

**Guidelines for the
development, implementation and evaluation of
National Public Health Strategies in relation to
Aboriginal and Torres Strait Islander peoples**

Approaches and Recommendations

**Report for the
National Public Health Partnership**

February 2002

Project team

Principal:

Richard Murray
Medical Director
Kimberley Aboriginal Medical Services Council
Broome, Western Australia

Project officer:

Kathy Bell
Project Officer to Kimberley Aboriginal Medical Services Council

Project team:

Jacinta Elston
Associate Professor
Head of Aboriginal and Torres Strait Islander Health Studies
School of Public Health and Tropical Medicine
James Cook University

Ian Ring
Professor
Head of School of Public Health and Tropical Medicine
James Cook University

Michael Frommer
Associate Professor
Effective Healthcare Australia and
School of Population Health and Health Services Research
University of Sydney

Angela Todd
Senior Associate
Effective Healthcare Australia
University of Sydney

Copyright: National Public Health Partnership, February 2002

This work is copyright. This work may be reproduced in whole or in part for research or training purposes subject to the inclusion of an acknowledgement of the source and provided no commercial usage or sale is to be made. Reproduction for purposes other than those indicated above requires prior written permission of the National Public Health Partnership, GPO Box 4057, Melbourne 3001, Victoria, Australia.

Acknowledgments

The Consortium wishes to thank:

All of the participants in the extensive consultation process that informed this project, who contributed both their time and their considerable expertise to the project.

The late Dr Puggy Hunter, whose commitment and insights were of critical importance both in the establishment of this project, and in the approach taken by the project team.

The Project Steering Committee, chaired by Professor Ian Anderson and with secretariat support provided by Ms Karen Roger. The Committee provided key advice to guide the conduct of the project and the content of this report.

Contents

Introduction	4
Background and objectives.....	4
Defining 'public health strategy'	4
Project methods	5
Section A: Issues and opportunities	7
1 Context of public health strategy development.....	7
2 Health policy and concepts of health	7
3 The value of national strategies	8
4 Primary health-care service development	9
5 The content of national public health strategies	9
6 Mainstream and specific Indigenous strategies	9
7 Indigenous representation in strategy development	10
8 Community consultation	11
9 Partnerships and coordination	11
10 Funding of programs and other initiatives	12
11 Public health strategy evaluation	12
Section B: Recommendations for the content of guidelines	14
1 Specification of target users of the guidelines	14
2 Background.....	15
3 Representation.....	17
4 Consultation.....	18
5 Issue identification.....	18
6 Structure of strategy.....	19
7 Implementation	20
8 Evaluation.....	22
Section C: Literature review	24
1 Introduction.....	24
1.1 Recent changes affecting public health strategy	25
1.2 Aboriginal and Torres Strait Islander perspectives on health.....	29
2 Public health strategy development process	30
2.1 What issues get onto the strategy agenda?.....	31
2.2 Community consultation and participation.....	32
2.3 Improving the community consultation process.....	35
3 Public health strategy implementation.....	39
3.1 From high level strategy to grass-roots action.....	39
3.2 Has the implementation of public health programs met the needs of Indigenous peoples?.....	40
3.3 How can we achieve better implementation processes in the future?	42
4 Public health strategy evaluation	43
4.1 What can we learn from past evaluations?	43
4.2 How can we perform better evaluations in the future?.....	45
References	46
Section D: Report of Consultations	54

Introduction

Background and objectives

This report presents the findings of a project commissioned by the National Public Health Partnership (NPHP) to review options and make recommendations for guidelines on the development of national public health strategies in relation to Aboriginal and Torres Strait Islander peoples. The purpose of the project is to enhance the development, implementation and evaluation of national public health strategies, with the intent of improving their effectiveness for Aboriginal and Torres Strait Islander populations.

The project was conceived as an adjunct to existing guidelines for improving the development and coordination of national public health strategies, produced by the NPHP in 2000. These guidelines can be found on the NPHP website (www.nphp.gov.au/natstrat/).

Defining ‘public health strategy’

The NPHP *Guidelines for Improving National Public Health Strategies Development and Coordination* define ‘national strategy’ as follows: (NPHP, 1999, www.nphp.gov.au/natstrat/)

A national strategy is an organised effort to address an identified issue or health issue within a policy framework. Ideally a public health strategy includes action and implementation plans which are consistent with its policy framework.

The *Guidelines* define ‘policy’ as:

The position adopted by an organisation/government(s) in relation to specific issue(s). Policy provides the context and framework for the development of action to address identified issues.

These definitions make a distinction between ‘policy’ as an agency’s expression of philosophy and intent on an issue, and ‘strategy’ as a means for the practical execution of that philosophy and intent.

However, we have found that the terms ‘strategy’ and ‘policy’ have often been used interchangeably. Our report therefore encompasses the spectrum of policy and strategy.

The national public health strategies to which the NPHP refers comprise a list of established strategies or policies (e.g. the National Immunisation Strategy and the National Mental Health Policy), and a list of strategies that are new, emerging, or under development, (e.g. the National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan, and the National Injury Prevention Strategy). They are listed in the Appendix to this report.

Project methods

The project had three components.

(1) Compilation of literature

We searched the international English-language literature, seeking materials that might help us to explore: (a) contextual factors that influence public health policy development in general, and (b) issues in health policy development, implementation and evaluation processes that are relevant to Aboriginal and Torres Strait Islander communities.

We employed search strategies typically used in the social and health sciences to identify relevant published works in the broad areas of national health, public health, Indigenous health, and health policy and/or strategy development, implementation and evaluation. We searched several electronic databases (Medline, Embase, AusRom and WebSPIRS), as well as the World Wide Web.

We also attempted to identify major pieces of unpublished literature, including materials that were drawn to our attention in the course of our consultations (see (2) below). Details of this component of our literature review are described in Section C.

However, despite our attempts to cast a wide net in our literature search, we are aware of potentially relevant materials which we were unable to find. Furthermore, references to some of the materials that were drawn to our attention in the course of our consultations were incomplete, and we were therefore unable to search for them. Therefore, our compilation of literature (particularly unpublished literature) was incomplete.

Because of this, we were unable to produce a comprehensive literature review. Consequently, our report provides a 'commentary on the literature', rather than a 'literature review'.

(2) Comprehensive consultation process

Targeted consultations were held in all States and Territories with personnel from Commonwealth, State and Territory health departments, peak national and State bodies in the Aboriginal Community Controlled Health Service (ACCHS) sector, a cross-section of service providers from State and Territory government health services and the ACCHS sector, and other key individuals and organisations. Some 60 meetings were held, with a total of almost 200 participants.

The consultations took the form of semi-structured interviews with individuals or groups. The interview questions, which were informed by the initial findings of the literature review, were circulated to participants beforehand. All interviews were documented and summaries were returned to participants for

verification. The summaries were then analysed using qualitative methods, and key themes were identified and described. Findings were presented in aggregate form without identification of commentators. The consultation process is further described and the findings are given in detail in Section D of this report.

(3) Synthesis of findings and development of recommendations

The findings of the literature review and the consultation process were brought together and summarised in Section A of this report. From these findings we formulated recommendations for guidelines on the development, implementation, and evaluation of national public health strategies in relation to Aboriginal and Torres Strait Islander health (Section B).

The project was guided by a steering group appointed by the National Strategies Coordination Working Group of the National Public Health Partnership. Its membership comprises representatives of Commonwealth and State health departments and the National Aboriginal Community Controlled Health Organisation (NACCHO). The steering group was chaired by Associate Professor Ian Anderson, Director, VicHealth Koori Health Research and Community Development Unit, University of Melbourne.

Section A: Issues and opportunities

1 Context of public health strategy development

Three factors have increasingly influenced public health thinking in Australia and overseas over the last decade:

- Increasing recognition of the potential value of primary health care in the implementation of public health priorities, promotion of the health of individuals and communities, prevention of illness, provision of early treatment and appropriate referral to other health-care services.
- A strengthening resolve by government and non-government agencies to accommodate the diverse needs of a diverse population, taking account of gender, age, ethnicity, language, religion, culture, and socio-economic status.
- A recognition of the extent of health inequalities within and among populations, and of the need to address these inequalities.

These three factors specify the main directions of contemporary public health policy, both nationally and at State or Territory level. They also define a context for action to improve Aboriginal and Torres Strait Islander health through the development and implementation of national public health strategies.

However, it is arguable that the influence of these “progressive” movements has been confounded to some extent by other contextual factors. These confounding factors include, most notably, a frequent separation in policy and practice between Aboriginal and Torres Strait Islander health on one hand, and public health on the other; and a limited commitment from governments and from the community to addressing and resourcing both public health generally, and Aboriginal and Torres Strait Islander health in particular.

2 Health policy and concepts of health

Public health policy tends to be thematic: it deals with specific health or disease problems (such as cancer, mental health, or HIV/AIDS), specific populations (such as young people or women), specific interventions (such as screening for cervical cancer or immunisation), and specific aspects of health system organisation (such as funding mechanisms, and the roles and responsibilities of health-service agencies). Health policy themes reflect problems and opportunities confronting the health system, and they lead to a concentration on specific issues that become the focus of resource allocation and the planning and implementation of programs and interventions. This concentration on specific issues is pragmatic, but it inevitably leads to fragmentation, and despite efforts to coordinate and integrate programs and services, public health policy remains the sum of the parts.

Thus policy is often inconsistent with Aboriginal and Torres Strait Islander views of health, which tend to be comprehensive and holistic, emphasise social, emotional and cultural well-being, and make little distinction between the well-being of the individual and the well-being of the community.

The dissonance between Aboriginal and Torres Strait Islander concepts of health on the one hand, and the thematic nature of public health policy on the other, may partly explain the failure of health-system initiatives to improve Aboriginal and Torres Strait Islander health. Both our review of the literature and our consultations strongly suggest that this dissonance could be resolved by invoking an over-arching framework for Aboriginal and Torres Strait Islander health. This framework should have three characteristics. First, it should project a broad view of health with both individual and community dimensions, influenced by social, cultural and economic factors as well as health services. Second, it should provide a structure for integrated, long-term commitments that link national strategies with targeted public health programs. Third, it should deliver the critical mass of funding required to implement and sustain these programs through the provision of adequate service delivery infrastructure and resources.

3 The value of national strategies

Individuals whom we consulted identified both strengths and weaknesses in the actual and potential contribution of national public health strategies to Aboriginal and Torres Strait Islander health. They recognised that national strategies could focus efforts to solve health problems, attract necessary resources, promote inter-sectoral collaboration, and improve the quality of programs and services. However, they noted that national strategies had often been ineffective because of a lack of real political commitment, associated with insufficient resources and fragmented, short-term programmatic initiatives.

Discussion often gravitated towards the identification of issues to be covered by national public health strategies. While generic or mainstream national public strategies (as distinct from specific Indigenous health strategies) address issues that are considered important at the national level, they do not necessarily give due priority to Aboriginal and Torres Strait Islander health needs, and fail to address some key health problems altogether. The identification of these issues depends on good data (which is unavailable for many problems), making better use of available data, and political leverage.

Concerns about the value of national strategies were reinforced by our review of the literature, which drew attention to inconsistencies which are often apparent between health problems that are recognised at the national level and problems that are perceived at a regional or local by Indigenous communities. The literature also highlighted the common pitfall of introducing programs to implement strategies without first ensuring that the interventions actually work. Strategies can fail because they are not relevant or

appropriate, because of a failure to develop interventions that can realise strategic objectives, or because of a failure to implement interventions properly. If they exist, any or all of these weaknesses are most likely to be exposed in relation to Aboriginal and Torres Strait Islander health, as it is here that the issues are most stark.

4 Primary health-care service development

Within the over-arching framework for Aboriginal and Torres Strait Islander health described in section 2 above, a clear priority (identified especially in our consultations) is the need for improved access to appropriate primary health-care services. Access to primary health care is essential for the promotion and implementation of the prevention and early-treatment recommendations of national public health strategies. It was identified clearly in the consultations for this project that the major reason for the limited impact of national public health strategies on Aboriginal and Torres Strait Islander health, is that the primary health care network available to support the implementation of these strategies is limited in coverage and severely under-resourced.

To fulfill the implementation of national strategies, primary health-care services must have resources and infrastructure for effective operation, they must help to build capacity and develop an Aboriginal and Torres Strait Islander primary-care workforce, and they must engage community participation.

5 The content of national public health strategies

As noted in section 3 above, national strategies can improve Aboriginal and Torres Strait Islander health only if they deal with the issues that contribute to Indigenous health problems. Accurate identification of these issues is often difficult because of a lack of data on them, especially at the national level. However, a lack of good research and data should not be an excuse for delaying intervention where the problems and issues are obvious. Where hard data are lacking at the national level, the important issues may be identifiable through better use of the knowledge and expertise of Indigenous communities in identifying their own problems. The issues may also be identifiable through the use of regional Aboriginal and Torres Strait Islander health plans that pick up local knowledge and expertise. Even in the presence of 'hard' data, pressure must often be brought to bear to ensure that national public health strategies incorporate the issues that are important for Aboriginal and Torres Strait Islander health.

6 Mainstream and specific Indigenous strategies

Participants in our consultations compared the relative merits of specific Indigenous strategies with the inclusion of Aboriginal and Torres Strait

Islander health as a priority within mainstream strategies. Both approaches have advantages and disadvantages. While the former approach makes clearer claims for Aboriginal and Torres Strait Islander health needs and tends to be more consultative and inclusive, the latter reduces the potential for marginalisation. However, in mainstream strategies, Indigenous issues can become conflated with the problems of other groups affected by disadvantage or discrimination, and Indigenous priorities may thus be overlooked. If Aboriginal and Torres Strait Islander health is incorporated in mainstream strategies, Indigenous issues must be given due priority and commitment, possibly through the allocation of dedicated funds.

A third possible approach was suggested, which would maximise the advantages of both mainstream and Indigenous-specific strategy approaches, and minimise their disadvantages. This consisted of producing Indigenous-specific strategies that were structured as 'companion' strategies to mainstream public health strategies. Such an approach was widely supported in the consultations. Again, the success of such approaches remains largely dependent on the allocation of sufficient resources for effective implementation.

7 Indigenous representation in strategy development

Effective Aboriginal and Torres Strait Islander representation is a central part of the planning and development of national public health strategies. The success of Aboriginal-specific strategies is likely to be enhanced by Indigenous leadership of the strategy-development process. Representation from peak bodies with a community mandate is the usual mechanism for obtaining input into mainstream national public health strategies. However, peak bodies in Aboriginal and Torres Strait Islander health are often overwhelmed by the large number of concurrent policy and consultation processes generated by governments, and lack the resources to support widespread representation and the related provision of technical advice on every issue relevant to the sector.

The task of appropriate balanced representation could be eased by the following initiatives:

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

8 Community consultation

The need for proper consultation was universally recognised. Participants in our consultations had differing views on the objectives and processes of consultation, and this topic stimulated a great deal of discussion among them. Our literature search and personal inquiries revealed several sets of consultation guidelines that had been issued by US, Canadian and Australian governments, and by Aboriginal organisations. These covered both general community consultation and consultation with Indigenous communities, including American Indian, Alaska Native and Inuit peoples.

The published literature and our consultations suggested that the objectives of consultation processes are often unclear, and that the people being consulted often have different expectations from those doing the consulting. The expectations include reaching consensus; giving and receiving information (e.g. about policy options and policy development and information); canvassing diverse views; contributing to decision making; and diffusing responsibility for decision making. In considering the objectives of a consultation process, it should be recognised that responses to consultation can change during the cycle of strategy formulation and implementation – conflict and divergent views strengthen the strategy-formulation process, while implementation requires consensus and unified commitment.

Issues raised in our consultations and in the literature include:

- the questions of who should be consulted, how community perspectives should be tapped, and who should carry out consultations;
- the need for people carrying out consultations to have skills in consultation processes and knowledge of the communities being consulted (e.g. community and cultural sensitivities);
- how consultations should be conducted;
- the allowance of adequate time;
- communities' needs for resources to be able to participate in consultations; and
- follow-through, so that participants know what use is made of their input and the effect of their input on decisions.

9 Partnerships and coordination

Participants in our consultations pointed out that the successful implementation of public health strategies depends upon good collaborative relationships among the major service-provider groups involved. These typically include the Aboriginal community-controlled health-service sector, State and Territory government services, and private general practice. In our literature review we provided examples of existing formal partnerships between such stakeholder groups, and several more were identified by participants in the consultations.

Participants made other suggestions to promote the successful implementation of public health strategies. These include enhancing the professional expertise and knowledge of staff in health departments; reducing staff turnover; enhancing links between different program areas within departments; and ensuring that departments had sufficient resources for policy development and program management.

An important theme raised in our consultations is the limited understanding of Aboriginal and Torres Strait Islander health issues among many personnel within health departments (other than units devoted to Aboriginal health). Participants therefore called for the wider employment or involvement of Aboriginal and Torres Strait Islander staff in health departments. Our literature review also highlighted the dissonance between the goals of national strategies, often developed in government departments using a 'top-down' approach, and the aims of implementation programs, typically developed by service providers using a 'bottom-up' approach.

10 Funding of programs and other initiatives

Participants called for more transparency and innovations in public health funding arrangements. They particularly emphasised the need for better communication between levels of government, and greater commitment to ensure that adequate funding is provided to meet Aboriginal and Torres Strait Islander needs in the implementation of national public health strategies (and for implementation processes generally).

A frequent theme in our consultations was the discrepancy between the levels of funding needed to implement national strategies in relation to Aboriginal and Torres Strait Islander health, and the levels of funding provided. Concerns were also raised that funding needs to be directed to service providers which are accessed by Aboriginal and Torres Strait Islander people. The adequacy of diverse mechanisms that are currently used for funding public health programs was debated. In particular, while the benefits of specific-purpose funding were acknowledged, many participants considered that more flexible mechanisms were needed. They considered that these mechanisms should allow for flexibility in the utilisation of funds within programs, pooling of funds across programs, and long-term commitments of funding.

11 Public health strategy evaluation

Our review showed that most public health strategies are either not evaluated, or evaluations of them are not published. Where evaluations were undertaken, they were often limited, done inadequately, and inadequately funded. The published evaluations that exist tend to cover single programs in a community or area, and very rarely include public health programs among Aboriginal and Torres Strait Islander peoples.

Participants in our consultations reaffirmed the need to conduct better evaluations. They suggested that the evaluation of national public health strategies should be seen as an integral and necessary component of strategy development and implementation. Such evaluations should include an assessment of how well the needs of Aboriginal and Torres Strait Islander peoples are being met. They should also allow sufficient 'lead time' for community consultation, capacity building and program implementation. Finally, the results of evaluations should be fed back to relevant groups in a timely manner and in formats that they can use.

Section B: Recommendations for the content of guidelines

Health strategies, policies and programs often reflect the values and culture of the decision-makers and other senior managers who design them. This is why principles and guidelines are needed to assist in the development of policies and programs that reflect the values and needs of the Aboriginal community.

The methodology for developing 'public health practice' guidelines is considerably less established than that for clinical practice guidelines. Nevertheless, many of the principles established for clinical practice apply at a population health level. The need for 'Aboriginal public health practice' guidelines was supported in the consultations and is evidenced by issues such as significant variation in practice, gaps between what is known and what is done, frequent instances of inappropriate initiatives, loss of collective memory and costly cycles of learning and re-learning.

Based on our literature review and consultation, we recommend that guidelines for the development, implementation and evaluation of national public health strategies in relation to Aboriginal and Torres Strait Islander peoples should include the elements listed below. These elements apply generally to mainstream public health strategies, but could also guide the development of Indigenous-specific strategies.

1 Specification of target users of the guidelines

The guidelines should specify the intended users. In general, users are likely to be people who have content knowledge of the topics covered by the strategy, and/ or a knowledge of the policy context of the strategy. However, they are unlikely to have extensive knowledge and/ or experience of Aboriginal and Torres Strait health issues and related cultural issues.

Likely target users suggested include:

- Central policy and program staff in state/territory and Commonwealth health departments (eg: Aboriginal health units, population health, primary care)
- State/territory health authorities at a regional level
- Regional public health units
- Committee members involved in national public health strategies
- Consultants engaged to undertake aspects of policy development, implementation or evaluation
- Health Ministers and staff
- NGOs such as Divisions of General Practice, health professional bodies (eg medical Colleges) and specific health issue groups (eg Heart Foundation, Diabetes Australia)
- Aboriginal and Torres Strait Islander organisations wishing to engage in health strategy development, implementation or evaluation or to monitor

the extent to which governments and others are using agreed processes to direct their efforts.

2 Background

The guidelines should provide information that helps the user to understand Aboriginal and Torres Strait Islander health services and health issues and the related cultural context. This information could either form a section of the guidelines (recommended), or it could refer the user to easily-accessible sources, e.g. Internet-based materials.

This background section would provide essential contextual information on Aboriginal health policy for people working in public health strategy development, implementation or evaluation. This will enable these people to work more efficiently, avoid inflaming sensitivities or repeating past mistakes, engage effectively with representative Aboriginal community bodies and use negotiated planning structures. The guidelines should emphasise the central role of effective primary health care services in Indigenous health, and the need for stable infrastructure support in the operation of these services.

Key items of background information suggested include:

- The unique history of Aboriginal and Torres Strait Islander peoples; the diversity of communities across urban, rural, and remote areas; current issues in health and well-being; and correct terminology.
- Policy structures in Aboriginal and Torres Strait Islander health: Framework Agreements, regional forums, the regional plans, the roles of NACCHO and affiliates, HAHU and so on.
- The policy and funding context for public health and Aboriginal and Torres Strait Islander health, including roles and responsibilities of governments, departments, and program areas; financing mechanisms; and policy processes including Budget cycles.
- “Mapping” of current national and State/Territory policies and strategies which are relevant to primary health care and public health approaches for Aboriginal and Torres Strait Islander peoples, and how these link together.
- Lists of appropriate people and organisations to discuss with and consult on national public health strategies, both inside and outside the ACCHS sector.
- Service delivery capacity for Aboriginal and Torres Strait Islander health, covering issues such as the range of service delivery agencies and models, funding issues, community capacity, infrastructure, and workforce issues.
- Monitoring and evaluation of public health approaches for Aboriginal and Torres Strait Islander health, including data availability, quality, and sensitivity, appropriate performance indicators, and so on.

Guideline summary checklist

It has been suggested that a summary 'checklist' should be incorporated in the guidelines (probably forming part of the background section). The checklist would permit users to run through the headline considerations in strategy development, implementation and evaluation processes for Aboriginal and Torres Strait Islander health. Page references to the body of the document provided after each point would support ready access to the relevant section in the body of the document.

Examples of what might be covered in a public health strategy guideline summary checklist are:

Strategy development: structure

- Have the needs of the Aboriginal and Torres Strait Islander population been given appropriate weight (based on the evidence of burden of disease and capacity to benefit) and will elements of the strategy be developed to address these needs?
- Are the strategy development and implementation issues involved sufficiently different for Aboriginal and Torres Strait Islander populations to warrant development of a separate strategy or linked companion strategy? What criteria should guide such a decision?
- Is development of a national strategy justifiable for the given issue, or would it be better to simply allocate resources for to service delivery without a formal strategy?

Strategy development: engagement and input

- What opportunities exist to enable Aboriginal and Torres Strait Islander organisations to drive the strategy development process?
- How will links be made with related existing strategies and programs?
- How will a co-ordinated all-of-government approach be achieved on an ongoing basis?
- How are Aboriginal and Torres Strait Islander communities and organisations, and other key players going to be genuinely engaged?
- What mix of representation, knowledge and skills will be required on the strategy development committee? What standard criteria should apply?
- How are Aboriginal and Torres Strait Islander interests to be represented in strategy development, implementation, and evaluation? What standard protocols apply?
- How is the processes for community consultation and negotiation to be conducted? What standard protocols for consultation apply?

Strategy funding

- Has the strategy been realistically costed and how do we go about securing allocations through the Budget processes?
- What methodology should be applied to determine the level of resources that should be directed to Aboriginal and Torres Strait Islander health from a funded national strategy?
- Are there likely to be implications for cost-shifting between governments? What are these and how are they going to be dealt with?

- What funding model will best support both sustainability and flexibility at the local level?

Strategy implementation

- How will representation and consultation be managed in the implementation phase? How will this relate back to the strategy development phase and what standard criteria apply?
- What role will the Commonwealth and state/territory governments have in managing the implementation phase? What guidelines should apply?
- How are relative needs to be assessed and funds allocated at a jurisdictional, regional or local level? What standard methodologies and criteria apply?
- What mode of implementation will best contribute to community development in Aboriginal and Torres Strait Islander communities?
- What balance should be struck between identifying and resourcing known effective models and funding innovation?
- What are the critical implementation issues for Aboriginal and Torres Strait Islander communities and how are they assessed? For example: what are the appropriate service delivery models; should resources be widely distributed or applied to a few discrete projects; what about community capacity; what are the infrastructure implications; and what will be the workforce development needs?
- How will health promotion materials and campaigns be developed so as best to address the needs of Aboriginal and Torres Strait Islander communities?

Strategy evaluation

- How and when should formal evaluation be undertaken to best assess how well strategies have worked for Aboriginal and Torres Strait Islander health and how they could work better?
- How should state and territory governments report on their national public health strategy-related activities that address Aboriginal and Torres Strait Islander health?

3 Representation

The guidelines should emphasise the importance of appropriate representation of stakeholders throughout the processes of strategy development, implementation and evaluation. Aboriginal and Torres Strait Islander representation should be particularly highlighted. The guidelines should provide explicit recommendations on the selection and invitation of Indigenous representatives for various aspects of policy work. The sometimes poor history of either no Indigenous representation or tokenism should be acknowledged (eg: the arbitrary selection of individuals or Indigenous departmental employees to represent the Aboriginal and Torres Strait Islander community). The issue of the 'representativeness' of mandated Indigenous peak bodies such as NACCHO or ATSIC continues to be raised as an issue and therefore clear and consistent protocols should apply.

These recommendations should also recognise that the involvement of Indigenous representatives is not simply a matter of identifying representatives and inviting them to participate in a meeting or to respond to existing draft material. Rather, it is a complex process that includes the resolution of organisational and resource issues for both the agency responsible for the strategy and for the proposed representatives.

4 Consultation

Community consultation is a sensitive and sometimes controversial issue and clear and consistent consultation protocols to be developed, agreed, and followed for all strategy development and implementation processes. Explicit recommendations should be made on how a consultation process should be designed and managed, who should be consulted, when, and where. The design of the consultation process should be determined by the objectives of the consultation. It should be recognised that consultation processes will differ from strategy development to implementation to evaluation, and that different consultation processes will be needed for these phases. For example, detailed regional consultation is often appropriate for strategy implementation, whereas strategy development or strategy evaluation may gather perspectives from a more limited number of representative areas.

Adequate time and resources should be committed to consultation and guidelines should attempt to quantify this. Mechanisms should be in place for documentation of the process and outcomes of consultation, and for feedback to individuals communities that are consulted. Ways of avoiding 'consultation burnout' should be covered (such as considering coordination of the consultative phases of related initiatives or using established planning structures at a national, state or regional level).

5 Issue identification

The guidelines should prompt the user to ensure that Aboriginal and Torres Strait Islander health needs in relation to the intent and coverage of the strategy are canvassed accurately and comprehensively. The guidelines should provide options on how to canvass Indigenous health needs, and how to relate these needs to policy options that can be incorporated in the strategy.

Some of the specific suggestions for the issues identification phase of national public health strategy development were to:

- ensure that available epidemiological data on Indigenous morbidity, mortality, and disability is systematically considered (regardless of Indigenous identification problems);
- not to let the lack of good data in some areas be an excuse for lack of action;

- ensure that available information on Aboriginal community perceptions and priorities about health needs are incorporated (for example, gathering information from the regional Aboriginal health plans);
- undertake a analysis of strategic opportunities to make a difference through the consultations;
- ensure that health issues peculiar to or particularly over-represented in Aboriginal and Torres Strait Islander populations are not neglected (eg: rheumatic fever, epidemic renal disease, suppurative skin diseases, otitis media, oral health, various child and youth issues).
- ensuring there is a consideration of health services availability, their usage and particularly their capacity when planning strategies; and
- considering other non-health issues such as environment, housing, education, transport etc. when planning strategies in Indigenous communities.

6 Structure of strategy

In a mainstream public health strategy, aspects that apply specifically to Indigenous health needs should be clearly identifiable and easy to find. They should not be blended with or embedded in recommendations that apply to other groups affected by disadvantage or discrimination. Elements of public health strategies that apply to Indigenous health should be expressed in terms that are consistent with Aboriginal and Torres Strait Islander concepts of health. For example, these elements should be presented in a holistic health context (eg: emphasising linkages in disease causation or public health intervention), rather than projecting a disease-oriented approach that emphasises particular aspects of pathology.

Guidelines for structuring public health strategies to best address Aboriginal and Torres Strait Islander health issues might cover the following points:

- An expectation that all national public health strategies should explicitly consider the Aboriginal and Torres Strait Islander health issues involved.
- The needs of the Aboriginal and Torres Strait Islander population should be given appropriate weight (based on evidence of burden of disease and capacity to benefit).
- A set of criteria to assist in deciding whether the strategy development and implementation issues involved are sufficiently different for Aboriginal and Torres Strait Islander populations to warrant development of a separate strategy or linked companion strategy.
- A set of criteria to assess whether the health issue warrants development of a national strategy, or would it be better to simply allocate resources for to service delivery without a formal strategy.
- How Indigenous-specific components of a national public health strategy should be linked with the national framework for Aboriginal and Torres Strait Islander health planning and other Indigenous health strategies.

7 Implementation

Strategy implementation is the most problematic area in the public health strategy process. It is during implementation that some of the most critical decisions for Indigenous communities are made - on issues such as: strategy costing; funds procurement; assessment of relative priorities; appropriate roles for Commonwealth and state/territory governments; links with existing planning processes; funds administration; merits of competing service delivery models; and funding innovation versus established models.

Guidelines should therefore provide comprehensive recommendations for the many aspects of strategy implementation. Recommendations will be around principles that should apply as well as methodological frameworks (eg: costing, relative needs analysis) or sets of criteria for particular strategic decisions. Suggestions include:

General points

- Flexibility is required to accommodate the diversity of Aboriginal and Torres Strait Islander communities.
- National public health strategy resources should be available for a wide range of purposes, depending on local need (eg: infrastructure, community development and advocacy, data collection, evaluation and broadly based healthy living programs).
- The special role of the ACCHS sector needs to be recognised in implementation planning and in funding of programs.
- A community development and capacity building approach should be supported in implementation (eg: development of structures to support community participation and advocacy in health, community-driven needs analysis and planning, training and management support).
- Local employment and training should be promoted as well as measures to keep health funds circulating in Indigenous communities.
- Infrastructure and workforce issues should be key considerations in implementation planning.
- The key role of Aboriginal and Torres Strait Islander Health Workers should be considered and efforts to improve workforce supply and development should be prioritised.

Engaging partners

- Established national, state/territory and regional Aboriginal and Torres Strait Islander health planning mechanisms should be used in strategy implementation.
- Adequate time for planning and execution of implementation processes is needed (and parameters for how much time is reasonable for different aspects of implementation may be useful).
- Partnerships are required between agencies with responsibility for the strategy or who are affected by it (Commonwealth and state/territory governments, non-government organisations and Aboriginal community-controlled organisations) are required.
- Accessible plain English summaries of complex national strategies and implementation plans should be developed.

Roles and responsibilities

- A set of criteria are required to assist in determining appropriate roles for the Commonwealth and state/territory governments in managing the implementation phase (who is to drive the planning process, who assumes responsibility for program development, funds administration, etc).
- Commonwealth and state/territory government roles in resourcing should be explicitly considered at joint planning forums – particularly matters such as: the cost-shifting risks involved; seed program funding vs recurrent funding; what the core responsibilities of jurisdictions are; how Aboriginal community controlled organisations are to be enfranchised; responsibilities of departments outside of health, etc.

Resourcing

- The procurement of sufficient resources to ensure that Aboriginal and Torres Strait Islander health needs are met must be a particular priority for all public health strategies.
- Costing of implementation should be based on analysis of the program model determined through the technical analysis, planning and consultation phase.
- Options for costing methodology should be set out and should take into account the burden of disease, capacity to benefit from known effective interventions as well as the cost-disabilities associated with remoteness, diseconomies of scale, population dispersal, educational and economic disadvantage.
- Where funds are identified for an Indigenous component of a national strategy, consideration should be given to flexible resourcing arrangements such as funds-pooling across strategies or at a regional level.
- Where a more rigorous costing process for implementation in Aboriginal and Torres Strait Islander populations cannot be undertaken, there should be at least notional weighted allocation of funds for Aboriginal and Torres Strait Islander health within a broader national strategy (eg 10%).

Allocating funds

- Competitive tendering is rarely an appropriate approach for the provision of public health programs to Aboriginal and Torres Strait Islander communities.
- Resources should be targeted at service delivery organisations that are supported by and accessed by the Aboriginal and Torres Strait Islander community.
- Funding of service providers on a long-term recurrent basis rather than on a one-off basis should be a priority planning objective.
- Where funds are provided as one-off grants, planning should be undertaken to ensure that funding is targeted to areas of need (as informed through Aboriginal health planning partnerships and epidemiological data) rather than relying on competitive submission-based processes that are widely seen as ineffective.
- Relative needs should be assessed and funds allocated accordingly using a standard methodology and consultation protocol.

- If funding is submission-driven, there should be timely dissemination of information about the availability of funding; support should be provided for the development of submissions by less well resourced organisations; support for collaborative inter-agency initiatives should be provided where appropriate; and streamlined administrative processes to reduce the administrative burden on service providers and departments should be introduced.
- Brokerage and technical support services should be provided to Aboriginal and Torres Strait Islander communities either directly or through other Aboriginal community controlled organisations.
- A set of criteria are needed to assist in the decision on whether to apply limited funds to a few discrete projects or attempt broad national implementation.
- An emphasis should be placed on identifying and funding successful approaches rather than on requiring continual innovation and change (ie: there should be a balanced approach to risk and innovation).

8 Evaluation

The guidelines should emphasise the importance of evaluation of strategic initiatives and their implementation, and should include feedback to those affected. Evaluation must be undertaken by people who have appropriate expertise and experience – particularly in Aboriginal and Torres Strait Islander health. Effective evaluation depends upon partnerships between affected communities and those responsible for the evaluation process; the provision of sufficient resources for the process; appropriate timing in relation to the development and introduction of strategic initiatives; and mechanisms for ensuring that the results of evaluation are used to improve the strategy and related programs.

Suggested guideline content on evaluation should cover the following:

- The need to ensure that evaluation plans are developed at the same time and in the same context as the original strategy and that the evaluation plan explicitly examines how well the strategy has addressed Aboriginal and Torres Strait Islander health (both access and impact).
- Clear protocols for developing evaluation plans in a consultative and community-driven manner involving Aboriginal and Torres Strait Islander organisations and Aboriginal health planning forums at all stages of the evaluation processes (and at a national, state/territory, and community level as appropriate).
- How formal independent feedback should be gathered from Aboriginal and Torres Strait Islander communities/organisations (local), regional Aboriginal health planning forums where they exist (regional) or joint planning forums (state and national level), regarding the extent to which the strategy or program has met community needs.
- Focussing evaluation on performance information that can be used as a basis for continuous improvement in strategy implementation, at both the government and service provider level.

- Performance data should be fed back to relevant groups as the basis for action to better meet community needs.
- Adequate lead time should be planned before evaluation –to allow time for strategy implementation and impact, as well as for adequate consultation.
- A set of criteria for selection of meaningful strategy and program performance indicators are required to ensure validity, reliability and feasibility (noting that it is generally unrealistic to expect a single-issue strategy to produce visible changes in absolute health outcomes in the short term).
- As well as reflecting outcome-related issues, performance indicators in Aboriginal and Torres Strait Islander health should include quantitative measures of equity of access to strategy resources/programs as well as qualitative indicators on issues such as cultural security, capacity building, appropriateness, continuity, acceptability, and responsiveness of services to community needs.
- Data collection and evaluation requirements of public health strategies for Aboriginal and Torres Strait islander populations should be no less, and certainly no more rigorous or burdensome than those applying to the general population.
- The reporting and evaluation requirements at a project level should be consistent with the scale of resources being applied.

Section C: Commentary on the literature

1 Introduction

We searched published and unpublished literature with two objectives.

- The first objective was to explore the influence of social and health-system factors on public health policy. These factors included contemporary changes in the structure of the health system, the need to accommodate social and cultural diversity, and the imperative to address variations in the health status of populations.
- The second objective was to explore processes for the development, implementation and evaluation of health policy relevant to Aboriginal and Torres Strait Islander communities. These processes included methods of identifying the needs and priorities of Aboriginal and Torres Strait Islander communities; methods of conducting appropriate consultation processes; options for translating national policies into local implementation programs; and mechanisms for ensuring that programs are properly evaluated and that evaluation results are used to improve outcomes.

We employed search strategies typically used in the social and health sciences to identify relevant published works in the broad areas of national health, public health, and Indigenous health, and health policy and/or strategy development, implementation and evaluation. We searched several electronic databases (Medline, Embase, AusRom and WebSPIRS), as well as the World Wide Web.

Because many references specific to Indigenous health are not published and/or indexed in electronic databases, we also attempted to gather materials that were drawn to our attention during the project (notably in the course of our consultations). These included internal planning and policy documents within health jurisdictions; papers presented at conferences, seminars and workshops; newsletters and pamphlets; and position papers which may have stimulated local discussion but were not necessarily disseminated. Of course, it was not possible to gather all such materials. Thus while our survey of the literature was wide-ranging, it was not (and could not possibly have been) comprehensive. However, this commentary has drawn on these diverse materials as well as published literature, and unpublished items are included in our list of references.

1.1 Recent changes affecting public health strategy

Three important changes have influenced the direction of public health policy and strategy in Australia and internationally:

1. The ascendancy of primary health care.
2. An increasing awareness of the importance of accommodating the diverse needs of people, taking account of gender, age, ethnicity, religion, culture and socioeconomic class.
3. The need to address health inequalities among population groups.

Ascendancy of primary health care

Internationally, the importance of primary health care was consolidated with the endorsement of the Alma-Ata Declaration (1978) and the Ottawa Charter (1981). These statements emphasised a need to make health resources and services more accessible and responsive to all communities (rather than just to privileged or elite groups). Primary health care services were seen as being crucial in addressing local health needs, and in encouraging greater community involvement, participation and control (Annett and Nickson, 1991, cited by Jewkes and Murcott, 1998).

The primary health care model depends upon partnerships between primary health care practitioners and the communities that they serve, and also between the primary health care sector and secondary and tertiary services providers, centrally-based planners and various other resources (National Centre for Epidemiology and Public Health (NCEPH), 1992).

The problems with the implementation of the primary health care model in practice are being re-examined as part of the so-called 'third-generation' of health system reforms. The World Health Organization (WHO, 2001) notes that 'primary health care' has too often meant government-run 'primitive health care' for poor and rural populations. Meanwhile, consumers (where they can exercise an option) continue to prefer high-technology and hospital-based care rather than community health posts offering only simple treatments. The impact of consumer preference (based on real or perceived quality or responsiveness of care) has been under-estimated as a barrier to health system reform. The new challenges in the development of primary health care are to accommodate consumer demand and harness the capacity of the private and non-government health sectors, and at the same time ensure that universal access to high-quality essential care is available. The WHO has described these imperatives in primary health care as the 'new universalism'.

In Australia, there was little serious consideration of primary health care in health policy prior to the late 1980s (NCEPH, 1992), although primary care services had been proliferating at that time. A small number of Aboriginal communities were among those at the forefront – the first Aboriginal community-controlled primary health care service was established in Redfern, Sydney, in 1971. The National Aboriginal Health Strategy (NAHS), developed in 1989, also rested on community-based primary health care as the major

mechanism for improving health service delivery and health outcomes (NAHS Working Party, 1989). At present more than 100 Aboriginal community-controlled health services in Australia provide primary health care services. While these services generally have strong community support, the strength of their partnerships with other health service providers and government agencies is variable.

Increasing awareness of diversity

Since the 1950s there has been a general paradigm shift towards a more holistic and flexible approach to health care. Central to this has been an increasing awareness of the need to accommodate different perspectives associated with people of different gender, age, ethnicity, religion, and socio-economic class (Morgan et al., 1997). In Australia, a formal Charter recognises that public service must meet the needs of a culturally diverse society, and sets out seven principles that are '...central to the design, delivery, monitoring, evaluation and reporting of quality government services...': access, equity, communication, responsiveness, effectiveness, efficiency, and accountability (Commonwealth Department of Immigration and Multicultural Affairs, 1998). While the Charter provides guidance only at the most general level, its significance lies in its very existence.

The different perspectives that exist in a culturally diverse society are often accompanied by differences in values and interests. These differences can contribute to conflict among community members, community agencies, and other groups, and can also contribute to the differing imperatives faced by State and Commonwealth governments (Palmer and Short, 1994).

The accommodation of such differences in the health sector requires an understanding of the potential sources of conflict among stakeholders. Wallerstein (2000) identified the following sources of conflict between and within stakeholder groups implementing a community-based health promotion project:

- divergence of mission and purpose
- lack of awareness of process
- abstractness of principles
- cultural diversity, racism and sexism
- challenges to existing power bases
- intra-community conflicts
- a service delivery focus versus a coordinating or organising focus
- poor communication among stakeholders (including between governments)
- lack of timely information about funding
- power differentials between people with local responsibilities and those with State or national responsibilities.

Health strategies, policies and programs often reflect the values and culture of decision-makers and other senior managers. In Australia, service models have been dominated by concepts originating in Europe and, more recently,

North America. Public policy development and tasks tend to reflect the values and priorities of those who undertake them, primarily those in politics and bureaucracies (NHMRC, 1991, www.health.gov.au:80/hfs/nhmrc/publicat). Some of the values underpinning these activities can be at odds with the wider general community, and with specific ethnic and cultural minority communities, including Aboriginal and Torres Strait Islander peoples. For example, communities with strong extended family networks find individual health consultations threatening or inappropriate. Communities that hold holistic models of health are at odds with health services focused on discrete illnesses or body parts (Morgan et al., 1997). As a result, there is considerable cynicism about the performance and relevance of public servants and their knowledge of the issues affecting 'ordinary people' (Berman, 1997; Manderson, Kelaher, Williams and Shannon, 1998).

Addressing health inequalities

The WHO Constitution, adopted in 1946, emphasised that one of the fundamental rights of every human being is to enjoy the highest attainable standard of health. This was reiterated in the Universal Declaration of Human Rights in 1948. In 1977 the 30th World Health Assembly resolved that the main social target of governments and the WHO by the year 2000 should be the attainment by all citizens of a level of health that will permit them to lead socially and economically productive lives ('Health for All'). One of the basic policies promoted by the 'Health for All' statement is that governments have a responsibility for the health of their people (United Nations, 1993, www.unhchr.ch).

Consistent evidence in the past decade has shown that health disparities among people are not declining, and in some cases increasing, particularly in Western countries such as the UK, USA and Australia. Such findings have fuelled the politicisation of discussions about equity and social justice. As Saltman (1997) observed, 'While nearly everyone is committed to it [equity in health] in principle and almost everyone would like to see it realized, there is considerable disagreement about how to define equity, and even more disagreement on the methods and instruments that would be necessary to achieve it.' However, there is general consensus that initiatives to address inequity should be targeted at the 'underprivileged' (although the meaning of 'underprivileged' varies among countries).

In Australia, Aboriginal and Torres Strait Islander peoples, as a group, suffer substantial health deficits, compared with the rest of the Australian population. These inequalities relate to historical and continuing disadvantage, dispossession and discrimination. The profiles of disease and disease determinants differ from those of the general Australian population. Life expectancies of Aboriginal and Torres Strait Islander men and women are some 15-20 years less than those of other Australians (Australian Bureau of Statistics and Australian Institute of Health and Welfare, 1997; 1999). Major gaps exist in basic health service delivery for many Indigenous communities.

Health programs often fail to address the remediable problems responsible for excesses of ill health in Aboriginal and Torres Strait Islander populations.

Despite widely-held perceptions that considerable funding has been directed at improving Aboriginal and Torres Strait Islander health, existing evidence does not support this view. It has been estimated that on a per capita basis, health funding utilised by Aboriginal and Torres Strait Islander peoples has been only 8 per cent to 22 per cent higher than that for the population as a whole. By comparison, many health outcomes among Aboriginals and Torres Strait Islanders could be crudely estimated to be about three times worse. The funding contribution from the Commonwealth Government has been found to be even less, with a lower Commonwealth expenditure for each Aboriginal and Torres Strait Islander person, compared with the population as a whole, mainly due to the lack of access by Aboriginal and Torres Strait Islander people to Commonwealth-funded general practice and pharmaceutical subsidy programs (Deeble et al., 1998; AIHW, 2001).

Efforts to improve Aboriginal and Torres Strait Islander health have been focused largely on health-related services. However, several commentators have noted that health services are not as important in determining health status as social, economic, dietary and other lifestyle and environmental factors (Anderson, 1999; Evans and Stoddart, 1994, cited by Baum, 1998; Palmer and Short, 1994; Saltman, 1997).

Studies have confirmed the importance of education, employment and income in improving the health outcomes of Aboriginal and Torres Strait Islander peoples (Tsey, 1997; Eades, 2000; O'Donoghue, 1999), and in indigenous populations in other countries, such as Maori in New Zealand (Hand, 1998; Durie, 2000). For example, people with a higher level of education are more likely to accept health messages, make healthier lifestyle choices and change 'unhealthy' behaviours (Tsey, 1997). Employment and income can support healthier lifestyle choices, improve access to health services and ensure that treatment is received (Baum, 1998; Palmer and Short, 1994; Saltman, 1997).

The fact that health services are likely to deliver only marginal improvements to equity and health outcomes does not mean these improvements are not important or should not be pursued (Saltman, 1997). However, since people's social and economic circumstances strongly affect their health outcomes, health policy must be linked to social and economic determinants of health (WHO, 1998). An analysis of health care reform in Europe specifically targeting equity in health drew three conclusions (WHO 1991; cited by Saltman, 1997):

1. Health care reform seems more successful economically, socially and clinically when it focuses on the producers of care rather than the funders of care.
2. Reforms should be implemented incrementally.
3. Health care reform should lead to a shift in the role of government that 'involves less rowing and more steering'.

Health policy is a major vehicle for steering such reform. Health policy must overcome cultural and individual financial barriers to the utilisation of health care, the promotion of healthy lifestyles, and the achievement of greater equity in the distribution and allocation of resources (United Nations, 1993, www.unhchr.ch).

1.2 Aboriginal and Torres Strait Islander perspectives on health

Historical and cultural factors influence the beliefs and perceptions about health that are held by Aboriginal and Torres Strait Islander peoples. Some beliefs and perceptions differ markedly from those held by non-Indigenous Australians, illustrated by the three examples below.

Concept of health

Aboriginal languages do not contain lexical equivalents or expressions for health (NAHS Working Party, 1989). Nevertheless, in recognition of the need to describe a concept of health that can be understood from a western perspective, the National Aboriginal and Islander Health Organisation (which was the precursor to the National Aboriginal Community Controlled Health Organisation [NACCHO]), developed a definition of Aboriginal health. This definition was subsequently incorporated in the National Aboriginal Health Strategy (NAHS) in 1989, and has since been used in numerous official policy documents and agreements. It states that Aboriginal health is *'the well-being of the individual and the social, emotional and cultural well-being of the whole of the community. This is a whole-of-life view and includes the cyclical concept of life-death-life'* (NAHS Working Party, 1989). While this definition is widely accepted by Aboriginal and Torres Strait Islander peoples, it should be borne in mind that there are subtle differences in health beliefs associated with the cultural diversity of Aboriginal and Torres Strait Islander communities (Maher, 1999).

As the definition implies, sickness or injury in an individual Aboriginal person is likely to be interpreted in relation to its effect on the person's ability to fulfil social and other community commitments. It is not uncommon for Aboriginal people to refuse or discontinue treatment if it has a negative impact on their community obligations. Similarly, decisions about seeking treatment will typically involve more than one person (Morgan et al., 1997). These observations have important implications for health promotion and treatment strategies predicated on individual responsibility and decision-making.

Acquisition of health knowledge

It has been argued that abstract concepts are foreign to many Aboriginal and Torres Strait Islander peoples, and that Aboriginal people have *'... a preference for concrete knowledge recognisably related to the immediate context of their lives ... actual, tangible things experienced directly or indirectly ...'* (Morgan et al 1997, p.598).

Aboriginal and Torres Strait Islander peoples, like many other Indigenous peoples, have culturally-specific ways of knowing about health: stories from oral tradition, authoritative knowledge of elders, spiritual knowledge, commonsense models of illness and health, and knowing oneself (Turton, 1997).

Individual versus community

Among Aboriginal and Torres Strait Islander peoples, personal identity is defined in terms of kinship and other relationships with people, communities and nature (especially land). Personal identity is not represented in terms of the individual as a single entity. A person's obligations to the group are often considered more important than individual needs. As a result, an individual person's well-being is dependent upon that person's fulfilment of obligations to his or her community and land (Morgan et al., 1997).

2 Public health strategy development process

The health strategy or policy-making process has been described as comprising the following five steps (Palmer and Short, 1994; Walt, 1994, cited by Baum, 1998):

1. Problem identification and agenda setting
2. Strategy or policy formation
3. Adoption
4. Strategy/policy implementation
5. Strategy/policy evaluation.

Commentators such as Baum (1998) note that, in practice, government policy and strategy development rarely follows such a rational, ordered linear process. Strategies are a product of the administrative, policy-making and political processes of government. In the development of national strategies, these processes tend to have little direct connection with the detailed and highly variable demographic, social and ecological factors that determine the health and health-service requirements of populations and communities. Funding allocations for national strategies tend to be determined by political and budgetary cycles rather than the (usually slower) timetables of program development and implementation.

Instead of the rational-deductive process described above, national strategy development tends to follow one of three courses:

- A politically supported desire for change and/or innovation, supported by identified funds, or a commitment of funds, that drives strategy development;
- An incremental, opportunistic approach to change that is shaped by what is politically and economically viable as a first step, which is then further

amended as the process unfolds and new information emerges, including the level of funding that becomes available;

- A response to 'new' funds unexpectedly being made available for a specified area of health, with the aim of subsequently identifying what that amount of money can buy.

2.1 What issues get onto the strategy agenda?

Palmer and Short (1994) asserted that national health strategies tended to deal less with identified health needs of populations, and increasingly with political issues, often driven by interest groups, or motivated by the existence of opposing views that demand a policy position from government.

The published literature, however, contains much discussion about effective methods of identifying and quantifying the health needs of communities and populations. This literature has been crystallised in the NPHP's *Guidelines for Improving National Public Health Strategies Development and Coordination* (www.nphp.gov.au/natstrat/) (1999), which advocate the need to assess the importance and relevance of identified issues when developing public policy. The Guidelines suggest the following trigger questions:

- How important is the issue to the affected community or communities, in relation to risks, morbidity and mortality of their constituency?
- Where does the issue rate as a priority across the broader community?
- What does the available evidence base indicate about the capacity to act on the issue in a way that will lead to improved and cost effective health outcomes and health gain?

However, while there is much discussion about assessing the needs of communities and populations, there is little exploration of the methods by which knowledge of these needs can influence the national policy or strategy agenda.

How well do public health strategies address the health needs of Aboriginal and Torres Strait Islander peoples?

There is a general belief that health priorities and programs determined by governments, bureaucrats or academics (rather than Indigenous people themselves) are unlikely to benefit their communities (Manderson, Kelaher, Williams and Shannon, 1998). Aboriginal and Torres Strait Islander people need to have a say in both determining priorities among problems, and determining approaches to solutions (Torzillo, 1999).

Health priorities vary across Aboriginal and Torres Strait Islander communities. The health-related issues affecting Indigenous people living in remote regions in Central Australia are likely to differ from those affecting people living in inner city Sydney or Melbourne. As noted by Bell (1996, cited by Robinson, 1996): *'Although we speak of 'Aboriginal Australia', this masks*

considerable local and regional differences amongst our people. ... (D)ifferent regions and communities face different health problems, or the same health problems but to different degrees. ... Yet non-Aboriginal Australia is constantly designing nation-wide strategies to deal with health problems as if we were all the same ...' (p.23).

A common method used to identify the health needs of communities is the community health survey. The use of community health surveys has been criticised, because in practice the gathering of information is often not followed by the delivery of health services and programs aimed at addressing the needs identified (Mak et al., 1998). It has also been argued that many community surveys do not adequately consider the relationship between a community's health needs and its historical, environmental, economic, social, educational and cultural circumstances and needs (Russell et al., 1996). A community analysis model, named GENISIS, combines approaches based on ethnography (the recording of people's beliefs, perceptions and values) and epidemiology (the study of the distribution and determinants of health-related states or events in specified populations, and the application of this study to the control of health problems (Last, 2001)). Application of this model in various American and Canadian settings has shown that it can enhance the application of health survey findings in rural and urban communities, and in Indigenous and non-Indigenous people (Russell et al., 1996). The model does not appear to have been used in Australia.

However, more accurate or more comprehensive identification of the health needs of Aboriginal and Torres Strait Islander communities and populations will not guarantee an appropriate policy response from government. Indeed, it has been frequently argued in Aboriginal health forums that tomes of information already exist about the major health issues affecting Indigenous people. If one accepts that public health policy making is inherently a political activity, as argued by some (for example, Baum, 1998; NCEPH, 1992; Palmer and Short, 1994), then one might suggest that efforts and resources would be more effectively directed at political action than at further research.

2.2 Community consultation and participation

The value of community participation in decision-making about health, health care and health policy is widely supported in the literature (for example, Jewkes and Murcott, 1998; Palmer and Short, 1994). The involvement of community representatives, and especially community leaders, can ensure the mobilisation of support for national policies and health reforms when they are implemented at the local level (Jewkes and Murcott, 1998). Community consultation is often a productive process for both gathering information and testing ideas about strategic directions on health issues.

Community involvement in consultation processes is influenced by various factors including the following (NCEPH, 1992):

1. Government policy. The political and economic climate strongly influences the likelihood of meaningful community involvement; contradictions can occur between government policies that emphasise community involvement and administrative practices that enforce centralist approaches.
2. Resources and support. Adequate provision of resources enables stakeholders to engage effectively in, and contribute to, the consultation process.
3. Information and education. The community sector often lacks knowledge and understanding of how the system is structured and how it works.
4. Attitudes. Ignorance, misunderstanding and prejudice can become evident in consultation processes, especially those involving minority and marginalised groups. Intimidation, manipulation or dismissal of community representatives on committees can also occur, especially if such representatives are perceived as lacking 'professional skills'.
5. Practical barriers. Regular attendance of community representatives at meetings can be limited by barriers such as time constraints, illiteracy, lack of transport, lack of child care, and expenses involved.

Expectations of the intended outcomes of community consultations vary. Some observers believe that the object of consultation is to reach consensus. This may not be the case. More often consultation aims to canvass a range of diverse views, but not necessarily everyone's views (Kazan, 1990, cited by NHMRC, 1991, www.health.gov.au:80/hfs/nhmrc/publicat/). However, consultations are often criticised for being a one-way rather than reciprocal exchange of information, leaving participants feeling that they have given a lot, without receiving much in return. Consultation processes should be designed to achieve a balance in providing and receiving information. Where consultation processes are directed at decision-making, the individuals and communities that are consulted should be informed as to who makes the final decision.

Consultation or tokenism?

Despite the recognised benefits of community consultation, consultation processes are often poorly delivered and managed. Many community and consumer organisations have taken part in consultation processes that have left them disappointed, frustrated, cynical and wary of future involvement (Palmer and Short, 1994). Participation in consultation processes usually requires significant contributions of time, expertise, resources and energy, often with minimal outcomes or return (Palmer and Short, 1994). As a result, consultation processes are often viewed cynically as a means for government to avoid action rather than as a prelude to action (Manderson, Kelaher, Williams and Shannon, 1998). Research has shown that people with lower levels of education, people living in areas with poorer economic growth, and people living in poverty express more cynicism towards government than those more socio-economically advantaged (Berman, 1997).

Berman (1997) has argued that, in order to overcome cynicism from the community towards government, a sense of trust must be developed. To this end, three key goals must to be achieved:

1. Show that government uses its power to help rather than harm citizens.
2. Incorporate citizen input into public decision-making.
3. Enhance the reputation of government for competency and efficiency.

Dooley and Fryxell (1999) have also shown that trust and trustworthiness have an important moderating effect in processes such as strategy development and implementation. They point out that conflict and divergent views are considered valuable in strategy formulation processes, but that implementation processes require consensus and commonality of views. Understanding how to manage the tension between dissent and consensus building is one of the fundamental challenges in strategy development and implementation. The authors suggest one approach to resolving this dilemma may be to follow Cicero's maxim of 'diversity in council, unity in command'; that is, to build consensus actively after strategy development. Dooley and Fryxell (1999), in a study of 88 American health services, showed that the level of shared trustworthiness among members of strategy formulation teams was a key element in synthesising dissent and consensus.

Identifying communities and community representatives for consultation

Two questions must be answered to establish effective community consultations: (1) which community, or communities, should be consulted? and (2) who are appropriate representatives of those communities? (NCEPH, 1992).

In the context of the broader population, leaving aside Aboriginal and Torres Strait Islander issues, no agreement exists on the meaning of 'community'. One study documented 28 distinctly different definitions for 'community' (Jewkes and Murcott, 1998). In practice, particular interpretations of 'community' tend to achieve prominence. Further, no agreed criteria exist for identifying community representatives. Representatives are often people who are known, and are appointed rather than elected (Jewkes and Murcott, 1998; Manderson, Kelaher, Williams and Shannon, 1998). Little consideration is given to whether the representative is recognised as such by the community, or has the skills to present the case for those he or she represents (Palmer and Short, 1994). Questions have also been raised about the accountability of community representatives. Many representatives in this broader whole-of-population context are not accountable to the people whom they ostensibly represent, and are not bound to give the views or advocate for the preferences of those people (Palmer and Short, 1994).

Baum (1998) argues that, in reality, most communities are made up of an amalgam of competing interests and factions, and often have competing objectives. It is therefore impossible for any individual to represent the community per se. Instead the crucial issue is to identify the constituency that

is being represented. Often the constituency is a community-based organisation, but many people in the community are not affiliated with these organisations, and are therefore not represented by them (Jewkes and Murcott, 1998). Further, consultations on issues of wide-ranging or national significance typically draw on representatives from umbrella community organisations positioned at the national level. These umbrella groups exist primarily to support other groups, and they are often removed from the community. However, umbrella groups are more likely to be funded, staffed and better able to participate in consultation processes (Jewkes and Murcott, 1998). This has given rise to concerns about the adequacy of coverage and representation achieved in community consultation processes: *'... you always feel there is a group of people out there who actually aren't getting their voices heard and nobody is making contact with them'* (Jewkes and Murcott, 1998, p. 855).

Consultations with Aboriginal and Torres Strait Islander peoples are complicated by a similar lack of agreement about the delineation of communities, the diversity across communities in different regions, States and Territories, and the complex gatekeeping that operates at different levels within communities and community organisations determining access to members (Manderson, Kelaher, Williams and Shannon, 1998). Aboriginal and Torres Strait Islander 'representatives' tend to be drawn from elected councils and organisations, or from an 'existing pool' of people sitting on other committees. Such representatives may not necessarily be the most appropriate to deal with the particular issue under discussion (Manderson, Kelaher, Williams and Shannon, 1998).

2.3 Improving the community consultation process

Clearly there is much room for improvement in the community consultation process. The following general and Indigenous-specific recommendations are drawn from various documents discussing effective community consultation (Agency for Healthcare Research and Quality, 2001, www.ahcpr.gov/about/tribalplan.htm; Andranovich, 1995; QAIHF, 2001; Queensland Transport/Main Roads, 1997; Russell et al., 1996; Singer, 1995).

General recommendations

- Identify who should be involved in the consultation process and what level of participation they should have;
- Consult with a range of stakeholders as early as possible before decision-making occurs;
- Name the decision-making person/people at the beginning of a consultation to add transparency to the process;
- Discuss consultation ground rules early;
- Ensure that 'negotiables' and 'non-negotiables' are outlined at the beginning of the consultation process;
- Recognise the emotions and values you bring to the consultation process;

- Be sensitive to cultural values, norms and variation;
- Be open and honest;
- Ensure that any required information is provided in time to allow sufficient consideration;
- Pay attention to what is actually being said;
- Keep the consulting group reasonably small;
- Seek a level playing field;
- Try to get people to explain their interests rather than their positions;
- Try to get people to offer trial solutions, and seek mutual gains;
- Try to restate things in the simplest terms (reduce abstractness to concrete terms);
- Break down complex problems into constituent parts (deconstruction);
- Be flexible about procedural matters;
- Provide feedback to stakeholders about decisions made;
- Allow 4-6 weeks for consultation, at a minimum;
- Consider the need for an 'information' phase prior to a 'feedback/input' phase in the consultation process;
- Recognise political and legal realities.

Indigenous-specific recommendations

- Acknowledge the history of adversarial relationships, and the need to move towards better mutual understanding and greater trust;
- Recognise the 'baggage' that people bring to consultations; let people blow off steam – absorb it and then keep going;
- Move beyond past hurts, don't argue about them. Try to focus on what you're doing now and in the future;
- Address the lack of resources among smaller communities, especially those needed to allow participation in consultation meetings (e.g. resources for travel, training, information technology and other costs);
- Recognise that consultation with peak bodies does not necessarily ensure that the views of local Aboriginal communities are represented;
- Encourage indigenous people to be pro-active in raising priorities with State and Commonwealth agencies;
- Provide education to Indigenous people on how to work with government;
- Make use of existing community communication channels and provide information using different media (especially television, radio and face-to-face communication);
- Ensure that communities are provided with copies of final recommendations or decisions in an appropriate format.

Examples of consultation principles and guidelines

To facilitate improvements in community consultation processes, guiding principles and guidelines have been produced. The following is a set of guiding principles for community consultation, published by the Government of Canada Privy Council Office (1992, www.pco-bcp.gc.ca/com-con/).

- Consultation with the community is intrinsic to effective public policy development and service to the public.
- Effective consultation is based on principles of openness, transparency, integrity, and mutual respect for the legitimacy and point of view of all participants, and transparency of purpose and process.
- The outcome of consultation should not be pre-determined.
- The initiative to consult may come from inside government or outside – each should respond as constructively as it can.
- Whenever possible, consultation should involve all parties who can contribute to, or are affected by, the outcome of the consultation.
- Participants in consultations should have clear mandates; they should have an influence over the outcome and a stake in implementing any action agreed upon.
- Some participants may not have the resources or expertise required to participate, and need such support for their representation to be assured.
- Effective consultation is about partnership.
- Participants should have a clear understanding about how much time a consultation is likely to take.
- Participants should have timely access to relevant and easily understood information, and commit to sharing information.
- Effective consultation will not always lead to agreement; however, it should lead to a better understanding of each other's positions.
- Participants should hold themselves accountable for implementing agreed actions/recommendations.
- Effective consultation requires follow-through. Participants are entitled to know what use is made of their views and information they provide, and their impact on decision-making.
- The skills required for effective consultation are: listening, communicating, negotiating and consensus building. Participants should be trained in these skills.

Several sets of guidelines have been published by government departments and other parties for general community consultations (for example, Government of Canada Privy Council Office, 1992; www.pco-bcp.gc.ca/com-con/; NHMRC, 1991, www.health.gov.au:80/hfs/nhmrc/publicat/; Queensland Transport/Main Roads, 1997; US General Services Administration, <http://hydra.gsa.gov>).

A smaller number of guidelines have been developed specifically for consultations with indigenous communities (for example, Agency for Healthcare Research and Quality, 2001, www.ahcpr.gov/about/tribalplan.htm; Commonwealth Department of Family and Community Services, personal communication; Queensland Aboriginal and Islander Health Forum, personal communication). Extracts from two of these guidelines are provided below as examples of their content.

American Indian/Alaska Native Consultation Plan – guidelines for government departments (Agency for Healthcare Research and Quality, 2001, www.ahrp.gov/about/tribalplan.htm)

Following unsuccessful efforts to develop one government-wide tribal consultation policy, each government department is required to develop its own policy addressing the following six key points:

- Each government department will develop a policy/plan that outlines its general direction on consultation.
- Each department will develop and describe its method of consultation.
- Each department will develop a short consultation plan that indicates to tribal governments how consultations will generally be carried out, their timeframes etc.
- Each department will have a plan for receiving input, allowing for an adequate response time, before it submits its fiscal budget. Each department should encourage tribal government input in its budget formulation process.
- Each department will use web-based technology as the primary medium for notifying tribes and the public about consultation plans and obtaining comments on them.
- Each consultation plan should ensure sufficient access and time for tribes to provide input before final decisions are made.

In addition to these six points, the following recommendations are made for consultations with American Indian and Alaska Native peoples:

- A single point-of-contact should be established within each Department for tribal leaders to obtain departmental program information and assistance;
- Sufficient background information should be provided in the consultation process, including a clear statement of the potential effect of the proposed action on Indian people;
- A clear statement should be made regarding the advice sought in the consultation, a specific time limit should be stated for responses, a clear indication should be given of who should will the reply; and
- Timely feedback should be provided to Indian tribes and organisations.

Protocols for conducting consultations and research in rural and remote Indigenous Communities, Commonwealth Department of Family and Community Services (personal communication)

- Be well-informed about local, state/territory and national laws, customs and cultures.
- Determine if formal permission is required to enter a community.
- Ensure all groups within a community have the opportunity to tell their story.
- Be aware that there may be factions within a community.
- Meet with community members at a place of their choosing.
- Negotiate and announce your arrival well ahead of time.

- Hold initial consultations with a mix of customary leaders, Indigenous organisations, ATSIC regional councils, local councils and concerned individuals.
- Follow-up initial consultations with written confirmation of the agreed outcomes.
- Involve local Indigenous people in all stages of planning and consultation.
- Conduct consultations in small groups.
- Be aware of who is needed for decision-making.
- Allow time at the beginning of any meeting for the airing of grievances.
- Be aware of the need to demonstrate you are trustworthy and sincere.
- Repeat back what you have been told to ensure you understand.
- It is unwise to conduct a formal meeting if you are unknown by the community – it is essential to have credibility and contacts before a formal meeting is organised.
- Be aware of protocols and cultural sensitivities associated with male/female issues.

3 Public health strategy implementation

3.1 From high level strategy to grass-roots action

The translation of public health strategy into programs and interventions on the ground has generally tended not to be a smooth and seamless process. Not uncommonly, strategies developed at national levels have been subsequently recast as State/Territory strategies. Sometimes, but not always, strategies are supported by implementation plans. Individual programs and interventions are then proposed, variably funded and variably implemented. Coordination across programs and/or States and Territories has been problematic, and evaluation and feedback following implementation has often been inadequate or non-existent.

National, State and Territory strategies have tended to focus on macro issues, while implementation efforts are operationalised at local and regional levels, usually focusing on individual people and programs. Baum and her colleagues (1996) have observed that national strategies are often defined by goals and targets that are not really relevant at the community level where many of the programs are delivered. National strategies also tend to take a top-down approach while implementation programs have commonly been developed from the bottom-up, so that there are often fundamental ideological differences between stakeholder groups. These paradoxes create an inevitable dissonance between the goals of national strategies and those of implementation programs (Baum et al., 1996).

Intervention programs are also frequently developed and implemented without evidence that they actually work (Stevens-Simon and Orleans, 1999). At the same time, in many fields there are no unequivocal answers to the question 'what works?' (Smith, Ebrahim and Frankel, 2001). Studies and reports of individual programs and their specific features usually do not allow

comparisons and generalisations. Programs are often tailored to meet the prevailing circumstances in the local area, including population characteristics, workforce and other resource issues. So what 'works' in one setting does not necessarily work in a slightly different one.

Within Aboriginal communities, the principles of self-determination and ownership also conflict with notions of duplicating successful programs from one community to another. While details of program implementation and/or outcomes are sometimes published (e.g. Hoy, Kelly, Jacups, McKendry, Baker et al., 1999; Hunt, Gless and Straton, 1998; Laming, Currie, DiFrancesco, Taylor and Mathews, 2000; Rowley, Daniel, Skinner, Skinner, White and O'Dea, 2000), the generalisability of these programs is usually heavily qualified.

In some cases, national public health strategies provide minimal guidance on the types of programs and activities that are needed to realise the stated goals and objectives. Consequently, implementation efforts across States and Territories can be highly variable.

Funding provisions are generally interpreted as a proxy for the level of commitment to a particular strategy. Some public health strategies have not been supported by dedicated funds for implementation actions, or more commonly, have been inadequately financed. Attempts to make a difference subsequently fail or have short-term but unsustainable impact, creating a negative feedback loop for future programs and funding opportunities.

At the same time, highly prescriptive and better-funded programs are not without problems, particularly in meeting the needs of non-mainstream subgroups such as higher risk and/or difficult-to-reach populations. Such problems can include a lack of goals and objectives reflecting the different needs of specific subgroups, access difficulties (due to location, eligibility criteria or cultural appropriateness) and funding problems despite 'adequate program funds' (because of limited infrastructure).

3.2 Has the implementation of public health programs met the needs of Indigenous peoples?

As part of this project, we undertook a review of four national public health strategies, that covered health topics relevant to Aboriginal and Torres Strait Islander peoples. They were: the National Indigenous Australians' Sexual Health Strategy (1996-97 to 1998-99), the National Diabetes Strategy and Implementation Plan (1998), the National Cervical Screening Program, and the Immunise Australia Program. We examined published details of implementation processes associated with these strategies for evidence of consultation and involvement of Indigenous representatives and/or communities, goals and objectives specific to Aboriginal and Torres Strait Islander peoples, commitment of adequate funds for implementation of programs for Aboriginal and Torres Strait Islander peoples, and identification of parties responsible for implementation.

Our cursory review showed variable results. The published materials available suggested that the National Indigenous Australians' Sexual Health Strategy, specifically designed by and for Indigenous peoples, addressed these Indigenous-specific requirements very well. On the other hand, the more 'generic' strategies designed for the broader community did not.

A recent review of the cervical screening program for Indigenous communities in Queensland, undertaken by Kirk, Hoban, Dunne and Manderson (2001), illustrates some of the types of problems that can arise. The reviewers found significant access difficulties to the cervical screening program for Indigenous women in rural and remote communities including travel over long distances at substantial cost and inconvenience. Indigenous women also preferred culturally appropriate, community-based and community driven services; in contrast, hospital clinics were the least favoured but one of the more common venues for cervical screening services. While women valued a trusting relationship with female service providers, many Indigenous women were itinerant or mobile so that the delivery of screening and recall services by the same practitioner, and effective follow-up were not easily achieved.

The review noted that 'body-part' programs, such as cervical or breast screening, also conflict with the principle of holistic health and well-being held by Aboriginal and Torres Strait Islander peoples. The Well Women's Program in the Northern Territory has addressed this issue by adopting a holistic approach in the delivery of its screening services and health checks for Indigenous women.

Evidence from this review and a similar evaluation of breast-screening services for Indigenous women in Queensland (Kirk, McMichael, Potts, Hoban, Hill and Manderson, 2000) also showed that there were chronic problems with insufficient and/or under-trained service providers, including Aboriginal Health Workers, and an absence of essential capital equipment to support and maintain public health program initiatives.

However, even if the above issues could be fully resolved, preventative health programs in Indigenous communities are often a lower priority than more pressing issues such as managing chronic illnesses and other public health concerns (e.g. over-crowding or substance misuse among adolescents).

Baum and her colleagues (1996) conducted a review of national health promotion programs in South Australia, several of which specifically targeted Aboriginal and Torres Strait Islander communities (women's health, nutrition, and hypertension). This review identified several areas for improvement, some of which were similar to those raised above in the Queensland review. Specifically, the South Australian review identified:

- the need for greater attention to structural change, with an emphasis on collaboration across sectors, and greater community participation;
- reconciling the difficult marriage between local initiatives with national health program objectives;
- the need for dedicated and assured funding; and
- the need for increased training and support.

3.3 How can we achieve better implementation processes in the future?

From the reviews described above there are at least three important areas for improvement: consultation with, and involvement of, community and stakeholder representatives; recognition and accommodation of cultural-specific concerns; and funding for infrastructure and core programs.

The NAHS (1989) has stated that the implementation of preventive health programs for Aboriginal peoples is the responsibility of community controlled primary health care services with appropriate support from other service providers. Given the depth and breadth of health and health-related problems facing Aboriginal and Torres Strait Islander communities, it is unlikely that the efforts of any one sector will be sufficient. Coordinated and collaborative efforts are necessary.

In recent years considerable work has been undertaken to establish multiple-stakeholder partnerships that work together to develop and implement health programs for Aboriginal and Torres Strait Islander peoples. Some examples include:

- Formal state and territory partnerships have been established between the state peak body representing Aboriginal Community Controlled Health Services, ATSIC, the State department of health and the Commonwealth Department of Health and Aged Care, to jointly make decisions about strategies and programs to improve the health status of Aboriginal and Torres Strait Islander peoples;
- The Aboriginal Health Council of South Australia, the State Department of Human Services, the Women's and Children's Hospital, Nunkuwarrin Yunti of South Australia and the Department of Education, Training and Employment, have developed an implementation plan to improve the nutritional status of Aboriginal peoples in South Australia;
- Townsville Aboriginal and Islander Health Services, Townsville Health Services District, North Queensland Clinical School, Royal Australian College of General Practitioners Training Program, James Cook University and others have an agreement to deliver better integrated community health services at the local regional level.

These partnerships offer great promise. Nonetheless, it must be acknowledged that partnerships like these, which bring together parties with different and often competing agendas, different ways of doing business, and different expectations of processes and outcomes, are challenging, and at times difficult.

There have also been efforts to increase the awareness and sensitivity of non-Indigenous stakeholders to the cultural needs of different Aboriginal and Torres Strait Islander communities. While there are some core principles and values that are common to most Indigenous communities, there are also

others that are specific to individual groups. There is no written record of such matters that might assist strategy developers or implementers. However, working partnerships, such as those listed above, have facilitated the development of more culturally appropriate strategies and intervention programs. Cultural awareness training for non-Indigenous peoples involved in strategy development and implementation has also helped. Increased employment of Aboriginal peoples in positions associated with public health strategy is beneficial too. These initiatives should be encouraged and supported.

With regards to changes to funding arrangements of public health programs for Indigenous communities, progress has been more limited. There appears to be better recognition of the significant gaps in the infrastructure and workforce required to support such programs. There has also been some increases in funding for Aboriginal-specific public health initiatives. Nonetheless, there is still a substantial mismatch between the enormity of the health problems facing Aboriginal and Torres Strait Islander peoples, and the funding provided to address them, particularly by the Commonwealth (Deeble et al., 1998). Funding reforms are needed, but these are likely to go beyond public health strategies and programs.

4 Public health strategy evaluation

4.1 What can we learn from past evaluations?

Statements about the importance of program evaluation and recommendations for its completion are typically included in most public health strategy documents, however effective evaluations to date have been the exception rather than the rule. Evaluations are generally not done well, and are not well funded (Manderson, Kelaher, Williams and Shannon, 1998).

Evaluations of public health intervention programs generally rely on one of three types of comparisons (Kirkwood, Cousens, Victora and de Zoysa, 1997):

1. pre versus post intervention comparison within a target group
2. comparison between an intervention group and a control group
3. comparison between post-intervention adopters versus non-adopters

There are weaknesses inherent in all three comparisons, including that they all suffer from the difficulty of 'proving' that any observed difference is due to the intervention and not some other factor.

Most public health preventive programs also do not lend themselves to direct evaluation. The time frames are often too long, and the links with final outcome often too uncertain. Much of the output of public health programs also consists of information and knowledge, which are difficult to evaluate since their final application is unknown (Deeble, 2000).

Evaluations of public health programs in Australia, particularly those associated with national strategies, and particularly those carried out relatively soon after the introduction of a program, have been viewed cynically as politically-motivated exercises, designed to account for expended funds, or to justify decisions to terminate, reduce or extend program funds in the near future. Some programs have published reports of quantitative performance indicators in lieu of evaluations. While the information is often interesting and useful, whether it represents an adequate proxy for program evaluation per se is probably open to debate.

Our efforts to gather published literature associated with public health strategy development, implementation and evaluation as part of this project revealed that comparatively little evaluation has been published. This does not necessarily mean that evaluations have not been performed. However, published examples of coordinated, comprehensive evaluations of programs related to public health were rare. More typically, published evaluations cover single programs in a community or region (for examples, see Ashenden, Silagy and Weller, 1997; Hunt, Gless, Straton, 1998; Lennings, 2000; Rowley, Daniel, Skinner, Skinner, White and O'Dea, 2000). Moreover, there has been relatively little published public health research among Indigenous communities, despite their experience of being over-researched (Aboriginal Coordinating Council, 1995, cited by Manderson, Kelaher, Williams and Shannon, 1998).

This is consistent with the broader context of published evaluations in health and medicine, which have generally been restricted to individualised interventions (Smith, Ebrahim and Frankel, 2001). In recent years, a small number of reviews has been published that synthesise the results of several intervention programs within a specific public health area, for example, cervical screening (Marcus and Crane, 1998) and smoking behaviour in public places (Serra, Cabezas, Bonfill and Pladevall-Vila, 2000). Apart from the evidence based Aboriginal health textbook produced by Kimberley Aboriginal Medical Services Council (Couzos and Murray, 1999), we found only one example of a review specific to interventions among Aboriginal and Torres Strait Islander peoples, in the area of alcohol misuse, conducted by Gray and colleagues (2000), summarised below.

Previous surveys and research studies have found that fewer Aboriginal than non-Aboriginal Australians drink alcohol, however Aboriginals who do drink are more likely to drink excessively. Excessive alcohol intake is a significant contributing factor to poor health and social well-being. For these reasons a broad range of interventions have been applied to reduce alcohol consumption and related harm among Aboriginal peoples. Gray, Saggars, Sputore and Bourbon (2000) recently reviewed 14 such studies. Their key findings included:

- there was some evidence that interventions aimed at reducing alcohol supply may be effective, but alone they appeared unlikely to provide long-term solutions;
- the effectiveness of programs was influenced by how well the program was administered and the experience of staff;

- the interventions were generally inadequately resourced;
- there were few systematic evaluations of the intervention programs;
- the methodologies employed were generally insufficient to allow robust generalisation.

The reviewers noted that alcohol misuse among Aboriginal Australians is a consequence of political and economic inequalities arising from colonialism and dispossession. Therefore, while effective and well-resourced intervention programs may reduce harmful drinking behaviour, fundamental inequalities needed to be addressed to improve the well-being of Aboriginal peoples (Gray, Siggers, Sputore and Bourbon, 2000).

4.2 How can we perform better evaluations in the future?

Program evaluations can generally be divided into assessments of structure, process and/or outcome (Donabedian, 1982). Evaluation designs and methods should then be determined by the questions being asked, the type of program being evaluated (e.g. preventive or curative) and the level at which the program is being delivered (e.g. individual, community, state/territory or national) (Kirkwood, Cousens, Victora and de Zoysa, 1997).

Several evaluation models have been developed and tested (for examples, see Malterud (1995), and Habicht, Victora and Vaughan (1999)). Russell and her team (1996) have designed the RE-AIM model, which comprises five dimensions: reach, efficacy, adoption, implementation and maintenance. These dimensions are assessed at various levels, for example, individual, clinic setting and/or community. The quality of evaluations is also improved when affected communities are engaged in the design and interpretation of the interventions, as well as the suggested changes that emerge from the evaluation results. Nonetheless, evaluation expertise is often not located in communities (Wallerstein, 2000), so collaborative partnerships that bring together people with technical expertise and those with community knowledge and experience offer greater potential. Examples were given above of multi-stakeholder partnerships working towards more effective strategy development and implementation. Similar partnerships should also be established to ensure more effective strategy evaluation.

Finally, there is a need for greater transparency about evaluation processes and outcomes. The dearth of published evaluations of existing national public health strategies and related initiatives suggests considerable room for improvement. A good evaluation can provide valuable information for program planners, managers and decision-makers. A poor evaluation is often a waste of time, money and effort. No evaluation at all allows a program to go on unchecked and potentially unimproved. Public health strategies offer much potential for improvement. Effective evaluations are a critical component of their success, and deserve greater commitment and resourcing.

References

Peer-reviewed journals/books

Anderson I. (1999) Reconciliation and policy reform: is there a link? *Australian and New Zealand Journal of Public Health*, 23: 231-232.

Andranovich G. (1995) Achieving consensus in public decision making: applying interest-based problem solving to the challenges of intergovernmental collaboration. *Journal of Applied Behavioral Science*, 31: 429-445.

Ashenden R, Silagy C, Weller D. (1997) A systematic review of the effectiveness of promoting lifestyle change in general practice. *Family Practice*, 14: 160-175.

Australian Bureau of Statistics (ABS) and Australian Institute of Health and Welfare (AIHW). (1997) *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*. Australian Bureau of Statistics Cat No. 4704.0. Canberra: Australian Bureau of Statistics.

Australian Bureau of Statistics (ABS) and Australian Institute of Health and Welfare (AIHW). (1999) *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*. Australian Bureau of Statistics Cat No. 4704.0. Canberra: Australian Bureau of Statistics.

Australian Institute of Health and Welfare (AIHW). (2001) *Expenditures on Health Services for Aboriginal and Torres Strait Islander People, 1998-99*. Canberra: AIHW.

Baum F. (1998) *The New Public Health: An Australia Perspective*. Melbourne: Oxford University Press.

Baum F, Santich B, Craig B, Murray C. (1996) Evaluation of a national health promotion program in South Australia. *Australian and New Zealand Journal of Public Health*, 20: 41-49.

Berman EM. (1997) Dealing with cynical citizens. *Public Administration Review*, 57: 105-112.

Commonwealth Department of Immigration and Multicultural Affairs. (1998) *Charter of Public Service in a Culturally Diverse Society*. Canberra: Government Publishing Service.

Couzos S, Murray R. (1999) *Aboriginal Primary Health Care: An Evidence-based Approach*. Oxford University Press.

Deeble J. (2000) *Resource Allocation in Public Health: An Economic Approach (2nd edn)*. Melbourne: National Public Health Partnership.

- Deeble J, Mathers C, Smith L, Goss J, Webb R, Smith V. (1998) *Expenditures on Health Services for Aboriginal and Torres Strait Islander People*. AIHW Cat No. HWE 6. Canberra: Commonwealth of Australia.
- Donabedian A. (1982) *The Criteria and Standards of Quality*. Michigan: Health Administration Press.
- Dooley RS, Fryxell GE. (1999) Attaining decision quality and commitment from dissent: the moderating effects of loyalty and competence in strategic decision-making teams. *Academy of Management Journal*, 42: 389-402.
- Durie M. (2000) Public health strategies for Māori. *Health Education and Behavior*, 27: 288-295.
- Eades SJ. (2000) Reconciliation, social equity and Indigenous health (editorial). *Medical Journal of Australia*, 172: 468-469.
- Gray D, Saggars S, Sputore B, Bourbon D. (2000) What works? A review of evaluated alcohol misuse interventions among Aboriginal Australians. *Addiction*, 95: 11-22.
- Habicht JP, Victora CG, Vaughan JP. (1999) Evaluation designs for adequacy, plausibility and probability of public health programme performance and impact. *International Journal of Epidemiology*, 28: 10-18.
- Hand, D. (1998) Indigenous health in New Zealand: 'by Māori, for Māori'. *Australian Nursing Journal*, 5:18-20.
- Hoy W, Kelly A, Jacups S, McKendry K, Baker P, MacDonald S, Wang Z, Punguatji N, Kerinauia J, Tipiloura E, Tipiloura E, Harrison C. (1999) Stemming the tide: reducing cardiovascular disease and renal failure in Australian Aborigines. *Australian and New Zealand Journal of Medicine*, 29: 480-483.
- Hunt JM, Gless GL, Straton JAY. (1998) Pap smear screening at an urban Aboriginal health service: report of a practice audit and an evaluation of recruitment strategies. *Australian and New Zealand Journal of Public Health*, 22: 7290-725.
- Jewkes R, Murcott A. (1998) Community representatives: representing the "community"? *Social Science and Medicine*, 46: 843-858.
- Kirk M, Hoban E, Dunne A, Manderson L. (2001) *Barriers to and Appropriate Delivery Systems for Cervical Cancer Screening in Indigenous Communities in Queensland*. Queensland Health/University of Queensland.
- Kirk M, McMichael C, Potts H, Hoban E, Hill DC, Manderson L. (2000) *Breast Cancer: Screening, Diagnosis, Treatment and Care for Aboriginal Women and Torres Strait Islander Women in Queensland*. Brisbane: Queensland Health.

- Kirkwood BR, Cousens SN, Victora CG, de Zoysa I. (1997) Issues in the design and interpretation of studies to evaluate the impact of community-based interventions. *Tropical Medicine and International Health*, 2: 1022-1029.
- Laming AC, Currie BJ, DiFrancesco M, Taylor HR, Mathews JD. (2000) A targeted, single-dose azithromycin strategy for trachoma. *Medical Journal of Australia*, 172: 163-166.
- Last, J.M. (editor, for the International Epidemiological Association) (2001). *A Dictionary of Epidemiology, 4th edition*. Oxford: Oxford University Press.
- Lennings CJ. (2000) Harm minimisation or abstinence: an evaluation of current policies and practices in the treatment and control of intravenous drug using groups in Australia. *Disability and Rehabilitation*, 22: 57-64.
- McDermott RA, Schmidt BA, Sinha A, Mills P. (2001) Improving diabetes care in the primary healthcare setting: a randomised cluster trial in remote Indigenous communities. *Medical Journal of Australia*, 174: 497-502.
- Mak DB, McDermott R, Plant AJ, Scrimgeour D. (1998) The contribution of community health surveys to Aboriginal health in the 1990s. *Australian and New Zealand Journal of Public Health*, 22: 645-647.
- Malterud K. (1995) Action research – a strategy for evaluation of medical interventions. *Family Practice*, 12: 476-481.
- Manderson L, Kelaher M, Williams G, Shannon C. (1998) The politics of community: negotiation and consultation in research on women's health. *Human Organization*, 57: 222-229.
- Marcus AC, Crane LA. (1998) A review of cervical cancer screening intervention research: implications for public health programs and future research. *Preventive Medicine*, 27: 13-31.
- Morgan DL, Slade MD, Morgan CMA. (1997) Aboriginal philosophy and its impact on health care outcomes. *Australian and New Zealand Journal of Public Health*, 21: 597-601.
- National Centre for Epidemiology and Public Health (NCEPH). (1992) *Improving Australia's health. The role of primary health care*. Canberra: The Australian National University.
- National Aboriginal Health Strategy Working Party. (1989) *National Aboriginal Health Strategy*.
- National Aboriginal Health Strategy: An Evaluation*. (December 1994).
- O'Donoghue L. (1999) Towards a culture of improving Indigenous health in Australia. *Australian Journal of Rural Health*, 7: 64-69.

Palmer GR, Short SD. (1994) *Health Care & Public Policy – An Australian Analysis (2nd edn)*. South Melbourne: Macmillan Education Australia Pty Ltd.

Robinson G. (Ed.) (1996) *Aboriginal Health: social and cultural transitions. Proceedings of a conference at the Northern Territory University, Darwin, 29-31 September 1995*. Darwin: NTU Press.

Rowley KG, Daniel M, Skinner K, Skinner M, White GA, O'Dea K. (2000) Effectiveness of a community-directed 'healthy lifestyle' program in a remote Australian Aboriginal community. *Australian and New Zealand Journal of Public Health*, 24: 136-144.

Russell CK, Gregory DM, Wotton D, Mordoch E, Counts MM. (1996) ACTION: application and extension of the GENESIS community analysis model. *Public Health Nursing*, 13: 187-194.

Saltman RB. (1997) Equity and distributive justice in European health care reform. *International Journal of Health Services*, 27: 443-453.

Serra C, Cabezas C, Bonfill X, Pladevall-Vila M. (2000) Interventions for preventing tobacco smoking in public places. *Cochrane Database of Systematic Reviews*, 3: CD001294.

Singer MA. (1995) Community participation in health care decision making: is it feasible? *Canadian Medical Association Journal*, 153: 421-424.

Smith GD, Ebrahim S, Frankel S. (2001) How policy informs the evidence. *British Medical Journal*, 322: 184-185.

Stevens-Simon C, Orleans M. (1999) Low-birthweight prevention programs: the enigma of failure. *Birth*, 26: 184-191.

Torzillo PJ. (1999) Clinical research in Aboriginal health (editorial). *Journal of Paediatrics and Child Health*, 35: 123-124.

Tsey K. (1997) Aboriginal self-determination, education and health: towards a radical change in attitudes to education. *Australian and New Zealand Journal of Public Health*, 21: 77-83.

Turton CLR. (1997) Ways of knowing about health: an Aboriginal perspective. *Advances in Nursing Science*, 19: 28-36.

Wallerstein N. (2000) A participatory evaluation model for healthier communities: developing indicators for New Mexico. *Public Health Reports*, 115: 199-204.

Strategy documents and other papers

Aboriginal Health Council of SA Inc. (June 2000) *Exploring the Smokescreen, Reducing the Stress*.

Australian Institute of Health and Welfare. (1997) *National Health Priority Areas Report, Cancer Control*.

Australian National Council on HIV/AIDS and Related Diseases Working Party. (1997) *The National Indigenous Australians' Sexual Health Strategy 1996-97 to 1998-99*, Office for Aboriginal and Torres Strait Islander Health Services, Department of Health and Aged Care.

Boffa J, Weeramanthri T. (June 2001) *Orienting health services and public health programs towards greater chronic disease control: a proposal for a network of zonal and regional public health services*. Discussion paper prepared for the Northern Territory Aboriginal Health Forum.

Commonwealth Department of Family and Community Services. (2001) *Protocols for Conducting Consultations and Research in Rural and Remote Indigenous Communities*. (personal communication).

Commonwealth Department of Health and Aged Care. (1999, revised 2000). *Immunise Australia Program*, Population Health Division.

Commonwealth Department of Health and Aged Care. (2000) *LIFE – Living Is For Everyone, A Framework for Prevention of Suicide and Self-harm in Australia, Areas for Action*, Mental Health and Special Programs Branch.

Commonwealth Department of Health and Aged Care. (2000) *National Action Plan for Promotion, Prevention and Early Intervention for Mental Health*, Mental Health and Special Programs Branch. (Joint Commonwealth, State and Territory Initiative under the Second National Mental Health Plan).

Commonwealth Department of Health and Aged Care. (1999, revised 2000). *Resource Allocation in Public Health: An Economic Approach*. A background discussion paper for the National Public Health Partnership.

Commonwealth Department of Health and Aged Care. (April 2001) *Sharing Health Care Initiative. Aboriginal and Torres Strait Islander Chronic Disease Self-Management Projects*.

Diabetes Australia. (1998) *National Diabetes Strategy and Implementation Plan*.

Environmental Health Workers Newsletter, Issue 16, June 2001.

Kickett D. (n.d.) *Aboriginal Terms of Reference: A Paradigm for the Future*. In *Towards 2000 – Maintaining the Momentum*, Centre for Aboriginal Studies, Curtin University.

Kimberley Aboriginal Medical Services Council. (n.d.) Health Education and Theatre Works, Health Promotion Unit.

Kimberley Public Health Unit. *Annual Report 1999-2000*, HealthWest.

National Aboriginal Community Controlled Health Organisation. (April 1999) *Issues Paper: The National Public Health Partnership and its Relevance to Improving Aboriginal Health*.

National Aboriginal and Torres Strait Islander Health Council. (February 2001). *National Aboriginal and Torres Strait Islander Health Strategy: Draft for Discussion*. Commonwealth Department of Health and Aged Care.

Osborne R, Dick C. (1994) *Aboriginal Terms of Reference (ATR) and its importance to the educative process*. Curtin University.

QAIHF (Queensland Aboriginal and Islander Health Forum). (2001) *Aboriginal Primary Health Care Project: Protocols for Consultation with Aboriginal Communities*, position paper.

Queensland Health. (n.d.) *Barriers to and Appropriate Delivery Systems for Cervical Cancer Screening in Indigenous Communities in Queensland, Final Report*.

Queensland Health. (2000) *Breast Cancer: Screening, Diagnosis, Treatment and Care for Aboriginal Women and Torres Strait Islander Women in Queensland Report*.

Queensland Health. (October 2000) *BreastScreen Queensland Annual Statistical Report for 1998*.

Queensland Health. (June 2001) *Melioidosis, information for general practitioners*.

Queensland Health. (December 2000) *North Queensland chronic disease strategy – community-level action*.

Queensland Health. *Strategic Plan 2000-2010*.

Queensland Health Tropical Public Health Unit. (April 2001) *Communicable Disease Control, Newsletter No.35*.

Queensland Health Tropical Public Health Unit. (n.d.) *Taking Big Steps, A Guide to Helping Young People Move from Rural and Remote Communities*.

Queensland Health Tropical Public Health Unit Network. *Strategic Plan 1995-2000*.

South Australian Aboriginal Health Partnership. (July 2000) *Living with Diabetes, The South Australian Aboriginal Experience. A State Strategy and Action Plan for Aboriginal Diabetes.*

South Australian Department of Human Services. (October 2000). *Aboriginal Nutrition Network Development Project.*

Torres Strait and Northern Peninsula Area Health Council Inc. (1996) *Meriba Zageth for Diabetes – Our Work for Diabetes, National Action Plan, Diabetes.*

Townsville Aboriginal and Islanders Health Service Limited. (n.d.) *Synergy, The Links are Strong.*

Townsville Health Service District. *Business Plan – 1999/2000.*

Urbis Keys Young (2001). *Mid-Term Review of the National Indigenous Australians Sexual Health Strategy.*

VicHealth Koori Health Research & Community Development Unit. (February 2001). *Aboriginal Primary Health Care in Victoria: Issues for Policy and Regional Planning*, Discussion Paper No.1.

VicHealth Koori Health Research & Community Development Unit. (December 2000) *Indigenous Health & 'Western Research'*, Discussion Paper No.2.

VicHealth Koori Health Research and Community Development Unit. (March 2001) *Talkin' Strong.* (Community Newsletter.)

VicHealth Koori Health Research and Community Development Unit. (December 2000) *We don't like research but in Koori hands it could make a difference.* (Community Report.)

WA Joint Planning Forum on Aboriginal Health. (February 2000) *Western Australian Aboriginal Health Strategy, A Strategic Approach to Improving the Health of Aboriginal People in Western Australia.*

World Health Organisation. The World Health Report 2000 - Health Systems: Improving Performance.

Web sites

Agency for Healthcare Research and Quality. (2001) American Indian/Alaska Native Consultation Plan – guidelines for government departments.
url: www.ahcpr.gov/about/tribalplan.htm

Government of Canada Privy Council Office (1992). Consultation Guidelines for Managers in the Federal Public Service.
url: www.pco-bcp.gc.ca/com-con/

National Health and Medical Research Council (NHMRC). Guidelines for consultation (1991).

url: www.health.gov.au:80/hfs/nhmrc/publicat/

National Public Health Partnership. (1999) Guidelines for Improving National Public Health Strategies Development and Coordination.

url: www.nphp.gov.au/natstrat/

Queensland Transport/Main Roads. (1997) Policy, Standards and Guidelines: Public Consultation – the way to better decisions.

url: www.transport.qld.gov.au/qt/clinfo.nsf/0f122c06d5c309

United Nations. (1993) World Conference on Human Rights, Preparatory Committee, Fourth Session, Geneva 19-30 April 1993, Item 5 of the provisional agenda: Contribution from the World Health Organization.

url: www.unhchr.ch

US General Services Administration. Some Guidelines for Effective Consultation (derived from: Fisher, R., Ury, W., Patton, B. (1991) Getting to Yes, Negotiating Agreement Without Giving In. Penguin Books.)

url: <http://hydra.gsa.gov>

World Health Organization (WHO). (1998) Social Determinants of Health: the solid facts.

url: www.who.dk/document/E59555.pdf

Section D: Consultation findings

CONTENTS:

- 1. Overview**
- 2. Consultation methodology**
- 3. Guidelines for national public health strategies to better address Aboriginal and Torres Strait Islander health**
- 4. A national approach to public health for Aboriginal and Torres Strait Islander peoples**
- 5. Strategy development: the issues identification stage**
- 6. Strategy development: targeting Aboriginal and Torres Strait Islander health within mainstream strategies**
- 7. Strategy development: Aboriginal and Torres Strait Islander representation**
- 8. Strategy development and implementation: consultation with Aboriginal and Torres Strait Islander peoples**
- 9. Strategy development and implementation: the roles of governments and health departments**
- 10. Strategy implementation: roles and relationships of key service providers**
- 11. Strategy implementation: funding issues at regional/local service provider level**
- 12. Other strategy implementation issues: community development and capacity building, infrastructure, workforce, training, and practice guidelines**
- 13. Strategy evaluation**

1. Overview

1.1. Background to the project and consultations

This report documents the findings of consultations undertaken as part of a project covering the **first stage of the development of guidelines**, which have the ultimate purpose of ensuring that national public health strategies better meet the needs of Aboriginal and Torres Strait Islander communities. This consultation report has been prepared for the purpose of providing feedback to participants, and will feed into the final project report. The final project report will include material drawn from relevant literature, as well as the findings from the consultations, and will make a range of recommendations.

The aim of the consultations was to seek the views and experiences of those involved in national public health strategy development, implementation, and evaluation, about how well the strategies have been working for Aboriginal and Torres Strait Islander health, how they could work better, and how guidelines could assist with this. The aim of the consultations was not to undertake a rigorous evaluation of each of the individual strategies. The focus was on the general approaches which have been taken with respect to the application of the strategies to Aboriginal and Torres Strait Islander health, and how participants felt these approaches could be improved.

There has been little improvement in recent decades in the health of Aboriginal and Torres Strait Islander peoples, in contrast to the progress which has been made in improving the health of indigenous peoples in countries such as New Zealand, the USA, and Canada. It is widely recognised that public health strategies can play a key role in improving the health of indigenous peoples, and the project is a step towards maximising the effectiveness of these strategies in this respect, in the Australian context.

Many national public health strategies have been developed and implemented in Australia over recent years. These cover areas as diverse as sexual health, diabetes and nutrition, immunisation, environmental health, and cancer screening programs, to name just a few.

Several of these strategies have had a real impact, and in some areas have made measurable contributions to the health status of the general community. However, prior to this project, little had been documented about their impact on Aboriginal and Torres Strait Islander communities, or on how efforts to address the needs of these communities could be better targeted. These are key issues given the poor health status of Aboriginal and Torres Strait Islander peoples, and the consultations undertaken through this project do indicate that urgent attention to these issues is warranted.

The National Public Health Partnership (NPHP) was established as the vehicle for Commonwealth, State, and Territory governments to work together on a nationally agreed and co-ordinated approach to public health. The Partnership has established a National Strategies Co-ordination Working Group (NSCWG), to advise on improving the co-ordination of national public health strategies.

One of the key initiatives of the NSCWG has been the development of *Guidelines for the Development of National Public Health Strategies*, which have been endorsed by the Australian Health Ministers' Advisory Council (AHMAC), and are expected to be applied by all jurisdictions. It is intended that the development of guidelines for national public health strategies to better address Aboriginal and Torres Strait Islander health will complement this initiative.

The Partnership, through the NSCWG, commissioned the current project, as the first stage of the development of these guidelines, which have the ultimate purpose of ensuring that national public health strategies better meet the needs of Aboriginal and Torres Strait Islander communities. Such guidelines are conceived of as a central source of documented advice for people responsible for the development, management, review and evaluation of national

public health strategies. It is intended that this advice will assist these people in understanding the context in which they should work with Aboriginal and Torres Strait Islander communities and their organisations, and in ensuring, among other things, that consultation is strategic.

This project was undertaken by a consortium comprising Kimberley Aboriginal Medical Services' Council, James Cook University, and Effective Healthcare Australia. The project was overseen by a Steering Committee established under the auspices of the NSCWG (details of Steering Committee are at **Attachment 1**).

The project commenced in March 2001. This first stage has involved not the actual development of guidelines, but the ground work needed for the development of guidelines in the next stage. The project team researched relevant literature (the findings are presented in a separate report), and consulted with a range of people - service providers in Aboriginal and Torres Strait Islander health, people from Commonwealth, State, and Territory governments, peak bodies, and other key informants - to document the key issues which need to be considered in the future development of guidelines.

This report sets out the findings of these consultations, and documents the range of suggestions made by participants relating both to the proposed guidelines, and to the need for broader reforms.

The project team would like to acknowledge and thank all those who contributed their time and ideas to this project, and we hope that you will be able to recognise your ideas, and perhaps some of your words, reflected back in the following report.

1.2 Methodology

Targeted consultations were held in all States and Territories, involving people from Commonwealth and State/Territory health departments, peak national and State bodies from the Aboriginal community controlled health service (ACCHS) sector, a sample of service providers from the State/Territory and ACCHS sectors, and a few other key individuals and organisations. Approximately 60 meetings were held, involving almost 200 participants (the term used in this report to refer to interviewees in the consultations).

These consultations took the form of semi-structured group or individual interviews, based on a pre-circulated list of questions. All interviews were documented and summaries were returned to participants for verification. The summaries were then analysed qualitatively according to key themes emerging from the consultations, and the results are presented in aggregated and/or de-identified form. Further detail on the consultation methodology is set out in the next section.

1.3 Key findings from the consultations

Several key themes emerged in the consultations. The need for improved access by Aboriginal and Torres Strait Islander peoples to appropriate primary health care services, to promote prevention and early treatment of the disease areas covered in the national strategies, was very widely identified as a prerequisite to making real improvements in health status. Many participants noted that achieving this will require greatly improved resourcing, a focus on community participation and capacity building, and support for infrastructure and workforce development. It was suggested that workforce development should take a particular focus on the needs of Aboriginal and Torres Strait Islander Health Workers, whose key role in implementing primary health care and public health strategies was widely noted.

Another key theme was the need for an over-arching framework for Aboriginal and Torres Strait Islander public health, which would focus not only on health services but also on the social and economic determinants of health. It was suggested that specific, targeted public health approaches addressing health issues such as those identified in the current national

strategies, should be undertaken within this framework. Many participants suggested that the national public health strategies could contribute resources to these efforts by quarantining a significant proportion of their funding (at least ten per cent) for Aboriginal and Torres Strait Islander public health. It was also suggested that there is a need to explore the potential for such funds to be pooled, and perhaps allocated and negotiated on a regional basis.

Many of the matters discussed in the consultations relate back to fundamental issues such as the history and current state of race relations in Australian society, roles and responsibilities of governments and service provider agencies in Aboriginal and Torres Strait Islander health, and the question of proper representation of Aboriginal and Torres Strait Islander interests in political and policy processes.

It is therefore not surprising that there was some controversy over some of the issues, such as the appropriate roles of Indigenous and non-Indigenous agencies in Aboriginal and Torres Strait Islander health service provision, and the roles of peak bodies in representing community views.

What was perhaps more surprising was the high degree of consensus amongst most participants about most of the issues, and about the general thrust of the changes which are needed. In particular, there was very widespread agreement about the failure of short-term, fragmented policy and funding approaches to adequately address Aboriginal and Torres Strait Islander public health needs, and about the need to take a more integrated, long-term approach.

It was clear in the consultations that the issues under discussion were matters of considerable interest to the participants. There has evidently been wide recognition and discussion of these issues by people in government departments and by service providers, so this report documents matters which are no doubt very familiar to many people who have been working in this field.

It was also striking that although these issues are heightened in Aboriginal and Torres Strait Islander health, many of the issues are also familiar to people working in other sectors of community and public health. It is likely that many of the findings are to a large degree transferable to the wider public health arena.

Information about the context of public health program development, implementation, and evaluation with respect to Aboriginal and Torres Strait Islander peoples, and about the current problems identified by participants, is detailed in the body of this report. Participants also made many suggestions for reform, which will feed into the final project report and its recommendations.

Guidelines for national public health strategies to better address Aboriginal and Torres Strait Islander health

There was fairly widespread support for the concept of such guidelines. Many departmental staff expressed the need for clear guidance on addressing Aboriginal and Torres Strait Islander health issues, including matters such as representation and consultation, which are seen as not only complex, but highly sensitive. It was suggested by many participants that the guidelines could be very useful for a range of people and organisations within and outside government.

It should be noted, though, that a significant minority of participants expressed doubts about the value of such guidelines, generally because they were of the view that bureaucrats generally ignore guidelines; and that guidelines in themselves would not address the need for structural changes in the way that national public health strategies address Aboriginal and Torres Strait Islander needs.

Participants in the consultations made many detailed suggestions for the content, format, and target groups for these guidelines. These suggestions are summarised in the body of this

consultation report, and these views will feed into proposals for guideline development which will be included in the final report of this project.

A national approach to public health for Aboriginal and Torres Strait Islander peoples

Most participants felt that the national strategies have great potential to address Aboriginal and Torres Strait Islander health, particularly through the contribution of material resources, the harnessing of strategic effort, encouragement for inter-sectoral collaboration, and support for best practice approaches.

However, there was a widespread view that most of the strategies have failed to reach their potential to make a difference to Aboriginal and Torres Strait Islander health. It was felt that this is due to a lack of real political commitment, a consequent lack of adequate resources “hitting the ground” for service delivery, and a fragmented, short-term approach to the issues. Many participants recommended that a long term, integrated, well resourced approach to Aboriginal and Torres Strait Islander public health is needed, under the over-arching framework of a national Aboriginal and Torres Strait Islander health strategy.

Strategy development: The issues identification stage

Participants in the consultations agreed that most of the key areas covered in the national public health strategies are high priorities in Aboriginal and Torres Strait Islander health. However, it was widely felt that despite the greater burden of morbidity and mortality experienced by Aboriginal and Torres Strait Islander peoples, their needs are not well identified and prioritised through many of the national strategies. In addition, it was noted that several specific public health problems experienced by these groups, such as rheumatic fever and skin diseases, are not addressed in national strategies.

It was suggested that as issues identification is driven by both epidemiological data and political considerations, the lack of focus on Aboriginal and Torres Strait Islander needs is likely to be due both to the lack of good data identifying the health needs of these target groups (and poor uptake of available data), and the lack of political leverage these groups have.

Strategy development: Targeting Aboriginal and Torres Strait Islander health within mainstream strategies

The consultations indicated that although the situation is improving, Aboriginal and Torres Strait Islander health has not generally had a high profile within national public health strategies.

It was widely argued by participants that given the high burden of disease and high level of unmet need amongst Aboriginal and Torres Strait Islander communities, all mainstream national public health strategies should identify Aboriginal and Torres Strait Islander health as a top priority, and should routinely quarantine a significant proportion of their funding to meet the needs of these communities.

It was generally felt that while addressing Aboriginal and Torres Strait Islander needs often requires Indigenous-specific approaches, separating these approaches completely from mainstream strategies carried dangers including potential marginalisation, resource disadvantage, and loss of key expertise. It was suggested that the best approach is to develop separate but linked “companion” strategies, addressing Aboriginal and Torres Strait Islander needs.

Strategy development: Aboriginal and Torres Strait Islander representation

Participants universally agreed that Aboriginal and Torres Strait Islander people must be effectively represented in national public health strategy development processes. This representation is seen as a vital part of ensuring that strategies prioritise Aboriginal and

Torres Strait Islander health, that they are appropriate and acceptable, and that they are accessible to communities and their service providers.

Both Aboriginal organisations and government participants described many difficulties with current representational processes. Aboriginal organisations are often inundated with demands to be involved in a range of separate policy and planning processes, which presents resourcing and capacity challenges; and they also experience frustration when individuals without a clear mandate are appointed by government to represent their communities. Government people are often unsure of correct protocols, and frequently feel frustrated in their attempts to achieve balanced and consistent representation and input.

Strategy development and implementation: Consultation with Aboriginal and Torres Strait Islander peoples

Community knowledge, understanding, and support are acknowledged as key factors in the success of public health initiatives. As with the issue of representation, community consultation was seen by many as a vexed issue. Aboriginal organisations described a situation where communities and their service providers hear about initiatives very late, and have little real input into decision making; or where communities invest considerable time and effort to provide input, often with no action resulting from this investment. Government people described the difficulties they experience with knowing how and with whom to consult, difficulties involved with resourcing consultation processes, and the need for more guidance on this sensitive issue. It was felt by many that regional level consultation and planning processes are the key to successful public health strategy implementation.

Strategy development and implementation: The roles of governments and health departments

The roles and relationships of Commonwealth and State/Territory governments in public health were identified by participants as quite complex, and in some ways problematic. For example, the inter-governmental funding arrangements were identified by many as lacking in transparency and accountability, and as allowing for “buck-passing” on key issues relevant to Aboriginal and Torres Strait Islander communities.

There was considerable discussion in the consultations about the potential for a reporting system on government efforts to address Aboriginal and Torres Strait Islander public health needs, as a means of bringing greater focus to these issues.

There were also suggestions for reform within health departments to address apparent problem areas, including limited subject matter and professional expertise in some areas of some departments; high staff turnover; lack of co-ordination between different program areas within departments; and limited departmental resources to support quality policy development and program management.

Strategy implementation: Roles and relationships of key service providers

The consultations focused on the working relationships between key service provider groups, primarily the Aboriginal community controlled health service sector, State/Territory government services, and private general practice. These relationships were identified as a key factor in the successful implementation of public health strategies and programs.

The value of public health efforts was seen to be maximised where there is clearly agreed role delineation, and collaborative working relationships between local and regional agencies. Good relationships and effective inter-agency communication were seen to promote integrated service provision, ownership, and cohesive action.

Predictably, such relationships vary from region to region, and are affected by a range of historical, structural, and personality factors. It was widely noted that national public health strategies have the potential to either support, or undermine, the development of partnerships between service providers.

Strategy implementation: Funding issues at regional/local service provider level

There was widespread criticism of the way that funding is currently made available under the national public health strategies, and particularly of competitive submission-based grants rounds resulting in short-term, specific-purpose grants to successful agencies.

The overall level of funding being made available for public health programs for Aboriginal and Torres Strait Islander communities is generally viewed as inadequate. Major problems were also identified with allocation processes for the funding that is made available. Short-term, specific purpose grants are seen as working against integrated, sustainable, long term public health approaches. There are perceived to be major inequities and high transaction costs involved in grants processes, and competitive processes are seen as working against the development of partnerships between service providers. There was widespread support for a move towards proactive, needs-based funding models for public health programs addressing Aboriginal and Torres Strait Islander needs.

Strategy implementation: Community development and organisational capacity, infrastructure, workforce, training, and practice guidelines

It was widely noted that many Aboriginal and Torres Strait Islander communities and organisations are highly disadvantaged in terms of lacking the basic community and organisational capacity, infrastructure, and adequate skilled workforce, on which to “layer” new strategies and programs. Unless national public health strategies take account of, and address this disadvantage, they may not be able to be effectively implemented in communities where they are most needed. It was also noted that there has been poor uptake of several key intellectual resources such as clinical guidelines developed in the past to support national strategies, and that dissemination and uptake strategies for such resources could be improved.

Strategy evaluation

There was a widely perceived need by participants for strategy evaluations to have a greater focus on providing performance information regarding the success or otherwise of the strategies in addressing Aboriginal and Torres Strait Islander health, and on how they could achieve more in this regard. It was suggested that there needs to be better integration of evaluation planning in the strategy development process; more attention on improving data collection with respect to Aboriginal and Torres Strait Islander access to programs; the development of appropriate performance measures; greater involvement of Aboriginal and Torres Strait Islander communities and organisations in evaluation planning, and in reporting on the success of initiatives in their communities; and realistic implementation periods prior to evaluations taking place.

2. Consultation methodology

2.1 Project brief

The brief for the consultations in the first stage directed the project team:

“to consult with key national and State level organisations representing Indigenous communities in relation to health matters, individuals responsible for national public health strategies that are targeted at a State and national level..., Chairs of National Health Strategies and other key individuals and groups, to ascertain the scope and content of a final document.”

2.2 Groups and individuals consulted

Following discussion with the project Steering Committee, it was agreed that consultations would be held in all States and Territories, involving:

- Staff from the Commonwealth Department of Health and Aged Care, in both Central Office (Canberra), and State/Territory Offices. Staff from both the Aboriginal and Torres Strait Islander Health area, and the population health/health programs areas were interviewed wherever possible, to reflect the involvement of a range of program areas in policy development and program implementation relevant to Aboriginal and Torres Strait Islander public health.
- Staff from State and Territory health departments in each capital city. Again, both Aboriginal and Torres Strait Islander health units, and mainstream public health/health program areas were targeted.
- The National Aboriginal Community Controlled Health Organisation (NACCHO), and its peak affiliates in each State and the Northern Territory.
- ATSIC National Policy Office.
- A limited number of regional and local level service providers targeting Aboriginal and Torres Strait Islander health. These included both Aboriginal community controlled health services (ACCHSs), and State/Territory services (community health centres, public health units, and district health managers). The project team considered it important to include the direct voice of service delivery agencies in the consultation process, and particularly targeted those in regional/rural areas.
- A few other key individuals and peak bodies, such as the Office of the National Health and Medical Research Council, and the Royal Australian College of General Practitioners.

A full list of participants is attached (**Attachment 2**). As well as participating in interviews, many of the participants also provided the project team with written comments, and other relevant documents and reports.

Briefings were also provided for some key organisations; and written input was received from several quarters, though it should be emphasised that the consultations in this first stage did not include a formal process of sending out information and seeking written submissions.

2.3 Groups not consulted

Inevitably, there were budgetary and time constraints on the consultation process. This was intended to be a limited and targeted consultation process to identify key issues. A more comprehensive consultation process on these issues could have included:

- A larger range of service providers from relevant sectors, including the ACCHS sector, the State/Territory sector, and private general practice.
- ATSI at State/Territory and regional level, and local government, including Indigenous Community Councils, as key players in environmental health strategies.
- The Torres Strait, and very remote Aboriginal and Torres Strait Islander communities, which were not visited in this round.
- Peak non-government organisations and professional associations such as the Public Health Association, Australian Divisions of General Practice, Diabetes Australia, the Heart Foundation, etc.

2.4 Consultation protocols

Letters of invitation were faxed or e-mailed to all targeted participants, along with a flyer, a list of relevant strategies drawn from those identified by the NSCWG as relevant for its general guidelines for strategy development, and a list of questions to be covered in the interview (**Attachment 3**). Slightly different versions of the latter were used, depending whether the interviewees were government/peak body people, or regional/local service providers. These initial contacts were followed up by phone calls and/or e-mails to discuss the project and make arrangements to meet.

The response to the letters of invitation was very positive, and nearly all of those contacted agreed to be interviewed. There were a few non-responses despite follow-up, and a couple of proposed meetings did not occur due to logistical problems.

The consultation meetings were held from late April through to mid-July 2001. Close to 60 meetings were held, involving almost 200 participants. Nearly all of the meetings were held at the participants' workplaces or nominated meeting areas, with only two interviews being held by phone. The meetings generally lasted between one and two hours, with most lasting around 90 minutes. The circulated questions formed the basis for semi-structured interviews, though they were used flexibly rather than followed rigidly, generally in a focus group type format. Participants were also encouraged to talk about their specific experiences in policy, program administration, or service delivery, to illustrate the key themes of interest to the project.

All interviews were attended and documented by the same member of the project team, occasionally accompanied by other members. This provided for consistency in approach, and contributed to a coherent appreciation of the issues.

Summaries of the meetings were forwarded to participants for their information and verification. The meeting summaries were used as the basis for compiling this consultation report. Input from participants has been used in an aggregated and/or de-identified way, to reflect the sensitivity of some of the information and views provided by participants, and the difficulty that people in some positions face in providing frank "on the record" comments on some of the issues.

2.5 Analysis of consultation material

The information and views provided by participants have been analysed qualitatively and organised in the following report according to key themes. Examples and quotes have been included to illustrate some key points.

The aim has been to present the views and comments of participants as objectively as possible in this report. In most cases, documented evidence is not referred to in this report, but this material will be brought together with the consultation findings in the overall project report.

3. Guidelines for national public health strategies to better address Aboriginal and Torres Strait Islander health

3.1 Concept and purpose of the guidelines

As noted earlier, this project was commissioned as the first stage of the development of guidelines for national public health strategy development, implementation, and evaluation, which would have the ultimate purpose of ensuring that national public health strategies better meet the needs of Aboriginal and Torres Strait Islander communities.

Such guidelines were conceived of as a central source of documented advice for people responsible for the development, management, review and evaluation of national public health strategies. It is intended that this advice will assist these people in understanding the context in which they should work with Aboriginal and Torres Strait Islander communities and their organisations, and in ensuring, among other things, that consultation is strategic.

Participants in the consultations were asked for their views on the value of such guidelines, as well as their views on the potential content of, format for, and audience for, such guidelines. Several participants made additional comments on matters such as endorsement and uptake processes for such guidelines.

3.2 Views on the value of such guidelines

There was fairly widespread support for the concept of the guidelines. Many departmental staff expressed the need for clear guidance on addressing Aboriginal and Torres Strait Islander health issues, including matters such as representation and consultation, which are seen as not only complex, but highly sensitive.

It was noted that Indigenous-specific areas of health departments (the Office for Aboriginal and Torres Strait Islander Health (OATSIH) in the Commonwealth Department of Health and Aged Care, and the Aboriginal and Torres Strait Islander health units in State/Territory departments), are currently called upon to provide comment and guidance on a wide range of policy and program issues in mainstream health areas. It was seen by some that the development of agreed guidelines could reduce the demands on these areas to provide continual, and often repetitive, input, and allow them to focus on more proactive activities. The Aboriginal health unit in one State health department has already embarked on a process to work towards documenting principles and a check-list which would serve a similar purpose to the planned national guidelines.

However, a significant number of participants expressed doubts about the value of such guidelines, generally because they were of the view that bureaucrats generally ignore guidelines, and guidelines in themselves would not address the really important issues. It was said that guidelines can only address process issues, which is necessary, but not sufficient, to making real changes. Those who felt that guidelines were of limited value identified the following as the areas where action is needed:

- Developing an overall policy and planning framework for public health approaches for Aboriginal and Torres Strait Islander communities.
- Addressing the tokenism that is seen by some as currently marking the way that public health people deal with Aboriginal and Torres Strait Islander health issues, and making these areas more accountable for addressing Aboriginal and Torres Strait Islander health.

- Channelling a proportion of resources from all national public health strategies into Aboriginal and Torres Strait Islander health, to be implemented flexibly under a national policy and planning framework.
- Developing real partnerships between Aboriginal and Torres Strait Islander communities and government.
- Defining the models that work, or could work, for integrating vertical public health approaches into Aboriginal primary health care service delivery.
- Developing improved co-ordination on these issues within and between bureaucracies, including between public health areas and Aboriginal and Torres Strait Islander health areas.
- Creating a more central role in policy development and implementation for some of the community-friendly scientists and health professionals.
- Getting politicians and bureaucrats out to visit and see Aboriginal and Torres Strait Islander communities for themselves, so they have a better understanding of the issues.

Some participants felt that focusing on the issues above was more important than developing process guidelines for national strategy development, implementation, and evaluation.

However, it should be emphasised that many participants also perceived a value in guidelines, as providing at least part of the necessary approach to improving the impact of national public health strategies in addressing Aboriginal and Torres Strait Islander health.

3.3 Views on the target group for the guidelines

It was generally felt that such guidelines would be primarily useful for departmental staff who are involved in national public health strategy development, implementation, and evaluation. This includes Commonwealth Department of Health and Aged Care (DHAC) staff in population health, and Aboriginal and Torres Strait Islander health and other health programs, in both Central and State/Territory Offices; staff in public health and Aboriginal and Torres Strait Islander health areas of State and Territory departments, at State/Territory, regional, and local level; and staff in relevant areas of other government departments. The guidelines could assist with induction into the issues, and regularly updated information would assist staff with keeping abreast of new developments.

It was suggested that the guidelines would also be useful for all committee members involved in national public health strategies; Ministers and their staff; program managers in service delivery organisations; and non-government organisations such as Divisions of General Practice and disease-based or “body parts” health organisations who are attempting to make a contribution to Aboriginal and Torres Strait Islander health.

It was also suggested that such guidelines would be a useful tool for Aboriginal and Torres Strait Islander organisations to advise governments and other service providers on accepted and documented approaches to addressing Aboriginal and Torres Strait Islander public health; and for holding such bodies accountable for following these approaches.

3.4 Views on the content of the guidelines

Many participants made similar, and overlapping, comments about the issues that need to be covered in the guidelines.

There was general support for the development of two companion documents which together would constitute the guidelines. These would be an information guide (or “primer”), which would provide readers with clear objective information on a range of contextual issues; accompanied by a process-oriented check-list, covering all the areas which need to be worked through in the process of strategy development, implementation, and evaluation. The content suggested by participants for these two documents is as follows.

Information guide (“Primer”)

It is seen as very important that the guidelines are presented with contextual material that distils critical issues in public health development and program roll out from an Aboriginal and Torres Strait Islander community point of view. Suggested content includes information about:

- The unique history of Aboriginal and Torres Strait Islander peoples; the diversity of communities across urban, rural, and remote areas; current issues in health and well-being; and correct terminology.
- Policy structures in Aboriginal and Torres Strait Islander health, eg the Framework Agreements, regional forums, the regional plans, the roles of HAHU, NACCHO and affiliates, and so on.
- The policy and funding context for public health and Aboriginal and Torres Strait Islander health, including roles and responsibilities of governments, departments, and program areas; financing mechanisms; policy processes including Budget cycles, and so on.
- “Mapping” of current national and State/Territory policies and strategies which are relevant to primary health care and public health approaches for Aboriginal and Torres Strait Islander peoples, and how these link together.
- Lists of appropriate people and organisations to discuss with and consult on national public health strategies, both inside and outside the ACCHS sector.
- The implementation process for Aboriginal and Torres Strait Islander health, covering issues such as the range of service delivery agencies and models, funding issues, community capacity, infrastructure, and workforce issues.
- Monitoring and evaluation of public health approaches for Aboriginal and Torres Strait Islander health, including, data availability, quality, and sensitivity, appropriate performance indicators, and so on.

Checklist

It was suggested that the check-list should be process-oriented and take people through the steps of policy development, implementation, and evaluation, including:

- A process for justifying that there would be value in developing a new national strategy for a given issue, rather than simply allocating resources to service delivery without an extended strategy development process.
- A process for ensuring that Aboriginal and Torres Strait Islander health is appropriately prioritised in every strategy, and that appropriate strategies are developed to address these needs.
- A process for providing opportunities for organisations other than government to drive particular national strategies, where appropriate.
- A process for developing links and achieving ongoing co-ordination between any specific strategy, and other relevant strategies and programs across government.

- Processes for ensuring a co-ordinated all-of-government approach.
- Advice on how to work in partnership with Aboriginal and Torres Strait Islander communities and organisations, and other key players.
- Standard protocols for committee establishment, to achieve a balance of required representation, knowledge and skills.
- Standard protocols for Aboriginal and Torres Strait Islander representation in strategy development, implementation, and evaluation processes.
- A standard process for community consultation and negotiation.
- Processes for realistic costing of strategies, and advice on securing allocations through Budget processes.
- A standard methodology for ensuring appropriate resources from national strategies are directed to Aboriginal and Torres Strait Islander health.
- A funding model which promotes sustainability and flexibility at the local level.
- A standard methodology for needs assessment and planning, and for allocation of funding at regional or local service delivery level.
- Methodologies for ensuring that the implementation of national public health strategies contributes to community development in Aboriginal and Torres Strait Islander communities.
- Standard methodologies for considering implementation issues, including service delivery models, community capacity, infrastructure, and workforce development needs, in relation to any given strategy.
- Processes for supporting the development of health promotion materials and campaigns which address the needs of Aboriginal and Torres Strait Islander communities.
- Processes and protocols for strategy evaluation, to assess how well strategies have worked for Aboriginal and Torres Strait Islander health, and how they could work better.
- Protocols for States and Territories to report on their national public health strategy-related activities which address Aboriginal and Torres Strait Islander health.

3.5 Views on the format of the guidelines

It was emphasised by many participants that these documents need to be concise and user-friendly, and that the issues need to be explained in a practical, objective way. It was widely felt that lengthy and overly wordy documents are not likely to be referred to. It was also suggested that the level of detail involved in the guidelines needs to be carefully considered, as they should be applicable to a wide range of areas, so should not be overly specific or prescriptive.

It was suggested by several participants that it would be useful for case studies and worked examples of strategy development (including real life “good practice” examples) to be included with the guidelines, to assist departmental staff with learning about how to deal strategically with Aboriginal and Torres Strait Islander health issues. It was also suggested that “question and answer” format would be a useful way to deal with some of the material.

There was a comment that the guidelines will only be taken seriously and be effective if they are scientifically based, and cross referenced to mainstream literature which supports the direction the guidelines are taking.

It was noted that some of the information in the “primer”, such as mapping of current strategies, and information about representative bodies, could quickly lose currency and would need to be kept up to date to be useful. It was noted that there will need to be processes to keep the information up to date, and it was suggested that the option of web-based guidelines should be considered.

The production of a video giving information about Aboriginal and Torres Strait Islander public health issues, illustrating these issues at community level, was also suggested as a useful adjunct to the guidelines. It was said that audio-visual material can often have a greater impact than written material.

3.6 Consultation, endorsement and uptake of the guidelines

Several participants noted that guidelines will only be useful if there is widespread support for and “ownership” of their content, and if there are measures to ensure their endorsement and uptake.

It is felt that a comprehensive stakeholder consultation process on draft guidelines will be required to ensure widespread support, ownership, and uptake.

It was suggested that once finalised and endorsed by key stakeholders, the guidelines should go through an AHMAC endorsement process, to ensure that all health departments are committed to using them. There was also a suggestion that it would be very helpful to get National Health and Medical Research Council (NH&MRC) endorsement of the guidelines, as this would help to promote their uptake.

It was stated that the guidelines will need to be “championed” and promoted by key people and organisations to ensure their wide uptake.

It was noted that the guidelines need to be backed up by education and training for departmental staff on the guidelines and their context, that is, Aboriginal and Torres Strait Islander issues which are pertinent to national public health strategies. It was suggested that the guidelines and any accompanying educational material could be incorporated into departmental staff induction and continuing education processes, particularly in public health and Aboriginal and Torres Strait Islander health program areas.

4. A national approach to public health for Aboriginal and Torres Strait Islander peoples

There was considerable discussion in the consultations about whether the current approach of developing national public health strategies is effective in addressing the needs of Aboriginal and Torres Strait Islander peoples, and about alternative approaches that may be more effective. This discussion is summarised in this section. Several of the key themes raised in this section recur in other contexts later in this report.

4.1 What are these “national public health strategies”?

It was widely noted that there are many different initiatives which are currently tagged “national public health strategies”, which makes it difficult to generalise about their success or lack of success in addressing Aboriginal and Torres Strait Islander health.

The strategies differ greatly in how and even whether they are funded. In some cases there are fully funded and very specific strategies with a focus on service delivery (eg BreastScreen Australia); in other cases new national strategies have been articulated without new funding being allocated through Budget processes. There are also cases (eg the National Illicit Drug Strategy), where considerable sums of Commonwealth funding have been allocated without the lengthy policy development and planning process, and strategy articulation, which usually precedes such allocations.

It also needs to be taken into account that the strategies are in varying stages of development and implementation. Some, such as the National HIV/AIDS Strategy and BreastScreen Australia, have been in operation for the past decade, while others are still in their very early stages. This makes comparative assessment of the impact of the strategies difficult.

In addition, several participants questioned whether the national approach to co-ordination of public health effort can be properly described as “national strategies”, or whether it would be better to talk of a “national framework” for State and Territory strategies. In the view of many participants, the latter terminology more accurately describes the reality. In most cases, States and Territories develop their own documented approaches (often including detailed regional level plans) within the national framework, and these are generally far more familiar and relevant to service providers than are the national strategy documents.

These caveats need to be taken into account in the following examination of the role that national public health strategies play in Aboriginal and Torres Strait Islander health.

For the purposes of this project, “national public health strategies” is taken to mean the attached list of more than twenty relevant strategies provided to participants, drawn from those identified by the NSCWG as relevant for its general guidelines for strategy development. Where participants raised issues relating to other health strategies with relevance for Aboriginal and Torres Strait Islander health (such as the Regional Health Services Program), these comments were also taken into consideration.

4.2 The potential for national public health strategies to make a difference

Most participants felt that national public health strategies do have the potential to play a critical role in Aboriginal and Torres Strait Islander health gain. It was observed that the major areas which have been identified for action in the national public health strategies and the National Health Priority Areas are key health issues for Aboriginal and Torres Strait Islander people, who experienced an excess burden of morbidity in almost all of these areas.

The key areas where the national public health strategies have the potential to contribute to improving Aboriginal and Torres Strait Islander health were identified by participants as follows.

The provision of resources to support primary health care

It was widely commented that the most important contribution that national strategies can make is to provide resources including funding for infrastructure and workforce, to support the “horizontal” primary health care framework in which many public health programs are delivered; as well as specific purpose funding and incentives to support “vertical” program approaches.

The existence of national strategies was identified as providing a lever to secure global government funding to address key health issues, and as providing an authorising environment for service provider organisations to lobby for resources at the regional and local level.

Strategic effort and inter-sectoral collaboration

The national approach to public health strategy development was seen as having the potential to provide co-ordinated direction for public health and environmental health management across the country. National strategies were also seen as having the potential to develop greater collaboration between levels of government, and between government and non-government agencies, to address key public health issues for Aboriginal and Torres Strait Islander peoples.

Support for “best practice” approaches

It was said that some of the strategies, particularly those produced in recent years, have been very useful in breaking down the issues, and presenting detailed action plans which can usefully guide service providers. The development and dissemination of intellectual resources such as guidelines for clinical practice and standards for clinical service delivery, was identified as a key area where national strategies can make, and in some cases have made, a key contribution. These materials can assist service providers to make the most effective use of available resources in addressing specific health issues. National strategies were also seen to have the potential to support best practice in culturally appropriate service delivery, in particular by fostering increasing Aboriginal and Torres Strait Islander participation and management in the provision of health services.

4.3 The need for greater commitment, resourcing, and long-term integrated approaches

Despite the recognised potential of the national public health strategies to make a difference, there was widespread agreement that in reality, most of the strategies appear to be making very little impact on Aboriginal and Torres Strait Islander health.

The key reasons for this were identified as a lack of political commitment, inadequate resourcing for implementation, and the need for longer-term, integrated approaches to be taken, within a nationally agreed over-arching framework for Aboriginal and Torres Strait Islander public health.

The need for greater political commitment

Lack of real political commitment was identified as a key limiting factor. The development of national strategies is seen as a politically expedient response to issues which need urgent action, and it was widely noted that strategies do not necessarily result in action.

It was commented that it is easier to get action on addressing living conditions in Timor, than on addressing living conditions in Aboriginal communities. There are seen to be few votes in

Aboriginal and Torres Strait Islander issues, and it was suggested that until Aboriginal and Torres Strait Islander health is identified as a national emergency in need of urgent action, little will change.

Several participants commented that not only is Aboriginal and Torres Strait Islander health an under-resourced area, but that public health generally is under-valued and under-resourced within the health care system, as acute care has a higher profile and gains more attention and funding. There is seen to be a need for greater recognition of the value and cost-effectiveness of expenditure in public health, particularly for Aboriginal and Torres Strait Islander communities.

Resource allocation has been identified internationally as the cardinal indicator of government commitment (as opposed to the mere existence of strategies and planning processes).¹ It was suggested that resources applied in Aboriginal and Torres Strait Islander health should be equitable: commensurate with the burden of disease, known access barriers, the generally greater capacity to benefit, chronic under-resourcing of health care, diseconomies of scale, and remoteness.

It was also suggested that there is a great need for courageous thought and real action to address Aboriginal and Torres Strait Islander public health issues, rather than continuing an approach seen by some to be characterised by political correctness, lip service, and tokenism. It was commented that a bipartisan approach to the issues must be taken, as Aboriginal and Torres Strait Islander health should not be a “political football”.

The need for improved resourcing for implementation

A key reason identified by many participants for the limited impact of the national public health strategies in Aboriginal and Torres Strait Islander health, is that few of the strategies have significantly increased the level of resources available on the ground for primary health care and environmental health improvements. This is widely seen to be what is needed to really make a difference.

It was said by many participants that there is an over-investment in strategy development and planning processes, and an under-investment in implementation. Participants spoke of the gap that often exists between a documented strategy and what happens “on the ground”. Strategy development processes are seen as often taking on a life of their own, diverting resources away from implementation, and delaying action. Community people are saying, “don’t give us any more strategies – just give us the resources here on the ground.” A number of participants commented on the need to re-think the approach of developing a strategy for every emerging issue, suggesting that it needs to be considered in each case whether a national strategy can deliver something that local action cannot.

It was noted that in the absence of adequate resourcing for primary health care services to Aboriginal and Torres Strait Islander communities, service providers are frequently forced to utilise vertical, disease based programs to access resources for core service delivery. This is seen as highly problematic. There is a widely identified need for adequate funding for core primary health care and preventive programs for Aboriginal and Torres Strait Islander communities, to provide the basic infrastructure on which vertical public health strategies can be implemented.

It was suggested by many participants that all national public health strategies should quarantine a significant proportion of their funding, to be used flexibly to address the public health needs of Aboriginal and Torres Strait Islander peoples. This proposal is discussed in greater detail later in this report.

¹ World Health Organisation, World Health Organisation Health for All, Series 4, 1981.

The need for long-term approaches

It was emphasised by many that effective action to address the underlying determinants of Aboriginal and Torres Strait Islander ill health requires a long term approach - there is no "quick fix". The project team was referred to the "Sure Start" approach in the UK, which is a national commitment to a twenty year population health program, in stark contrast to the three to four year Budget-driven approaches currently seen in Australia.

It was widely commented that there is a tension in public health between the political environment in which strategies are developed and implemented, which requires quick action and early wins; and the longer term strategic approach to public policy. The challenge is to achieve both political wins and long term gains.

The need for improved integration of strategy approaches

The fragmentation of national public health strategies into a vertical, issues-specific approach was identified by many participants as inappropriate for Aboriginal and Torres Strait Islander health, where a holistic, comprehensive approach is widely recommended.

Many participants identified a need for national public health strategies to address the underlying determinants of Aboriginal and Torres Strait Islander health. These determinants relate not only to the classical risk factors for chronic and infectious diseases, but also to the particular historical and socio-economic issues facing Aboriginal and Torres Strait Islander people.

It was suggested that there is a need to look at the evidence base for public health interventions, which points to the implications of poverty, social deprivation, community breakdown and disempowerment, in leading to dysfunction, risk taking behaviour, and ill health.

A number of participants commented that addressing health determinants requires a focus on underlying behavioural issues which affect a range of chronic diseases, notably through the promotion of healthy eating and physical activity, and efforts to minimise smoking, and alcohol and other substance misuse. There is also a need to address environmental determinants including housing, healthy water, sewage control, food supply, and so on.

In addition, it was widely noted that many of the determinants of Aboriginal and Torres Strait Islander health lie outside of the health portfolio, in areas such as education and employment; and that poverty and social justice issues also need to be addressed. It was commented that the links between education and literacy, and health, have been well established, and that it is well accepted that these factors have been critical in improving health and increasing life spans in Western society. Addressing the need for higher educational attainment for Aboriginal and Torres Strait Islander people, as a precursor to real health gains, was identified as an issue of key importance.

It was widely commented that most of the national strategies tend to focus on "end points", such as asthma, diabetes, and cancer; rather than on general preventive approaches. This was seen as partly being due to vested interests, especially health professional groups, operating at the wrong end of the spectrum – the disease end. Entrenched program divisions within the bureaucracy, and the interests of powerful non-government organisations, are also seen as contributing to the continuation of a disease-based approach.

This narrow, vertical approach is not seen as an effective way to address the needs of Aboriginal and Torres Strait Islander peoples. As one participant commented:

...many of the issues relating to the public health of Aboriginal people today are linked with the history of dislocation and dispossession. This has produced many social, emotional and economic problems for Aboriginal people, including dependency, and these issues need to be acknowledged and addressed as the starting point for addressing Aboriginal health. Because of the huge crises that many

Aboriginal people and communities are experiencing, attracting their interest and participation in specific public health programs can be very difficult, as they may be seen to have little relevance.

It was suggested that strategies need to “go back to basics” and look at what is needed for Aboriginal and Torres Strait Islander people to “have happy and healthy lives”. This would involve looking at the key tools and approaches available in public health, such as epidemiological data and analysis, education, legislation, community capacity development, and so on, to examine how these resources can be used more effectively to address Aboriginal and Torres Strait Islander public health needs. It was emphasised that an integrated cross-program and cross-portfolio approach is needed. This would require significant political and operational reform, but there is little evidence of the necessary momentum for such change at present.

The need for an over-arching framework

There was considerable support for public health approaches targeting Aboriginal and Torres Strait Islander communities to be integrated under an over-arching national framework. Several participants identified the 1989 National Aboriginal Health Strategy (NAHS), as having the potential to provide the broad framework for the integration of individual disease-based strategies, with the latter providing a greater level of detail on the approach to each issue. The difficulties with the current controversial and politicised review of the NAHS were cited as a limiting factor to achieving this in the short term. It was also commented by some participants that the revised strategy document pays little attention to the link between Aboriginal health and mainstream strategies and programs, and that this is a major shortcoming.

It was noted by one organisation that in New Zealand, Maori issues are far more integrated into public policy, perhaps because Maoris make up a higher proportion of the population. New Zealand has a set of principles for all health services to address Maori health, which are very similar to the NAHS approach, focusing on holistic primary health care, cultural awareness, community development, and so on. It was suggested that the revised NAHS may provide a blueprint for the development and adoption of such principles across the Australian health care system.

It was also suggested by another participant that a formal partnership needs to be developed at the national level between NACCHO and the Commonwealth Government, and that all national health initiatives relevant to Aboriginal health, including in public health, should be generated and developed through this partnership. While there is a National Aboriginal and Torres Strait Islander Health Council which includes representatives of the Commonwealth and NACCHO, as well as other members, the extent to which this forum has been playing an active role in policy and program development has been questioned.

4.4 Movement towards new models: Integrated approaches to chronic disease

Several people referred to the renewed focus on cross-program approaches to chronic disease which are being developed nationally, and the potential for this to provide a useful model for better integrated strategies. The national “Sharing Health Care” (Chronic Disease Self Management) initiative includes a strong focus on cross-program co-ordination and integration, and on a holistic and comprehensive approach. Aboriginal and Torres Strait Islander health is included as a key theme.

Similar initiatives are occurring at a State and regional level. Queensland Health has developed a North Queensland Chronic Disease Strategy for remote communities, encompassing prevention, early detection, and management of a range of health conditions and their underlying determinants. The strategy is taking a funds pooling approach, creating a single funding pool from pockets of State public health funding (though community health service delivery funds are not being pooled). There is a community development and

capacity building focus, involving the development of Health Action Groups to promote community participation and advocacy, and the development of partnerships with existing Aboriginal and Torres Strait Islander organisations. A community development training package is being developed to support these efforts. The strategy also recognises and supports the key role of Aboriginal and Torres Strait Islander Health Workers in the detection and treatment of chronic disease, addressing training, legislative, and practice issues.

The project team was also provided with a discussion paper prepared jointly by authors from the ACCHS sector and the Northern Territory government sector, setting out a proposal for an integrated approach to chronic disease control in the Northern Territory.² This proposal emphasises the need for a more explicit focus on the comprehensive primary health care model and greater Aboriginal community control in addressing chronic disease; and outlines a plan to achieve improved health outcomes for Aboriginal people in the medium to long term through measures including better resourced primary health care services, primary health care and public health support systems at the regional and local level, training initiatives, funds pooling, and inter-sectoral effort.

It was suggested by several participants that these chronic disease approaches may provide a starting point for the greater integration of a range of strategies and funding, including primary health care and environmental approaches.

4.5 Barriers to integrated approaches

While there was widespread agreement on the difficulties inherent in fitting vertical, disease-based strategies into comprehensive primary health care service delivery models, several participants also discussed the difficulties in moving to integrated models, and some also advised caution about moving away entirely from vertical strategies.

There was some feeling that cross-program integration sounds good, but in reality is not very practical. Several participants noted that the need for cross-program and cross-portfolio action had been identified and recommended in the past, but had been unsuccessful due to the fact that there are many structural issues working against such approaches. These include the vested interests of Ministers, government departments, and program areas, who are keen to take credit for new programs and grants. In the Federal arena, scrutiny of program approaches and expenditure by central departments such as the Departments of Finance and Administration, and Prime Minister and Cabinet, was also said to work against program integration and funds pooling; and it was commented that Senate Estimates committees, which hold bureaucrats at central level accountable for the detail of program implementation, also hinder flexible, devolved approaches.

There were some comments about the logistical problems in attempting cross-program and cross-portfolio approaches, notably the danger that efforts to co-ordinate approaches require the involvement of personnel across a range of areas, and could lead to the establishment of inter-divisional and inter-departmental committee structures which can actually add to the bureaucratic processes and further delay meaningful action.

Several participants also commented that there is inherent value in vertical, disease-based strategies in terms of bringing a focus to particular health issues which may otherwise be overlooked, and driving excellence in areas such as research and program development and implementation. Vertical approaches were seen by some as useful in producing clarity about objectives and activities. There was seen to be a danger in cross-program approaches, in that they could lead to over-generalisation and loss of specificity, focus, and expertise. One participant pointed out that the strategies which have had the greatest impact in the general

² Boffa, John, and Weeramanthri, Tarun (June 2001), *Orienting health services and public health programs towards greater chronic disease control: A proposal for a network of zonal and regional public health services*, Discussion paper prepared for the Northern Territory Aboriginal Health Forum.

community, such as the HIV/AIDS and anti-smoking strategies, have been focused on particular problems, not general issues.

There was also some concern raised that pooling of funds to support generalised approaches could lead to a loss of accountability, and that there is an inherent danger of wastage of funds and effort.

It was suggested that much of the current difficulty experienced in integrating vertical approaches into primary health care settings is actually due to the inadequate resourcing of primary health care, rather than to inherent problems with the vertical programs. Service providers are currently looking to vertical strategies to provide infrastructure and staffing for core programs, and as this is not the intent of the vertical strategies, the results are often less than optimal. It was argued that if the core infrastructure and staff resources of services are brought up to an adequate level, the vertical strategies will be able to add value to a much greater degree than they currently do. In the meantime, there is a case for the role and integration of all "vertical" strategies in "horizontal" health service delivery to be better considered by policy makers.

5. Strategy development: the issues identification stage

Participants in the consultations contributed their views on how public health issues are identified as priority areas for national strategies, and how well Aboriginal and Torres Strait Islander needs are considered in the issues identification process.

While it is widely acknowledged that the existing strategies do address many priority health issues for Aboriginal and Torres Strait Islander people, there is a feeling that they take a fragmented approach, and that Aboriginal and Torres Strait Islander issues are not generally well prioritised within the strategies. These issues are dealt with elsewhere in this report.

It was also pointed out that several important public health issues for Aboriginal communities are not addressed through strategic national approaches, often because they are not health issues which affect many people in the general community.

5.1 Factors driving the identification of public health issues for national strategic action

Virtually all participants, whether from Aboriginal peak bodies, service delivery organisations, government, or other organisations, agreed that there are two main driving forces for the identification of public health issues for national strategic action.

The first, but not necessarily the most important, is evidence, in the form of epidemiological data and community needs analyses, sometimes complemented by examples of successful public health approaches overseas.

The second driving factor identified by participants is political pressure. It was noted that public health issues often come to the fore when there is a convergence of interests between medical and research groups, community based organisations, and government. Media attention can also drive the pressure on governments to act, and some participants stated that the development of a strategy was a preferred means by which governments deflect attention and pressure on difficult issues. Several participants referred to the considerable resources provided in recent years for the National Illicit Drug Strategy, and for a range of rural health initiatives, as examples of politically driven approaches.

5.2 Implications for Aboriginal and Torres Strait Islander health

Based on these perceptions, participants considered that Aboriginal and Torres Strait Islander health needs are unlikely to gain due attention in national public health strategies due to lack of good data, and lack of political leverage.

Problems with data availability and quality

It was commented that Australia has a reasonable public health surveillance infrastructure, but that this does not greatly benefit Aboriginal and Torres Strait Islander people, partly because of poor identification of Aboriginality in the data. The issue of data availability and quality in Aboriginal and Torres Strait Islander health has been dealt with, and continues to be dealt with, through specific processes under the auspices of AHMAC. It is not suggested that the NPHP initiate separate activity in this area, but rather that the NPHP acknowledges this matter and supports efforts through AHMAC to improve Indigenous identification in health data collections.

The other issue identified as a barrier was the resistance from some Aboriginal groups to Indigenous-identified data collection and use. While it was suggested that community sensitivities around identified data collection are an impediment to good planning and advocacy, these sensitivities are also understandable in view of bad experiences in the past:

for example resentment by communities at being identified as “a hotbed of sexual ill health”. A great deal of genuine effort will be needed to address these concerns.

It was pointed out in the consultations that the current emphasis on requiring an evidence base for action can actually be an impediment, as Aboriginal and Torres Strait Islander needs are often not well documented. It was pointed out, for example, that the National Immunisation Strategy has been driven by epidemiological data on poor immunisation rates and the effectiveness and cost-effectiveness of childhood immunisation in addressing vaccine-preventable diseases. However, the data on childhood immunisation rates in Aboriginal and Torres Strait Islander communities is often poor, and this has been a barrier to effective strategy development and implementation.

It was suggested that particularly in the absence of “hard” data, there needs to be more acknowledgement of the value of Aboriginal knowledge systems, and use of the knowledge and expertise of Aboriginal communities in identifying their own problems. It was noted that there is some available community-based information on Aboriginal and Torres Strait Islander health priorities, contained in the regional Aboriginal and Torres Strait Islander health plans, which is under-utilised in public health issues identification, strategy development, and program planning. This matter is discussed in more detail elsewhere in this report.

Lack of political leverage

Aboriginal and Torres Strait Islander people make up only two per cent of the population, and as an impoverished, marginalised, and diffuse group have limited political leverage. There are seen to be few votes in Aboriginal health, and consequently little political imperative for action. The convergence of powerful interests which drive strategy development on many issues is not often seen in Aboriginal and Torres Strait Islander health. In addition, the political and media focus is often on very visible issues such as illicit drug use, youth suicide, and so on, whereas underlying issues such as workforce and community capacity, which are critical in addressing these issues in Aboriginal and Torres Strait Islander communities, can be lost in politically-driven policy processes.

5.3 Health issues not addressed in national strategies

It was commented by several participants that although there have been national strategies developed on issues which are high priorities for Aboriginal and Torres Strait Islander health, these strategies have not been well targeted and have had little impact in these communities. Examples here included diabetes, and maternal and child health.

As noted above, it also was pointed out that several important public health issues for Aboriginal communities are not addressed through strategic national approaches, often because they are not health issues which affect the general community, or because they mainly affect disadvantaged and disempowered groups in the community. Some major areas where national strategies are lacking were identified as oral health, rheumatic fever, renal disease, skin diseases, and suppurative ear disease. It was commented by a significant number of participants that child and youth issues are very high priorities for Aboriginal and Torres Strait Islander communities, but are currently not addressed in any co-ordinated way through national strategic action. There was also a suggestion that lifestyle and welfare issues, including parenting, need to be better considered in the context of public health approaches.

6. Strategy development: targeting Aboriginal and Torres Strait Islander health within mainstream strategies

6.1 The need for inclusion and prioritisation

Most of the national public health strategies under consideration in this project are mainstream whole-of-population strategies. Participants in the consultations frequently referred to the extraordinary public health needs of Aboriginal and Torres Strait Islander peoples, and to the compelling arguments for all mainstream strategies to prioritise these needs despite the small size of the Aboriginal and Torres Strait Islander population.

Many participants commented that in the past, national public health strategy development processes have tended to consider Aboriginal and Torres Strait Islander health only quite late in the process if at all, after the main part of the strategy had been developed or even implemented. It was also widely felt that in the past, the attention and resources directed to Aboriginal and Torres Strait Islander health within the mainstream strategies have been far from commensurate with the level of need.

It was generally acknowledged that this situation is improving. However, some participants suggested that there is still a tendency for Aboriginal and Torres Strait Islander needs to be seen as a “clip-on” to the main strategy. It was also commented that consideration of these needs can be part of a tokenistic approach where a range of special needs groups are lumped together, and there is rhetoric about the importance of addressing their needs, but little real commitment to action.

There was a general consensus amongst participants that Aboriginal and Torres Strait Islander needs should routinely be identified as a top priority for all mainstream national public health strategies, and addressed in an inclusive manner from the outset of issues identification and strategy development. It was generally agreed that this approach should be based on appropriate participation in priority-setting and decision-making by Indigenous representatives throughout the processes of strategy development, implementation, and evaluation.

There appear to be some good models for an inclusive approach. For example, the development and implementation of the BreastScreen program in Queensland appears to have been quite inclusive, according to this participant:

From the outset, this national strategy was conceived of and developed as a specific public health intervention, with clear aims and objectives, based on equitable access. There was much thought at both Commonwealth and State level about how to ensure access by all groups, including Aboriginal and Torres Strait Islander women. Standards for access by all groups were set for all BreastScreen services. Indigenous issues were therefore considered and integrated from the outset, rather than being an add-on to an already developed strategy.

In Queensland, the principle for ensuring Indigenous access is to take the service to where the women are. To do this, mobile and relocatable services are widely used (using four wheel drives etc). There is also an emphasis on culturally appropriate service delivery, based on cultural training for service providers, and use of appropriate educators at community level, including female Aboriginal and Torres Strait Islander Health Workers. There are also efforts to integrate the program with horizontal primary health care service delivery.

The data on Indigenous access in Queensland indicates this strategy has been fairly successful, though there is still room for improvement:

To support improved access, Queensland Health has commissioned research into both breast and cervical cancer service delivery for Indigenous women, looking at barriers and appropriate services. This research was based on extensive community consultation, and has led to the development of peer education programs, and to the development of State guidelines for service delivery to Indigenous women, which are highly regarded and are likely to be adopted nationally.

Such inclusive but targeted approaches may provide good models for other strategies.

6.2 The case for quarantining of funds

It was commented by several participants that there is a common but incorrect view in the community and amongst many in politics, that large amounts of funding have gone into Aboriginal and Torres Strait Islander health, to little effect. It was said that there also tends to be an assumption that Aboriginal and Torres Strait Islander people are well served by the funding provided through Indigenous-specific programs, and therefore do not also need access to mainstream programs. It was commented that these views could lead to “resource allocation racism” in public health: that is, a lack of recognition that Aboriginal and Torres Strait Islander communities have a legitimate claim to whole-of-population public health resources.

It was widely argued by participants that given the high burden of disease and high level of unmet need amongst Aboriginal and Torres Strait Islander communities, all mainstream national public health strategies should routinely quarantine a significant proportion of their funding for Aboriginal and Torres Strait Islander health.

There were varying views on the appropriate level of funding to be quarantined, but the general consensus supported quarantining at least 10 per cent of funds. It was suggested that the level of funds quarantined should be based on Aboriginal and Torres Strait Islander people’s capacity to benefit, compared with the capacity of the general community to benefit from the same expenditure.

It was also felt that this should not preclude the remaining funds also being accessible for public health initiatives targeting Aboriginal and Torres Strait Islander communities. This is seen as an appropriate way to respond to the need for both equitable access to mainstream programs, and for gap-closing measures which reflect the enormous burden of disease and disadvantage.

It was also widely argued that the quarantined Aboriginal and Torres Strait Islander health funding component should be allocated in such a way that it can be used flexibly to meet needs at the local/regional level, within the framework of broad macro level policy.

In the recent implementation of some mainstream public health strategies, the Commonwealth has taken the approach of quarantining around 10 per cent of their funds for Indigenous-specific projects, as well as allowing Indigenous access to the remainder of the funds where appropriate. There is widespread support for this approach. Ten per cent reflects a five-fold loading and represents the minimum required to address the excess burden of disease, access barriers, generally greater capacity to benefit, diseconomies of scale and remoteness.

However, there is also some anecdotal evidence that once funds have been quarantined, there can be some “political” resistance to allowing Indigenous access to the remainder of the funds. This indicates that the reasoning behind the system which encompasses both funds quarantining, and access to mainstream funds, needs to be clearly articulated and widely understood.

6.3 The perceived advantages of separate Indigenous-specific approaches

There was considerable discussion in many of the consultation meetings about the pros and cons of developing and implementing separate public health strategies for Aboriginal and Torres Strait Islander communities.

There are precedents (in the sexual health and mental health areas) for funds quarantined from mainstream national strategies being used for separate approaches administered by the Office for Aboriginal and Torres Strait Islander Health (OATSIH) in the Commonwealth Department of Health and Aged Care. For most of the national strategies, however, the approach has been to seek to address Aboriginal and Torres Strait Islander health issues as a component of the mainstream strategy, with efforts administered by the mainstream program areas of health departments.

The arguments put forward by participants in favour of separate Indigenous-specific approaches were as follows.

More appropriate program development

It was noted that Aboriginal and Torres Strait Islander life experiences and health needs are generally significantly different from those of the general community, and that it is often not feasible to simply “adapt” a mainstream strategy to meet Indigenous health needs. As one participant with lengthy experience said:

The Aboriginal people we see at the health clinics in communities are dealing with the basic survival issues, and consequently are not as empowered as middle class Australia to take on board public health strategies and implement them in their lives.

A key example given by participants was the need for the development of an Indigenous-specific approach to sexual health, distinct from the approach taken in the mainstream HIV/AIDS Strategy. The differing epidemiology in Aboriginal and Torres Strait Islander communities, along with cultural differences, required a specific approach based on screening for and treatment of STDs in the primary health care context, and broad community education on sexual health, as opposed to the information and awareness campaigns aimed at gay men which were the focus of the mainstream strategy.

Another example cited was the National Injury Prevention Strategy, which has a major focus on falls prevention in the elderly. This is irrelevant for Aboriginal and Torres Strait Islander people, as very few community members live to an old age, and the major causes of injury which need to be addressed include those related to substance misuse and interpersonal violence, motor vehicle accidents, and injuries to children.

It was also noted that the women’s health policy was based on a feminist perspective, which many Aboriginal and Torres Strait Islander women do not identify with; and that most strategies on ageing have been largely irrelevant for Aboriginal and Torres Strait Islander people, whose life span is around 20 years less than the general community.

More appropriate health promotion efforts

Participants raised many examples in the health promotion area, where national and State-wide campaigns were often completely inappropriate for Aboriginal and Torres Strait Islander communities. The recent National Illicit Drug Strategy media campaign aimed at parents was cited by several participants as being inappropriate, as family structures are different, in many cases the carers are not parents. For this and many other reasons, Aboriginal and Torres Strait Islander people would not identify with the family images promoted in the campaign. The “Quit” campaign was also singled out as having been ineffective in addressing high rates of smoking in Aboriginal and Torres Strait Islander communities.

On the other hand, health promotion campaigns which are developed locally, reflect community realities and culture, and have support and ownership from the community, are far more likely to be successful.

There are some good examples of this from the Kimberley, where both the ACCHS sector and the State sector undertake considerable health promotion work. Over several years, the ACCHS health promotion efforts have taken an emphasis on visual and oral methods – theatre, dance, and reflective counselling – to engage the community on issues such as HIV/AIDS awareness, diabetes awareness, pap smear awareness, environmental health and hygiene issues, youth self-esteem, substance misuse, and emotional and social well-being issues generally. These activities have not only had a considerable impact in the region, but have drawn considerable national and international attention.

The State sector has also developed several successful local campaigns, including an anti-smoking campaign aimed at primary school children, utilising an Aboriginal puppet and encouraging children to never start smoking. This approach was developed by a very remote desert community, and has spread to become popular across the region. The unit has also engaged in a major health promotion effort to address the problem of deaths and injuries relating to unrestrained passengers travelling in the back of utilities. This initiative involved research, community consultation, and the development of a major health promotion campaign utilising several tools including some advertising using the same puppet as in the anti-smoking campaign. This represents a regional approach to addressing an issue which is significant in the region, but which is not a national issue.

It was felt by participants in the Kimberley that these locally managed, Aboriginal-specific health promotion campaigns, involving local project officers and performers, generate a sense of ownership by the local community, and have a far greater chance of success than generic national or State-wide campaigns. By creating local employment, they also play an important part in community development.

A greater degree of community participation in the strategies

It was frequently commented that Aboriginal and Torres Strait Islander communities have far more engagement with Indigenous-specific strategies than with mainstream strategies. This could be due to greater efforts by Indigenous-specific strategies to engage and consult with these communities, or to greater community interest in strategies that are seen as more relevant. In this context, one Aboriginal organisation referred to the 1989 National Aboriginal Health Strategy as

the only one of the strategies that Aboriginal and Torres Strait Islander organisations are conversant with, feel ownership of, and refer to regularly and actively – it is the 'Bible' for the Aboriginal health movement.

Other Aboriginal participants expressed similar views.

It was also noted that some recent Indigenous-specific strategy development processes, such as the development of the National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan, have involved high levels of participation by Aboriginal and Torres Strait Islander people, and have produced strategy documents that are well accepted and “owned” by community organisations. It was felt that such engagement and ownership is far more likely to occur with Indigenous-specific approaches.

The ability to target funding through appropriate service provider agencies

It was noted that mainstream services do not tend to be geographically, culturally, or financially accessible to Aboriginal and Torres Strait Islander people, and that individualised treatment services are not the most appropriate model to address the health inequalities which exist. There is a widely perceived need to resource Indigenous-specific organisations, particularly ACCHSs, to implement national strategies, as they are better accessed by

Aboriginal and Torres Strait Islander people, and can deliver programs in a more culturally appropriate way. In the words of one participant:

Koori-specific strategies can take a more appropriate approach to community issues: for example, rather than operating programs with a narrow 'mental health' focus, Koori organisations can provide more holistic social and emotional well being programs taking into account socio-economic issues and connection to land.

Aboriginal and Torres Strait Islander organisations were seen to be more likely to be targeted by funding programs that are linked to Indigenous-specific strategies, whereas Indigenous components of mainstream strategies were seen as often being rolled out through mainstream organisations.

Better monitoring of effort

It was suggested that Indigenous-specific strategies are likely to be administered and/or monitored by Indigenous-specific program areas in departments, which was an advantage as these areas had a better track record in this regard than did mainstream program areas, which often overlooked performance measures for their programs to address Aboriginal and Torres Strait Islander health.

6.4 The potential disadvantages of separate Indigenous-specific approaches

Several participants also identified some potentially negative consequences of separate approaches. These included:

The danger of marginalisation

Several participants were concerned that separate Indigenous-specific approaches could lead mainstream public health areas, which have the bulk of funding and expertise on public health matters, to abrogate any responsibility for considering and addressing Aboriginal and Torres Strait Islander health.

Resourcing disadvantage

There were related concerns that the quarantining of funding could lead to inadequate amounts being allocated for Aboriginal and Torres Strait Islander health, with the real value of allocations being eroded over time. There is a fairly widespread feeling that this is the common history of Indigenous-specific funding programs.

Loss of expertise

It was also suggested that there is a danger that the bulk of the expert knowledge on any specific public health issue could be captured by the mainstream rather than Indigenous-specific approaches, and that new knowledge and innovative approaches may not spread beyond the boundaries of the mainstream approaches to reach Indigenous programs.

6.5 The need for linked strategies

Overall, there was a general view that national public health strategies should aim to achieve the benefits of both Indigenous-specific approaches and integrated effort, by developing linked “companion” strategies for Aboriginal and Torres Strait Islander health. It was suggested that there needs to be an ongoing dialogue between the mainstream and Indigenous-specific strategies, and that they could represent parallel approaches within a common framework. There was said to be a need for mainstream strategies to “build bridges” to address Aboriginal and Torres Strait Islander health needs.

It was widely agreed that quarantined funding should be attached to these linked, Indigenous strategies; but that the mainstream strategies must still retain a focus on addressing Aboriginal and Torres Strait Islander health, including by keeping mainstream funding and resources available for Indigenous health initiatives. It was also suggested that the linked Indigenous-specific strategies need to be integrated under an over-arching national framework for Aboriginal and Torres Strait Islander public health, as outlined earlier.

The development of the National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan, in parallel to, and published in the same volume as, the mainstream Eat Well Australia strategy, was cited by several participants as possibly offering a good model for separate but linked strategy development.

There were differing views on whether Indigenous-specific approaches linked to national public health strategies should be administered by mainstream or Indigenous-specific program areas. There is the related question of whether such strategies should be administered by the Commonwealth through OATSIH (as with the mental health strategy), or by States and Territories as part of their overall public health approaches. The arguments on this issue are much the same as the arguments for and against Indigenous-specific approaches generally. It is suggested that this is an area where more comprehensive consultation and debate is needed.

7. Strategy development: Aboriginal and Torres Strait Islander representation

Participants universally agreed that Aboriginal and Torres Strait Islander people must be effectively represented in national public health strategy development processes. This representation is seen as a vital part of ensuring that strategies prioritise Aboriginal and Torres Strait Islander health, that they are appropriate and acceptable, and that they are accessible to communities and their service providers.

Unlike the situation only a few years ago, when Aboriginal and Torres Strait Islander issues were often only considered as a “post-script” to national strategy development, national committees now generally include some Aboriginal and Torres Strait Islander representation. This appears to be largely an outcome of the funding of national and State/Territory peak Aboriginal health organisations (NACCHO and its affiliates), as agreed under the Framework Agreements in Aboriginal and Torres Strait Islander health. This has greatly increased the capacity of the ACCHS sector to engage in policy processes.

There are, however, no agreed protocols for representation, and consequently committees may approach NACCHO, ATSIC, Torres Strait Islander organisations, OATSIH, staff of State/Territory government departments, and/or individual Aboriginal and Torres Strait Islander people, to represent community views and experiences.

A number of people in government departments stated that they need more guidance on Aboriginal and Torres Strait Islander representation issues, including information about representative structures and protocols.

Currently, there appears to be little consensus about how appropriate representation should be achieved. The consultations suggest that this is an area where the NPHP and representative bodies, particularly NACCHO, need to work together to reach agreed protocols that address the needs and concerns of all parties.

7.1 NACCHO’s view: Mandated representation

Peak bodies from the Aboriginal community controlled health sector, that is, NACCHO and its affiliates, are strongly of the view that national strategies must seek Aboriginal input through their structures. They point out that NACCHO is the only national body representing Aboriginal people in health. The sector’s processes of electing community representatives through ground-up processes at local, State/Territory, and national level ensures that those nominated by NACCHO speak with a mandate from the community, and are held accountable by the community to represent their views and report back. There are also written policies which provide a framework within which delegates from the ACCHS sector can work.

It is acknowledged by NACCHO that ATSIC’s elected structures also produce representatives with a community mandate³, though it is pointed out by some that their mandate is limited by the low turnout at ATSIC elections, and that ATSIC has limited involvement in health issues apart from environmental health. It should also be noted that NACCHO does not claim to speak for Torres Strait Islander peoples, but supports self-determination and a separate mandated voice for Torres Strait Islanders.

NACCHO points out that the appointment to strategy committees of individual Aboriginal and Torres Strait Islander people is problematic. Individual appointments bypass and undermine elected structures and protocols, and create a situation where people with no clear mandate are speaking for other Aboriginal and Torres Strait Islander people. This is seen as tokenistic

³ NACCHO (April 1999), *The National Public Health Partnership and its relevant to improving Aboriginal health* (Issues Paper submitted to NPHP).

and patronising (“any black face will do”). Governments are sometimes seen to be taking the easy option of appointing individuals who may be easier to work with than empowered and mandated representatives.

NACCHO has also brought to the attention of government departments the need to facilitate Aboriginal participation in strategy development committees through mechanisms including:

- Appropriate resourcing of committee/meeting attendances;
- Allowance for technical advisers to accompany the representative;
- Appointment flexibility eg. the nomination of proxies;
- Acknowledgement that absences are generally the consequence of limited resources;
- Holding over of decision-making until representation is possible⁴.

There is widespread acknowledgement that the ability to engage the ACCHS sector and obtain competent technical, strategic, and community perspectives, has been greatly facilitated by the funding of a national NACCHO Secretariat.

7.2 Difficulties experienced by the ACCHS sector

In consultation, staff from NACCHO and its affiliates discussed the challenge of finding suitable representatives and achieving participation in the large number of policy and strategy processes which operate concurrently at national, State/Territory, and regional level. It was suggested by some participants that an industry has been built around policy development, planning, and consultation, and that although the issues may be important, it is becoming increasingly burdensome for community organisations to participate.

The ACCHS sector is relatively small and resource-poor, and its organisations at local, State/Territory, and national level struggle to engage with the large number of separate processes and strategies which may impact on community health. It is not generally recognised that there are very differing levels of resourcing for the State/Territory peak bodies, which greatly affects their ability to engage in consultation and representation processes.

Representatives from the ACCHS sector are generally CEOs or senior staff from services, and putting time into policy and strategy processes can be detrimental to their immediate service delivery functions.

The result is that participation currently relies on attendance by a small number of representatives and peak body staff from the sector.

Mechanisms which were suggested to address this problem included:

Rationalisation of the large number of concurrent policy and consultation processes generated by governments

It was suggested that government agencies need to consider reducing the number of separate policy and planning processes they generate, or to group them together for the purpose of consulting with Aboriginal organisations. As an example, it was noted that in the Macquarie area of Western NSW, all inter-agency meetings relevant to Aboriginal health are scheduled together for a specific day every two months, which increases the ability of Aboriginal organisations to participate in discussions on relevant health issues.

⁴ NACCHO (April 1999), *The National Public Health Partnership and its relevance to improving Aboriginal health* (Issues Paper submitted to NPHP).

Mechanisms within the ACCHS sector to enhance representation

It was noted by some participants from within the ACCHS sector that the peak bodies in this sector are only in the early phase of establishment and operation, and that protocols for effective representation still need further development. One Aboriginal organisation suggested that NACCHO could draw more widely on the expertise within its sector, by developing registers of people willing and able to represent the sector on specific issues. These people need not be CEOs; in fact, it was suggested that there was an over-reliance on CEOs to carry the burden of representation, when there were some policy processes into which experienced staff with subject-matter knowledge may be able to provide effective input. It was suggested that training and support for these representatives, and agreed policies and procedures covering representation, would also be useful.

It was suggested that governments and the NPHP should be supportive of efforts by NACCHO to enhance the quality and consistency of its internal consultation and representation processes. This was seen as an issue for the developing peak structures within the ACCHS sector to deal with, and it was suggested that external players should allow this process to take its course, and continue to engage with the ACCHS sector according to its stated protocols, in a supportive and respectful way.

7.3 Difficulties expressed by departmental people

A number of people from government departments expressed difficulties with relying on NACCHO as the sole source of Aboriginal input into strategy development. The difficulties which were raised in consultations include:

Not all communities or individuals are directly represented by NACCHO

There are many communities which do not have an ACCHS, and where there is an ACCHS, it may not be supported or accessed by all sections of the community; with the consequence that NACCHO is seen as not directly representative of all Aboriginal and Torres Strait Islander communities or individuals. In response to this, NACCHO and its affiliates point out that no elected representatives from mainstream politics or from non-Aboriginal health organisations (such as medical organisations) have the support of or speak for all sections of their constituency, but that this is never questioned outside of Aboriginal politics. There is a concern that government departments appear to approach Aboriginal people and organisations outside of the ACCHS sector, as a means of undermining NACCHO and its affiliates.

Diversity of Aboriginal and Torres Strait Islander communities and viewpoints

There were many comments about the high degree of community diversity, and the inherent difficulties involved with one representative in a committee process being required to represent the views of all communities. Some participants commented that the views and needs of urban Aboriginal communities, in particular, tend to be overlooked in national strategies, as there is an over-concentration on remote communities. Some government people felt that the national view provided by NACCHO was not always representative of the views of its membership at local level. This view drew the following response from one participant with considerable experience of community decision-making processes:

There is a need to be clear about the parameters of consensus. Indigenous politics at local level works through family and community networks, while Indigenous politics at the national level is quite different – people are operating outside of their local contexts. This makes national level decision making processes more difficult to read and respond to appropriately.

The issue of translating a range of local views and experiences into a national position would appear to be one for the ACCHS sector to deal with. Departmental people and policy makers

expressed a need for more information about these complex matters, to promote better understanding and mutual respect.

A review of representative arrangements in Aboriginal and Torres Strait Islander health has recently been undertaken, which may also assist to provide increased clarity on these issues.

Difficulties with consistency and continuity in representation

Departmental people commented that it is uncommon for the nominated representatives from the ACCHS sector to attend all meetings on a particular issue: apologies are often given, and proxy arrangements sought. This can work against consistency and continuity in the policy development process. It was acknowledged by these commentators that this relates back to organisational capacity issues, and that an investment in this area would help to address this problem. NACCHO has also noted that allowing technical support (generally staff members) to accompany representatives, promotes continuity and consistency.

Representatives nominated by NACCHO may present a political viewpoint rather than contributing subject matter expertise

Several participants commented that the representatives nominated by NACCHO for committee processes sometimes lack subject matter expertise, and that their input is “overly political”. NACCHO’s expressed view on this issue is that its nominated representatives bring community expertise and a community controlled philosophy to these processes, and that this is more important than subject matter expertise. NACCHO also points out that its preference for technical experts to accompany its representatives to meetings provides for this aspect to also be covered.

However, as noted above, there were also comments from within the ACCHS sector that a wider range of people, including health professionals from within the ACCHS network, could be utilised in representative processes. It is suggested that this is a matter which could be further considered by NACCHO.

There are also underlying issues which need to be considered. One government participant commented that:

There is a level of disenchantment among government people about working with Aboriginal organisations, due to negative experiences – bureaucrats now don’t know what to do. There is a reluctance to make any decisions at all in Aboriginal health... for fear of conflict and disagreement.

Peak bodies in the ACCHS sector are aware that they are seen by governments and departments as “hard to deal with” and “negative”. Their view is that this is due to cultural bias. They see that in many cases, Ministers, departments and committees have pre-conceived ideas about how Aboriginal health issues should be dealt with, and that these views are often uninformed and incorrect. When Aboriginal representatives work to turn these ideas around, they are characterised as “knocking everything”, as government people and experts on committees believe that “they know best” and are beyond criticism. One participant suggested:

The government needs to support the role of peak advocacy bodies in Aboriginal health, rather than undermining them. Aboriginal people are very accountable to their own communities – more so than politicians – and governments need to accept this mandate and work with the people the communities elect to represent them.

It was also pointed out that advocacy has played a key, well-recognised role in promoting public health improvements in many fields, and that this was a valid reason to support and strengthen advocacy for Aboriginal and Torres Strait Islander people in health.

There is expertise outside of the ACCHS sector which needs to be brought into strategy development processes

It was pointed out that there are many people working in other sectors, particularly in State and Territory government departments and agencies and in OATSIH, who have considerable expertise in Aboriginal and Torres Strait Islander health, and that it is important to value and utilise this expertise.

Limitations on public discussion of new policy directions

Aboriginal and Torres Strait Islander organisations are sometimes frustrated by formal Budget announcements of new initiatives into which they have had little or no input. In some cases, these organisations believe the policy and program directions are problematic and need to be reconsidered, but there is little opportunity to influence or change the direction once announced in a Budget context. However, it was noted by Departmental staff that Budget processes include Cabinet-in-Confidence requirements which place severe limitations on their ability to consult in the pre-Budget context. It is suggested that means of dealing with this need to be considered.

The need for protocols

There are clearly many difficult and sensitive issues relating to representation of Aboriginal and Torres Strait Islander peoples in strategy development, which need to be resolved. It is suggested that there should be frank and positive discussion between the NPHP and NACCHO about these issues, with the aim of seeking agreed protocols for representation.

7.4 The case for a new approach: Indigenous leadership in strategy development

While putting forward suggestions for improved representative arrangements, NACCHO has also suggested that the usual approach of national strategies being developed by government-appointed committees needs to be re-thought. NACCHO has argued that where Aboriginal-specific strategies (including linked “companion” strategies to mainstream national public health strategies) are to be developed, the process should be led by representative Aboriginal organisations rather than by government.

A current example of this approach is the Commonwealth DHAC’s decision to resource NACCHO to undertake research and consultations to develop recommendations for a national approach to tobacco control in Aboriginal and Torres Strait Islander communities. This is seen as preferable to commenting on a process undertaken by others, or being part of a government-determined process.

7.5 The need for organisational capacity building to support participation and advocacy

As noted above, peak bodies in Aboriginal and Torres Strait Islander health are often overwhelmed by the demands on them to contribute to a wide range of policy development processes. Requests for resourcing, in terms of funding for staff positions to support this participation, are seen in this context as fundamental to effective participation and advocacy.

There is also seen to be a need to support the capacity of local organisations to be better involved in policy processes. Several Aboriginal people who participated in the consultations commented on the barriers to their effective participation in policy and planning processes, arising from social and educational disadvantage, lack of experience in presenting issues in public forums, and lack of confidence in public speaking.

These participants spoke of their feelings of being overwhelmed by expert committees whose discussions involve a great deal of bureaucratic and technical jargon. They felt that they struggled to present their communities' issues and have their voices heard in these forums. It was commented that these were common experiences for Aboriginal and Torres Strait Islander people who participate on committees.

Community capacity building and skills development to support participation and advocacy, is widely seen as an important element of achieving health improvements for Aboriginal and Torres Strait Islander people. It is suggested that the NPHP consider its role in providing support in this area.

7.6 The value of input from health professionals directly involved in service provision

Many participants stated that existing strategies do not adequately consider implementation issues, including the local service delivery context, community capacity issues, funding issues, and infrastructure and workforce issues. This was seen to be because strategy development processes are dominated by people with research and bureaucratic expertise, and have little participation from people involved in service delivery at local level. Several participants commented that greater representation from this level, especially from health professionals with expertise in specific health issues, would help strategy development committees to understand and focus more on implementation issues.

While representation from the ACCHS sector can provide some of this service delivery expertise, there appears to be room to consider the greater involvement of health professionals both within and outside the ACCHS sector, some of whom feel that their potential to make a valuable contribution to strategy development is currently under-utilised.

It was commented by departmental people that the voice of hands-on service providers in strategy development processes can actually be very influential in persuading Ministers and departments to take action on specific issues, as this "real world" input can present a stark contrast to the abstraction of many policy discussions.

Several health professionals engaged in direct service provision expressed an interest in having greater input into national strategy development, but pointed out that this was resource intensive for their organisations and would take them away from hands-on service delivery. There were several suggestions that national committees should not just do their work in Canberra, but should base themselves in different parts of Australia, to bring them closer to a range of communities and enable input by a wider range of people at service provision level.

8. Strategy development and implementation: consultation with Aboriginal and Torres Strait Islander peoples

8.1 The need for adequate and appropriate consultation

There was widespread agreement amongst participants on the need to consult properly with Aboriginal and Torres Strait Islander peoples in the processes of national public health strategy development and implementation.

Consultation issues are difficult to separate from the representational issues discussed in the previous section. Representation on national committees is one aspect of consultation with Aboriginal and Torres Strait Islander communities, and representatives on these committees could be expected to consult with their constituencies and to bring their views to the table. There are of course resource limitations to this, as the representatives are generally not resourced to consult face to face with communities. Even representatives from peak bodies may find it difficult to manage more than a fax out to member organisations briefing them on the issues and seeking input.

There is seen to be a need for broader consultation in the implementation phase, and in some cases also in the strategy development phase. It was clear from the consultations that the majority of local level service providers and community people have very little awareness of the existence of the national strategies. It was commented by several participants that Aboriginal communities and organisations frequently only learn very late about the implementation of strategies at the regional/local level, and the availability of funding; and have little opportunity to provide input into program planning and decisions about resource allocation. One local Aboriginal organisation commented that:

Many strategies “arrive” in the community – both national and State initiatives, both Indigenous-focused and mainstream – and it is often hard to tell where they have come from, how they link together, or what implications they have for health care service provision at the local level.

It was also widely commented that community understanding of and support for initiatives is a key success factor. An example given was the National Indigenous Australians’ Sexual Health Strategy, where it was seen that the investment of effort into community consultation has been critical to the acceptance and success of the strategy in many remote communities.

8.2 The need for guidance on consultation processes

Community consultation is a sensitive and sometimes controversial issues, and several people in government departments identified the need for clear and consistent consultation protocols to be developed, agreed, and followed in all strategy development and implementation processes.

Currently, there is said to be an over-reliance on heads of Aboriginal and Torres Strait Islander peak bodies and Indigenous community councils, to speak on behalf of communities; or alternatively a reliance on engaging Indigenous consultants, or Indigenous staff within government departments, to “come up with the answers”. It is felt that while each of these sources can provide part of the picture, there is a need for comprehensive community consultation to occur as a matter of course.

While there are several available documents which may provide some guidance on these matters, there is currently no one nationally agreed document which clearly outlines the agreed protocols for community consultation. It was widely commented that such a document needs to be developed.

One Aboriginal organisation referred the project team to community-driven literature on “Aboriginal Terms of Reference”, as a framework for considering consultation issues:

*Aboriginal Terms of Reference encompasses the cultural knowledge, understanding and experiences that are associated with a commitment to Aboriginal ways of thinking, working, and reflecting. ATR incorporates specific and implicit cultural values, beliefs and priorities from which Aboriginal standards are derived, validated, and practised. These standards will and can vary according to the diverse range of cultural values, beliefs, and priorities from within local settings or specific contexts.*⁵

This literature, along with other documents and guides on consultation prepared by Aboriginal and Torres Strait Islander organisations, could provide a good starting point for the development of nationally agreed consultation guidelines.

8.3 Some pointers from participants on consultation issues

Participants made several suggestions about how consultations should be carried out.

Paradoxically perhaps, some communities feel over-consulted, as they are repeatedly visited by departmental staff and consultants seeking responses on a range of issues, generally with little action resulting from these consultations. It was widely suggested that there needs to be co-ordination of consultation processes by different agencies and programs, so that fewer, more consolidated, consultations are held. The Fred Hollows motto of “no survey without service” was also quoted by several people in the consultations, as a means of addressing “consultation fatigue”. It was also commented that the gap between survey and service needs to be made as small as possible.

It was noted that effective consultation requires true partnership, and involvement of communities in decision-making, not just “telling people what is going to happen”.

It was widely noted that adequate timeframes must be allocated for consultation processes. The importance of communities receiving timely feedback on the outcomes of the consultations, in terms of overall findings and recommendations, and any resulting action, was also emphasised.

It was also seen as important to make the issues relevant for Aboriginal and Torres Strait Islander communities. The sheer number of strategies was seen as a barrier to community involvement, as it is difficult to engage any group of people on so many different issues. It was considered important to place the strategies in a context meaningful to Aboriginal and Torres Strait Islander people, such as “building a better life for our kids”.

There was also said to be a need to ensure that all relevant sections of the community are included in the consultation process, including men, women, elders, and youth.

It was also identified as important that the people undertaking consultation processes should have a track record of a working with, and developing good relationships with, people from Aboriginal and Torres Strait Islander communities. Consultations led by people without this experience and insight could be inappropriate, intimidating, and unproductive.

Several participants also commented on the need to consult appropriately with urban Aboriginal and Torres Strait Islander people. Remote area issues are seen by some as dominating much of the thinking in Indigenous health, while urban issues are less attractive to governments, and urban Aboriginal and Torres Strait Islander people are seen as “hard to

⁵ Osborne, Richard, and Dick, Charlie, with contributions from other academic staff members (1994), “Aboriginal Terms of Reference (ATR) and its importance to the educative process”, Curtin University, Perth, WA. See also: Kickett, Darryl, with contributions from Scott Fatowna and other staff members (n.d.), “Aboriginal Terms of Reference: A paradigm for the future”, Centres for Aboriginal Studies, Curtin University of Technology, WA.

deal with". However, it was noted that urban communities also suffer enormous health disadvantage, and often have their own specific issues and problems, related to the impact of a longer period of colonisation and dispossession on their culture and well being. It was noted that Governments have a responsibility to consider the issues and needs of Aboriginal and Torres Strait Islander people from all geographical settings.

These stakeholder views provided in the consultation process could provide a useful starting point, along with relevant literature, for the development of national consultation protocols.

8.4 Limitations on the value of consultation processes

A few participants advised caution regarding over-reliance on consultation alone to guide action. It was argued that communities cannot be expected to know about or have the answers on every issue, particularly where technical expertise or epidemiological data is needed to guide public health action; and that governments and technical experts do have a role in providing advice and guidance. It was also noted that the absence of leadership from communities in identifying and demanding action on particular issues should not be an excuse for inaction, in situations where governments have epidemiological data to show that there is urgent unmet need. Delays in national action to address cervical cancer in Aboriginal and Torres Strait Islander communities were mentioned in this context.

One government participant commented that the obligation to consult should be at a reasonable level, and should not lead to governments "disowning" strategies:

There is now a paralysing level of community consultation in [this jurisdiction], and a concomitant abrogation of government decision-making. Strategies should be inclusive, but at the same time they need to be "owned" by the governments implementing them, after taking into account the range of community and other opinions.

8.5 Resource implications of consultation

A number of participants commented on the need for broad consultation, addressing the diversity of Aboriginal and Torres Strait Islander communities and viewpoints around Australia. It was also noted that "active" rather than "passive" consultation is needed. It is widely acknowledged that sending out documents for comment is not an effective way of consulting with Aboriginal and Torres Strait Islander communities.

However, it was also acknowledged that for each national strategy in its developmental phase to undertake comprehensive face-to-face national consultation processes with local communities across Australia would probably be prohibitively costly in terms of time and money, leaving few resources for implementation and service delivery. Extensive consultations on a range of different strategies which may or may not be implemented locally, at least in the short term, would also be unnecessarily burdensome for communities. As a realistic approach, it was suggested that consultation in the strategy development phase should largely be undertaken through the representative processes of peak Aboriginal and Torres Strait organisations, but that implementation plans should be sufficiently flexible to allow regional and local communities to provide input into decision making, and for their priorities to be addressed.

8.6 The use of existing planning data and consultation forums

It was widely suggested that there needs to be greater use of existing consultation findings and planning data. In particular, a number of participants suggested that data from the regional Aboriginal and Torres Strait Islander health plans should be utilised more widely in public health program planning. These plans are based on extensive community

consultation, and aim to articulate community priorities. Currently, they are used as an information source by OATSIH and possibly by State Aboriginal and Torres Strait Islander health units, but do not appear to have been made widely available to, or used by, mainstream program areas at either Commonwealth or State level.

Others saw some drawbacks to reliance on these plans for public health program planning, noting that issues such as substance misuse and renal failure, which are very visible and cause death and distress in communities, tend to be prioritised in the plans; whereas the plans pay less attention to underlying health determinants and to preventive action, or to “hidden” problems such as sexual health issues.

It was also widely suggested that the Aboriginal health partnership forums at State/Territory and regional level could be utilised more in informing, consulting, and negotiating with relevant players on national public health strategy development and implementation, including funding allocations.

8.7 Support for a regional approach to consultation and negotiation

Several participants suggested that it is very important to inform and consult with Aboriginal and Torres Strait Islander communities at the regional level on public health issues, as public health strategies are often most sensibly implemented at this level. There were also some suggestions for funding to be allocated at regional level, and negotiated between service providers in regional inter-sectoral forums. There were suggestions by some for regional workshops to be held on a regular basis to inform Aboriginal organisations of relevant developments in health policy and programs, and to seek feedback.

There are some structures in place in the ACCHS sector to support regional consultation, but they are far from comprehensive. In the Kimberley region of WA, there is an incorporated and resourced umbrella body for the ACCHS sector, which takes a key role in public health planning and advocacy for its member services. There is growing interest in the ACCHS sector in developing similar models. Six Western NSW ACCHSs have recently formed an incorporated umbrella body (“Bila Muuji”), and are seeking resourcing to carry out regional functions; and there is anecdotal evidence that other groupings are interested in following suit. The outlook for the movement towards regional resource bodies in Aboriginal and Torres Strait Islander health is unclear, as governments will no doubt need to consider and respond to the resource implications.

There are also some inter-sectoral structures established under the Aboriginal and Torres Strait Islander health partnerships which may provide a plank for regional consultation and planning on public health issues. These vary between jurisdictions, and the acceptability of these forums by all sectors may also vary. For example, in South Australia, regional inter-sectoral Aboriginal Health Advisory Councils (AHACs) have been established to promote Aboriginal community participation and advocacy in health. However, it was commented by some observers that while these forums are useful where there is no ACCHS, in areas where there is an ACCHS the community already feels it has a voice, and the AHACs may be resented and seen as superfluous.

9. Strategy development and implementation: the roles of governments and health departments

9.1 Government roles and responsibilities in public health

Participants noted that as in most areas of the health care system, the roles and responsibilities of Commonwealth and State/Territory governments and health departments in the public health arena are quite complex.

The Australian Constitution places responsibility for health care service delivery with the States, except in special circumstances. The Commonwealth therefore does not generally take a role in direct service provision, or in direct funding of service providers, but sees its role in terms of funding the States/Territories for public health activities, and providing national leadership in areas such as co-ordination, benchmarking, guidelines development, and monitoring and evaluation.

There are a few notable exceptions to this. Aboriginal and Torres Strait Islander health has been identified as a “special circumstance”, and the Commonwealth is a direct funder of service provision, with funding mainly being channelled to the Aboriginal community controlled health service sector. The Commonwealth also funds general practice through both Medicare (including blended payments) and the General Practice Program, and this funding is increasingly being directed to encourage public health activities undertaken by GPs and Divisions of General Practice. Direct short term funding is also provided by the Commonwealth for demonstration projects in public health, which are seen to link in with the Commonwealth’s role in promoting quality practice.

The role of the States and Territories brings them closer to communities and service providers. States and Territories are involved in direct provision of primary health care and public health services, as well as in liaison with and funding of other service providers. States and Territories engage in a range of public health activities including research, communicable diseases surveillance, population based approaches such as mass immunisation programs, infrastructure and environmental health programs, health promotion campaigns, and so on.

9.2 Commonwealth-State/Territory funding arrangements

Overall, it was widely acknowledged that there is no real logic to the overall amount of funding that is allocated to any particular national public health strategy. Allocations appear to be driven not so much by need or logic as by political considerations, including how much a government feels it can afford, whether there appears to be any potential for savings elsewhere in the health system as a consequence of the introduction of a strategy, the politics of Commonwealth-State/Territory relationships, and so on.

There was concern from service providers and Aboriginal peak bodies that strategy development processes, sometimes including community consultation, were generally undertaken prior to any guarantee of a funding allocation. This was seen as wasted effort, and as leading to community frustration if funding did not follow from consultations. These participants suggested that if an issue is identified as a priority, funding should be allocated prior to the development of implementation strategies through consultation and planning processes. In reflecting on national public health strategy development and implementation, one observer described Australia as “the home of the resource-free health strategy.”

However, some participants with policy development experience suggested that a predetermined funding level would constrain activities to the level of funds available, and could therefore end up being “unstrategic”.

It was recognised by many people in health departments that there does need to be more logic in the funding of public health strategies by Commonwealth and State/Territory governments, and better integrated effort within and between levels of government, to address the current situation where unco-ordinated and even conflicting strategies and funding programs are sometimes developed and implemented.

Many of the strategies are funded by both the Commonwealth and the States. Some Commonwealth funding is directed via the States and Territories, through the Public Health Outcomes Funding Agreement (PHOFA) process and specific purpose payments. The States and Territories generally also contribute their own funding to strategies, and make decisions about the allocation of public health strategy funding to their own agencies and to other service providers.

The move away from specific purpose payments towards “broad banding” of Commonwealth-to-State public health funding is viewed by participants from State and Territory departments as a positive move, allowing for greater flexibility to utilise funding in ways which best meet local needs. They view their departments as being in a better position to identify and meet areas of need, than the Commonwealth department.

There are some tensions around PHOFA funding. Commonwealth participants, along with Aboriginal peak bodies, expressed concerns about the lack of transparency in the PHOFA process. It was seen as very difficult to track State/Territory public health expenditure, and there was a concern that the system is open to cost-shifting by States/Territories.

On the other hand, several participants from State/Territory governments raised their own concerns about the process. There are concerns that some “national” strategies for which the Commonwealth is keen to take credit, come with little Commonwealth funding. There are also concerns that Commonwealth activity and partial funding forces State and Territories into a situation where they have no choice but to commit resources to the strategy: for example, in the immunisation area, the Commonwealth funds vaccines but the means for their delivery, other than through private GPs, are generally State/Territory funded. There are particular concerns about the provision of short-term funding by the Commonwealth, either via the State or direct to service providers. In both cases, programs are developed which raise community expectations, and when the short-term Commonwealth funding commitment ends, there are expectations on the State/Territory to pick up the funding responsibility.

However, State and Territory government participants greatly prefer the PHOFA funding arrangements to specific purpose payments, which are seen as administratively difficult for both levels of government. It was noted that where such arrangements still operate, they can be very problematic. An example given in one jurisdiction was the negotiation of funding arrangements between the two levels of government to auspice community organisations to work in the alcohol and other drugs area. Inter-governmental funding agreements and contracts have taken over twelve months to negotiate, due to disagreements over issues such as liability and indemnity. This has greatly delayed the process of resources getting to the community organisations, so that programs can be delivered to communities. Untied funding is seen as a much better option.

9.3 Service provider views on inter-governmental funding arrangements

Aboriginal community organisations expressed frustration at the lack of transparency in the public health funding arrangements. Several Aboriginal organisations stated that they have been unable to access information about the extent and purpose of the public health resources which are being channelled through mainstream organisations. From the community level, it is unclear what funding has been provided by either the Commonwealth or the State, and to whom; and what responsibilities governments and service providers have for addressing Aboriginal needs.

At service provider level, both Aboriginal organisations and State/Territory agencies were often unable to readily identify whether their specific programs were funded under the national

strategies. Where one-off grant funding had been accessed, it was more likely (but not certain) that service providers were aware of the source; but the source of ongoing program funding was less likely to be readily identifiable.

There is also seen to be a culture of “buck-passing” between levels of government on key public health priorities for Aboriginal communities. Two which were singled out for comment by several participants were environmental health and oral health.

Oral health has consistently been identified as a high priority by Aboriginal and Torres Strait Islander communities. It is well documented that the Commonwealth’s withdrawal from dental health service funding has had a major detrimental impact on disadvantaged groups who cannot afford private dental services, and that State and Territory governments have failed to adequately fill the gap⁶. The oral health status of Aboriginal and Torres Strait Islander people is extremely poor, and the prevalence of rheumatic heart disease and diabetes makes the need for adequate oral health care critical. Due to lack of agreement between levels of government regarding roles and responsibilities in this area, there has been little progress towards a national strategic approach.

Environmental health was nominated by several participants as an area in which the Commonwealth has led the development of a national strategy, but has failed to provide funding for its implementation. Again, there are disagreements between levels of government, and between departments, over funding responsibilities. The following example, provided by a State-funded regional organisation, illustrates the consequences.

This organisation participates in a very successful Environmental Health Worker training program, by providing training and support at community level. The program helps to develop and keep skills in the community. EHWs play a very important role in the region, particularly in areas such as food and water safety, monitoring of pump stations and rubbish tips, dog control, mosquito and rat control, health education in schools, etc.

The major problem facing the program is lack of funding for EHW positions. Many EHWs are working on CDEP, some with top-up, but this is inadequate given their qualifications and competence. A recognised award, backed up with adequate position funding, is needed. EHWs are being lost to other non-health sectors – several well trained EHWs have recently been lost due to lack of funding, which is very demoralising, and threatens the whole program.

Commonwealth, State, and local government, and ATSIC, cannot agree whose responsibility it is to fund EHWs. The Commonwealth claims it is a State government responsibility. Local government falls under the auspices of the State, and the State claims that it funds local governments to a reasonable level and that it is up to them to decide on their spending priorities. Indigenous community councils lack a rate base and are totally dependent on limited grant funding, and tend to prioritise tangible capital improvements and health hardware over EHW positions. Intensive efforts to identify a funding source for EHWs in the region have not so far been productive.

Only a very modest amount of funding is required to address this problem across the whole State. The lack of funding is the only problem with the EHW program – everything else is working very well: accredited training, employment creation, community support, health impact, etc. The National Environmental Health Strategy is not proving effective in getting funding where it is needed, for programs such as the EHW program which have an impact at community level.

Examples such as this indicate a need for greater clarity about the funding responsibilities between levels of government, and between departments.

⁶ Report of the Senate Inquiry into Public Dental Services.

9.4 State and Territory reporting requirements in Aboriginal and Torres Strait Islander health

Some participants from peak Aboriginal organisations and from the Commonwealth outlined their concerns about the lack of leverage the Commonwealth has to ensure that the States/Territories address specific areas such as Aboriginal and Torres Strait Islander health.

Performance indicators included in the PHOFA process

States and Territories are currently required to report back to the Commonwealth under the PHOFAs for their PHOFA-funded efforts in Aboriginal and Torres Strait Islander health. The PHOFAs include some performance indicators in this area, based on a set of National Performance Indicators for Aboriginal and Torres Strait Islander Health developed under the auspices of the Heads of Aboriginal Health Units (HAHU) in each government, and endorsed through the AHMAC process.

However, it was commented that several jurisdictions are currently unable to report on several of these indicators, due to lack of good identified data. It was also noted that funding agreements such as the PHOFAs (and the Australian Health Care Agreements) are “blunt instruments” in terms of the Commonwealth’s ability to hold jurisdictions accountable on specific non-core issues. In reality, it would seem that the Commonwealth is highly unlikely to withhold PHOFA funding on the basis of jurisdictions failing to meet any or all of the performance indicators in Aboriginal and Torres Strait Islander health. This, along with the fact that much State and Territory effort in public health is self-funded, not PHOFA-funded, limits the value of the PHOFA reporting process in influencing States and Territories to increase their focus on Aboriginal and Torres Strait Islander health, within their public health programs.

Suggestions for annual reports by the NPHP

Given the limitations on the PHOFA reporting process, there were some suggestions about alternative ways of increasing focus on, and accountability about, efforts by jurisdictions to address Aboriginal and Torres Strait Islander public health needs.

It was suggested that annual reporting, and publication and promotion by the NPHP, of a document detailing the concrete contributions made by each of the national strategies to Aboriginal and Torres Strait Islander public health. Such reports could include a greater level of detail than the reporting under the PHOFAs. This process could be co-ordinated by the Chair of National Strategies. The UNICEF annual report on the state of children was suggested by one participant as a good model for such a report.

This suggestion was supported by some participants, but not by others. There were comments from some that reporting processes of this nature do not generally lead to increased commitment and effort in addressing the issues and needs, but lead instead to wasted effort on burdensome reporting processes, and to “fudging” of figures (as has allegedly occurred in some cases in relation to jurisdictional reporting against the National Performance Indicators for Aboriginal and Torres Strait Islander Health). There was also a feeling from some that such reports are generally produced with a focus on “making governments look good”, rather than giving and honest appraisal of what is happening on the ground.

On the other hand, greater reporting requirements were seen by some participants as a key means of improving focus and effort. It was noted by one participant that the focus on the issue of Aboriginal deaths in custody had led to enormous pressure on the prison system to account for any such deaths, and consequently a concern by prison staff to ensure they did not occur. It was suggested that a similar approach of heavy accountability could be taken in the public health area, to ensure that Aboriginal access to mainstream services is improved. Others, however, felt that “heavy-handed” approaches do not lead to genuine commitment and effort, and should not be recommended.

It was also pointed out that in many cases, data systems do not support detailed reporting of access to programs by Aboriginal and Torres Strait Islander people, and that a significant investment of resources would be required to bring systems and human resources up to a level of capacity to provide robust data.

Several of those who supported the idea of annual reporting emphasised that the framework should be supportive rather than punitive, as this was more likely to achieve frank reporting and genuine efforts to improve performance.

It is suggested that there needs to be further consultation and debate on the potential to develop an annual report under the auspices of the NPHP, on efforts across the nation to address the public health needs of Aboriginal and Torres Strait Islander people.

9.5 Departmental issues

The issue of expertise within departments

Aboriginal organisations expressed strong views about the inappropriateness of policies and programs being driven by bureaucrats rather than by the community. There is a widespread feeling that non-Indigenous departmental staff have little insight into the issues, because “most of them have never lived in an Aboriginal family or community”, and because many also lack experience in health service delivery.

It was commented that the Commonwealth, by its own definition, does not have a major role in the implementation of public health strategies, and that national strategy development processes led by the Commonwealth consequently pay inadequate attention to implementation issues.

There were many comments from participants from both State/Territory governments and from Aboriginal organisations, about what is seen as the excessive movement of staff within the Commonwealth Department of Health and Aged Care. This was seen as working against the development of subject matter expertise, and against the development of productive working relationships with communities, service providers, and other departments.

It was also commented by several participants from State/Territory health departments that there is a need for the Commonwealth department to value and develop subject matter expertise in its management and staff, in both public health and Aboriginal and Torres Strait Islander health, rather than taking a “content-free” approach as it was described by one participant.

Several participants from State/Territory Offices of DHAC felt that they have greater insight into service provision issues than do Canberra-based Central Office staff, and that there is a need for their experience and expertise to be better utilised in policy development and program planning. It was suggested that State/Territory Office staff have a greater focus on the needs of local communities, and on how to utilise available programs to meet those needs. Some of these staff also suggested that they could play a greater role in negotiating with State and Territory governments and monitoring their efforts in the public health area, as they have considerable knowledge of and insight into State/Territory activities.

Making mainstream areas more aware of Aboriginal and Torres Strait Islander needs

Participants from both Commonwealth and State/Territory departments indicated that there is a need for improved liaison and communication between mainstream population health/health program areas, and Aboriginal and Torres Strait Islander health areas, within departments. One consequence of the separation of responsibilities is that mainstream program areas are often not aware of key structural and policy issues, such as the potential to utilise the regional Aboriginal health plans and the State/Territory Aboriginal health forums in public health planning. It was also queried whether the potential to utilise strategic research (such as that

undertaken through the NH&MRC) as the basis for national public health strategy development, was being met.

It was also commented that the location of Indigenous-specific programs within Indigenous-specific areas of departments contributes to a “deskilling” of mainstream health areas in relation to Aboriginal health issues. It was noted that in several of the health departments, most or all of the Aboriginal and Torres Strait Islander staff work in Indigenous-specific program areas, and that this also reduced the ability of mainstream areas to take culturally appropriate approaches to Aboriginal and Torres Strait Islander issues. As one departmental participant commented:

Mainstream public health areas in health departments need to include teams of Aboriginal staff to ensure that the mainstream strategies do address Aboriginal needs. Having such staff in place would also help to educate other staff about Aboriginal issues, and would encourage Aboriginal organisations to apply for mainstream funds. It is problematic that most Aboriginal people in health departments work in Aboriginal-specific areas - Aboriginal people need to be intrinsically involved in mainstream health programs to achieve equity across the board.

It was also suggested that the “gatekeeper” role of Indigenous-specific program areas in departments needs to be carefully monitored to ensure that it leads to positives such as better co-ordinated effort in meeting community needs, rather than to negatives such as “ownership” of issues by the Indigenous-specific areas which could lead to either abrogation of responsibility by other program areas, or bureaucratic obstacles to action by other program areas.

Limitations on departmental staff resources

Many departmental staff also expressed a feeling of being over-stretched and overwhelmed by the demands on their time, in a context of multiplying responsibilities, and limited staff resources to implement new programs. This was a particular issue of staff in small State/Territories, where numbers were very limited and a small number of people were responsible for a large number of programs.

This issue needs to be seriously considered, in balance with the concern raised by many participants of the need for more resources from public health strategies to “hit the ground”, rather than being eaten up in bureaucratic processes. It is possible that an approach involving fewer separate strategies and programs could reduce the demands on departmental staff, whilst also allowing more resources to flow into service delivery.

10. Strategy implementation: roles and relationships of key service providers

There are three main sectors providing primary health care and public health services to Aboriginal and Torres Strait Islander peoples:

1. The Aboriginal community controlled health service sector.
2. State and Territory government funded and operated services.
3. General practitioners in private practice.

There are other relevant service providers, including ATSIC and local government, who are key players in environmental health programs; non-government organisations such as Diabetes Australia which are active in specific program areas; and some other specialist and allied health service providers who may deliver services outside of the above structures. However, this discussion will focus on the three major sectors listed above.

10.1 Roles of the major service provider sectors

*The Aboriginal community controlled health service sector*⁷

There are about one hundred ACCHSs operating in urban, rural and remote areas throughout Australia. The sector plays a considerable role in primary health care service delivery to Aboriginal and Torres Strait Islander peoples, with over one million occasions of service being delivered by these services in the 1999-2000 financial year. However, there are major gaps in coverage: many towns and communities with significant Aboriginal populations, and some quite large geographical areas such as the Cape York peninsula, lack an Aboriginal community controlled primary health care service.

There is considerable diversity within the sector, with vast differences in the levels of infrastructure and staffing, and consequently in the range of services offered. Large services with several medical practitioners and other health staff operate in the capital cities and several regional and remote centres; major devolved services operate in the central and western desert regions; and there are small services in some rural towns, some of which lack the services of a full time medical practitioner. The services on offer vary: the larger services offer a comprehensive range of clinical and public health programs, while some of the smaller services may concentrate on health promotion, liaison and advocacy, rather than clinical work.

The common and distinguishing factor with the services, is that they are governed by boards of management elected from the local Aboriginal and Torres Strait Islander community. The Boards oversee the policy and operations of the service, and appoint management staff. Around 70% of staff in the ACCHS sector are Aboriginal and Torres Strait Islander people, and Aboriginal Health Workers form a core component of the staff. This is a critical difference from other service providers, as many community people see the involvement of Aboriginal and Torres Strait Islander staff in service delivery as the single most important element in making a service accessible and appropriate. The services also operate within a holistic concept of health, and aim to provide comprehensive primary health care and public health programs within a multidisciplinary team approach. In practice, their ability to do so is often limited by resource constraints.

The services are funded through a variety of means. Most receive their core funding from the Commonwealth Department of Health and Aged Care, through OATSIH. This core funding is historically based and does not reflect population or need. The core funding may be

⁷ Statistical information in this section is drawn from DHAC/NACCHO Service Activity Reporting data.

supplemented by income from other sources such as specific purpose grants from OATSIH and other areas of DHAC, including grants under some of the national public health strategies; a range of grants from State/Territory governments; some ATSIC grants, though these are reducing; income from Medicare, as ACCHSs have the same rights as other general practices to access Medicare; a small amount of Commonwealth GP program funding (eg Practice Incentives Program funding); and some services also receive funding from other sources such as private and corporate donations.

It is generally acknowledged that the ACCHS sector is under-resourced to meet the primary health care needs of Aboriginal and Torres Strait Islander people across Australia.

State and Territory services

Each jurisdiction has its own structure and priorities for service provision to Aboriginal and Torres Strait Islander communities, reflecting differing demographics and perspectives. Some jurisdictions, especially those with large identifiable Aboriginal and/or Torres Strait Islander communities which have very clear primary health care and public health needs, identify Aboriginal and Torres Strait Islander health as a high priority in community health and public health program development and service delivery.

For example, in the NT, where around 30% of the population, and an even higher proportion of children, are Aboriginal, all health programs have Aboriginal health as a top priority. Queensland and WA also have large identifiable Aboriginal and/or Torres Strait Islander communities, and State agencies such as Queensland Health's Tropical Public Health Unit, and WA's Kimberley Public Health Unit, have a strong focus on Indigenous public health. Other jurisdictions have a varying focus on Aboriginal health and on public health generally. For example, in Tasmania, the Aboriginal population is small and dispersed, and there is consequently little specific targeting of Aboriginal people through community health and public health programs.

Most jurisdictions operate a network of community health centres, based either at hospitals or in other locations in the community. Some of these are in areas with high Aboriginal and/or Torres Strait Islander populations, and in some cases these services may take a largely Indigenous-oriented focus, and some may be significant service providers to Aboriginal and Torres Strait Islander communities. In some jurisdictions, State/Territory governments also provide outreach services (generally resident community nurses and/or AHWs⁸, and visiting doctors) to remote communities.

These community health networks are generally administered separately from the public health unit networks, with the latter taking a focus on research, preventive programs, and surveillance, in liaison with service delivery agencies.

The service delivery model for State/Territory community health services in predominantly Aboriginal and Torres Strait Islander communities differs significantly from the ACCHS model. Key differences include that the State/Territory services are not community controlled (though there may be some community participation in the management of some services); they generally have far lower proportions of Aboriginal and Torres Strait Islander staff, including AHWs; and their philosophy and approach differs in many other respects. One manager in the State service sector commented that the State community health services have a greater focus on working to outputs, due to drivers for efficiency in the State system; but this could actually work against providing a culturally appropriate service, which may involve longer consultations and lower throughput, amongst other things.

Private general practitioners and Divisions of General Practice

Statistically, GPs in private practice are significant providers of primary health care to Aboriginal and Torres Strait Islander people across Australia, and in this context have a role

⁸ The term "AHW" is used in this paper as shorthand for Aboriginal and Torres Strait Islander Health Workers.

in providing services which are relevant to the national public health strategies (eg immunisation, cervical and breast cancer screening, communicable diseases surveillance, and so on).

Private general practice is increasingly being brought into the organised approach to population health, but this process is still in its early stage of development. It was commented by a GP participant that although GPs have a high degree of expertise on relevant issues, their high caseloads, the many demands on their time, and their individualistic approaches to health care delivery, make their role in national public health strategies quite limited.

The process of greater GP involvement is being promoted by Commonwealth government policy, which is supporting and resourcing an increasing public health role for Divisions of General Practice, and at practice level is providing an increasing range of financial incentives for GPs to focus their efforts on population health activities such as immunisation, cervical screening, and annual health assessments.

There is little good data on the level of access to private GPs by Aboriginal and Torres Strait Islander people, as Indigenous status is not identified in the Medicare database. Extrapolations from the 1998 and 1999 BEACH data lead to an estimate of over 1.2 million GP consultations per year with Aboriginal and Torres Strait Islander clients. However, the role of GPs in private practice in focusing on Aboriginal health should not be over-stated. While nearly 90% of ACCHS clients are Aboriginal or Torres Strait Islander, Indigenous consultations account for only about 1% of encounters with GPs generally. This means that the majority of GPs in private practice probably never see an Aboriginal or Torres Strait Islander client, while fewer than 5% of GPs have more than 5% of their encounters with Aboriginal and Torres Strait Islander clients⁹.

Given the extreme economic and social disadvantage of Aboriginal and Torres Strait Islander people, and locational issues, key factors affecting the level of access to private GPs are the location of GPs (that is, there are few in remote areas), the attitudes and approach of the GP/practice to Aboriginal and Torres Strait Islander people, and whether the practice bulk bills.

Participants in the consultations indicated that these factors vary considerably between locations. While the measures to increase the numbers of GPs in rural and remote areas are making some impact, the numbers are still limited, and initiatives which rely on GPs being "at the centre of primary health care" are generally irrelevant and ineffective in these settings.

In relation to the cultural and clinical appropriateness of GPs services to Aboriginal patients, the consultations pointed to both positive and negative experiences. To some extent, these issues are being addressed through training initiatives developed by the RACGP in conjunction with Indigenous organisations.

The continuing reduction in the proportion of practices which bulk bill, especially in rural areas, along with the low numbers of private GPs operating in remote and many rural areas, are key factors limiting access by Aboriginal and Torres Strait Islander people to primary health care and public health services delivered through private general practice.

With regard to the Divisions of General Practice Program, the Department of Health and Aged Care advises that funding for this program totals approximately \$90 million per annum. The Divisions program is still in the relatively early stages of development, and there is a great deal of diversity between Divisions. The membership numbers and budgets of Divisions vary greatly, and consequently their role and capacity also varies. The urban, rural and remote settings and population needs are also variable, and Aboriginal people are a more prominent target group for Divisions in rural and remote areas.

⁹ NACCHO (February 2001), "National network for GPs in Aboriginal and Torres Strait Islander health: Background paper".

Probably around 70% of Divisions have targeted Aboriginal and Torres Strait Islander health in their strategic/business plans. The Innovations Funding Pool is a small grants program which has funded approximately 80 innovative projects by Divisions over the past few years, and about 10% of these related directly to Indigenous health.

Divisions are seen by the Department as a developing the infrastructure and networks through which sustainable public health programs will be rolled out, and most new public health initiatives are likely to involve Divisions. There have already been several Commonwealth-led initiatives to give Divisions a greater role in public health approaches, and to foster a greater involvement with other professionals, such as allied health professionals (for example, nurses, diabetes educators, and so on) and pharmacists.

10.2 Relationships between service providers

The importance of good inter-agency relationships

The working relationships between service providers were identified in the consultations as a key factor in the successful implementation of public health strategies and programs. The value of public health efforts was seen to be maximised where there is clearly agreed role delineation, and collaborative working relationships between local and regional agencies. Good relationships promote integrated service provision to the community, and avoid duplication of services. Effective communication processes within and across sectors were seen as valuable in promoting co-ordination, ownership, and cohesive action.

Predictably, relationships between the major service provider sectors vary considerably across regions, and over time.

The historical context

Several participants commented on the need to take the historical context of racism and dispossession into account in considering present day inter-sectoral relationships. For example, forced resettlement of communities onto missions and government settlements, and forced removal of children, in many cases strongly affects communities' views of governments, government services, and government employees into the present day. One Aboriginal participant commented that:

...the current difficult relationships between the government and the Aboriginal community controlled health sector is rooted in Australia's race relations history. There is a great deal of mistrust on both sides, and a lot of pain remaining amongst Aboriginal people. To move forward, compromise and willingness to change is needed from both sides.

These historical relationships also affect local consultation and planning processes around the implementation of public health strategies. In the words of another participant:

Aboriginal communities are generally not included or involved in the planning process for local initiatives. Where community people are present at local meetings, they can't get their voice heard, because their views are not considered important – 'there are no votes in it'. There is also an assumption that Aboriginal people don't have the ability to understand the big picture, so there is a patronising process whereby they are given a small slice of the funding and told to go away and use it as they see fit ("keep quiet money"). These processes have bred hostility within Aboriginal organisations towards government. Many organisations are simply unwilling to be involved in planning processes or to apply for grants, as it is not considered to be worth the grief.

Since the emergence of ACCHSs beginning in the early 1970s, there have been tensions between these services and State/Territory governments. State/Territory service provision to Aboriginal communities was established in most places prior to the emergence of the ACCHS

movement; and in this context the development of the ACCHS sector, based on Commonwealth support and funding, could be interpreted as an indication that State/Territory providers were not meeting community needs. It is probably also fair to say that some State/Territory providers have felt threatened by the politics and rhetoric of Aboriginal self-determination and community control. There has therefore historically been competition between the sectors for legitimacy, for clients, and for funding.

Positive examples

In many areas, the relationship has moved forward, and there is close collaboration and good working relationships at manager and program levels between the sectors.

One of the positive examples is Townsville in northern Queensland, where the State-funded services and the ACCHS agreed that they take a collaborative approach to meeting the health needs of the local community. Several joint programs are delivered between the State and ACCHS sector, in areas including antenatal shared care, sexual health, tobacco and other drugs, dental care, and hearing health. The success in developing joint programs was said to be a function of the positive attitudes of key individuals from each service. It was said that each organisation recognised that they could not meet all of the community needs on their own, and that there was a need to combine their approaches to achieve the best outcome for the community, and to take an “open book” approach to sharing information about their programs. While there is a formal “Framework for Action” between the agencies, which is a kind of local level partnership agreement, the role of specific individuals is still seen as the key to the positive relationship.

There were several examples in the consultations where mainstream service delivery agencies provide their staff resources to deliver a service in the ACCHS setting. There is anecdotal evidence that such arrangements are widespread across Australia, and are seen by those involved as a very good model for collaboration. It was widely observed that Aboriginal community people are generally far more likely to access programs which are delivered in an Aboriginal-oriented setting, than from a mainstream setting. It is suggested that where national strategies involve the allocation of funds to mainstream service providers, there is encouragement of these kinds of arrangements as a means of addressing Aboriginal and Torres Strait Islander health needs.

Problem areas

In other areas, difficulties remain. The problem areas generally seem to relate to demarcation of roles and responsibilities, and competition for resources and even for patients, which is unfortunate given the overall limited and inadequate resourcing for Aboriginal and Torres Strait Islander primary health care. There were also said to be problems in some areas which relate back to personal conflicts and power struggles between particular individuals.

In the consultations, some ACCHSs expressed anger about “mainstream services” (a generic term often used in the ACCHS sector to describe non-Aboriginal service providers organisations, particularly State/Territory services, but sometimes also other organisations such as general practices and Divisions) accessing funding to provide services to Aboriginal and Torres Strait Islander communities. These ACCHSs described a history of institutionalised racism, and inadequate and inappropriate service provision by mainstream services. These ACCHSs believe that their own community controlled organisations are the only appropriate service providers for their communities, and that all funding aimed at Aboriginal and Torres Strait Islander health should be directed to ACCHSs. It is argued by these organisations that they should not have to compete against mainstream organisations for these funds.

State/Territory service providers are often aware of this viewpoint, but argue that the reality is that there is a range of service providers on the ground, each of which has a role to play and has legitimate claims to funding. They feel that the ACCHS sector alone cannot meet all of the needs of all communities, and that community choice of service providers needs to be considered and supported.

There was concern stated from some ACCHSs that in some cases mainstream services (including Divisions) sought endorsement from ACCHSs for funding proposals for Aboriginal-oriented projects and programs, but that once funding was provided, there was no further attempt to involve the ACCHS.

There were comments from Aboriginal organisations and from some other participants, that there needs to be real effort from mainstream service providers to develop cultural competence and take an approach based on cultural security.

There were comments about the problems which arise when mainstream organisations such as State community health clinics or public health units undertake activities such as screening programs, which duplicate and undermine holistic programs already being provided by the ACCHS for the same population. It was suggested that there is a need for all parties to recognise the concept of the “practice population”, and to reach agreement on which agency has the role of primary health carer.

Some mainstream organisations referred to the high transaction costs of building relationships and working collaboratively with Aboriginal and Torres Strait Islander communities and organisations at local level. A great deal of time and effort is often required to properly inform and consult with Indigenous organisations, and it was observed that in some cases, mainstream organisations become frustrated and give up on their efforts.

Compounding the difficulties, many community health services face problems of high professional staff turnover, particularly in rural and remote areas. This is a barrier to the establishment of productive working relationships; it is also a significant burden for Aboriginal and Torres Strait Islander staff who have to reorientate a succession of new staff.

It was also noted that service providers in community health are often overwhelmed with the demands on their time, and in this context, it can be difficult for staff in mainstream organisations to pause, and work proactively on relationship building and on improving Aboriginal and Torres Strait Islander access to their already stretched services. Funding levels and performance measures are often linked to client throughput, and this does not encourage health service staff to “take time out” to work on Indigenous access issues. As one mainstream service commented:

It is acknowledged that [our service] needs to focus more on Aboriginal health, and that access by Aboriginal people to our programs is not optimal. The difficulty is that many [of our] programs are overwhelmed by demand from non-Aboriginal people, and in this context, it is difficult to stop and concentrate on increasing demand from and access by Aboriginal people to their services. To increase Aboriginal access requires investing time in relationship building with the community, not just in service delivery, and this is a challenge when resources are stretched and funding is linked to client contacts. High staff turnover in the service also affects the ability to take a proactive approach to relationship building.

In some cases, there is good inter-sectoral relationships at management level, with signing of documents such Memoranda of Understanding, and with regular management meetings, but little collaboration at worker level. Participants noted that to achieve good service integration, it is necessary for those involved hands-on in service delivery to be meeting regularly and discussing joint approaches.

It was clear from the consultations that competitive grants processes serve to heighten competition between agencies, rather than promoting collaboration. It was suggested that funding programs need to provide incentives for agencies to work together. There have been some recent funding programs where efforts have been made to develop local partnerships and channel funding through these partnerships. Examples provided by participants include the implementation of the Regional Health Services Program in Queensland, the Primary Care Partnerships in Victoria, and the Aboriginal Vascular Health Program in NSW. It is

suggested that these and other relevant approaches should be evaluated to see whether and how they might provide models for future funding structures which promote collaboration.

Relationships with private general practice and Divisions

Relationships between ACCHSs and GPs in private practice appear to be quite variable. In many cases, there appears to be little relationship or communication at all, and in a few cases there can be a hostile relationship, especially where there are feelings of competition for clients or for legitimacy. There are some areas where there is a more positive role between Aboriginal organisations, and private GPs and Divisions. In several local areas, Aboriginal and Torres Strait Islander people do have reasonable access to private GPs, particularly where the GPs bulk bill, and even more particularly where the GPs have a history of working with the ACCHS, or continue to do sessional work for the ACCHS, and are therefore known to the community.

Several participants in the consultations commented that there is little systematic work at Divisional level to address Aboriginal health, and little involvement by GPs in an organised public health approach, including preventive care, particularly in relation to Aboriginal and Torres Strait Islander communities.

These participants felt that the current Commonwealth focus on developing the role of Divisions and private general practices in primary health care and public health, is unlikely to prove effective in targetting the needs of Aboriginal and Torres Strait Islander peoples.

Several Aboriginal organisations, and some State service providers, expressed serious concerns about the Federal Government's agenda to develop a greater role for GPs in public health, by providing resources through Divisions. Service providers from these sectors have often been working in the community for many years, and generally find it very difficult to access additional resources for public health activities. There is some resentment at the level of resources being channelled through Divisions for public health activities, as it is seen that the majority of GPs and Divisions have shown little interest or involvement in Aboriginal and Torres Strait Islander primary health care or public health, and that the resources could be more appropriately utilised by service providers who have a track record in, and commitment to, this work. Concerns were also raised that Divisions receive additional weighted funding for the proportion of Aboriginal and Torres Strait Islander people in their catchment area, regardless of their efforts to meet the needs of these communities.

A positive example of Divisional work in Indigenous public health mentioned by participants was in Central Australia, where the Division has evolved to become a "Division of Primary Health Care". The Division includes doctors from the ACCHS sector and the Territory government sector, as well as private GPs; and also includes other health professionals and community representatives in its management. In the words of one participant:

The Central Australian Division of Primary Health Care is seen as a positive model for the future of GP Divisions, with not only GPs, but a range of health care professionals and community representatives participating. This is helping to reorient GPs to a primary health care/public health approach, and is promoting joint work between different sectors. The Division is taking a major public health role in the region, and is supporting community action.

Several participants commented on the need for more Divisions to take the lead of Central Australian Division and develop to become Divisions of Primary Health Care. It appears that the Government is not opposed to the concept, but intends to leave it up to GPs in Divisions to decide on their own directions in this respect.

The lack-of-fit of the Division model is particularly apparent in some areas. One remote region with a large Aboriginal population has a Division comprising the salaried medical officers from hospitals and ACCHSs, with only a single private practice. This group of doctors is effectively the new regional planning structure for an increasing volume of Commonwealth

primary care and public health investment, operating outside of established regional planning processes.

Another concern raised by participants, discussed further below, was the emerging role of Divisions as employers of allied health and other health professionals, which can create a drain on the local health workforce.

Success factors

Overall, it was difficult to identify structural success factors in the development of good inter-agency relationships. There was a widespread view amongst participants that the successful relationships depended on a positive and empathic approach by key people from each agency. Personality factors were seen as very important in achieving shared vision and commitment, mutual respect, and valuing of one another's role and expertise. These positive relationships were sometimes backed up with formal inter-agency agreements and vision statements, but these documents were seen as a product rather than the cause of the good relationship.

It was commented that this dependence on key individuals to promote partnership means that the partnerships are rather fragile, and could be lost if there is staff turnover and the key people move on.

This indicates that rather than promoting the development of such documents, national public health strategies should seek to promote and reward positive inter-agency relationships through implementation plans and funding structures.

It was also noted that fostering positive inter-agency working relationships takes time – it does not happen overnight. While short cultural awareness training programs can fill some gaps, their usefulness is generally limited, and a longer term investment of time and effort is needed to build partnerships.

11. Strategy implementation: funding issues at regional/local service provision level

11.1 The funding context

As noted above, many of the national public health strategies are funded by both the Commonwealth and the States/Territories. Some Commonwealth funding is directed via the States and Territories, through the PHOFA process and specific purpose payments. The jurisdictions often also contribute their own funding to strategies, and make decisions about the allocation of public health strategy funding to their own agencies and to other service providers.

In general, the Commonwealth is not a direct funder of health service provision. A striking exception to this rule is the Aboriginal and Torres Strait Islander Health Program administered by OATSIH, which directly funds a large number of health and substance misuse services, the bulk of which are Aboriginal community controlled services.

As well as administering core funding for these agencies, OATSIH also administers a growing number of specific purpose grants. Some of these funding programs (eg the OATSIH eye health program) are sourced from the Aboriginal and Torres Strait Islander Health Program budget; others come from other sources – eg there are Stolen Generations Counsellors funded as part of the Government's response to the *Bringing Them Home* report.

Some Commonwealth funding related to the national public health strategies has been quarantined and diverted directly to OATSIH for administration, to address Aboriginal and Torres Strait Islander health needs. This includes funding from the National Mental Health Policy, diverted to fund the Emotional and Social Well-Being program administered by OATSIH; and funding from the National HIV/AIDS Strategy, which is administered by OATSIH as the National Indigenous Australians' Sexual Health Strategy.

The Commonwealth Department of Health and Aged Care, through its Population Health Division (PHD), also operates grants programs under several of the national public health strategies. In line with the Commonwealth's position of not funding recurrent health service delivery, these are generally one-off grants for demonstration or pilot projects. In consultation with OATSIH, PHD is also increasingly quarantining a proportion of this grant funding to direct to projects addressing Aboriginal and Torres Strait Islander health, whilst also not excluding access to the remainder of funding for Indigenous health projects.

Several recent grants processes, including funding rounds under the National Child Nutrition Strategy, the National Youth Suicide Prevention Strategy, and the National Illicit Drug Strategy, have been accessed by service providers in Aboriginal and Torres Strait Islander health.

11.2 Problems with current national public health strategy funding programs

Nearly all participants in the consultations made strong comments about the failure of current funding programs under the national public health strategies to meet Aboriginal and Torres Strait Islander public health needs. There was a particular focus on the inappropriateness of short-term submission-driven funding approaches, in addressing Aboriginal and Torres Strait Islander health. The problems described by participants are multiple and inter-related, and include:

Available funding does not meet service delivery needs

The level and purpose of the grants made available under these programs often bear little relevance to service delivery realities. In several cases, participants spoke of an apparently random amount being made available at State/Territory level, and then divided as equally as possible between service providers, with no account being taken of the need of the community or the actual costs of delivering a service. For example, in one jurisdiction each Aboriginal health organisation was to receive \$20,000 from the injury prevention strategy, but this amount was seen as insufficient for any community to implement a useful and sustainable program.

In other cases, funding is only available for staffing positions, and not for the infrastructure and administrative support (office space, vehicle costs, and so on), required to actually deliver a program. Small services with no “spare” infrastructure have great difficulty accessing such programs. A key example was the Regional Health Services Program, which targets funding for innovative primary health care and public health services to communities of less than 5,000 people. The program has in many respects been well targeted, but a major problem is that it does not include funding for infrastructure, which is exactly what many small communities need as a prerequisite for delivering new programs.

Specific purpose funding works against the provision of integrated programs in response to community needs

Service providers frequently access short term grants as the only available means of funding important primary health care and public health programs. The provision of grant funding for very specific purposes can drive service delivery in directions which do not meet community priorities and needs.

For example, there can be a focus on a specific disease issue for which funding is available, at the expense of other health issues of equal or greater importance, for which funding is not available. There can also be a requirement to take a “body parts” approach rather than a holistic approach; for example, the community may need a holistic women’s health program, but funding may be available only for cervical screening. Funding may be available only for specific activities within a health issue, which may not be the community priority. For example, one community had a high need for a residential rehabilitation program for illicit drug users, and wished to access National Illicit Drug Strategy funding for this purpose, but found they were only able to access funds for a project officer. Other services received funding under the National Diabetes Strategy for DCA 2000 machines, but said that they would have found funding for other purposes such as diabetes education more useful.

Nutrition in remote Aboriginal and Torres Strait Islander communities was widely commented on as a key issue which requires very broad attention, and resourcing effort on several fronts. Poor nutrition has been identified as a major risk factor for many chronic diseases, and it has been shown that even small improvements in Aboriginal and Torres Strait Islander nutrition can make a large impact on health outcomes. It was seen to be futile to concentrate resources on community education about healthy eating, if the need for an adequate supply of affordable healthy food is not addressed. This requires action both within and outside the health portfolio, encompassing infrastructure, transport, economic development, and so on. Narrowly focused funding programs are not addressing such issues effectively.

No funding available for broadly based healthy living programs

There appear to be no recurrent allocations in the health portfolio for truly innovative preventive health approaches which are widely supported in Aboriginal communities, particularly community camps and sport and recreation programs, which are seen as a key means of addressing youth and other community health and well-being issues. One Aboriginal community controlled health service made the following comments, which are typical of the experiences of many other organisations.

There is a great unmet need here for a men's health program. This service takes men on camps, with about 25 men attending the most recent. This takes men away from alcohol, and allows them to focus on healthy living and cultural matters. The camps are quite expensive to run, and this service funds them from our general budget, as there are no specific program funds for this area. This can be problematic when we report back to the funding bodies, as the performance indicators for our core funding don't cover these activities. Our service takes the risk of holding the camps without seeking the permission of the funding body. Similar camps have also been held for women, and for elders.

There is a need for a station in the area, to hold camps and to undertake a broad range of work such as alcohol rehabilitation, and training for young people. This would have a great impact on community health, but funding programs are currently not structured to address these needs. Governments need to take a broader view of health, rather than seeing health as "just patching people up as they come in".

Short term funding work against sustainable improvements to public health

It was widely stated that there is no "quick fix" for Aboriginal and Torres Strait Islander health, and real changes require well planned and sustained long term approaches. Short term funding approaches, for one-off projects, are widely seen as antithetical to making sustainable changes.

A continuous stream of "innovative programs" is also antithetical to Aboriginal community values. It was stated that "the community wants continuity of services, not continual change". There is often a long process involved for service providers to gain community trust and support for a service or program, and this trust can then be lost if funding ceases and the program is withdrawn. It was widely stated in consultations that there is a need for programs which have proved successful to be continued, rather than an emphasis on continual innovation and change.

As noted above, many service providers access short term grants as the only available means of funding important primary health care and public health programs. Successful programs are frequently developed and implemented, only to cease when the funding ends. This is frustrating for service providers and for the community, and short-term stop-start funding also works against recruitment and retention of staff, as long term contracts cannot be offered.

"Demonstration projects" are only valuable if they can be reproduced

It was commented that "best practice projects" are often not able to be reproduced in other settings due to inadequate staffing and infrastructure. A government participant provided the following example:

Nganampa Health Council received considerable funding for a demonstration project which modelled best practice in the delivery of sexual health programs. The model was very good, but other services have been unable to emulate it because they do not have access to the level of funding which was allocated to Nganampa, and the infrastructure with which to implement the model was lacking. This demonstrates the futility of demonstration projects unless there is a commitment to fund best practice models more broadly.

There are major inequities in the grants application and allocation processes

It was widely pointed out that the playing field is not level. Larger organisations with greater staff resources and expertise are in a better position to develop competitive funding submissions, and typically continue to attract additional grants, while smaller and fledgling services with lower capacity have little ability to compete in this context, and stagnate. It was commented that small organisations often only hear about funding programs when deadlines for submissions are looming, and this creates additional difficulties.

Many participants felt that the selection criteria for allocating grants are inappropriate. Organisations which have greater skills in writing good submissions are more likely to be funded, irrespective of whether there is community support for their proposal, or whether the organisation has a commitment and ability to deliver a good service to the community. One participant likened the process to an "essay competition". It was also felt by some participants that some of the committees making recommendations on grant funding know little about service delivery realities, and are not supportive of Aboriginal and Torres Strait Islander community organisations.

Departmental staff are often aware of these inequities and do take measures to address them, but they also noted that from the point of view of funding bodies, directing funding to larger, experienced organisations was a "safer bet" than backing smaller, less experienced organisations. It was suggested that there needs to be a risk-management approach where funding is directed to areas of need even where organisations have limited capacity, and it is accepted that there will be some failures and that this is an appropriate cost involved in promoting community development.

There are high transaction costs involved in grants funding programs

It was widely commented by service providers that the limited amount of funding available is often not commensurate with the effort required to develop funding submissions, collect performance data, and report back to funding bodies. The requirements are particularly onerous when funding is being accessed from several different sources, as is often the case. Departmental staff also commented on the high administrative effort required within departments to administer grants programs.

Competitive submission-driven grants processes promote inter-agency competition rather than collaboration

For service providers within and between sectors to invest significant, and often wasted, effort to compete for a limited funding pool, is not conducive to promoting inter-sectoral collaboration and co-operation. This competition for funds was a clear underlying factor in several of the negative comments from service provider organisations, regarding other local organisations.

State-funded service providers may have difficulty accessing some grants

It was commented by one State-funded service provider in a remote region that eligibility for Commonwealth grants is sometimes limited to Commonwealth-funded service providers, or other NGOs, and that State providers are sometimes ineligible. This was seen as anomalous and inequitable in areas where the State may be the major provider of certain public health services, and there may be no suitable NGOs in the region. The result was that the region could miss out on funding under the Commonwealth program.

On the other hand, some other State-funded providers had good access to Commonwealth public health grant funding, and noted that their departmental corporate offices had provided key support and brokerage in negotiating this funding. Such support is not currently available to community organisations which are competing for the same funds.

There are problems with moves towards competitive tendering

It was noted that in line with national competition policy, there have been moves by governments towards competitive tendering processes for the delivery of health-related services to Aboriginal and Torres Strait Islander communities. This is seen by Aboriginal and Torres Strait Islander community organisations as being highly inappropriate, as their unique role as culturally appropriate service providers to their communities should be accepted and supported. There were also comments from departmental people that these requirements are highly problematic, as departments should ideally be taking a community development

approach, and working towards supportive relationships with community organisations. Competitive tendering requirements were seen to work counter to this approach.

Grants processes do not identify and address need in a proactive way

Grants processes rely on local organisations identifying and demonstrating the community's need, and bringing a submission to the funding body which fits the conditions of the grants program. This is seen by some as an abrogation by governments of their duty to identify and target areas of need. As one local Aboriginal organisation commented:

A number of AMSs have identified the need to establish drug and alcohol services. The impetus and direction have come from AMSs who have been required to lobby government about pressing health needs which should be obvious. The prevailing attitude of government appears to be not so much "how can we help you", but "convince us that you have an impregnable case".

11.3 Possible models

Moves towards proactive needs-based funding approaches were widely supported by participants in the consultations.

Several participants nominated the Primary Health Care Access Program (PHCAP) as a promising model. The program aims to improve access to primary health care, by taking a partnership approach to developing services based on priorities identified in regional Aboriginal health plans. An approach is being taken which involves weighted per capita funding to meet comprehensive primary care and public health program needs.

The development of Primary Care Partnerships in Victoria, involving fostering and resourcing of inter-sectoral partnerships and collaboration and including the involvement of Koori health organisations, was also nominated as a promising model.

12. Other strategy implementation issues

As well as the need for funding reforms, participants suggested there is a need for national public health strategies to also take a greater focus on other implementation issues, including community development and capacity building, infrastructure requirements, workforce and training needs, and the role of resources such as guidelines in promoting quality service delivery.

12.1 Community development and capacity building

The need for community development and capacity building approaches

It was pointed out that Aboriginal and Torres Strait Islander communities and their organisations, including health services and community councils, often face specific difficulties including relatively small community numbers and consequent lack of critical mass to develop successful comprehensive programs; dependence on grant funding; disempowerment; and disadvantages in terms of educational levels, skills, and experience in program development and management. This, along with general under-resourcing and limited physical infrastructure in community organisations, has a direct impact on the ability of communities and community organisations to engage with national public health strategies.

Aboriginal and Torres Strait Islander people comprise only two per cent of the total Australian population, and experience extreme socio-economic and educational disadvantage and marginalisation. This has produced a “skills deficit” in many Aboriginal and Torres Strait Islander communities and organisations, with only a very limited pool of community people with the skills and confidence to take on leadership and management roles in health and other areas.

The danger with not addressing issues of community capacity is that communities which are already disadvantaged become further disadvantaged. New resources, such as those available under national public health strategies, tend to flow to communities and organisations which already have relatively good capacity and infrastructure, and are therefore a “safer bet” for managing government funding. There is a strong argument that all strategies should include a component of resourcing to bring the capacity of more disadvantaged communities and organisations up to the point where they are able to deliver relevant programs.

There are specific disadvantages experienced by many remote Aboriginal and Torres Strait Islander communities, which are operating at subsistence level, with local economies based on transfer payments and CDEP. It was pointed out that implementing programs in these settings is setting communities up for failure, unless there is a very significant community development approach. One problem which was identified with the existing approach to policy action in remote communities is that health funding intended to flow into communities often does not stay in the community. Instead, funding tends to immediately flow out of the community for goods and services purchased with the funding. For example, health promotion resources are not developed by paid community members, and non-Indigenous urban consultants are often engaged to undertake planning and program development. This represents a significant lost opportunity to improve the local economy simultaneously with interventions.

Current initiatives

Some work is already being undertaken by government departments to support community development and organisational capacity building. Examples include the use of the OATSIH Management Support Program to assist with the development of management and planning systems in some Indigenous organisations; the provision of small seeding grants in the NT for Aboriginal community organisations to develop project submissions and access funding to

initiate health promotion projects; the provision of small amounts of funding under the Regional Health Services Program, to assist communities and organisations to undertake planning and develop funding proposals; and support for the development of Health Action Groups and other structures in North Queensland, to promote community engagement and advocacy in health policy and planning.

Examples of initiatives in other areas to develop local community-driven health promotion campaigns which used local knowledge, develop local skills, and create local employment, have already been mentioned.

Suggested approaches

It was suggested that community development and capacity building efforts need to be more widespread, and become an accepted underpinning component in all public health strategies targeting Aboriginal and Torres Strait Islander communities. Participants suggested several possible ways to address these issues in the national public health strategy context.

It was also suggested that all national public health strategies targeting Aboriginal and Torres Strait Islander health should include a component of funding for community capacity building. This could be used for purposes such as the development of structures to support community participation and advocacy in health, community-driven needs analysis and program planning, development of funding proposals, training and management support, and so on.

It was also suggested that strategies need to take community development approaches which take into account local employment and training needs. Having community-based positions and programs can help to keep health funds circulating in communities, leading to a multiplier effect as money changes hands before leaving the community.

There is seen to be an unmet need for brokerage and technical support to communities. This role could include providing community organisations with information about national and State/Territory strategies, and the availability of funding; assisting them with undertaking needs analyses and developing funding submissions; assisting with the development of improved linkages, networks, and co-ordination; and so on. It was noted by some participants that ATSIC regional offices had previously been able to meet some of these needs, but their ability to do so had been dramatically reduced due to funding cuts. In some cases, health department staff were attempting to meet communities' requests and fill this gap, but this created a heavy burden on limited staff numbers, and could lead to conflict of interest situations when departmental staff are also involved in making recommendations for funding. Regional ACCHS co-operative structures also have the potential to broker access to strategy funding among established and emerging member services.

There is also seen to be a need for distilled plain English summaries of complex national strategies, to promote their use by communities and local service providers. These summaries could include pictures, diagrams, case studies, stories, etc, to make them more accessible. It was also suggested that information and training about the strategies in the form of workshops for Aboriginal and Torres Strait Islander organisations, at local or regional level, would be helpful.

Finally, it was suggested that there needs to be encouragement of public health research carried out by and for Aboriginal and Torres Strait Islander people. It was argued that by adding the benefit of their community knowledge and contacts to the research process, Aboriginal and Torres Strait Islander researchers are able to get a more accurate picture than outside researchers. Support of this role through sponsorships, scholarships, fellowships, and so on, would contribute towards community development and capacity building.

12.2 Infrastructure and workforce issues

It was widely noted by participants that the availability of an adequate physical infrastructure and an adequate skilled workforce is critical to the successful implementation of any public

health strategy. It follows that all national strategies should consider infrastructure and workforce issues as a key component of their planning processes. This should include an assessment of the physical infrastructure and workforce required to implement the strategy, an assessment of whether this is currently available in appropriate service provider organisations, and if not, the measures needed to achieve an adequate infrastructure and an adequate skilled workforce.

Consultations also indicated the need for all national and State/Territory health strategies to consider the implications of their activities on the health workforce as a whole, as there may sometimes be unintended consequences of these activities.

The role of Aboriginal and Torres Strait Islander Health Workers in strategy implementation

Although Commonwealth policy and programs place GPs “at the centre of primary health care”, the reality in many Aboriginal and Torres Strait Islander health settings is that the role of AHWs is the central one. AHWs are often in the front line of both clinical and non-clinical care, and while turnover is often high amongst other health professionals such as GPs and nurses, AHWs stay in the community and form the stable backbone of the workforce.

It was commented by several participants that the implementation of public health strategies in Aboriginal communities relies heavily on the efforts of AHWs. This is problematic, because this is currently a relatively small and in many places poorly developed workforce.

The limited number of AHWs across Australia has a major role in providing core primary health care services, as well as providing specialist services in many strategic areas. The implementation of the range of public health strategies relies on AHWs to specialise in areas including nutrition, environmental health, eye health, sexual health, mental health, and so on. Given the small workforce and the need for generalists, there is a real limit on the amount of specialisation that is possible. As one participant commented:

Workforce issues are critical. Aboriginal organisations often lack the staffing to successfully implement new programs. The AHW workforce is relatively small, yet it is expected to carry the responsibility for implementing an enormous range of strategies. It is impossible for such a small and undeveloped workforce with a limited skills base to specialise in the more than twenty areas covered by the national public health strategies, at the same time as providing a holistic primary health care service to their communities. There are often unrealistic expectations on the AHW workforce – for example, on top of everything else, they are expected to be in the front line for the implementation of computerised patient information and recall systems; and they are expected to be able to take on the role of Stolen Generations counselling with very limited training. The limitations on, and overloading of, the AHW workforce is a key reason why many of the public health strategies have a very limited impact in Aboriginal communities.

It was stated that the limited number of AHW positions funded has a very real impact on strategy implementation. An example given was in the diabetes area, where a number of useful initiatives have been funded, including best practice guidelines and treatment protocols, and patient registers; however, some services have found that they have an insufficient team of AHWs to deliver services to patients according to these registers and protocols.

While the term “Aboriginal Health Worker” is used generically, there is great variation across Australia in the education and training levels, and roles of AHWs. In the north and centre of Australia there is greater involvement of AHWs in clinical work, and greater access to accredited clinical training. The role of AHWs in much of southern Australia concentrates more on liaison and health promotion, and there is less access to clinical training. There has been much activity recently to work towards a greater degree of consistency across Australia in role definition, terminology, access to education, standards and protocols, career development, and so on.

It was also suggested by several participants that these issues can largely be addressed through increased funding for AHW education and training, and for the funding of more AHW positions across Australia. It was noted that these efforts need to be linked: there is no point in training people for positions that do not exist, and there was concern that this could be happening (for example, there were some concerns about whether jobs would be there for people trained through the Regional Centres for Emotional and Social Well-Being).

A particular concern expressed was the need to ensure that well-intentioned effort to “standardise” AHW training and industry roles nationally does not erode established professional “Aboriginal primary health care practitioner” role where they exist, particularly in western, northern, and central Australia.

Overall, there was a widely identified need to address issues relating to the Aboriginal and Torres Strait Islander Health Worker profession, including qualifications, accreditation, awards, recognition of life skills, career structures, and work environments. While these issues are being addressed through several linked initiatives, there would appear to be a role for the national public health strategies to contribute resources to these efforts.

Access to specialist and allied health services

Access to specialist and allied health staff within the public hospital and community health sector was identified as a major limiting factor in the success of public health strategies. In many cases, primary health care services undertake screening in areas relevant to the national public health strategies, and refer patients on to specialists. There is a need to link the national public health strategies to public access to specialist services which are currently funded through the hospital sector, to ensure adequate access to follow up services for people in need.

In the mainstream health care system, a general under-supply of specialist and allied health personnel such as nutritionists, psychiatrists, and physiotherapists, was identified by participants in several geographical areas. Unless workforce needs are considered in the development of national strategies, new positions can be funded for which there is only the same very limited pool of people available in these areas. The result can be that these people follow the pools of funding around, with no overall gain to the community. This is particularly true for rural and remote areas.

There can actually be negative consequences for the community if the funding structures influence these people to move out of the public system (hospitals, community health centres) and into other structures such as private practice or Divisions of General Practice. This can actually represent lost resources and a reduction in access for the community.

General practitioners and Divisions of General Practice

This government is seen to be concentrating on supporting and funding private GPs, in the context of the corporatisation of general practice, at the expense of the public system. Many rural and remote areas have few or no bulk billing GPs, which means poor access for Aboriginal and Torres Strait Islander people and other disadvantaged groups. It was suggested that there is a need for further measures to improve access by Aboriginal and Torres Strait Islander people to GP services, by addressing both availability and affordability issues.

There was significant comment on the emerging role of GP Divisions as employers of allied health and other health professionals. It was noted that there is frequently not a pool of trained professionals available to fill the posts that are being created, and the net result is that health professionals simply “move sideways”, with no overall gain to the community. It was seen as important that Divisions add value, rather than simply moving scarce health professionals sideways into administrative roles, which creates a drain on service provision.

12.3 Dissemination of resources to guide practice

Intellectual resources, such as “best practice guidelines”, are frequently developed under the auspices of the national public health strategies. It was noted by participants that such efforts need to take into account the very different cultural, clinical, and service delivery issues in Aboriginal and Torres Strait Islander health. Due to these differences, generic resources are often of little value in the Indigenous health context.

Some Indigenous-specific resources which have been funded by OATSIH and produced and disseminated under the auspices of the national strategies were identified by several participants as being of high quality and very useful: specifically the STD manual developed by Nganampa Health Council, and the best practice guidelines for diabetes management developed by KAMSC. However, in relation to the latter, the dissemination strategy was widely criticised. The guidelines had been posted to all ACCHSs, but not to other service providers in Aboriginal health, who had to find out about their existence and purchase them; and because there had been no follow-up to the mail-out, several ACCHSs providing diabetes care are not aware of them or do not refer to them in their clinical practice. It was commented that for over-stretched service providers, resources like this tend to “sit on a shelf and collect dust” unless they are actively promoted. There was also a comment that the guidelines for clinical management of alcohol-related problems amongst Aboriginal and Torres Strait Islander people, produced by the University of Queensland, were similarly not familiar to and used by service providers.

It was suggested by several participants that there needs to be more effective marketing of such resources, otherwise the investment in their development is essentially wasted, and their potential to make an impact is not reached. The marketing strategies suggested to accompany dissemination of resources included workshops for health professionals, and/or visits to services to explain and promote the products (similar to pharmaceutical company detailing).

It was commented that OATSIH is aware of these issues, and is working on improved take-up of these resources. Other program areas also need to take note of this issue.

13. Strategy evaluation

Suggestions by some participants for annual reporting by the NPHP regarding the achievements of national public health strategies in addressing Aboriginal and Torres Strait Islander health, were discussed earlier in this paper. Whether or not these suggestions are taken up, there was a widely perceived need by participants for strategy evaluations to have a greater focus on providing performance information regarding the success or otherwise of the strategies in addressing Aboriginal and Torres Strait Islander health, and on how they could achieve more in this regard.

13.1 The political and funding context of program evaluations

Several participants commented that the political and funding context of program evaluations was not generally conducive to the generation of useful performance information to guide future practice. One participant with extensive experience of government policy processes summarised the situation this way:

Evaluations are carried out for all kinds of funding reasons – they are generally not a genuine attempt to discover how things have gone and how they ought to go. They are more often an attempt to defend what has happened, and/or to come up with results when funding is running out, so that more funding can be sought. Such evaluations therefore have little real potential to provide a guide to how the strategies have addressed Aboriginal and Torres Strait Islander health, or how they could do this better.

There is seen to be a need to shift the focus of program evaluations, to provide useful performance information that can be used as a basis for continuous improvement in strategy implementation, at both the government and service provider level.

It was suggested that there would be a higher degree of honesty and value in program evaluations if they were not viewed in a pass/fail context, and linked directly to funding. It was said that evaluations should focus not on “failures”, but on the opportunities to do things better. It was suggested that service providers and communities need access to good information about how their programs are performing in comparison with programs from other areas, so that good ideas can be disseminated and adapted. This would make evaluations more useful in driving continuous improvement of service delivery.

13.2 Evaluation as an integrated part of strategy development

It was widely commented that all evaluation frameworks for national public health strategies should include an assessment of how well the particular strategy has addressed Aboriginal and Torres Strait Islander health. It was noted that in the past, strategies have not necessarily addressed this question, and there is very little publicly available performance information on this issue.

It was stated that the key to effective evaluation is to formulate a performance-based evaluation strategy at the same time and in the same context as the original strategy development, in a consultative and community-driven manner, based on needs assessment and on community ethics. The data should be fed back to relevant groups as the basis for action to serve community needs.

It was widely commented that data collection and evaluation strategies need to be included in the original strategy development processes, rather than being an “add-on”. This requires the appropriation of adequate resources for data collection and evaluation processes, and a planning framework for the use of performance information to drive continuous improvement in strategy implementation.

13.3 The need for realistic implementation times prior to evaluation

It was commented that many programs targeting Aboriginal and Torres Strait Islander communities seem to be reviewed or evaluated very early in their implementation phases: the PHCAP was given as a prime example. This was seen as reflecting Budget funding cycles, as well as a negative political context where there is an over-emphasis on defending expenditure on Aboriginal and Torres Strait Islander issues, and an under-emphasis on equity issues.

Participants suggested that there needs to be greater recognition of the lead times needed for community consultation, capacity building, and implementation; and the funding and evaluation cycles should reflect this. The time needed for effective implementation may vary between programs (for example, immunisation programs may demonstrate results more quickly than emotional and social well being programs), so the appropriate timeframe needs to be considered in the context of each program.

13.4 The need for greater involvement of Aboriginal and Torres Strait Islander people and organisations in evaluations

It was commented by some participants that involvement of Aboriginal and Torres Strait Islander communities and organisations in national strategy evaluation processes was often limited and ad hoc. It was argued that Aboriginal and Torres Strait Islander representatives should be involved from the very start of the process, and all the way through. It was commented that it would be very useful to have explicit guidelines for Aboriginal and Torres Strait Islander involvement in the evaluation processes. This would range from representation in national and State/Territory level planning processes for evaluations, to feedback at community level about the extent to which program implementation has met community needs.

For example, at national and State/Territory level, representative organisations should be involved in developing evaluation plans and statements of requirement for external evaluators, in selecting external evaluators, and in steering evaluation consultancy processes. At community level, it was said that there is a need for communities and community organisations to have a direct say in whether programs have met their needs, rather than relying on those delivering programs to report on community acceptability. It was seen as problematic that service providers can make apparently unverified claims to funding bodies about the level of access that Aboriginal and Torres Strait Islander people have to their services, and about the impact they are making, and it was stated that there is a need for funding bodies to seek comment by Aboriginal and Torres Strait Islander communities and their organisations, to verify such claims.

It was also commented that if external evaluators are brought in to evaluate initiatives on the ground with Aboriginal and Torres Strait Islander communities, they must have appropriate experience and expertise in working and communicating with Aboriginal and Torres Strait Islander peoples.

The establishment of Aboriginal and Torres Strait Islander reference groups for a range of health programs and issues was suggested, along with the negotiation and inclusion of evaluative measures which are meaningful to the community and people involved. It was suggested that there is also a need to be prepared to accept and record oral evaluation, which can subsequently be coded and validated by qualitative research methods. Resources are needed to support more inclusive and participatory evaluation methods of this nature.

13.5 Appropriate performance measures for national public health strategies with regard to Aboriginal and Torres Strait Islander health

Appropriate indicators of success also need to be considered. Many participants pointed out that given the many inter-related determinants of Aboriginal and Torres Strait Islander health, it is generally unrealistic to expect a single-issue strategy to produce visible changes in health outcomes in the short term. Structure, process, output, and impact indicators may therefore generally be more realistic than actual “health outcome” indicators.

It was said that Aboriginal and Torres Strait Islander organisations often measure the success of their programs in terms of how well the community accesses the program, how well the program is received by the community (measured through either anecdotal or formal feedback), and whether the program appears to be producing changes in community attitudes and behaviour which could be expected to lead to positive health outcomes. However, it was noted that funding bodies often seemed uninterested in these issues, and focused on activity levels rather than qualitative analysis of the value of the service. It was suggested that performance information should include qualitative as well as quantitative measures.

It was also noted that some activities are difficult to quantify, for example program co-ordination across a region, community development work, preventive programs that aim to build self-esteem; etc.

Some indicators suggested by participants as being useful for assessing the success of national public health strategies in addressing Aboriginal and Torres Strait Islander health included:

- The proportion of strategy resources which have reached Aboriginal and Torres Strait Islander communities.
- Evidence that governments and mainstream service providers have made efforts to build real partnerships with and Aboriginal and Torres Strait Islander communities and organisations.
- Measures of access by Aboriginal and Torres Strait Islander people to programs implemented under the national strategies.
- Qualitative indicators on issues such as cultural security, capacity building, appropriateness, continuity, acceptability, and responsiveness of services to community needs, are seen as very important.

It was also emphasised that performance indicators and benchmarks developed for the general community should apply to Aboriginal and Torres Strait Islander health, rather than allowing lower standards or goals to apply (or equally, requiring higher or more onerous standards and reporting).

13.6 Data collection and data quality issues

The issue of data collection and quality has already been raised in this report. It was widely commented that good quantitative performance measures for national public health strategies, such as measures of Aboriginal and Torres Strait Islander access to programs, relied on improvements data quality, including better Indigenous identification in health data collections.

NATIONAL PUBLIC HEALTH PARTNERSHIP

NATIONAL STRATEGIES COORDINATION WORKING GROUP

PROJECT STEERING GROUP on *Aboriginal and Torres Strait Islander Best Practice Guidelines for National Public Health Strategy Development, Audit and Evaluation Project*

MEMBERS

Associate Professor Ian Anderson (Chair)
Director, VicHealth Koori Health Research and Community Development Program
University of Melbourne

The late Dr Puggy Hunter
Chairperson
National Aboriginal Community Controlled Health Organisation

Mr Stanley Nangala
Director
Aboriginal and Torres Strait Islander Health Policy Unit
Queensland Health

Ms Kez Hall
Director
Health Promotion and Public Health Strategy Unit
Territory Health Services

Mr Tim Agius
Director
Aboriginal Branch
NSW Health Department

Ms Gabriela Samcewicz
Director
Health Issues Section
Office of Aboriginal and Torres Strait Islander Health

Steering Group supported by NPHP Secretariat.

List of interviews held

Date	Interviewee/s
27 April 30 April	Ms Lee-anne Daley, Deputy CEO Ms Nerida Bellis-Smith, Diabetes/Nutrition Co-ordinator Dr Sophie Couzos, Public Health Officer Ms Helen Kehoe, Health Financing Policy Officer Ms Kylie Lindorff, Tobacco Control Project Officer National Aboriginal Community Controlled Health Organisation (NACCHO) PO Box 168 DEAKIN WEST ACT 2601
7 May	Ms Liz Furler, CEO Mr Richard Lawrance, A/g Director, Rural Royal Australian College of General Practitioners 1 Palmerston Crescent STH MELBOURNE VIC
7 May	Mr Ron James, Manager Koori Health Unit Department of Human Services, Victoria GPO Box 4057 Melbourne VIC 3001
7 May	Ms Jennifer McDonald, Executive Officer, Food and Health Development Mr Tony Blackwell, Team Leader, Population Group Health Department of Human Services, Victoria Level 16, 120 Spencer St MELBOURNE VIC 3000
8 May	Mr Ray Ahmat, Health Service Manager Mr Daniel Briggs, Co-ordinator Mental Health Ms Kaye Briggs, Birthing Program Mr Larry Jackson, CJP Ms Elizabeth Latorre, Co-ordinator, Stolen Generations Program Ms Jodie Miller, Alcohol and Drug Worker Ms Lynne Parker, Juvenile Justice Worker Ms Donna Rumbiola, Community Nurse Rumbalara Aboriginal Co-operative MOOROOPNA VIC 3629
8 May	Ms Leigh Gibson, Director of Community Services Mr Peter Borthwick, Manager, Goulburn Valley Area Mental Health Service Goulburn Valley Health Goulburn Valley Base Hospital SHEPPARTON VIC 3630
9 May	A/Prof Ian Anderson, Director Vic Health Koori Health Research and Community Development Unit University of Melbourne
9 May	Ms Karlene Dwyer, CEO Ms Wanda Braybrook, Regional Centre ESW Co-ordinator Ms Kelly Faldon, Project Worker, Regional Centre Mr Alister Thorpe, PCP/Policy Victorian Aboriginal Community Controlled Health Organisation (VACCHO) PO Box 1328 COLLINGWOOD VIC 3066

9 May	Mr Ian Hamm, Assistant Director, OATSIH Ms Lois Atkinson-Farrant, Senior Project Officer, OATSIH Ms Meni Frawley, Health Strategies Program Co-ordinator Ms Karen Wood, Project Officer, OATSIH Department of Health and Aged Care Victorian State Office
10 May	Mr Robert Griew, Consultant
14 May	Ms Sandra Bailey, CEO, AH&MRC Dr John Daniels, Medical Director, AMS Redfern, and Medical Adviser to AH&MRC Ms Pat Delaney, Programs Manager, AH&MRC Aboriginal Health and Medical Research Council of NSW PO Box 1565 STRAWBERRY HILLS NSW 2012
14 May	Mr Tim Agius, Director, Aboriginal Health Branch Mr Steve Corbett, Head, Environmental Health Branch Mr Ross O'Donoghue, Director, Health Protection Ms Carmen Parter, Manager, Policy and Planning, Aboriginal Health Branch Mr Ian Raymond, Senior Project Officer, Health Promotion Branch Dr Andrew Wilson, Chief Health Officer and Deputy Director General Ms Geraldine Wilson, Senior Project Officer, Policy and Planning, Aboriginal Health Branch New South Wales Department of Health Locked Mail Bag 961 NORTH SYDNEY NSW 2059
16 May	Ms Julie Tongs, Chief Executive Officer Winnunga Nimmityjah Aboriginal Health Service 91A Wakefield Gardens AINSLIE ACT 2602
17 May	Mr Tom Brideson, Social Health Mr Denzil Burke, Substance Use and Male Health Ms Sue Green, Assistant Director, Immunisation Dr Ana Herceg, Medical Adviser, Health and Community Strategies Branch Mr Barny Lee, Assistant Director, Health Financing Ms Helen Pampling, Assistant Director, CPHC, Program Development and Evaluation Section Mr Bernard Pearce, A/g Assistant Director, Sexual Health Ms Lesley Roxbee, A/g Director, Social Health Office for Aboriginal and Torres Strait Islander Health Department of Health and Aged Care GPO Box 9848 CANBERRA ACT 2601
21 May	Dr Chris Kennedy, District Manager Townsville Health Service District PO Box 670 TOWNSVILLE QLD 4810
21 May	Ms Rachel Atkinson, CEO Ms Des Lavery, Research and Development Officer Townsville Aboriginal and Islander Health Service

22 May	Mr Phil Peachey, Indigenous Health Co-ordinator Ms Nan Muir, Director, Community Health Townsville Health Service District PO Box 670 TOWNSVILLE QLD 4810
22 May	Ms Lynore Geia, Lecturer School of Public Health and Tropical Medicine James Cook University TOWNSVILLE QLD 4810
23 May	Dr John Scott, State Manager, Public Health Services Ms Debra Blumel, Public Health Law and Indigenous Health Project Queensland Health GPO Box 48 BRISBANE QLD 4001
23 May	Ms Sandy Angus, Indigenous Project Officer, Women's Cancer Screening Services, Corporate Office Ms Linda Bertram, Central Zone Oral Health Promotion Co-ordinator Ms Debra Blumel, Public Health Law and Indigenous Health Project Mr Chris Caromolo, Southern Zone Aboriginal and Torres Strait Islander Environmental Health Co-ordinator Mr Andrew Casasola, A/Senior Project Officer, Public Health Planning and Research Unit Ms Noeleen Dempsey, Southern Zone Indigenous Communicable Disease Ms Sophie Dwyer, Manager, Central Public Health Network Unit Mr George Hapgood, Communicable Diseases Unit Ms Karmen Hellmuth, State Health Promotion Co-ordinator (Oral Health), Oral Health Unit Ms Katrina Smith, Environmental Health Adviser Mr Michael Tilse, Manager, Statewide Health Promotion Unit Queensland Health GPO Box 48 BRISBANE QLD 4001
23 May	Ms Jennifer Muller, Manager, Women's Cancer Screening Services Ms Alison Thompson, Women's Cancer Screening Services Queensland Health GPO Box 48 BRISBANE QLD 4001
24 May	Mr Mick Adams, CEO Ms Mary Martin, Co-ordinator, Workforce Issues Queensland Aboriginal and Islander Health Forum
24 May	Ms Jaki Adams, Senior Policy Officer, OATSIH Ms Natasha Hazel, Project Officer, Population Health Ms Helen Hewett, Finance Officer, OATSIH and Health Services Ms Liz Mackinlay, Senior Program Officer, Rural Health Ms Roslyn Walker, A/g Assistant Director, Population Health Queensland Office Department of Health and Aged Care GPO Box 9848 BRISBANE QLD 4001

30 May	<p>Dr Mark Jacobs, Director, Environmental and Public Health Mr Shane Nichols, Policy Officer, Aboriginal Health Unit Mr Michael Plaister, A/g Manager, Division Support Unit, Health Advancement</p> <p>Tasmanian Department of Community and Health Services GPO Box 125B HOBART TAS 7001</p>
30 May	<p>Mr Anthony Speed, Program Manager, Population Health Mr Frank McCann, State Director, OATSIH Ms Janice Klar, Senior Project Officer, OATSIH</p> <p>Tasmanian Office Department of Health and Aged Care GPO Box 9848 HOBART TAS 7001</p>
30 May	<p>Ms Heather Sculthorpe, CEO Dr Maureen Davey, Medical Practitioner, Tasmanian Aboriginal Health Service</p> <p>Tasmanian Aboriginal Centre PO Box 569F HOBART TAS 7000</p>
6 June	<p>Ms Pam Mitchell, CEO, Coomealla Health Aboriginal Corporation Ms Grace Beetson, CEO, Brewarrina Aboriginal Health Centre Ltd Mr David Kelly, CEO, Wellington Aboriginal Corporation Health Service Mr William Stanley, Men's Sexual Health, Wellington Aboriginal Corporation Health Service Ms Lillian Elemes, Thubbo Aboriginal Medical Co-operative Ms Elva See, Thubbo Aboriginal Medical Co-operative Ms Lavinia Howey, Thubbo Aboriginal Medical Co-operative</p> <p>Bila Muuji C/- Coomealla Health Aboriginal Corporation DARETON NSW 2717</p>
8 June	<p>Ms Bronwen Harries, Project Manager, Environmental Health Section Ms Helen Heaney, Project Manager, Environmental Health Section Ms Andriana Koukari, A/g Director, Cancer Screening Section Ms Kathleen Graham, Primary Prevention Section Ms Chrys Athanaros, Tobacco and Alcohol Strategies Section Ms Kim Nguyen, Health Inequalities and Partnerships Mr Graeme Rossiter, Sharing Health Care Mr Callum McKenzie, Health Inequalities and Partnerships</p> <p>Population Health Division Department of Health and Aged Care GPO Box 9848 CANBERRA ACT 2601</p>
12 June	<p>Ms Margaret Scott Project Manager, Aboriginal Vascular Health Program</p> <p>New South Wales Department of Health Locked Mail Bag 961 NORTH SYDNEY NSW 2059</p>

13 June	<p>Mr David Banham, Senior Project Officer, Health Outcomes Unit, Epidemiology Ms Patricia Carter, Senior Project Officer, Public Health Nutrition and Diabetes, Health Promotions SA Ms Sally Castell-McGregor, Principal Planning and Policy Adviser, Aboriginal Services Division Ms Sharon Clarke, Promotion Officer, Aboriginal Services Division Mr David Egeye, Senior Project Officer, Aboriginal Services Division Ms Catherine Morgan, Senior Policy and Planning Officer, Aboriginal Services Division Mr Ron Somers, Unit Head, Injury Control Ms Anne Taylor, Manager, Population Health Surveys, Epidemiology</p> <p>SA Department of Human Services PO Box 287 Rundle Mall ADELAIDE SA 5000</p>
13 June	<p>Ms Polly Sumner, CEO Ms Kaye Wilson, Team Leader, Diabetes Program Ms Julie Coulthard, Community Health Worker, Diabetes Program Ms Susan Cameron, Sexual Health</p> <p>Nunkuwarrin Yunti of SA Inc</p>
14 June	<p>Ms Fran Lovell, Program Manager, OATSIH Mr Harry Stewart, Project Manager, OATSIH Mr Daniel Dollard, Project Manager, OATSIH Mr Lance Riley, Project Manager, OATSIH</p> <p>SA Office Department of Health and Aged Care GPO Box 9848 ADELAIDE SA 5000</p>
14 June	<p>Mr John Evans Deputy Director Aboriginal Health Council of South Australia PO Box 75 FULLERTON SA 5063</p>
18 June	<p>Mr Paul Stephenson, General Manager, Public Health Dr Gary Dowse, Medical Epidemiologist, Communicable Diseases Control Branch Mr Wayne Jolley, Principal Food Scientist, Environmental Health Service Dr Virginia McLoughlin, Principal Medical Consultant, Office Executive Director, Public Health Dr Sandra Thompson, Medical Co-ordinator, Sexual Health Program Ms Beth Woods, Health Promotion Officer, Aboriginal Nutrition</p> <p>Public Health Health Department of Western Australia PO Box 8172 Stirling St PERTH WA 6849</p>

18 June	<p>Mr Cliff Collard, Project Officer Mr Arthur Cook, Manager, Corporate Services Ms Jo Cullinane, Project Officer Prof Michael Gracey, Principal Medical Adviser, OAH, Professor of Aboriginal Health, Curtin University Mr Dick Hallson, Manager, Systems Reform and Development Ms Marian Kickett Dr Tia Rolbstom, SMO Mr Fred Stacey, Manager Ms Jean Thornton, Senior Portfolio Manager Mr Dave Waters, Project Officer Ms Ali Weston, Senior Policy Officer Mr Colin Xanthis, Acting General Manager Office of Aboriginal Health Health Department of Western Australia PO Box 8172 Stirling St PERTH WA 6849</p>
18 June	<p>Mr James Lamerton Senior Manager, Service Delivery Derbarl Yerrigan Health Service 156 Wittenoom St EAST PERTH WA 6004</p>
19 June	<p>Ms Margaret Culbong, Chairperson Ms Di Potter, CEO WAACCHO Unit 2-4, Wellington Fair 200 Wellington St PERTH WA 6000</p>
19 June	<p>Mr Ian Bigg, Manager, Health Branch Mr Michael Fowle, Primary Health WA Office Department of Health and Aged Care GPO Box 9848 PERTH WA 6001</p>
20 June	<p>Dr Stuart Garrow, Director Kimberley Public Health Unit PMB 912 DERBY WA 6728</p>
20 June	<p>Ms Marie Cox, Co-ordinator, KAMSC Health Promotions Ms Kathy Hamaguchi, Co-ordinator, Regional Centre for Emotional and Social Well Being Ms Sue Metcalf, Regional Public Health Program Co-ordinator Dr Richard Murray, Medical Director Kimberley Aboriginal Medical Services' Council</p>
21 June	<p>Mr Ian Smith, General Manager Kimberley Health Service PMB 930 DERBY WA 6728</p>

22 June	Ms Janice Barr, A/g State Director, Health Strategies Mr Roger Brailsford, A/g State Director, OATSIH Ms Kate Race, OATSIH NT Office Department of Health and Aged Care GPO Box 9848 DARWIN NT 0801
25 June	Mr Xavier Schobben, Director, Environmental Health Mr Brian Parkin, Senior Policy Officer, Environmental Health Environmental Health Territory Health Services PO Box 40596 DARWIN NT 0801
25 June	Mr Terry Barker, Senior Policy Officer, Mental Health Ms Paula Convery, Health Promotion Policy Officer Mr Ali McLay, Section Head, Alcohol and Other Drugs Program SOEWELL Territory Health Services PO Box 40596 DARWIN NT 0801
25 June	Dr Karen Finch, Women's Cancer Prevention Dr Justine Glover, Chronic Disease and Injury Prevention Dr Vicki Krause, Director, CDC Dr Barbara Patterson, Community Paediatrics, Maternal and Child Health Dr David Peacock, Head of Surveillance Dr Jan Savage, Sexual Health, HIV/AIDS Dr Christine Selvey, Head, Immunisation Dr Peter Whelan, Senior Medical Epidemiologist Communicable Diseases Control Territory Health Services PO Box 40596 DARWIN NT 0801
26 June	Dr John Boffa, Public Health Medical Officer Central Australian Aboriginal Congress
27 June and 28 June (several meetings)	Dr Ross Spark, Manager Ms Carmelita Almain, Senior Health Promotion Officer Ms Louise Broomhead, Senior Public Health Nutritionist Mr Peter Falk, Environmental Health Officer Dr Jeffrey Hanna, Medical Director, Communicable Diseases Control Mr Stuart Heggie, Director, Environmental Health Dr Robyn McDermott, Medical Epidemiologist Mr Geoff Miller, Co-ordinator, Well Person's Health Check Dr Paul Sandery, Clinical Co-ordinator Ms Ursula Weston, Indigenous Environmental Health Worker Ms Dallas Young, Senior Health Promotion Officer Queensland Health, Tropical Public Health Unit PO Box 1103 CAIRNS QLD 4870
28 June	Dr Komla Tsey School of Public Health University of Queensland, Cairns

2 July	<p>Mr David Braggett, Assistant Director, Divisions Section, General Practice Branch Ms Dallas de Brabander, Project Officer, Promotion and Prevention, Mental Health Branch Ms Rita Evans, Director, Special Access Programs Section, Mental Health Branch Ms Sue Hunt, Project Officer, Promotion and Prevention, Mental Health Branch Ms Alison Ross, Assistant Director, Special Access Programs Section, Mental Health Branch Ms Joelle Roussety, Project Officer, Special Access Programs Section, Mental Health Branch Ms Andrea Symons, GAA, Divisions Section, General Practice Branch Dr Kim Webber, Assistant Director, Office for Rural Health</p> <p>Health Services Division Department of Health and Aged Care GPO Box 9848 CANBERRA ACT 2601</p>
4 July	<p>Mr Cephas Stanley Chief Executive Officer Pika Wiya Health Service 5 Jervois St PORT AUGUSTA SA 5700</p>
4 July	<p>Ms Rosemary Box, Child Health Team Leader/Speech Pathologist Mr Garnett Brady, Senior Project Officer, Port Augusta Hospital Ms Melissa Koch, Team Leader, Acute and Rehabilitation Team Ms Michelle Kuerschner, Health Promotion Project Officer Ms Cheryl Russ, A/Team Leader, Domiciliary Care</p> <p>Flinders and Far North Community Health Service Flinders Terrace PORT AUGUSTA SA 5700</p>
20 July	<p>Prof Alan Pettigrew, CEO Mr David Adcock, Director, Health Advisory Section Ms Sharon Hill, Health Ethics Section Ms Gillian Treloar, Research Development Section</p> <p>Office of the NHMRC GPO Box 9848 CANBERRA ACT 2601</p>
25 July	<p>Dr Shirley Bowen Chief Health Officer/Executive Director ACT Department of Health, Housing and Community Care PO Box 825 CANBERRA ACT 2600</p>
27 July	<p>Ms Jenny Gould, Director, Strategic Development Mr Noel Baxendell, Health Policy Officer</p> <p>ATSIC National Policy Office PO Box 17 WODEN ACT 2606</p>

Written input provided by:

Mr Stanley Nangala and staff
Aboriginal and Torres Strait Islander Health Unit
Queensland Health
GPO Box 48
BRISBANE QLD 4001

Mr Darren Armitage
Health Promotion Manager
Central Australian Service Network
Territory Health Services

Ms Caroline Barton
Research Assistant
WA Aboriginal Road Safety Strategy

Dr Tarun Weeramanthri
Community Physician
Territory Health Services
PO Box 40596
DARWIN NT 0801

List of briefings held

4 May, Canberra	Ms Gabriela Samcewicz, Director, Health Issues Section, OATSIH
11 May, Sydney	Head of Aboriginal Health Units meeting
16 May, Canberra	Mr Craig Ritchie, Chief Executive Officer, NACCHO
22 May, Townsville	Professor Ian Wronski, James Cook University
23 May, Brisbane	Mr Stanley Nangala and staff, Aboriginal and Torres Strait Islander Health Unit, Queensland Health
25 May, Canberra	NACCHO Board of Directors meeting
20 June, Broome	Kimberley Aboriginal Medical Services' Council – Council meeting
3 July, Adelaide	NPHP Aboriginal and Torres Strait Islander Working Group meeting
15 August, Canberra	Staff from Aged and Community Care Division, DHAC

**Development of Best Practice Guidelines for Public Health Strategy
Development, Implementation, and Evaluation with Aboriginal and Torres Strait
Islander Peoples**

Many national public health strategies have been developed and implemented in Australia over recent years. These cover areas as diverse as sexual health, diabetes and nutrition, immunisation, environmental health, and cancer screening programs, to name just a few.

Several of these strategies have had a real impact, and are making significant improvements to the health status of Australians now and into the future. However, little has been documented about how national public health strategies could be developed, implemented, and evaluated in a way that would better meet the needs of Aboriginal and Torres Strait Islander communities.

These are important issues to address, given the poor health status of Aboriginal and Torres Strait Islander people, and the lack of significant impact many health services and other resources have had on improving Aboriginal and Torres Strait Islander health and well-being.

The National Public Health Partnership has been established as the vehicle for Commonwealth, State, and Territory governments to work together on a nationally agreed and co-ordinated approach to public health. The Partnership has established a National Strategies Co-ordination Working Group, to advise on improving the co-ordination of national public health strategies.

The Partnership, through this Working Group, has commissioned a project covering the first stage of the development of guidelines which have the ultimate purpose of ensuring that national public health strategies better meet the needs of Aboriginal and Torres Strait Islander communities.

The project is being undertaken by a consortium comprising:

- Kimberley Aboriginal Medical Services' Council (Dr Richard Murray)
- James Cook University (Prof Ian Ring and Assoc Prof Jacinta Elston)
- Effective Healthcare Australia (Assoc Prof Michael Frommer and Dr Angela Todd)

Kathy Bell has been engaged by the consortium as project officer for the project.

The project commenced in March 2001 and will be completed over approximately six months. This first stage involves not the actual development of guidelines, but the ground work needed for the development of guidelines in the next stage.

In the first stage, the project team is researching relevant literature, and talking with a range of people - service providers in Aboriginal health, people from Commonwealth, State, and Territory governments, peak bodies, and other key informants - to document the key issues which need to be considered in the development of guidelines.

As part of this, the project team will be seeking people's views, based on their experience, of whether specific public health strategies have or have not worked effectively for Aboriginal and Torres Strait Islander communities, and why they have or haven't worked. The team will be looking at what this says about the key factors in the success or failure of public health approaches for Aboriginal and Torres Strait Islander communities.

Documenting the knowledge and experience of people who have worked in developing and delivering public health strategies should provide a sound basis for the subsequent development of guidelines to better target Aboriginal and Torres Strait Islander communities. Such guidelines could help with the real-world dilemmas and issues facing public service health policy officers, project officers, health service managers, Ministers and their staff and others in relation to Aboriginal health strategy work.

***For more information contact: Karen Roger, NPHP Secretariat, on 03 9637 5448 or
Kathy Bell, Project Officer, on 02 6282 9755 or 0419 460 820***

MAJOR NATIONAL STRATEGIES RELEVANT TO PUBLIC HEALTH

National HIV/AIDS Strategy

National Indigenous Australians' Sexual Health Strategy

National Diabetes Strategy

Draft National Nutrition Strategy (Eat Well Australia)

Draft National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan

Immunise Australia Program (National Immunisation Strategy)

National Environmental Health Strategy

National Aboriginal Health Strategy

National Cancer Control Initiative

National Asthma Strategy

National Communicable Diseases Surveillance Strategy

Active Australia

National Injury Prevention Strategy

National Drug Strategy

National Alcohol Action Plan

National Tobacco Strategy

National Mental Health Policy

National Youth Suicide Prevention Strategy

BreastScreen Australia

National Cervical Screening Program

National Women's Health Policy and Program

Maternal and Child Health Strategy

National Healthy Ageing Strategy

National Strategy for an Ageing Australia

Public health strategies: Questions for government departments, peak bodies, etc

Public health strategy development

What role do you think national health strategies play in efforts to improve the health and well-being of Aboriginal and Torres Strait Islander peoples?

How do you believe health issues generally get onto the national public health agenda?

What is your understanding of the processes used to develop national health policy?

To date, have you been involved in the development of any of the national public health strategies? If yes, can you describe your involvement?

How have Aboriginal and Torres Strait Islander people/organisations been brought into national public health strategy development? Can these processes be improved? How?

What are the pros and cons of developing national strategies specific to Aboriginal and Torres Strait Islander peoples, versus 'general' or 'mainstream' strategies with a separate section addressing Aboriginal and Torres Strait Islander issues?

Public health strategy implementation

What involvement have you had with the implementation of public health strategies with respect to Aboriginal and Torres Strait Islander peoples?

Have you been involved in efforts to translate national level strategies to local level initiatives? If so, what were some of the issues you faced?

How well do you think Aboriginal and Torres Strait Islander people/organisations have been involved in the planning and implementation of these local level initiatives?

What do you think about the way national public health strategies have been funded?

Which national public health strategies have been implemented particularly well for Aboriginal and Torres Strait Islander peoples? What was good about the process?

Which of the national public health strategies could have been implemented more effectively for Aboriginal and Torres Strait Islander peoples? Where were the problems and how could they have been addressed?

Public health strategy audit and evaluation

If you have been involved in evaluations focusing on programs or issues for Aboriginal and Torres Strait Islander peoples, can you describe the process and outcomes?

What suggestions would you have for involving Aboriginal and Torres Strait Islander peoples in the design and conduct of evaluations of national public health strategies?

How else might these evaluation processes be improved?

Guidelines to improve strategy development, implementation and evaluation with respect to Aboriginal and Torres Strait Islander peoples

What do you think would be some useful items to include in such guidelines?

Who might these guidelines be written for - who should be the target audience/s?

Public health strategies: Questions for regional/local health service providers

Public health strategy development

Do you know much about the national public health strategies? Were you aware of them when they were being developed? Were you involved in their development in any way?

Do you think these health strategies are helping to improve the health and well-being of Aboriginal and Torres Strait Islander peoples? If yes, in what way? If not, why?

Which health issues for Aboriginal and Torres Strait Islander peoples do you believe need urgent attention in terms of new national strategies? Why?

Public health strategy implementation

What involvement have you had in the planning and implementation of local programs for Aboriginal and Torres Strait Islander peoples, associated with these national public health strategies? Would you have liked more involvement?

Who was responsible for running these programs - were they run by Aboriginal organisations, government agencies, or other service providers; or by partnerships across these bodies?

How would you describe the relationship between the service providers delivering health services for Aboriginal and Torres Strait Islander peoples in your region (eg AMSs; government-run clinics and hospitals; and others)?

Do you think these public health strategies have led to good programs for Aboriginal and Torres Strait Islander peoples? If so, what made them good? If no, what were the problems?

Have you received funding to support any national public health programs? How has the funding been used, and has it been adequate?

What do you think about the way national public health strategies have been funded – in terms of information provided about the funding, how the funding was allocated, etc?

In your opinion, what lessons can we learn from the national public health strategies that have been developed and implemented so far, in terms of positives and negatives for Aboriginal and Torres Strait Islander peoples?

Public health strategy audit and evaluation

What involvement have you had with the design and conduct of evaluations of public health programs for Aboriginal and Torres Strait Islander peoples? Did you have enough opportunity to provide input and feedback? What were the outcomes?

What suggestions would you have for improving these types of evaluations?

Guidelines to improve strategy development, implementation and evaluation with respect to Aboriginal and Torres Strait Islander peoples

If we were trying to help people develop better national health strategies, what would be some useful items to include in guidelines for them? What tips would they need?