

***ABORIGINAL PRIMARY
HEALTH CARE IN VICTORIA:
ISSUES FOR POLICY AND REGIONAL PLANNING***

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VICHEALTH KOORI HEALTH RESEARCH & COMMUNITY DEVELOPMENT UNIT

Discussion Paper Series

The VKHRCDU was launched in June 1999 and has been developed in partnership with the Victorian Community Controlled Health Organisation, the Victorian Health Promotion Foundation (which funds the Unit) and the University of Melbourne through the Centre for the Study of Health and Society where the Unit is located.

At the core of the Unit's work is a commitment to undertaking, collaborating in and supporting research that directly benefits the Koori community. The work of the Unit spans academic and applied research, community development, and medical education. The combination of these activities is a central and innovative aspect of the Unit's function, as is the identification and use of mechanisms to link research with the improvement of health care practices and policy reform. Overall, these tasks are guided by both an Advisory Committee and a Research Advisory Group.

In relation to the research program, five key areas govern the inquiry undertaken within the Unit. These comprise: historical research into Koori health policy and practice; historical and contemporary research into health research practice, ethics and capacity building; applied research on the social and cultural experience of Koori health, well-being and health care delivery; health economics research on the factors and processes that impact on the provision and use of Koori health care; and the evaluation of Koori primary health care and related health promotion programs.

The Discussion Paper Series is directly linked to this diverse program of research and provides a forum for the Unit's work. The DP series also includes papers by researchers working outside the unit or in collaboration with Unit staff. Individual papers aim to either summarise current work and debate on key issues in Indigenous health, discuss aspects of Indigenous health research practice and process, or summarise interim findings of larger research projects. It assumed that the readership for the series is a broad one, and each paper is closely edited for clarity and accessibility. Additionally, draft papers are 'refereed' so as to ensure a high standard of content.

More information on the series, on the preparation of draft papers, and on the work of the Unit can be obtained by directly contacting the VKHRCDU.

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ABORIGINAL PRIMARY HEALTH CARE IN VICTORIA: ISSUES FOR POLICY AND REGIONAL PLANNING

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Summary

Recently in national Aboriginal and Torres Strait Islander health policy there has been an increasing focus on developing collaborative approaches to planning health services. The Framework Agreements in Aboriginal and Torres Strait Islander health were developed by the Commonwealth to provide a mechanism through which the Commonwealth and State governments, together with the Aboriginal and Torres Strait Islander Commission (ATSIC) and the Aboriginal community controlled health sector, could work collaboratively on regional planning in Aboriginal health. In addition, the national approach has placed a priority on improving the capacity of Aboriginal primary health care services.

In this discussion paper we examine the extent to which this national approach has made an impact upon the planning of Koori health in Victoria. We did this by reviewing the existing policy and strategy documents, and interviewing key informants.

There are different ways of understanding primary health care. The World Health Organization, for instance, defines it as 'the first level of contact of individuals, the family and the community with the national health system bringing health care as close as possible to where people live and work, and [it] constitutes the first element of a continuing health care process' (WHO 1978: 4). These ways of thinking about primary health care have important implications for the development of primary health care funding models.

In principle, primary health services should address the main health problems in a community and provide a range of health-promoting, preventive, curative and rehabilitative services (WHO 1978). This mix should be determined by need. Primary health care may also involve services outside the health sector, such as education, housing, food, and industry. Kooris also currently access primary health care services both through Aboriginal community controlled health services and co-operatives as

well as through mainstream health care providers. Effective primary health care will require the development of links or partnerships between Aboriginal community organisations, mainstream health care agencies and primary health care support services.

Despite the priority given to primary health care in national Aboriginal health strategies, there has been little work done to translate the concepts of primary health care into funding (or what we call operational models) relevant to Victorian communities. For example, we argue that an operational model for Koori primary health care should take into account:

- the distribution of the Koori population in Victoria;
- the health needs of the Victorian Koori community;
- the current patterns of service utilisation by Victorian Kooris and the cultural, social and economic factors that shape these; and
- current evidence concerning the factors that impact on the effectiveness and efficiency of primary health care.

Further, we argue that these models for primary health care should specify:

- the components of primary health care services provided for (primary clinical care, maternal and child health services, health promotion, etc.
- resources and technical infrastructure required to administer, plan and co-ordinate the integration of services;
- the mechanisms needed to develop and sustain service delivery collaborations between primary care services, community services and non-primary health services;
- the mechanisms necessary to develop and sustain supportive collaborations between organisations and structures that are vital to the development of the primary care workforce, thereby promoting evidence-based service delivery and encouraging the development of collaborations;
- an approach to the governance of Koori primary health care that balances support for community control with measures to ensure that mainstream health services share the responsibility for Koori health care provision;
- the funding structures, accountability requirements and performance measures that provide the basis of this system of care; and
- the capital infrastructure required to support such program delivery.

Progress in developing a regional plan in Victoria has been relatively slow. Some preliminary work was finalised in June 2000 for the Victorian Advisory Council on Koori Health (VACKH), which is overseeing the process. Further, we argue in the second section of the paper that, despite slow progress in regional planning, there is evidence that some of the national priorities have made progress. This is clearest in some of the new workforce initiatives, and in the initiatives to improve the quality of data collection and other health information. There is evidence of some interest in reforming financing and funding of Koori primary health care, but few steps have been taken other than through incremental and ad hoc funding initiatives.

There are a number of issues that need to be resolved for regional planning to progress. First, there needs to be a consensus on how the Commonwealth definition of a region relates both to State level regions in the health sector, and the Aboriginal and Torres Strait Islander Commission regions. Second, the Commonwealth and State approaches to planning need to be better integrated. This will require the Victorian Department of Human Services to review and evaluate existing planning frameworks relevant to Koori health. Currently these include the Primary Care Partnerships, the Koori Health Reform Strategy and the Koori Services Improvement Strategy.

Given that it is likely that Commonwealth initiatives in Aboriginal health will be increasingly linked to the joint planning process it is critical that these barriers to the development of a collaborative regional plan in Koori health be addressed.

ABORIGINAL PRIMARY HEALTH CARE IN VICTORIA: ISSUES FOR POLICY AND REGIONAL PLANNING

Introduction

The World Health Organization's (WHO) *Alma-Ata* declaration (1978) on primary health care has conventionally been applied in developing countries, where medically trained personnel and other highly skilled health professionals and medical infrastructure are limited. Although such concepts have salience in relatively resource-rich countries like Australia, it is in Aboriginal and Torres Strait Islander health policy that they have become pivotal.

There has been a growing national focus on the development of Aboriginal primary health care capacity following the release of the National Aboriginal Health Strategy (NAHS) in 1989 (Anderson 1997). This focus was consolidated further following the evaluation of the NAHS implementation in 1994, which preceded the transfer of administrative responsibility for the Commonwealth Aboriginal health program from the Aboriginal and Torres Strait Islander Commission to the Commonwealth health portfolio (National Aboriginal Health Strategy Evaluation Committee 1994). Since that time there has been a greater focus on the development and utilisation of health portfolio mechanisms, structures and policy levers to achieve Aboriginal health outcomes through improved capacity and performance in the health sector.

A key element in Commonwealth strategy has been the development of inter-governmental agreements (Framework Agreements in Aboriginal and Torres Strait Islander Health). These are based on the principle that both Commonwealth and State levels of government are 'jointly responsible for responding to the needs of all Australians [including] Aboriginal and Torres Strait Islander peoples' (DHFS 1997). In summary, the Framework Agreements in Aboriginal Health (DHFS 1997: 221–2) support:

- the development of national and State/Territory level forums that involve stakeholders in providing advice and input into policy and planning processes;
- the introduction of planning processes at a regional level with a focus on improving the capacity and effectiveness of primary health care services, and reducing access barriers to mainstream services by making these services more appropriate and sensitive to the needs of Indigenous people and establishing standards and quality assurance processes;
- an increase in the allocation of health sector resources that reflects the level of need; and
- an improvement in data collection and evaluation mechanisms.

This national framework established key principles and relationships that are intended to shape policy development and planning. There is some room for modifying the approach to be taken within a particular jurisdiction. This includes critical issues such as the definition of regional planning or the range of stakeholders to be included in the planning process. Within the strategic framework outlined by these agreements, the development of primary health care services is a key priority. In the current national policy framework, the domains of policy and strategy development have been identified as the key aims (DHAC 1999a: 1). These include:

- *developing the infrastructure and resources necessary to achieve comprehensive and effective primary health care for Indigenous peoples;*
- *addressing some of the specific health issues and risk factors affecting the health status of Indigenous peoples;*
- *improving the evidence base which underpins the health interventions; and*
- *improving communication with primary health care services, Aboriginal and Torres Strait Islander peoples and the general population.*

Having identified the national approach to Aboriginal primary health care, we now focus on Victorian Koori primary health care policy and strategy, and explore the impact of this approach on Koori health policy and strategy.¹ In particular, given the emphasis on collaborative planning, we wish to assess the extent to which the Commonwealth and Victorian State planning frameworks have been integrated and regional planning progressed. Finally, we want to determine the extent to which policy development has taken up the developmental themes most relevant to primary health care services. That is, we are seeking to determine the extent to which Koori health policy and planning have initiated both the development of infrastructure and Koori primary health care. In considering the development of the infrastructure we will focus on the issues related to health financing and workforce development. We will not give detailed consideration in this context to investments in capital or technology (such as information management systems), or in the health-related developments in community and environmental health infrastructure. Our focus in this analysis is on policy and strategy development rather than an evaluation of policy implementation.

In the development of this paper, we have reviewed (up to September 2000) existing policy documents and conducted key informant interviews with relevant stakeholders in the Koori community, Commonwealth Department of Health and Aged Care (DHAC) and the Victorian Department of Human Services (DHS).² The purpose of

¹ In this paper the term Aboriginal will be used generically to refer to Indigenous Australians. Where we refer specifically to Indigenous Australians in Victoria we use the local term Koori.

² The list of key informants is provided in the Acknowledgments. These interviews were conducted between June and August 1999.

these interviews was to develop our understanding of the context of various initiatives. The original data collection was conducted prior to the Victorian State Election in September 1999. Subsequent to this, we have endeavoured to modify our analysis to take on board some changes in State government health and community services policy inasmuch as this is possible at this stage.

In the first section we:

- explore the conceptual development of models of primary health care and their uptake within Aboriginal health policy;
- describe the limited development of operational models of primary health care applicable to Victorian Koori communities; and
- explain the progress to date in the development of regional planning in Victoria for Koori primary health care services.

In Section 2 we describe the extent to which Commonwealth developmental priorities relevant to primary health care have progressed, in particular, issues related to:

- reform of financing and funding of Koori primary health care;
- development of Koori health workforce strategies; and
- development of evidence systems to support effective policy and practice.

Section 1: Primary Health Care – Conceptual Issues

In the *Declaration of Alma-Ata* primary health is defined as:

essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's overall health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and the community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process (WHO 1978: 3–4).

In principle, primary health services should address the main health problems in a community and provide a range of promotive, preventive, curative, and rehabilitative services (WHO 1978). This mix should be determined by need. Primary health care may also involve institutional structures beyond the health sector, including education, housing, food, and industry. However, in most countries, inter-sectoral collaboration is poor, and primary health care tends to be limited to the most basic provision of curative and preventive services (e.g., diagnosis of illnesses, referrals, and vaccinations).

Authors such as Rifkin and Walt (1986) further develop the *Alma-Ata* concept of primary health by distinguishing between comprehensive and selective primary health care. Comprehensive primary health care is defined as ‘a developmental process by which people improve both their lives and life-styles’, and incorporates community development and community participation strategies in order to realise primary health care objectives (Rifkin & Walt 1986: 560). In contrast, selective primary health care is limited to ‘medical interventions aimed at improving the health status of the most individuals at the lowest cost’ (Rifkin & Walt 1986: 560). In the majority of poor country settings, the implementation of primary health care has been limited to selective programs. Given the developmental character of comprehensive primary health care, its implementation will require a health policy that addresses issues of equity in the provision of health resources. This is, in theory, achievable in relatively resource-rich countries such as Australia, and is consistent with broader aims of empowerment for Indigenous Australians. At the same time, the sustainability of comprehensive primary health care would appear to depend on the extent to which primary health services are adapted to local settings and supported by relevant local and regional services. Hence, a single model of comprehensive primary health care should not be applied universally to all population groups (in Australia or elsewhere), but adapted to local needs and regional infrastructure.

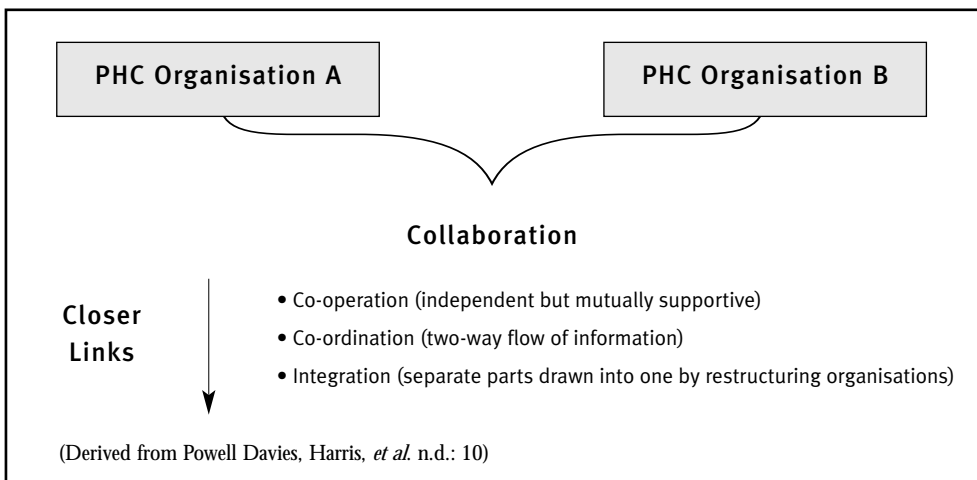
Comprehensive primary health care and linkages

An effective referral system that enables individuals to be referred to appropriate services according to their need is a critical element in the development of a comprehensive primary health care system (WHO 1978). Given the resources available more broadly within the Australian health and community service sector, it should be feasible to improve the collaborations between services. However, before we discuss these issues further we need to acknowledge that the use of concepts such as ‘collaboration’ or ‘service integration’ in health policy can encompass a range of different strategies or mechanisms, which have quite different implications. For instance, many advocates in the Koori community would resist strategies that were seen to weaken existing Koori community organisations or involve some form of cultural assimilation.

Work undertaken by the Centre of General Practice Integration Studies at the University of New South Wales provides a useful conceptual framework for thinking about issues of collaboration development. The centre identified a 'continuum of collaboration', which ranged from working in isolation at one extreme and then moved through co-operation and co-ordination to full integration at the other end (Powell Davies, *et al.* n.d.: 10). This framework uses the term collaboration to describe any working relationship, while co-operation, co-ordination and integration are used to illustrate different approaches to achieving collaboration. Co-operative arrangements involve each partner working independently, but in a mutually supportive way. Co-ordinated collaborations involve the two-way exchange of flow of information between organisations and individuals. Integration is described as the process through which otherwise separate elements are drawn into a larger whole through a process of re-structured inter-organisational relationships. According to the framework, integration has three components: the separate parties being drawn together, the links between them, and the larger entity created.

Currently, the focus in Koori health policy has been on facilitating co-operative and, to a certain extent, co-ordinated collaborations. As the type of collaborative relationship being fostered has implications for Koori community organisations, formulating an approach to the development of collaborations between these organisations and the mainstream health and community services system will require ongoing consultation and consensus building. We will use the more general term, noting that the approach taken to building working relationships will need ongoing policy development.

Figure 1: Model of Primary Health Care (PHC) collaboration



From the perspective of primary health care services, the development of collaborations between services has a number of dimensions. Firstly, collaborations can be developed between the different components of comprehensive primary health care (such as primary clinical care, maternal and child health services, and immunisation services). Secondly, they can be developed between primary care services and relevant non-primary health service delivery organisations (employment, housing and other community services). And thirdly, collaborations can also be strengthened between primary health care and secondary or specialist medical services. We will refer to this type of collaboration as *service delivery* collaborations.

Additionally, primary health care services relate to a range of organisations that are important for developing quality, effective service delivery. For instance, workforce development agencies assist primary health services to develop and maintain their workers' skills. Primary care services also need access to the outcomes of relevant research and evaluation, and the capacity to undertake evaluations of their own services. Collaborations with universities and health research organisations are critical to this. Primary care services also relate to organisations that support the development of service collaborations such as the Divisions of General Practice. We will refer to this type of collaboration as *service support* collaborations.

Current delivery of primary health care

Primary health care is currently provided in a loose and uncoordinated fashion for most Australians. Although primary clinical care is offered by general practitioners, poor Australians and others, at times of perceived need for urgent medical attention, may also use hospital emergency and outpatient services. Additionally, primary clinical care may be sought from alternative healing modalities (such as homeopathy or naturopathy), and advice requested routinely from pharmacists or others working in chemist shops. While such advice is usually limited to over-the-counter medication for symptomatic relief, pharmacists also provide first-level screening and referral in much the same way as do nurses and midwives in primary health care settings in poor countries. Both pharmacists' advice and over-the-counter medication, and general practitioners' consultations and treatment supplement the first level of care that occurs in any and all Australian communities, involving self-medication or other non-medical treatments during initial periods of ill health.

However, as we have already argued, primary clinical care is not synonymous with primary health care. General practitioners believe they have a role in providing health education, opportunistic screening and health promotion. But as general practice interventions are characteristically episodic and brief, health promotion and prevention activities consequently tend to be short-term 'clinical' interventions (such as giving advice to stop smoking, referral for a breast screen, etc.). Most general practitioners and pharmacists provide health education through the use of pamphlets and/or posters in surgeries and chemist shops. Health education in surgeries, however,

is accessible only to those who present for medical care; that in chemist shops is typically product related.

Other health education and promotion programs are delivered with varying effectiveness, and are infrequently evaluated. Some health promotion and prevention takes place in schools (as a component of sports, science and/or personal development curricula), and via the media, either in health-explicit columns in newspapers, magazines and radio, and, obliquely, through the inclusion of health-related material in television fiction (serials, soap operas, etc.). The enforcement of legislation acts both to regulate health behaviours and provide periodic reminders of certain key public health initiatives (alcohol, tobacco and illicit drug laws, seat-belt legislation, domestic violence prevention, etc.). Although there is little direct funding for health promotion, the Victorian Health Promotion Foundation (VicHealth) does fund various interventions and strategic projects.

Finally, a variety of initiatives take place at a community level either through the work of community-based organisations or via local councils. These include fitness programs; neighbourhood watch and safety house programs; community-based initiatives such as the nursing mothers' association (promoting breastfeeding); drug and alcohol referral and support groups (such as Alcoholics Anonymous and Narcotics Anonymous); women's refuges; support groups for people who have been victims of violence, sexual abuse, rape, and so on; associations for people with particular health conditions (e.g., schizophrenia, diabetes, cystic fibrosis, etc.); and charities such as the Smith Family and St Vincent De Paul that provide emergency food, clothing and shelter. Individual social workers have such information and are able to make appropriate referrals, but none of these services are integrated at the primary health care level through a single fixed point. Indigenous workers, however, are able to provide outreach to their own communities.

Conceptual Issues in Aboriginal Primary Health Care

Issues of cultural appropriateness and self-determination are critical to the model of primary health care advocated in the National Aboriginal Health Strategy (NAHS). The NAHS, for example, advocates a holistic approach to health which recognises that Aboriginal people perceive 'health' to encompass 'all aspects of their life, including control over their physical environment, of dignity, of community self-esteem, and of justice. It is not merely a matter of the provision of doctors, hospitals, medicines or the absence of disease and incapacity' (NAHS 1989: ix). It is also argued that improvements in Indigenous health status will occur when Aboriginal people are 'able to control their destiny and to accept responsibility for their own decision-making' (NAHS 1989: xiii). The approach to primary health care adopted by the NAHS remains influential, particularly within Aboriginal community controlled health services.

Such health services were developed in the early 1970s in response to the concerns of Indigenous communities about poor access to, and discrimination within, mainstream health services. The Kimberley Aboriginal Health Services Council in Western Australia, for example, currently provides primary medical care that enables the treatment 'of individuals and families in a community setting' (KAMSC 1999: 1). It also offers primary health care 'which seeks to involve a community through ownership of health problems and meaningful involvement in provision of health services', by placing 'particular emphasis on disease prevention and health promotion' (KAMSC 1999: 1). This model of health care is similar to that articulated by Rifkin and Walt (1986).

Aboriginal and Torres Strait Islander primary health care services are currently funded by a number of distinct Commonwealth and States/Territories programs. As might be expected, there are sometimes subtle differences in the understanding of the nature, role and functions of primary health care adopted by distinct funding programs. This may be the case even within a single administrative system. For example, the Office for Aboriginal and Torres Strait Islander Health (Services) (OATSIHS), one division in the Commonwealth Department of Health and Aged Care, makes the distinction between a primary health care delivery structure that integrates clinical care with population health/health promotion activities, from one that in essence delivers primary clinical care for Aboriginal people (DHFS 1997: 250-60). However, other divisions within DHAC (such as Population Health and Health Services) see primary health care as primary clinical care, and *public* health as 'the promotion of health and prevention of illness and injury, rather than treatment' (DHAC 1999b: 1). While such differences may be subtle, they nevertheless have implications for the allocation of resources and the development of health policy. They also highlight the current importance in Aboriginal strategy on the integration of population health and clinical care activities within primary care services.

However, similar conceptual frameworks in primary health care can also mask quite significant differences in the ways in which such concepts are translated through funding into services. Consider, for instance, the concept of primary health that was used in the Victorian Primary Health and Community Sector Services Reform Strategy (PHACS) (DHS 1998e). The model advocated within the PHACS reform agenda is quite close to the social model of health incorporated in the *Declaration of Alma-Ata* and the World Health Organisation *Ottawa Charter for Health Promotion* (1986), as well as in some Aboriginal models of health. However, it was intended that 'contestability' or competitive tendering would be used in the PHACS to promote service efficiency and develop service integration. Arguably, this would have significant implications for the type of primary health care service produced (which we consider below, see also Appendix 1). Our point is that conceptual models of primary health care usually represent 'ideal service models'. Similar conceptual models may in fact obscure critical differences that result from the approaches to resource provision for

primary health care. Hence, it is critical to develop policy further so that agreed conceptual frameworks in primary health care can be appropriately matched with systems of funding, accountability and strategy. We will refer to this as the development of operational models of primary health care.

Primary health care for Victorian Koori people

Population estimates of the Victorian Koori community are generally acknowledged to be problematic, reflecting some of the broader issues with the recording of Aboriginality. Nevertheless, according to Australian census estimates for 1996, there were 22,598 Aboriginal and Torres Strait Islander people resident in Victoria. Overall, the Aboriginal and Torres Strait Islander population in Australia was 386,049 (representing 2.1 per cent of the total population). Victoria had the lowest proportion of Aboriginal and Torres Strait Islander people, 0.5 per cent of the total, and the Northern Territory the highest with 28.5 per cent (ABS/AIHW 1999).

The demographic structure of the Victorian Aboriginal and Torres Strait Islander population is markedly younger than the non-Indigenous population. In 1996, 38.7 per cent of Aboriginal and Torres Strait Islanders were under the age of fifteen years (compared with 20.8 per cent of the total Victorian population), and 3.2 per cent aged over sixty-five years (compared with 12.5 per cent of the total Victorian population) (ABS 1998).

A significant proportion of the Victorian Koori community lives in urban areas, but less so than for the total Victorian population. For instance, in 1996, approximately 47 per cent of Aboriginal and Torres Strait Islander people in Victoria lived in major urban areas and 39.6 per cent in other urban areas. The comparative figures for the total Victorian population was 68.3 per cent and 19.3 per cent respectively (ABS 1998).

Quality, detailed data on the health status of Victorian Kooris is generally not available. But a recent study of the burden of mortality in Victoria estimated the life expectancy of Victorian Kooris to be between 57.1 to 67.2 years for men (8–18 years less than for non-Aboriginal Victorian men) and 62.5 to 72.5 years for women (9–18 years less than for non-Aboriginal Victorian women) (PHDD 1999). With respect to illness in the Koori community (and in relation to non-Indigenous Victorians) we can assume that, even allowing for some regional variation, the patterns of morbidity are similar to that documented elsewhere in Australia (ABS/AIHW 1999). Pertinent features of this include:

- a relatively high burden of chronic illness morbidity due to non-insulin dependent diabetes, ischaemic heart disease, stroke, and end-stage renal disease;
- a relatively high burden of mental illness, substance misuse, and related social and emotional health problems;

- relatively poorer maternal and child health outcomes (such as low birth weight and childhood infectious disease);
- relatively higher rates of fatal and non-fatal injuries; and
- for some infectious diseases, relatively higher rates of morbidity and mortality (such as respiratory infections, etc.).

Aboriginal and Torres Strait Islander people currently access primary health care services through a variety of different institutional structures. For instance, a Commonwealth strategy document identified a range of primary health care providers nationally relevant to Indigenous Australians (DHFS 1997: 252). These included:

- *Aboriginal community controlled health service*
- *General practitioners in private practice*
- *Mainstream community health centres*
- *State - or Territory-funded primary care clinics*
- *Outpatients or emergency departments of hospitals*
- *Royal Flying Doctor Service*

A range of additional providers—including pharmacists, alternative health care specialists (e.g., chiropractors, naturopaths, traditional healers) and dental services—could also be listed. Furthermore, if we shift our focus from the institutional structures to primary health care workers, we would need to consider the critical role played by Aboriginal health workers and Aboriginal hospital liaison officers in the delivery of Indigenous primary health care services. It is likely that the range and mix of services utilised by Aboriginal people in a particular region will depend on a number of factors, including service availability, accessibility and the perceived relevance of such services. This assumption also underlies the current approach to policy.

In planning for improved primary health care delivery in Koori Victoria, it would be beneficial to have a detailed picture of the current mix of services engaged in Koori primary health care. While it is generally accepted that Aboriginal and Torres Strait Islander people use a mix of Indigenous-specific and mainstream primary care services, quality data is not available. Some data on patterns of service utilisation was provided in the National Aboriginal and Torres Strait Islander Survey (conducted by the ABS in 1994), but the lack of detail in the information sought and the poor comparability of this data with that collected in non-Indigenous contexts limited the usefulness of the information (Anderson & Sibthorpe 1996). In the BEACH (Bettering Evaluation and the Care of Health) program, an ongoing national study of general practice activity that collects information about general practice encounters from some 1000 GPs, each

patient was asked whether or not they identified themselves as an Aboriginal and/or a Torres Strait Islander. Of all the encounters recorded, 1.2 per cent of patients stated that they were either Aboriginal and/or a Torres Strait Islander. The study's authors (Britt, *et al.* 1999: 134–9) claim that this represents a greater number of consultations than is currently conducted by Aboriginal medical services. However, they concede that the figures may be an overestimate of consultations in private general practice given that some of the participating general practitioners may have recorded activity conducted in Aboriginal community controlled health services. However, it was not clear how the estimates of general practice encounters in Aboriginal community controlled health services were reached. Nevertheless, the point to be made from this study is that Koori people do access, to varying degrees, mainstream general practice. The development of quality utilisation data would greatly assist policy in this area.

In Victoria the Aboriginal community controlled sector has been influential in the development of Koori primary health care provision since the first such organisation was developed in Fitzroy in 1973. Currently, these organisations provide a range of primary health care services, including clinical care, dental care, health promotion/education, maternal and child health, disability support, mental health, and essential drugs programs. Only a few of these organisations have a full range of general practice and related primary health care services, while others supply a mix of primary care services. In addition there are a few community organisations that have a particular focus, for example, in substance misuse programs. Critically, the Aboriginal Community Controlled Health Services (ACCHS) provide a point of access and referral to mainstream health and community services.

In policy and planning the Aboriginal community controlled health organisations are represented by The Victorian Aboriginal Community Controlled Health Organisation (VACCHO). Formally, this organisation is the peak advocacy body for twenty-five organisations across the State. VACCHO is affiliated with the National Aboriginal Community Controlled Health Organisation (NACCHO)—the national peak body.

Operational models for Koori primary health care

Currently there is no agreed operational model for the provision of Aboriginal-specific primary health care services in urban/rural regions such as Victoria. Work has been developed that translated the *Declaration of Alma-Ata* primary health care concepts into a model that can be used as a basis for resource allocation and planning. One approach has been to define the components of primary health care. Consider, for example, Figure 2, which presents a composite list of components of primary health care that have been developed from the WHO framework. In relation to Koori health, some immediately apparent problems emerge from this model. For instance, there is no mention of chronic disease management, a critical issue in Koori health. Further, the prevention and control of locally endemic (vector-borne) disease is not an issue for Koori health in Victoria. These operational models must be specific to health needs.

Figure 2: WHO derived model of core components of primary health care

- Education concerning prevailing health problems and method of preventing and controlling them.
- Promotion of food supply and proper nutrition.
- An adequate supply of safe water and basic sanitation.
- Maternal and child health, including family planning, prenatal care, qualified birth attendance, care of newborn, and monitoring child growth.
- Immunisation against the major infectious diseases.
- Prevention and control of locally endemic (vector-borne) diseases.
- Appropriate treatment of common disease and injuries; and the provision of essential drugs.
- Basic oral health care.
- Mental health care.
- Care of the physically disabled.
- The use of effective traditional medicines.

(Derived from Zakus 1998)

The Remote Areas Issues Sub-Committee of the Aboriginal and Torres Strait Islander Health Council commissioned a discussion paper to develop a model for the provision of remote area primary health care (RAIS 1997). This model (summarised in Figure 3) not only describes the relevant components of care but also defines the support systems required to sustain delivery (such as management, information systems), and presumes that no other services are available for people to use (not unreasonable in remote communities). However, in Victoria, Kooris rely on Aboriginal community organisations for many of their service needs, but also use and interact with mainstream services. Linkage and advocacy functions are critical in this context. It also means that what is needed within Indigenous-specific primary care varies according to local and regional patterns of access.

Figure 3: Remote area Aboriginal primary health care model

Primary clinical care

- Treatment of illness, using standard treatment protocols.
- 24-hour emergency care.
- 24-hour access to the advice of a doctor, either onsite or via telecommunications.
- Ongoing management of chronic illness.
- Provision of essential drugs.

Population health/preventative care

- Immunisation.
- Antenatal care.
- Appropriate screening and early intervention (including growth monitoring, well-women's checks, and well-men's checks).
- STD management activities.
- Secondary prevention of complications of chronic diseases.

Specialist and ancillary services

- Appropriate visiting specialist and allied health professionals (including dental, mental health, and environmental health services).
- Medical evacuation services.
- Access to hospital facilities.
- Costs of transport and accommodation to access specialist and ancillary care.

Support systems needed for delivery of primary health care

- A comprehensive health information system including functional medical records; a population register and recall systems to support population health activities; a chronic disease register and recall systems to support the ongoing management of chronic diseases; and data collection to enhance evaluation and quality assurance.
- Staff training and support, including Aboriginal health workers' education; orientation of new staff in the management and presentation of major illness problems, as well as in cross-cultural and other issues, and continuing education opportunities for all staff.
- Financially accountable management systems that include effective recruitment and termination practice. Where primary health care is managed by a community organisation, it must be adequately resourced to implement and maintain good management systems.
- Adequate infrastructure at the community level, including staff housing and clinic facilities.
- Functional transport facilities so that people can access appropriate health care when needed. This includes roads, airstrips and the use of road and air transport.

(Derived from RAIS: 1997)

Operational models for Koori primary health care need to take into account:

- distribution of the Koori population in Victoria;
- health needs of the Victorian Koori community;
- current patterns of service utilisation by Victorian Kooris and the cultural, social and economic factors that shape this; and
- current evidence concerning the factors that impact on the effectiveness and efficiency of primary health care.

Therefore, it is necessary to develop operational models *specific* to the context and circumstances of Koori primary health care delivery in Victoria. This would articulate:

- the components of primary health care services provided for (primary clinical care, maternal and child health services, health promotion, etc.);
- resources and technical infrastructure required to administer, plan and co-ordinate integration of services;
- the mechanisms needed to develop and sustain service delivery collaborations between primary care services, community services and non-primary health services;
- the mechanisms necessary to develop and sustain supportive collaborations between organisations and structures important for the development of the primary care workforce, thereby promoting evidence-based service delivery and encouraging the development of collaborations;
- an approach to the governance of Koori primary health care that balances support for community control with measures to ensure that mainstream health services share the responsibility for Koori health care provision;
- the funding structures, accountability requirements and performance measures that provide the basis of this system of care; and
- capital infrastructure required to support such program delivery.

Planning Koori Primary Health Care Services

Recent Commonwealth developments

In November 1996, a Framework Agreement on Aboriginal and Torres Strait Islander Health, valid until 30 June 2000, was signed between the Commonwealth government, State government, Aboriginal and Torres Strait Islander Commission, and the Victorian Aboriginal Community Controlled Health Organisation (DHS, *et al.* 1996). Signatories of this agreement are not bound to achieve specific targets. As with the Framework Agreements more generally, the parties have agreed to contribute jointly to strategies that aim to improve Koori access to mainstream and Aboriginal-specific services and achieve equitable health outcomes for Koori people relative to the broader community. The Victorian Advisory Council on Koori Health, a State-level body comprising members of all the signatory parties, is responsible for implementing joint planning.

The Commonwealth approach to regional planning was outlined in a series of papers developed in the early stages of the implementation of the Framework Agreement structures (OATSIHS 1996a; 1996b; 1996c; 1996d). The overarching aim of the regional planning process was to identify gaps and opportunities in health service provision, and identify priorities to improve health services (including mainstream services) and environmental health in the region. Six elements of regional planning were identified and agreed upon by the Australian Aboriginal and Torres Strait Islander Health Council and the Australian Health Ministers' conference (OATSIHS 1996c: no pagination):

- *To allow for full and formal Aboriginal and Torres Strait Islander participation in decision making and determination of priorities.*
- *To generate and present data to facilitate analysis and decision making and, where possible, improve the quality of the data available.*
- *To identify priorities, on the basis of transparent measures of relative need, in regions or communities within regions, where some action could be taken to improve the health status and/or access to health services.*
- *To involve all players in identifying problems and devising co-operative, co-ordinated solutions to health issues, including the mainstream sector and those responsible for environmental health.*
- *To inform funding decisions with respect to new and existing health services for Aboriginal and Torres Strait Islander peoples.*
- *To monitor effort and report on the implementation of regional plans.*

The focus on primary health care was not well developed in these early regional planning documents. However, in 1996–97 the Commonwealth made an additional \$24 million available for the development of primary health care services in thirty-five remote Aboriginal and Torres Strait Islander communities that had no, or inadequate, access to such services. A draft discussion paper providing guidelines for this was produced (OATSIHS 1996b). The Remote Areas Issues Sub-committee of the Aboriginal and Torres Strait Islander Health Council subsequently commissioned some modelling work for remote area primary health care to assist this process (RAIS 1997).

Nationally, by August 1999 Aboriginal Health Framework Agreements had been signed in all jurisdictions but progress in the development of regional plans was still at various stages. By this time, regional planning forums had been established in all States and Territories (including the national forum, the Aboriginal and Torres Strait Islander Health Council); regional plans completed for South Australia, Central Australia (Northern Territory) and Queensland (DHAC 1999a). The Commonwealth allocated \$6.8 million in the 1999–2000 financial year through its new Primary Health Care Access Program to priorities identified within these completed regional plans (DHAC 1999a).

To date, a Victorian regional plan has not been completed, although VACKH has initiated some developmental work towards the plan, which was completed in June 2000. There remains, however, some uncertainty about the scope of the regional planning process in Victoria. There have been a number of concurrent developments within both the mainstream State primary health care sector, and the Koori community service sector, which also need to be considered within the context of service planning. Furthermore, the relationship between the Commonwealth and State planning processes remains unclear.

Recent Victorian developments

In parallel with some of the developments in Commonwealth policy in Aboriginal primary health care, there have been three relevant strategic frameworks developed in Victoria. These include: the Victorian Primary Health and Community Sector Services Reform Strategy (PHACS, now replaced with Primary Care Partnerships); the Koori Health Reform Strategy (KHRS, and the related Health Outcome Agreements) and the Koori Services Improvement Strategy (KSIS). These are described below.

Primary Health and Community Services Reform Strategy to Primary Care Partnerships

The PHACS reform aimed to develop effective collaborations between primary health and community services so those clients could receive appropriate care regardless of their point of entry into the health sector. It was anticipated that horizontal

collaborations would be developed between services in aged care, community health (e.g., health promotion, community education, skills development), drug treatment, dental care, and mental health (DHS 1998e: ix-x). The PHACS was to involve 'those services to which most people usually turn first when they are sick, injured, or having difficulty coping with their life circumstances' (DHS 1998e: xviii). The original list of PHACS services to be included in the reform extended primary health well beyond clinical services, and included:

- medical treatment and advice by GPs in clinics, home or residential settings;
- therapy and treatment services (e.g., counselling, allied health services, community nursing) in non-institutional, community-based settings or in the home;
- the development of networks and self-help strategies reducing reliance on direct services;
- provision of community support for frail and elderly people to be able to live independently at home;
- strategies oriented towards prevention and health promotion (e.g., early identification, intervention, information and education services);
- rehabilitation and support for people with long-term illness, disability, or continuing care needs enabling them to live in the community;
- medical, nursing and allied health services oriented towards people who would otherwise be in hospital or those discharged to intensive home-based care; and
- provision of treatment and health maintenance services by pharmacists in community pharmacies.

The PHACS also provided a framework through which unit-costing funding models would be introduced into the health and community services sectors. Koori services were not included in the original PHACS purchasing framework, but tender specifications required that PHACS groups establish effective service links with Aboriginal community controlled health services and meet the needs of the whole population in the catchment area (DHS 1998e: 45-47; DHS 1999a: 55). Uptake of this strategy by the Koori community sector was limited (with only a couple of rural communities using PHACS as a framework for reform). With its emphasis on contestability the PHACS would have been, at best, poorly integrated with the approach adopted by the Commonwealth in regional planning, and, at worst, may even have undermined the development of collaborations between Indigenous-specific and mainstream services.

The incoming Labor government reviewed the approach to primary health care reform and commissioned an independent review of primary health care development. The review, however, did not give any consideration to Koori health issues or involve interviews with any stakeholders in Koori health (Raysmith 2000). But the findings of the review did signal a shift in policy direction, including a move away from the central role given to competitive tendering. The new directions in policy were consolidated in a strategy statement 'Primary Care Partnerships: Going Forward' released in April 2000. In this statement, it was indicated that 'funding and support will be provided to groups of primary care providers that form, or have already formed, voluntary alliances in their local communities. These alliances, called Primary Care Partnerships (PCP), usually involve agencies which together cover two or three local government areas' (DHS 2000: 5). It is further intended that these Primary Care Partnerships will develop and implement Community Health Plans that include three main elements: service planning, service co-ordination and service partnerships. Again, no detail is provided in the document regarding Koori primary care. However, in the foreword it is stated that the Primary Care Partnership Strategy recognised and aimed to build on the primary care collaborations developed to date, including the Health Outcomes Agreement signed by DHS and VACCHO in 1996. This suggests, although it is not explicitly stated, that the Health Outcomes Agreements are being seen as the Koori version of the Primary Care Partnerships. If this is the case, further work will need to occur to develop the links between Health Outcomes Agreements (which develop service relationships) and community planning (which will presumably set local and regional population health priorities).

Both the KHRS and the KSIS were developed by the Department of Human Services in consultation with Victorian Koori communities. Based on the regional/local development of priorities, strategy and implementation through processes that facilitate the full participation of Kooris, both strategies also advocate partnerships between mainstream and Aboriginal-specific services to meet Koori needs.

The Koori Health Reform Strategy

The KHRS advocates the development of a network of adequately resourced Aboriginal health services and community organisations that are collaboratively linked to relevant mainstream services through Health Outcome Agreements, which are regionally focused. In principle, it was envisioned that each Aboriginal Health Service would co-ordinate the planning process for development of Health Outcome Agreements, which 'will provide a framework for the Aboriginal Health Services and other agencies to develop strategies for responding to particular health issues' (DHS & VACCHO 1997: 3). The Health Outcome Agreements are not legally binding documents, but an 'expression of agreed objectives and arrangements' (DHS & VACCHO 1997: 7). The primary underlying principle of the KHRS is that 'improved health for Aboriginal people will only be achieved when Aboriginal people and their

organisations are empowered to act on their own behalf and *when adequate resources are available* (DHS & VACCHO 1997: 1, emphasis added). Implicit in this arrangement is the assumption that resources, time and skills are available in Aboriginal community controlled health services for development and implementation of these agreements.

For example, the Rumbalara Aboriginal Co-operative developed a Health Outcome Agreement with the Goulburn Valley Base Hospital in the Hume region (RAC & GVBH 1998). Initially, consultation was held with the local Koori community to identify priority issues for Aboriginal health and appropriate strategies for dealing with them (RAC 1997). Following this, the hospital was consulted to determine an implementation plan to meet these health needs, and consequently a Health Outcomes Agreement was negotiated. Although this is encouraging, the Goulburn Valley Base Hospital has been the only mainstream service provider involved in this process to date.

In addition to the Hume region, two other areas were chosen to pilot Health Outcome Agreements—Lodden Mallee and Northern Metropolitan Region—with two more regions to be selected shortly. Funding was provided in 1997–98 to assist Aboriginal Health Services in these regions to implement this planning process. In a report to the Australian Health Ministers Council, it was identified that \$38,000 was targeted for the Hume Region and \$50,000 had been allocated to the Lodden Mallee Region (which actually includes five Aboriginal co-operatives) (DHAC 1999a). A further \$150,000 was allocated to the Loddon Mallee to develop and implement the related Koori Services Improvement Strategy (see below) (DHAC 1999a). To date, only one Health Outcome Agreement has been signed, although the planning process has been initiated in all three regions. While the whole process is progressing slower than expected, and despite the lack of formal agreements, anecdotal reports indicate that some good links have been formed between Aboriginal Health Services and mainstream services.

The Koori Services Improvement Strategy

The Koori Services Improvement Strategy developed by Aboriginal Affairs Victoria aims to incorporate Koori well-being into all DHS divisional and regional programs, including health (DHS 1998a; see for example DHS 1998b). Although in some respects the KSIS and KHRS are similar, the stakeholders within the Koori community for each strategy differ in some respects. The KHRS draws in those directly involved in Koori health (including the VACCHO membership) while the KSIS also involves those community organisations involved in the delivery of Koori community services. Further, the locus for development of the KHRS lies within the community sector, while the KSIS appears to focus primarily on the DHS's leading role. The KSIS also has a distinctive approach to facilitating participation of Kooris

through local/regional and State reference groups. In negotiation with these reference groups, it was intended that the regional DHS offices would develop Koori Community Service Plans as a basis for a Statewide Service Plan. It was intended that these plans would incorporate all services funded by the DHS, not only health services. The Statewide Service Plan has not yet been completed.

DHS and planning in Koori primary health care

It is not clear, given the change of government, how either the KSIS or the KHRS will be further developed. This is an area of government policy that has yet to be clearly articulated. Before any further strategic planning is done with respect to Koori primary health care, it would be important to obtain a much clearer picture of the uptake and outcomes to date of both the KSIS and KHRS. Information from the pilot initiatives has been largely anecdotal, and without formal evaluation it is not possible to make evidence-based judgments concerning the further development of an effective planning framework. Furthermore, the development of two distinct, but similar planning frameworks, by the DHS suggests that approaches to Koori primary health care and community services planning and development need to be further integrated.

Progress in Commonwealth regional planning in Koori health

In Victoria, Commonwealth regional planning has been relatively slow to develop. Some of the consultation and policy development work that will inform the health plan has been commenced and preliminary outputs were made available to the VACKH stakeholders in June 2000. Further, it does seem that the broad approaches taken by the Victorian DHS and the Commonwealth to primary care development are now more closely aligned than when the Framework Agreements in Aboriginal health were originally signed. However, there are a number of issues that need to be resolved, through consensus, by all the stakeholders.

First, the relationship between the four distinct planning frameworks (VACKH, PCP, KSIS, KHRS) relevant to Koori primary health need to be thought through if there is to be effective integration of the planning processes. At an even more basic level there needs to be an agreement between the stakeholders regarding the definition of a region within the Commonwealth regional planning process, and agreement concerning how this relates both to DHS and ATSIC regions. It would also assist planning if a consensus view were to be developed concerning the components of primary health care (or broader operational models) that need to be supported within the Victorian context. In addition, a more collaborative approach to planning in Koori primary health care needs to take into account the relationship between service planning and Koori community processes and structures. Particular approaches to planning may have different implications in terms of the particular set of Koori community stakeholders that needs to be engaged in the planning process.

The Framework Agreements commit signatories to the joint planning process, as a basis for a more rational approach to providing resources for Koori health. The failure to develop a regional plan is a significant barrier to the development of a collaborative allocation of funding to Koori health. In the last section of this paper we will illustrate the relevance of these development agendas by focusing on those issues in Commonwealth strategy most directly relevant to primary health care. These are:

- developing the infrastructure and resources necessary to achieve comprehensive and effective primary health care for Indigenous peoples;
- addressing some of the specific health issues and risk factors affecting the health status of Indigenous peoples; and
- improving the evidence base which underpins the health interventions.

Section 2: Developmental Issues for Primary Health Care

Financing and funding of Koori primary health care

There are two broad issues that need to be considered with respect to the funding and financing of Koori primary health care. Firstly, it is necessary to look at the issues that relate to the funding of Indigenous-specific primary health care services, in particular the Aboriginal community controlled health organisations. Secondly, there is a growing argument that suggests it is also critical to reform Indigenous access to mainstream primary health-funding programs such as the Medical and Pharmaceutical Benefits Schemes (see below) (see DHS & VACCHO 1997: 1).

Issues related to funding Aboriginal community controlled health organisations have not been explored in great detail for services in regions such as Victoria. The questions that are important in this regard should not only be focused on the appropriate level of funding for these services, but also on the mechanisms for funding. In particular, it is important to consider how accountabilities or reporting arrangements should be built into Koori health programs. These issues are particularly vital given that Aboriginal Health Services and co-operatives are funded in Victoria by a mix of program grants from the Commonwealth (OATSIHS and ATSIIC) and the DHS, which often have distinct reporting arrangements and accountabilities. This mix of different grant programs may or may not add up to a coherent primary health care program. Further reform could also focus on reduction of administrative complexity. In addition, it should be possible to align that approach to funding from the relevant agencies in a way that better supports ACCHS adopting an outcomes-focused or strategic approach to organising the delivery of their services.

More generally, the case for reforming the financing of Koori primary health care has

been built on a comprehensive review of expenditure on health services for Aboriginal and Torres Strait Islander people (Deeble, *et al.* 1998). The National Centre for Epidemiology and Population Health (NCEPH) at the Australian National University and the Australian Institute of Health and Welfare (AIHW) conducted this review, which used a narrow definition of health services as 'only formal activities directed *primarily* towards improving health or reducing the effects of illness and injury' (Deeble, *et al.* 1998: 2–3; emphasis in original). Compared to other Australians of a similar income group, expenditure on the health of Aboriginal and Torres Strait Islander people is about the same, despite their worse health status (Deeble, *et al.* 1998: ix). This suggests that, given the greater burden of morbidity in Aboriginal Australia, Indigenous health is not currently financed on the basis of need.

In 1995–96, the Commonwealth provided 11 per cent of the combined Commonwealth/State governments' expenditure on services to Indigenous people. According to the AIHW/NCEPH study, if all Commonwealth expenditure is considered, the per capita expenditure for and by Indigenous Australians was 63 per cent of that of non-Indigenous Australians (Deeble, *et al.* 1998: 12). In addition to Aboriginal utilisation of mainstream services, as funded through the Medical and Pharmaceutical Benefits Schemes (MBS, PBS), the Commonwealth also funds an Aboriginal health program that provides core funding to Aboriginal community controlled health services and substance misuse services across Australia.

The Medical and Pharmaceutical Benefits Schemes are Commonwealth-funded primary health care programs available to all Australians. However, Indigenous Australians have limited access to these schemes. In 1995–96 an Indigenous person's benefits under Medicare was only 27 per cent of the average spent on a non-Indigenous person, and the proportion was only 22 per cent for prescribed drugs (Deeble, *et al.* 1998: viii). A report prepared for the Health Insurance Commission (HIC) identified that between 15–38 per cent of Aboriginal and Torres Strait Islanders do not have an effective Medicare card/number, including those who have previously held them (Keys Young, 1997: ii). Identified barriers for Indigenous access to these schemes are as follows:

- Lack of proof of Australian residency (e.g., exact spelling of the name, signature of a birth parent, precise date of birth, etc.). The HIC introduced the option of a referee attesting to the identity of a person and hence eligibility for Medicare. However, this option is not practised widely, and administrative staff may not be aware of it.
- Medicare card-holders are sometimes denied access to health care because some practitioners, specialists in particular, do not bulk-bill. This is more of an issue in rural and remote areas where there are fewer health providers. Consequently, either an Indigenous client must meet the fee costs or seek another service provider, both of which may delay treatment. This can also lead to late

presentation at a tertiary health institution, which will ultimately cost the government more and consequently worsen Aboriginal health status. Research regarding reasons for poor presentation for cervical and breast cancer screening has found that lack of bulk-billing is a factor that discourages screening and maintenance of treatment (Kirk, *et al.* 1998; 2000).

- Identifying and retaining a health care card presents a barrier for Indigenous peoples' access to the Pharmaceutical Benefits Scheme. Secondly, even the subsidised fee for each prescription (\$2.70) may be prohibitive.
- Medicines for health problems common among Indigenous groups, such as topical steroids, antihistamines, anti-fungals, etc., are not on the Pharmaceutical Benefits Scheme's list.

The Commonwealth government is the most significant funder of primary health care in Australia. It directly subsidises primary health care through the Medical Benefits Scheme and the Pharmaceutical Benefits Scheme. It also provides some funding directly for primary care related services and indirectly through agreements such as the Australian Health Care Agreements. The relatively low investment of Commonwealth health portfolio resources in Aboriginal health does suggest a global problem in the provision of primary care finances. However, States also give funding for mainstream primary health care and related population health programs and, in some cases, also directly fund Aboriginal-specific primary health care programs.

States and Territories manage nearly 80 per cent of all services for Aboriginal people (combined Commonwealth and State/Territories source) (Deeble, *et al.* 1998: 12). In Victoria, the Department of Human Services funds specific primary health programs in Aboriginal Health Services on a submission basis (e.g., PapScreen Victoria Koori Program, Koori Diabetes Service) (DHS 1998d: 35). No discrete funding for Aboriginal or Torres Strait Islander people is available within mainstream primary health programs (e.g., community health, women's health, sexual assault services, family planning, and the homeless youth program) (DHS 1998d: 34).

Nationally, gross expenditures through State and local government programs are relatively higher with respect to Aboriginal and Torres Strait Islanders at a ratio of 2.19:1 (Deeble, *et al.* 1998). This is a consequence of a number of factors. States and Territories provide, in some jurisdictions, Indigenous-specific primary care services. Use of acute-care hospital services is relatively higher, reflecting patterns of morbidity and, in some instances, poorer access to comprehensive primary health care. This level of government also picks up the cost of transporting patients from geographically remote centres. In all other States, per capita expenditure on community health services for Indigenous people is on average approximately two to three times higher than for other Australians (Deeble, *et al.* 1998: 120–2). In Victoria it was estimated that gross per capita expenditure on community health services for Kooris is

approximately 30 per cent less than for other Victorians (Deeble, *et al.* 1998: 120). However, there were general problems in the provision of State estimates for this study. Victoria initially only provided data on the limited Indigenous-specific program expenditure, then provided estimates of inpatient expenditure using hospital morbidity data routinely provided to the AIHW. The error in identification within data sets was estimated to be greater in Victoria, relative to some other jurisdictions (Deeble, *et al.* 1998: 28–9).

There has been some limited progress in the reform of the MBS and PBS. In order to improve access to the Medical Benefits Scheme, the Commonwealth has made it possible for Aboriginal community controlled health services to bulk-bill eligible services by salaried doctors to the MBS. These additional funds are then used by Aboriginal Health Services (DHFS 1997: 264). The Health Insurance Commission has also indicated that it will work with services to pilot new approaches to enrolment, bulk-billing and the renewal of Medicare cards in remote communities. Reform of the provision of pharmaceuticals has also been focused on developing strategies to streamline access to pharmaceuticals, at no cost, using an administrative arrangement provided for by section 100 of the National Health Act (DHAC 1999a). The administrative reforms of the MBS and PBS have only been progressed to date in remote/rural regions. The pooling of MBS and PBS with other funding streams as part of the Commonwealth co-ordinated care trials is also currently being investigated as a model for the funding of primary care.

Funding reform in Aboriginal health tends to follow the mainstream agenda, and consequently there has been a general shift in both the Commonwealth and State sectors towards outcomes/output-oriented funding. The approach taken, however, does differ. The Commonwealth has recently introduced annual service activity (or performance indicator) reports for Aboriginal Health Services.³ For 1999 a newly developed service activity report was introduced, with service funding tied to the completion of this report (interview with Nancy Walke, June 1999). Activity reporting may be regarded as a shift towards output-based funding at the Commonwealth level. These reports include narrative/qualitative indicators—for example, lists and brief descriptions of components of primary health care work undertaken—but these are not linked directly to health care for individuals. They also include population-based health promotion work, community development work, and screening campaigns (NACCHO & DHAC 1998: 5). Health outcome indicators (e.g., life expectancy, decrease in heart disease) are not used in service activity reports, given the general difficulty in attributing specific health outcomes to the activities of an individual primary health care service provider.

³ We do not wish to infer that this was the first instance in which Aboriginal community controlled health services have been required to complete performance indicators reports (see Anderson & Brady 1995). It was, however, the first instance in which the reporting framework, process and approach to collation and analysis was developed collaboratively with the Aboriginal community sector.

The approach taken to developing output-based funding in DHS-funded services has focused on calculating the unit costs of services, and developing funding formulae on this basis. Some Aboriginal Health Service programs are now funded on this basis, although there has not been any specific work to date which analyses the relative costs of providing services in Aboriginal contexts.

Output-based funding is a somewhat general goal in health sector reform, and a number of possible strategies are being taken to reach it. In the case of Koori health, it is important that any approaches to reform across all levels of government is integrated, otherwise some of the current complexities that Aboriginal co-operatives encounter in the administration of primary care funds may actually worsen. A key challenge in developing an integrated (Commonwealth/State) approach to funding reform in Koori primary health care is to develop agreed models for Aboriginal-specific primary health care programs that are relevant to Victorian circumstances.

Developing an effective primary health care workforce

Koori health providers

In 1996, in the Victorian *State-funded* health sector, there were approximately 66,000 employees, of whom only forty-seven were identified as being Koori (DHS 1998d: 60). Most of these employees were Koori hospital liaison officers, drug and alcohol workers, etc. The Medical Practitioners Board and the Nurses Registration Board do not have information about the number of doctors and nurses who identify as Aboriginal and/or Torres Strait Islander (DHS 1998d: 62). Since 1998, it is no longer mandatory for government departments in Victoria to report Aboriginal employment initiatives or figures (DHS 1998d: 60). The Office for Aboriginal and Torres Strait Islander Health's preliminary data indicate that there are twenty-seven Aboriginal doctors in Australia (NHIMG 1999: v).

Aboriginal health workers have become pivotal to primary health in Indigenous Australian communities, as they provide 'culturally appropriate health services to Aboriginal people, and contribute to improving the health of Aboriginal communities' (Adams & Spratling 1999: 9). Today they are employed in a number of primary care and related health services including Aboriginal community controlled health services, State/Territory community health services and hospitals. As workers in mainstream health care contexts, they have a key role in creating accessible, user-friendly services for Koori clients (DHS 1998c: 3-6). In primary care services, such as Aboriginal community controlled health services, their roles are diverse and include primary clinical care, case management, screening, administration, health promotion/education, and so on. In Victoria, seventy-three Aboriginal health workers were employed by Aboriginal Health Services in 1998 (Adams & Spratling 1999: 13).

Since 1989, there has been no accredited training program for Aboriginal Health Workers in Victoria (DHS 1998d: 57), with the only prerequisite a Victorian driver's licence. In practice, 48 per cent have successfully completed accredited training, most commonly in nursing and dental nursing (Adams & Spratling 1999: 39), while the rest have little or no formal training. Relatively fewer men work as Aboriginal health workers, which is a problem in developing appropriate Koori men's programs. For instance, of all the Aboriginal health workers in Victoria in 1998, 72 per cent were women and 28 per cent were men (Adams & Spratling 1999).

In August 1998, the Victorian Aboriginal Community Controlled Health Organisation was funded to develop an accredited training course for Aboriginal health workers in Victoria. Training in this program commenced in 2000. Other organisations in Victoria have also been developing training courses for Aboriginal health workers; these include the Koorie Diabetes Services Victoria (Diabetes Educator Training), VACCHO (spiritual and emotional well-being training) and Turning Point (drug and alcohol worker training) (Adams & Spratling 1999: 46). Nationally, relevant recent developments include national competency standards for Aboriginal and Torres Strait Islander health workers by the Australian National Training Authority in 1996 (Adams & Spratling 1999: 42), and a current national review of the training of Aboriginal health workers conducted by the Office for Aboriginal and Torres Strait Islander Health. The competency standards could potentially be used as a benchmark against which training courses for Aboriginal health workers can be accredited, assessed and reviewed.

Non-Indigenous health providers and Aboriginal health

Aboriginal Health Services find it difficult to attract and retain health care providers (DHFS 1998: 148-152). Such a high turnover is likely to undermine continuity of care, which is an acute issue in rural areas. However, similar problems also exist in urban areas. Lack of incentives for general practitioners to work in Aboriginal health (especially in rural and remote areas) include lower earning potential, less favourable conditions of employment, stress associated with living in a different cultural environment, isolation, and low status in terms of career advancement for those who choose to work in Aboriginal practice (DHFS 1998: 151).

The Commonwealth government has addressed some of these issues by providing \$8 million for the construction of housing for doctors in remote communities and payments to general practitioners for training expenses and relocation to rural/remote areas (DHFS 1997: 272; Swerissen & Duckett 1997: 18). For urban regions it is likely that the barriers to effective recruitment and retention are in some respects different. Private general practice, for example, has the potential to provide general practitioners with greater earning capacity. In Victoria, an Aboriginal health recruitment and promotion service has been established (DHFS 1997: 273) in collaboration with VACCHO, the major focus of which

is to provide recruitment support across all staff categories to the community-controlled sector. It is also expected to offer recruitment support to mainstream services.

In Victoria, there is no requirement that hospitals provide Aboriginal cultural awareness programs for staff (DHS 1998d: 63), although such courses are available (twenty to thirty providers in Victoria) and hospitals may apply to the State government for funding. We argue that hospitals themselves should ensure that all staff members participate in these courses, and that this becomes a prerequisite for accreditation of all public and private hospitals. In addition, partnerships between Aboriginal and mainstream services, advocated by the Koori Services Improvement Strategy and the Koori Health Development Strategy, will promote cross-cultural exchange and increase awareness in mainstream organisations of Aboriginal cultural issues. For example, the Health Outcomes Agreement between the Rumbalara Aboriginal Co-operative and the Goulburn Valley Base Hospital includes cross-cultural training for hospital staff members who provide services to Koori communities, and an exchange of staff between these two health care providers (RAC & GVBH 1998). This partnership arrangement is also applicable to other mainstream health care providers.

In order to improve the provision of primary health care services to Kooris by health providers, it is necessary to improve the inclusion of Koori issues in existing mainstream training structures. The General Practice Strategy Review (DHFS 1998: 158) noted that Aboriginal health issues should become an integral part of academic training for medical students and vocational trainees. In addition, it advocated that students and trainees gain clinical experience of working with Indigenous people within these courses. Continuing medical education needs to be provided in the area of Indigenous health by educational institutions (DHFS 1998: 158).

A sustained improvement in the quality of the delivery of primary health care services will require focusing on the upgrading of skills in the health workforce. Critically, a Statewide plan in Indigenous health will need to articulate a workforce development strategy. This will focus on Aboriginal health worker training, improved participation of Kooris in health sciences education, and improved training in Koori health of non-Indigenous health care providers. Victorian workforce development initiatives need to be co-ordinated, and linked to a Commonwealth-wide strategic framework for Aboriginal health worker training and education (Schwab & Anderson 1998: viii). Any Statewide approach to strengthen the provision of educational support to Aboriginal health workers will need to provide pathways for health workers into other higher education health programs. In addition, ways of recruiting Indigenous students into the health sciences need to be developed within an understanding of national strategies (DHFS 1998: 155; Schwab & Anderson 1998: viii).

Developing health information systems and research to support primary health care

Health information systems

One of the critical deficiencies in Aboriginal health policy and strategy is the poor quality of existing health information systems, and research and evaluation practices. For example, the effective development of health policy and health services, as well as the implementation, monitoring and evaluation of programs, requires a knowledge of the size and the health of the total populations at State, regional and local levels. Accurate information, however, is not available for Indigenous Australians in Victoria. The Australian Bureau of Statistics estimates that approximately 90 per cent of Koori births and only 40 per cent of Koori deaths in Victoria are reported at present (ATSIHWIU, 1997:24). Incorrect recording of Aboriginal status and the failure of administrative staff (e.g., funeral directors) to complete relevant forms and submit them to government departments contribute to these gaps.

- Current health information sources about Koori people include:
- Aboriginal Health Service Activity Reports provided by the Commonwealth-funded services and collated for the first time in 1999.
- National surveys (e.g., National Aboriginal and Torres Strait Islander survey æNATSISæ or national survey activity in general). We also referred earlier in this paper to the work on general practice activities currently being auspiced through the Better Evaluation and Health Care program (NHIMG 1999: 35).
- Health service administrative collections (e.g., Victoria in-patient minimum database, communicable diseases and cancer data collections). Collections do not always include an Indigenous identifier; for example, the Victorian Communicable Disease data collection only has an Indigenous identifier for HIV (ATSIHWIU 1997: 108). Mainstream primary health services (e.g., general practitioners, community health centres) are not required to supply data.

Data quality is an issue in all these health information systems. Firstly, even when there is an Indigenous identifier—as occurs in the census, health service admission, and registration of births—service providers may fail to seek this information directly from their clients, or the clients fail to identify as being Aboriginal (DHS 1998d: 32). Secondly, Koori clients may be concerned about the potential misuse of information (ATSIHWIU 1997: 56). And thirdly, some collections do not include an Aboriginal identifier, such as data on sexually transmitted diseases excluding HIV. Poor quality data from health information systems undermines the ongoing planning and monitoring of Koori health interventions, both generally and in specific program areas such as cervical cancer (Baillie, *et al.* 1998: 303).

Recently a new national approach to the development of Indigenous health information systems was agreed (ATSIHWIU 1997). In Victoria, these issues are being addressed through the Koori Health Information Planning Group and the Koori Health Unit. In addition, the DHS is in the process of developing a Koori Information Plan to be endorsed by all divisions and regional offices. The following strategies have been outlined (ATSIHWIU 1997: xiv–xvii; DHS, *et al.* 1996: 6; DHS & VACCHO 1997: 3):

- Develop protocols to ensure sensitive handling of data supplied by Aboriginal clients, addressing ownership and appropriate use of data, and principles for returning information to communities.
- Promote the importance of collecting health information among Aboriginal communities, health agencies, and relevant government departments.
- Build the capacity of Indigenous communities to collect and use health information for planning and service delivery.
- Improve capacity of health and other related mainstream data collections to identify Indigenous people.
- Develop a national survey collection system for gathering national and State Indigenous statistics currently unavailable from administrative data collections.

Leaving aside issues in health information systems, research and evaluation could also contribute to developing the capacity of primary care services to deliver effective and efficient care. While Indigenous health research has documented and characterised Aboriginal and Torres Strait Islander health disadvantage, it has provided a poor focus on research and evaluation activities that might lead more directly to such improvements. In general, there is a need to strengthen the link between research and reform in Koori primary health care policy and practice. Over the last triennium, the National Health and Medical Research Council (NHMRC) has worked to develop a framework and methodology for priority-driven research in Aboriginal health (NHMRC 1998). Emphasis has been given to the development of research priorities that build collaborations between the research sector, ACCHS and communities, and those involved in Aboriginal and Torres Strait Islander health policy.

Conclusion: Regional Planning and Koori Primary Health Care

It would be wrong in this conclusion to focus only on the fact that there is still no collaboratively developed regional plan in Victoria as was anticipated under the Framework Agreements in Aboriginal Health. This remains a clear deficiency in Victorian Koori health policy and strategy, and one that will potentially disadvantage Victorian Kooris if the Commonwealth continues to lock new funding in primary health care to completed regional plans. However, there is strategy and program

development occurring that would be consistent with the activities anticipated in the Framework Agreements. For example, the workforce development activities and the work that is progressing to improve the quality of health information related data systems are entirely consistent with national priorities in Aboriginal health.

The lack of a regional plan is, in a sense, indicative of the failure to develop an integrated approach to Koori health in Victoria. This is an issue even within the Victorian Department of Human Services. As a consequence, it is not clear how the four distinct planning frameworks relevant to the development of Koori primary care services actually interrelate. While the strategic differences between these frameworks are less significant now than they were prior to the last State election, it is still not clear how the Commonwealth and State approaches to funding reform will be aligned. This would seem to be a particularly critical issue as Commonwealth and State agencies fund different components of the primary health services provided through the Aboriginal community controlled health services.

However, before any of this can progress there needs to be greater clarity about the model of Koori primary health care that is being operationalised. This is a necessary step if Commonwealth and State planning processes are to be better integrated.

Appendix 1: Contestability and Primary Health Care

Contestability in mainstream services

In 1995, a national competition policy was introduced into government-funded public services (Nevile 1999: 1). In order to provide the public with cost-effective quality services, competitive tendering was used as a mechanism for selecting service providers. This also involved a shift from recurrent funding to output- and outcome-based funding of services (DHCS 1994). In competitive tendering, a government department advertises for a particular type of service, including the budget allocation; interested providers respond to the request and, if successful, are awarded a tender (DHS 1999b). So far, competitive tendering has taken place in mainstream health and welfare services. There are a number of critical insights into competitive tendering for public services (see Hodge 1996; Muetzelfeldt 1999; Nevile 1999; PFCC 1999), as follows:

- Economic rationalisation underpins competitive tendering, bringing a focus on the lowest cost bids rather than service quality. However, there are examples in Great Britain of tender selection being based not only on price, but also on quality and public interest (Muetzelfeldt 1999: 166). Nevile (1999: 37) points out that government and non-government agencies believe that service providers' expertise and infrastructure must not be lost in the competitive tendering process.
- Governments are able to allocate fewer funds for private health services by excluding implicit costs (e.g., risk management) from contracts, which may disadvantage employees and clients.
- The government decides which services are to be provided and how much funding should be allocated for their provision; individuals' and communities' needs for the services may not be taken into account. For example, reducing eligibility for services may mean that individual clients need to seek services elsewhere. Alternatively, since health service providers are paid on the basis of the number of clients who have been discharged, this may lead to the burden of care provision shifting to families and relatives (e.g., day surgery). These alternatives hamper the disadvantaged, although the extent to which this is the case has not been extensively researched.
- The market model values efficiency over equity. Constant political justification is necessary to ensure that disadvantaged groups can access services.
- Fixed contracts with specified outcomes hinder services' ability to meet the changing needs of the population they serve. Hence, agencies lack the flexibility to increase the number of clients they are able to serve and the scope of services they provide.

Contestability in Aboriginal Health Services in Victoria

Commonwealth and State governments jointly fund Aboriginal community controlled health organisations. At the time of writing, there is no indication that the Commonwealth will introduce competitive tendering for Aboriginal services. The intention of the State, prior to the last election, was to subject Koori services to competitive tendering (DHS 1998a: 28). This was postponed in 1998 for a period of three years in a moratorium approved by the Victorian Health and Community Services Ministers. The KSIS stated that competitive tendering for Koori organisations would *only* proceed (DHS 1998a: 29, emphasis added) when there are:

- clearly defined service specifications (including those that address cultural issues associated with service provision to Koori communities), outputs, performance indicators and purchasing models in line with the Koori Services Improvement Strategy;
- Koori and/or culturally appropriate service providers who have reached an agreed skill capacity and resource base to be competitive; and
- culturally appropriate and acceptable alternative providers.

The Victorian government recognises that Koori organisations are preferable for service delivery to Aboriginal communities (DHS 1998a: 28). However, if the government selects 'culturally appropriate and acceptable alternative providers' for programs currently offered by Aboriginal Health Services, this will potentially lead to loss of community control.

An evaluation of the impact of competitive tendering in mainstream health and welfare services in Australia has so far been limited, mainly because the concept has only recently been introduced. However, an evaluation of the effect of competitive tendering on the provision of employment support services to Kooris in regional Victoria did point to significant disadvantages (Alford & Gullo, 2000). It would appear, then, that the potential disadvantages of competitive tendering are manifold (Nevile 1999), even though this may reflect policy implementation rather than the concept itself. For instance, competitive tendering:

- May act to discourage collaboration and co-operation between service providers (PF & CC 1999: 49). Competitive tendering has been reported to damage communication flows and information sharing between service providers (Nevile 1999: 18). Potentially, two Aboriginal community controlled health services may be competing for the same tender, undermining the Koori Health Development Strategy that advocates for a Statewide network of Aboriginal Health Services.

- Could increase administrative costs. Victorian welfare agencies reported that tender preparation costs between \$10,000 and \$20,000 (Nevile 1999: 10). Tender development also takes health care providers away from direct provision of care and diverts resources from this (Black 1995: 442; Smith 1999: 180). The costs involved in writing tenders cannot be recuperated if a tender is not won. Larger agencies that lose tenders may be able to cover these by using funds from other projects. However, the majority of Aboriginal community controlled services have an insufficient resource base and limited capacity to engage in such processes.
- Is short-term by nature. If the health of Aboriginal people is to improve, long-term strategies and continuity of care are essential. Three-year competitive tendering cycles leading to possible turnover of service providers and upheaval in service provision will have detrimental effects on Aboriginal well-being and community development.

References

- ABS 1998, *Census of Population and Housing, Aboriginal and Torres Strait Islander People, Victoria, 1996*, Commonwealth of Australia, Canberra
- ABS & AIHW 1999, *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*, Commonwealth of Australia, Canberra.
- Adams, K. & Spratling, M. 1999, *Future Directions for Aboriginal Health Worker Training in Victoria: A Report to VACCHO Members about Issues and Considerations Relating to the Development of Aboriginal Health Worker Training*, Victorian Aboriginal Community Controlled Health Organisation Inc., Melbourne.
- Alford, K. & Gullo, N. 2000, 'The Privatisation of Employment Services: Has it worked for the most disadvantaged', *Economic Papers*, vol. 19, pp. 65–79.
- Anderson, I. 1997, 'The National Aboriginal Health Strategy', in *Health Policy: Development, Implementation, and Evaluation in Australia*, ed. H. Gardner, Oxford University Press, Melbourne.
- Anderson, I. & Brady, M. 1995: 'Performance Indicators in Aboriginal Health', *Centre for Aboriginal Economic Policy Research Discussion Paper No. 81*, Centre for Aboriginal Economic Policy Research, Australian National University, Canberra.
- Anderson, I. & Sibthorpe, B. 1996, 'The NATSIS and Policy and Planning in Aboriginal Health', in *The 1994 National Aboriginal and Torres Strait Islander Survey*, eds J. Altman & J. Taylor, Centre for Aboriginal Economic Policy Research, Australian National University, Canberra.
- ATSIHWIU 1997, *The Aboriginal and Torres Strait Islander Health Information Plan... This Time Let's Make it Happen*, Australian Institute of Health & Welfare, Canberra.
- Bailie, R., Sibthorpe, B., Anderson, I. & Smith, L. 1998, 'Data for Diagnosis, Monitoring and Treatment in Indigenous Health: The case of cervical cancer', *Australian and New Zealand Journal of Public Health*, vol. 22, pp. 303–06.
- Black, D. 1995, 'A View on NHS Reforms', *Journal of the Royal College of Physicians London*, vol. 29, pp. 442–5.
- Brit, H., Sayer, G., Miller, G. C., Charles, J., Scahill, S., Horne, F., Bhasale, A. & McGeechan, K. 1999, *General Practice Activity in Australia 1998–99*, University of Sydney and Australian Institute of Health & Welfare, Canberra.
- Deeble, J., Mathers, C., Smith, L., Goss, J., Webb, R. & Smith, V. 1998, *Expenditures on Health Services for Aboriginal and Torres Strait Islander People*, Australian Institute of Health & Welfare, Canberra.
- DHAC 1999a, 'Commonwealth Report on the Progress Made under the Framework Agreements for Aboriginal and Torres Strait Islander Health', in *Jurisdictional Report to the Australian Health Ministers Conference on Progress made under the Aboriginal and Torres Strait Islander Framework Agreement*, Australian Health Ministers' Conference, August 1999, Canberra.
- DHCS 1994, *A Guide to Output-Based Funding*, Industry Analysis Unit, Office of Deputy Secretary,

- Victorian Government Department of Health and Community Services, Melbourne.
- DHFS 1997, 'Submission from the Commonwealth Department of Health and Family Services to the House of Representatives Standing Committee on Family and Community Affairs: Inquiry into Indigenous health', in House of Representatives Standing Committee of Family and Community Affairs, *Inquiry into Indigenous Health, Submissions Authorised for Publication, Volume 1 National Organisations*, Canberra, pp. 215–316.
- DHFS 1998, *General Practice: Changing the future through partnerships: Report of the General Practice Strategy Review Group*, Commonwealth Department of Health & Family Services, Canberra.
- DHS 1998a, *Improving Human Services for Victorian Koories: The Koori Services Improvement Strategy, a Five Year Strategic Plan*, Department of Human Services, Melbourne.
- DHS 1998b, *A Koori Community Service Plan for Ballarat and District 1998–99*, Department of Human Services, Melbourne.
- DHS 1998c, *Koori Health Plan for the Southern Metropolitan Region*, Department of Human Services, Melbourne.
- DHS 1998d, *National Aboriginal and Torres Strait Islander Health Performance Indicators: Report for Victoria 1997–98*, Department of Human Services, Melbourne.
- DHS 1998e, *A Stronger Primary Health and Community Support System: Policy Directions*, Aged, Community & Mental Health Division, Department of Human Services, Melbourne.
- DHS 1999a, *A Stronger Primary Health and Community Support System Demonstration Projects: Requests for Proposals*, Aged, Community & Mental Health Division, Department of Human Services, Melbourne.
- DHS 1999b, *Understanding Competitive Tendering*, Department of Human Services, Barwon South Western Region, Melbourne.
- DHS 2000, *Primary Care Partnerships: Going Forward*, Department of Human Services, Melbourne.
- DHS, DHFS, ATSIC & VACCHO 1996, *An Agreement on Aboriginal and Torres Strait Islander Health*, Victorian Department of Human Services, Commonwealth Department of Health and Family Services, Aboriginal and Torres Strait Islander Commission, Victorian Aboriginal Community Controlled Health Organisation.
- DHS & VACCHO 1997, *Achieving Improved Aboriginal Health Outcomes: Approach to Reform*, Department of Human Services, Melbourne.
- DHS 1998a, *Improving Human Services for Victorian Koories: The Koori Services Improvement Strategy, a Five Year Strategic Plan*, Department of Human Services, Melbourne.
- DHS 1998b, 'A Koori Community Service Plan for Ballarat and District 1998–99', Department of Human Services, Melbourne.
- DHS 1998c, 'Koori Health Plan for the Southern Metropolitan Region', Department of Human Services, Melbourne.
- DHS 1998d, *National Aboriginal and Torres Strait Islander Health Performance Indicators: Report for Victoria 1997–98*, Department of Human Services, Melbourne.
- DHS 1998e, *A Stronger Primary Health and Community Support System: Policy Directions*, Department of Human Services, Aged, Community & Mental Health, Melbourne.

DHS 1999a, *A Stronger Primary Health and Community Support System Demonstration Projects: Requests for Proposals*, Department of Human Services, Melbourne.

DHS 1999b, *Understanding Competitive Tendering*, Department of Human Services, Barwon South Western Region, Melbourne.

DHS 2000, 'Primary Care Partnerships: Going forward', Department of Human Services, Melbourne.

References

Hodges, G. 1999, 'Contracting Out Government Services: A Review of International Literature', Montech International, Melbourne.

KAMSC 1999, 'Principles of Primary Health Care', Kimberley Aboriginal Medical Services Council, Kimberley. <http://www.hcn.net.au/kamsc/primehlth.htm>.

Kirk, M., Hoban, E., Dunne, A. & Manderson, L. 1998, *Barriers to and Appropriate Delivery Systems for Cervical Cancer Screening in Indigenous Communities in Queensland: Final Report*, Government Press, Brisbane.

Kirk, M., McMichael, C., Potts, H., Hoban, E., Hill, D.C. & Manderson, L. 2000, *Breast Cancer: Screening, Diagnosis, Treatment and Care for Aboriginal and Torres Strait Islander Women in Queensland. Final Report*, Queensland Health, Brisbane.

Keys Young 1997, *Market Research into Aboriginal and Torres Strait Islander Access to Medicare and the Pharmaceutical Benefits Scheme: Report*, Keys Young, Milsons Point, NSW.

Muetzelfeldt, M. 1999, 'Contracting out in the Health Sector', in *Health Policy in the Market State*, ed. L. Hancock, Allen & Unwin, St Leonards, NSW.

NACCHO & DHAC 1998, 'Service activity reporting questionnaire', National Aboriginal Community Controlled Health Organisation and Commonwealth Department of Health and Aged Care, Canberra.

NAHS 1989, *A National Aboriginal Health Strategy*, Australian Government Printing Service, Canberra.

National Aboriginal Health Strategy Evaluation Committee 1994, 'The National Aboriginal Health Strategy: an Evaluation', Department of Human Services and Health (Commonwealth) and Aboriginal and Torres Strait Islander Commission, Canberra.

Neville, A. 1999, *Competing Interests: Competition Policy in the Welfare Sector*, Anglicare Australia & Australia Institute Ltd, Canberra.

NHIMG 1999, *National Analysis of the 1998 Jurisdictional Reports against the Aboriginal and Torres Strait Islander Health Performance Indicators*, Commonwealth Office for Aboriginal & Torres Strait Islander Health, Canberra.

NHMRC 1998, *Annual Report of the National Health and Medical Research Council*, Commonwealth of Australia, Canberra.

OATSIHS 1996a, 'Data Requirements for Regional Planning', Department of Health & Family Services, Canberra.

OATSIHS 1996b, 'Guidelines on Prioritising for the Provision of Primary Health Care Services through Regional Planning', Department of Health & Family Services, Canberra.

OATSIHS 1996c, 'Regional Planning, Essential Elements', Department of Health & Family Services, Canberra.

- OATSIHS 1996d, 'A Step by Step Guide to Regional Planning', Department of Health & Family Services, Canberra.
- PFCC 1999, *Health Services Policy Review Discussion Paper*, Department of Human Services, Melbourne.
- Powell Davies, P. G., Harris, M. F., Comino, E., Bolton, P., Fridgant, Y., Betbeder-Matibet, L., Mira, M. & MacDonald, J. [n.d.], *General Practice Integration Research Program, Integration of General Practitioners with Hospital and Community Health Services, Summary Report*. Centre for General Practice Integration Studies, University of New South Wales, Sydney.
- PHDD 1999, *The Victorian Burden of Disease Study: Mortality*, Department of Human Services, Melbourne.
- RAC 1997, 'Koori Health Outcomes Project Report', Rumbalara Aboriginal Cooperative, Shepparton.
- RAC & GVBH 1998, 'Health Outcomes Agreement between Rumbalara Aboriginal Cooperative and Goulburn Valley Base Hospital for the Improvement of Koori Health Status in the Goulburn Valley', Rumbalara Aboriginal Cooperative and Goulburn Valley Base Hospital, Shepparton.
- RAIS 1997, 'Health Service Delivery for Remote Aboriginal Communities', National Aboriginal & Torres Strait Islander Health Council, Canberra.
- Raysmith, H. 2000, 'Review of Primary Health Care Development', Department of Human Services, Melbourne.
- Rifkin, S. & Walt, G. 1986, 'Why Health Improves: Defining the issues concerning "comprehensive primary health care" and "selective primary health care"', *Social Science and Medicine*, vol. 23, pp. 559–66.
- Schwab, R. G. & Anderson, I. 1998, 'Indigenous Participation in Health Sciences Education: Recent Trends in the Higher Education Sector', *Centre for Aboriginal Economic Policy Research Discussion Paper No. 171*, Centre for Aboriginal Economic Policy Research, Australian National University, Canberra.
- Smith, J. 1999, 'Shifts in Community Health Care', in *Health Policy in the Market State*, ed. L. Hancock, Allen & Unwin, St Leonards, NSW.
- Swerissen, H. & Duckett, S. 1997, 'Health Policy and Financing', in *Health Policy in Australia*, ed. H. Gardner, Oxford University Press, Melbourne.
- WHO 1978, 'Declaration of Alma-Ata', *Primary Health Care: Report of the International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978*, World Health Organisation, Geneva.
- WHO (1986) *Ottawa Charter for Health Promotion*, World Health Organisation, Geneva.
- Zakus, J. D. L. 1998, 'Resource Dependence and Community Participation in Primary Health Care', *Social Science and Medicine*, vol. 46, pp. 475–94.

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Abbreviations

ABS	Australian Bureau of Statistics
ACCCHS	Aboriginal Community Controlled Health Services
AHMC	Australian Health Ministers' Conference
AIHW	Australian Institute of Health & Welfare
ATSIC	Aboriginal & Torres Strait Islander Commission
ATSIHWIU	Aboriginal and Torres Strait Islander Health and Welfare Information Unit
BEACH	Bettering Evaluation and the Care of Health
DHAC	Department of Health & Aged Care (also DHFS: Department of Health & Family Services, Commonwealth)
DHCS	Department of Health & Community Services (Commonwealth)
DHFS	Department of Health & Family Services (Commonwealth)
DHS	Department of Human Services (Victorian)
GVBH	Goulburn Valley Base Hospital
OASTSIH(S)	Office for Aboriginal & Torres Strait Islander Health (Services)
NACCHO	National Aboriginal Community Controlled Health Organisation
NAHS	National Aboriginal Health Strategy
NCEPH	National Centre for Epidemiology & Population Health
NHIMG	National Health Information Management Group
PCP	Primary Care Partnerships
PFCC	Phillips Fox and Casemix Consulting
PHDD	Public Health and Development Division, Department of Human Services
RAC	Rumbalara Aboriginal Cooperative
RAIS	Remote Areas Issues Sub-committee
WHO	World Health Organization
VACCHO	Victorian Aboriginal Community Controlled Health Organisation