow, Ellie Kirov, Bianca McGougan and Ann Valenti were the authors of the literature review, from which material in this short report is drawn. We recognise their substantial contribution to the project. The complete literature review is available electronically on the Cooperative Research Centre for Aboriginal Health website.

Executive summary

In 2001, the Achievements in Aboriginal and Torres Strait Islander Health project was commissioned by the Office for Aboriginal and Torres Strait Islander Health (OATSIH) on behalf of the Heads of Aboriginal Health Units (HAHU) forum, a former subcommittee of the Australian Health Ministers' Advisory Council (AHMAC). The Project reported to the Standing Committee on Aboriginal and Torres Strait Islander Health (SCATSIH), which replaced the HAHU forum.

Although there has been anecdotal evidence of achievements in Aboriginal health, program evaluations and reports of successful outcomes have not been consistently or comprehensively recorded. This project was commissioned with a view to extending the critical analysis of achievements in Aboriginal health beyond the past emphasis on comprehensive primary health care programs to include secondary and tertiary health care and other sectors relevant to health outcomes.

This is a summary report which has been prepared to inform health policy and planning decision-makers about the critical factors which have contributed to successful health initiatives. The full two volume scientific report from which this short report is derived, including a comprehensive literature review, is available on-line at www.crcah.org.au.

A team of researchers associated with the Cooperative Research Centre for Aboriginal and Tropical Health (CRCATH) undertook the project. It comprised three phases, including a comprehensive review of the literature and development of a framework for measuring success, nomination of successful projects by each of the jurisdictions, and detailed case analyses of a small number of the nominated projects.

From these nominated projects, and the set of detailed case studies, the project elucidated the underlying factors contributing to achievement in health projects, and provided an understanding of how these factors led to success, and the relationships between them. Broader lessons for Aboriginal and Torres Strait Islander health policy were then drawn from these analyses, giving consideration to factors related to model of health, the community, resources and evaluation, partnerships, workforce, and capacity building and sustainability.

This study has highlighted the following policy implications arising from detailed analysis of case studies of successful programs across primary, secondary and tertiary health sectors, as well as other sectors.

- The continued development of a policy framework for Aboriginal and Torres Strait Islander health is imperative.
- There is a need for more comprehensive and accurate information on health outcomes, and evaluation data generally, in order to monitor and effectively manage health initiatives.

- 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.
- Funding models need to be established that reward effectiveness in terms of outcomes and prevent ‘stop-start’ problems that projects endure because of short-term funding cycles. 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.
- Partnerships between a range of government, non-government and academic institutions, whilst not without difficulty and cost, have contributed to successful programs and require strong policy support.
- The Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework, endorsed by AHMAC, proposes a reform agenda that addresses the significant challenges in building the Aboriginal and Torres Strait Islander workforce.

In view of Australia’s performance in health generally—and the country’s wealth—the achievements in Aboriginal and Torres Strait Islander health in the past decade in terms of health outcomes, have been disappointing. However, given long lead times, only recent concerted effort and overall under-funding, the overall assessment of achievements in Aboriginal and Torres Strait Islander health is more encouraging. Improvements in health outcomes will come from coordinated and sustained effort, and this project has analysed and documented the salient factors which will result in successful programs and improvements in health outcomes.

The lessons learnt from successful programs confirmed a way forward that would build on progress made in the past decade—of improved infrastructure, greater integration, better access to resources, a growing Aboriginal and Torres Strait Islander workforce, and progress in a range of specific disease control strategies. With persistent adequately resourced effort grounded in a cohesive national strategic framework and having the capacity for flexibility in local implementation, significant changes in health outcomes can be anticipated.

Background

In 2001 the Office for Aboriginal and Torres Strait Islander Health (OATSIH) commissioned the Achievements in Aboriginal and Torres Strait Islander Health project, on behalf of the Heads of Aboriginal Health Units (HAHU) forum, a former subcommittee of the Australian Health Ministers' Advisory Council (AHMAC). The Project reported to the Standing Committee on Aboriginal and Torres Strait Islander Health (SCATSIH), which replaced the HAHU forum.

The project arose from a perception that, while progress had been made in Aboriginal and Torres Strait Islander health, these achievements had not been comprehensively documented, nor the experience of successful programs systematically integrated into policy. The need for such a study reflected the complexity of governance in Aboriginal and Torres Strait Islander health, and the disparate sources of funding and accountability for Aboriginal and Torres Strait Islander health in Australia.

Project aims

1. Document information about achievements in Aboriginal and Torres Strait Islander health;
2. Share information about achievements in Aboriginal and Torres Strait Islander health;
3. Promote and build on health services, programs and strategies that have been shown to work, and other programs or strategies that have had a positive effect on the health of Aboriginal and Torres Strait Islander people.

The Cooperative Research Centre for Aboriginal and Tropical Health (CRCATH) was commissioned to conduct the project. The project team is listed in *Appendix 1*.

Study design

A three-phased approach was employed:

- **Phase 1** comprised an initial literature review, parallel key informant interviews and additional information gathering to inform the development of a case definition of an 'achievement' and a framework for the more detailed data collection phase.
- **Phase 2** identified successful health services, programs and strategies. The initial data analysis of all nominated programs took place during this phase.
- **Phase 3** included a detailed critical analysis of selected case studies in order to examine further the factors identified as contributing to successful programs and draw conclusions about policy implications.

This is an abbreviated report. The fully referenced two-volume report, including literature review, is available on-line at <www.crcath.org.au>.

Results

Phase 1

Literature review

The literature revealed achievements in Aboriginal and Torres Strait Islander health over the past decade across a variety of areas, including improvements in some health outcomes; process indicators with proven links to better health outcomes; areas of the health system or components thereof; and other areas (e.g. education, employment and housing) that were known to lead to improved health and wellbeing.

There were three factors pertinent to any consideration of achievements in Aboriginal and Torres Strait Islander health. The first was the variable lead-time required between an intervention and the realisation of an outcome. For some interventions, the time period between intervention and health outcome may be of short or medium duration. For most health conditions, however, the lead-times between interventions and outcomes were long and/or uncertain. The relationship between health outcomes and ‘up-stream’ factors such as health policy, education or employment, while recognised, were even more complex, and the lead-times very uncertain.

Secondly, it was important also to recognise that concerted efforts addressing the enormous health and other disadvantages experienced by Aboriginal and Torres Strait Islander people began very recently (ANAO 1998). Thirdly, recent levels of government funding for Aboriginal and Torres Strait Islander health have been judged by the Commonwealth Grants Commission (CGC) to be at most about half those required, with the funding of ‘up-stream’ areas also less than needed (CGC 2001).

However, it was encouraging that governments have started to move towards the level of commitment required to achieve equitable health outcomes for Aboriginal and Torres Strait Islander people. This move could be seen not only in the considerable increase in expenditure since the mid-1990s, which has assisted in increasing the availability of community-controlled services and in the growth and development of the National Aboriginal Community Controlled Health Organisation (NACCHO) and its affiliates, but also in improvements in the health infrastructure (ANAO 1998). Examples of the improvements in the health infrastructure were the Agreements on Aboriginal and Torres Strait Islander Health (Framework Agreements), the establishment of the National Aboriginal and Torres Strait Islander Health Council, and the strengthening of inter-governmental mechanisms with the establishment of the Standing Committee on Aboriginal and Torres Strait Islander Health.

Accompanying these improvements in the health infrastructure were: improved access by Indigenous people to mainstream services (including the medical and pharmaceutical benefits schemes); growth in the Aboriginal and Torres Strait Islander health workforce; greater availability of Aboriginal and Torres Strait Islander health knowledge and

information; and the development of a strategic research capacity in Aboriginal and Torres Strait Islander health (particularly through establishment of the Research Agenda Working Group).

In terms of health outcomes, there appeared to have been little, if any, improvement in recent years in some key health indicators (e.g. expectation of life and the infant mortality rate), but there was evidence of increased birth weights in response to specific programs. There was little evidence also of any real improvements in the overall levels of the major chronic health conditions (e.g. heart disease, cancer, diabetes and renal disease), but substantial improvements have been documented for a number of communicable diseases, at least in some areas. These included invasive pneumococcal disease and other respiratory infections, inflammatory trachoma, some sexually transmissible infections, hepatitis B virus infection, diarrhoeal disease and gastrointestinal infestations among Aboriginal and Torres Strait Islander children, and invasive *Haemophilus influenzae* type B (Hib) disease.

As well as the overall improvements in the health system summarised above, there has been substantial progress in a number of the system components. These included programs focusing on maternal and child health, initiatives in the area of substance use, the development of a variety of disease-specific programs (e.g. renal disease, ear disorders and skin conditions) and injury prevention and control strategies.

Culturally specific health program achievement was the major component of the literature review. There were many examples of culturally appropriate programs for a disease or condition at primary, secondary or tertiary levels of care. Service provision was identified as a major theme. Success has been achieved in overcoming barriers to the access of services, including in rural areas. The availability of interventions in appropriate settings has also been an achievement.

Aboriginal and Torres Strait Islander representation in decision-making and Aboriginal and Torres Strait Islander people's actions to improve their health were highlighted. Community control, community consultation, community identification of needs and participation in decision-making contributed to accessibility and awareness. The establishment of advocacy pathways has provided for the most vulnerable.

Training and the employment of Aboriginal and Torres Strait Islander health workers and other Aboriginal and Torres Strait Islander health professionals have important implications for Aboriginal and Torres Strait Islander health. The establishment of networks has improved communication, respect, empathy and trust between Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander people. Increased collaboration between organisations has strengthened intersectoral actions. Aboriginal community-controlled health services have liaised with governments, departments, and organisations within both the Aboriginal and Torres Strait Islander and non-Aboriginal communities on matters relating to the wellbeing of Aboriginal and Torres Strait Islander communities.

Conflict has also characterised these networks. Some issues, such as the meanings given to terms such as community control in relation to the role of Aboriginal and Torres

Strait Islander Health Workers, have been avoided or suppressed leading to outbreaks of conflict which remain unresolved obstacles to further progress.

Definition of 'achievement' and factors contributing to success

As a result of the framework consultations and preliminary analysis of the literature, the definition of 'achievement' or success developed and used in the research process was:

A program, project or intervention, or element thereof, that produces or contributes to a demonstrated improvement in Aboriginal and Torres Strait Islander wellbeing. This may be measured by an improvement in health outcome, other health indicators or in other process or infrastructural indicators.

Two broad measures of success or achievement were then developed and used in the project to identify and explore achievements in Aboriginal and Torres Strait Islander health. These were:

- indicators of progress; and
- contributors to success—underlying factors explaining how and why programs have worked.

There were four indicators of progress:

- improvements to health outcomes;
- improvements to process indicators with a proven link to better health outcomes;
- improvements in the health system or components thereof; and
- improvements in other areas.

The factors that emerged as being likely to be important, or potential **contributors to success**, and subsequently tested and explored in the Phase 3 analysis of the case studies were:

- community control;
- community participation/involvement;
- resourcing;
- sustainability;
- partnerships, including intersectoral collaboration;
- workforce;
- evaluation;
- accountability; and
- capacity building.

Phase 2

During this phase, 90 project nominations (*Appendix 2*) were received from identified officers in each of the States and Territories, and the Australian Government Department of Health and Ageing, for inclusion as achievements in Aboriginal and Torres Strait Islander health. Fifty-eight of these nominations contained complete information, and an additional 32 projects were identified as ones that fitted the nomination criteria and for which additional information could be provided if required.

In order to select a subset of cases for further detailed analysis, four members of the project team independently assessed each nominated project using the following criteria:

- completed activities and evaluation data—a number of the projects had not yet been completed and were nominated on the basis of projected outcomes;
- high quality evaluation data—this was largely in the form of external or independent project evaluations, often published and in the public domain;
- evaluation data available—a number of projects had not been formally evaluated, but could provide some evidence of evaluation measures being available;
- significant area relating to Aboriginal health—links were drawn to the national performance indicators for Aboriginal and Torres Strait Islander Health (OATSIH 2000) and the national health priority action areas (NHPC 2001); and
- spread of cases across primary, secondary, tertiary health sectors and other relevant sectors.

The last two criteria, addressing significance and distribution of cases, were applied only after the first three threshold criteria were met. As a direct consequence of short project time spans (frequently three years or less, as dictated by funding cycles), with only a fraction of projects completed, and the low availability of quality evaluation data, a limited pool of projects was identified for detailed case study analysis. As a result, 14 projects were selected for further follow-up.

Phase 3

In this phase, the hypothesis established in the first phases of the project—that there were identifiable elements associated with successful projects, and that these included the contributors to success that were identified in the project framework—was tested. In addition it sought further factors that had not been identified at this point, and their contribution to achievement.

The cases that were selected for detailed follow up then required additional data collection to enable case study analysis. Of these, ten provided sufficient information to allow analysis. A summary of each of the cases analysed is provided in *Appendix 3*. The ten case studies were:

- the Western Australian Aboriginal Identification Project;
- Fixing Housing for Better Health;
- the Australian Government Aboriginal and Torres Strait Islander Employment Policy;
- Koori Maternity Services Program (Victoria);
- NSW Aboriginal Vascular Health Program;
- Queensland Health *Indigenous Workforce Management Strategy 1999 – 2002*;
- the Western Australia Swimming Pools in Remote Aboriginal Communities Project;
- Katherine West Coordinated Care Trial;
- the Nutrition Policy for Remote Retail Stores in Queensland; and
- Healthy Jarjums Project (Queensland).

Discussion

Based on the literature review, key informant interviews and the subsequent case study analyses, a framework was developed that drew out the policy lessons from the project.

Policy framework for Achievements in Aboriginal Health

1. Model of health

- Comprehensive primary health care
- Specific health interventions and secondary/tertiary health care
- Intersectoral intervention

2. Community factors

- Community control
- Community participation

3. Funding and evaluation factors

- Resourcing
- Accountability
- Evaluation

4. Implementation factors

- Partnerships
- Workforce
- Capacity building
- Sustainability

5. Other factors

- Leadership
- Policy niche

1. Model of health

There have been substantial developments in health systems infrastructure since the early 1990s. The establishment of the National Aboriginal and Torres Strait Islander Health Council, OATSIH in the Australian Government Department of Health and Ageing and SCATSIH, representing the State, Territory and Australian Government health departments, has strengthened coordination of health policy and program development. This has been complemented by the strengthening the NACCHO and its State and Territory affiliates.

There was evidence of improvement in access to primary health services through the extension of community controlled health services, the coordinated care trials, and improved access to the Medical and Pharmaceutical Benefits Schemes.

In terms of specific health outcomes, or changes in process indicators with proven links to better health outcomes, the literature and case studies documented that a range of primary health care initiatives—often multi-sectoral in approach—had resulted in improvements in a number of areas:

- community promotion of **physical activity** with a view to preventing diabetes and cardiovascular disease;
- improved dietary patterns as a result of **nutrition** programs;
- multi-strategic approaches to **alcohol abuse, cigarette smoking, illicit drug use** and **petrol inhalation**;
- improved **maternal and child health** services resulting in improved ante-natal contact, increased birth weights and breast-feeding;
- increased attention to **mental health**;
- programs for the prevention of **cardiovascular disease** including rheumatic heart disease;
- targeting of **respiratory infections** through vaccination, and more effective management of **asthma**;
- raising awareness of **diabetes** and its risk factors and complications;
- specific programs to manage **renal disease** and in particular end-stage renal disease;
- screening programs for **cervical** and **breast cancer**;
- programs for diagnosing and managing **ear, eye** and **oral** health problems;
- implementation of strategies for **sexually transmitted disease (STD)** and **human immunodeficiency virus (HIV)** prevention and treatment;
- reduction of **Hepatitis B** infection rates through vaccination and increased awareness of **Hepatitis C** risks;
- development of guidelines for the management of **Meningococcal** outbreaks; and
- reduction in certain kinds of **injury** and an increased awareness of **disability**.

The establishment of a primary care services through the Katherine West Coordinated Care Trial, the NSW Aboriginal Vascular Health Program and the Victorian Koori Maternity Services, focused on improving primary care coverage and quality. Each involved collaboration between Aboriginal community controlled service provision and State service provision and, in the NSW Aboriginal Vascular Health Program, also disease specific non-government organisations.

The Fixing Housing for Better Health methodology was developed within an Aboriginal community controlled health service in remote Central Australian communities. This

model demonstrated a number of specific features suggestive of successful intersectoral intervention.

2. Community factors

The literature documented the fact that all major reports in recent years on Aboriginal and Torres Strait Islander health stressed the importance of engaging the community—principally through the community controlled health sector—in achieving health outcomes. This was advocated both in general primary health services and specific programs or interventions, in areas as diverse as petrol and alcohol abuse, STDs, nutrition, renal disease and injury prevention and control.

The evidence did not support any one pre-eminent model or ‘gold standard’. Both the level and mechanism of engagement varied. For example, in Queensland, the Queensland Health Alliance, Regional and Local Forums and Health Action Groups all provided mechanisms for community participation. The case studies demonstrated a broader continuum of engagement with the Aboriginal and Torres Strait Islander community. The process for nomination of projects contributed in part to this—liaison officers in each of the jurisdictions sought to ensure that the community controlled health services were represented in the nomination process. Examples beyond the health sector that resulted in health outcomes were also actively sought. While community participation was broadly seen as a key contributor to achievement, no single model of participation dominated, and in some cases, the issue of community engagement was not prioritised in the planning and implementation of the project.

The case analyses demonstrated a five-tiered taxonomy of community participation:

- 1. Community controlled projects:** These projects were characterised by the model of governance and community participation established through the Aboriginal Medical Services, an emphasis on holistic approaches to health that affirmed Aboriginal and Torres Strait Islander culture, and accountability to boards of directors elected by the Aboriginal and Torres Strait Islander community.
- 2. Community initiated projects:** These projects showed strong evidence of being conceptualised and implemented within Aboriginal and Torres Strait Islander communities, though not necessarily through community controlled structures. The Well Persons’ Check in Far North Queensland, initiated through the Apunipima Health Organisation, was developed as a model for voluntary health screening, and repeated extensively in Cape York and other Queensland communities. Similarly, the Strong Mothers, Strong Babies project from the Northern Territory, was developed as a result of local community motivation to address the problems of infant nutrition in Aboriginal communities.
- 3. Community tested projects:** Community tested projects integrated the lessons of Western technical knowledge into Aboriginal and Torres Strait Islander contexts, through extensive long- term collaboration with Aboriginal and Torres Strait Islander communities. Implementation of these projects often reflected the depth of integration of technical and cultural perspectives. The Fixing Houses for Better Health project has allowed the design, public health and architectural expertise of Healthabitat to develop a practical model based on their origin

within an Aboriginal community controlled health service in South Australia. The extension of that model to five States continued the close ties to Aboriginal Community Councils, and the functional emphasis on safety and healthy living, employing Aboriginal staff in both survey and data analysis, and providing skills transfer for domestic maintenance work.

- 4. Community adopted projects:** Though projects may have been developed without extensive community engagement, some showed subsequent acceptance and adoption by community groups, with increasing participation during implementation. There was some evidence of this occurring in the Swimming Pools for Remote Aboriginal Communities project in Western Australia, where, although the project was resourced and conceptualised outside the community, there was increasing utilisation of the facilities for community-based activities and early evidence of interest in training in lifesaving that might have led to community management of swimming programs.
- 5. Community oriented projects:** A significant proportion of projects were designed to benefit Aboriginal and Torres Strait Islander health, but their success was not dependent on the direct involvement of the community. For example, the Western Australian Aboriginal Identification Project offered improved data on Aboriginal identification in hospital admission, but with the exception of hospitals in communities with a large proportion of Aboriginal residents, was conducted with limited Aboriginal participation in the data collection and analysis.

The evidence from the study was limited by refusal of the community controlled sector in some states to provide information. The community controlled model was not, however, the only effective model supported by the evidence.

3. Funding and evaluation

Adequate **resourcing** could be considered a prerequisite for project success, and the literature review highlighted the fact that, in the estimation of the Commonwealth Grants Commission (2001) recent levels of expenditure in Aboriginal and Torres Strait Islander health are about half of what is required.

Despite this, there was evidence of better and more consistent funding of Aboriginal community controlled health organisations, and improved access to Medical Benefits Scheme (MBS) and Pharmaceutical Benefits Scheme (PBS) financing, targeted support for specific disease oriented strategies and attempts to enhance services through pooled funding under the Coordinated Care Trials.

Examples include the following:

- The *strategic* use of resources in the Katherine West Coordinated Care Trial in which the Australian Government provided an allocation based on per capita PBS/MBS expenditure, and the Northern Territory government contributed to the purchase of health services and administrative costs. An agreement between the two governments allowed pooling of the financial resources, along with an administrative contribution from OATSIH.

- The Koori Maternity Services was resourced as part of a larger health program, the Victorian Department of Human Services' *Maternity Strategy*. This allowed for upgrading government health facilities and services, as well as promoting the development of community-based services for Aboriginal women.
- The Fixing Houses for Better Health project showed that improved outputs were possible from a program that had higher levels of funding. In NSW the budget allowed \$7500 per house, compared with \$3000 in other States. However, the project also demonstrated that repairs were constrained by funding allocations, and more extensive work still needs to be undertaken.
- Opportunistic access to resources was demonstrated in the Swimming Pools for Remote Aboriginal Communities project, which was partly funded by the Lotteries Commission.

Also clear in the literature was the fact that insufficient resources had been allocated for ongoing **monitoring and evaluation** of projects. The problem of (lack of) evaluation influenced both the methodology and results of this study: of more than 100 projects nominated, fewer than 15 had evaluations that were sufficiently complete to enable case study analysis to be considered. In part this was due to short funding cycles, with few projects having an extensive history of achievement.

The limited contribution of **accountability** to achievement in Aboriginal and Torres Strait Islander health reflects broader issues of governance, with responsibility for projects diffused over a range of stakeholders. In most cases, projects were financially accountable to the funding agency, though projects were less likely to represent themselves as *strategically* accountable for their outcomes within a specific policy framework. The development of OATSIH within the Australian Government Department of Health and Ageing, the State and Territory Aboriginal and Torres Strait Islander Health Policy offices and the evolution of community controlled health organisations has provided an increasingly comprehensive policy framework for Aboriginal and Torres Strait Islander health. However, the complex network of responsibilities for Aboriginal and Torres Strait Islander health often precludes the establishment of a single locus of accountability for outcomes of health projects. Where collaboration between agencies has resulted in a single point of accountability, as with the Katherine West Coordinated Care Trial, evidence suggests that health service provision improves significantly, though it is too early to judge the impact on health status overall.

4. Implementation factors

Partnerships

The importance of partnerships, especially at grass-roots level, has been recognised for several years, and was highlighted within the *National Aboriginal Health Strategy* of 1989. This has been acknowledged through the development of the Framework Agreements between Australian Government and State governments, community controlled health services and the Aboriginal and Torres Strait Island Commission (ATSIC). While it would be some time before the impact of these agreements was measurable, NACCHO

has noted an improvement in communication and collaboration in several states, the development of joint regional plans and improvements in resourcing for health services.

The case studies demonstrated a number of innovative partnerships in sponsoring, planning and implementing the projects. The range of partners included:

- health departments and departments of Aboriginal and Torres Strait Islander policy, housing, youth, sport and recreation;
- the private sector;
- non-government organisations;
- mainstream health services;
- Aboriginal community-controlled health services;
- secondary and tertiary health services; and
- academic institutions.

Examples of successful partnerships included the following:

- The Swimming Pools for Remote Aboriginal Communities included the Western Australian Department of Housing and Works, the Department of Sport and Recreation and the Lotteries Commission.
- The Fixing Houses for Better Health project involved ATSIC, and State departments of health and Indigenous housing agencies.
- The Healthy Jarjums was implemented through Queensland Education and Aboriginal community schools.
- The Katherine West Coordinated Care Trials combined Australian Government and Northern Territory Government agencies funding an incorporated community board.
- The Nutrition Policy for Remote Retail Stores brought Queensland Health technical expertise together with Department of Aboriginal and Torres Strait Islander policy management.
- The Indigenous Employment Policy provided a useful example of a matrix of relationships between government agencies, the private sector, community-based organisations and training and education providers to achieve employment outcomes.
- The NSW Aboriginal Vascular Health Program collaborated with the National Heart Foundation, the Australian Kidney Foundation and Diabetes Australia in its training and health promotion activities.

Workforce

The literature review demonstrated a commitment to increasing the representation of Aboriginal and Torres Strait Islander people in the workforce generally and the health workforce in particular. The growth in rural employment opportunities through health, housing, tourism and mining had direct benefits on health in communities where employment options have been limited. Attention had also been given to increasing

participation in tertiary education and linking this to employment outcomes, with improved identification of Aboriginal and Torres Strait Islander students enabling retention and outcomes to be monitored. There have been increases in the training of Aboriginal and Torres Strait Islander doctors, nurses, health workers and research assistants, with a focus on recruitment, learning and retention strategies. There is, however, still an important debate to be had about the relative priority of different health professional groups and, in particular, the future path for Aboriginal and Torres Strait Islander Health Workers.

Workforce implications varied across the case studies:

- in the *Indigenous Employment Policy* and the Queensland Health *Indigenous Workforce Management Strategy*, workforce represented the core focus;
- in other programs (e.g. the Koori Maternity Services Program and the NSW Aboriginal Vascular Health Program), the impact was made through recruitment and training of Aboriginal and Torres Strait Islander Health Workers in specific roles; and
- in the Fixing Housing for Better Health, the recruitment of a community-based workforce for the duration of the project had resulted in a skills transfer in the area of maintenance that made an enduring contribution to local social capital.

Capacity building and sustainability

The literature review documented many examples of capacity building in the skills, knowledge and confidence of Aboriginal and Torres Strait Islander organisations, communities, families and individuals. This has enabled increased self-determination, deepened participation in decision making, and representation in management, as well as enhancing influence at regional and community levels.

To some extent, capacity building and sustainability resulted from a number of the factors already considered: essential resourcing and infrastructure, community participation, development of a skilled workforce, the synergy provided by appropriate partnerships and the strategic influence of evaluation on objectives. In a sense, capacity building and sustainability could be considered key outputs of successful projects, as well as process factors contributing to success:

- the Katherine West Coordinated Care Trial provided a model for capacity building, with sustainability built into its structure;
- the development of the Aboriginal and Torres Strait Islander workforce, both *in* health and *for* health, was crucial to establishing capacity and ensuring sustainability;
- two aspects of the NSW Aboriginal Vascular Health Program contributed to its capacity building: the training of Aboriginal vascular health workers, and the development of a network of over 170 members exchanging ideas on vascular health promotion in Aboriginal communities, and linking government services, community controlled services, projects, non-government organisations, university departments and divisions of general practice;

- the Nutrition Policy for Remote Retail Stores in Queensland has improved organisational capacity of this retail network through its policy approach and management support that should be sustainable through the transition from government to commercial or community-based management; and
- Fixing Houses for Better Health had an approach that located its capacity building and sustainability internally, within the project structure. The project has developed a process that has been tested over time within Aboriginal communities, and was implemented under license, allowing control of the model itself.

Given the focus on capacity building and sustainability in international development assistance, however, the lack of emphasis on these factors in project design and evaluation in Aboriginal and Torres Strait Islander health was surprising.

5. Other factors

In the analysis of the case studies, two other factors emerged as being significant contributors to success:

Leadership

Strong and sustained leadership by a skilled individual was key to a number of projects but was often not acknowledged despite the evidence for inclusion as a precursor to gains in complicated areas. For example the Swimming Pools for Remote Aboriginal Communities project had sustained support from the Western Australian Aboriginal Affairs Minister and a number of key individuals in the communities involved. Queensland Health's *Indigenous Workforce Management Strategy* had a champion and sponsor in the Director-General.

Policy framework

One of the clear contributors to the success of projects, not previously identified from the key informant interviews, was evidence of political commitment, and the location of projects within a supportive policy framework. For example, the Katherine West Coordinated Care Trial utilised the opportunity afforded by an innovation in health service provision to explore new funding and structural options, with a resultant improvement in health services. Having established its policy 'niche', the Katherine West Coordinated Care Trial has allowed the models of coordinated care to be extended and modified to bring additional primary care resources within a new framework of community control, effectively changing policy direction. This was accomplished through an established mechanism of local and national evaluation of the coordinated care trials.

Policy Implications

Model of health

The wider policy context in which these examples sat was one with wide support for the centrality of primary health care within Aboriginal health policy. There were, however, disagreements about the meaning of primary health care and, to some extent, its continued centrality. The Office for Aboriginal and Torres Strait Islander Health had recently articulated comprehensive service delivery in the Aboriginal primary health care setting. In this approach, it includes the following elements:

- clinical care covering treatment of acute illness, emergency care, and the management of chronic conditions;
- population health programs (e.g. immunisation, ante-natal care, screening);
- facilitation of access to secondary and tertiary care; and
- client/community assistance and advocacy on health related matters within the health and non-health sectors (OATSIH 2001).

Mobilising all of the disparate elements of the health system to achieve a comprehensive service, especially given the limited workforce on which both Aboriginal and non-Aboriginal services could draw, was, however, a very difficult task.

Tensions will continue to play out between the Aboriginal community controlled health sector and governments. Over time, the Aboriginal community controlled sector has been frustrated at the slowness of establishing intersectoral initiatives and of engaging non-health portfolios. There has also been frustration about the Australian Government's perceived general practice centred view of primary health care.

The implications of this study were that, with attention paid to specific objectives and stable professional support, a wider set of intersectoral and specialist areas could be addressed successfully, and in fact there were examples of government and community collaboration achieving this. The past emphasis on comprehensive primary health care has been useful. While recognising the outcomes in targeted primary health care programs, this approach now needs to broaden to include secondary and tertiary care.

Community factors

The study points to the range of viable and constructive engagements actually in place. While community engagement of some degree and for a variety of reasons was evident, Aboriginal community control was not a pre-requisite factor for a successful outcome. There were different reasons for community involvement contributing to a successful program. For example, Fixing Houses for Better Health was a very intrusive program and required strong community support. For other cases, such as the Queensland Well Persons Health Check and the Katherine West Coordinated Care Trial, community

control was a key and essential feature. Whilst community control might not have been a pre-requisite, the longer-term impact might be significant in relation to capacity building and underlying social determinants of health.

Funding and evaluation factors

There was acceptance across Aboriginal health policy that funding needed to be increased and services accountable both for funding and for service provision. However, the mechanisms through which funding was made available and the service models for which services became accountable were contested.

These case studies demonstrated that the projects with superior evaluation and accountability strategies also had a more plausible story to tell about results. They also showed that it was possible not only to reconcile accountability with community ownership but also that accountability constructed around the very specific outcomes for community were the most powerful. Accountability, evaluation and funding reform are all possible, most usefully tied together in one package and necessarily related to processes of defining accountabilities to communities as well as funders.

Implementation factors

The case studies revealed a diverse range of partnerships, with the strength of collaboration between a range of government, non-government and academic institutions. What the available literature did not document were the barriers, difficulties, significant organisational cultural shifts and costs of successful collaborations. There was an identified need for strong policy support and incentives to build effective collaborations. In the areas of workforce and capacity building, the case studies and literature reflected some of the gains in these areas, but indicated there was still a long path ahead. The Queensland Health *Indigenous Workforce Management Strategy* was important because it has received a level of profile and priority, also because it addressed labour market as well as workforce development. A number of the other case studies also illustrated creative and useful strategies for capacity development in communities. One remaining outstanding need was for leadership in defining the roles for Aboriginal staff—at the full range of professional roles in the health system—and strategies that would develop people across the full range, given the starting point.

The Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework (2002), endorsed by AHMAC, proposed a reform agenda that acknowledged the significant challenges in the development of workforce for Aboriginal and Torres Strait Islander health and sought to give urgent priority to the workforce within the context of the Australian health system.

Conclusion

In view of Australia's performance in health generally—and overall wealth—the achievements in Aboriginal and Torres Strait Islander health in the past decade in terms of health outcomes, have been disappointing. However, given long lead times, only recent concerted effort and overall under-funding, the overall assessment of achievements in Aboriginal and Torres Strait Islander health is more encouraging. Improvements in health outcomes will come from coordinated and sustained effort, and this project has analysed and documented the salient factors which will result in successful programs and improvements in health outcomes.

It was encouraging that governments have started to move towards the level of commitment required to achieve equitable health outcomes for Aboriginal and Torres Strait Islander people. This move could be seen not only in the considerable increase in expenditure since the mid-1990s, but also in improvements in the health infrastructure. Examples of the improvements in the health infrastructure were the Framework Agreements, the establishment of the National Aboriginal and Torres Strait Islander Health Council, and the strengthening of inter-governmental mechanisms with the establishment of SCATSIH.

Accompanying these improvements in the health infrastructure were: improved access for Aboriginal and Torres Strait Islander people to mainstream services; growth in the Aboriginal and Torres Strait Islander health workforce; greater availability of Aboriginal and Torres Strait Islander health knowledge and information; and the development of a strategic research capacity in Aboriginal and Torres Strait Islander health.

There have been some improvements also in 'up-stream' factors of importance to health, such as education and housing. But, as is the case with health, the Commonwealth Grants Commission recognised that much more needed to be done in these and other areas.

This study has highlighted policy implications arising from detailed case studies of successful programs across primary, secondary and tertiary health sectors, as well as other sectors.

Firstly, 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 were crucial to effective progress, as evidenced in the Katherine West Coordinated Care Trials. The current fragmentation of the health system for Aboriginal and Torres Strait Islander people contributed to inequity, duplication and inefficiency. There was a rich patchwork of initiatives responding to meet local needs, but lack of an overall strategic approach. A long-term strategic policy framework with appropriate resource commitment would support and sustain further achievements in Aboriginal and Torres Strait Islander health and should further develop the notion of capacity building in order to ensure sustainability of programs and improved health outcomes.

Secondly, there was a need for more comprehensive and accurate information on health outcomes, in order to monitor and effectively manage health initiatives. There was a general paucity of outcomes data and lack of a solid evidence base. The literature review and projects initially nominated by jurisdictions revealed this lack of data. Another result of past policy evidenced in the literature review and cases examined was the lack of communication and coordination of effort across the health and other sectors. Even several of the detailed case studies had very little useable data, despite in some cases having acquired good reputations for having achieved results. Reports of a sense of positive community engagement were not as strong as actual utilisation data and/or a direct assessment of consumer satisfaction. This highlighted the need for stronger evaluation through adequate funding for evaluation, establishing reliable baseline data and appropriate performance indicators, and partnerships between service providers and institutions with evaluation expertise, as well as services building their own monitoring and evaluation capacity. Related to this was the need to re-examine the assumptions around process indicators whose links to health outcomes have not been established.

Thirdly, the project showed 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. This diversity needed to reflect the diversity inherent in Aboriginal and Torres Strait Islander communities, but be shaped within the broad strategic directions that would ensure comprehensive management of the health issues and equity in access to care.

Fourthly, funding models needed to be established that rewarded effectiveness in terms of outcomes. The literature review and the range of projects initially nominated demonstrated the 'stop-start' nature of past Aboriginal and Torres Strait Islander health policy and inherent short funding cycles which 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. Given the strong focus on capacity building and sustainability in international development assistance, the limited attention given to these issues in project development in Aboriginal and Torres Strait Islander health in Australia was remarkable.

The lessons learnt from successful programs confirmed a way forward that would build on progress made in the past decade of:

- improved infrastructure;
- greater integration;
- better access to resources;
- a growing Aboriginal and Torres Strait Islander workforce; and
- progress in a range of specific disease control strategies.

With persistent, adequately resourced effort, grounded in a cohesive national strategic framework and having the capacity for flexibility in local implementation, significant changes in health outcomes can be anticipated.

Bibliography

- Aboriginal and Islander Health Worker Journal. (2000). *Indigenous health promotion resources*. (3rd ed.). Sydney: Aboriginal and Islander Health Worker Journal.
- Australian Bureau of Statistics, & Australian Institute of Health and Welfare. (2001). *The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples 2001* (ABS Catalogue No.4704.0. AIHW Catalogue No. IHW 6). Canberra: A joint program of the Australian Bureau of Statistics and the Australian Institute of Health and Welfare.
- Australian Institute of Health and Welfare. (2000). *Australia's health 2000. The seventh biennial health report of the Australian Institute of Health and Welfare* (AIHW Cat No. AUS-19). Canberra: Australian Institute of Health and Welfare.
- Australian Institute of Health and Welfare. (2001). *Expenditures on health services for Aboriginal and Torres Strait Islander people 1998-99*. (AIHW Catalogue No. IHW 7). Canberra: Australian Institute of Health and Welfare and Commonwealth Department of Health and Aged Care.
- Australian National Audit Office. (1998). *The Aboriginal and Torres Strait Islander Health Program. Department of Health and Aged Care* (The Auditor-General Audit Report No. 13 Performance Audit). Canberra: Australian National Audit Office.
- Commonwealth Grants Commission. (2001). *Report on Indigenous funding*. Canberra: Commonwealth Grants Commission.
- Couzos, S., Metcalf, S., Murray, R., & O'Rourke, S. (1998). *Recommendations for clinical care guidelines on the management of non-insulin-dependent diabetes in Aboriginal and Torres Strait Islander populations*. Canberra: Office for Aboriginal and Torres Strait Islander Health Services, Commonwealth Department of Health and Family Services.
- Couzos, S., Metcalf, S., & Murray, R. B. (2001). *Systematic review of existing evidence and primary care guidelines on the management of otitis media in Aboriginal and Torres Strait Islander populations*. Canberra: Commonwealth Department of Health and Aged Care.
- Deeble, J., Mathers, C., Smith, L., Goss, J., Webb, R., & Smith, V. (1998). *Expenditure on health services for Aboriginal and Torres Strait Islander people*. (AIHW Catalogue No. HWE-6). Canberra: National Centre for Epidemiology and Population Health, Australian Institute of Health and Welfare and Commonwealth Department of Health and Family Services.
- Department of Health (U.K.). (1999). *Saving Lives: Our Healthier Nation*. London: The Stationery Office.
- Hunter, E. (1993). *Aboriginal Health and History*. Cambridge: Cambridge University Press, 1993.
- Keys Young Report: Market research into Aboriginal and Torres Strait Islander access to Medicare and the Pharmaceutical Benefits Scheme. (1997) Prepared for the Health Insurance Commission.
- Mackerras, D. (2001). Birthweight changes in the pilot phase of the Strong Women Strong Babies Strong Culture Program in the Northern Territory. *Australian and New Zealand Journal of Public Health*, 25(1), 34-40.
- McDermott, R., & Beaver, C. (1996). Models for horizontal equity in resource allocation Aboriginal health. *Australian and New Zealand Journal of Public Health*, 20(1), 13-15.
- Menzies School of Health Research. (2001). *Recommendations for clinical care guidelines on the management of otitis media in Aboriginal and Torres Strait Islander populations*. Canberra: Commonwealth Department of Health and Aged Care.
- National Aboriginal and Torres Strait Islander Nutrition Working Party. (2001). *National*

- Aboriginal and Torres Strait Islander nutrition strategy and action plan, 2000–2010.*
- National Public Health Partnership 2001. <http://www.nphp.gov.au/signal/natsinsa1.pdf>
Retrieved October 2002: <http://www.nphp.gov.au/signal/natstrat.htm>
- National Aboriginal Health Strategy Working Party. (1989). *A National Aboriginal Health Strategy*. Canberra: Commonwealth Department of Aboriginal Affairs.
- National Health Performance Committee. (2001). *National Health Performance Framework Report: a report to the Australian Health Ministers' Conference*. Brisbane: Queensland Health.
- Office for Aboriginal and Torres Strait Islander Health. (2000). *National Performance Indicators for Aboriginal and Torres Strait Islander Health: Technical Specifications*. Canberra: Commonwealth Department of Health and Aged Care.
- Office for Aboriginal and Torres Strait Islander Health. (2001). *Better Health Care: Studies in the Successful Delivery of Primary Health Care Services for Aboriginal and Torres Strait Islander Australians*. Canberra: Commonwealth Department of Health and Aged Care.
- Office for Aboriginal and Torres Strait Islander Health. (2001a). *Aboriginal and Torres Strait Islander Health Workforce: Draft National Strategic Framework, Consultation Draft*. Canberra: Commonwealth Department of Health and Aged Care.
- Office for Aboriginal and Torres Strait Islander Health. (2001b). *Specialist eye health guidelines for use in Aboriginal and Torres Strait Islander populations*. Canberra: Commonwealth Department of Health and Aged Care.
- Statistics Division and Central Health Monitoring Unit (Department of Health, U. K. (2001). *NHS Plan: Technical supplement on target setting for health improvement*. London: Department of Health, [U.K.].
- World Health Organization. (2001). *The International Classification Of Functioning, Disability And Health (Icf)*. Geneva: World Health Organization.

Appendix 1:

Project Team

The CRCATH was commissioned to conduct this study project.

Project team

Associate Professor John Wakerman, Director of the Centre for Remote Health managed the project on behalf of the CRCATH.

Associate Professor Cindy Shannon, assisted by Mr Condry Canuto, an Indigenous epidemiologist, and a team from the University of Queensland, was responsible for the substantive components of the project, including consultations with key stakeholders; developing the framework; leading and managing the data collection about successful programs; critical analysis of case studies; and production of the final project report.

Professor Neil Thomson and the Australian Indigenous Health *InfoNet* team, conducted the literature review.

Professor Tony Barnes (CRCATH), Dr Peter Hill (University of Queensland), Dr David Thomas (CRCATH) and Mr Robert Griew provided expert guidance and contributions to the critical analysis.

Ms Ann Ritchie provided expert editorial input.

Appendix 2:

Project nomination list by jurisdiction

ACT

1. Alcohol and Other Drug Indigenous Project – Gudan Gulwan Aboriginal Youth Corporation
2. Development of Primary Prevention Activities in ACT Aboriginal Community
3. Diabetes Clinic Project
4. Ginninderra Scholarship for Nursing and Medical Students
5. Improving Access to Health Services for Aboriginal people in Correctional Institutions
6. Indigenous Support and Education Program
7. Midwifery Access Program
8. Narrabundah Health and Well Being Project named KOOTARA WELL
9. The Opiate Program (TOP)
10. Towards a Model for Transfer of skills between AMS and Research Institutes
11. Winnunga Nimmityjah Aboriginal Community Controlled Health Service
12. Winnunga Nimmityjah Home Budgeting – ‘Train the Trainer’ – Program
13. Healthy City Canberra

Queensland Department of Health

1. Aboriginal and Torres Strait Islander Injecting Drug Use Project
2. Better Health Outcomes Project (BHOP)
3. Improving Diabetes in the Primary Health Care Setting
4. Improving Indigenous Status Collection in Public Hospitals
5. Far Northern Queensland Indigenous Well Persons Health Check
6. Nutrition Policy for remote Retail Stores
7. Queensland Health *Indigenous Workforce Management Strategy 1999–2002*
8. Healthy Jarjums Make Healthy Food Choices
9. QLD Health Aboriginal and Torres Strait Islander Cultural Awareness Program
10. Implementation of Enhanced Model of Primary Health Care
11. Strong in the City Project

New South Wales Health Department

1. Aboriginal Environmental Health Officer Traineeship
2. NSW Aboriginal Vascular Health Program
3. NSW Housing for Health Unit

Department of Human Services Victoria

1. Koori Maternity Services Program
2. Darebin Community Health Centre – Koori Access Worker
3. Mercy Hospital for Women Transitions Clinic – Gynaecological Services at Victorian Aboriginal Health Services – Family Counselling at Victorian Aboriginal Child Care Agency
4. Koori Hospital Liaison Officer program - Aboriginal Family Support Unit – Royal Children’s Hospital

Department of Health Western Australia

1. Aboriginal Identification Project
2. Employment of Dedicated Environmental Health Officer
3. Environmental Health Needs Coordinating Committee
4. Impact on Health of Children and Adolescents to introduction of swimming pools in remote Aboriginal Communities
5. South West Aboriginal Medical Service – WA Aboriginal Coordinated Care Trial

Office for Aboriginal and Torres Strait Islander Health – Department of Health and Ageing

1. Croc Festivals – held nationally throughout regional and remote communities
2. Department of Family and Community Services (FaCS) is leading a multi-agency project to develop a regional stores policy
3. Ngunytju Tjitjti Purni – Aboriginal Community Controlled organisation
4. Ngaanyatjarra Health Service – delivery of health services
5. Wirraka Maya – Diabetes Screening
6. Tobacco control and drug prevention
7. Sharing health care – enhanced primary care package
8. Nganampa Health Council – aged care program
9. Bulgarr Ngaru – asbestos screening program
10. Indigenous Employment policy

Department of Health and Human Services Tasmania

1. Aboriginal Liaison Officer – Royal Hobart Hospital

Northern Territory – Department of Health and Community Services

1. NT DHCS *Aboriginal Employment and Career Development Strategy*
2. NT DHCS *Aboriginal Health Worker Workforce Development Strategy*
3. NT Food and Nutrition Program 2001 – 2006
4. NT Strong Woman, Strong Babies, Strong Culture Program
5. Growth Assessment and Action (GAA) Program
6. Healthy School Aged Kids Program For Remote Area Communities
7. Tiwi and Katherine West Coordinate Care Trials
8. Indigenous Male Health Policy Developments
9. NT Aboriginal Health Framework Agreement
10. The Structured Employment Training Program (STEP)
11. Environmental Health improvements in remote communities throughout NT

Projects identified as potential achievements – details not provided

1. Indigenous Immunisation Program – QLD
2. Numbulwar Community Council Community Store Nutrition Program – NT
3. Nunkuwarrin Yunti of South Australia – SA
4. Rumbalara Football and Netball Club, Shepparton – VIC

Office for Aboriginal and Torres Strait Islander Health, Department of Health and Ageing

List of Responses by Australian Government Agencies as at 11/04/02

1. *Aboriginal and Torres Strait Islander Aged Care Strategy* (Flexible Care Services)
2. Information from Service Activity Reporting 1999–2000
3. Information from Draft National Strategic Framework for Aboriginal and Torres Strait Islander Health (2001)

Other Projects of Interest as nominated by Department of Health and Ageing

1. Umoona Tjutagku Health Service Inc – SA
2. Mulungu Aboriginal Corporation Medical Centre – SA
3. Ngaanyatjarra Pitantjatjara Yankuntjatjara (NPY) Women's Council – NT
4. Tiwi Health Board Trust – NT
5. Gallang Place Aboriginal and Torres Strait Islander Corporation – QLD
6. Townsville Aboriginal and Islander Health Service Ltd – QLD
7. Townsville Aboriginal and Islander Health Service Ltd – QLD
8. Central Gippsland Aboriginal Health and Housing Cooperative – VIC

Other projects of interest noted in Draft National Strategic Framework for Aboriginal and Torres Strait Islander Health

1. Queensland Health, ATSIC and DEWRSB jointly funded and supported a project to provide and train Indigenous Community Health Information Officers in Yarrabah, Pormpuraaw and Wujal Wujal
2. The Geraldton Regional Aboriginal Medical Service and the Redfern Aboriginal Medical Service Cooperative Limited support similar programs
3. The Kimberley Aboriginal Medical Services Council published a textbook on primary health care within the context of Aboriginal community control

South Australia

1. Aboriginal Custodial Health – Human Services for Prisoners, Offenders and Detainees
2. *Aboriginal Substance Abuse Strategy*
3. Aboriginal Women's Health and Healing Project
4. Aboriginal Women's Screening Program
5. Adelaide Aboriginal Step down Unit
6. Anangu Pitjantjatjara (AP) Lands Project
7. 'Homemaker'/Family Support and Youth Programs
8. Indigenous Environmental Health Initiative
9. The Agreement on Aboriginal and Torres Strait Islander Health
10. The Emotional and Social Wellbeing (Mental Health) Action Plan
11. The First Step program
12. The Healthy Ways Nutrition Project
13. The Nursing Job Shadowing (Work Experience) Program
14. The Safe Living in Aboriginal Communities Project – Whyalla

Appendix 3:

Case study summaries

1. The Western Australian Aboriginal Identification Project

This project was developed to address the recommendations in the Aboriginal and Torres Strait Islander Health Information Plan, endorsed by the Australian Health Ministers' Advisory Council in 1997. As such it had high-level political support, as well as the support of the Aboriginal community, which is disadvantaged by under-reporting in hospital data collection. Its broad aim was to evaluate the quality of the Indigenous identifier in the Western Australian hospital morbidity database.

In summary, the project has resulted in improved identification of Aboriginal and Torres Strait Islander people in hospital morbidity data systems resulting in more informed policy and program development. The study found that the number of Aboriginal people recorded in hospital inpatient data substantially understates the actual number of Aboriginal and Torres Strait Islander people admitted as patients. In metropolitan Perth, 78.3% of Aboriginal and Torres Strait Islander patients were correctly identified. This rose to 93.5% in the Kimberley/Pilbara and for the state as a whole, averaged 85.8%.

The study also identified areas where training and promotional activities need to be undertaken to improve the recording of Indigenous status. Training for all staff involved in collecting patient information is being implemented.

Incorrect identification of Aboriginal patients is perceived to be a problem limited to government health facilities, and does not apply to Aboriginal Community Controlled Health Services. Similar problems of under-recording of Aboriginal and Torres Strait Islander identity have been identified in other States and the study highlighted factors that need to be considered in planning similar surveys.

2. Fixing Housing for Better Health

Fixing Housing for Better Health is a process developed by Healthabitat to address the health issues associated with poor housing conditions, including leaking taps, unsafe power, inadequate hot water and inoperative showers. What started as a small public and environmental health review in central Australia in the mid 1980s (UPK), is now a national program that aims to make urgent safety and 'health hardware' repairs to existing housing and immediate surrounding living areas. Fixing Housing for Better Health is a collaboration between Healthabitat, ATSIC and State/Territory Aboriginal and Torres Strait Islander Housing Agencies and Departments of Health in New South Wales, Queensland, South Australia, Western Australia and the Northern Territory.

These projects focus on assessing and fixing the health hardware in houses and living areas in order to allow families to maintain healthy living practices. In summary, the project has surveyed and undertaken repairs in 1387 homes in 37 communities in five States. Analysis of the work undertaken shows that 60% of all works were due to a lack

of routine maintenance, and that less than 3% of works completed were the result of vandalism, damage, overuse or misuse.

Survey Fix data collection has documented the extent of work requiring to be done, and provides a base for realistic planning. Sustainability of the project depends on resources to extend the project to other communities, and the establishment of ongoing community maintenance systems. The training of community members in undertaking basic repairs has provided a skilled resource within the community for primary repairs.

One of the essential aims of the project is informing better housing design, specifications and quality control to improve the quality of housing, which has long-term implications for sustainability in Aboriginal and Torres Strait Islander housing. The participation of the community in the survey and repair process appears to be critical to the success of the program.

3. The Indigenous Employment Policy

The Indigenous Employment Policy (IEP) is a policy of the Australian Government Department of Employment and Workplace Relations. It was developed in consultation with the Aboriginal and Torres Strait Islander Council (ATSIC) and complements ATSIC Business Development, Community Development and Employment Project (CDEP) and its Industry strategies.

The aim of the policy is to generate more employment opportunities for Australia's Aboriginal and Torres Strait Islander peoples, with a particular focus on job creation in the private sector and the promotion of small business activities in the Aboriginal and Torres Strait Islander community. The policy includes the Indigenous Employment Programme, the Indigenous Small Business Fund and the Job Network.

The early data suggest that private sector projects, placements and outcomes are improving with the introduction of the IEP. There are some 130 federal funding projects under the IEP from 1 July 2001. Examples include the Corporate Leaders project, wage assistance, the structured training and employment projects, and the National Indigenous Cadetship Program, the CDEP Placement Incentive, and the Voluntary Service to Indigenous communities.

Most encouraging are the high outcome rates reported in the *Labour Market Assistance Outcomes Quarterly Reports*. During 2000, there was a 74% increase in projects undertaken under structured training and employment projects (STEP) and 67% increase in Indigenous Employment Programme Wage Assistance, totalling 5300 new job commencements. Although early performance indicators are encouraging, it is still too early to draw from conclusions, given most program elements have long lead times.

The encouragement of the private sector to engage in Aboriginal and Torres Strait Islander employment is critical in both social and economic terms. The sustainability of employment beyond the provision of incentives and assistance needs to be clearly evaluated. The long-term goal should be profiles of Aboriginal and Torres Strait Islander employment in both public and private sectors consistent with that of the population as a whole, at all levels. Employment strategies need to be complemented by strategies in education, public transportation and communication to achieve effectiveness.

4. Koori Maternity Services Program

In 1998, the State Department of Human Services committed \$14.9 million in recurrent funding to enhance public maternity services across Victoria. From 1999/2000 onwards \$600 000 annual recurrent funding has been provided to eight cooperatives and health services. The aim of the Koori Maternity Services Program is to provide additional and culturally appropriate support to Aboriginal and Torres Strait Islander women throughout pregnancy and in the immediate postnatal period, by creating cooperative partnerships that enable the Aboriginal women of Victoria to access the best possible maternity care.

The program has the advantage of being part of a broader reform process in maternity services across Victoria, with an enhancement in the level and range of services available, an emphasis on consumer information and a responsiveness to individuals and groups with specific needs, improved health outcomes and shift towards collaborative models of care, with more effective interfaces and linkages.

The project places a strong emphasis on Aboriginal community control, the need for the provision of holistic health care; and the need for recognition of diversity within and between communities.

The program has been successful in improving access to antenatal care, which is considered to be a key strategy for improving Aboriginal and Torres Strait Islander birth outcomes. This is achieved through the delivery of maternity services through Aboriginal community-controlled health services, and through partnerships with mainstream agencies. Evaluation of the service has resulted in a number of reported improvements in a number of the centres where services are provided.

The principle of community control was a key element in defining the project. However, the aim of the project was to complement mainstream targeted services, not to establish stand-alone services. The Victorian Aboriginal Community Controlled Health Organisation (VACCHO) is provided with some of the funds in order to coordinate the program at state-wide level as well as to support, advocate for and develop training for Victoria's Koori maternity workers. Their relationships with clients and other mainstream and community health care providers has been reportedly critical to its success.

In this project, there is an important synergy between the changes to government maternity services and the outreach into the Aboriginal community made possible through the Koori Maternity Services program. The effectiveness of the interface between mainstream services and the Koori Maternity Services is integral to the success of the project. It is clear that there has been attitudinal and structural change within Victorian Maternity Services that complements the strong advocacy, support and clinical care provided by the Koori Maternity Services Program.

5. NSW Aboriginal Vascular Health Program

The Aboriginal Vascular Health Program was established in July 2000 and is responsible for facilitating and supporting the implementation of the components of the NSW Aboriginal Health Strategic Plan that relate to diabetes, diseases of the circulatory system

and renal disease. The program was developed jointly between the Aboriginal Health and Medical Research Council (AH&MRC), the NSW Department of Health, OATSIH and the ATSIC.

The program is a State-wide strategic initiative to address prevention and management of vascular diseases including diabetes, cardiovascular disease, renal disease and stroke. A broad vascular approach has been adopted because of the shared causal factors, common management approaches and shared barriers to disease self-management for a range of conditions. A series of demonstration site projects have been funded across the state and are being implemented through local Aboriginal health partnerships between Aboriginal community controlled health services and mainstream health services with collaboration in some areas with local divisions of general practice and university departments.

The projects aim to improve the prevention, early detection and self-management of vascular diseases. All projects involve the employment of designated Aboriginal vascular health workers and the provision of training and support for these positions. The program has also established the State-wide Aboriginal Vascular Health Network with more than 170 members to disseminate information, share stories about projects and resources. A range of education and training initiatives are also in place. It also promotes the involvement of other non-government organisations (e.g. National Heart Foundation, Kidney Foundation, Diabetes Australia in collaboration in Aboriginal health).

An innovative NSW Health framework for monitoring changes in Aboriginal vascular health has been developed by the program and includes a new set of indicators to measure local intervention and capacity along with some routine measures from state-wide collections. The framework is intended to provide a clearer picture of improvements in infrastructure and processes of care at a local level as more proximal indicators of changes that will impact longer-term health outcomes.

Most measures to date are qualitative and relate to building capacity at State, regional and local levels. This includes establishment of local taskforces, partnerships, increased health worker education and training initiatives, shared planning processes, and increased sharing of access to resources.

The changes in the health system relate to development and implementation of new collaborative working relationships, joint development of clinical protocols, health assessment tools, development of new disease self-management programs, improved monitoring and evaluation mechanisms, new outreach services, and increased community-based home assessments.

Interim evaluation of the Aboriginal Vascular Health Network has confirmed that it is a valuable means of health workers accessing information.

6. Queensland Health *Indigenous Workforce Management Strategy 1999 – 2002*

The Queensland Health *Indigenous Workforce Management Strategy* was launched by the Minister for Health in NAIDOC (National Aboriginal and Islander Day of Observance

Committee) Week July 1999, and provides a framework for Queensland Health District Services to improve their Aboriginal and Torres Strait Islander workforce management practices. The current strategy addresses the period 1999 – 2002 and aimed to increase Aboriginal and Torres Strait Islander participation in health workforce through a two-pronged approach:

- the implementation of the Labour Market Development Program that aims to encourage and support Aboriginal and Torres Strait Islander students through school and university into health careers; and
- the implementation of the Indigenous Workforce Development Program that takes a pro-active approach to the recruitment, retention, and promotion of Aboriginal and Torres Strait Islander people across Queensland Health.

The Indigenous Workforce Team has been established to coordinate the implementation of the strategy and its evaluation, and three zonal Aboriginal and Torres Strait Islander human resource officer positions have been established to support district human resource management units implementation of the *Indigenous Workforce Management Strategy*.

Since the inception of the *Indigenous Workforce Management Strategy* in July 1999, Aboriginal and Torres Strait Islander employment rates with Queensland Health have risen. In July 1999, 420 staff identified as Aboriginal or Torres Strait Islander.

According to recent Queensland Health equal employment opportunity (EEO) data, Queensland Health employed approximately 903 (1.9%) Aboriginal and Torres Strait Islander people within the Department in 2001. It is anticipated that Queensland Health will achieve and/or exceed its target of 2% Aboriginal and Torres Strait Islander employee representation by the end of 2002.

The strategy applies only to government services. However, the reports of the State Working Group for the Queensland Review of Aboriginal and Torres Strait Islander Health Worker Training that contributed to the development of this strategy were a collaboration between Queensland Health and the Queensland Aboriginal community controlled health services. Promotion of health careers and initiatives in training and education that are part of the strategy, have long-term outcomes for both sectors.

7. The Western Australia Swimming Pools in Remote Aboriginal Communities Project

The Swimming Pools project is jointly funded by the Western Australian Department of Housing and Works, the Department of Sport and Recreation and the Lotteries Commission. The Royal Life Saving Association manages the pools. The Swimming Pools project is essentially an evaluation of the impact of the introduction of swimming pools as a health intervention for Aboriginal children aged 0–17 years. The primary focus of the evaluation is limited to the effect of the initiative on skin and upper respiratory tract infections, though broad trends in childhood morbidity will be analysed.

Swimming pools were opened in the remote Aboriginal communities of Jigalong, Burringurrah and Mugarinya in Western Australia in September 2000, and the Institute for Child Health Research was asked to evaluate the impact the pools have on the

health of children in two of these communities (Jigalong and Burringurrah). Baseline screening was conducted prior to the opening of the pools, with assessments at six-monthly intervals since then, in summer and winter.

There have been several important outcomes demonstrated in preliminary findings over the first twelve months of the project.

- Middle ear disease: there has been an overall reduction from 31% to 21% of both wet and dry perforations of the ear drums in Burringurrah, a maintenance of overall levels (30%) of perforations of the ear drums in Jigalong, but a halving of the numbers of wet perforations from 16% to 8%.
- Skin sores: there has been a reduction in overall numbers and severity of skin sores in both communities. In Burringurrah, overall figures for sores fell from 64% to 21%, with severe sores requiring antibiotics falling from 28% to 3, and in Jigalong, overall sores remained stable, but severe sores dropped from 28% to 5%.
- Nasal discharge: there has been an overall reduction in nasal discharge in both communities, 26% in Burringurrah and 23% in Jigalong.
- Swimming safety: swimming instruction is provided by the Royal Life Saving Association, with general increase in aquatic skills through the 'Swim and Survive' program and a number of children reaching the highest levels of competency.
- School attendance: there has been a reported improvement in school attendance as a result of the 'school means pool' policy. In Burringurrah school attendance was reported as doubling following introduction of the 'school means pool' policy.
- Juvenile crime: there has been a reported decrease in juvenile crime in Burringurrah.
- Social benefits: the pool has provided a suitable meeting place for social interaction for both children and adults

The Swimming Pools project has relied on significant external funding, and local inputs in terms of management, training and maintenance are still being developed. Issues of sustainability are crucial to this project, as management, salaries and maintenance costs will be recurrent.

8. Katherine West Coordinated Care Trial

The Katherine West Coordinated Care Trial (KWCCT) was one of a number of Aboriginal specific trials and was designed as a 'whole-of-population' trial; that is, all Aboriginal and Torres Strait Islander people normally resident in a participating community are, by definition, participants in the trial.

Like all coordinated care trials, the purpose of KWCCT was to design and implement a trial in which service delivery inputs were 'pooled' under common management with the expectation that this would lead to improved services and consequently improved health outcomes for the clients covered by the trial.

The KWCCT has, in effect, two components:

- to deliver coordinated care to the population in the region (CCT); and
- to create the Katherine West Health Board (KWHB).

The trial formally ran from July 1997 to March 2000.

The KWCCT demonstrates achievements at a number of levels.

Key levels

The establishment of KWHB initially as a fund-holding body and later as a service delivery manager leading to increased Aboriginal control over purchasing and provision of local health care services.

Pooling of funds for health care purchase for the local population leading to:

- increased resources within the region;
- changes in expenditure patterns on services including new services;
- improved coordination, development and health care administration; and
- increased intersectoral collaboration.

Improved effectiveness of local health service delivery in many specific areas including clinical care.

Efficiency gains in health service delivery, documented through high quality evaluation.

Additional funds for preventative/public health programs as a consequence of documented efficiencies.

This project is about implementing major changes in health service governance and management to achieve community control over health service delivery and planning issues. The CCT initiative was possible because Australian and Northern Territory governments agreed to work together to allow the fund pooling to occur. Partnerships and intersectoral collaboration are critical to providing effective health service in this regional context, and success in this regard has largely been due to the greater availability of resources for building such partnerships.

A comprehensive evaluation process has provided clear documentation of the success of the Trial, and has been instrumental in convincing governments to commit to long-term funding for the changes in the region. The quality and comprehensiveness of the evaluation and the demonstrable independence of the team have been key elements in effecting policy change.

9. The Nutrition Policy for Remote Retail Stores in Queensland

This is a joint project between the Department of Aboriginal and Torres Strait Islander Policy (DATSIP) and Queensland Health to develop strategies that could improve the

food supply situation in the six DATSIP managed retail stores. The stores involved in this project are located in the communities of Doomadgee, Kowanyama, Lockhart River, Palm Island, Pormpuraaw and Woorabinda. The aim of the store nutrition policy is to ensure that people have access at all times to the foods they need to stay healthy.

There have been several important outcomes, including:

- fresh fruit and vegetables are available at all times, even during the wet season;
- sales of fresh fruit and vegetables have increased markedly, as have some other healthy food lines;
- due to the limited mark-up approach for fresh fruit and vegetables, two stores have at various times managed to keep fruit and vegetable costs to consumers below that recorded in Brisbane for equivalent items;
- the range of healthy food is more extensive so a choice is available to customers;
- the upgrade of store infrastructure during the last five years has been a great support to implementing the policy—improvements in modern floor layout(s), merchandising, storage and food handling facilities and the internal store environment can persuade customers to purchase more in the store, especially fruit and vegetable lines; and
- integrity and quality of fresh products is maintained at all times (e.g. long-term storage facilities for fruit and vegetables were installed during the infrastructure up-grade to ensure specific fruit and vegetable stock can be stored for several months during the wet season and sold at dry season prices).

The project demonstrates that agency coordination is important if Aboriginal and Torres Strait Islander people living in remote communities are to have ready access to a wide variety of nutritious foods. By increasing the range and availability of healthy food choices, demand has also increased, thus providing a model that can be adopted for the benefit of both consumers and retailers.

A significant factor for sustainability is the formal recognition of the retail stores projects within a policy context. The endorsement of the Nutrition Policy for Remote Retail Stores ensures a continuing commitment, politically and financially, to the importance of having healthy foods accessible for remote Aboriginal and Torres Strait Islander community members.

10. Healthy Jarjums Project

The Healthy Jarjums Make Healthy Food Choices project was developed by Inala Indigenous Health Program. Its focus is on traditional and contemporary food and food related practices of Aboriginal and Torres Strait Islander cultures, with learning outcomes in nutrition, food practices, food safety and personal hygiene. It targets children in the early years of school, from preschool to year three (5–8 years).

A school-based nutrition education resource has been developed specifically for Aboriginal and Torres Strait Islander children. A local Indigenous teacher, in consultation with community members and nutrition experts, designed the program.

The resource has been trialled and an extensive evaluation completed. This showed that the resource was effective in improving reported nutrition knowledge and preferences for healthy everyday foods. Important processes issues included:

- the establishment of a project reference group to provide ongoing support to the project officer;
- the importance of having an Aboriginal person as the project officer was evidenced during the community consultation phase;
- for cross-sectoral programs such as this, developing appropriate partnerships is critical; and
- the presence of a high quality evaluation contributes to the sustainability and possible transferability of this program.