

Achievements in Aboriginal and Torres Strait Islander Health: Final Report

Volume One

**Cindy Shannon
John Wakerman
Peter Hill
Tony Barnes
Robert Griew**

**with assistance from
Ann Ritchie**

October 2002

*Cooperative Research Centre for Aboriginal and Tropical Health
On behalf of
Standing Committee for Aboriginal and Torres Strait Islander Health*

CONTENTS

Volume 1: Achievements in Aboriginal and Torres Strait Islander Health: Final Report

Acknowledgements.....	4
Executive summary.....	5
1 INTRODUCTION	17
Overview of project origin and outcomes.....	17
Project team.....	17
Aims.....	18
Project design.....	18
Ethical considerations.....	19
Scope of the project.....	19
Purpose of this report.....	19
2 METHODS	21
Literature review.....	23
Data collection.....	24
Data analysis.....	27
3 RESULTS.....	30
Phase 1: Literature review and framework development.....	30
Phase 2: Data collection and initial analysis.....	39
Phase 3: Case study analysis.....	40
4 DISCUSSION AND POLICY LESSONS	43
Methodological issues.....	43
Indigenous Health Policy Context – Past and Present.....	45
Literature review, interviews, case studies: lessons learned and policy implications.....	49
5 CONCLUSION.....	65
REFERENCES	67

APPENDIXES **70**
Appendix 1: Matrix for categorization of projects 70
Appendix 2: Framework description and proforma for project nominations 71
Appendix 3: Project nomination list by jurisdiction 79
Appendix 4: Case study analysis reports 82

FIGURES
Figure 2: Project Methodology Flowchart..... 22
Figure 2: Project Themes..... 40

Volume 1: Achievements in Aboriginal and Torres Strait Islander Health

Acknowledgements

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

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

Executive summary

Background

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

Although there has been anecdotal evidence of achievements in Aboriginal health, program evaluations and reports of successful outcomes have not been consistently or comprehensively recorded. At the same time, there has been a common public perception of high expenditure and limited outcomes. Reviews of Aboriginal health expenditure (AIHW, 2001; Keys Young Report, 1997) have refuted the notion of excessive expenditure, but there was a recognised need to document successful outcomes. In response to this need, case studies of successful programs in Aboriginal primary health care were compiled by OATSIH (OATSIH, 2001).

This project was commissioned with a view to extending the critical analysis of achievements in Aboriginal health beyond primary health care programs to include secondary and tertiary health care and other sectors relevant to health outcomes. Through a process of literature review and the nomination of projects in each jurisdiction, this project sought to capture an overview of achievement in Aboriginal and Torres Strait Islander health. From these nominated projects, and a set of detailed case studies, the project elucidated the underlying factors contributing to achievement in health projects, and provided an understanding of how these factors led to success, and the relationships between them. Broader lessons for Aboriginal and Torres Strait Islander health policy were then drawn from these analyses.

Aims

The aims of the project were to:

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

Project Team

The Cooperative Research Centre for Aboriginal and Tropical Health (CRCATH) was commissioned to conduct the project. The project team comprised:

- Associate Professor John Wakerman, Director of the Centre for Remote Health managed the project on behalf of the CRCATH;
- Associate Professor Cindy Shannon, assisted by Condy Canuto, an Indigenous epidemiologist, and a team from the University of Queensland, was responsible for the substantive components of the project, including consultations with key stakeholders; developing the framework; leading and

managing the data collection about successful programs; critical analysis of case studies; and production of the final project report;

- Professor Neil Thomson and the Australian Indigenous Health *InfoNet* team, conducted the literature review;
- Professor Tony Barnes (CRCATH), Dr Peter Hill (University of Queensland), Dr David Thomas (CRCATH) and Robert Griew provided expert guidance and contributions to the critical analysis.
- Ann Ritchie provided expert editorial input.

Study design

A three-phased approach was employed:

Phase 1 comprised an initial literature review, parallel key informant interviews and additional information gathering to inform the development of a case definition of an ‘achievement’ and a framework for the more detailed data collection phase.

Phase 2 identified successful health services, programs and strategies. The initial data analysis of all nominated programs took place during this phase.

Phase 3 included a detailed critical analysis of selected case studies in order to examine further the factors identified as contributing to successful programs and draw conclusions about policy implications.

The literature review was completed in conjunction with the data collection and analysis, and comprises Volume 2 of this report.

The multi-stage design consisted of parallel activities which informed one another. There was interaction with and feedback from SCATSIH at critical points in each stage.

Methodological issues

The methodology followed in the project is outlined in Figure 1: Project Methodology Flowchart in section 2 of this report. In particular it shows the three-phased approach, and the inter-relatedness of the interactions of the project team with the reference group. The research process itself highlighted issues in Aboriginal and Torres Strait Islander health, some of which were themselves pertinent to future policy, and demanded consideration.

- The commissioning of the project by OATSIH on behalf of AHMAC, accountable through HAHU and SCATSIH influenced the selection of projects for further analysis.
- Turnover of staff within each jurisdiction and structural changes and had an impact on project continuity.
- There was a lack of a comprehensive ‘framework’ for Aboriginal and Torres Strait Islander health policy. There has not been a single point of consensus among key stakeholders since the 1989 National Aboriginal Health Strategy, creating difficulties in identifying a nationally acceptable frame from which the identification of appropriate projects could proceed, or through which the current policy platform could be analysed.
- There was only a limited number of completed projects with high quality evaluation data available. This was a direct consequence of ‘stop-start’ policy and funding structures, with short project life-

spans linked to government budgetary cycles, and limiting the utilisation of outcome evaluation to determine continued funding and feeding back into policy formulation.

- Finally, this project was not funded to undertake independent evaluation of nominated health projects. The research team was obliged to take at face value the data presented for analysis by the nominated projects. Thus, a further consequence was that this study relied on secondary sources of data which had been collected for the purpose of evaluating whether those projects were effective, and perhaps, how the outcomes were achieved. The evaluations were not conducted for the purposes of understanding *why* the projects were effective. Thus, even when high quality evaluation data was available, the primary purpose for which those data had been collected was (without exception) *not* for the purpose of evaluating or diagnosing factors leading or contributing to the success of each project.

Findings

Literature Review

The literature revealed achievements in Indigenous health over the past decade across a variety of areas, including improvements in some health outcomes; process indicators with proven links to better health outcomes; areas of the health system or components thereof; and other areas (such as education, employment and housing) that were known to lead to improved health and wellbeing. However, attempting to document achievements in Indigenous health by reviewing the literature was like trying to describe an iceberg from a glimpse of its tip, in that the bulk of achievements was not within view – they had never been written up for publication in the literature. So, any literature review would be, by its very nature, an incomplete summary of achievements.

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

Secondly, as well as the long (and often uncertain) lead-times between most interventions and the achievement of positive outcomes (and even process indicators), it was important also to recognise that concerted efforts addressing the enormous health and other disadvantages experienced by Indigenous people began less than a decade ago, with Commonwealth efforts really dating only from the mid-1990s (Australian National Audit Office, 1998). Thirdly, recent levels of government funding for Indigenous health have been judged by the Commonwealth Grants Commission (CGC) to be at most about half those required, with the funding of ‘up-stream’ areas also less than needed (Commonwealth Grants Commission, 2001).

In view of Australia’s performance in health generally - and the country’s wealth - the achievements in Indigenous health in the past decade in terms of health outcomes, have been disappointing. However, given long lead times, only recent concerted effort and overall under-funding, the assessment of achievements in Indigenous health was much more encouraging.

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

Accompanying these improvements in the health infrastructure were: improved access of Indigenous people to mainstream services (including the Medical and Pharmaceutical Benefits Schemes); growth in the Indigenous health workforce; greater availability of Indigenous health knowledge and information; and the development of a strategic research capacity in Indigenous health (particularly through establishment of the Research Agenda Working Group).

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

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

In terms of process indicators with proven links to better health outcomes, there were some encouraging signs in the areas of physical activity and dietary patterns.

Definition of 'achievement' and factors contributing to success

The definition of 'achievement' or success developed and used in the research process was:

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

Contributions to Success

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

The factors that emerged as being likely to be important, or potential **contributors to success** from the initial literature review and the expert consensus, and subsequently validated and explored in the analysis of the case studies were:

- Community control
- Community participation / involvement
- Resourcing
- Sustainability
- Partnerships, including intersectoral collaboration
- Workforce
- Evaluation
- Accountability
- Capacity building

The **role of the community** was seen as a crucial aspect. This role encompassed a broad range of responsibilities, from the community-control of primary health care services to more general community participation and involvement in health and other matters.

Adequate **resourcing** of projects, programs and interventions was seen as important, especially as it was acknowledged that one of the main aims of the Australian health care system was to achieve equity for all Australians. Attention was drawn to the report of the Commonwealth Grants Commission of inquiry into Indigenous funding (Commonwealth Grants Commission, 2001), which acknowledged that reliable data on need were not generally available for a range of reasons; and that the Commonwealth Grants Commission found that there was no evidence that excessive amounts were spent on Indigenous health (Commonwealth Grants Commission, 2001). This was consistent with the findings of the Deeble report (Deeble et al., 1998), which had a profound effect on Commonwealth policy and resulted in a number of initiatives to reform the Australian financing system in Indigenous health (Australian Institute of Health and Welfare, 2001).

Issues to be considered were: the adequacy of resources and whether funding was sufficient to meet the needs and objectives of the program, project or intervention; that projects were ‘set up to fail’ when they did not have/receive adequate funding; and whether programs, projects or interventions represented value for money.

Sustainability included aspects related to appropriate resourcing of programs, projects and interventions and problems associated with the short-term commitment of funds to projects such as the inability to plan ahead, high staff turnover, and general uncertainty. Other resourcing considerations included the need to review funding levels periodically, to ensure they were adequate and had the capacity to respond to emerging and changing needs within communities; the problems with one-off, demonstration or pilot projects, unless there was a longer-term commitment to ongoing funding, if successful, and wider uptake of models developed through such projects.

It was emphasised, however, that funding alone should not be seen as the key to sustainability and other factors – such as the changes in specific staff involved, a failure to sustain behavioural changes or a change in community priorities (because of the perception that a particular issue was no longer a problem in the community) – could be equally important.

The importance of **partnerships, including intersectoral collaboration** was expressed by The Commonwealth Grants Commission inquiry into Indigenous funding, which concluded: ‘the

importance of effective agreements and partnerships between levels of government and Indigenous communities, both within the health sector and in other areas, cannot be overstated' (Commonwealth Grants Commission, 2001). This sentiment was very similar to the importance attached to partnerships and intersectoral collaboration in the 1989 National Aboriginal Health Strategy (National Aboriginal Health Strategy Working Party, 1989).

Formal partnerships included the joint planning forums established in each jurisdiction from the Framework Agreements on Aboriginal and Torres Strait Islander Health. These forums included Commonwealth and State/Territory governments, Aboriginal community-controlled health organisations and ATSIC. The Primary Health Care Access Program (PHCAP) aimed to assist in improving comprehensive primary health care provision in areas where needs had been identified through joint regional planning. Within the research area, there was an increasing number of collaborations between Indigenous communities and research agencies. Examples included the Cooperative Research Centre for Aboriginal and Tropical Health, the University of Queensland's Indigenous Health Program and the TVW -Telethon Institute of Child Health Research.

It was important also to consider informal partnerships at the local community level which demonstrated a genuine commitment by a number of sectors to working together to address community-identified priorities. However, despite agreement about the importance of intersectoral collaboration, there was a paucity of documented examples of successful collaborations.

Workforce issues identified included the fact that a number of significant developments in the Indigenous health workforce had occurred over the past decade, but there was a continuing Indigenous under-representation in the medical, nursing and allied health workforce.

It was evident that workforce issues would play an important role in understanding the contributors to success in relation to specific projects. While there have been numerous reviews and reports on workforce issues in relation to Aboriginal and Torres Strait Islander health, there was little evidence of work that specifically documented a detailed analysis of the workplace issues and the underlying reasons why, in particular instances, the success of a project or program may have been attributed to the workforce.

Evaluation of programs and interventions in Aboriginal and Torres Strait Islander health were only just beginning to take place, and there was a general lack of information on what did or did not work. The health sector overall, however, had been moving towards an evidence-based approach that informed decisions about policy direction and the targeting of resources. The importance of an evaluation strategy and adequate resources allocated as part of the budget to meet the costs of evaluation was stressed. Further, the dissemination and availability of high quality information – both the appropriate methods of evaluation and the results of these evaluations - were important.

In the past, **accountability** had often been linked to the financial performance of an organisation and its compliance with the reporting requirements of the funding body. Greater attention was now being given to the need for accountability to Aboriginal and Torres Strait Islander communities. It was acknowledged that appropriate accountability measures – both to funders and to the community – could contribute to the sustainability and success of programs through maintenance of adequate funding and outputs appropriate to community needs.

Capacity building, at community and individual level, was seen as an important component of most of the other factors. It was recognised as an area that needed special consideration in the assessment of the success of specific programs, projects and interventions.

The literature review, in parallel with the key informant interviews confirmed the important roles of the community (in terms both of community control and participation) and of partnerships. Appropriate resourcing was recognised as crucial at an overall level, but it was not possible to discern any clear picture of the resourcing of individual programs from the literature - except that insufficient resources have been allocated for evaluation. The importance of capacity building, emphasised by the National Aboriginal and Torres Strait Islander Council and the CGC, was clear from the literature. There have also been encouraging developments in the Indigenous workforce, and in accountability mechanisms.

Lessons learnt from case studies and policy implications

The policy implications drawn from the case studies and literature review were described in the following framework:

1. Model of health
 - Comprehensive primary health care
 - Specific health interventions and secondary/tertiary health care
 - Intersectoral intervention
2. Community factors
 - Community control
 - Community participation
3. Funding and evaluation factors
 - Resourcing
 - Accountability
 - Evaluation
4. Implementation factors
 - Partnerships
 - Workforce
 - Capacity building
 - Sustainability
5. Other factors
 - Leadership
 - Policy niche

This study intentionally ventured beyond the strong focus on the comprehensive primary health care **model of health care** which has been central to Aboriginal health policy development. It analysed successful programs in the secondary and tertiary health care sectors, as well as non-health sectors. There were a number of relevant implications that could be drawn from the case studies, which also related to other areas in this framework:

- Specificity and measurability in intersectoral interventions and the importance of a clear analysis, and focussed objective;
- The potential of collaboration between State, Aboriginal community controlled sector and professional non-Aboriginal non-government sector in programs to enhance primary health care (admittedly on a very small number of examples);
- Partnership with academic institutions in design and evaluation;
- The importance of local and political leadership and support; and
- The importance of long-term support from key staff.

The implications of this study were that, with attention to specific objectives and stable professional support, a wider set of intersectoral and specialist areas could successfully be addressed, and in fact there were examples of government and community collaboration achieving this.

The case studies and literature review confirmed the importance of **community control and community participation**. The study described a broad continuum of engagement with Aboriginal and Torres Strait Islander communities which was reflected in a five-tiered taxonomy. This described community controlled projects, community initiated projects, community grounded projects, community adopted and community oriented projects.

There was a range of viable and constructive engagements actually in place. Whilst community engagement of some degree and for a variety of reasons was evident, Aboriginal community control was not a pre-requisite factor for a successful outcome. There were different reasons for community involvement contributing to a successful program. For example, *Fixing Houses for Better Health* was a very intrusive program and required strong community support. For other cases, such as the *Queensland Well Persons Health Check* and the *Katherine West Coordinated Care Trial*, community control was a key and essential feature. Whilst community control may not be a pre-requisite, the longer term impact may be significant in relation to capacity building and underlying social determinants of health.

Adequate **resourcing** could be considered a self-evident prerequisite for project success. Analysis of the case studies revealed the potential for *strategic* use of resources to significantly enhance the potential of the project. This was most apparent in the *Katherine West Coordinated Care Trial*, where a new approach and commitment to pooled and increased funding was made. The *Koori Maternity Services* project benefited from being part of a larger State health program. The *WA Swimming Pools for Remote Aboriginal Communities* project was predicated on significant capital investment and represented an opportunistic access to Lotteries Commission funding, that might not otherwise have been available to remote communities. The main consistent problem around these different resourcing needs was not so much quantum as the short funding cycles, unpredictability of funding and time consumed in pursuing ongoing funds.

The limited contribution of **accountability** to achievement in Aboriginal and Torres Strait Islander health reflected broader issues of governance, with responsibility for projects diffused over a range of stakeholders. In most cases, financial accountability was to the funding agency, though projects were less likely to represent themselves as *strategically* accountable for their outcomes within a specific policy framework. The development of OATSIH within the Commonwealth Department of Health and Ageing, the State and Territory Aboriginal Health Policy offices and the evolution of community controlled health organisations has provided an increasingly comprehensive policy framework for Indigenous health. However, the complex network of responsibilities for Indigenous health often

precluded the establishment of a single locus of accountability for outcomes of health projects. Where collaboration between agencies resulted in a single point of accountability, as with the *Katherine West Coordinated Care Trial*, evidence suggested that health service provision improved significantly, though it was too early to judge the impact on health status overall.

The lack of **evaluation** influenced both the methodology and results of this study, and also linked to the project funding cycle for Indigenous health. Of more than one hundred projects, fewer than fifteen projects had project evaluations that were sufficiently complete to enable case study analysis to be considered. In part this was due to short project funding cycles – frequently three years – with few projects having an extensive history of achievement. The short project life cycle meant that meaningful analysis of health outcomes resulting from the project was difficult, as many of these depended on longer term change, or were influenced by multiple factors, to which the project components may have contributed. The absence of a clear link between continued funding and demonstrable project outcomes further reduced the incentive for rigorous evaluation.

These case studies demonstrated that the projects with superior evaluation and accountability strategies also had a more plausible story to tell about results. They also showed that it was possible not only to reconcile accountability with community ownership but also that accountability constructed around the very specific outcomes for community were the most powerful. Both the *Fixing Houses for Better Health* and the *Katherine West Coordinated Care Trial* were exemplars of this. As such they had strong lessons for both funders and service providers in Aboriginal health. Accountability, evaluation and funding reform were all possible, most usefully tied together in one package and necessarily related to processes of defining accountabilities to communities as well as funders.

The case studies demonstrated a number of innovative **partnerships** in sponsoring, planning and implementing the projects. The case studies provided examples of collaborations for Aboriginal and Torres Strait Islander health that included a range of players, including:

- Health Departments and Departments of Aboriginal and Torres Strait Islander Policy, Housing, Youth Sport and Recreation
- The private sector
- Non-Government Organisations
- Mainstream health services
- Aboriginal Community Controlled Health Services
- Secondary and tertiary health services
- Academic institutions

The case studies revealed a diverse range of partnerships, with the strength of collaboration between a range of government, non-government and academic institutions. A number of these collaborations were between agencies that had a history of conflict, and the surmounting of these tensions was a major contributor to the success of the projects. What the available literature did not document were the barriers, difficulties, significant organisational cultural shifts and costs of successful collaborations.

Workforce implications varied across the projects – in some projects, such as the *Indigenous Employment Policy* and the Queensland Health *Indigenous Workforce Management Strategy* it represented the core focus. In others such as the *Koori Maternity Services Program* and the NSW *Aboriginal Vascular Health Program*, the impact was made through recruitment and training of Aboriginal health workers in specific roles; and in the *Fixing Housing for Better Health* the recruitment

of a community-based workforce for the duration of the project resulted in a skills transfer in the area of maintenance that made an enduring contribution to local social capital

The development of an Indigenous workforce, both *in* health and *for* health, was crucial to establishing capacity and ensuring sustainability. Clearly, the combined impact of a range of employment programs would be experienced in both mainstream and community controlled health services, as well as producing health outcomes through economic growth and employment opportunities. The eventual impact of workforce development was dependent to some extent on its ability to alter decision-making within community organisations, and in government health departments, through a greater Indigenous presence in management and professional roles.

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

The *Katherine West Coordinated Care Trial* provided a model for capacity building, with sustainability built into its structure. This was achieved primarily by the structural changes achieved through the creation (and commitment to its support and training) of the community controlled Katherine West Health Board and the pooling of both Commonwealth and Territory financial resources that assured predictable on-going funding. In addition, secured funding of this nature and the resultant improved access to health services provided some sustained incentive for community members to take on the responsibilities of governance and management. For most projects, short project cycles and the need to ‘invent’ innovation in order to secure ongoing funding, worked against the development of institutional capacity and sustainability, and undermined rigour in evaluation because of the difficulties in demonstrating change over such short time frames and the absence of a direct link between performance and ongoing funding.

In the areas of workforce and capacity building, the case studies and literature reflected some of the gains in these areas, but indicated there was still a long path ahead. The Queensland Health *Indigenous Workforce Management Strategy* was important because it received a level of profile and priority, also because it addressed labour market as well as workforce development. A number of the other case studies also illustrated creative and useful strategies for capacity development in communities for example. One need that stood out still was for leadership in defining the roles for Aboriginal staff – at the full range of professional roles in the health system – and strategies that would develop people across the full range, given the starting point.

Two further factors that were not evident from the initial key informant interviews emerged from the case study analysis. These were leadership and the policy framework itself. Strong and sustained **leadership** by a skilled individual was key to a number of the projects but was not acknowledged despite the evidence for inclusion as a precursor to gains in some of these complicated areas. This was a reality that people in Aboriginal health talked about often. The examples examined bore this out. For example the *Swimming Pools for Remote Aboriginal Communities* project had sustained support from the WA Aboriginal Affairs Minister and a number of key individuals in the target communities. Queensland Health’s *Indigenous Workforce Management Strategy* had a champion and sponsor in the Director-General. Political leadership was also evident in the Western Australian *Aboriginal Identification Project*

One of the other clear contributors to the success of projects, not previously identified from the key informant interviews, was evidence of political commitment, and the location of projects within a supportive **policy framework**. Indigenous employment was based on a strong national policy. Queensland Health's *Indigenous Workforce Management Strategy* – sponsored by the Director-General – provided the necessary authority and policy commitment to make Indigenous recruitment an acceptable performance indicator at District level, and ensured workforce change. The Western Australian *Aboriginal Identification Project* was a response to recommendations of the Aboriginal and Torres Strait Islander Health Information Plan as endorsed by the Australian Health Ministers' Advisory Council. The Queensland *Nutrition Policy for Remote Retail Stores* provided a clear structure to initiate change that proved to be both cost-effective as well as health promoting. The *Aboriginal Vascular Health Program* also displayed the feature of local flexibility in implementation.

The *Katherine West Coordinated Care Trial* utilised the opportunity afforded by an innovation in health service provision to explore new funding and structural options, with a resultant improvement in health services. Having established its policy 'niche', the *Katherine West Coordinated Care Trial* allowed the models of coordinated care to be extended and modified to bring additional primary care resources within a new framework of community control, effectively changing policy direction. This was accomplished through an established mechanism of local and national evaluation of the co-ordinated care trials.

Conclusions

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

Firstly, there was a general paucity of outcomes data and lack of a solid evidence base. The literature review and projects initially nominated by jurisdictions revealed this lack of data. Even several of the detailed case studies had very little useable data, despite in some cases having acquired good reputations for having achieved results. This highlighted the need for stronger evaluation through establishing reliable baseline data and appropriate performance indicators, and partnerships between service providers and institutions with evaluation expertise, as well as services building their own monitoring and evaluation capacity.

The study raised the question as to whether the emphasis on processes has gone too far and whether some of the process objectives were no longer either useful or acceptable as proxy outcome measures. Some of the questions thrown up by the study addressed fundamental principles, such as community control of primary health care. It questioned whether it was the particular mechanism of community control that was the objective or the outcomes that particular forms of community control could achieve, if indeed those outcomes were dependent on particular models of community engagement.

The literature review and the range of projects initially nominated demonstrated the 'stop-start' nature of past Aboriginal health policy and the inherent short funding cycles that programs endured. There had been a repeated search for innovation which resulted in a high turnover of projects and recycling of ideas, rather than utilising the not insignificant knowledge currently available and properly evaluating its effectiveness.

Another result of past policy evidenced in the literature review and cases examined was the lack of communication and co-ordination of effort across the health and other sectors. There was a rich patchwork of initiatives responding to meet local needs, but lack of an overall strategic approach. A

long term strategic policy framework with appropriate resource commitment would support and sustain further achievements in Aboriginal and Torres Strait Islander health and should further develop the notion of capacity building in order to ensure sustainability of programs and improved health outcomes.

1 Introduction

Overview of project origin and outcomes

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

Although there has been anecdotal evidence of achievements in Aboriginal health, program evaluations and reports of successful outcomes have not been consistently or comprehensively recorded. At the same time, there has been a common public perception of high expenditure and limited outcomes. Reviews of Aboriginal health expenditure (AIHW, 2001; Keys Young Report, 1997) have refuted the notion of excessive expenditure, but there was a recognised need to document successful outcomes. In response to this need, case studies of successful programs in Aboriginal primary health care were compiled by OATSIH (OATSIH, 2001).

This project was commissioned with a view to extending the critical analysis of achievements in Aboriginal health beyond primary health care programs to include secondary and tertiary health care and other sectors relevant to health outcomes. Through a process of literature review and the nomination of projects in each jurisdiction, this project sought to capture an overview of achievement in Aboriginal and Torres Strait Islander health. From these nominated projects, and a set of detailed case studies, the project elucidated the underlying factors contributing to achievement in health projects, and provided an understanding of how these factors led to success, and the relationships between them. Broader lessons for Aboriginal and Torres Strait Islander health policy were then drawn from these analyses.

Project team

The Cooperative Research Centre for Aboriginal and Tropical Health (CRCATH) was commissioned to conduct the project. The project team comprised:

- Associate Professor John Wakerman, Director of the Centre for Remote Health managed the project on behalf of the CRCATH;
- Associate Professor Cindy Shannon, assisted by Condy Canuto, an Indigenous epidemiologist, and a team from the University of Queensland, was responsible for the substantive components of the project, including consultations with key stakeholders; developing the framework; leading and managing the data collection about successful programs; critical analysis of case studies; and production of the final project report;
- Professor Neil Thomson and the Australian Indigenous Health *InfoNet* team, conducted the literature review;
- Professor Tony Barnes (CRCATH), Dr Peter Hill (University of Queensland), Dr David Thomas (CRCATH) and Robert Griew provided expert guidance and contributions to the critical analysis.
- Ann Ritchie provided expert editorial input.

The collective networks and expertise of the project team members provided the potential for the collection and dissemination of important information on achievements in Aboriginal and Torres Strait Islander health that may not otherwise have been available in the public domain.

Aims

The aims of the project were to:

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

Project design

A three-phased approach was employed to fulfil the project's objectives.

Phase 1

This comprised an initial literature review, parallel key informant interviews and additional information gathering to inform the development of a case definition of an 'achievement' and a framework for the more detailed data collection phase. Considerable effort was expended on developing an appropriate framework for further data collection and analysis, as this was considered critical to the success of the project.

Phase 2

In the second phase, the project relied on State and Territory health authorities and non-government health services to identify successful health services, programs and strategies and to provide information about these programs to the research team. All relevant programs, including those conducted outside the health sector, were eligible for consideration as an achievement in Aboriginal and Torres Strait Islander health. SCATSIH members nominated projects for consideration, and facilitated, coordinated and advised on the collection of data within their jurisdictions. The initial data analysis of all nominated programs took place during this phase.

Phase 3

The final project report was produced in Phase 3 following a detailed critical analysis of case studies selected in order to examine further the factors that were identified as contributing to successful programs.

The literature review was completed in conjunction with the data collection and analysis, and comprises Volume 2 of this report.

The multistage design consisted of parallel activities which informed one another. For example, in Phase 1 the initial literature review informed the development of the data collection framework at the same time as the key informant interviews informed the literature review. These processes are detailed in section 2 Methods and in Figure 1: Project Methodology Flowchart. There was also interaction with and feedback from SCATSIH at critical points in each stage.

Ethical considerations

Although the most likely source of data was published reports and reviews, it was acknowledged that potential existed for the further collection of data through interviews, advice from key informants, and access to informal communication and reports. Ethical approval for the project was therefore, sought from the Top End Human Research Ethics Committee. Approval was granted for the project methodology as outlined in section 2 Methods.

Scope of the project

The project aimed to document and share information about achievements in Aboriginal and Torres Strait Islander health over the past decade, and to use this information to promote and build on the models and experience of health services, programs and strategies that have been shown to work or to have had a positive effect on the health of Aboriginal and Torres Strait Islander people. It was intended that the knowledge gained during the project could also identify gaps in knowledge, practice and policy to inform future initiatives.

The scope of the project included primary, secondary and tertiary health care (both hospital and community health settings), as well as relevant programs in non-health sectors, such as housing and education, which have led to or are already proven to contribute to better health outcomes.¹

While the literature review revealed an impressively broad and varied range of successful Aboriginal health programs, the purpose of the project was not to produce a comprehensive record of all achievements in Aboriginal and Torres Strait Islander health in Australia. Many programs were not formally evaluated or published. Neither was it intended to select and analyse a geographically or programmatically representative sample. Rather, the focus of the project was to explore documented examples of achievements – either published or in the ‘grey’ literature – in order to gain insights into the underlying factors which contributed to their success and their policy implications.

The target audience for this project was government and larger health services. It was also intended that the project would be of interest to a range of other sectors and the general community.

Purpose of this report

The purpose of this report is to document and disseminate the findings of the project: *Achievements in Aboriginal and Torres Strait Islander Health*. Volume 1 of the report describes the research design and

¹ Brief examples of primary, secondary and tertiary health care services (and also Community/welfare; Education/research; and other sectors) were provided in the Information Package sent out requesting nominations for projects – see Appendix 1: Matrix for categorization of projects.

process, and presents and explores examples of achievements in Aboriginal and Torres Strait Islander health over the past decade. In addition to this, the report documents the outcomes of the analyses which were conducted on selected case studies, so that information about critical success factors can be used to promote and build on the models and experience of health services, programs and strategies that have been shown to work or to have had a positive effect on Aboriginal and Torres Strait Islander health. The different factors or elements which were identified as ‘contributors to success’ and which explained how and why these services, projects, programs and strategies have worked, are explored in *Lessons arising from case study analyses* (see section 4 Discussion and policy lessons).

A listing of the projects nominated by the jurisdictions as examples of successful services, projects, programs and strategies is provided in Appendix 3: Project nomination list by jurisdiction.²

The detailed analyses of 10 case studies are documented in Appendix 4: Case study analysis reports. These case study analyses were carried out in order to critically analyse the underlying factors which contributed to successful programs and to highlight the implications for policy-makers.

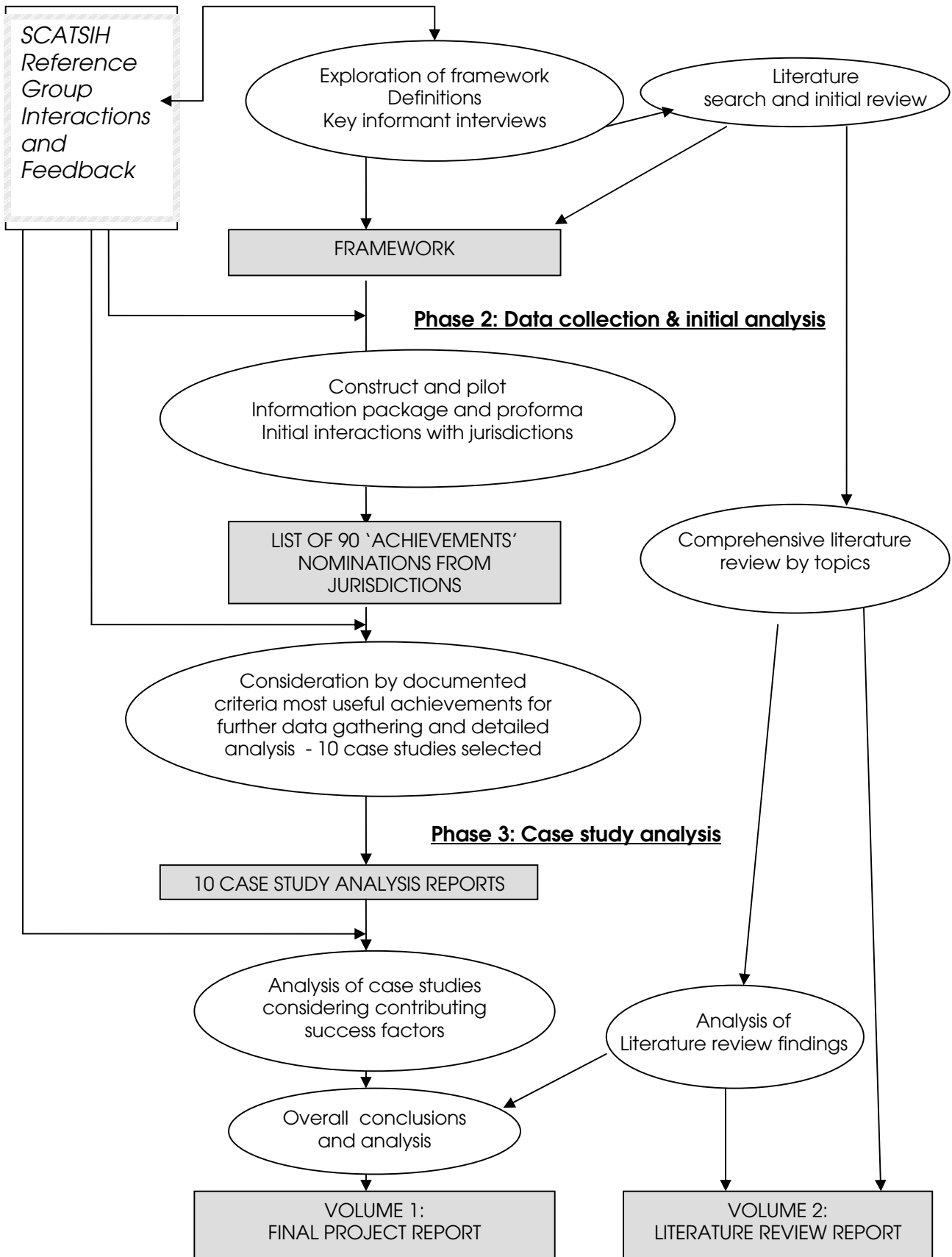
The detailed findings of the literature search and review are presented in Volume 2: Literature Review - *Describing an iceberg from a glimpse of its tip: a summary of the literature on achievements in Aboriginal and Torres Strait Islander health*.

² This list includes 58 nominations for which complete information was obtained and 32 nominations with incomplete information supplied

2 Methods

The following Figure outlines the methodology followed in the project. In particular it shows the three-phased approach, and the inter-relatedness of the interactions of the project team with the reference group, the research process, and the literature review.

Figure 1: Project Methodology Flowchart
Phase 1: Framework development & literature review



Literature review

Scope of the review

A thorough review of the literature - both published and unpublished - was undertaken by a team at the Australian Indigenous Health*InfoNet* between October 2001 and March 2002. The review was limited largely to references published since 1992.

Reflecting recent international approaches to assessing achievements in the health sector – and current ‘definitions’ of Aboriginal and Torres Strait Islander health (Australian Bureau of Statistics & Australian Institute of Health and Welfare, 2001) – a broad, inclusive approach to the identification of achievements in Aboriginal and Torres Strait Islander health involved attention to physical, mental, social and cultural aspects. Social and cultural determinants, environmental context, the provision of services, lifestyle factors, and vulnerability to specific health conditions were taken into account. Short and potential long-term achievements were considered.

Sources searched

In the initial stage of the review, databases and other sources of information were searched to find information about international and national methods of assessing health achievements. Databases searched were Science Direct, HealthSTAR, Australian Public Affairs Information Service (APAIS), Cumulative Index to Nursing and Allied Health Literature (CINAHL) and Medline. Documents were sourced through holdings at Edith Cowan University and on the Internet.

The Australian Indigenous Health*InfoNet* Bibliography was a primary source of information for achievements in Indigenous health and for information about the context of those achievements. This was supplemented by searches of bibliographic databases as outlined above.

Search strategy

Searching for material on ‘achievements’ and ‘success’ was a complex and developmental process, as none of the main bibliographic databases (including the Australian Indigenous Health*InfoNet* Bibliography) used ‘achievement’ or ‘success’ as an indexed term. A number of keywords were relevant. Some were evident at the start of the project (examples included ‘health outcomes’ and ‘best practice’) and others were discovered in the process of the review. Some keywords were relevant only to specific health areas.

Limitations

As noted above, the review was limited largely to material published after 1992. It focused on Australian material, although some international publications from UK, USA and Canada on methods of assessing health achievements, were included. Within this scope, the comprehensiveness of this review was limited firstly, by the difficulties associated with locating material in the ‘grey’ literature, and secondly by the variability in relevant keywords in different databases and in different topical

areas. In addition to these limitations, the most recent achievements were excluded from the literature review, as information about these programs had not yet have reached publication stage.

Methodology

The literature review was undertaken in two phases in conjunction with the first two phases of the project. The initial phase focused attention on evidence in the literature that would inform the framework developed for data collection and analysis in Phase 2 of the project. The second phase concentrated on a selection of the literature identified during the first phase, and summarised and synthesised this according to areas of achievements. These chapters form the bulk of the report contained in *Volume 2: Literature Review*.

Approximately 1600 items were identified as possibly relevant to the project. Of these, good examples of achievements were selected for inclusion in the summary of the literature according to indications of improvement for Aboriginal and Torres Strait Islander health. Wherever possible, examples of interventions demonstrating generally acceptable measures of success – such as decreased incidence/prevalence of disease, improvements in health trends, the identification and reduction of risk factors and the improvement of social determinants of health – were included.

Data collection

Phase 1: Framework development

To develop the data collection framework, an initial literature review, parallel consultations, including discussions and a series of in-depth key informant interviews with a variety of people involved in Indigenous health, were carried out. The aim was to gather information relevant to Indigenous health in order to:

- define ‘achievement’ or ‘success’;
- provide examples of achievements in Indigenous health;
- identify examples of measures and methods of assessing achievements;
- identify key factors contributing to achievements;
- identify priority areas for the construction of the framework; and
- identify gaps within available information.

Key informants were identified through the collective knowledge of the project team, advice from SCATSIH members and other expert advisers to the project in the area of Aboriginal health. The target group for the in-depth interviews included Indigenous and non-Indigenous people working in government and non-government health organisations and academic institutions, particularly members of the Standing Committee on Aboriginal and Torres Strait Islander Health (SCATSIH). People with international experience, especially those working with other Indigenous groups were also interviewed. Respondents held a wide range of positions, and, collectively, had very extensive experience in Indigenous health, with at least four having twenty or more years experience in the field.

The interview questions were developed following a series of meetings of the project team to brainstorm the issues. They were then piloted on staff of Australian Indigenous Health *InfoNet* to ensure an appropriate fit with the data emerging from the literature.

In-depth interviews, of approximately thirty minutes duration were carried out over a two-week period in December 2001. Nineteen people were initially contacted as part of the recruitment process, and were invited to arrange an interview time at their convenience. Project information packages were forwarded by electronic mail to the invited interviewees. In addition, the project summary and interview questions were forwarded to all SCATSIH members for their information and input.

Project team members interviewed thirteen of the nineteen people contacted. Two additional respondents chose to reply by electronic mail. Thus, fifteen people provided responses to the interview questions. For those interviewed, a semi-structured technique was employed, thereby providing an opportunity for participants to provide additional information about their area(s) of expertise. Most interviews were conducted via teleconference, with four conducted as face-to-face interviews. Two of the respondents were interviewed concurrently (due to a shared workplace). Notes were taken during all interviews, and a number of interviews were also taped (after the respondents granted permission). At least two interviewers were present at most interviews – one filling the role of primary investigator and the other documenting the information generated.

Summaries were created immediately following each interview, with responses entered on a collective form. This data entry process allowed for immediate and continuing analysis, enabling the identification of common themes and alternative, novel views in relation to successful approaches to Indigenous health and associated contributing factors.

Phase 2: Nomination of successful projects and analysis

In order to fulfil the project's aims, the research needed firstly to identify health services, programs and strategies which had been shown to work, and/or to have had a positive effect on Aboriginal and Torres Strait Islander health, and secondly to analyse the programs to distil the underlying critical success factors which explained how and why these programs were successful.

The following **working definition for success** emerged from the framework consultations and was subsequently adopted for the project:

A success in Indigenous health is a program, project or intervention, or element thereof, that produces, or could contribute to, a demonstrated improvement in Indigenous wellbeing.

The two broad measures of success or achievement developed and used in the project to identify and explore achievements in Aboriginal and Torres Strait Islander health were:

- indicators of progress – these fell into four categories - improvements to health outcomes; improvements to process indicators with a proven link to better health outcomes; improvements in the health system or components thereof; and improvements in other areas; and
- contributors to success - underlying factors explaining how and why programs have worked.

Phase 2 depended heavily on liaison with each of the States/Territories to nominate projects meeting the criteria for achievement from within their jurisdictions, and to provide the data necessary for analysis of these projects.

An information package was sent to the CEOs of all State/Territory Health departments and the Commonwealth Department of Health and Ageing, and a letter was sent to the Chairperson of NACCHO seeking advice in relation to input from the community-controlled sector. Included in the information package was a detailed letter explaining the background to the project and the assistance requested during Phase 2, as well as a summary of the project framework and a nomination form for completion in relation to successful projects. (See Appendix 2 for the Framework description and proforma for project nominations.)

State and Territory health authorities (including SCATSIH members) and non-government health services were asked to identify projects, programs, interventions or strategies for which they were able to demonstrate the following:

- achievement of an outcome in accordance with one of the four outcome areas identified in the project's framework, including a brief description of the activity;
- the factor(s) to which the successful outcome could be attributed - consistent with the key elements of success identified in this framework; and
- a clear statement of the measures (and changes in those measures) used to show evidence of firstly, what was achieved and secondly, why it was successful. That is, what evidence, either qualitative or quantitative, existed to demonstrate the success of the nominated program or project.

The Framework description contained a list of the elements or factors³ which were considered likely to contribute to the success of a project. This list had been developed from the preliminary analysis of the literature and the key informant interviews. The elements were:

- Community control;
- Community participation / involvement;
- Resourcing;
- Sustainability;
- Partnerships, including intersectoral collaboration;
- Workforce;
- Evaluation;
- Accountability; and
- Capacity building (human & physical infrastructure)

Respondents were also asked to consider whether there were any known limitations of the data available and other issues related to the measures used, and an appropriate response to these.

Nominated projects were categorised according to a matrix combining area of achievement and relevant sector (see Appendix 1: Matrix for categorisation of projects).

³ For a detailed analysis of the 'contributors to success' see the section in 4 Results - Framework development: defining an 'achievement' and contributors to success.

‘Area of achievement’ included aspects such as access to services, community control, environmental conditions, and social and economic measures, as well as specific health problems (e.g. CVD, mental health, injury and cancer). The relevant sectors were primary health care, secondary / tertiary health care, health infrastructure, and other sectors (including community, welfare, education and research.) This approach was adopted to demonstrate the full spectrum of achievements in Aboriginal and Torres Strait Islander health over the past decade.

Each jurisdiction had been asked to nominate a contact or liaison person to assist the project in further data collection. These liaison people in each jurisdiction were contacted by a member of the project team to organise a more detailed teleconference to discuss the requirements and project process. Most requested an opportunity to pilot a nomination form and seek feedback, proposing deferral of the site visits until they could give greater consideration to the process and ensure input from other sectors.

During the teleconferences, the co-ordination role of the liaison person and the need to ensure appropriate input from the community-controlled health sector, as well as other sectors within their jurisdictions, were reinforced. It should be noted that there was some variation of internal departmental processes between jurisdictions.

Follow up telephone calls were made to the liaison person in each of the jurisdictions, and site visits to six States/Territories were made by project team members. Members of the project team located in the Northern Territory and Western Australia were available for consultation in relation to these jurisdictions.

Data analysis

From the 90 projects originally nominated in the data collection phase as being successful programs, 10 case studies were selected for more detailed follow up and case study analysis. The definition of achievement or success, and the means of measuring it, remained consistent with the working definition of success identified in Phase 1 of the project:

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

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

1. Completed activities and evaluation data
A number of the projects had not yet been completed and were nominated on the basis of projected outcomes.
2. High quality evaluation data
This was largely in the form of external or independent project evaluations, often published and in the public domain.

3. Evaluation data available

A number of projects had not been formally evaluated, but could provide some evidence of evaluation measures being available.

4. Significant area relating to Aboriginal health

Links were drawn to the national performance indicators for Aboriginal and Torres Strait Islander Health (Office of Aboriginal and Torres Strait Islander Health, 2000) and the national health priority action areas (National Health Performance Committee, 2001).

5. Spread of cases across primary, secondary, tertiary health sectors and other relevant sectors

A project matrix was developed in Phase 1 as a working document to monitor the scope of the nominated projects (see Appendix 1).

This sequence had important consequences for the selection of individual case studies. There was consideration of analysis of collected data at three levels:

- all nominations received;
- program area case clusters; and
- individual case studies.

The last two criteria, addressing significance and distribution of cases, could not be applied until the first three threshold criteria were met. This meant that the available pool of projects for detailed case study analysis was limited as a direct consequence of the short project time span (frequently three years or less, as dictated by funding cycles), with only a fraction of projects completed, and the availability of quality evaluation data.

Phase 3 tested the hypothesis established in the first phases of the project that there were identifiable elements associated with successful projects, and that these included the nine contributors to success that were identified in the project framework.⁴ In addition it sought further factors that had not been identified at this point, and their contribution to achievement.

The cases that were selected for detailed follow up then required additional data collection to enable case study analysis. The contact person named in the nomination form was then contacted by a member of the project team to seek access to available data and clarification in relation to specific issues. Where possible, data was made available electronically, but for many projects, access in print form only was available. This caused some delays in the case analysis.

The information used to analyse the case studies included formal external evaluations, internal reviews, interim reports, working documents, published reports and discussions with project staff. The quantity and quality of the data and availability of relevant information varied quite substantially for each of the cases. Where difficulties were experienced in obtaining the information, or where insufficient information was provided to enable an analysis to be undertaken, a replacement case study was identified. This was taken from a reserve list that was established in the application of the case study selection criteria and subsequent ranking of the cases.

Upon receipt, the case study data were interrogated to provide responses to the following questions:

⁴ Triangulation was used to ensure the validity of the research findings – a combination of three methods of data collection and analysis - literature review, expert consensus and case study analyses, was used to test the indicator variables as factors which were 'contributors to success'.

- What has been achieved?
- What measures have been used to provide evidence of what has been achieved?
- What documentation is available to support this evidence?
- How did the ‘success factors’ contribute to the outcome/s achieved?
- Are there pre-requisite success factors?
- Are some success factors more critical than others?
- Are some more relevant to certain program areas than others?
- How important was context - is the program transferable?
- Are there any known limitations to the above?
- What are the lessons from these findings for Aboriginal and Torres Strait Islander health policy?

Appendix 4 contains the completed case study analyses. A tabulation of elements of success against the analysed projects and project clusters was carried out to answer the question relating to whether some elements of success were more relevant to certain projects or activities. In considering this issue, reference was made back to the full project list, to explore linkages between the findings of the detailed case analyses and the summary information provided on the nomination forms for projects that were of a similar nature to each of the detailed case studies.

Understanding the contributors to success for each of the case studies could then be linked to the larger frame of nominations and the lessons drawn from the literature review. Examination of these three sources allowed the synthesis of conclusions from the data that could inform policy direction and program implementation, with lessons on how success might well be achieved in projects in Indigenous health.

3 Results

Research in the area of outcomes of health services, programs and strategies in Aboriginal and Torres Strait Islander health is not prolific. There is therefore a dearth of research-based evidence about achievements in this area, and more particularly, critical analyses describing why some health services, programs and strategies are successful and others are not. It should be acknowledged that at the outset of the project, it was expected that there would be some program evaluations and case studies available, but it was likely that the highest level of evidence about successful outcomes would be ‘expert opinion’.

Phase 1: Literature review and framework development

Initial literature review

The literature review, which took a holistic approach to health, identified quantitative and qualitative measures of success. It was necessary to compile comprehensive overviews of specific health conditions to provide a base to assess improvements. Health records, including statistical data analysis and clinical observations, provided insights into needs, issues and progress made over the last decade. Trends were difficult to monitor due to Indigenous identification difficulties (Australian Bureau of Statistics & Australian Institute of Health and Welfare, 2001). Measures included: fulfilling program objectives; production of outputs and successful health outcomes. If an effective program or useful information was disseminated this was considered a major success. Program evaluations provided direction for the identification of success.

International approaches to achievements in the health sector

Assessment of achievements in the health sector has long relied on specific health indicators. These have included various mortality and morbidity measures (for example, death rates, expectation of life at birth and the incidence of specific diseases, such as cancers), and the prevalence of health-related behaviours (for example, cigarette smoking, alcohol consumption and physical activity). Reliance on such indicators is not adequate, however, largely because health depends on a complex interaction of socio-economic, cultural, environmental and personal factors (biological and behavioural), and the nature and availability of health services (Australian Institute of Health and Welfare, 2000; Department of Health (U.K.), 1999).

Appropriate indicators, and health strategies, therefore need to include attention to the various determinants of health. Such an approach was incorporated into a technical supplement developed recently by the U.K. Department of Health for measuring progress towards a number of national health targets (Statistics Division and Central Health Monitoring Unit, 2001). The targets have been set largely using traditional indicators (such as level of reduction in mortality in a time period).

However, progress in the shorter term was assessed by a broad range of measures, including ‘upstream’ fundamental factors ‘closer to the point of causation’ (for example, educational achievements, access to affordable nutritious foods, etc.) and lifestyle determinants.

The nature of the measures used to monitor progress depended, to some degree, on the scope and focus of the health strategy. To cope with a full range of strategies, including those tackling the fundamental social determinants of health, the U.K documents categorised measures of progress into four broad groups:

- lifestyle – aspects relating to health-related behaviours (for example, cigarette smoking, alcohol consumption and physical activity);
- environment – external aspects impacting on health (such as environmental contamination, housing and associated infrastructure, transport, etc.);
- services – availability [and accessibility] of appropriate services (for example, cancer-screening programs, pharmaceutical services, and tertiary-level services);
- social and economic – broad social indicators (such as personal and community control and empowerment, education, employment, income).

In parallel with these developments, the World Health Organization, in releasing its ‘International Classification of Functioning, Disability and Health’, has extended key health indicators to include aspects relating to functioning and disability (World Health Organization, 2001). This shifts the focus from mortality and morbidity to ‘life’ (that is, how people live with their health conditions and how these can be improved to achieve productive, fulfilling lives).

Achievements in Aboriginal and Torres Strait Islander health – themes in the literature

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

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

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

An example of successful collaboration between government and community organisations is the National Aboriginal and Torres Strait Islander nutrition strategy and action plan, 2000–2010.

The National Aboriginal and Torres Strait Islander nutrition strategy and action plan, 2000–2010 was designed to: build on existing state and local nutrition programs; address gaps in the promotion of good nutrition; and ensure national coordination and cooperation across a wide range of agencies,

including those in the health, food industry, transport, catering, education and training sectors. (National Aboriginal and Torres Strait Islander Nutrition Working Party, 2001.)⁵

Many culturally appropriate resources have been developed and were available for Indigenous health needs (Aboriginal and Islander Health Worker Journal, 2000). There were examples of art, theatre and media health messages with input from Aboriginal and Torres Strait Islander people.

Success was identified as originating from policy, goals, targets and guidelines that have provided focus and direction. Infrastructure changes, strategies for targeting those at risk, the development and actions associated with interventions have led to improvements. The identification of Aboriginal and Torres Strait Islander people in health-related collections have contributed to these and other aspects of addressing health needs.

The availability of specific funding has been a major contributor to improvements in the provision and accessibility of culturally appropriate services. Raising the profile and prioritising Aboriginal and Torres Strait Islander health have been demonstrated to be effective.

The Strong Women, Strong Babies, Strong Culture Program commenced in August 1993 with the specific goals of increasing infant birthweights by earlier attendance for antenatal care and improving maternal weight status. Aboriginal women in three pilot communities worked with pregnant women in a program that emphasised both traditional practices and Western medicine. Data from the Northern Territory Midwives Collection showed that the mean birthweight of infants of Aboriginal women increased by 171 grams between 1990-1991 and 1994-1995 in the pilot communities and by 92 grams in the surrounding three rural regions. Ongoing evaluation of the program will determine the extent to which the change in birthweight can be attributed to the program and whether the effects can be replicated elsewhere. (Mackerras, 2001)

This example also illustrated the way in which good quality data and information can be disseminated to inform future initiatives. This is an important element of knowledge management, particularly in providing the evidence base for effective health policy-making and in enabling informed decisions for Aboriginal and Torres Strait Islander health. The knowledge base has benefited from Aboriginal and Torres Strait Islander health research⁶, for which there are now culturally-specific ethical guidelines.

The literature also provided evidence of increasing health knowledge for Indigenous and non-Indigenous people by compiling information from various perspectives.

⁵ It is recognised that, while plans of themselves may be viewed as an achievement, there are examples of plans in Indigenous health which have not realised the goals set and expectations of the drafters of those plans. The evaluation of the National Aboriginal Health Strategy documents one such example National Aboriginal Health Strategy Evaluation Committee, & Gordon, S. (1994). *National Aboriginal Health Strategy: an evaluation*. Canberra: Aboriginal and Torres Strait Islander Commission.

⁶ It is acknowledged that many past studies have been descriptive, with little in the way of interventions or evaluation of existing programs that would benefit the participants. See, for example, 'Review of the state of knowledge of cardiovascular disease among Aboriginal and Torres Strait Islander populations' Thomson, N., Winter, J., & Pumphrey, M. (1999). *Review of the state of knowledge of cardiovascular disease among Aboriginal and Torres Strait Islander populations*. Perth: National Aboriginal and Torres Strait Islander Health Clearinghouse.

Framework development: defining an 'achievement' and contributors to success

The key informants who were contacted in the initial phase of the framework development found the task of defining a success or achievement in Indigenous health complex and, at times, difficult. Many believed that the one true success in Indigenous health - addressing the inequities and inequalities between Indigenous and non-Indigenous health status - was not close to being achieved.

While there were areas in which health gains have been achieved over the past couple of decades, such as reduced infant mortality rates and levels of some communicable disease, respondents clearly expressed concern in relation to the failure of recent initiatives to have a significant impact in closing the overall gap in health status between Indigenous and non-Indigenous Australians. At the same time, it was recognised that reducing the inequalities between Indigenous and non-Indigenous health status may take a long time, linked as they were with substantial social and other inequalities. It was thought, however, that there were other ways of measuring and talking about success, and that this project had an important role in that area.

On a more pragmatic level, many respondents thought that while entire projects may not have been regarded as successful, elements of a program, project or other intervention often represented a significant achievement. These elements could be considered important in their own right and were often transferable to other communities or situations where the project as a whole may not have been suitable.

Despite difficulties in defining success precisely, common themes emerged from the interviews and in discussions as to what constituted a success or achievement.

The need for successes to be seen in an inter-generational manner rather than focusing on the health of individuals was raised by a number of respondents, as was the need to change health policy. The broad view of a success in Indigenous health, as defined by key informants, was consistent with the accepted definition of health within the Indigenous context, which sees health holistically – comprising physical health and social and emotional wellbeing.

The 'contributors to success' were derived from the initial literature review and thematic analysis of key informant interviews. They were used in the development of the framework for collecting and analysing data in Phase 2 and in the analysis of the case studies.

The broad areas that emerged from the initial literature review and the expert consensus view from key informant interviews as being likely to be important, or potential **contributors to success** were:

- Community control
- Community participation / involvement
- Resourcing
- Sustainability
- Partnerships, including intersectoral collaboration
- Workforce
- Evaluation
- Accountability

- Capacity building

A discussion of each of these factors or contributors to success follows.

Role of the community

The role of the community was seen as a crucial aspect. This role encompassed a broad range of responsibilities, from the community-control of primary health care services to more general community participation and involvement in health and other matters. Factors seen as important were:

- community participation should exist at all levels, including management;
- community involvement should be actual and not symbolic;
- when considering issues of community control, government and other mainstream services should not be excluded;
- consideration needs to be given to what constitutes appropriate community representation and Indigenous ownership;
- community control of research processes (including ethical assessment and oversight) and outcomes;
- often the priorities of government and other funding bodies do not match community perceptions and values;
- the enhancement of community capacity is critical, in a broad sense that includes all aspects of community wellbeing.

Resourcing

Key informants, who noted that one of the main aims of the Australian health care system is to achieve equity for all Australians, saw adequate resourcing of projects, programs and interventions as important also. The common definition of equity – ‘equal access to health care for equal need’ (McDermott & Beaver, 1996) – raises questions as to how need and access are defined and how they are measured.

Attention was drawn to the report of the Commonwealth Grants Commission of inquiry into Indigenous funding (Commonwealth Grants Commission, 2001), which acknowledged that reliable data on need are not generally available because:

- measures may not assist with resource allocation decisions (for example, hospital separation data reflect met need and not the extent to which there are unmet needs and gaps in service delivery);
- it is difficult to identify funds used to meet Indigenous needs in some cases, especially within mainstream programs;
- needs may not be met because of systemic or other structural problems;
- broad measures mask variations at the local level;
- The Commonwealth Grants Commission finding that there was no evidence that excessive amounts were spent on Indigenous health (Commonwealth Grants Commission, 2001) is consistent with the findings of the Deeble report (Deeble et al., 1998). Key informants noted that the Deeble report had a deep effect on Commonwealth policy and resulted in a number of initiatives to reform the Australian financing system in Indigenous health (Australian Institute of Health and Welfare, 2001).

Generally, the framework consultations suggested the following issues be considered:

- whether funding was sufficient to meet the needs and objectives of the program, project or intervention – adequacy of resources;
- projects are often ‘set up to fail’ when they don’t have/receive adequate funding; and
- whether programs, projects or interventions represented value for money.

Sustainability

Appropriate resourcing was seen also as one important aspect in the sustainability of programs, projects and interventions. Key informants noted the problems associated with the short-term commitment of funds to projects. These problems included the inability to plan ahead, high staff turnover, and general uncertainty. There was a need also to review funding levels periodically, to ensure they were adequate and had the capacity to respond to emerging and changing needs within communities. Informants commented on the problems with one-off, demonstration or pilot projects, unless there was a longer-term commitment to ongoing funding, if successful, and wider uptake of models developed through such projects.

The interviews noted examples in which improved health outcomes had been demonstrated, but the improvement had not been sustained. Failure to sustain improvements may simply be the result of loss of special funding. However, funding alone should not be seen as the key to sustainability. Other factors – such as the changes in specific staff involved, a failure to sustain behavioural changes or a change in community priorities (because of the perception that a particular issue is no longer a problem in the community) – can be equally important.

Partnerships, including intersectoral collaboration

In commenting on the importance of partnerships, key informants noted that the Commonwealth Grants Commission inquiry into Indigenous funding concluded: ‘the importance of effective agreements and partnerships between levels of government and Indigenous communities, both within the health sector and in other areas, cannot be overstated’ (Commonwealth Grants Commission, 2001). This sentiment is very similar to the importance attached to partnerships and intersectoral collaboration in the 1989 National Aboriginal Health Strategy (National Aboriginal Health Strategy Working Party, 1989).

Formal partnerships include the joint planning forums established in each jurisdiction from the Framework Agreements on Aboriginal and Torres Strait Islander Health. These forums include Commonwealth and State/Territory governments, Aboriginal community-controlled health organisations and ATSIC. The Primary Health Care Access Program (PHCAP) aims to assist in improving comprehensive primary health care provision in areas where needs have been identified through joint regional planning. Within the research area, key informants noted that there were an increasing number of collaborations between Indigenous communities and research agencies. Examples include the Cooperative Research Centre for Aboriginal and Tropical Health, the University of Queensland’s Indigenous Health Program and the TVW -Telethon Institute of Child Health Research.

Key informants noted that it is important also to consider informal partnerships at the local community level which demonstrate a genuine commitment by a number of sectors to working together to address community-identified priorities.

The following issues were raised also during the consultations:

- the need for partnerships between all those active at a community level (paid, unpaid, government and non-government);
- a broad range of strategies is needed (for example, strong links between a night patrol, a sobering up shelter, counselling facilities and a treatment centre);
- there are examples of Aboriginal community controlled health services advocating for intersectoral collaboration, such as in the area of housing; and

- despite agreement about the importance of intersectoral collaboration, there is a paucity of documented examples of successful collaborations.

Workforce issues

Key informants noted that a number of significant developments in the Indigenous health workforce have occurred over the past decade, but there is continuing Indigenous under-representation in the medical, nursing and allied health workforce. Significant changes have occurred in the training of Indigenous doctors – for example, the University of Newcastle’s problem-based learning curriculum, specific support structures for Indigenous students and community-oriented recruitment processes have given it substantial success in graduating Indigenous doctors.

The important role of Indigenous health workers in the delivery of services to communities was noted. However, respondents reported substantial differences across States and Territories in relation to the roles of health workers, educational standards, and recognition within a career structure. These issues are recognised in the National Strategic Framework for the Aboriginal and Torres Strait Islander workforce (Office for Aboriginal and Torres Strait Islander Health, 2002).

Key informants pointed out that the Master of Applied Epidemiology (Indigenous Health) program at the Australian National University was providing opportunities for public health and research training for Indigenous people. It was acknowledged that an increasing number of Indigenous people were involved in research, but key informants commented that there was need for more widespread training for Indigenous researchers.

Interest from Indigenous doctors in MPH courses and in advanced public health training through the Australian Faculty of Public Health Medicine have created career paths for Indigenous doctors interested in public health.

Career pathways for non-medical disciplines, particularly nursing, were being developed through the Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN), the Council of Remote Area Nurses of Australia (CRANA) and the network of University departments of rural and remote health.

During the consultations, it was evident that workforce issues will play an important role in understanding the contributors to success in relation to specific projects. While there have been numerous reviews and reports on workforce issues in relation to Aboriginal and Torres Strait Islander health, there is little evidence of work that specifically documents a detailed analysis of the workplace issues and the underlying reasons why, in particular instances, the success of a project or program may be attributed to the workforce.

Specific issues raised during the consultations included the following:

- management practices and the need for management training;
- personal skills as well as specialised health worker skills required;
- the need for clear descriptions and objectives for staff positions;
- staff support issues, particularly in relation to recognition of skills and ongoing professional development needs;
- management skills needed to liaise with a wide range of stakeholders in Indigenous health; and
- the need to train and develop the skills of Indigenous researchers.

Evaluation

A number of key informants expressed the view that evaluation of programs and interventions in Aboriginal and Torres Strait Islander health are only just beginning to take place, and there is a general lack of information on what works and what doesn't. The health sector overall, however, has been moving towards an evidence-based approach that informs decisions about policy direction and the targeting of resources. Systematic reviews of the evidence base for clinical and public health practice are being used for the development of clinical care guidelines and intervention programs for conditions such as type 2 diabetes (Couzos, Metcalf, Murray, & O'Rourke, 1998), otitis media (Couzos, Metcalf, & Murray, 2001; Menzies School of Health Research, 2001) and eye health Office for Aboriginal and Torres Strait Islander Health, 2001a).

In terms of the evaluation of specific programs, projects or interventions, the following issues were raised during the consultations:

- an evaluation strategy should be a requirement of program or service planning;
- adequate resources should be allocated as part of the budget;
- performance criteria need to be appropriate and achievable so the project is not 'set up' to fail;
- funding bodies need to be flexible in negotiating these and to make sure that projects are not over ambitious;
- longitudinal data are important in effectively measuring the success of a project - commonly used point-in-time evaluation processes are often carried out early in a project and are not so useful; and
- the dissemination and availability of high quality information – both the appropriate methods of evaluation and the results of these evaluations - are important.

Accountability

Key informants noted that, in the past, accountability has often been linked to the financial performance of an organisation and its compliance with the reporting requirements of the funding body. Greater attention is now being given to the need for accountability to Aboriginal and Torres Strait Islander communities. Therefore, in addition to the traditional accountability measures, the following need to be considered in the assessment of programs, projects and interventions:

- how service providers should be accountable to their own communities; and
- the extent to which government funding commitments reflect a greater accountability to communities – based on joint planning, community identified needs and real costs of service delivery.

Key informants acknowledged that appropriate accountability measures – both to funders and to the community – can contribute to the sustainability and success of programs through maintenance of adequate funding and outputs appropriate to community needs.

Capacity building

Capacity building, at community and individual level, was seen as an important component of most of the other factors. It was recognised as an area that needed special consideration in the assessment of the success of specific programs, projects and interventions.

Health outcomes and other indicators of progress in Indigenous wellbeing

All achievements in Indigenous health may be defined as producing positive change in some variable which contributed to Indigenous wellbeing or community empowerment. These could be considered under the following four categories:

- an improvement to health outcomes, for example an improved infant mortality rate;
- improvements to process indicators with a proven link to better health outcomes, such as improved antenatal care leading to better obstetric outcomes;
- improvements in the health system or components thereof, such as health policy, data collection or the shape of service delivery, which are also known to lead to improved health outcomes; and
- improvements in other areas, such as education, employment, housing, etc., which are also known to lead to improved health and wellbeing.

This approach was consistent with the broad areas identified in the National Performance Indicators for Aboriginal and Torres Strait Islander Health (Office for Aboriginal and Torres Strait Islander Health, 2000). In summary, these related to government inputs, social equity, access to health services, risk markers and health outcomes. Clearly, it was not possible to consider a single outcome area in isolation from one or more of the others, and the measurement of outcomes was often difficult. For example, an achievement in health outcomes will result from improvements in process (indicators) and health systems changes.

As noted above, the literature review showed that the indicators of health outcomes and progress in other areas were consistent with the broad areas identified in the National Performance Indicators for Aboriginal and Torres Strait Islander Health (Office for Aboriginal and Torres Strait Islander Health, 2000). As such, they were standard indicators for measuring progress in these areas. They were consistent also with the indicators identified by the U.K. Department of Health's Statistics Division and Central Health Monitoring Unit (2001) and the Australian National Health Performance Committee (National Health Performance Committee, 2001).

The three categories proposed by the National Health Performance Committee (2001) for health-related indicators were:

Health status and outcomes – direct measures of health and well being, such as indicators of morbidity and mortality. These included incidence and prevalence of specific disorders, injury of other health-related states; standardised and age and/or sex and/or condition specific death rates; expectation of life; alterations to body, structure or function (impairment), activities (activity limitation) and participation (restrictions in participation); broad measures of physical, mental, and social wellbeing of individuals and other derived indicators such as Disability Adjusted Life Expectancy (DALE).

Determinants of Health – factors that had either a positive or negative influence on health at the individual or population level. These included: pattern of tobacco use; percentage of people achieving 'sufficient' physical activity; percentage of people overweight or obese; unemployment and participation in the labour force; and environmental tobacco smoke.

Health System Performance – indicators for a range of service categories and types of interventions across the spectrum of the health care system. This included population health

programs, primary care services, and the acute and continuing care sectors. The types of indicators related to the specific area within the health system.

- Population health indicators include: percentage of women aged 50-69 years who are screened for breast cancer; and percentage of children fully vaccinated at 12 months of age.
- Primary care indicators include: number of general practitioner services per patient per region per year; and rate of general practitioner antibiotic prescribing for presentations of upper respiratory tract infection.
- Acute care indicators include: hospital separation rates per 1,000 population; emergency department waiting times; cost per casemix adjusted separation; and average length of stay.
- Continuing care indicators include: separations from hospitals to aged care homes for patients over 70 years; and ratio of HACC hours of service provision.

Phase 2: Data collection and initial analysis

Ninety project nominations were received from identified officers in each of the States/Territories and the Commonwealth Department of Health and Ageing, for inclusion as an achievement in Indigenous health. Fifty-eight of these nominations contained complete information, and an additional 32 projects were identified as ones that fitted the nomination criteria and for which additional information could be provided if required.

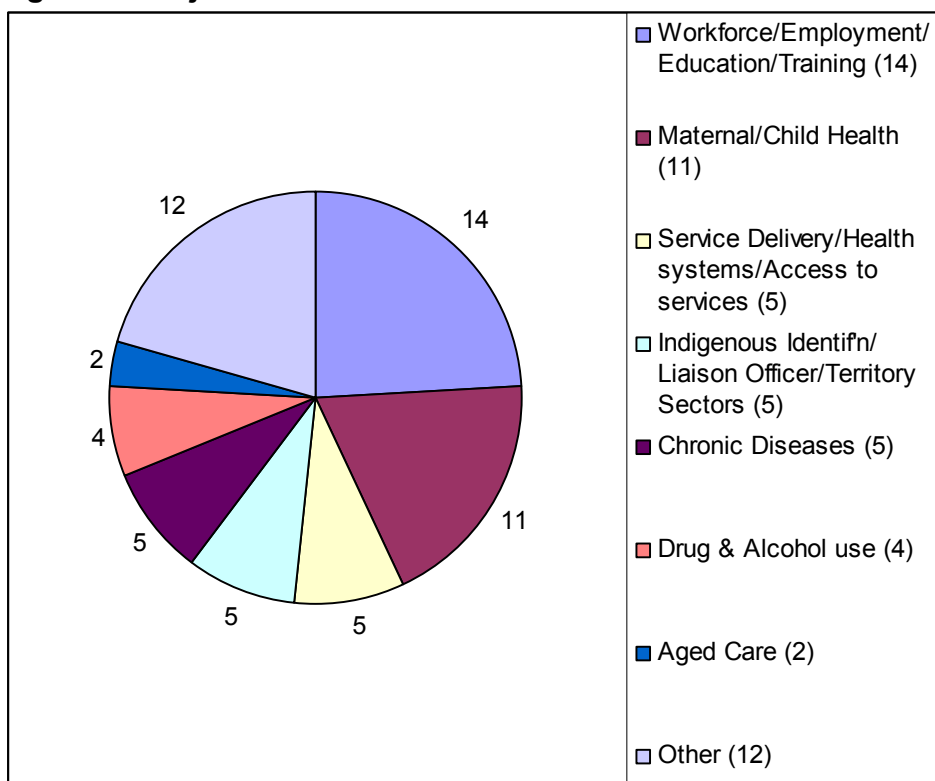
General issues that emerged during telephone discussions and site visits in the various jurisdictions included the following:

- Limited time frame for completion of the data collection.
- The phase two data collection period was February/March 2002. It was also highly dependent upon a rapid response by each of the jurisdictions to the nomination of a project officer with responsibility for this task.
- Clear evidence of a commitment to inclusion of projects in other sectors and the community-controlled sector.
- Some of the jurisdictions engaged their local NACCHO affiliate and inter-departmental working groups in the nomination process.
- Little difficulty in providing information in relation to the area of achievement, as well as the measures being used to substantiate this.
- Some difficulties in terms of providing evidence in relation to the factor/s that contributed to success.
- Because of the lack of any form of evaluation for many of the projects nominated, respondents often had little difficulty describing the existence of the contributing factors for a particular project, but they had problems in providing evidence that linked these factors to the outcome being reported.

The initial data analysis summarised the projects into 7 clusters or themes. These were: Indigenous Identification/ Liaison Officer/ Territory Sectors (5 projects); Maternal/Child Health (11 projects);

Chronic Diseases (5 projects); Workforce/ Employment/ Education/ Training (14 projects); Service Delivery/ Health systems/ Access to services (5 projects); Drug and Alcohol use (4 projects); Aged Care (2 projects) and others (12 projects).

Figure 2: Project Themes



Phase 3: Case study analysis

Using the assessment criteria described in section 2 Methods (see Data analysis section), 10 of the nominated programs were selected for further detailed case study analysis.

These projects were:

Projects selected for case study analysis
<p>1. Aboriginal Identification Project Western Australia The aim of this WA Department of Health project was to evaluate the quality of the Indigenous identifier in the WA hospital morbidity database. It resulted in improved identification of Aboriginal and Torres Strait Islander people in hospital morbidity data systems.</p>
<p>2. Fixing Housing for Better Health NSW and SA Fixing Housing for Better Health was a collaboration between Healthabitat, ATSIC</p>

Projects selected for case study analysis

and State/Territory Indigenous Housing Agencies and Departments of Health in New South Wales, Queensland, South Australia, Western Australia and the Northern Territory. These projects focused on assessing and fixing the health hardware in houses and living areas in order to allow families to maintain healthy living practices.

3. Healthy Jarjums Project Qld

An Inala Indigenous Health Program (Queensland Health.), *Healthy Jarjums make healthy food choices* was a curriculum-based resource design for use in a Health Promoting Schools context, implemented through Queensland Education and Aboriginal Community Schools. The program focused on traditional and contemporary food and food related practices of Aboriginal and Torres Strait Islander cultures, with learning outcomes in nutrition, food practices, food safety and personal hygiene.

4. Impact of introduction of swimming pools on health of children & adolescents in remote areas of Western Australia

The Swimming Pools project was jointly funded by the Western Australian Department of Housing and Works, the Department of Sport and Recreation and the Lotteries Commission. The aim of the project was to investigate whether there was any change in prevalence and severity of ear disease, skin sores and nasal discharge as a result of the introduction of swimming pools in remote Aboriginal communities in Western Australia.

5. Indigenous employment policy

The Indigenous Employment Policy was introduced by the Federal Government in July 1999 in recognition of the particular disadvantage experienced by Aboriginal and Torres Strait Islander people in the labour market. The aim of the policy was to generate more employment opportunities with a particular focus on job creation in the private sector and the promotion of small business activities in the Aboriginal and Torres Strait Islander community. From 1 July 2001, there were some 130 federal funding projects under this policy. It provided a useful example of a matrix of relationships between government agencies, the private sector, community based organisations and training and education providers to achieve employment outcomes.

6. Katherine West Coordinated Care Trial NT

The Katherine West Coordinated Care Trial was one of a number trials funded, implemented and evaluated in the second half of the 1990's. It combined Commonwealth and Territory government agencies funding an incorporated community board, and was designed as an Aboriginal specific, 'whole of population' trial. The purpose was to design and implement a trial in which service delivery inputs were 'pooled' under common management with the expectation that this would lead to improved services and consequently improved health outcomes.

7. Koori Maternity Services Program Victoria

The aim of the Koori Maternity Services Program was to provide additional and culturally appropriate support to Koori women throughout pregnancy and in the immediate postnatal period, by creating cooperative partnerships that enabled the Aboriginal women of Victoria to access the best possible maternity care. The program was funded through the Acute Health Division of the Victorian Department of Human Services as part of the Victorian Maternity Enhancement Strategy.

8. NSW Aboriginal Vascular Health Program

Projects selected for case study analysis

This state-wide Program was established in July 2000 to implement components of the NSW Aboriginal Health Strategic Plan that related to diabetes, diseases of the circulatory system and renal disease. A series of demonstration site projects was funded and implemented through local Aboriginal health partnerships between Aboriginal Community Controlled Health Services and mainstream health services with collaboration in some areas with local Divisions of General Practice and University Departments. The projects aimed to improve the prevention, early detection and self-management of vascular diseases and involved the employment of designated Aboriginal Vascular Health Workers and the provision of training and support for these positions.

9. Nutrition Policy for Remote Retail Stores Qld

This joint project brought Queensland Health technical expertise together with Department of Aboriginal and Torres Strait Islander Policy management to develop strategies that could improve the food supply situation in the six DATSIP managed retail stores. The aim of the store nutrition policy was to ensure that people had access at all times to the foods they need to stay healthy. The key objectives of the policy were to improve the capacity to provide a range of affordable, healthy food of good quality and to ensure that Indigenous customers were able to make informed choices on foods necessary to maintain good health and meet specific dietary requirements.

10. Queensland Health Indigenous Workforce Management Strategy 1999 – 2002 Qld

This strategy was launched in July 1999, and provided a framework for Queensland Health District Services to improve their Indigenous workforce management practices. It was designed to be dynamic, providing a basis for districts to take innovative action. It provided a framework to work with educational institutions and Indigenous communities to encourage more young Indigenous people to aspire to health careers, and improve recruitment, retention and development of Indigenous employees.

Detailed case study analyses

In order to provide a common structure for Phase 3 analysis, an analytical framework was developed, based on the nine factors identified by the initial literature review and key informant interview process as likely to be contributors to success. This ensured that each case, despite its unique attributes, was analysed in the same way, enabling commonalities to be established and lessons identified. The detailed analysis of each case study is in Appendix 4.

In effect, the Phase 3 analysis sought to test the hypothesis that these factors contributed to the success of projects, and to determine the contribution of other factors, not previously identified. The lessons learnt from the case study analyses and their policy implications are discussed in Chapter 4 below.

4 Discussion and Policy lessons

Methodological issues

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

The project resulted in 90 initiatives in all State and Territory jurisdictions being analysed for their policy lessons. The research process itself, however, highlighted issues in Aboriginal and Torres Strait Islander health that were themselves pertinent to policy futures, and demanded consideration.

The project was commissioned by the Commonwealth Office of Aboriginal and Torres Strait Islander Health, Department of Health and Ageing, on behalf of the Australian Health Minister's Advisory Council (AHMAC). The project was accountable through the Heads of Aboriginal Health Units (HAHU), a sub-committee of AHMAC, and the Standing Committee on Aboriginal and Torres Strait Islander Health (SCATSIH), which subsequently replaced it. This positioning of the project had a number of consequences.

Firstly, issues around selection required further elucidation. The use of HAHU representatives to coordinate the nomination of projects brought with it the potential for selection bias, with selectors more familiar with or sympathetic to projects within the government, rather than the community-controlled sector. Efforts were made to minimise this bias – in one jurisdiction, the selection process was undertaken by a panel with both government and community-controlled representation; in others, the input of the community-controlled sector was actively sought; the National Aboriginal Community Controlled Health Organisation (NACCHO) was directly approached to contribute to the study. Despite this, the selection process demonstrated the extent to which recognition of success was dependent on the perceptions of those making the decision, and was informed by such things as personal experience, organisational alliances, political ideologies and regional and local networks. The nomination process was independent of the researchers – interestingly, none of the seven 'examples' of achievement used by the researchers in a preliminary matrix to demonstrate the potential spread of projects was included in the final list of nominations. Projects undertaken in the institutions represented by the researchers were not eligible for inclusion in the project.

The question then arose as to the extent to which this potential for bias raised questions about the validity of the findings. The experience of the researchers was that the spread of projects was broad, with representation from all of the categories identified in the conceptual development of the project, and with the literature review, project nomination and case studies complementing each other in ensuring that the breadth of issues was covered. While the selection of projects may have been quite different, given a different nomination mechanism, the profile of problems identified was felt likely to coincide with those identified in this project. In a sense, any process of selection would have brought its own particular bias, but the diversity of project themes, and saturation of data from the projects selected would have produced similar material for analysis. Furthermore, the distillation of factors

contributing to success from this diverse range of projects would likely be the same regardless of the selection process.

The second issue related to structural changes. Over the course of the project, the replacement of HAHU by SCATSIH, meant that the composition of the group to whom the project team were reporting had changed. In some jurisdictions, representatives who had been responsible for initial decisions around nomination of projects were no longer available at the point at which data collection was commenced, and project continuity was difficult to sustain in some jurisdictions, with some coordinators uncertain of the history or objectives of the project, and their positioning within it. The problem of institutional memory is pertinent not only to the implementation of this project, but to the development, implementation and evaluation of policy and programs.

The third limitation of the research methods was the lack of a comprehensive 'framework' for Aboriginal and Torres Strait Islander health policy. There has not been a single point of consensus among key stakeholders since the 1989 National Aboriginal Health Strategy, creating difficulties in identifying a nationally acceptable frame from which the identification of appropriate projects could proceed, or through which the current policy platform could be analysed. The problems of defining boundaries were exacerbated where there was a (justifiable) attempt to include the contributions of non-health sector projects within the ambit of this study. The divisions between and within the Commonwealth-State government and community-controlled sectors resulted in the diffusion of policy direction through its multiple implementing agencies. In differing jurisdictions, the same 'projects' may have been implemented in different forms, and the lack of common reporting systems made evaluation in Indigenous health generally problematic.

Despite the identification of 90 projects for analysis, the limited pool of defined 'cases' suitable for case study analysis presented a fourth methodological limitation, which had widespread policy significance. The first three criteria for selection as case studies related to completion of the project and its evaluation, and access to, and quality of, evaluation data. Only then were issues of policy significance able to be considered, with less than fifteen projects meeting the initial three criteria. This was a direct consequence of funding structures, with short project life-spans linked to government budgetary cycles, and limiting the utilisation of outcome evaluation as a determinant for continued funding. The promotion of 'innovation' over performance in new funding, of 'stop-start' funding, the limited evidence of strategic, as against financial accountability and the absence of cost effectiveness parameters in evaluation of projects were issues of concern that were directly reflected in the limited number of case studies. As a consequence, the case studies could not be considered a 'representative sample' suitable for statistical analysis. Though arguments regarding trends, or relative strengths, or direct causal links could not be made, each case offered relevant lessons exposed through qualitative analysis, that may be extrapolated to the broader policy framework.

While it could be demonstrated that a number of the projects included issues and programs related to both Aboriginal and Torres Strait Islander people, it was acknowledged that of the nominated projects, none specifically dealt with issues unique to Torres Strait Islanders (either those living in the Torres Straits or on mainland Australia) as a separate cultural group.

The final limitations related to the lack of resources to undertake independent evaluation of projects. The research team was obliged to take at face value data presented by the projects for analysis, relying on their internal and external assessment processes to provide adequate rigour in evaluation.

A further consequence was that this study relied on secondary sources of data which were collected to determine whether those projects were effective and perhaps how the outcomes were achieved, but not why. Even when high quality evaluation data was available, the purpose for which those data had been collected was universally not to evaluate or diagnose factors leading to or contributing to the success of each project. In order to further build the evidence base relating to successful programs, this should be a consideration for future evaluation research.

Indigenous Health Policy Context – Past and Present

To consider the implications of this project for Aboriginal health policy it was necessary first to outline the precepts that made up Aboriginal health policy. At the time of Federation, health care was identified as an area of Constitutional responsibility of State government. The exception was quarantine issues that were the responsibility of the Commonwealth. Thus, States had the responsibility for hospitals and service provision. Responsibility for Aboriginal health was primarily with State governments.

Following the 1967 referendum, the Commonwealth had become increasingly more involved in Aboriginal and Torres Strait Islander health, with the establishment of its new Office of Aboriginal Affairs to make specific grants to the States for ‘Aboriginal advancement’. Health was one of four functional areas that were covered by these arrangements. It has been suggested that this was a conservative response at the time (Anderson & Sanders, 1996), and that it did not respond to the new politics that were emerging among Aboriginal people, which specifically called for rights and autonomy. This resulted in the formation of Aboriginal community-controlled organisations, and the establishment of the first Aboriginal Medical Service at Redfern in Sydney in 1971.

The mood changed when the Whitlam government came to power in 1972, with the adoption of ‘self-determination’ as the key term in Aboriginal affairs policy and the establishment of a Commonwealth Department of Aboriginal Affairs (DAA) in 1973. An Aboriginal Health Branch was also established within the Public Health Division of the Department of Health and a National Plan for Aboriginal health was developed, its major aim being to raise the standard of Aboriginal health to that enjoyed by fellow Australians. This initiative, administered jointly by Commonwealth, State, Territory and Aboriginal agencies was to be achieved within ten years and was driven at the time by the high infant mortality rates in Indigenous communities.

However, by 1979, it was clear that this target would not be reached, and recognition was given to the priority to be accorded to basic environmental health facilities if the goal was to be reached. This resulted in the Aboriginal Public Health Improvement Program (APHIP), which ran in the early 1980’s and was responsible for the provision of essential facilities to a number of communities. This still failed to meet the original aims of the Plan, with many communities still not having a safe and reliable water supply in the late 1980’s. Another important development during this period was the transfer of responsibility for the funding of Aboriginal Medical Services from the Commonwealth Department of Health to DAA. As a result of this shift, DAA came to have a clear lead role in Aboriginal health within the Commonwealth system.

In the late 1980’s, having achieved no significant improvements and in the absence of any nationally agreed Aboriginal health strategy, the Commonwealth, State and Territory ministers for Aboriginal Affairs and Health agreed that a working party be established with responsibility for the development

of such a strategy. This resulted in the National Aboriginal Health Strategy (1989), an important milestone in the development of national Indigenous health policy. This Strategy provided, according to the then Commonwealth Minister for Aboriginal Affairs, an ‘opportunity for dramatic and measurable improvements in Aboriginal health’. Its recommendations addressed three broad areas:

- Health services – increasing resources to, and upgrading facilities of, existing Indigenous-controlled health services; resources to be provided for new Indigenous-controlled services; and improved availability of secondary and tertiary services.
- Essential services and community infrastructure – adequate funding for basic services such as housing, clean water, safe waste disposal, roads, power and communications.
- Education, training and employment in Indigenous health – for both Indigenous and non-Indigenous health workers.

A total of \$232m was allocated for the implementation of the strategy over an initial five year period, some \$171m of which was for housing and infrastructure, with only a small proportion being allocated for Aboriginal Medical Services. The 1994 evaluation of the NAHS concluded that it had never really been effectively implemented and that significant changes to institutional arrangements for Aboriginal health were inevitable. With strong advocacy from the community-controlled sector, this resulted in the transfer back to the Commonwealth Department of Health responsibility for Aboriginal health service funding and the formation of the Office of Aboriginal and Torres Strait Islander Health Services.

The focus on review of arrangements for funding had been influenced by recent reports, including the AIHW Report on Expenditure on Health Services for Aboriginal and Torres Strait Islander people (Deeble et al 1998), the report of the Commonwealth Grants Commission’s inquiry into indigenous funding (2001), and the Health is Life report (2000).

Funding arrangements between the State and Commonwealth governments had often been reviewed, and various new initiatives had been implemented. For example:

The **Aboriginal Health Framework Agreements** set up joint processes for planning for improved access to health services, full and formal Aboriginal and Torres Strait Islander participation in decision making and priority determination and the collection of better data. The Agreements did not include funding. The Agreements were between the Commonwealth, individual State governments, State affiliates of the National Aboriginal Community Controlled Health Organisations, and Aboriginal and Torres Strait Islander Commission.

The Framework Agreements:

- Set out the shared responsibilities of each of the parties noting in particular that the Commonwealth and each State and Territory were jointly responsible for responding to the health needs and had complementary roles in doing so;
- Identify joint planning and consultation processes;
- Identify arrangements for data collection and evaluation; and
- Make a commitment for inter-sectoral collaboration.

The **Australian Health Care Agreements** were bilateral Agreements between the Commonwealth and each state and Territory government to provide and jointly fund health

services in public hospitals. The current agreements ran from 1 July 1998 to 30 June 2003. Under the Agreements the Commonwealth:

- contributed to the cost of the health services;
- funded and developed policy in relation to health services for which the Commonwealth had direct responsibility; and

The roles of the State or Territory were to:

- ensure that public hospital services were provided in accordance with the terms of the Agreement;
- work in collaboration with the Commonwealth and other states and Territories to develop and co-ordinate national health policy; and
- ensure that eligible persons were able to access public hospital services as public patients.

The Commonwealth and State and Territory governments were required to implement the Agreement consistent with the principles outlined in the Aboriginal and Torres Strait Islander Health Framework Agreement. They also agreed to report against and to refine and develop performance indicators of Aboriginal and Torres Strait Islander health.

The **Public Health Outcome Funding Agreements** were bilateral funding agreements between the Commonwealth and each State and Territory to provide funding for public health programs. The key features of the Agreements were:

- broad banding of funding;
- agreed outcomes or proxy outcomes;
- flexibility to apply funds as appropriate to achieve mutual objectives;
- key principles, values or processes to be upheld in the operative of the agreement; and
- measurement of performance in relation to objectives.

The Agreements allowed the States and Territories the flexibility to tailor expenditure to local priorities and high need populations within the context of national priorities.

The Public Health Outcome Funding Agreements required the State or Territory to provide a yearly report in relation to commitments made in the Aboriginal and Torres Strait Islander Framework Agreements. Specifically States and Territories were required to report against the following activities:

- providing more effective public health services to Aboriginal and Torres Strait Islander peoples;
- areas of joint Commonwealth, state or Territory, Aboriginal and Torres Strait Islander Commission and Aboriginal and Torres Strait Islander People, planning in public health;
- improving quality of data on Aboriginal and Torres Strait Islander health outcomes; and
- improving the utilisation of mainstream health services by Aboriginal and Torres Strait Islander peoples.

The National Aboriginal Health Strategy (NAHS), released in 1989, was built on extensive community consultation to produce a landmark document that set the agenda for Aboriginal and Torres Strait Islander health. Although never fully implemented (as indicated by its 1994 evaluation), the NAHS

remained the critical document, articulating Aboriginal and Torres Strait Islander peoples' health aspirations and goals. It was still used by services and service providers specifically targeting Aboriginal and Torres Strait Islander peoples' health and continued to guide policy makers and planners. The draft National Strategic Framework for Aboriginal and Torres Strait Islander Health (NSFATSIH) was a complementary document that built on the 1989 NAHS and addressed approaches to primary health care and population health within contemporary policy environments and planning structures.

The nature of a national policy framework such as the NSFATSIH was that it had to answer both questions about goals ('what to do?') as well as questions about methods and process ('how to do it?'). The focus of this study has been more on the questions of 'how to?' The first and second stages of the *Achievements in Aboriginal and Torres Strait Islander Health* project were to hypothesise pre-conditions of success in implementing Aboriginal health-related programs. These hypotheses were very similar to the Key Result Areas in the NSFATSIH, especially those with a greater focus on process, the 'how to?' questions.

However, there was an overlap between 'how to?' and 'what to?' questions in Aboriginal health. The entrenched nature of Aboriginal health disadvantage meant that many Aboriginal health advocates placed a very high emphasis on the achievement of process steps, such as the establishment of services or the conversion of services to Aboriginal community control, as an indicator of long term progress in health outcomes.

This was also a reflection of the importance of the acceptability of health interventions to any disadvantaged community. Means and ends were related. 'We will welcome government cooperation and collaboration, but your history and our history demand that such takes place on our terms' (Victorian Aboriginal Health Service, in National Aboriginal Health Strategy, 1989 p.xiv). Community control was an example of a process which had also become an end in itself – a goal. The objective of community ownership of health interventions was regarded by many as so key to ways of implementing Aboriginal health programs that it could also be regarded as an outcome in itself. Indeed increased community engagement was claimed as evidence of a positive outcome by a number of project sponsors in this study.

Reference was made to a historical analysis of the period since the development of the National Aboriginal Health Strategy, which focused on the politics of Aboriginal health policy (Griew, Sibthorpe, Anderson, Eades & Wilkes 2002: 'On our own terms – the politics of Aboriginal health in Australia' book chapter in press). This historical analysis reinforced the importance of the points of intersection. They converged with key consensus areas of Aboriginal health policy over the last fifteen years, cited by those authors to include:

'five key policy areas around which there is a strong degree of unanimity among Aboriginal health policy makers and advocates... The first is:

- an emphasis on primary care ... that the NAHS clearly tied ... to a particular meaning of that term, as spelt out by WHO in the Alma Ata Declaration (1978.)

Nested under this are the other four key policy propositions that are:

- the notion of holism as a defining concept in both health and health care and intersectoral action that follows from it;

- the value of Aboriginal and Torres Strait Islander community control and/or participation;
- the Aboriginalisation of the health workforce; and
- the need for fairness and balance in accountability for both government and non-government providers.’

Literature review, interviews, case studies: lessons learned and policy implications

These frameworks, the historical analysis, the project’s own hypothesised contributory success factors, literature review, interviews, case study analyses and the new **draft** National Strategic Framework Aboriginal and Torres Strait Islander Health, together supported an overall framework to draw out the policy lessons from the project. It should be stressed that these were headings for a policy analysis, within which there were arguments about meaning and strategy. We were not suggesting there was consensus within each of these areas, only that these were the areas for discussion.

Policy framework for Achievements in Aboriginal Health

1. Model of health
 - Comprehensive primary health care
 - Specific health interventions and secondary/tertiary health care
 - Intersectoral intervention
2. Community factors
 - Community control
 - Community participation
3. Funding and evaluation factors
 - Resourcing
 - Accountability
 - Evaluation
4. Implementation factors
 - Partnerships
 - Workforce
 - Capacity building
 - Sustainability
5. Other factors
 - Leadership
 - Policy niche

Against each of these areas an overview analysis of the findings within our case studies is presented, followed by commentary on the implications for policy, especially for contemporary policy debate.

1. Model of health

The review of the literature drew attention to the substantial developments in health systems infrastructure since the early 1990s. The establishment of the National Aboriginal and Torres Strait Islander Health Council, the Office for Aboriginal and Torres Strait Islander Health (OATSIH) and the Standing Committee on Aboriginal and Torres Strait Islander Health (SCATSIH) have strengthened coordination of health policy and program development, complemented by a consolidation of the role of the community-controlled sector through the National Aboriginal Community-Controlled Health Organisation (NACCHO) and its State/Territory affiliates.

There was evidence of significant improvement in access to primary health services through the expansion of community-controlled health services, the coordinated care trials, and improved access to the Medical and Pharmaceutical Benefits Schemes. The growing Indigenous health workforce was documented in a national strategic framework for workforce reform, with progress evident in a range of health related disciplines – medicine, nursing, public health and health management – and in the growing numbers and increasing recognition of Aboriginal and Torres Strait Islander health workers.

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

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

The detailed case studies did not contain multiple examples across the full range of areas of health intervention. There was a low return of examples with useful data from within the primary care sector, especially the Aboriginal community controlled primary care sector, and a particular focus on capturing activity across other sectors (see discussion on methodological issues). Successful case studies of primary health care initiatives had been recently documented by OATSIH (Office of Aboriginal and Torres Strait Islander Health 2001). The study did thus include a range of well-

documented examples from a range of other sectors – including environmental health, the hospital sector, national and local economic policy, and health related data strategy.

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

Among the other examples, a number stood out as successful intersectoral interventions. These included the *Fixing Housing for Better Health* methodology developed within an Aboriginal community controlled health service in remote Central Australian communities. This model demonstrated a number of specific features suggestive of successful intersectoral intervention. First it operated on an empirically grounded analysis of specific problems (e.g. functionality of waste removal systems) and refused to engage with other, tangential issues (e.g. the aesthetics of housing design.) Second it was driven over years by a stable and small team, who gathered data throughout enabling refinement and impact assessment.

Some similar lessons were demonstrated by the *Swimming Pools for Remote Aboriginal Communities* project, although not from within an Aboriginal community controlled context. This was a pilot, without guaranteed ongoing funding, and therefore faced an inherent sustainability challenge. However, it also showed the strength of having both local and higher level political support, a clear and measurable objective based on an equally clear proposition as to why the intervention would work (in this case to reduce skin infections and various measures of the alienation of young people from their community.) It was also arguable that this project demonstrated the potential benefit from the involvement of highly skilled public health academics as evaluators throughout innovative projects such as this, especially on the sort of partnership modelled in this case.

The *Indigenous Employment Policy* sought to improve Aboriginal employment levels, an objective which, if successful, would be very supportive of health. This policy project, however, lacked a clear analysis, stable sponsors or an evidence base. It was based on encouraging private sector involvement (as opposed to a public-private mix model) and on a goal of extending participation beyond periods supported by funding incentives. There was not such a clear analysis, as in the *Swimming Pools* or *Fixing Housing* projects, and the policy direction was derivative of general government dispositions as much as any evidence base.

On the other hand the Queensland *Nutrition Policy for Remote Stores* was based on a very specific analysis with clearly articulated objectives and with clear sponsorship at both government and community level. The biggest issue with this project was less the analysis or intervention on which it was based, but the sustainability of results given that the Queensland Health Department was determined to divest itself of the remaining stores in Deed of Grant in Trust communities. This looked likely to remove one of the key avenues for implementing healthy stores policy. From a health perspective this would be enough to question the decision to divest but was of course only one factor operating on the decision within the Aboriginal Affairs portfolio.

The *Aboriginal Identification Project* in WA aimed to improve access, awareness and accuracy of recording of Aboriginal people in secondary and tertiary health services. It gained from high level sponsorship and clear objectives. It also had a clear rationale in terms of access to and safety of Aboriginal people in the health system.

Policy implications

There were a number of implications that could be drawn from the literature review and case studies:

- Specificity and measurability in intersectoral interventions and the importance of a clear analysis, and focussed objectives;
- The potential of collaboration between State, Aboriginal community controlled sector and professional non-Aboriginal non-government sector in programs to enhance primary health care (admittedly on a very small number of examples);
- Partnership with academic institutions in design and evaluation;
- The importance of local and political leadership and support; and
- The importance of long-term support from key staff.

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

- Clinical care covering treatment of acute illness, emergency care, and the management of chronic conditions;
- Population health programs (e.g. immunisation, ante-natal care, screening);
- Facilitation of access to secondary and tertiary care; and
- Client/community assistance and advocacy on health related matters within the health and non-health sectors (Office of Aboriginal and Torres Strait Islander Health, 2001).

Mobilising all of the disparate elements of the health system to achieve a comprehensive service, especially given the limited workforce on which both Aboriginal and non-Aboriginal services could draw was, however, a very difficult task (Office for Aboriginal and Torres Strait Islander Health, 2000).

Tensions continue to played out between the Aboriginal community controlled health sector and governments about this, because over time the Aboriginal community controlled sector had been frustrated at the slowness of establishing intersectoral initiatives and to engage non-health portfolios, as they had been at the Commonwealth's perceived general practice centred view of primary health care.

More recently, greater policy interest had also begun to be expressed in secondary and tertiary health services, especially on the role of specialist medical leadership ((cf Cass et al, 2002; Anderson et al, 2002).

The implications of this study were that, with attention paid to specific objectives and stable professional support, a wider set of intersectoral and specialist areas could be addressed successfully, and in fact there were examples of government and community collaboration achieving this.

2. Community factors

The literature documented the fact that all major reports in recent years on Aboriginal and Torres Strait Islander health stressed the importance of engaging the community – principally through the community-controlled health sector - in achieving health outcomes. This was advocated for both

general primary health services and specific programs or interventions, in areas as diverse as petrol and alcohol abuse, sexually transmissible diseases, nutrition, renal disease and injury prevention and control.

The case studies demonstrated a broader continuum of engagement with the Aboriginal and Torres Strait Islander community. The nomination process contributed in part to this; liaison officers in each of the jurisdictions sought to ensure that the community controlled health services were represented in the nomination process. Examples beyond the health sector that resulted in health outcomes were also actively sought. While community participation was broadly seen as a key contributor to achievement, no single model of participation dominated, and in some cases, the issue of community engagement was not prioritised in the planning and implementation of the project.

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

Community controlled projects: These projects were characterised by the model of governance and community participation established through the Aboriginal Medical Services, an emphasis on holistic approaches to health that affirmed Indigenous culture, and accountability to boards elected by the Aboriginal and Torres Strait Islander community. Three case studies demonstrated the direct contribution of community controlled principles to the success of projects: the *Koori Maternity Services Program*, the *Katherine West Coordinated Care Trial*, and the *NSW Aboriginal Vascular Health Program*.

The *Koori Maternity Services Program* placed a strong emphasis on community participation in the evaluation of services, the recruitment and training of Aboriginal health workers and midwives, and the development of outreach, advocacy and health promotion activities. The strength of community control rhetoric was thought by the project's evaluator to have contributed significantly to 'ownership' of the project and the increased participation of young Aboriginal mothers in maternity services. Unfortunately the evaluation appeared to have been lacking in a solid evidence base, largely relying on impressionistic interviewing.

In the *Katherine West Coordinated Care Trial*, the development of the community controlled Katherine West Health Board was critical to both the conceptualisation of the models of health care provision and in the implementation of the services themselves. Similarly, Aboriginal Community Controlled Health Services collaborated in the development of the *NSW Aboriginal Vascular Health Program* and played a key role in implementation of the project in a number of centres.

Interestingly, all three of these projects demonstrated close collaboration with mainstream and other services, without compromising their principles of community control.

Community initiated projects: These projects showed strong evidence of being conceptualised and implemented within Aboriginal and Torres Strait Islander communities, though not necessarily through community controlled structures. The *Well Persons' Check* in Far North Queensland, initiated through the Apunipima Health Organisation, was developed as a model for voluntary health screening, and repeated extensively in Cape York and other Queensland communities. Similarly, the *Strong Mothers, Strong Babies* project from the Northern Territory, was developed as a result of local community motivation to address the problems of infant nutrition in Aboriginal communities.

Community tested projects: Community tested projects integrated the lessons of Western technical knowledge into Indigenous contexts, through extensive long term collaboration with Aboriginal and

Torres Strait Islander Communities. Implementation of these projects often reflected the depth of integration of technical and cultural perspectives.

The *Fixing Houses for Better Health* project has allowed the design, public health and architectural expertise of Healthabitat to develop a practical model based on their origin within an Aboriginal community controlled health service in SA. The extension of that model to five States continued the close ties to Aboriginal Community Councils, and the functional emphasis on safety and healthy living, employing Aboriginal staff in both survey and data analysis, and providing skills transfer for domestic maintenance work.

The *Healthy Jarjums* project combined technical nutrition input from the Inala Aboriginal Community Health Service and local community knowledge into a healthy lifestyle curriculum for Queensland primary school children. Introduction of the curriculum into local government and community run schools was facilitated by the strong local participation and ownership in the development of the curriculum, and implementation involved continuing community support.

Community adopted projects: Though projects may have been developed without extensive community engagement, some showed subsequent acceptance and adoption by community groups, with increasing participation during implementation. There was some evidence of this occurring in the *Swimming Pools for Remote Aboriginal Communities* project in Western Australia, where, although the project was resourced and conceptualised outside the community, there was increasing utilisation of the facilities for community based activities and early evidence of interest in training in lifesaving that might have led to community management of swimming programs.

Community oriented projects: A significant proportion of projects were designed to benefit Aboriginal and Torres Strait Islander health, but their success was not dependent on the direct involvement of the community. The Western Australian *Aboriginal Identification Project* offered improved data on Aboriginal identification in hospital admission, but with the exception of hospitals in communities with a large proportion of Aboriginal residents, was conducted with limited Indigenous participation in the data collection and analysis.

The Queensland *Nutrition Policy for Remote Retail Stores* was currently in transition from community oriented to a community adopted model. Most retail stores in remote Queensland Aboriginal and Torres Strait Islander communities were currently managed by the Department of Aboriginal and Torres Strait Islander Policy with the exception of Cherbourg, which was managed by the community council. The development of the policy had direct implications for the health of these communities through improving food security, though through state controlled mechanisms. The process of competitive tender, with transfer expected to community-based organisations was currently being prepared.

Policy Implications

There was widespread though hard won *general* support within Aboriginal health policy for the participation of Aboriginal people and organisations in primary health care, along the lines promulgated by the World Health Organisation in the Alma Ata Declaration (WHO 1978), the Ottawa Charter (WHO 1986) and the Jakarta Declaration (WHO 2001). For key advocates of Aboriginal community controlled health services this had always been about community *control* of service delivery - the single most important principle around which the modern Aboriginal health movement was built. For this reason, it had been an important issue of contention between governments and

Aboriginal health organisations and activists. Despite NAHS being fairly explicit on this point, governments had preferred more general formulations of the principle.

State governments in the north of the country had traditionally run primary health care infrastructure in remote communities. These governments had started to indicate a preparedness to embrace more community participation in direction setting, even including a migration to some form of community control. The *Katherine West Coordinated Care Trial* was a good example of this commitment in the NT.

On the other hand, a substantial proportion of Aboriginal people could not access an Aboriginal community controlled health service (ACCHS), either because of distance or the complete lack of such a service in their region. While growth in the number of ACCHS's was one answer to this problem, the reality was that many communities had no chance of accessing an ACCHS in the foreseeable future, largely because of diseconomies resulting from the small and dispersed nature of the Aboriginal population in many areas. Thus a range of primary health care models and of models of Aboriginal involvement in health was inevitable, just as it was inevitable that NACCHO would continue to advocate strongly for community governance as key.

The policy implication of this study was to point to the range of viable and constructive engagements actually in place. Whilst community engagement of some degree and for a variety of reasons was evident, Aboriginal community control was not a pre-requisite factor for a successful outcome. There were different reasons for community involvement contributing to a successful program. For example, *Fixing Houses for Better Health* was a very intrusive program and required strong community support. For other cases, such as the *Queensland Well Persons Health Check* and the *Katherine West Coordinated Care Trial*, community control was a key and essential feature. Whilst community control might not have been a pre-requisite, the longer term impact might be significant in relation to capacity building and underlying social determinants of health.

2. Funding and evaluation factors

Resourcing

Adequate resourcing could be considered a self-evident prerequisite for project success. The literature review, however, pointed to estimates from the Commonwealth Grants Commission (2001) that recent levels of expenditure on Indigenous health were about half of that required. However, despite persisting under-resourcing, there was evidence of better and more consistent funding of Aboriginal Community Controlled Health Organisations and their 'umbrella' organisations, and improved access to both MBS and PBS financing, targeted support for specific disease oriented strategies (e.g. ear and eye health, diabetes, renal disease, sexual health and rheumatic heart disease) and attempts to enhance services through pooled funding under the Coordinated Care Trials.

Evidence of adequacy of funding at individual project level was difficult to establish from the literature available. What was clear, however, was that insufficient resources had been allocated for evaluation of projects, reflected in the limited evaluation documentation available to this study.

Analysis of the case studies revealed the potential for *strategic* use of resources to significantly enhance the potential of the project. This was most apparent in the *Katherine West Coordinated Care Trial*, where the Commonwealth government provided an allocation based on a calculated per-capita

PBS/MBS expenditure, and the Northern Territory government contributed its budget for the purchase of health services and administrative costs. An agreement between the two governments allowed pooling of those financial resources, together with an administrative contribution from OATSIH. In this sense the finances themselves were a crucial input; the financing mechanisms a significant output of the project.

As well, however, the trial tested a potentially sustainable alternative method for funding primary health care that drew on Commonwealth medical and pharmaceutical benefits, capitating but adjusting for relative need. There were arguments for and against – from AMSANT who supported the approach on the one hand and Gavin Mooney and his colleagues who critiqued relative need and favour capacity to benefit as methodology (e.g. Mooney & Houston, 2002). The key point, however, was the commitment to test a new approach and commit increased funding.

Projects which were resourced as part of a larger health program benefited from concurrent reform and infrastructure development in other elements of the health care system. The *Koori Maternity Services* was a specific component of the Victorian Department of Human Services' Maternity Enhancement Strategy, which upgraded government health facilities and services, while promoting the development of community based services for Aboriginal women. Improved access to, and ownership of antenatal, clinical and health promotion services proved synergistic with more receptive and better resourced hospital care.

The *Fixing Housing for Better Health* provided an example of the improved outputs possible from a program where higher levels of funding were available, and in NSW where the budget allowed \$7500 per house, compared with \$3000 in other states. The project also documented more extensive maintenance and repair work unable to be undertaken within the constraints of this project phase.

The Western Australian *Swimming Pools for Remote Aboriginal Communities* project was predicated on a significant capital investment, in part funded through the Lotteries Commission. As such it represented opportunistic access to resources that otherwise might not have been available to remote communities.

For most projects, however, the vulnerability around resourcing lay not so much in terms of the quantum of funding - though the *Koori Maternity Services Program* argued that funding did not allow the development of desired services in some communities, and the *Fixing Housing for Better Health* demonstrated that repairs were constrained by the funding allocated – as in the short funding cycles, the time consumed in pursuing continued funding and the unpredictability of funding applications.

Accountability

The limited contribution of accountability to achievement in Aboriginal and Torres Strait Islander health reflected broader issues of governance, with responsibility for projects diffused over a range of stakeholders. In most cases, financial accountability was to the funding agency, though projects were less likely to represent themselves as *strategically* accountable for their outcomes within a specific policy framework. The development of OATSIH within the Commonwealth Department of Health and Ageing, the State and Territory Aboriginal Health Policy offices and the evolution of community controlled health organisations provided an increasingly comprehensive policy framework for Indigenous health. However, the complex network of responsibilities for Indigenous health often precluded the establishment of a single locus of accountability for outcomes of health projects. Where collaboration between agencies resulted in a single point of accountability, as with the *Katherine West*

Coordinated Care Trial, evidence suggested that health service provision improved significantly, though it was too early to judge the impact on health status overall.

The literature showed a growing emphasis on evidence-based approaches, with performance indicators linked specifically to outcomes. Improved identification of Aboriginal and Torres Strait Islander people in hospital, birth, death and other health data bases has been a recent pre-occupation, with the potential to substantially improve the accuracy of knowledge and information systems on Indigenous health. The Western Australian *Aboriginal Identification Project* was a key example, initiated in response to the recommendations of the Aboriginal and Torres Strait Islander Health Information Plan (endorsed by the Australian Health Ministers' Advisory Council (AHMAC) in 1997) to assess the accuracy of recording of Indigenous status in hospital inpatient data.

The Queensland Health *Indigenous Workforce Management Strategy* set recruitment targets for Aboriginal and Torres Strait Islander health staff for both the short and long term, and extended accountability to District Health Managers for recruitment levels in their districts. While achievement of crude recruitment levels appeared possible, higher targets (and strategies) for the recruitment of Indigenous professionals would need to be considered in future phases.

The *Nutrition Policy for Remote Retail Stores* had a built in mechanism for monitoring outputs in stores currently administered by the Department of Aboriginal and Torres Strait Islander Policy. Store profiles and performance were reviewed at 6 monthly intervals to ensure availability and affordability of healthy food through the healthy food access basket survey. The transition to local – and potentially community – ownership, of these stores might alter this direct link in terms of accountability, though supportive networking should maintain current policy directions.

Evaluation

The problem of (lack of) evaluation influenced both the methodology and results of this study, and was linked to the project funding cycle for Indigenous health. Of more than one hundred projects, fewer than fifteen projects had project evaluations that were sufficiently complete to enable case study analysis to be considered. The pattern was similar in the literature review – few of those projects reported had been subjected to rigorous, formal examination, and observation confirmed independently in reviews of programs addressing alcohol abuse, smoking and physical activity.

In part this was due to short project funding cycles – frequently three years – with few projects having an extensive history of achievement. The short project life cycle meant that meaningful analysis of health outcomes resulting from the project was difficult, as many of these depended on longer term change, or were influenced by multiple factors, to which the project components might contribute. The absence of a clear link between continued funding and demonstrable project outcomes further reduced the incentive for rigorous evaluation.

Of the case studies, the Western Australian *Swimming Pools for Remote Aboriginal Communities* project was conspicuous for its commitment to evaluation of the health impact of the intervention – in this case the introduction of a swimming pool with swimming instructors and a link to school attendance. The collaboration with the Institute for Child Health Research was examining the incidence of skin sores, ear disease and nasal discharge following the introduction of the pool. Records of school attendance, swimming skills and observations on juvenile crime were also being kept. The evaluation would need at least one further screening to accommodate the effects of seasonal variation, but

evidence to date was positive. Interestingly, the broader social and political impact of the project was not the main focus of the evaluation process, though this was pertinent to issues of sustainability.

The *Koori Maternity Services Program* noted early improvements in service utilisation and claimed positive trends in birth weights, a reduction in pre-term deliveries, sudden infant death syndrome and post-natal depression. Again, as the project only commenced in 1999, further studies would be needed to demonstrate maintenance of this progress and it had to be noted that the evaluation conducted was weakened by relying on the perceptions of people with an interest in seeing the impact positively. The data available for the case study did not allow independent statistical analysis. The reviews of the program have both noted the lack of a common record keeping system among participating agencies involved in the project, a major constraint to effective and comprehensive evaluation in Aboriginal and Torres Strait Islander health services across Australia, as evidenced in the literature review.

A number of the projects incorporated evaluation in the process of implementation. The *Fixing Houses for Better Health* utilised a two stage survey process to record baseline housing defects and a subsequent review of change effected by the project. The project also documented repair work unable to be completed for consideration in subsequent phases of the project. Over more than ten years, the approach has now established an evaluation database across projects across the country.

Queensland Health's *Indigenous Workforce Management Strategy* evaluated recruitment against targets, though critical evaluation of strategies would be more pertinent in the next phase of the project, where the distribution of recruitment against salary levels and professional categories would become imperative. The Western Australian *Aboriginal Identification Project* incorporated quality control of its own processes as well as the analysis of Indigenous identification, and the six monthly healthy food access basket survey undertaken as part of the *Nutrition Policy for Remote Retail Stores* has been discussed above.

In the case of non-health projects such as the *Indigenous Employment Policy*, measurement of health outcomes, affected directly and indirectly by changes in employment status, was not practicable. As with the *Fixing Houses for Better Health* project, where health benefits arose from improved safety, living conditions and hygiene, the known link to health outcomes provided the justification for support, with evaluation of the project focussing on other indicators.

Policy Implications

There was acceptance across Aboriginal health policy that funding needed to be increased and services accountable both for funding and for service provision. However, the mechanisms through which funding was made available and the service models for which services became accountable were contested. For example the managed care aspects of coordinated care drew criticism from both Aboriginal and non-Aboriginal services as it was developed.

These case studies demonstrated that the projects with superior evaluation and accountability strategies also had a more plausible story to tell about results. They also showed that it was possible not only to reconcile accountability with community ownership but also that accountability constructed around the very specific outcomes for community were the most powerful. Both the *Fixing Housing for Better Health* and the *Katherine West Coordinated Care Trial* were exemplars of this. As such they had strong lessons for both funders and service providers in Aboriginal health.

Community controlled health services pointed out that they were much more accountable than State services or the general Medicare Benefits Scheme that funds private general practice on a demand basis. They criticised the Commonwealth Health Department for not holding the States or the recipients of funding under the medical benefits programs accountable. Interestingly the strength of the *Katherine West Coordinated Care Trial* was that it showed that accessing those very benefit programs enabled a primary health care service being transferred to the local community to define outcomes against which accountability would work.

The implication was that accountability, evaluation and funding reform were all possible, most usefully tied together in one package and necessarily related to processes of defining accountabilities to communities as well as funders.

3. Implementation factors

Partnerships

The importance of partnerships, especially at grass-roots level has been recognised for several years, and was highlighted within the National Aboriginal Health Strategy of 1989. This has been acknowledged through the development of the framework agreements between Commonwealth and State governments, community controlled health services and ATSIC. While it would be some time before the impact of these agreements was measurable, NACCHO has noted an improvement in communication and collaboration in several states, the development of joint regional plans and improvements in resourcing for health services.

The case studies demonstrated a number of innovative partnerships in sponsoring, planning and implementing the projects. The case studies provided examples of collaborations for Aboriginal and Torres Strait Islander health that included a range of players, including:

- Health Departments and Departments of Aboriginal and Torres Strait Islander Policy, Housing, Youth Sport and Recreation
- The private sector
- Non-Government Organisations
- Mainstream health services
- Aboriginal Community Controlled Health Services
- Secondary and tertiary health services
- Academic institutions

A number of these collaborations were between agencies that had a history of conflict, and the surmounting of these tensions was a major contributor to the success of the projects.

Collaborations between governments and departments in funding and implementation were common, with a number of combinations. The *Swimming Pools for Remote Aboriginal Communities* included the WA Department of Housing and Works, the Department of Sport and Recreation and the Lotteries Commission. The *Fixing Houses for Better Health* project involved ATSIC, and state Departments of Health and Indigenous Housing Agencies. *Healthy Jarjums* was implemented through Queensland Education and Aboriginal Community Schools. The *Katherine West Coordinated Care Trials* combined Commonwealth and Territory government agencies funding an incorporated community

board. The *Nutrition Policy for Remote Retail Stores* brought Queensland Health technical expertise together with Department of Aboriginal and Torres Strait Islander Policy management.

The *Indigenous Employment Policy* provided a useful example of a matrix of relationships between government agencies, the private sector, community based organisations and training and education providers to achieve employment outcomes. Aware of the current low participation rate of Aboriginal people in employment, the high proportion of youth, lower skills levels and the heavy reliance on government for employment, the *Indigenous Employment Policy* sought to engage corporate leaders to provide employment opportunities, as well as promoting business opportunities in Aboriginal and Torres Strait Islander communities. The Community Development Employment Projects (CDEP) Placement Incentive supported the transfer of CDEP workers into fulltime employment, while the Structured Training and Employment Projects and Cadetships supported business in recruiting Indigenous job seekers.

The involvement of non-government organisations in Aboriginal and Torres Strait Islander communities was significant to a number of projects. The *Swimming Pools for Remote Aboriginal Communities* project was managed by the Royal Life Saving Association, which also provided swimming training and instruction. The NSW *Aboriginal Vascular Health Program* collaborated with the National Heart Foundation, the Australian Kidney Foundation and Diabetes Australia in its training and health promotion activities.

Aboriginal Community Controlled Health Services and government health providers collaborated in the *Katherine West Coordinated Care Trails*, the NSW *Aboriginal Vascular Health Program* and the *Koori Maternity Services Program*. The Institute for Child Health Research was contracted to undertake the evaluation of the *Swimming Pools for Remote Aboriginal Communities* project, and education and training providers played important roles in skills development for employment in the *Indigenous Employment Policy*.

Workforce

The literature review demonstrated a commitment to increasing the representation of Indigenous people in the workforce generally and the health workforce in particular. The growth in rural employment opportunities through health, housing, tourism and mining had direct benefits on health in communities where employment options have been limited. Attention had also been given to increasing participation in tertiary education and linking this to employment outcomes, with improved identification of Indigenous students enabling retention and outcomes to be monitored. There have been significant increases in the training of Indigenous doctors, nurses, health workers and research assistants, with a focus on recruitment, learning and retention strategies.

Workforce implications varied across the case studies – in some projects, such as the *Indigenous Employment Policy* and the Queensland Health *Indigenous Workforce Management Strategy* it represented the core focus; in others such as the *Koori Maternity Services Program* and the NSW *Aboriginal Vascular Health Program*, the impact was made through recruitment and training of Aboriginal health workers in specific roles, and in the *Fixing Housing for Better Health* the recruitment of a community-based workforce for the duration of the project had resulted in a skills transfer in the area of maintenance that made an enduring contribution to local social capital.

The *Indigenous Employment Policy*, while not defined as a ‘health’ project, addressed the issue of Indigenous employment with a range of strategic options that reflected the complexity of the problem.

The differing employment problems inherent in differing populations were recognised: the young were offered training and cadetships, with wage assistance an incentive for first-time employment, leading to more permanent options. Urban unemployment was addressed through projects that sought the support of corporate leaders, and that provided structured assistance to businesses employing Indigenous staff. Collaborations with training and education providers assisted with the up-skilling of the workforce. For rural and remote communities, the Community Development Employment Programs were treated as bridges to employment in the private sector, with placement incentives offered to agencies. The need to generate opportunities other than government funded employment in these communities was reflected in the development of the Indigenous Small Business Fund, designed to encourage local economic initiatives, with a view to providing long-term, sustainable employment.

The Queensland Health *Indigenous Workforce Management Strategy* promoted the recruitment of Indigenous staff into the Queensland Health workforce. The Strategy showed some understanding of the potential benefits of the policy in reshaping the department through increased recruitment of Aboriginal and Torres Strait Islander staff. It addressed the need to create culturally safe workplaces, to build relationships with Indigenous communities in order to improve health service models and influence health outcomes. In some senses it recognised that the recruitment of an Indigenous health workforce was important as a social, economic and political target in itself, in addition to its potential impact as a workforce *for* Indigenous health.

In its setting of targets that were lower than State Indigenous population percentages, however, it was forced to acknowledge the limited pool of Indigenous health professionals from which to recruit. This was problematic for the strategy, in that recruitment to lower levels, even where absolute numbers proportionally reflected the Indigenous population, was unlikely to have a significant impact on reshaping the organisation itself. Whether the strategies for recruitment and training, and collaborations with education providers were adequate to substantially enlarge the pool by the 2010 targets for proportional representation at all levels, remains to be seen.

Capacity building and sustainability

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

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

The *Katherine West Coordinated Care Trial* provided a model for capacity building, with sustainability built into its structure. This was achieved primarily by the structural changes achieved through the creation (and commitment to its support and training) of the community controlled Katherine West Health Board and the pooling of both Commonwealth and Territory financial resources that assured predictable on-going funding. In addition, secured funding of this nature and the resultant improved access to health services provided some sustained incentive for community members to take on the responsibilities of governance and management. For most projects, short project cycles and the need to ‘invent’ innovation in order to secure ongoing funding, worked against the development of institutional

capacity and sustainability, and undermined rigour in evaluation because of the difficulties in demonstrating change over such short time frames and the absence of a direct link between performance and ongoing funding.

As discussed under Workforce, the development of an Indigenous workforce, both *in* health and *for* health, was crucial to establishing capacity and ensuring sustainability. Clearly, the combined impact of a range of employment programs would be experienced in both mainstream and community controlled health services, as well as producing health outcomes through economic growth and employment opportunities. The eventual impact of workforce development was dependent to some extent on its ability to alter decision-making within community organisations, and in government health departments, through a greater Indigenous presence in management and professional roles.

Two aspects of the NSW *Aboriginal Vascular Health Program* contributed to its capacity building: the training of Aboriginal vascular health workers, and the development of a network of over 170 members exchanging ideas on vascular health promotion in Aboriginal communities, and linking government services, community controlled services, projects, NGOs, university departments and Divisions of General Practice.

The *Nutrition Policy for Remote Retail Stores* in Queensland has improved organisational capacity of this retail network through its policy approach and management support that should be sustainable through the transition from government to commercial or community based management. The policy changes have been directly linked to financial incentive, with stakeholder participation in regular performance monitoring and evaluation, ensuring their continued impact on health food purchases and sales in remote and rural communities.

Interestingly, *Fixing Houses for Better Health* had an approach that located its capacity building and sustainability internally, within the project structure. The project has developed a process that has been tested over time within Aboriginal communities, and was implemented under license, allowing control of the model itself. The survey and repair cycle allowed for skills transfer at the local level, which remained in community, and documented the work remaining at the end of the project. Though funding might not be continuous, the project retained its conceptual integrity and was able to be ‘re-activated’ with additional funding.

Given the focus on capacity building and sustainability in international development assistance, however, the lack of emphasis on these factors in project design and evaluation in Australian Indigenous health was surprising. The WA *Aboriginal Identification Project*, while it provided crucial data for decision making and planning for Indigenous health, could have been designed to enhance research and analysis skills in Aboriginal organisations, or to promote a greater Indigenous presence within government admission processes. Sustainability of the WA *Swimming Pools for Remote Aboriginal Communities* project would depend on developing local ownership through a commitment to professional development in Aboriginal pool management and swimming safety programs.

Policy Implications

Aboriginalisation of the health workforce has been one of the most difficult areas of policy discussion within Aboriginal health. Training of Aboriginal and Torres Strait Islander people to work in health services commenced in Australia long after Indigenous participation in training began in New Zealand and North America. For example, the first indigenous medical graduates in North America and New

Zealand were in 1889 and 1899 respectively, whereas the first Australian Aboriginal medical practitioners did not graduate until the 1980s.

Australia developed the model of the Aboriginal health worker (AHW) in the Northern Territory, based on a hospital assistants course that itself started in the mid 1960s. AHWs were meant to receive a year of training and operated at that front line in Aboriginal primary health care settings. They have been seen as a kind of primary care ‘barefoot doctor’ by some advocates of the model.

AHWs are mostly trained in vocational not tertiary training settings and there have been many debates within the sub-system about the nature of appropriate competencies that should be expected of them. Numbers of Aboriginal people enrolled in such courses have nonetheless climbed sharply since the mid-1990s, during a time when the number of Aboriginal people enrolled in tertiary level courses has remained stagnant - and in the case of nursing students, actually fallen. (Schwab & Anderson, 1998). There was also, however, a fairly robust emerging discussion about the future of AHWs. As they were obtaining wage levels comparable at least to Assistants in Nursing, value for money questions about the relative contributions of AHW versus mainstream health training were starting to arise for some Aboriginal community controlled health services (OATSIH, 2001).

There was less widespread but still powerful support for more Aboriginal medical graduates but some ambivalence about the role of both them and nurses. Professional associations for Aboriginal doctors and nurses have been established and graduates work in community controlled health services, State government and private practice. They were not always well received within community organisations, sometimes seen as ‘tall poppies’ or a threat to management. Governments have supported curriculum initiatives for medical training, but have generally failed to support initiatives to boost Aboriginal nursing numbers. Until recently policy coverage of workforce issues in Aboriginal health also focussed solely on AHWs and doctors, with no serious planning for a public health workforce, dental workforce, allied health, nursing or health management (OATSIH, 2001).

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

The Aboriginal and Torres Strait Islander Workforce Strategic Framework, recently endorsed by AHMAC, proposed a comprehensive reform agenda. It acknowledged the significant challenges that workforce has posed in Aboriginal and Torres Strait Islander health for some time and sought to give urgent priority to the Indigenous health workforce in the Australian health system as a whole, as well as in the delivery of comprehensive primary health care to Aboriginal and Torres Strait Islander communities.

5. Other Factors

Leadership

A further overarching factor was the role of individuals and leadership by individuals in many of the successful programs examined. Strong and sustained leadership by a skilled individual was key to a number of projects but was not acknowledged despite the evidence for inclusion as a precursor to gains in some of these complicated areas. This was a reality that people in Aboriginal health talked about often. The case study examples examined bore this out. For example the *Swimming Pools for Remote Aboriginal Communities* project had sustained support from the WA Aboriginal Affairs Minister and a number of key individuals in the target communities. Queensland Health's *Indigenous Workforce Management Strategy* had a champion and sponsor in the Director-General. Political leadership was also evident in the Western Australian *Aboriginal Identification Project*

Policy framework

One of the clear contributors to the success of projects, not previously identified from the key informant interviews, was evidence of political commitment, and the location of projects within a supportive policy framework. Indigenous employment was based on a strong national policy. Queensland Health's *Indigenous Workforce Management Strategy* – sponsored by the Director-General – provided the necessary authority and policy commitment to make Indigenous recruitment an acceptable performance indicator at District level, and ensure workforce change. The Western Australian *Aboriginal Identification Project* was a response to recommendations of the Aboriginal and Torres Strait Islander Health Information Plan as endorsed by the Australian Health Ministers' Advisory Council. The Queensland *Nutrition Policy for Remote Retail Stores* provided a clear structure to initiate change that has proved to be both cost-effective as well as health promoting. The *Aboriginal Vascular Health Program* also displayed the feature of local flexibility in implementation.

The *Katherine West Coordinated Care Trial* utilised the opportunity afforded by an innovation in health service provision to explore new funding and structural options, with a resultant improvement in health services. Having established its policy 'niche', the *Katherine West Coordinated Care Trial* has allowed the models of coordinated care to be extended and modified to bring additional primary care resources within a new framework of community control, effectively changing policy direction. This was accomplished through an established mechanism of local and national evaluation of the co-ordinated care trials.

5 Conclusion

In view of Australia's performance in health generally - and the country's wealth - the achievements in Indigenous health in the past decade in terms of health outcomes, have been disappointing. However, given long lead times, only recently concerted effort and general under-funding, the overall assessment of achievements in Indigenous health was much more encouraging.

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

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

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

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

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

Secondly, there was a need for more comprehensive and accurate information on health outcomes, in order to monitor and effectively manage health initiatives. There was a general paucity of outcomes data and lack of a solid evidence base. The literature review and projects initially nominated by jurisdictions revealed this lack of data. Another result of past policy evidenced in the literature review and cases examined was the lack of communication and co-ordination of effort across the health and other sectors. Even several of the detailed case studies had very little useable data, despite in some cases having acquired good reputations for having achieved results. The *Koori Maternal Health* project was evaluated by asking health service providers their perceptions of increased access by Koori women to antenatal services. Reports of a sense of positive community engagement were not as strong as actual utilisation data and/or a direct assessment of consumer satisfaction. However, the lack of a strong evidence base was not limited to that case. This highlighted the need for stronger evaluation

through adequate funding for evaluation, establishing reliable baseline data and appropriate performance indicators, and partnerships between service providers and institutions with evaluation expertise, as well as services building their own monitoring and evaluation capacity. Related to this was the need to re-examine the assumptions around process indicators whose links to health outcomes have not been established.

Thirdly, the project showed the value of diversity at a local level within a national framework that provided consistency in policy direction. The success of a range of models of community participation reflected the importance of engagement of the community, rather than the necessity of one prescriptive model. This diversity needed to reflect the diversity inherent in Aboriginal and Torres Strait Islander communities, but be shaped within the broad strategic directions that would ensure comprehensive management of the health issues and equity in access to care.

Fourthly, funding models needed to be established that rewarded effectiveness in terms of outcomes. The literature review and the range of projects initially nominated demonstrated the 'stop-start' nature of past Aboriginal health policy and inherent short funding cycles which programs endured. There has been a repeated search for innovation which results in a high turnover of projects and recycling of ideas, rather than utilising the not insignificant knowledge currently available and properly evaluating its effectiveness. The combination of rigorous evaluation, with realistic performance indicators, and extended cycles of funding would contribute to greater organisational stability and enable capacity building to occur. Given the strong focus on capacity building and sustainability in international development assistance, the limited attention given to these issues in project development in Indigenous health in Australia was remarkable.

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

References

- Aboriginal and Islander Health Worker Journal. (2000). *Indigenous health promotion resources*. (3rd ed.). Sydney: Aboriginal and Islander Health Worker Journal.
- Anderson, I., Clarke, A., Renhard, R., Otim, M., Andrews, S. (2002). Linking acute care to a strategy for improving Aboriginal health. *Australian Health Review*. 25 (5), 118-129.
- Anderson, I. & Sanders, W. (1996). *Aboriginal health and institutional reform within Australian federalism. Discussion Paper No. 117/1996*. Canberra: Centre for Aboriginal Economic Policy Research.
- Australian Bureau of Statistics, & Australian Institute of Health and Welfare. (2001). *The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples 2001* (ABS Catalogue No.4704.0. AIHW Catalogue No. IHW 6). Canberra: A joint program of the Australian Bureau of Statistics and the Australian Institute of Health and Welfare.
- Australian Institute of Health and Welfare. (2000). *Australia's health 2000. The seventh biennial health report of the Australian Institute of Health and Welfare* (AIHW Cat No. AUS-19). Canberra: Australian Institute of Health and Welfare.
- Australian Institute of Health and Welfare. (2001). *Expenditures on health services for Aboriginal and Torres Strait Islander people 1998-99*. (AIHW Catalogue No. IHW 7). Canberra: Australian Institute of Health and Welfare and Commonwealth Department of Health and Aged Care.
- Cass A, Cunningham J, Arnold PC, Snelling P, Wang Z, Hoy W. (2002). Delayed referral to a nephrologist: outcomes among patients who survive at least one year on dialysis. *Medical Journal of Australia*, 177 (3), 135-8.
- Commonwealth Grants Commission. (2001). *Report on Indigenous funding*. Canberra: Commonwealth of Australia.
- Couzos, S., Metcalf, S., Murray, R., & O'Rourke, S. (1998). *Recommendations for clinical care guidelines on the management of non-insulin-dependent diabetes in Aboriginal and Torres Strait Islander populations*. Canberra: Office for Aboriginal and Torres Strait Islander Health Services, Commonwealth Department of Health and Family Services.
- Couzos, S., Metcalf, S., & Murray, R. B. (2001). *Systematic review of existing evidence and primary care guidelines on the management of otitis media in Aboriginal and Torres Strait Islander populations*. Canberra: Commonwealth Department of Health and Aged Care.
- Deeble, J., Mathers, C., Smith, L., Goss, J., Webb, R., & Smith, V. (1998). *Expenditure on health services for Aboriginal and Torres Strait Islander people*. (AIHW Catalogue No. HWE-6). Canberra: National Centre for Epidemiology and Population Health, Australian Institute of Health and Welfare and Commonwealth Department of Health and Family Services.
- Department of Health (U.K.). (1999). *Saving Lives: Our Healthier Nation*. London: The Stationery Office.

Griew, R., Sibthorpe, B., Anderson, I., Eades, S. & Wilkes, T. (2004). On our own terms – the politics of Aboriginal health in Australia. In: *Accessing Health Care: Responding to Diversity* / Judith Healy and Martin McKee. Oxford University Press: Oxford.

Health is Life: Report on the Inquiry into Indigenous Health (2000). Canberra: Commonwealth of Australia.

Hunter, E. (1993). *Aboriginal Health and History*. Cambridge: Cambridge University Press.

Keys Young Report: Market research into Aboriginal and Torres Strait Islander access to Medicare and the Pharmaceutical Benefits Scheme. (1997) Prepared for the Health Insurance Commission.

Mackerras, D. (2001). Birthweight changes in the pilot phase of the Strong Women Strong Babies Strong Culture Program in the Northern Territory. *Australian and New Zealand Journal of Public Health*, 25(1), 34-40.

McDermott, R., & Beaver, C. (1996). Models for horizontal equity in resource allocation Aboriginal health. *Australian and New Zealand Journal of Public Health*, 20 (1), 13-15.

Menzies School of Health Research. (2001). *Recommendations for clinical care guidelines on the management of otitis media in Aboriginal and Torres Strait Islander populations*. Canberra: Commonwealth Department of Health and Aged Care.

Mooney, G. & Houston, S. (2002). Addressing issues of inequality in Aboriginal health. In *Health inequalities and sustainable futures*. Perth: Edith Cowan University.

National Aboriginal and Torres Strait Islander Nutrition Working Party. (2001). *National Aboriginal and Torres Strait Islander nutrition strategy and action plan, 2000-2010*. National Public Health Partnership 2001.

<http://www.nphp.gov.au/signal/natsinsa1.pdf> Retrieved October 2002:

<http://www.nphp.gov.au/signal/natstrat.htm>

National Aboriginal Health Strategy Working Party. (1989). *A National Aboriginal Health Strategy*. Canberra: Commonwealth Department of Aboriginal Affairs.

National Health Performance Committee. (2001). *National Health Performance Framework Report: a report to the Australian Health Ministers' Conference*. Brisbane: Queensland Health.

Office for Aboriginal and Torres Strait Islander Health. (2000). *National Performance Indicators for Aboriginal and Torres Strait Islander Health: Technical Specifications*. Canberra: Commonwealth Department of Health and Aged Care.

Office for Aboriginal and Torres Strait Islander Health. (2002). *Aboriginal and Torres Strait Islander Health Workforce: National Strategic Framework*. Canberra: Commonwealth Department of Health and Aged Care.

Office for Aboriginal and Torres Strait Islander Health. (2001). *Better Health Care: Studies in the Successful Delivery of Primary Health Care Services for Aboriginal and Torres Strait Islander Australians*. Canberra: Commonwealth Department of Health and Aged Care.

Office for Aboriginal and Torres Strait Islander Health. (2001a). *Specialist eye health guidelines for use in Aboriginal and Torres Strait Islander populations*. Canberra: Commonwealth Department of Health and Aged Care.

Schwab, R.G., & Anderson, I. (1998). *Indigenous participation in health sciences education: recent trends in the higher education sector* (Discussion paper no. 171). Canberra: Centre for Aboriginal Economic Policy Research.

Statistics Division and Central Health Monitoring Unit (Department of Health, U. K. (2001). *NHS Plan: Technical supplement on target setting for health improvement*. London: Department of Health, [U.K.].

World Health Organization. (2001). *The International Classification of Functioning, Disability and Health (ICF)*. Geneva: World Health Organization.

Appendixes

Appendix 1: Matrix for categorization of projects

The purpose of this matrix is to stimulate ideas about Achievements in Aboriginal health that may be worthwhile exploring as part of this project. The categories across the top of the table refer to the sectors from within which initiatives have arisen and the categories down the right side reflect the specific health areas targeted. We have included some examples by way of illustration. There are a couple of rows at the bottom of the table left blank. These are to allow you to identify other examples that targeted another issue or where the categories used above do not quite describe what you want to suggest. The key point is that we need to know who undertook the initiative and what was it aimed at. We also need to know that there were some concrete achievements that can be described. That does not necessarily mean the example produced a measurable change in health statistics for Aboriginal and Torres Strait Islander people. It may have produced a measurable change in something that there is a good case will improve health in the future.

Primary health care	Secondary / tertiary health care	Community / welfare services	Education and Research sector	Other sectors	
			TVW ICHR Bibulung Gnarneep network		Maternal and child health
Nganampa Health STD program	Royal Perth Hospital remote dialysis program				Infectious disease
“Thirsty Thursday” grog sale restrictions Tennant Creek					Chronic preventable disease Social and emotional well being Alcohol and other drug
					Social determinants of health Access to services
KAMSC Aboriginal health worker training			Uni of Newcastle med school Aboriginal prog		Workforce development
				AFAO Indigenous gay men and sistagirl proj	Cultural security
					Aboriginal community control

Appendix 2: Framework description and proforma for project nominations

Achievements in Aboriginal and Torres Strait Islander Health Project - Framework

Description of Framework

This document outlines the framework to be used in Phase 2, and identifies a number of factors seen as important in assessing achievements. It will be used to clarify the scope of reference and to ensure a consistent approach for the collection and dissemination of information about achievements in Indigenous health. To develop this framework, an initial literature review, discussions with a variety of people involved in Indigenous health, and a series of in-depth interviews were carried out.

The following working definition for success emerged during the framework consultations:

A success in Indigenous health is a project, program or intervention, or an element thereof that produces or could contribute to a demonstrated improvement in Indigenous wellbeing. This may be measured by an improvement in health outcome, or other health indicators or in other process or infrastructural indicators.

While achievements in Indigenous health may be defined as producing positive change in some variable which contributes to Indigenous well being or community empowerment, four areas emerged as a means by which to identify an achievement:

1. An improvement to health outcomes, for example an improved infant mortality rate or reduced prevalence of disease in a community
2. An improvement to process indicators with a proven link to better health outcomes, such as improved antenatal care leading to better obstetric outcomes; higher levels of physical activity leading to better outcomes in terms of cardio-vascular disease or diabetes
3. An improvement in the health system or components thereof, such as health policy, data collection or the shape of service delivery, which are also known to lead to improved health outcomes.
4. Improvements in other areas such as education, employment and housing that are also known to lead to improved health and well-being.

The above areas of achievement are consistent with those identified in the National Performance Indicators for Aboriginal and Torres Strait Islander Health.

Contributors to success

From the preliminary analysis of the literature and collated data, it has been possible to develop a list of common elements that, if present, are likely to contribute to the success of a project. The following broad areas have emerged as key elements of success to be further defined and investigated in Phase 2 of the project:

- Community Control
- Community participation / involvement
- Adequate resources
- Sustainability
- Capacity-building
- Partnerships & intersectoral collaboration
- Workforce Issues
- Information, including evaluation and research
- Accountability

Information gathering

Respondents will be to identify projects, programs, interventions or strategies for which they are able to demonstrate the following:

1. Achievement of an outcome in accordance with one of the four outcome areas identified in this framework
2. the factor to which the successful outcome can be attributed – consistent with the key elements of success identified in this framework and a clear statement of:
 - the measures (and changes in those measures) used to show evidence of what was achieved; and
 - information on why it was successful

Measuring success

There is a distinction between measuring achievements and measuring elements of success, as identified above. This is the difference between measuring what was achieved and measuring why it was achieved. Assessment of achievements in the health sector has long relied on specific health indicators, including various mortality and morbidity measures, and the prevalence of health related behaviours (eg., smoking, alcohol consumption and physical activity levels). Reliance on such indicators alone is not adequate, largely because of the fact that health depends on a complex interaction of socio-economic, cultural, environmental and personal factors, and in nature and availability of health services.

In phase 2, it is important to be able to identify not only the measure being used to demonstrate success of a project, program, strategy or intervention but also the elements of success, such as community control and capacity building to the extent this is possible. The latter are less easily quantifiable and usually require a more qualitative approach. Measures used to demonstrate an achievement may not specifically explain why a successful outcome has been achieved.

Examples are provided below:

Example 1

Cervical cancer screening rates may increase in a community, over a period following the employment of an Indigenous women's health officer by a service provider for that area.

On the basis of the evidence in the literature it would be possible to argue that decreased mortality will result from the measurable increase in more women being screened and earlier detection of disease (although there would be a higher recorded incidence of the disease in the short term).

The factor(s) which contributed to the increase in women presenting may not be as clearly measurable (they could potentially relate to workforce, community control, the model of service delivery or other factors). However, available information about the situation may help to identify the likely key contributors to success – in this case one is likely to be the employment of the health officer.

Achievement: Improved outcomes in terms of mortality from cervical cancer in community.

Measure being used: change in rates of women being screened for cervical cancer over a period of time.

Possible contributor to success - (why achieved): employment of Indigenous women's health worker.

Example 2

The implementation of an Indigenous health workforce strategy may result increased numbers of Indigenous health professionals. The literature may provide evidence of Indigenous involvement as a contributor to improved health outcomes. However, in order to attribute success to this outcome, a range of workplace issues would need consideration eg., recognition within the workplace, participation in management and decision making, skill level and capacity to practice, range of health professions covered, security of employment etc.

Achievement: Improved health outcomes as a result of health system changes.

Measure being used: change in employment rates for Indigenous health professionals

Possible contributor to success: Implementation of a workplace strategy that gives recognition to the role and skill level of the Indigenous health worker.

In addition, respondents will be asked to consider whether there are any known limitations to the data available and other issues related to the measures used, and an appropriate response to these.

Examples of measures that provide indicators of an achievement across different sectors.

The purpose of this table is to stimulate ideas about achievements in Aboriginal health that may be worthwhile exploring as part of this project. The categories across the top of the table refer to the sectors from within which initiatives have arisen. Examples have been included as illustration only. The key point is that we need to know who undertook the initiative and what was it aimed at. We also need to know that there were some concrete achievements that can be described. That does not necessarily mean the example produced a measurable change in health statistics for Aboriginal and Torres Strait Islander people. It may have produced a measurable change in something that there is a good case will improve health in the future

Primary health care	Secondary / tertiary health care	Health infrastructure	Other sectors – Community / welfare / Education / Research
<p>Maternal & child health program resulting in increased access to antenatal care</p> <p>Sexual health program which reduces the incidence of sexually transmitted diseases</p> <p>Renal disease management which results in decreased hospitalisation rates</p> <p>Information technology improving continuity and quality of primary care for patients</p>	<p>Linkages to hospitals resulting in better access to tertiary services for safe delivery of infants</p> <p>Specialist access program which has increased the availability of appropriate secondary/tertiary care</p> <p>Home based dialysis program enabling improved access to appropriate care</p> <p>Hospital liaison workers or similar arrangements resulting in increased numbers completing appropriate care regimes</p> <p>Effective linkages between ACCHSs &/or GPs, hospitals and community care providers resulting in continuity of care</p>	<p>Improved identification of Aboriginal and Torres Strait Islander people in data systems resulting in better informed policy and program development</p> <p>Training programs for Board of management members and for the general community on the role and responsibilities of Board members which have been evaluated as effective by participants</p> <p>Health Service Management development programs evaluated as effective.</p> <p>Workforce training programs resulting in increased numbers of Indigenous health professionals eg doctors, nurses, AHWs, epidemiologists etc</p>	<p>School based education programs on health issues such as nutrition, substance use or safe sex</p> <p>Provision of fresh food in remote communities resulting in improved opportunities for good nutrition.</p> <p>Alcohol restriction program which has reduced the number of alcohol related cases identified by the health service</p> <p>Incorporation of training on Indigenous health issues into undergraduate medical, nursing and other health programs</p> <p>Environmental health programs – housing, water, sewerage resulting in decreased environmental risks to health.</p>

Achievements in Aboriginal and Torres Strait Islander Health Project

NOMINATION FORM

This form is to be completed by those individuals/ organisations wishing to nominate a program, project, strategy or intervention (hereafter called a “project”) in Aboriginal and Torres Strait Islander health over the past decade, as an achievement, in accordance with the project framework. (copy attached).

While an achievement in Indigenous health may be defined as producing a positive change in some variable which contributes to Indigenous well being or community capacity building, four areas emerged as a means by which to identify an achievement:

1. An improvement to health outcomes.
2. An improvement to process indicators with a proven link to better health outcomes
3. An improvement in the health system or components thereof.
4. An improvement in another area such as housing, education or employment that is known to lead to improved health or well-being

Any queries regarding this process should be directed to:

Associate Professor Cindy Shannon
Ph. (07) 3365 5529
c.shannon@mailbox.uq.edu.au

Mr Condyc Canuto (epidemiologist)
Ph. (07) 3365 5525
condyc@acithn.uq.edu.au

Mr Michael Meehan (Project Officer)
Ph. (07) 3346 4641
m.meehan@sph.uq.edu.au

1. CONTACT DETAILS

Name :
Address :

Email :
Phone :

2. PROJECT DETAILS

Name of Project (please identify the project being nominated)

Description of Project (please provide a brief description of the project)

3. AREA OF ACHIEVEMENT

Specify Project Outcomes - note that in order for a project to be regarded as an achievement, an outcome in at least one of the following areas must be able to be specified:

1. An improvement in health outcomes eg., mortality rates, disease incidence rates, life expectancy
2. An improvement to a process indicator that is known to have a link to better health outcomes eg., cervical cancer screening rates, higher levels of physical activity, reduced levels of smoking, better retention rates in schools
3. An improvement to the health system or a component thereof, that is known to be linked to improved health outcomes eg., new models of service delivery, workforce development, policy changes
4. A change in another area such as housing, employment or education that can be linked to improved health or well-being

Area of Achievement- What has been achieved?

4 MEASURE OF ACHIEVEMENT

Specify the measure being used to demonstrate the achievement identified above – refer to attachment 1 for examples of the various sectors and types of measures For example:

- if the outcome identified is an improvement in obstetric outcomes as a result of better antenatal care, the measure used may be changes in ante-natal clinic attendance rates over a period of time.
- If the outcome identified is better education that can be linked to improved health outcomes, the measure used might be changes in school retention rates over a period of time, or increased numbers of Indigenous students completing secondary school
- If the outcome is related to changes in the health system, such as the implementation of a cultural-awareness training package in hospitals, the measure might relate to changes in administrative processes of identifying Indigenous patients on hospital records.

Measure of Achievement

5. ELEMENT OF SUCCESS – (Why was success achieved)

6. CONTRIBUTORS TO SUCCESS

Please provide information in relation to the factor to which the achievement identified in section 2 might be attributed. You can try and link your response to one or more of the following key elements of success identified in the project framework: community control, community participation, workforce, partnerships, sustainability, evaluation, capacity building, adequate resources, accountability.

Note that these factors may be considered as the determinants of success, but may not represent the measures used to demonstrate success

For example:

- factors to which an increase in physical activity levels might be attributed could be community control, but the measure used to support the achievement might be participation rates in organised activities;

OR

- sexual health outcomes may be measured by a decrease in the prevalence of disease while the factor attributable to such outcomes may be the employment of a sexual health worker, or the introduction of a new model for service delivery.

Contributors to Success

7 INFORMATION TO SUPPORT IDENTIFICATION OF THE CONTRIBUTOR

Are you able to describe how you know that the identified contributor to success was achieved? This may be difficult to measure. This measure may be qualitative or quantitative.

What information can you provide to demonstrate that the factor(s) contributed to an achievement?

Is there any other relevant or documented information available to support the contribution of the factor(s) towards success?

Please comment on any known limitations or other issues relating to the information you are providing?

8. COMMENTS

Is there any additional information in relation to this project that you think might be of relevance?)

Additional Information

Appendix 3: Project nomination list by jurisdiction

ACT

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

QUEENSLAND DEPARTMENT OF HEALTH

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

NEW WALES HEALTH DEPARTMENT

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

DEPARTMENT OF HUMAN SERVICES VICTORIA

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

DEPARTMENT OF HEALTH WESTERN AUSTRALIA

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

OFFICE OF ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH – DEPARTMENT OF HEALTH AND AGEING

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

DEPARTMENT OF HEALTH & HUMAN SERVICES TASMANIA

1. Aboriginal Liaison Officer – Royal Hobart Hospital

NORTHERN TERRITORY – DEPARTMENT OF HEALTH & COMMUNITY SERVICES

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

Projects identified as potential achievements – details not provided

1. Indigenous Immunisation Program - Qld
2. Numbulwar Community Council Community Store Nutrition Program - NT
3. Nunkuwarrin Yunti of South Australia – SA
4. Rumbalara Football & Netball Club, Shepparton. - Vic

Office For Aboriginal & Torres Strait Islander Health, Department of Health & Ageing

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

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

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

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

Other projects of interest noted in Draft National Strategic Framework for Aboriginal & Torres Strait Islander health

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

South Australia

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

Appendix 4: Case study analysis reports

1. Aboriginal Identification Project WA
2. Fixing Housing for Better Health NSW and SA
3. Healthy Jarjums Project Qld
4. Impact of Introducing Swimming Pools on the Health of Aboriginal Children & Adolescents living in remote areas of Western Australia
5. Indigenous Employment Policy
6. Katherine West Coordinated Care Trial NT
7. Koori Maternity Services Program Victoria
8. NSW Aboriginal Vascular Health Program
9. Nutrition Policy for Remote Retail Stores in Queensland
10. Queensland Health Indigenous Workforce Management Strategy 1999 – 2002

1. Aboriginal Identification Project Western Australia: Case Study Analysis

1. Case summary

This project was developed to address the recommendations in the Aboriginal and Torres Strait Islander Health Information Plan, endorsed by the Australian Health Ministers' Advisory Council in 1997. The project aimed to evaluate the quality of the Indigenous identifier in the WA hospital morbidity database.

The objectives of the Project were to:

- Assess the accuracy of the recording of Indigenous status Western Australia hospital inpatient data;
- Assess the accuracy of the recording of gender, date of birth, country of birth and usual residence information in Western Australian hospital inpatient data;
- Calculate a correction factor in relation to the numbers of Aboriginal and/or Torres Strait Islander people recorded in Western Australian hospital inpatient data; and
- Identify areas where training and promotional activities need to be undertaken to improve the accuracy of the recording of Indigenous status and other demographic data.

2. What has been achieved?

The project has resulted in improved identification of Aboriginal and Torres Strait Islander people in hospital morbidity data systems resulting in better informed policy and program development.

The study found that the number of Aboriginal people recorded in hospital inpatient data substantially understates the actual number of Aboriginal and Torres Strait Islander people admitted as patients. In metropolitan Perth, 78.3% of Indigenous patients were correctly identified. This rose to 93.5% in the Kimberley/Pilbara and for the state as a whole, averaged 85.8%.

The study developed a correction factor to account for the underestimate of Aboriginal and Torres Strait Islander people. This correction factor was determined for each health region (Metropolitan 1.14, Kimberley/Pilbara 1.05) and for the state (1.09).

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

3. What measures have been used to provide evidence of what has been achieved?

The HIC Occasional Paper 13 ISSN 1329 7252 *Assessing the Quality of Identification of Aboriginal & Torres Strait Islander People in Western Australian Hospital Data, 2000*, (Health West, WA Govt, May 2001) provides detailed findings on information collected from 10,106 face-to-face patient interviews conducted in 26 government hospitals throughout WA from July 2000 to January 2001. The information collected from these interviews was then compared with the patients' hospital records using the Unit Medical Record Number (UMRN). Nearly all (99.3) of the interviews were matched with patient hospital records using the UMRN.

This methodology is based on the assumption that the information collected from the independent source of information, in this case the face-to-face interview, is correct and can therefore be used as a benchmark by which accuracy of hospital records can be measured. A correction factor for the recording of the indigenous status for Aboriginal and Torres Strait Islander patients has been developed for each health region and for the state to improve the reliability of hospital data collected prior to this study.

4. What documentation is available to support this evidence?

Young, M.J. (2001). *Assessing the Quality of Identification of Aboriginal and Torres Strait Islander People in Western Australian Hospital Data, 2000*. Health Department of Western Australia. Health Information Centre Occasional Paper 13.

5. How did the following factors contribute to the outcome/s achieved?

A. Community control

The study was undertaken with the support of the WA Department Health Office of Aboriginal Health and the Health Information Centre (HIC) and the WA Community Control Organisations (WACCHO). The study was undertaken in 26 WA government hospitals.

B. Community participation / involvement

All patients admitted as inpatients to hospital, both Indigenous and non-Indigenous, were included in the survey.

C. Resourcing

This project was funded by the WA Department of Health. It is a response to the recommendations of the Aboriginal and Torres Strait Islander Health Information Plan, endorsed by the Australian Health Ministers' Advisory Council in 1997.

D. Sustainability

The sustainability of the project relies upon policy determination by WA Department of Health for implementation of its findings, together with their application in health facilities.

E. Partnerships, including intersectoral collaboration

The WA Department Health Office of Aboriginal Health and the Health Information Centre (HIC) collaborated with the WA Community Controlled Health Organisations (WACCHO) in the development of this study.

The training package was developed by the Australian Bureau of Statistics and utilised.

F. Workforce

The study has major implications for health staff interacting with Aboriginal patients, and will result in better identification of Indigenous patients in the public hospital system. These are further explored under Capacity Building.

Interviewers were specifically recruited for the survey, with experienced ABS interviewers employed in the majority of hospitals. Aboriginal interviewers were employed where the majority of the patients were Aboriginal and Torres Strait Islander.

G. Evaluation

The study is an evaluation of current practice in identification of Aboriginal and Torres Strait Islander patients in hospital. Data checking processes were used to avoid duplication of patient records during the research.

H. Capacity building (human & physical infrastructure)

As well as providing an estimate of under-reporting of Aboriginal and Torres Strait Islander patients, the study identified areas where training and promotional activities need to be undertaken to improve the recording of Indigenous status. The training package developed by ABS is being used by the Health Department to ensure a consistent approach in the collection of data. Training for all staff involved in collecting patient information is being implemented. All staff involved in collecting patient information are being provided with training regarding identifying Indigenous status. Priority has been given to training staff working at hospitals that have the lowest level of accuracy in the recording of Indigenous status for Aboriginal and Torres Strait Islander people.

It is suggested that the training address the following objectives:

- to demonstrate the need for a consistent approach to the collection of data.

- to assist staff in feeling confident in asking the standard ABS question, i.e. ‘Are you of Aboriginal or Torres Strait Islander origin?’
- to provide strategies to manage patients who feel upset or become hostile after being asked whether they are of Aboriginal or Torres Strait Islander origin.

Interviewers at some hospitals encountered difficulties with patient reaction. The findings showed that nearly all (37 out of 38) of the patients who did not answer the Indigenous status question were recorded as non-Indigenous in hospital records. Some non-Indigenous patients interpreted the study to be an example of Aboriginal and Torres Strait Islander people receiving better treatment and they were also hostile.

I. Accountability

The Office of Aboriginal Health takes the lead role in the implementation of recommendations made in this report. A working party has been formed to assist in the implementation of the recommendations. It is suggested that the group comprise members from the Australian Bureau of Statistics, Office of Aboriginal Health, and Health Information Centre. Members from the Aboriginal Community Controlled Health Services and Aboriginal and Torres Strait Islander Community groups are recruited as required.

The Western Australian Aboriginal Health Information and Ethics Committee approved the project. Following this approval, the Confidentiality of Health Information Committee (CHIC) allowed access to hospital inpatient data. As the project did not involve collecting any information not already collected by the hospital, it did not require the approval of individual hospital ethics committees. None of the hospitals in the sample requested that individual hospital ethics committees approve the project.

6. Are there any pre-requisite success factors?

This project was developed to address the recommendations in the Aboriginal and Torres Strait Islander Health Information Plan, endorsed by the Australian Health Ministers’ Advisory Council in 1997. As such it had high level political support, as well as the support of the Aboriginal community, which is disadvantaged by under-reporting in hospital data collection.

It was essential for the successful implementation of the project that staff viewed the study as a legitimate exercise. This included gaining support of senior management and staff who would be directly involved in data collection e.g. Nurse coordinators for each ward and medical record staff. The increasing professional recognition of the importance of accurate data collection for Aboriginal health has contributed to acceptance of the project.

Quality of interview was an important pre-requisite. Interviewers were specifically recruited for the task, with experienced ABS interviewers employed in the majority of

hospitals. In areas where there was no ABS interviewer available, a local person who either worked for, or was known by the health service, was employed. In accordance with ethical guidelines, Aboriginal interviewers were employed in areas where the majority of the patients were Aboriginal and Torres Strait Islander.

On a technical level, a two-day pilot study was conducted in a large metropolitan hospital in order to inform and determine survey/interview best practice methodology. This included procedures for conducting interviews, patient consent or refusal processes, and questionnaire development.

7. Are some success factors more critical than others?

The perceived legitimacy of this study was critical to its success. The high level of political support, management support in the workplace and a professional approach to the research were necessary to achieve this.

8. Are some success factors more relevant to certain programs than others?

The project responds to policy direction of the WA Department of Health. The implementation of the project was carried under the auspices of the Health Information Centre - a sub-department of WA Health.

9. How important was the context? Is the program transferable?

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

The study highlighted factors that need to be considered in planning similar surveys. The time taken for the study (and thus cost) depends on:

- The number of patients in the hospital who were available and appropriate to be interviewed. Elderly and confused patients required more time.
- Patient turnover. Even in the large metropolitan hospitals where patient turnover is high, the average length of stay is still about three days, and the number of new patients was lower than predicted, requiring revision of interview schedules.
- The available time of interviewing staff for the project. In a hospital with a low patient turnover an interviewer may have been able to interview five patients a day which would take an hour to complete. In contrast, an interviewer in a hospital with a high patient turnover may have been able to complete 50 interviews a day which would take five hours to complete.

The methodology developed and implemented in the project, including the pilot study, provides a model framework for other “identifier” projects.

There is a need to apply the methodology to out-patient information, and studies of Indigenous identity recording on other health data would be useful.

10. Are there any known limitations to the above?

Hospitals are made aware of the under-counting of Aboriginal and Torres Strait Islander patient in hospital inpatient data. It is suggested that the correction factor developed in this report be used as an indicator of the under-reporting of the number of Aboriginal and Torres Strait Islander patients in hospital inpatient data.

It was intended that patients would only be interviewed once within the data collection period. As patients were often re-admitted to hospital or moved to different wards during the data collection period, it was difficult for interviewers to accurately remember patients they had interviewed before. Patients themselves demonstrated a poor recall if they had already been interviewed.

Printouts of patient UMRNs were used to reduce the possibility of duplication, with deletion of records for patients previously interviewed. However, this required a high level of administrative support. The level of duplication was three percent. In these cases the most recent duplicate was deleted from the data set. In a few cases there were discrepancies in the demographic information.

11. What are the lessons from these findings for Aboriginal and Torres Strait Islander health policy?

The study has confirmed the extent of under-reporting of Aboriginal and Torres Strait Islander patients in WA hospitals, and has developed a correction factor for interpreting current estimates. The problem of under-identification has clear implications for planning and resource allocation related to Indigenous health.

In addition, the study has identified areas where staff would obtain benefit from training in the collection of Indigenous identity data, and has provided access to a training package for this purpose.

In the broader policy context, the level of under-reporting, the reluctance of staff to ask the standard question, and the levels of hostility to the process expressed by staff and patients, raise issues of persisting racial discrimination within the hospital system. It is unlikely that awareness of the levels of under-reporting alone will provide the necessary stimulus to correct the behaviours that contribute to it. Political and organisational commitment to change at all levels will be required in order to eliminate this anomaly.

2. Fixing Housing for Better Health: Case Study Analysis

1. Case summary

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

These projects focus on assessing and fixing the health hardware in houses and living areas in order to allow families to maintain healthy living practices. These are prioritised so that limited funds are expended on those issues of most importance for health. These healthy living practices that are targeted are:

- Safety – especially electrical safety
- Washing children and adults
- Washing clothes and blankets and the immediate living space
- Removing waste
- Improving food storage, preparation, cooking
- Reducing crowding
- Reducing impact of pests, animals and vermin
- Dust control
- Temperature control
- Reducing trauma

An essential feature of this work is that specific tests of function have been developed for the health hardware and services so that performance can be reproducibly quantified not just observed from a distance.

There are 6 main stages in the Fixing Housing for Better Health process:

1. CONSULTATION AND FEASIBILITY: The community is consulted and agrees to participate in a ‘Fixing Housing for Better Health’ project. A feasibility study is done in accordance with the HH licence to confirm:

Which houses are to be surveyed?

Logistics of running the project (eg, confirming what services are available)

Budget for associated repairs and for people involved in the survey teams

Community acceptance of the project

2. SURVEY FIX 1 (SF1): A group of people from the community and the area health service, with support from qualified tradespeople, survey the houses and fix urgent safety and health problems.

3. DESIGN SPECIFICATION AND TENDER: A work-list of further items to fix is made using the information from Survey Fix 1. This is prioritised in terms of safety and healthy living practices (as per the HH methodology). Community nominated trades are asked to tender.

4. CAPITAL UPGRADE WORKS: Over the next 4-10 months (depending on the number of houses involved) plumbers, electricians and other trades will carry out the larger and less urgent repairs or upgrades that are specified.

5. SURVEY FIX 2 (SF2): After the upgrade works are completed, a second survey fix is done. Again, a group of people from the community, area health service and tradespeople survey the houses and fix any outstanding urgent safety and health problems.

6. FINAL REPORTS: All work that has been done to the houses in the community goes into a confidential report. Another report lists all the problems that still need to be fixed. Both reports will help the community, health and housing organisations to understand what safety and health problems are being experienced by communities.

This program focuses on housing repair and maintenance with an explicit focus on health hardware. These programs do not address issues that aren't directly linked to health improvement (such as house painting or fencing). New housing design and construction are not part of this program.

The program collects significant data, which will be used by NSW Health to drive future policy changes and improvements in housing design and quality.

2. What has been achieved?

The project has surveyed and undertaken repairs in 1387 homes in 37 communities in 5 states. The results of the project include:

- Immediate repairs carried out to health and safety components of Community Houses (see Figure 1).
- Skills transfer to community members and community housing providers
- Training of Community staff in housing surveys and education on links to health.
- Likely reduction in infectious diseases and risk factors for chronic disease and trauma.
- Data collected to provide a significant evidence base to future directions in housing design and quality. (Around 210 items are assessed and recorded in each house, and in NSW over 1000 houses will have been surveyed by the end of 2002.)

- Relationships have been built between the community and Public Health Units and subsequently a number of other "follow-on" programs have been initiated with those communities to address other public health issues.

Critical Healthy Living Practices	Function rate at SF1	Function rate at SF2
Safety: Power, water and waste connected	67%	80%
Safety: Electrical system	13%	64%
Safety: Gas	69%	75%
Safety: Structure and access	43%	46%
Safety: Fire	3%	16%
Washing people: Shower working	33%	74%
Washing people: Young child in basin, bath or tub	66%	67%
Washing clothes & bedding: Laundry services with/without washing machine	23%	39%
Removing waste safely: Flush toilet working	52%	78%
Remove waste safely: All drains working	11%	19%
Improving nutrition: Ability to store, prepare & cook food	1%	5%

Figure 1: comparison of function rates between SF1 (792 houses) and SF2 (777 houses) in 21 communities in Qld, NT, WA, SA

3. What measures have been used to provide evidence of what has been achieved?

The following measures have been used to provide evidence of achievements:

- Comparisons of the condition of houses at Survey Fix1 and at Survey Fix2
- Percentage of community people involved in the projects
- Number of community members trained
- NSW Health is currently looking into the impact on health status - it is too early to determine whether it will be possible to measure any significant change as a result of this initiative.

4. What documentation is available to support this evidence?

The process provides documentation of the functional status of facilities within the housing environment at the Survey Fix 1 (SF1) and then following intervention at Survey Fix 2 (SF2).

Two reports of the project have been submitted, the first on Queensland, Western Australia, the Northern Territory and South Australia, and the second on the project in New South Wales:

Fixing Houses for Better Health (draft) Healthhabitat, 2002.

Housing for Health (Powerpoint) NSW Health/NSWDAA/ACDP, 2002.

5. How did the following factors contribute to the outcome/s achieved?

A. Community control

The project is a collaboration between ATSIC and State/Territory Indigenous Housing Agencies and Departments of Health, under licence from Healthhabitat. As part of the methodology community consultation plays a major role in the project. In talks with the project officer, high-risk communities were identified, with each community having the option to accept or decline their participation.

B. Community participation / involvement

Community participation involves community members being involved with the survey work, with training to provide them with skills to a level where they can undertake basic household repairs. They have worked on household assessment, fix works, data entry and provide liaison with trades and householders. In four states excluding NSW, over 250 local community Aboriginal staff were trained by March 2002. This comprised over 75% of all project staff. Given the intrusive nature of the work, requiring over an hour per household assessment, the participation of community members is considered critical to the success of the project.

C. Resourcing

“Fixing Housing for Better Health” is implemented under licence by Healthhabitat, and funded by a collaboration of ATSIC and Commonwealth and State departments. In NSW, the project is funded at the level of \$7500 per house, though in other states the amount is \$3000 per house. The original budget for the 2000/2001 project agreed by ATSIC in collaboration with the Commonwealth housing department was \$3.65 million.

D. Sustainability

Analysis of the work undertaken shows that 60% of all works were required due to a lack of routine maintenance, and that less than 3% of works completed were the result of vandalism, damage, overuse or misuse. Issues of sustainability of improvements achieved through this project need to address systems of housing maintenance in public housing for Aboriginal and Torres Strait Islander communities.

The training of community members in undertaking basic repairs has provided a skilled resource within the community for primary repairs.

Survey Fix data collection has documented the extent of work requiring to be done, and provides a base for realistic planning. Sustainability of the project depends on resources to extend the project to other communities, and the establishment of ongoing community maintenance systems.

One of the essential aims of the project is informing better housing design, specifications and quality control to improve the quality of housing, which has long term implications for sustainability in Indigenous housing.

E. Partnerships, including intersectoral collaboration

A number of partnerships has been established with the program; these include Healthabitat, ATSIC and Commonwealth and State/Territory departments and CDEP programs in New South Wales, Queensland, South Australia, Western Australia and the Northern Territory.

F. Workforce

An Indigenous project officer is employed within the project. Over 250 community members were trained as part of a team to be involved with Survey Fix 1 and 2, and in basic household repairs. Over 40 tradesmen were involved.

G. Evaluation

The survey data provides a mechanism for monitoring of the project; an evaluation of its impact is due to be conducted.

H. Capacity building (human & physical infrastructure)

The “Fixing Housing for Better Health” project improves living standards and reduces risk from electrical, gas and fire safety issues. It ensures capacity for households to maintain the full range of healthy living practices:

- Safety – especially electrical safety
- Washing children and adults
- Washing clothes and blankets and the immediate living space
- Removing waste
- Improving food storage, preparation, cooking
- Reducing crowding
- Reducing impact of pests, animals and vermin
- Dust control
- Temperature control

- Reducing trauma

The training of community members in undertaking basic repairs provides additional skills in household maintenance within the community.

I. Accountability

The project is accountable to the Commonwealth and State agencies responsible for its funding.

6. Are there any pre-requisite success factors?

The project is based on a model developed through the UPK project, and implemented under licence from Healthabitat. The model defines priority areas of concern, and defines a process to be followed. As a result there is a consistency of approach in each state/territory where the project is implemented.

The design of the project ensures immediate benefits to households through basic repairs undertaken at the time of survey - “no survey without service” - and skills transfer through training of community members ensures sustainability of this aspect of the project.

The collaboration between ATSIC, departments of health and housing, and CDEP programs is important in terms of the short term outputs and long term change in housing design and construction. High level support from these agencies has been a characteristic of the project.

Because of the intrusive nature of the assessment, the trust and cooperation of communities selected is crucial to the success of this project. Community participation included negotiations for inclusion of the community in the project, representation on the survey teams and in some cases employment in capital upgrade works.

7. Are some success factors more critical than others?

The participation of the community in the survey and repair process appears to be critical to the success of the program.

The fact that most repairs were the result of inadequate maintenance programs, rather than through vandalism, overuse or misuse, indicates that establishing on-going maintenance programs in communities will be critical to sustainability.

8. Are some success factors more relevant to certain programs than others?

Where projects are linked directly to Indigenous households and lifestyles, community participation is critical to the viability and sustainability of the project.

9. How important was the context? Is the program transferable?

The project has been operating in five states/territories, mainly in rural areas. Given the heavy dependence of Indigenous people on public housing, and pressures on that housing due to population growth, the project has an important role in ensuring the safety and maintenance of that housing and the resultant health benefits. The project is clearly transferable, depending on funding available. It would appear that it has applicability to urban housing in addition to rural housing.

10. Are there any known limitations to the above?

The project is clear that it does not address factors in housing that are not directly or indirectly related to health. For example, the project does not address paintwork, design or other structural issues except where these impact on safety or health. In this sense, the project does not replace the need for continuing housing maintenance review in community housing projects, but complements it in drawing attention to health and safety issues in housing.

11. What are the lessons from these findings for Aboriginal and Torres Strait Islander health policy?

There are a number of lessons available from the findings:

- that a significant proportion of available public housing for Aboriginal and Torres Strait Islander communities include safety and health risks at the time of survey
- that infrastructural maintenance and repair in housing has potential for health benefits
- that incorporation of lessons learned into future design of Indigenous public housing has the potential to reduce the demands on communities in terms of maintenance, and reduce the risks in terms of health and safety
- that the provision of immediate and demonstrable benefits to community members builds trust and cooperation
- that models of management that have been developed in close collaboration with communities and in the communities themselves (as with UPK) are readily replicated in similar contexts

3. Healthy Jarjums: Case study analysis

1. Case summary

Healthy Jarjums make healthy food choices is a curriculum-based resource design for use in a Health Promoting Schools context. The program focuses on traditional and contemporary food and food related practices of Aboriginal and Torres Strait Islander cultures, with learning outcomes in nutrition, food practices, food safety and personal hygiene. It targets children in the early years of school, from pre-school to year three (5-8 years).

2. What has been achieved?

A school-based nutrition education resource developed specifically for Aboriginal and Torres Strait Islander children. From the trial of the resource an extensive evaluation was completed with the main findings including the resource was effective in improving reported nutrition knowledge and reported preferences for *everyday* foods.

3. What measures have been used to provide evidence of what has been achieved?

Reported changes in nutrition knowledge and food preference improved after the resource/program was implemented.

- A local indigenous teacher in consultation with nutritionists and community people designed the program. This ensures community participation, delivery methods and the programs education methods, evaluation and adequate resources.
- The program involved parent's participation and invited members of the local community.

4. What documentation is available to support this evidence?

Healthy Jarjums make healthy food choices Evaluation Report.

5. How did the following factors contribute to the outcome/s achieved?

A. Community control

The *Healthy jarjums make healthy food choices* was developed by Inala Indigenous Health Program, who requested input and assistance from the Southern Public Health

Unit Network with establishing and implementing an evaluation framework. (Qhealth, 2002, p23)

B. Community participation / involvement

The target group for *Healthy jarjums make healthy food choices* in children from pre-school to year three (Levels 1&2 of new curriculum) or children approximately 5 to 8 years of age. The resource was designed for use in schools with high proportion of Aboriginal and/or Torres Strait Islander students. For Intervention schools, this classification was at the discretion of each school and their perceived needs. (Health, 2002,p26)

The needs assessment and community consultation were addressed in three ways:

- Consultation with community, schools and key stakeholder organisations
- Formation of a reference group
- Literature review (Qhealth, p9)

C. Resourcing

The current cost of the resource for schools should be reviewed by Management of the QEII Health Service District and a subsidisation or loan scheme be considered, (Health, p3)

D. Sustainability

The program should continue to be implemented in target group schools as a result of the positive response received from educators and local coordinators and the positive outcomes shown in the program.

E. Partnerships, including intersectoral collaboration

Qld Health, Qld Education in conjunction with Eat Well Australia (EWA), the National Aboriginal & Torres Strait Islander Nutrition Strategy and Action Plan (NATSINSAP) (Qhealth, p6)

F. Workforce

Appointment of an Aboriginal project officer to extend and formalise initial Healthy Murri's are Deadly Murri's program. The importance of having an Aboriginal person as Project Officer was evidenced during the community consultations. (Qhealth, p9)

In the future implementation of the program, particular attention should be directed to establishing and supporting the involvement of local Aboriginal & Torres Strait Islander parents and community members. This will be best achieved by involving local

Indigenous Health Workers in the program and the various support strategies employed. (Health, 2002,p3)

G. Evaluation

General objectives of the evaluation were to:

- Determine whether the program resulted in nutrition knowledge and behaviour changes by participants;
- Establish if the resource was user friendly and appropriate to the target group: and
- Gather evidence, to promote the future uptake of the resource in schools. (Health, 2002, p23)

Recommendations for Future Evaluation Studies

- The evaluation instruments show considerable potential for future studies but the reliability of the evaluation instruments in both an individual and group testing scenario needs to be determined.
- Alternative methods of measuring parent and community participation in the program should be developed.
- Future evaluation studies should consider the evaluation of the impact on cross cultural understanding and behaviours of young children attending target schools, particularly in relevance to Aboriginal and Torres Strait islander cultures in Queensland (Health, 2002,p4)

Data Collection Instruments

Four data collection instruments were developed for use in this study. These include:

- *Educator Questionnaire*
- *Circle the everyday Foods* activity
- *My Lunch* activity
- *My Food Book* record (Health, 2002, p29)

H. Capacity building (human & physical infrastructure)

The capacity building initiatives include:

- strategic management
- research and development
- workforce development
- communication (Qhealth, p7)

Within this framework, the evaluation of *Healthy jarjums make healthy food choices*, informs practice and builds Indigenous expertise across a number of the priority areas. (SIGNAL, 2001)

An objective of this program was to involve parents and community members, in particular Aboriginal and Torres Strait Islander people in the delivery of the program. The purpose was to have expert local knowledge about customs and cultural practices integrated into the program as well as to foster or strengthen links between the Indigenous community and the school. (Health, p3) This objective was not met.

I. Accountability

Qhealth/ QEII Health Service District

6. Are there any pre-requisite success factors?

The program was written within the National Curriculum guidelines. It was divided into four topics:

- The importance of Food and Digestion
- The Food Star
- Senses and Traditional Bush Foods
- Food Preparation (safety & Hygiene) (Qhealth,p10)

The development and appointment of a Reference Group established to provide ongoing support to the Project Officer and provide expertise and guidance at all stages of the project development. The reference Group consisted of a nutritionist, parent/ASSPA committee member, an Indigenous health worker, an Indigenous teacher and a non-Indigenous teacher. (Qhealth,p10)

7. Are some success factors more critical than others?

The importance of having an Aboriginal person as the project officer was evidenced during the community consultation phase. Utilising both informal and professional networks the Project officer was able to speak with a wide range of people, and promote open discussion in a culturally sensitive manner. (Qhealth, p9)

8. Are some success factors more relevant to certain programs than others?

For cross-sectoral programs such as this, developing appropriate partnerships is critical. Educational initiatives are probably more effective if Indigenous workers/educators are

involved, as in Healthy jarjums. Finally, as with all types of programs, the presence of a high quality evaluation contributes to the sustainability and possible transferability of this program.

9. How important was the context? Is the program transferable?

The findings of the evaluation indicate that Healthy jarjum make healthy food choices can be successfully implemented in disadvantaged areas with a high Indigenous population, and can be effective in improving reported nutrition knowledge and reported preferences for everyday foods. (Qhealth, 2002,p45)

10. Are there any known limitations to the above?

A number of limitations exist in the study design and the evaluation instruments. These limitations include the non-random sampling and the lack of reliability data for the study instruments. (Qhealth, p61)

- Study Design – Schools approached for inclusion were based on their likelihood to identify as the target group – it is possible that these schools placed greater importance on nutrition education, put in a greater effort in delivering the program and/or in showing that a positive outcome may have occurred.
- Response rate for the study was unable to be determined as the number of schools initially approached (the denominator) was not recorded. The lack of response rate could be addressed by instructions and training for local coordinators (Qhealth, p45)
- Sample Selection Bias occurred as a result of allowing the schools the flexibility to select the years, and numbers of students involved in the study. (Qhealth, p46)
- Study Timing - The time of the implementation of the program may have created limitations. Implementing a new program in term 3&4 is not a preferred option by teachers and may affect response rate for future implementation. (Qhealth, p46)
- Flexibility of the Program - Allowing teachers to be flexible in the program delivery introduced some confounding factors (Qhealth, p47)
- Limitations of Educator/Everyday Foods/My Lunch Questionnaire & My Food Book Record/Parent Involvement (Qhealth, pp47-53)
- Parental/Community involvement – whilst the focus of this evaluation was on student outcomes, the lack of parental involvement in the implementation was noted. Poor parental involvement is reported in a number of school programs in Qld. (Qhealth, p59)

- Age of Participants
- Group v Individual Testing
- Generalisability

11. What are the lessons from these findings for Aboriginal and Torres Strait Islander health policy?

- The program relied upon quantitative data collection through the employ of data collection instruments designed to engage the children within the scope of the program. – children were an integral part of the data collection process by having them actively involved in knowledge gaining and record keeping activities.
- The implementation of a culturally appropriate nutrition education program has been shown to be effective in increasing reported nutrition knowledge and reported food preferences of everyday foods for 5-8 year old school children. (Qhealth, p60)
- The evaluation instruments developed have an identified use for evaluations with the target group, but require further study to reduce the limitations that exist in this study. (Health, p60)

4. Impact of Introducing Swimming Pools on the Health of Aboriginal Children & Adolescents Living in Remote Areas of Western Australia: Case Study Analysis

1. Case summary

The aim of the swimming pools project was to investigate whether there was any change in prevalence and severity of ear disease, skin sores and nasal discharge as a result of the introduction of swimming pools in remote Aboriginal communities in Western Australia. The project responded to anecdotal evidence from some Aboriginal communities that children may have derived health benefits from regular access to chlorinated swimming pools in the community. There is also documented evidence that deaths from drowning of children in Aboriginal communities occur at higher rates than for the population as a whole.

Swimming pools were opened in the remote Aboriginal communities of Jigalong, Burringurrah and Mugarinya in Western Australia in September 2000. The Institute for Child Health Research was asked to evaluate the impact the pools have on the health of children in two of these communities (Jigalong and Burringurrah). Base-line screening was conducted prior to the opening of the pools, with assessments at 6 monthly intervals since then, in summer and winter.

The initial screening was undertaken by a paediatrician, with hearing testing and tympanometry conducted, to be repeated after 2 years. Skin examination for skin sores utilised a 'sore score' to measure numbers of sores and their severity. Swabs of skin sores have also been collected to obtain information on the strains of Group A streptococcus circulating in the communities and to determine whether there is any change in strain distribution associated with pool use. The presence/absence of nasal discharge was noted. Where possible, video-otoscope photography of eardrums were taken and filed on a computer data base. Children with severe ear disease were referred to an ENT specialist. Correlation with clinical records has allowed the project to collect data on clinic presentations between screenings, and the total number of courses of antibiotics prescribed. Data for the initial screening and two post-pool screenings was available at the time of reporting. Data on school attendance is also being collected.

The Swimming Pools project is jointly funded by the Western Australian Department of Housing and Works, the Department of Sport and Recreation and the Lotteries Commission.

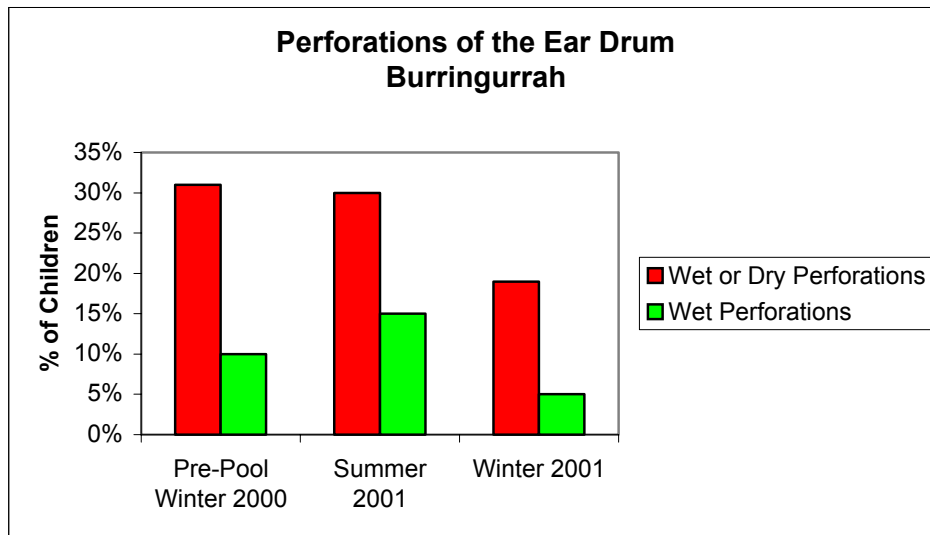
The Royal Life Saving Association manages the pools.

2. What has been achieved?

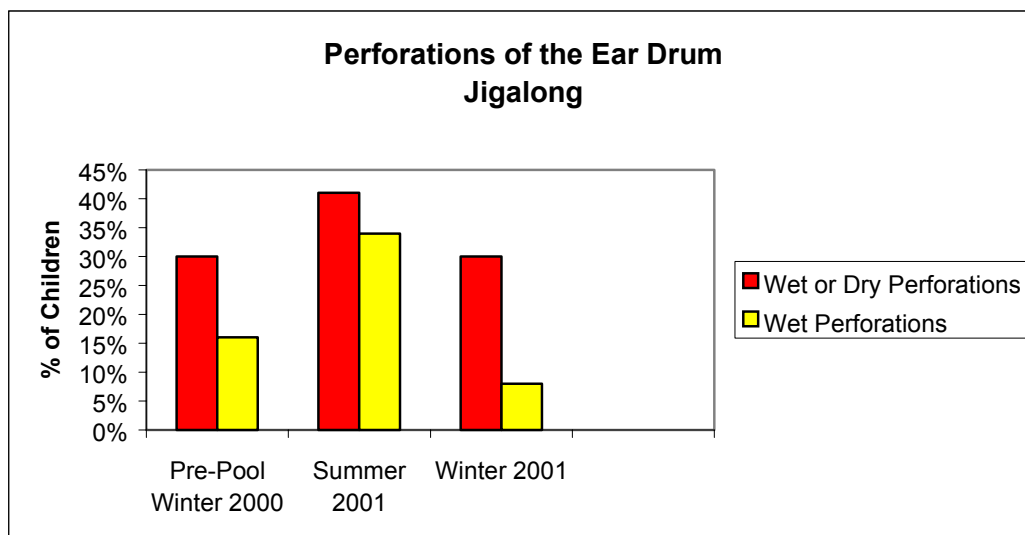
There have been several important outcomes demonstrated in preliminary findings over the first twelve months of the project:

Middle ear disease

There has been an overall reduction from 31% to 21% of both wet and dry perforations of the ear drums in Burringurrah.



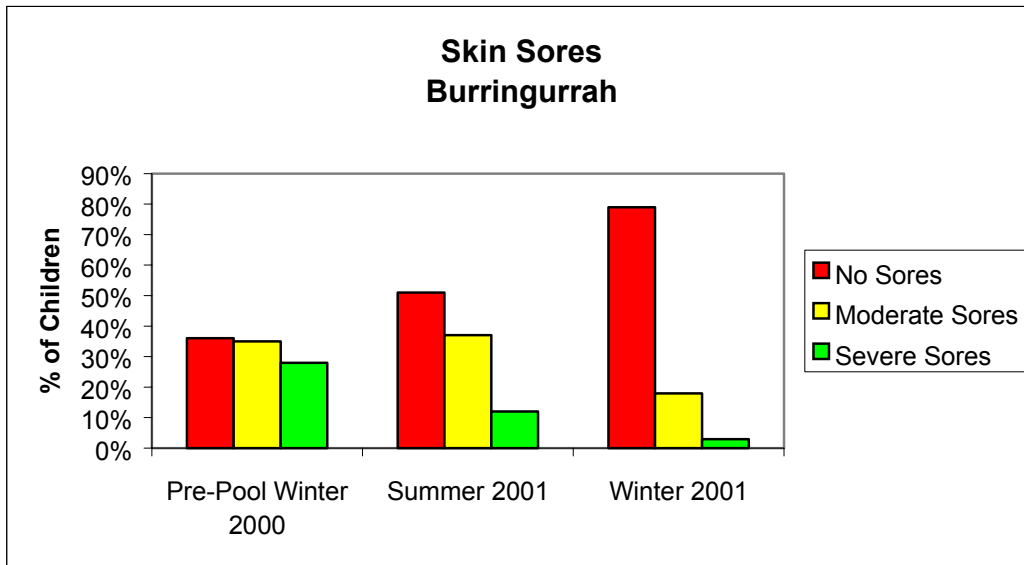
There has been a maintenance of overall levels (30%) of perforations of the ear drums in Jigalong, but a halving of the numbers of wet perforations from 16% to 8%, suggesting clinical improvement. The cleaning away of exudate as ear perforations become dry enhances the probability of the perforation healing.



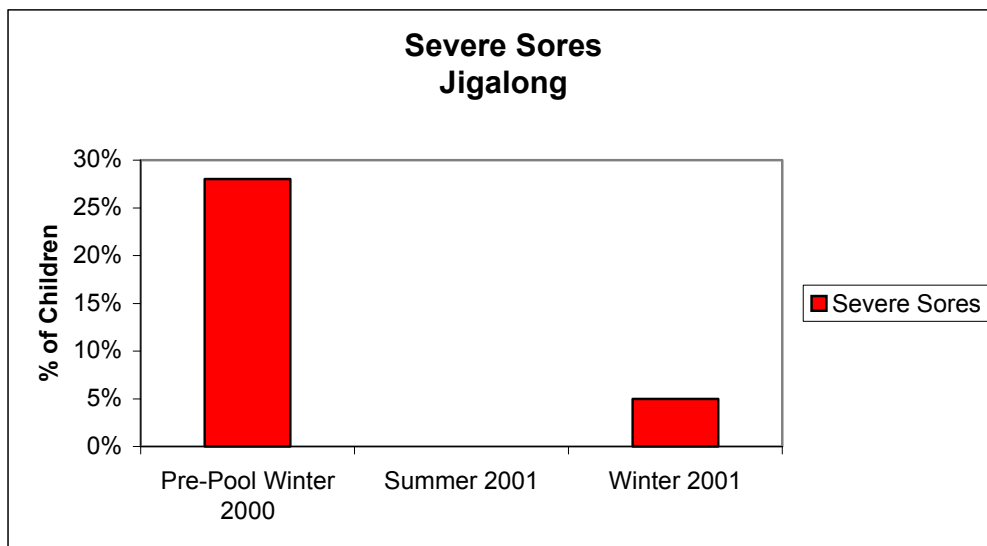
There is a seasonal increase in perforations in the summer, and final testing (audiometry and tympanometry) has not been completed.

Skin sores

There has been a reduction in overall numbers and severity of skin sores in both communities. In Burringurrah, overall figures for sores fell from 64% to 21%, with severe sores requiring antibiotics falling from 28% to 3%.

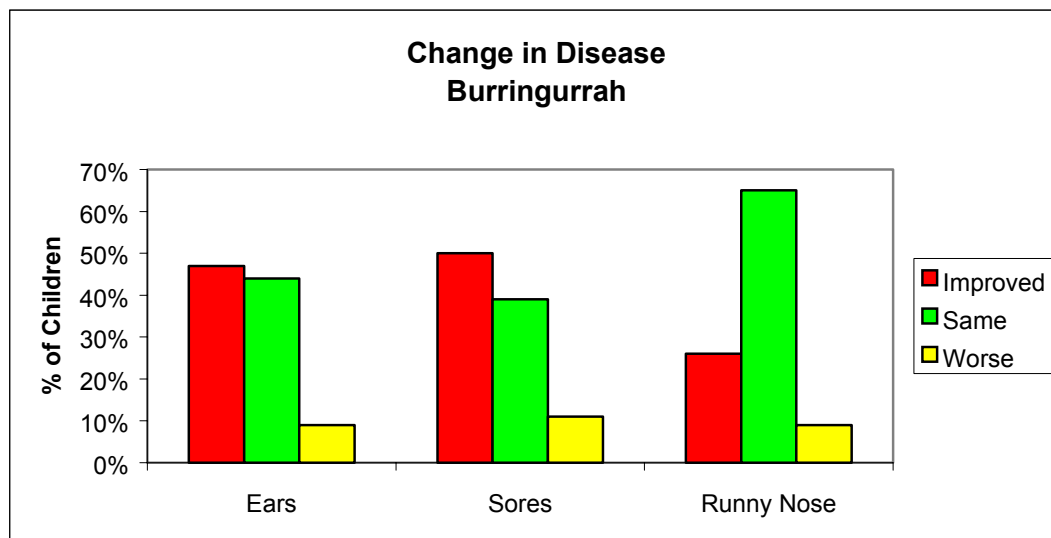


In Jigalong, overall sores remained stable, but severe sores dropped from 28% to 5%.



Nasal discharge

There has been an overall reduction in nasal discharge in both communities, 26% in Burringurrah and 23% in Jigalong.



Swimming safety

Swimming instruction is provided by the Royal Life Saving Association, with general increase in aquatic skills through the 'Swim and Survive' program and a number of children reaching the highest levels of competency (Stage 9)

School attendance

There has been a reported improvement in school attendance as a result of the 'school means pool' policy. In Burringurrah school attendance was reported as doubling following introduction of the 'school means pool' policy.

Juvenile crime

There has been a reported decrease in juvenile crime in Burringurrah.

Social benefits

The pool has provided a suitable meeting place for social interaction for both children and adults holiday programs run by the pool canteen have included cooking and healthy lunches Aboriginal Health Workers and Research Assistants were employed by the project the Councils in both communities were involved and were provided with regular feedback on progress of the project

3. What measures have been used to provide evidence of what has been achieved?

The following measures were used in order to provide evidence for these outcomes:

Population 0-17 years

65 children aged 0-17 at Burringurrah and 64 at Jigalong in initial screening, of which 29 and 26 were re-screened on two occasions at Burringurrah and Jigalong respectively.

Total numbers screened were:

	Winter 2000	Summer 2001	Winter 2001
Burringurrah	65	41	38
Jigalong	64	35	39

Middle ear disease

Screening has been undertaken by a paediatrician and nurse, with ENT specialist referral. ear drums have been photographed with video-otoscope. base-line audiometry and tympanometry were conducted.

Skin sores

A 'sore score' was developed to record total numbers of sores and their severity, with moderate sores being those requiring clinical intervention in the form of dressings, and severe requiring antibiotic therapy swabs were taken of sores to analyse pattern shift in Group A streptococcus strains in the community following the introduction of the pool.

Nasal discharge

presence or absence of nasal discharge was noted on examination

Swimming safety

Royal Life Saving Association records were analysed for swimming competencies achieved

School attendance

school attendance records were analysed to note the number of days a child attended school in the pre-pool period and the number of days after the pool had opened.

Juvenile crime

juvenile crime rates were estimated through discussions with police

Social benefits

direct observation and key informant interviews provided information on social outcomes and community participation

4. What documentation is available to support this evidence?

- Results of clinical examinations of the children in the pre and post phase of the project, including video-otoscope photographs, are stored on file at the Telethon Institute for Child Research.
- Health clinic morbidity data on all children engaged throughout the study, beginning one year prior to construction of the pool. This will demonstrate any change in overall morbidity and in the number of courses of antibiotics that have been prescribed.
- Skin sore swabs are being cultured and strains of Group A streptococcus identified.

- Royal Life Saving Association instructors maintain records of swimming levels achieved.
- Daily pool attendance has been recorded by pool managers.
- School attendance has been recorded by the school.
- Key informant interviews have been documented.

5. How did the following factors contribute to the outcome/s achieved?

A. Community control

The Aboriginal Community Councils in both communities were involved in the swimming pools project and remain a stakeholder interest. The project management provides them with regular feedback. The project is jointly funded by the Western Australian Department of Housing and Works, the Department of Sport and Recreation and the Lotteries Commission, and the pools are managed by the Royal Life Saving Association.

B. Community participation / involvement

There is evidence of broad community support for the pools from the communities of Burringurrah and Jigalong. Interviews with adults in the community revealed very positive attitudes towards the pool, and the facilities provided. The pools are valued as centres for social activities, and as diversions from crime and substance abuse.

Support from the schools for the research project has been strong, with the adoption of a 'no school, no pool' policy. (At Jigalong this is referred to as 'school means pool'.) This policy enables those children who have attended school for the whole day to get a pool pass at the end of the school day. The School Principals at each of the schools provided support which facilitated examination of the children. Aboriginal teaching assistants assisted in identifying children and interpreting where required.

C. Resourcing

Funding for the research project is from the WA Department of Housing and Works and Healthway.

D. Sustainability

The swimming pool health research project is currently in its second year with four visits to the communities of Burringurrah and Jigalong occurring through to March 2002. An interim report to May 2002 is available. The final report is due November 2002 with further visits envisaged throughout the later part of this year.

The ongoing effectiveness of the pools as an intervention depends on continued funding for management of the pool and its programs, and maintenance of the physical environment. The cooperation of the schools through their 'school means pool' policies is integral to health outcomes.

The WA Royal Life Saving Association continues to manage the pools and provides training programs to members/youth of the communities interested in the sustained continuation of the 'Swim and Survive' program. It is envisaged that in time local Indigenous residents will be trained to take on this responsibility.

E. Partnerships, including intersectoral collaboration

There is evidence of intersectoral collaboration between a number of government departments and non-government agencies.

The funding, development and support of the pools depends on the collaboration of the Western Australian Department of Housing and Works, the Department of Sport and Recreation and the Lotteries Commission, together with the Royal Life Saving Association.

The Institute for Child Health Research is undertaking evaluation of the impact of the pools on the health of children in the communities of Jigalong and Burringurrah. Derbarl Yerrigan (Perth's Aboriginal Medical Service) have provided an Aboriginal Health Worker trained in ear health to the research project.

The Schools have been actively supportive of this initiative and have introduced complementary health programs – such as 'nose-blowing' - into the school.

The community councils represent a stakeholder interest and receive regular feedback.

F. Workforce

Researchers include epidemiologists, paediatricians, ENT specialists, an audiologist, and a registered nurse. Indigenous participation in the research team included an Aboriginal Health Worker trained in ear health from Derbarl Yerrigan, and Aboriginal research assistants. Aboriginal teaching assistants in the schools identified children and interpreted as necessary.

G. Evaluation

The swimming pool project is essentially an evaluation of the impact of the introduction of swimming pools as a health intervention for Aboriginal children aged 0-17years. As such it represents a conscious attempt to provide evidence of health benefits from the introduction of the pools into remote Aboriginal communities. The primary focus of the evaluation is limited to the effect of the initiative on skin and upper respiratory tract infections, though broad trends in childhood morbidity will be analysed. Water safety

does not appear to have been directly evaluated. With the exception of correlations to school attendance and juvenile crime rates, the evaluation does not address other social, political or economic issues implicit in the introduction of swimming pools to remote communities. No cost-benefit analysis is being undertaken.

H. Capacity building (human & physical infrastructure)

The project evaluates the health impact of swimming pools in the remote Aboriginal Communities of Jigalong and Burringurrah in Western Australia. The project itself offers the Aboriginal Health Workers and research assistants employed in the project some exposure to the process of research.

The pools themselves are a significant capital investment in the communities, with ongoing maintenance requirements. They are integral to the success of the project. They were jointly funded by the Western Australian Department of Housing and Works, the Department of Sport and Recreation and the Lotteries Commission.

The presence of the Royal Life Saving Association, as managing agent, represents an engagement by a mainstream (non-Indigenous), not-for-profit non-government organisation in the community. The Association is providing aquatic skills training through its 'Swim and survive' program, and anticipates community members may be trained to deliver this program in future.

I. Accountability

Accountability for the project lies outside of the communities themselves. It is expected that the accountability responsibility of this project would remain that of the WA Department of Housing and Works, the department of Sport & recreation and the lotteries Commission being the key stakeholder funding bodies. Accountability for the policy rests with an ongoing commitment by the WA Government to ensure that the policy implementation is resourced adequately and sustained. While the community councils will be provided with feedback on the research, the principal target of the research appears to be the WA Government, with the research aimed at justifying the ongoing funding of such projects.

6. Are there any pre-requisite success factors?

The success of the project is predicated on a number of pre-requisite factors:

- an inter-sectoral partnership between government agencies supporting the development of the swimming pools initiative
- adequate resource commitment for the physical infrastructure, management and maintenance of the pools
- technical competence on the part of the managing agents, and skills instructors, the Royal Life Saving Association

- inter-sectoral collaboration between agencies (school, health services, community council, research institute) in implementing the programs associated with the pool – ‘school means pool’, ‘swim and survive’, holiday nutrition programs, research evaluation.
- the commitment to evaluation, reflected in the decision to fund the research project, reflects a desire for effective, sustainable outcomes

7. Are some success factors more critical than others?

The combined factors that have been outlined are all considered important. However, the following are perhaps of greatest significance:

- capital investment in the infrastructure and maintenance of the pools is integral to the intervention.
- the inter-sectoral collaboration at the local level provides a synergy between school, health, community and pool that sustains the project.
- the evaluation will provide the evidence of outcomes necessary to influence the replication of this project in other contexts.

8. Are some success factors more relevant to certain programs than others?

The Swimming Pools project is dependent on an initial and continued capital investment to ensure that the physical and human resource infrastructure was in place before the other initiatives could be successfully implemented.

There is also a requirement in this project for specific technical expertise in swimming pool management and training. The participation of a mainstream not-for-profit non-government organisation (the Royal Life Saving Association) in the project is distinctive. Another success factor specific to this project is the links that it has with the retailing industry. This includes the adoption of standards regarding teaching children to swim and modern lifesaving techniques.

The project appears to have a limited formal role for the community council in the management of the project, but a significant collaboration between a number of institutions both outside and within the community that sustains the project.

The strong emphasis on evaluation in this project is relevant to all programs, but under-represented in design and implementation of most programs.

9. How important was the context? Is the program transferable?

The following context-specific issues are believed to relate to this project, and would impact on transferability:

The swimming pools project is being undertaken in three remote Aboriginal communities, with health evaluation undertaken in two of these. The early results show different patterns of outcome for the two communities, though both are positive. Part of the success of the project depends on the remoteness of the community, the absence of competing options and the potential to collaborate with the school etc. This is unlikely to be replicable in an urban context.

The involvement of the RLSA in the management of the pools is also important, bringing with it a particular NGO ethos. Commercial management is unlikely to be a successful alternative. Local community management will take time to establish. The model would optimally include the RLSA if repeated elsewhere.

The collaboration that has provided funding for the physical infrastructure, human resources and maintenance is important to establishing the pool, and would provide a source for replication. Sustainability is a critical issue.

The existence of a Swimming Pools project has created a locus for community activity, focussing partnerships between health, education, the RLSA, council, community groups and researchers and facilitating information sharing, research, shared strategies for interventions and evaluation and building local social capital. Transferability depends on more than just the physical infrastructure, however, and the collaborations would also need to be replicated in other centres.

Sustainability is linked to the ongoing maintenance and eventual management of the pools by the community members. This will need to be assessed over time and is critical to transferability of the concept.

10. Are there any known limitations to the above?

Though we have seen a change in the health of the children in the period in which the study was carried out it is impossible to conclude that the pool was the only factor that caused the change. There are always other factors that will influence the health of children. The introduction of school health programs on nose blowing, greening of the community and sealing of the roads to reduce dust in the community may also have contributed.

The seasonal increase in ear and skin disease has not yet been evaluated, as results from the second summer screening are not available. Evaluation of outcomes over a longer timeframe are needed to assess sustainability of the project.

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

11. What are the lessons from these findings for Aboriginal and Torres Strait Islander health policy?

Health outcomes can be achieved through infrastructural change in communities – in this case, through the provision of chlorinated swimming facilities for children, and an attractive environment for social activities.

- Health outcomes can be achieved as the result of intersectoral collaborations between a range of government departments, not health departments alone.
- NGOs such as the RLSA have a role that has not been fully explored in building social capital in Aboriginal communities.
- There is a critical level of infrastructure required to implement this kind of project. This needs to be identified and a commitment of the capital and recurrent resources made before a policy can be successfully implemented.
- Capacity building includes a number of components – in this case physical infrastructure as well as human resource development and longer term potential for community control of the stores.
- Collaborations between agencies at both central and local levels are necessary for the success of these projects.
- Evaluation and the provision of accurate and timely information are important and needed to inform the project development.

5. Indigenous Employment Policy: Case Study Analysis

1. Case summary

The Indigenous Employment Policy was introduced by the Federal Government in July 1999 in recognition of the particular disadvantage experienced by Aboriginal and Torres Strait Islander people in the labour market.

The policy was introduced against a background of:

- a growing Indigenous population (twice the rate of the total Australian population)
- a significantly larger proportion (60%) of young Indigenous people under 25 years of age compared to about 21% for the total population who will seek to join the labour market in the future
- a more widely dispersed population than other Australians. 20% live in remote areas where job opportunities are scarce. Only 1% of other Australians live in remote areas
- a lower participation rate for Indigenous Australians – 2000 ABS figures estimated that 32% compared to 64% generally
- higher unemployment rates for Indigenous people than for other Australians. Official figures put the rate at around 17% but this is likely to be higher
- a reliance on the public sector for the employment of Indigenous people. Estimates have suggested that up to 70% of all jobs held by Indigenous people are reliant to some extent on public funding. Labour market growth and wealth generation is concentrated in the private sector and this is where more jobs for Indigenous people need to be identified
- lower skill levels - nearly a quarter of all jobs held by Indigenous people were for unskilled work compared to 9% for the total workforce. This is a critical disadvantage for the future as labour demand is increasingly in areas of high skill.

The aim of the policy is to generate more employment opportunities for Australia's Aboriginal and Torres Strait Islander peoples, with a particular focus on job creation in the private sector and the promotion of small business activities in the Aboriginal and Torres Strait Islander community. The policy includes the following elements:

- The Indigenous Employment Programme
- The Indigenous Small Business Fund
- Job Network

2. What has been achieved?

A range of initiatives has been developed in each of the three elements of the policy: The Indigenous Employment Programme (comprising a number of projects), the Indigenous Small Business Fund and Job Network. There are some 130 federal funding projects under the Indigenous Employment Policy from 1 July 2001.

- 1. The Indigenous Employment Programme** includes the following projects:

- ***Corporate Leaders Project***

The Corporate Leaders Project is a partnership between companies and the Commonwealth Government, which aims to encourage and assist Australian companies to generate more jobs for Indigenous Australians. Companies commit to employing Indigenous people and the Commonwealth provides access to flexible funding for that purpose. Companies can design an employment project or strategy to suit their own business environment and can access a mix of assistance under the IEP.

- ***Wage Assistance***

Wage Assistance helps Indigenous job seekers to find long term jobs, either through Job Network or their own efforts, using an eligibility card. Employers can receive up to \$4400 over 26 weeks to assist with costs. To be eligible, job seekers must be registered as looking for work with Centrelink and in receipt of an income support payment (this includes CDEP).

- ***Structured Training and Employment Projects (STEP)***

Structured Training and Employment Projects provide flexible financial assistance to businesses that offer structured training, for example, apprenticeships, leading to lasting employment opportunities for Indigenous job seekers.

- ***National Indigenous Cadetship Project (NICP)***

The National Indigenous Cadetship Project supports companies prepared to sponsor indigenous tertiary students as cadets. Cadets undertake full-time study and work experience during long vacation breaks and are usually employed by the company at the completion of their studies.

- ***Community Development Employment Projects (CDEP) Placement Incentive***

The Community Development Employment Projects (CDEP) Placement Incentive provides a \$2,200 bonus to CDEP sponsors for each placement of a participant in a job outside CDEP and off CDEP wages. Indigenous Employment Centres will help Community Development Employment Project (CDEP) participants find suitable long-term jobs. They will help participants get ready for work outside of the CDEP and support them while they are in their chosen job.

- ***The Voluntary Service to Indigenous Communities***

Matches skilled volunteers with needs of Aboriginal and Torres Strait Islander communities.

2. Indigenous Small Business Fund

The [Indigenous Small Business](#) Fund provides funding for the development and expansion of indigenous businesses and enterprises. It can fund indigenous organisations to assist indigenous people to learn about business, develop good business skills and expand their business. It also provides funding to individuals for the development of business ideas that have good business potential, and complements ATSIC's programs for business development.

3. Job Network

Job Network provides measures to improve outcomes for Indigenous job seekers

3. What measures have been used to provide evidence of what has been achieved?

The Indigenous Employment Policy was introduced on 1 July 1999 to address the continuing disadvantage in the labour market for Indigenous people, and evidence from population research that this situation had the potential to get substantially worse. The reliance of the public sector for employment opportunities for Indigenous people highlighted the need to create opportunity in private industry and small business, where economic growth and employment are concentrated.

The early data suggests that private sector projects, placements and outcomes are improving with the introduction of the IEP.

Most encouraging are the high outcome rates reported in the *Labour Market Assistance Outcomes Quarterly Reports*. Over 2000, there was a 74% increase in projects undertaken under Structured Training and Employment Projects (STEP) and 67% increase in Indigenous Employment Programme Wage Assistance – totalling 5300 new job commencements.

Although early performance indicators are encouraging, it is still too early to draw firm conclusions, given most programme elements have long lead times.

4. What documentation is available to support this evidence?

Quantitative measures are available in the Department of Employment and Workplace Relations *Annual Report* and its *Labour Market Assistance Outcomes Quarterly Reports*. (Dec 2000 accessible on www.workplace.gov.au/WP/CDA/Files/WP/Dec2000.pdf).

5. How did the following factors contribute to the outcome/s achieved?

A. Community control:

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

B. Community participation / involvement:

Aboriginal and Torres Strait Islander community organisations are key recipients of the Indigenous Small Business Fund. Examples include the Tiwi Islands Training and Employment Board, Mid North Coast Indigenous Broadcasters Association, Cape York Corporation and Aboriginal Tourism Australia.

Indigenous Employment Centres have been developed in collaboration with Community Development and Employment Programs to enable participants to find long term employment. They prepare workers already engaged in CDEP for their work outside and support them in their chosen job, building on community based employment to access other work opportunities.

C. Resourcing:

The Indigenous Employment Policy is funded through the Commonwealth Department of Employment and Workplace Relations. The Policy provides incentives, seeding funding, wage assistance and grants that are complemented by private and community based organisations providing employment opportunities.

D. Sustainability:

The Policy is intended to create employment opportunities for Aboriginal and Torres Strait Islander people, particularly through the private sector. Current Commonwealth funding is intended to provide incentives and seed funding for business, with a view that economic growth in Aboriginal and Torres Strait Islander communities will continue to generate employment opportunities. Similarly, Indigenous Employment Centres are funded to assist the transition of workers from CDEP to outside employment. Given the existing high unemployment rates, low skill levels, the proportion of the Indigenous population in remote and rural Australia, and the significantly larger proportion of that population under 25 years of age, continuing support for Indigenous employment strategies will continue to be necessary.

E. Partnerships, including intersectoral collaboration:

The [Indigenous Employment Programme](#) creates partnerships with the private sector, community organisations, small business and community members to create employment options for Aboriginal and Torres Strait Islander workers. This involved multi-sectoral collaborations, with significant diversity in employment and business opportunities. The shift away from employment partnerships with government towards private sector and community businesses is a key direction of the policy.

The partnership with Indigenous communities developed through the [Voluntary Service to Indigenous Communities Foundation](#) is innovative, and provides an alternative model for engagement with communities.

The [Indigenous Small Business](#) Fund provides funding for the development and expansion of Indigenous businesses and enterprises, serving both to create opportunities for economic growth as well as employment.

There are also examples of transitions in the models of partnership, with [Indigenous Employment Centres](#) assisting Community Development Employment Project (CDEP) participants find suitable long-term jobs, moving away from community based, government-funded employment to mainstream employment opportunities.

F. Workforce:

As with the *Queensland Health Indigenous Workforce Management Strategy* the changed Indigenous workforce is integral to the project. In a sense, the workforce issues are both input and output issues, with the achievement of employment and business opportunities offering social and economic benefits beyond the direct effects of employment itself.

The overall aim of the Indigenous Employment Policy is the creation of new employment opportunities in industry and small business for Aboriginal and Torres Strait Islander people. This is achieved through a number of complementary strategies.

Collaborations between companies and the Commonwealth such as the *Corporate Leaders Project* provide companies committed to increasing Indigenous employment with access to flexible funding for employing Indigenous employees under strategies appropriate to their own business environment.

By contrast, *Wage Assistance* provides Indigenous job seekers registered with Centrelink and seeking long term jobs, with an eligibility card, that provides employers up to \$4400 over 26 weeks to assist with costs.

Structured Training and Employment Projects (STEP) and the *National Indigenous Cadetship Project (NICP)* provide flexible financial assistance to businesses that offer structured training that lead to lasting employment opportunities for Indigenous job seekers, such as cadetships. Cadets undertake full-time study and work experience during

long vacation breaks and are usually employed by the company at the completion of their studies.

Community Development Employment Projects (CDEP) Placement Incentive

The transition from Community Development Employment Projects to full time employment is managed through Indigenous Employment Centres under the CDEP Placement Incentive. This provides a \$2,200 bonus to CDEP sponsors for each placement of a participant in a job outside CDEP and off CDEP wages.

G. Evaluation:

The Commonwealth Department of Employment and Workforce Relations is currently evaluating the Indigenous employment Program. Monitoring of outcomes is undertaken by each of the components of the strategy.

H. Capacity building (Human and Physical infrastructure):

The Indigenous Employment Strategy seeks to build capacity at an individual level – through training, cadetships and apprenticeships, upgrading of employment, access to employment - and at a community level through the development of Indigenous business enterprises and employment opportunities, transforming CDEP employees to full employment, creating a business climate receptive to the employment of Indigenous people and promoting economic growth in Indigenous communities. Overall, the strategy aims to shift dependence from the welfare sector (including CDEP) to employment in Indigenous businesses and the broader business sector. It aims to increase Indigenous employment participation rates and reduce unemployment through increasing the skill base through training and education, cadetships and apprenticeships, and providing incentives to employers to engage Indigenous employees.

I. Accountability:

This is a Commonwealth policy directive, funded and accountable to the Commonwealth Department for Employment and Workplace Relations.

6. Are there any pre-requisite success factors?

Significant gains in Indigenous employment need a policy framework that directs, coordinates, funds and resources a sustainable and comprehensive initiative.

7. Are some success factors more critical than others?

The interfaces between the public and private sectors are crucial to this strategy, with employment opportunities promoted through encouraging industry to accept responsibility to create employment for Indigenous people, funding assistance to employ Indigenous people, promoting Indigenous small businesses, providing incentives for workers to move from CDEP to mainstream positions, and from unemployment to employment.

8. Are some success factors more relevant to certain programs than others?

The promotion of Indigenous small business has the potential for outcomes both in terms of employment opportunities and long-term economic development. Both are known to contribute to improved health outcomes and have a synergistic effect on each other.

The engagement of Corporate Leaders in employing Indigenous employees has significant outcomes in terms of challenging negative stereotypes of Aboriginal and Torres Strait Islander people, and promoting acceptance of Indigenous people in the broader social context.

9. How important was the context? Is the program transferable?

The IEP is a commonwealth funded national employment policy managing projects based on Government directives and determinates. The IEP has three elements Job Network, The Indigenous Employment Programme (comprising a number of projects) and the Indigenous Small Business Fund.

The projects that are nationally managed by the IEP are focused on sustainable employment prospects for individual Aboriginal and Torres Strait Islander people both in the public sector but especially within the private sector through the promotion of skill and qualification attainment and enhancement.

Application of the policy depends on creating the collaborations between government agencies, business and communities, and is transferable where effective collaborations are possible.

10. Are there any known limitations to the above?

The Indigenous Employment Policy has been developed to offset the combined disadvantage of a young, growing population, which is widely dispersed, with 20% living in areas where job opportunities are rare.

It addresses a high unemployment profile, with lower education and skill levels, with existing employment heavily dependent on the public sector.

These issues, which are the rationale for developing the policy, also challenge its successful implementation.

11. What are the lessons from these findings for Aboriginal and Torres Strait Islander health policy?

Effective strategy needs to be a complementary patchwork of approaches and projects. Sustainable change depends on the development of an economic base within Aboriginal and Torres Strait Islander communities that will create ongoing employment, with the resulting benefits to the community.

The encouragement of the private sector to engage in Indigenous employment is critical in both social and economic terms. The sustainability of employment beyond the provision of incentives and assistance needs to be clearly evaluated. The long term goal should be profiles of Indigenous employment in both public and private sectors consistent with that of the population as a whole, at all levels.

Employment strategies need to be complemented by strategies in education, public transportation and communication to achieve effectiveness.

6. Katherine West Coordinated Care Trial: Case Study Analysis

1. Case summary

The Katherine West Coordinated Care Trial is one of a number of health service coordinated care trials funded, implemented and evaluated around the country in the second half of the 1990's.

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

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

The "Case" for this project goes beyond the Trial itself and includes the local evaluation, necessary to determine any achievement resulting from the Trial.

"Katherine West" is a geographical area of central western Northern Territory covering an area of 162,000 sq km (2 ½ times Tasmania). It includes several large remote Aboriginal communities with an Aboriginal population of about 2500 and a non-Aboriginal population of much less than a quarter of this. Prior to KWCCT, health services for the region were largely delivered by the Northern Territory's, Territory Health Services (THS), either from primary care clinics based in communities within the region or from secondary and tertiary care available from facilities in the towns of Katherine and Darwin outside the region.

The KWCCT has, in effect, two components: one being initiatives to deliver Coordinated Care to the population in the region (CCT) and the second the creation of the Katherine West Health Board (KWHB). In some senses the second of these is a component of the first; however, it is so important it is useful to consider it separately. The development of the CCT and the KWHB proceeded in parallel for some time during the late 1990's.

Improved health care for local people has been an expressed aspiration of the local population for decades, as has the kernel of organized local community effort and initiatives. The KWHB emerged from community consultation initiated in early 1997, eventually being formally incorporated on 3rd February 1998. In July 1997, the Commonwealth formally approved the KWCCT plans.

The KWCCT formally ran from July 1997 to March 2000, and was followed initially by a Transition year, and subsequently by an on-going arrangement for health care provision under to control of the local KWHB.

2. What has been achieved?

The KWCCT has achievements at a number of levels. The key achievements are.

1. The establishment of KWHB initially as a fund-holding body and later as a service delivery manager leading to increased Aboriginal control over purchasing and provision of local health care services.
2. Pooling of funds for health care purchase for the local population leading to
 - i. increased resources within the region
 - ii. changes in expenditure patterns on services including new services
 - iii. improved coordination, development and health care administration
 - iv. increased intersectoral collaboration
3. Improved effectiveness of local health service delivery (many specific areas including clinical care)
4. Efficiency gains in health service delivery
5. Documented efficiency gains through high quality evaluation
6. Additional funds for preventative/public health programs as a consequence of documented efficiencies.
7. A high quality evaluation which improves clarity and assists understanding of the underpinning change mechanisms in these complex issues and provides an evaluation model for other health service interventions.

3. What measures have been used to provide evidence of what has been achieved?

The Evaluation Report sets out a comprehensive model for the analytical component of the evaluation.

Much of the evidence of achievements is comprehensive documentation of facts and events. Thus, qualitative documentation is the basis for measuring/recording achievements against (1), (5), (7) and (8), (see above achievements)

Quantitative measures have been used to provide evidence of changes in funding (Achievements (2) and (6)); Service delivery activities (Achievements (3) and (4)); Health Care Planning developments (Achievements (4) and (5)) and Clinical Care standards through Clinical Audits (Achievement 4).

4. What documentation is available to support this evidence?

- a) Jirntangku Miyrta, Katherine West Coordinated Care Trial, Final Report; April 200; Local Evaluation Team, Katherine West Coordinated Care Trial; MSHR, Darwin.
- b) Jirntangku Miyrta, Katherine West Coordinated Care Tria, Transition year, April 2002, D'Abbs P, Tangi S, Bailie R, Fitz J, Wales N; MSHR, Darwin.
- c) Katherine West Remote Health Board Aboriginal Corporation (Jirutangku Miyrta), 1999, Year 2000 and Beyond. Katherine, Katherine West Health Board Aboriginal Corporation.
- d) Local Evaluation Team, Katherine West Coordinated Care Trial (1998). KWCCCT: Report on General Programs with the Local Evaluation. Darwin MSHR.
- e) Other reports by these authors
 - 1999a Report on Baseline Clinical Audit
 - 1999b Mid-Term Report
 - 1999c Report on Baseline and Mid-Term Clinical Audits
 - 1999d Third Progress Report
 - 1999e Visual Report on Baseline and Mid-Term Population Care Plan and Diabetes Care Plan Audits

5. How did the following factors contribute to the outcomes achieved?

A. Community Control

This is fundamental to the success of the KWCCCT. A necessary requirement by all stakeholders was that there must be an effective community-based incorporated management system, with proper governance systems. The first part of this exercise was the creation of the Katherine West Health Board, followed by its formal incorporation under a Parliamentary Act. Without this happening the Coordinated Care part of the exercise, with its consequential flow-ons could not have occurred. In essence, community control and decision making is at the heart of this project – without it there is no project.

B. Community participation/involvement

All persons resident within the KW region were participants in this project in that the health services for all people were effected. Data on care plans treatments etc. for individual clients was required for various purposes during the project. Only data for clients who had provided written contents could be used in this way.

Community participation also has occurred in many other ways, through community consultations as part of the preliminary discussions to set up the Katherine West Health Board, processes for nominating each community's representatives to the Board, Board consultation and planning process and also evaluation discussions.

C. Resourcing

Resourcing is a core issue in this project both as an input and also, in a sense, as an output. The most obvious incentive to stakeholders for being involved in this project is the increase in resources available to fund service for KWHB region if the project were to proceed; see funding sources indicated in table below. In the absence of this project, only Territory Health Service funding (the first row of the table) would have been available for services.

Resources are relevant as an output in the sense that, if the Trial was found to be successful, then there was a strong likelihood that resources would be made available to continue the project after the trial had been completed. This has been the case, and has created a precedent for new models in health care service delivery and financing for Aboriginal communities.

Source	Purposes	1998-99(\$)	Live phase (July 98-Sept 99) (\$)
THS funds pool	Purchase of health services, & associated administrative costs.	2,070,129	2,592,300
MBS	Purchase and/or provision of new or expanded services/programs & associated administrative costs.	1,009,953	1,262,441
PBS	As above	631,584	789,480
OATSIH Non-Trial Administration	Administrative costs	320,630	401,531
Sponsorship Fundholder	Salaries (inc. on-costs) for finance Manager and Client Recruitment Coordinator	182,316	228,318
Total		4,214,612	5,274,070

Table 1. Funds to be administered by Katherine West Health Board during Live Phase, as at commencement of Live phase

*From:– Katherine West Coordinated Care Trial Local Evaluation Final Report
April 2000. MSHR: p.23*

D. Sustainability

Sustainability again is crucial, probably as important as the availability of resources. This whole project is about implementing major changes in health service governance and management to achieve community control over health service delivery and planning issues. It is inconceivable that a Trial which implements such major changes could be contemplated if there was little or no prospect of the project moving from a short term Trial to a longer (on-going) sustained change. It would be considered unethical to initiate

such a project without the prospect of continuing resources over the medium to long term, in the event of a positive result.

E. Partnerships, including intersectoral collaboration

The CCT initiative was possible because Commonwealth and NT governments agreed to work together to allow the fund pooling to occur. Partnerships and intersectoral collaboration are critical to providing effective health service in this regional context, though the prospects of useful partnerships and intersectoral collaboration being developed were greater within the KWCCT setting than prior to it. This has largely been due to the greater availability of resources for building such partnerships.

F. Workforce

As with partnerships, workforce considerations are relevant but secondary to and dependent on resourcing issues in this project. Adequate resources are not the only issue determining the availability of key professionals, and recruitment to remote Aboriginal Australia is a persisting problem. The improved working environment, and the enhanced work-force morale resulting from improved resourcing, however, has a direct impact on retention of professional staff.

With respect to the members of the KWHB, the project had a critical and early workforce issue relating to the motivation of individuals to nominate for membership and, most importantly, the essential training in a range of governance, management and administration issues which was provided to Board members to equip them to operate as an effective, independent decision making body.

G. Evaluation

Evaluation played an important and plays a continuing part in this Trial. Two forms of evaluation were incorporated in the original design of this project. These include the local evaluation, undertaken within the project, and the national evaluation, examining all CCTs around the country, partly through the information collected in the individual local evaluations. All evaluators were independent of the project(s) but worked continuously with projects. In the case of the KWHB evaluation, a series of very comprehensive reports was prepared at approximately six monthly intervals with an overall Final Local Evaluation report and even a report on the evaluation of the transition year between the completion of the Trial and the commencement of the new recurrent funding model developed following the Trial.

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

H. Capacity building

The training provided to KWHB members was an essential and fundamentally important component of this project (see section F where it is described). Without this training, the Health Board would have been unable to begin to grapple with issues of fund holding and, later, service management.

A key issue concerning the capacity building was the engagement of an organization, Pangea Ltd., which had relevant experience of conducting this type of training. This, of course, could not have been done if sufficient resources were unavailable.

I. Accountability

Accountability is an issue in this project in a number of respects. In one sense, it is a central component of the capacity building for the KWHB. Board members need to understand the reciprocal issues of accountability and authority. Board members, when providing good governance and management of funds entrusted to them have the authority to make decisions but, as an independent incorporated organization, they are accountable for decisions they make.

Accountability of a somewhat different kind is also relevant to the governments which developed this project. The Commonwealth Government has a recognized responsibility to provide primary health care services to remote Aboriginal people. Similarly, NT government has a responsibility for secondary and tertiary care. This project is driven primarily, by the decision of the Commonwealth Government to “cash out MBS/PBS” funds to the value thought equivalent to their primary health care responsibilities to the KW region. Given this decision the agencies agreed to make available other sources of funds to be managed by the KWHB. In this sense, it can be said that the governments were behaving in an accountable manner (living up to their agreed service delivery responsibilities) in setting up the innovative alternative funding model on which the project is based.

6. Are there any pre-requisite success factors?

This project is part of a large nation-wide initiative. This, in itself, is a great advantage to the project in its efforts to achieve creditability and, later, sustainability. This issue cannot be underestimated.

The essential pre-requisite for success for this project was the decision of governments to find increased funding for health services in the KW region. It may not have been enough on its own to pool existing funds, create a Health Board and expect improvements to follow. The increased funding was essential.

A second crucial issue must have been the quite widely held understanding amongst key stakeholders that, if the KWCCCT was a reasonable success or better, then there was a

very good prospect that governments would follow-up the Trial with on going recurrent funding, according to the Trial model or something similar, such that the advances/advantages made during the Trial could be sustained. That is, there was strong pre-existing commitment from both Commonwealth and NT government to making a success of the venture.

7. Are there some factors more critical than others?

If one considers the increased funding, and commitment to sustainability by governments as pre-requisites, then the next key critical factor is probably the creation of the KWHB and the training provided to it. In many ways this is not the biggest or most apparent part of the project but it is critical.

8. Are some factors more relevant to certain programs than others?

The development of an effective community-controlled management board has been critical to this project, and this has been achieved through incremental. This has involved a decision to separate the Board activities and functions and introduce them sequentially: firstly, recruitment to the Board following community consultation, then training, then the fund holding role, then service delivery managing, and more recently assisting neighbouring regions in their development of Boards etc.

9. How important is the context? Is the program transferable?

Context is important. In this case it includes issues that are largely concerned with how details of the project might be implemented, and include geographical location, unity of the people, sources of services, availability of skilled people etc. They do not change either of the crucial issues, which are, creation of an independent Board and introduction of coordinated care through the provision of pooled funding. The model of this CCT and other similar ones has been used to underpin the broad based PHCAP zonal health systems now being introduced throughout the country. Thus, the project is highly transferable. There are even possible “snow-balling” benefits to be had from the momentum introduced with new projects.

10. Are there any limitations to the above?

If the model is rapidly and widely introduced as seems likely in many parts of Australia, some significant limitations are likely to be encountered. Of these, the most important is probably the ability of appropriately skilled training bodies to provide the necessary training and support to the new Boards. The increased funding could also produce an overheated workforce recruitment scene in which key professionals are fought over, (or recruited from each other) by different Regional health Boards. Thus, there need to be a

rapid response from both training bodies and workforce bodies for widespread implementation of CCT to be successful. Although this is likely to be a significant future problem it should be recognised as a problem arising from success rather than failure.

11. What are the lessons from these findings for Aboriginal and Torres Strait Islander health policy?

Key lessons include:

- a) Adequate funding is essential in order for innovative, effective services to be provided.
- b) Political commitment is also critical to the success of the project. The success of the project not only needed money but also needed governments fairly committed to sustaining the changes introduced by the project.
- c) Projects must relate to existing government policy frameworks. Projects are more likely to be incorporated into ongoing funding cycle if it is part of a policy framework, or is able to influence change within current policy.

On reflection, the success of this project reflects this relationship to policy. The project itself was in fact a response to government policy directions, if not a fully formulated and adopted policy. In addition, the project was not an isolated experiment, but was part of a larger series of trials. The success of the project was, in a sense, that it provided much needed evidence needed to further develop current policy. This project, and similar projects around the country provided confirming evidence of the value of the government's existing policy directions and allowed development of the new framework.

In short, perhaps the take home message here is, don't expect projects to write the policies, rather

The most effective projects with respect to policy, are those which are developed within an existing policy framework and provide confirming evidence or refinement of detail. This allows policy makers to continue in the development of their adopted policy framework. It could be argued that projects which produce findings, no matter how convincing, that do not support or concur with current policy thinking and require policy makers to change their policy framework have an exceptionally difficult task. Even for good projects, there has to be some reason which makes policy makers listen to the project findings, and incorporate them into policy. This may be very difficult, often impossible for projects which are not well located in relation to the current policy framework.

7. Koori Maternity Services Program: Case Study Analysis

1. Case summary

The aim of the Koori Maternity Services Program is to provide additional and culturally appropriate support to Koori women throughout pregnancy and in the immediate postnatal period, by creating cooperative partnerships that enable the Aboriginal women of Victoria to access the best possible maternity care. The program is funded through the Acute Health Division of the Victorian Department of Human Services as part of the Victorian Maternity Enhancement Strategy. From 1999/2000 onwards \$600,000 annual recurrent funding has been provided to eight cooperatives and health services.

The program is seen to be a response to Recommendation 23 of the Ministerial Review of Birthing Services in Victoria (1990):

In support of the National Aboriginal Health Strategy, action should be taken to:

- Maintain the role of Aboriginal health workers and liaison officers in hospitals servicing an Aboriginal population;
- Ensure the continuing involvement of female Aboriginal health workers in the provision of antenatal and postnatal support for Aboriginal women;
- Investigate the development of education programs on birthing issues for health workers of Aboriginal background, with an emphasis on antenatal and postnatal care; and encourage the participation of Aboriginal women in the planning of health services and the establishment of different models of care.

The program addresses the reproductive health needs of Aboriginal women in Victoria. Aboriginal women are regarded as a “high-risk” group during pregnancy. In 2000 almost 20% of Koori women giving birth were aged less than 20 years, compared to only 3.2% in this age group for Victoria as a whole. Rates for pre-term births, low birth weight babies and perinatal mortality are all higher in the Koori community than for Victoria as a whole and Koori women are less likely to access antenatal and postnatal care.

The project places a strong emphasis on:

- Aboriginal community control
- The need for the provision of holistic health care; and
- The need for recognition of diversity within and between communities.

These themes have been reiterated in consultations with communities.

2. What has been achieved?

The program has been successful in improving access to antenatal care, which is considered to be a key strategy for improving Koori birth outcomes. This is achieved through the delivery of Maternity services through Aboriginal Community Controlled Health Services, and through partnerships with mainstream agencies. Evaluation of the service has resulted in a number of reported improvements in a number of the centres where services are provided. Improvements associated with the Program include:

Improved service provision

- Services have been made more flexible
- Continuity of care has been improved
- Midwife and Aboriginal Health Worker positions/hours have increased
- Education and outreach services have increased
- Domiciliary care is being provided

Improved collaborations with other services

- Good working relationships with many mainstream organisations established
- A good relationship has been established with obstetricians and GPs
- Women are more comfortable using other mainstream agencies
- Women are more familiar with the hospital before they give birth
- Women are more comfortable using the hospital
- Women are starting to use the Maternal and Child Health Service

Improved utilisation of services

- Women who would not have accessed mainstream antenatal care are now receiving care
- More Koori women are accessing antenatal care
- Women are accessing antenatal care earlier in pregnancy
- Women's understanding and use of contraception has increased
- Women are visiting the doctor more regularly
- Women stay in hospital longer
- Immunisation of newborns and their siblings has greatly increased
- Social networks for young women and their families have been improved

Improved health outcomes

- The mothers' and babies' health have improved
- Newborns' birth weight has improved
- The number of pre-term births has decreased
- Women are more knowledgeable about the birth process
- Incidence of SIDS has decreased
- Incidence of postnatal depression has decreased

3. What measures have been used to provide evidence of what has been achieved?

The evidence has been collated through structured and unstructured interviews with health care providers, community controlled health service members, community members and clients. Estimates of Aboriginal births have been developed through consulting health service records, staff, and personal knowledge. Reported improvements are based on health service records and staff observations.

4. What documentation is available to support this evidence?

Two evaluation documents are available that provide a summary of reports on the Koori Maternity Services from Aboriginal communities in Victoria.

Campbell, Sandy. (2000) *From her to maternity: a report to the VACCHO members and the Victorian Department of Human Services about maternity services for the Aboriginal women of Victoria*. Melbourne, VACCHO and Department of Human Services.

Coyle, L & Thompson, L. (2001) *Koori Maternity Services in Victoria Statewide Evaluation*. Melbourne, VACCHO.

The reports note the limitations of data collection, differing reporting systems between health services, small client numbers for statistical analysis and the significant underestimation of Aboriginal births in health department records. They propose that other qualitative methods, such as the community consultation process employed in the evaluations, should be given consideration in analysis of community needs.

5. How did the following factors contribute to the outcome/s achieved?

A. Community control

The principle of community control was a key element in defining the project. The evaluations argue that when community members control how health care is provided, they guarantee local control, ownership and accessibility for themselves. Community control was defined as being:

Community Initiated – Aboriginal people are experts in Aboriginal health.

Community based – The community is empowered immeasurably when its health programs are culturally appropriate, community based, accessible and operated by the community itself.

Community Controlled – Community control is a fundamental principle of self determination, and is codified in the United States declaration of Human & Political Rights.

However, the aim of the project was to complement mainstream targeted services, not to establish stand-alone services. Cooperation with mainstream services was essential in all cases to varying degrees.

B. Community participation / involvement

There was extensive consultation with community members from Victorian Koori communities before the project began and the gaps, strengths and weaknesses of existing services were examined.

At the beginning of the Koori Maternity Services Program two effective models of care were identified. Both services were planned and implemented by community health services, and offered postnatal and antenatal programs including client education, and had strong links with key mainstream maternity service providers in the relevant area.

Evaluation of the project involved extensive community consultation, with interviews of a range of community representatives undertaken in women's health meetings, at health services, at community lunches and barbeques and in shopping centres.

C. Resourcing

The Koori Maternity Strategy receives \$600,000 per year of the \$14.3 million provided to the Victorian Maternity Enhancement Strategy. Funding is distributed to the Aboriginal Community Controlled Health Organisations (ACCHOs) to improve maternity service delivery to Koori women and their babies and to improve Koori women's birth outcomes.

VACCHO is provided with some of the funds in order to coordinate the program at statewide level as well as to support, advocate for and develop training for Victoria's Koori maternity workers.

D. Sustainability

The KMS receives \$600,000 per year out of the \$14.3 million. At present, only 8 of 25 ACCHOs are receiving some sort of financial help through the DHS's Koori Maternity Strategy. The evaluation documents note the improvements that have resulted from the introduction of the project, but recommended that more funding is needed to create some much needed services and, secondly, to improve existing programs being conducted throughout Victoria.

E. Partnerships, including intersectoral collaboration

The Koori Maternity Strategy promotes the development of maternal health services that are complementary to existing mainstream services, and through models of advocacy, support and shared clinical care, seeks to improve utilisation of both mainstream and community controlled maternal health services.

At Fitzroy, in Melbourne, the *Clinical-Linkage-Advocacy-Health promotion* maternity service operates at the Victorian Aboriginal Health Service. An Aboriginal maternity health worker and a midwife are employed as a complementary team, and form the primary antenatal and postnatal care provider. They provide shared care with the two major metropolitan maternity hospitals.

The second model, the *Linkage-Advocacy-Health promotion* maternity services, is most effective in small communities or where the Aboriginal health services employs a doctor with expertise in the provision of maternity care.

The Aboriginal maternity health worker creates strong links to clinical services providers and co-ordinates the antenatal and postnatal care of her clients. Babies are delivered at the nearest Base Hospital. This model operates successfully at Rumbalara Aboriginal Cooperative at Shepparton in the Goulburn Valley where there is a large Aboriginal population in the area.

Other successful models of care operate at Morwell and Wodonga. A targeted maternity service operates successfully at Morwell, in the Gippsland region, where the community employs a community-based midwife specifically to provide care for Aboriginal families of the region. The service is comprehensive and provides a high level of continuity of care.

At Wodonga Regional Health Service, which provides midwifery services to both Albury and Wodonga, an Obstetric Aboriginal Liaison Officer was appointed after extensive consultation with the Aboriginal community of Albury/Wodonga.

F. Workforce

The project has provided resources for the recruitment of additional Aboriginal midwives and Aboriginal Health Workers, and for the training of Aboriginal Health Workers in maternal health. Their relationships with clients and other mainstream and community health care providers have been critical to its success.

G. Evaluation

An initial evaluation of maternity services for Aboriginal women in Victoria was commissioned by the Victorian Department of Human Services and VACCHO, and undertaken by Sandy Campbell. The report *From her to maternity* was released in March 2000. The report is based on a process of consultation with Aboriginal community members, health care providers and staff of community controlled health

services across Victoria and documents perceptions of maternal health services in those communities and projected needs. It also provides some insight into the underestimation of Aboriginal births in Victoria through comparing official estimates with local knowledge of births in the previous year.

In 2001, a further evaluation of the Koori Maternity Services in Victoria was prepared by Leanne Coyle and Laura Thompson of the Koori Maternity Strategy, Victorian Aboriginal Community Controlled Health Organisation.

Problems with data collection were noted by both evaluations. There is no common data collection format between services, and Coyle and Thompson recommended development of a standardised data-collection method as an important element in documenting success and in lobbying for funding.

H. Capacity building (human & physical infrastructure)

Capacity building in this project focussed on the development of knowledge and skills in maternal health and health promotion for Aboriginal Health Workers and Aboriginal Liaison Officers.

I. Accountability

The Project is financially accountable to the Department of Human Services (DHS) Victoria, and the Victorian Aboriginal Community Controlled Health Organisation (VACCHO). At a professional level, each Aboriginal Community Controlled Health Service maintains responsibility for the activities of their staff.

6. Are there any pre-requisite success factors?

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

In 1998, the State Department of Human Services committed \$14.9 million in recurrent funding to enhance public maternity services across Victoria. The broad objectives of the four-year implementation strategy were:

- to promote measurable improvements in the continuum of antenatal, intrapartum and postnatal care, individualised to the needs of particular women
- to provide women with increased birthing options and with evidence based information on the benefits and risks associated with different options
- to encourage improvements in models of care in line with best available evidence
- to improve outcomes through appropriate performance measures and service audits.

This comprehensive framework for the improvement of maternity services across the state provides the context for the specific initiatives in the Koori Maternity Services program. The majority of recurrent funding is provided to health care networks and rural regions, on the basis of recent birth numbers, to implement regional Maternity Services Enhancement Plans. Approximately 2.5% of the recurrent funding is available to implement the Koori Maternity Services Program, which interfaces with the health care networks.

The Koori Maternity Services Program has worked to establish strong links to the community within the program, giving a sense of local ownership and strong links to community structures and organisations. This has clear implications for the improved utilisation of services by Aboriginal women, and has potential flow on effects to other areas, including child health, sexual health and family planning, and reflects their desire for a holistic approach to health issues. Although the rhetoric of community control has been strongly articulated within the consultation, there is also evident diversity between communities, the models of care and their relationships with mainstream services.

7. Are some success factors more critical than others?

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

The contribution of individual health practitioners – obstetricians, midwives, nurses, Aboriginal health workers and Aboriginal liaison officers – to the success of this program is also clear in the project documentation. It is the building of trust between individuals that makes enhancement of maternity service outcomes possible.

8. Are some success factors more relevant to certain programs than others?

Utilisation of maternity services by Aboriginal women is dependent on a number of social, cultural and economic factors. The history of discrimination remains strong within the community and change depends on a rebuilding of trust with health services. Young Aboriginal women remain vulnerable in a system that is to some extent culturally alien to them. In this context, the affirmation of community control of services serves to create an environment where access to services becomes possible, and in this project, provides a bridge to mainstream services.

9. How important was the context? Is the program transferable?

The shift in organisational culture within Victoria's Maternity Services is a major contributor to the success of the project, as is the commitment of Aboriginal Community Controlled Health Services to building models of shared care that address Aboriginal women's needs in collaboration with those services. The program is transferable where the primary commitment of both mainstream and community controlled services is to collaborations that achieve outcomes for Aboriginal women.

10. Are there any known limitations to the above?

While improved relationships and effective models of service delivery have been achieved in a number of regions, there remain areas where choices for Aboriginal women are severely limited by gaps in service provision and weaknesses in current services. In the review of maternity services undertaken by Campbell in 2000, all services indicated areas in which they felt improvements could be made. There were particular issues for Aboriginal communities where birth rates were low, and these were exacerbated by under-recording of Aboriginal identity in official records. The independence of community controlled health services means that health information systems differ between services both in the nature and quality of health service data collected and analysed. A common system of data collection and analysis is a necessary base for the development of comprehensive strategies and the improvement of services.

11. What are the lessons from these findings for Aboriginal and Torres Strait Islander health policy?

Maternal and neonatal health outcomes depend on a combination of the provision of technical and professional health services as well as the promotion of access to and utilisation of those services. In these circumstances, strategies to improve outcomes depend on the enhancement of both components. Within the public hospital system this requires an expansion in the level and range of maternity services available in rural and urban areas, and a change in the organisational culture that makes it more responsive to the specific needs of women. In the community, it demands initiatives that inform women about their pregnancy and health, and makes them more aware of their choices. It requires the development of services that link community and hospital, such as the Koori Maternity Services, and collaborative models that ensure access and continuity of care. The emphasis on complementarity, rather than duplication of services, is important.

For Aboriginal women, programs with a strong cultural and community identification such as the Koori Maternity Services program promote access in the antenatal period and support during delivery, with follow up options for the postnatal period and links to child health and women's health services.

8. NSW Aboriginal Vascular Health Program: Case Study Analysis

1. Case summary

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

The Program is a state-wide strategic initiative to address prevention and management of vascular diseases including diabetes, cardiovascular disease, renal disease and stroke. A broad vascular approach has been adopted because of the shared causal factors, common management approaches and shared barriers to disease self-management for a range of conditions. A series of demonstration site projects have been funded across the state and are being implemented through local Aboriginal health partnerships between Aboriginal Community Controlled Health Services and mainstream health services with collaboration in some areas with local Divisions of General Practice and University Departments.

The projects aim to improve the prevention, early detection and self-management of vascular diseases. All projects involve the employment of designated Aboriginal Vascular Health Workers and the provision of training and support for these positions. The program seeks to address a number of issues, including the under-utilisation of primary health care services and consequent late diagnosis of vascular and related conditions, the resultant excess morbidity and mortality, and preventable complications and hospitalisation. It will improve workforce capacity and linkages between services, identifying and responding to service gaps such as podiatry. It will promote better models of self-management, seeking to empower clients, and offset the pessimism and fatalism that frequently surrounds vascular disease in the Aboriginal community.

The Program has also established a state-wide Aboriginal Vascular Health Network with more than 170 members to disseminate information, share stories about projects and resources. A range of education and training initiatives are also in place.

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

2. What has been achieved?

As the Program is relatively new and developmental many of the achievements will be apparent over the next couple of years. However, many achievements are already apparent in a number of domains. There are identifiable achievements of the overall Program and specific achievements in local demonstration site projects that are being closely monitored and evaluated.

Program achievements include:

- change in overall policy and strategic approach. The project has adopted a holistic approach to vascular disease which is consistent with Aboriginal notions of health, dealing with health as a whole, rather than focussing on single organ or disease processes
- A Strategic Framework has been developed which incorporates the following Program strategies:
 - Resource development strategy
 - Health workforce strategy
 - Service development strategy
 - Coalition building strategy
 - Programs management and development strategy
 - Monitoring and evaluation strategy
 - Communication strategy
- development of a NSW Aboriginal Vascular Health Indicators Framework
- building of capacity through improved local, regional and state networks and partnerships
- improved communication and information dissemination systems
- development of research capacity, building of evidence base of what works and why
- advocacy in mainstream health reforms with departmental and NGO initiatives eg Heart Foundation, Kidney Foundation etc

Improvements to health services include:

- development of new models of service delivery through the demonstration projects which are all establishing mechanisms for improved co-ordination of care, improved access to care. Each project is being developed according to local priorities, personnel and resources. Some involve specific research projects eg developing testing new models for chronic disease self-management which are appropriate for Aboriginal people. Many projects also link with other initiatives eg EPC for care planning etc
- development of close working partnerships between community controlled services and mainstream services and in some cases Divisions of General Practice
- collaborative development of local clinical care protocols, referral pathways
- development and implementation of health assessment tools for use in communities

- establishment of outreach clinical services
- development of models of disease self-management programs through adaptation and piloting of existing models
- establishment of local registration and client recall systems

Preliminary results suggest that in one project (Illawara), diabetes self-management initiatives have achieved improvements in clinical measures (HBA1c, BP and serum lipids) in a majority of patients, sustained over the first 6 months of the project.

3. What measures have been used to provide evidence of what has been achieved?

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

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

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

4. What documentation is available to support this evidence?

There are two key documents that outline the program:

Scott, M. (2002) *The NSW Aboriginal Vascular Health Program Report*. Sydney, NSW Department of Health.

Scott, M. (2002) *Aboriginal Vascular Health Demonstration Site Projects*. Sydney, NSW Department of Health.

Information about the program and projects is made available both in hard copy and on the Department of Health's website (doh.health.nsw.gov.au)

5. How did the following factors contribute to the outcome/s achieved?

A. Community control

The NSW Aboriginal Vascular Health Program was developed jointly between the Aboriginal Health and Medical Research Council (AH&MRC), the NSW Department of Health (DOH), the Office of Aboriginal and Torres Strait Islander Health (OATSIH) and the Aboriginal and Torres Strait Islander Council (ATSIC).

A series of demonstration site projects has been implemented through local Aboriginal Health Partnerships, with a strong emphasis on collaborations between mainstream and Aboriginal Community Controlled Health Services.

B. Community participation / involvement

The Aboriginal communities are seen as key stakeholders in this program, with projects funding collaborations between community and mainstream services. Aboriginal Vascular Health Workers are seen as key members of the workforce, with community participation in preventive and health promotion strategies an integral part of the strategy.

The recruitment of non-government organisations into collaborations is another feature of community involvement in this program.

In 2001 the program funded eight (8) projects in Area Health Services, and three (3) in correctional centres, targeting the health of Aboriginal inmates. In 2002 a further four (4) Area Health Service projects and three (3) correctional centre projects were initiated. The emphasis is on strengthening local approaches and capacity and collaborating with a range of stakeholders, particularly Aboriginal Community Controlled Health Services. It is also seeking to promote the involvement of other non-government organisations eg National Heart Foundation, Kidney Foundation, Diabetes Australia, in collaborations in Aboriginal health.

C. Resourcing

Initial funding for the Program was \$1.4 million in October 2000, with further funds made available in 2001 and 2002 through Aboriginal State-wide Enhancement Funds. This has largely been allocated to a series of demonstration site projects, implemented through local Aboriginal health partnerships between Aboriginal and Community Controlled Health Services and mainstream health services. Projects are being evaluated to gather evidence and develop a better understanding of effective systems and models of care. It is anticipated that in 2002/2003 there will be a move towards recurrent funding for the Aboriginal Vascular Health Program.

D. Sustainability

Sustainability is dependent on recurrent funding from State and Commonwealth sources, and on the maintenance of collaborative relationships between stakeholders in local projects.

E. Partnerships, including intersectoral collaboration

The Aboriginal Vascular Health Program is committed to working with the NSW Aboriginal Health Partnership Framework at the levels of funding and policy and strategic development, and at local levels on demonstration site projects.

The Program was developed jointly by the Aboriginal Health and Medical Research Council (AHMRC), the NSW Department of Health (DOH), the Office of Aboriginal and Torres Strait Islander Health (OATSIH) and the Aboriginal and Torres Strait Islander Council (ATSIC).

The Program funds a range of demonstration site projects across the state, implemented through local Aboriginal health partnerships between Aboriginal and Community Controlled Health Services and mainstream health services with collaboration in some areas with local Divisions of General Practice and University Departments, and involving non-governmental organisations such as the National Heart Foundation, Diabetes Australia and the Australian Kidney Foundation.

F. Workforce

The Program has a strong focus on building a community of health professionals with a commitment to improved outcomes in vascular health through the creation of the Aboriginal Vascular Health Network. This includes Aboriginal and non-Aboriginal health professionals, clinicians, researchers and staff of the National Heart Foundation, Diabetes Australia and the Australian Kidney Foundation. The network provides a forum for dissemination of information and produces a quarterly publication Vascular Health Matters.

In addition, the Program has promoted the development and training of designated Aboriginal Vascular Health workers who are engaged in each of the demonstration site projects.

Initiatives in workforce development include:

- provision of local training and education for Aboriginal Vascular Health Workers
- establishment of explicit local support and mentoring mechanisms for AVHW employed in demonstration site projects
- delivery of a 2 day Aboriginal Vascular Health Forum for education, workshopping targeted issues eg evaluation networking for AVHW
- development and delivery of an Aboriginal Kidney Disease education workshop training module
- provision of technical advice and assistance in the development of funding submissions for community controlled services

G. Evaluation

All projects are being individually evaluated and the overall evaluation of the Aboriginal Vascular Health Program will include consideration of individual project outcomes. As the projects are developmental and focussing initially on developing infrastructure and improved processes of care, evaluation will not in the short-term focus on changes in individual health status and clinical indicators as these changes are more likely to be realised when appropriate services and infrastructures are established.

H. Capacity building (human & physical infrastructure)

The project has an explicit capacity building approach, with a strategic framework which incorporates health workforce development, service development, resource development, research evaluation and coalition building communication.

The establishment of an Aboriginal Vascular Health Network with more than 170 members has provided a mechanism for sharing project experience, resources and outcomes. The quarterly publication Vascular Health Matters offers a forum for information and communication within the network and into the broader public health community.

The program has established an evaluative framework for monitoring changes in Aboriginal vascular health with indicators that will allow measurement of local intervention and capacity, as well as state-wide parameters.

A series of training initiatives, including workshops and training manuals, is being developed to assist in building the capacity of the Aboriginal health workforce in the prevention and management of vascular disease.

An Aboriginal Vascular Health Projects forum was held in November 2001 for all those workers involved in projects to share stories and ideas and facilitate networking. A second Forum will be held in June 2002 and it is anticipated that this will become a regular event to support implementation.

I. Accountability

The Program is accountable to the State and Commonwealth funding agencies. Individual project are funded by the Program as demonstration site projects and are subject to ongoing monitoring and individual evaluation.

6. Are there any pre-requisite success factors?

A number of pre-requisite factors have contributed to the success of this program. These include:

- The comprehensive policy and strategic approach taken by the Aboriginal Vascular Health Program has been a key to securing the funding base for an integrated state-wide approach to vascular health. Integral to this has been the holistic, rather than disease or organ based approach to the program
- Project development and implementation through local Aboriginal Health Partnerships, including Aboriginal Community Controlled Health Services and non-government organisations
- A central focus on improved access to treatment, early detection of disease and risk, and referral for care along with improved coordination of services
- The establishment of a network for all health professionals involved in work related to Aboriginal Vascular Health
- Recruitment and training of designated Aboriginal Vascular Health Workers
- Integration with the Chronic and Complex Care Cardiovascular projects in local Area Health Services
- The inclusion of Correctional Centres as a locus for projects targeting health risks relevant to vascular health
- Close monitoring and evaluation

7. Are some success factors more critical than others?

The development of a comprehensive policy and strategic framework for the Aboriginal Vascular Health Program has enabled the complex network of project and professional development to be sustained across a range of diverse projects. The decision to frame the Program within a holistic, rather than disease or organ-specific framework, has provided a common understanding of health with Aboriginal community groups, and facilitated their participation.

At a local level, the individual projects are dependent on collaborations between Aboriginal Community Controlled Health Services, Area Health Services, GP and University Divisions and Non-Government Organisations. The cumulative successes of these individual projects will contribute to the overall outcomes of the program.

8. Are some success factors more relevant to certain programs than others?

In order to achieve an impact on vascular disease on a state-wide basis, a comprehensive policy and strategic framework is necessary, addressing the funding, workforce, health service, communication, monitoring and evaluation components of the Program. Access to Aboriginal communities, however, depends on local strategies and collaborations, bringing the resources and technical expertise of mainstream and NGO services together with those of Aboriginal Community Controlled Health Services.

9. How important was the context? Is the program transferable?

In 2001 projects were funded in eight (8) Area Health Services and three (3) Correctional sites serviced by Corrections Health Service (Broken Hill, Tamworth, Grafton). Initial project sites are Central Coast, Hunter, South Western Sydney, Western Sydney, Macquarie, Illawarra, Mid-Western, New England and Corrections Health.

In 2002 additional projects have been funded in Mid-north Coast Northern Rivers, Greater Murray, South Eastern Sydney and three additional Correctional Centres (Emu Plains, Mannus, Ivanhoe).

The Program provides a model of collaboration, based on a policy and strategic framework that is replicable and transferable where existing Aboriginal Community Controlled Health Services or similar agencies are operating.

10. Are there any known limitations to the above?

The Program is a complex, multifaceted development and it is difficult to separate out and measure individual elements of success. The short time frame for the project to date makes it difficult to evaluate. Overall Program outcomes are dependent on the cumulative effect of individual project outcomes, and will become more evident over the life of the project.

11. What are the lessons from these findings for Aboriginal and Torres Strait Islander health policy?

Effective programs depend on:

- clear and comprehensive policy and strategic frameworks
- a holistic, rather than organ or disease based approach to health issues
- strong local collaborations between mainstream, Aboriginal Community Controlled and Non-Government Organisations
- flexibility in adaptation and implementation of the programs in response to local contexts.

The recognition of the importance of Correctional facilities as targets for health change in the Aboriginal community is a significant innovation in this program.

The potential contribution of Non-Government Organisations such as the National Heart Foundation, Diabetes Australia and the Australian Kidney Foundation needs to be considered in future responses to Aboriginal and Torres Strait Islander health.

9. The Nutrition Policy for Remote Retail Stores in Queensland: Case Study Analysis

1. Case summary

This is a joint project between the Department of Aboriginal and Torres Strait Islander Policy (DATSIP) and Queensland Health to develop strategies that could improve the food supply situation in the six DATSIP managed retail stores. The aim of the store nutrition policy adopted by DATSIP retail stores is to ensure that people have access at all times to the foods they need to stay healthy. The key objectives of the policy are:

- To improve the capacity of the stores to provide a range of affordable, healthy food of good quality including fresh fruit and vegetables.
- To ensure that Indigenous customers are able to make informed choices on foods necessary to maintain good health and meet specific dietary requirements.

2. What has been achieved?

There have been several important outcomes:

- Fresh fruit and vegetables are available at all times, especially core items such as potato, pumpkin, apples, oranges and other popular lines (even during the wet season).
- Sales of fresh fruit and vegetables have increased markedly, as have some other healthy food lines.
- Due to the limited mark-up approach for fresh fruit and vegetables two stores have at various times managed to keep fruit and vegetable costs to consumers below that recorded in Brisbane for equivalent items.
- The range of healthy food is more extensive so a choice is available to customers (there are two or three varieties of sugar-free soft drinks, low fat cheeses and similar items).
- The upgrade of store infrastructure during the last five years has been a great support to implementing the policy. These improvements in modern floor layout(s), merchandising, storage and food handling facilities and the internal store environment can persuade customers to purchase more in the store, especially fruit and vegetable lines
- Integrity and quality of fresh products is maintained at all times (eg long-term storage facilities for fruit and vegetables were installed during the infrastructure up-grade in the previous dot point to ensure specific fruit and vegetable stock can be stored for several months during the wet season and sold at dry season prices).

3. What measures have been used to provide evidence of what has been achieved?

The following evidence is available to support these outcomes:

- Fruit and vegetable sales figures in each of the six communities from 96/97 to 01/02
- Consolidated fruit and vegetable sales figures for 96/97 to 01/02
- Consolidated department sales figures for 96/97 to 01/02 for each of the following departments: dry grocery, dairy, freezer, fruit and vegetables, service deli, variety, cigs and tobacco, garden/plant, confectionery, cold drinks, meat, electrical, auto/fuel, bakery, sport/outdoor, hardware, takeaway, music/equipment, clothing
- Overall percentage of sales made by EFTPOS from 96/97 to 01/02
- Data in relation to the number of product lines available in each of the six stores
- Retail stores aggregated profit data for each year from 96/97 to 01/02

4. What documentation is available to support this evidence?

Some of the information is provided in the Nutrition Policy for Remote Stores document, but most of it is contained within DATSIP reports and internal reporting documents. The Manager of the Retail Stores Branch made the information available to members of the project team.

5. How did the following factors contribute to the outcome/s achieved?

A. Community control

The stores involved in this project are located in the communities of Doomadgee, Kowanyama, Lockhart River, Palm Island, Pormpuraaw and Woorabinda. The Retail Stores Unit of the Department of Aboriginal and Torres Strait Islander Policy currently manages these stores. Other remote community stores in Queensland are managed privately, with the exception of Cherbourg. Management of the Cherbourg community store has been transferred from DATSIP to the local community. Plans are now in place to transfer management of the remaining stores under the control of DATSIP to private management. It is understood that the process will involve a competitive tendering one, and communities involved will be able to compete in this process.

B. Community participation / involvement

A reference group was established to advise on the development of this policy. It comprised representatives from DATSIP, Queensland Health, ATSIC, the Aboriginal Coordinating Council, Apunipima Cape York Health Council, and the Australian Medical Association. This group played a significant role in ensuring appropriate consultation with communities, store staff and others. The executive director of the Aboriginal Co-

ordinating Council and the general manager of the Apunipima Cape York Health Council are both signatories to the foreword of the policy.

C. Resourcing

This is considered to be a major contributor to success in this case. In 1998 DATSIP and Queensland Health began a joint project to start healthy food initiatives in the six communities where the retail stores were managed by DATSIP. A conscious decision was made by DATSIP to invest a significant amount of its Retail Stores Unit budget to upgrading and improving the community stores infrastructure. Without such improvements, it is doubtful that the Nutrition Policy for Remote Retail Stores could have been successfully implemented.

In addition, one of the management tools for the stores involves cross-subsidisation to ensure that essential foods are sold at affordable prices. A pricing strategy that allows for higher prices to be charged for core non-essential items to keep prices of core essential items at a minimum level has been adopted.

D. Sustainability

A significant factor for sustainability is considered to be the formal recognition of the retail stores projects within a policy context. The endorsement of the Nutrition Policy for Remote Retail Stores ensures a continuing commitment, politically and financially, to the importance of having healthy foods accessible for remote Indigenous community members. The impetus for this initiative grew out of the success achieved by the Retail Stores Unit and the Queensland Aboriginal and Torres Strait Islander Food and Nutrition Strategy (1994). One of the five key action areas within this strategy was that of food supply, which had the overall goal of increasing availability and access to a variety of affordable and nutritious foods in Queensland Aboriginal and Torres Strait Islander communities through:

- Increasing awareness
- Promoting co-operation and co-ordination between and within relevant sectors of the food and distribution system
- Encouraging local food production
- Co-ordination of food supply and money supply
- Development of community store, supermarket and agency nutrition policies that prioritise the consistent supply of safe and affordable nutritious food.

It was recognised that this provided a broad framework for action in relation to food supply, but that a more detailed strategy was required. The Nutrition Policy for Remote Retail Stores is thus the product of a fairly lengthy investigation into the issues related to food supply to Indigenous communities and an ongoing commitment to ensuring improved outcomes are achieved.

E. Partnerships, including intersectoral collaboration

The Policy itself is a joint policy of the Departments of Aboriginal and Torres Strait Islander Policy and Queensland Health, thus representing a partnership in policy development and implementation. The partnership is considered essential to the ongoing commitment to the policy and its implementation.

The project also demonstrates that agency co-ordination is important if Indigenous people living in remote communities are to have ready access to a wide variety of nutritious foods. Clearly, there has been a huge increase in the number of product lines available in the community stores. By increasing the range and availability of healthy food choices, demand has also increased, thus providing a model that can be adopted for the benefit of both consumers and retailers.

F. Workforce

When the project commenced, a nutritionist was employed by DATSIP to work on food and nutrition issues. The position was filled by a qualified Indigenous person, who is understood to have played a significant role in achieving some of the project outcomes and in the development of the policy.

In addition, the Retail Stores Unit completed a training needs analysis to identify staff development needs and to ensure that processes were in place to provide the necessary training. By adopting standards consistent with retailing practices generally, it has been essential that store management practices and associated workforce issues be addressed. Provision has been made to ensure the ongoing skills development of store staff and for retraining opportunities to occur, given the relatively high rates of turnover.

G. Evaluation

A strategy for monitoring and evaluation is built into the policy. It contains the following components:

- The healthy food access basket survey that is undertaken every six months by Queensland Health nutritionists (an example of why the partnership is important). Nutritionists compare the availability of a selected list of foods in the store with that of a supermarket in Brisbane. The price of a basket of 'mostly healthy' food is also compared between the remote stores and Brisbane to gauge changes to prices of essential food over time.
- A six monthly review and analysis of healthy food sales is undertaken, using the data from sales through the cash registers
- Regular meetings with the project reference group to obtain feedback from communities
- Monitoring against a set of performance indicators for the project.

H. Capacity building (human & physical infrastructure)

Clearly, the improvements to community store infrastructure have been essential to the outcomes achieved in this project. These include the following:

- Installation of long-term storage facilities in communities that are cut off from road access during the wet season.
- Upgrade of store buildings, including new floor coverings, electrical and lighting systems, ceilings, fresh food preparation areas, air conditioning, administration offices and staff amenities.
- New design layouts for each store
- The introduction of new technology such as point of sale terminals and EFTPOS
- Establishment of a business plan for each store
- A comprehensive training program for each store, based upon identified needs
- Adoption of retail practices and standards that are consistent with the current best retail methodology in the private sector
- Improvements in the range and display of nutritious foods

I. Accountability

This is an example where the funds were expended by government and not an Indigenous community or organisation. Accountability for the policy rests with an ongoing commitment by the Queensland Government to ensure that the policy implementation is resourced adequately and the successful outcomes achieved thus far are sustained.

6. Are there any pre-requisite success factors?

It is thought that having a policy context for Nutrition in Aboriginal and Torres Strait Islander communities was an important starting point for this project, and without the existence of a broad framework, it is not clear whether this project would have progressed.

The improvements to community store infrastructure were essential. Without these, many of the other initiatives could not have taken place. For example, the increase in number of product lines was dependent upon appropriate storage and display facilities. In addition, the adoption of retailing standards and practices was dependent upon having the resources (both physical and human) to implement these practices. The pre-requisite to this was having an appropriate commitment of resources to undertake the infrastructure improvements and develop human capacity.

7. Are some success factors more critical than others?

The combined factors that have been outlined are all considered important. However, the following are perhaps of greatest significance:

- Capacity building provides the foundation for the project. The physical infrastructure required to run and maintain the stores, and the human resources required to run and manage them, are very important
- Resources were critical to the improvements needed to upgrade the stores and facilities within communities
- Evaluation provided the information and evidence of outcomes required to get the commitment to a formal policy approach.

8. Are some success factors more relevant to certain programs than others?

In many ways, this project was about responding to a policy in relation to Aboriginal and Torres Strait Islander nutrition in Queensland. While a policy existed, it was a broad framework for action and it was not possible to implement it successfully without first providing the necessary physical infrastructure.

In this case, there was a need for a heavy capital investment to ensure that the physical infrastructure was in place before the other initiatives could be successfully implemented.

Another success factor specific to this project is the link with the retailing industry. This includes the adoption of standards for product pricing, display, storage etc., and implementation of management strategies to ensure that a wide range of nutritious foods is available and affordable within communities. Marketing strategies played an important role.

9. How important was the context? Is the program transferable?

The following context specific issues are believed to relate to this project:

- Management of the stores – at this stage, the Nutrition Policy for Remote Retail Stores applies very much to the six community stores that are currently managed by DATSIP
- The existence of a Queensland Aboriginal and Torres Strait Islander Food and Nutrition strategy provided a framework and political commitment for the specific policy initiative in relation to remote community stores
- The project is very much about availability and affordability of nutritious foods in remote communities – it does not provide a response to the need to achieve similar outcomes for Indigenous people living in other settings, such as major urban centres.

- Sustainability is linked to the maintenance of industry standards, and not specifically tied to community control of the stores

10. Are there any known limitations to the above?

While there is clear evidence that sales of fresh fruit and vegetables have increased substantially in each of the six communities over the past five years, and that the number of product lines available for sale has grown enormously, there is a lack of qualitative data to provide evidence of community and other stakeholder views about these initiatives in remote communities.

It is not known what the likely implications of the forthcoming transfer of control to the private sector will be. However, with the physical infrastructure now in place and retailing practices well established, it is considered an appropriate time to transfer control. At the time of doing this work, data on the potential outcomes from this process is not available.

11. What are the lessons from these findings for Aboriginal and Torres Strait Islander health policy?

- That the trend towards developing policy in relation to specific areas within Indigenous health is important. While the National Aboriginal Health Strategy and other related documents provide a framework for action, many lack the detail required for action in relation to a specific issue.
- That a minimum level of infrastructure required to implement a policy needs to be identified and a commitment of resources needed to achieve this level made before a policy can be successfully implemented
- That the provision of accurate and timely information is important and needed to inform policy development – the data available from store sales and product availability provided the necessary evidence to gain political support for the further development of this initiative
- Capacity building includes a number of components – in this case physical infrastructure as well as human resource development and longer term potential for community control of the stores
- That a policy such as this can provide a basis for action from the private sector as well as government
- Partnership between two Queensland Government departments
- Behavioural change that resulted as a result of this project – not tied to a health education program

10. Queensland Health Indigenous Workforce Management Strategy 1999 – 2002: Case Study Analysis

1. Case summary

The Queensland Health Indigenous Workforce Management Strategy was launched by the Minister for Health in (NAIDOC Week) July 1999, and provides a framework for Queensland Health District Services to improve their Indigenous workforce management practices. The Director-General is the sponsor of the Strategy. It is designed to be dynamic, providing a basis for districts to take innovative action. It provides a framework for Districts to work with educational institutions and Indigenous communities to encourage more young Indigenous people to aspire to health careers, and improve recruitment, retention and development of Indigenous employees.

The current strategy addresses the period 1999 – 2002 and aimed to increase Indigenous participation in health workforce through a two-pronged approach:

- The implementation of a **Labour Market Development Program**, which aims to encourage and support Indigenous students through school and university into health careers. The rationale behind the strategy is to respond to the low numbers of Indigenous people in the labour market with the appropriate health qualifications, skills and experience for careers in Queensland Health.
- The implementation of **Indigenous Workforce Development Program** that takes a pro-active approach to the recruitment, retention, and promotion of Indigenous peoples across Queensland Health. This is due to the under-representation across occupational categories and salary levels of Indigenous employees.

An Indigenous Workforce Team has been established to coordinate the implementation of the Strategy and its evaluation, and three Zonal Indigenous Human Resource Officer positions have been established to support District Human Resource Management Units implement the Indigenous Workforce Management Strategy.

2. What has been achieved?

The Indigenous Workforce Management Strategy has set the following targets for Queensland Health and the Districts for the employment of Indigenous staff:

- Queensland Health has committed to targets of 2% Indigenous representation in overall Queensland Health workforce by 2002 and
- 2% Indigenous representation across all 9 Office of Public Service, Merit & Equity (OPSM&E) salary levels by 2010.

State Government targets for Indigenous employment are 2.4%, and reflect the proportion of Indigenous people in the population. Queensland Health has successfully negotiated a lower target (2%) because of the low numbers of Indigenous graduates in professional categories. The Strategy aims to meet these lower targets, while encouraging the education and retention of greater numbers of Indigenous health professionals.

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

According to recent Queensland Health Equal Employment Opportunity (EEO) data, Queensland Health employed approximately 903 (1.9%) Indigenous people within the Department in 2001. A breakdown of Indigenous employees in the Queensland Health workforce is given in Figure 1. It is anticipated that Queensland Health will achieve and/or exceed 2% Indigenous employee representation by the end of 2002.

Employment Stream	Indigenous Employees	Percentage of QH Workforce
Administration	169	2.3%
Professional	35	0.8%
Technical	39	3.2%
Operational	449	4.5%
Medical	12	0.3%
Dental	1	0.3%
Nursing	192	1.0%
Other	6	1.5%
TOTAL	903	1.9%

Figure 1: Queensland Health Indigenous Employees 2001.

3. What measures have been used to provide evidence of what has been achieved?

The available measures include Queensland Health policy documentation, and two reports of the State Working Group for the Queensland Review of Aboriginal and Torres Strait Islander Health Worker Training (2000). These include detailed findings regarding the employment of Indigenous Health Workers in both Queensland Health and the Aboriginal Community Controlled Health Services, and recommendations regarding their recruitment and training. In addition, the results of a survey of Indigenous employees of Queensland Health undertaken in 1998 provides detailed information of their age and

gender distribution, employment category, qualifications and deployment across the districts.

4. What documentation is available to support this evidence?

In addition to information provided by the Queensland Health Equal Employment Opportunity (EEO) Office for Indigenous Employment in 2001, the following documents that contributed to the development of the Strategy were provided:

- Queensland Health (1999) Queensland Health Indigenous Workforce Management Strategy: our jobs, our health, our future. Queensland Health, Brisbane.
- Workforce Planning and Development Team, Aboriginal and Torres Strait Islander Health Unit. (1998) A profile of Queensland Health's Indigenous Workforce: Summary Report. Queensland Health, Brisbane.
- State Working Group for the Queensland Review of Aboriginal and Torres Strait Islander Health Worker Training. (2000) Detailed findings - Queensland Aboriginal and Torres Strait Islander Health Workers employed by Queensland Aboriginal Community Controlled Health Services and Queensland Health. Queensland Aboriginal and Torres Strait Islander Health Partnership, Brisbane.
- State Working Group for the Queensland Review of Aboriginal and Torres Strait Islander Health Worker Training. (2000) The Queensland Aboriginal and Torres Strait Islander Health Worker Training Plan 2000. Queensland Aboriginal and Torres Strait Islander Health Partnership, Brisbane.

5. How did the following factors contribute to the outcome/s achieved?

A. Community control

The Strategy is an internal document for Queensland Health, and targets and recommendations included in it apply only to government services. However, the reports of the State Working Group for the Queensland Review of Aboriginal and Torres Strait Islander Health Worker Training that contributed to the development of this strategy was a collaboration between Queensland Health and the Queensland Aboriginal Community Controlled Health Services. The reports of that review have recommendations for both government and community-controlled sectors, and promotion of health careers and initiatives in training and education that are part of the Strategy, have long term outcomes for both sectors.

B. Community participation / involvement

Indigenous employees of Queensland Health provided data for the compilation of the reports leading to the development of the Strategy. Consultation with Indigenous Health Workers and the Queensland Aboriginal Community Controlled Health Services contributed directly to the reports informing the Strategy.

C. Resourcing

Queensland Health funded the Indigenous Workforce Team to coordinate the implementation of the Strategy and its evaluation, and three Zonal Indigenous Human Resource Officer positions were established, and have now been made permanent positions as Zonal Indigenous Workforce Development Officers.

The Strategy has funded the **Labour Market Development Program**, including promotion of health careers by QH staff in High Schools, training of mentors for school students, and joint strategies with Universities, TAFE and Rural Health Training Units. An Indigenous High School Scholarships Program has been proposed, in addition to the Queensland Health Rural Health University Scholarship Scheme to provide financial assistance to successful applicants.

The **Indigenous Workforce Development Program** has been funded to provide District managers with an understanding of the importance of increasing recruitment from the Aboriginal and Torres Strait Islander community, modifying practice in recruitment, induction, workplace structuring and career planning, and promoting linkages with other agencies that facilitate this.

The Strategy has been resourced to 2002, with a further Strategy planned for the next phase.

D. Sustainability

Significant elements of the strategy involve adaptation of current employment and management practice to enhance the recruitment and retention of Indigenous employees. It also promotes an awareness of complementary Commonwealth and State programmes, cadetships and scholarships that to provide support for training and employment of Aboriginal and Torres Strait Islander people, and encourages the formation of links to community and other organisations that enhance awareness of employment opportunities and give Indigenous people a sense of connection with their own communities as part of their employment. Many of these practices are able to be sustainably incorporated into reflective management at District and Program level.

E. Partnerships, including intersectoral collaboration

The Strategy forms direct links with a number of groups to establish a network of support for enhancing training and employment, including Aboriginal Community Controlled

Health Services, other government agencies (both Commonwealth and State), professional groups and educational institutions - universities, TAFE, the VET sector and primary and secondary schools.

F. Workforce

Workforce is the focus of this project, and the changes to the Indigenous health workforce are integral to the success of the project. In contrast to other projects, the workforce contributes to both inputs and outputs of the project.

The aim of the Strategy is to create an environment which raises the profile of health careers in Indigenous communities, promotes Indigenous recruitment into training and education programs, and motivates District health management to institute changes that will enable the active recruitment and support of Aboriginal and Torres Strait Islander employees in the workforce.

What has been crucial is the increased awareness of the Department's own responsibilities towards employment of Indigenous people, and a recognition of their potential to re-shape the organisation itself, given a significant presence in strategic positions.

The increase from an Indigenous workforce of 420 in July 1999, to 903 (or 1.9% of the total QH workforce) in 2001 brings the Indigenous workforce close to the target of 2% set for this phase of the Strategy. While the Indigenous Workforce is characterised by some volatility – the 1998 report records 595 Indigenous staff, and notes a high turnover rate – the increase during the life of the Strategy is significant.

Revision of the targets would be appropriate in future Strategies, with more Indigenous students graduating as health professionals, and with evidence of significant growth in the Indigenous population as a proportion of Queensland's total population.

Consideration will also need to be given to the success in achieving employment at all levels within the department, as indicated by the targets for 2010.

G. Evaluation

The Strategy will be evaluated at the completion of its cycle, in December 2002. Interim employment figures appear encouraging, but do not allow identification of what elements of the Strategy have proved most satisfactory. Some elements of the strategy – such as promoting the profile of health professions among Aboriginal and Torres Strait Islander school children – will have a long latent period and are dependent in part on educational initiatives.

H. Capacity building (human & physical infrastructure)

The Strategy seeks to build capacity within the Aboriginal and Torres Strait Islander workforce, with numerical targets set for overall recruitment to the department, and eventual proportional representation at all levels. In terms of the overall employment ratios this is likely to be achieved, but the greatest proportion of Indigenous employees are appointed to the operational and administrative streams, with continuing significant under-representation in professional (including medical, nursing and dental) and technical streams.

The evaluation will need to examine whether initiatives currently undertaken in the Strategy – scholarships, cadetships, expos and role modelling, liaison with educational institutions etc – are increasing the pool of potential health professionals.

The Strategy also seeks to build capacity within the Department – particularly at District level – in terms of its social responsibilities as an employer. The Strategy argues that the recruitment of Indigenous Australians has benefits for the organisation itself, increasing its capacity to:

- develop culturally safe workplaces
- build relationships with Indigenous communities
- develop a holistic approach to health
- improve service models
- identify Indigenous people in human resource and client information systems
- provide timely, responsive and flexible health services and
- improve the health status of Indigenous peoples.

I. Accountability

Queensland Health is accountable to the Director-General, sponsor of the Strategy, for the outcomes of its implementation. The targets are factored into performance contracts at District level.

6. Are there any pre-requisite success factors?

The workforce Strategy has set short term and long term targets that are dependent on an increasing pool of Aboriginal and Torres Strait Islander health professionals. This requires improvements in education, from primary through secondary schooling to TAFE, VET sector and University. The Strategy acknowledges these links and includes element to promote appropriate activity in the education sector, but is dependent on changes within that sector for success.

The Strategy is also dependent on change in the organisational culture that results in District health management recognising the value of Indigenous employment, and the

worth of setting in place long term strategies to ensure continuing recruitment is possible at all levels.

The Strategy also looks to international models and experience for examples of possible approaches to promoting Indigenous employment, broadening the range of knowledge and options from which the Strategy can draw.

7. Are some success factors more critical than others?

The recruitment into the higher OPSM&E salary levels –particularly to the health professional and management - is critical to achieving the organisational changes implicit in the Strategy. Currently, the bulk of appointments are to the Operational and Administrative streams, where Indigenous staff are less well positioned to significantly alter the structure, culture and services of Queensland Health. Stronger attention to education and professional formation is critical to the long term success of the Strategy.

8. Are some success factors more relevant to certain programs than others?

Queensland Health indicates 449 Indigenous people were employed in the Operational Stream, of which the majority are Aboriginal Health Workers. Current career structures do not provide for education beyond the TAFE and VET sectors – a significant ‘ceiling’ for Indigenous employees. Industrial change will be necessary to address this.

The Aboriginal and Torres Strait Islander community also faces a double disadvantage in is dispersal over remote areas, and limited educational opportunities in those areas. The development of an Indigenous health workforce with representation in each of the professional categories depends on sustained educational strategies at every level leading to vocational training, and support through that training and into the early professional years.

Indigenous role models are critical in terms of promoting the health professions to the Aboriginal and Torres Strait Islander community.

9. How important was the context? Is the program transferable?

Data from the 1998 survey shows a number of specific District where significant numbers of Indigenous health staff are employed – including Torres, Cairns, Mt Isa, Cape York, Townsville and the metropolitan Districts. This reflects both the concentration of the Aboriginal and Torres Strait Islander community, but also the historical distribution of positions prior to Regionalisation in 1991. The strategy is transferable, though the

pool of potential employees is greater where the Indigenous population is larger, and where educational standards are higher, and appropriate programs available.

10. Are there any known limitations to the above?

Lower education levels within the Aboriginal and Torres Strait Islander community limits recruitment, though, in part, the Strategy seeks to address this specific disadvantage in several professional areas.

11. What are the lessons from these findings for Aboriginal and Torres Strait Islander health policy?

There are a number of lessons for policy available from these findings;

- That there is a significant body of international experience that may be drawn upon to inform strategies in Indigenous health
- That political will and commitment at the highest levels of the organisation – in this case with the launch by the Minister and sponsorship of the Director-General – are critical to the implementation of policy.
- That the organisational culture needs to be changed both in terms of departmental policy but also at the District level, where managers understand the potential benefits of increasing Indigenous employment and targets reflect on their performance.
- That effective Strategy requires the synergy of multiple approaches, addressing each of the elements of the problem addressed. In terms of Indigenous employment, both the recruitment and retention of employees, but also the education and training of potential employees are important.
- That more effective use may be made of the existing programs, incentives, scholarships, cadetships and educational opportunities, where employers are made aware of these, and partnerships are formed to ensure optimal use of existing resources.
- That the specific targets set by policy have different implications in terms of their achievement – in this case, Indigenous employment targets set for all levels of the organisation (the long term target) is both more difficult, but also more effective an outcome than overall employment rates. The revision of targets (increasing from the current 2%) will be necessary as the educational base from which current targets are set, improves.