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INQUIRY INTO OVERCOMING INDIGENOUS DISADVANTAGE

Name: Ms Jane Lloyd

HOW IS

ABORIGINAL HEALTH POLICY

IMPLEMENTED?

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Abstract

The development of Aboriginal-led, evidence-based policy is vital to the future of Aboriginal health, and there is now a considerable body of evidence identifying the steps in developing effective public policy. However, there is much less evidence to guide policy implementation. There is a perception in the public health literature and among practitioners, that Aboriginal health policies are either partly, or not well implemented.

Qualitative research was conducted to explore the extent to which Aboriginal health policy is implemented. The research was based on a case study of the implementation of the Northern Territory Preventable Chronic Disease Strategy and involved 35 in-depth interviews with service providers and administrators across urban and remote areas of the Northern Territory.

This research found Aboriginal health policies are not implemented seamlessly across all components of the health care system at the same time. Policies evolve as they are implemented. The ways in which these ideas evolve are influenced by the context in which they are received. Health professionals migrate to implementing aspects of policy that are most familiar to them rather than according to evidence or population needs. Pre-existing limitations in the structure of the health care system generate further inequities as policies evolve. If there is diminished capacity within Aboriginal health services, these services will have less ability to respond to, and therefore benefit from, policy ideas. This undermines the effectiveness of policy and the capacity of the health care system to do things differently.

The implications of this research are relevant at two levels. This research has shown that, prior and during implementation, certain steps are required to enhance the effectiveness and equity with which policy ideas are implemented. When implementing policy it will be important to discern proactively who needs to be involved in the policy decision-making process and at what point; identify the deal breakers in negotiations about which aspects of policy are implemented; find ways to build the capacity of health services during implementation; and monitor the evolution of policy ideas.

In addition, the research found the implementation of policy depends upon there being a robust health care system. In a region such as the Northern Territory of Australia, in which many communities are very small and very remote, and even then they are not, when there has been long-standing under-investment in developing culturally-effective health services, it is common to find health services that are inadequate to meet the demands of the communities they serve. Developing and implementing stand alone policies is not the solution to improving Aboriginal health. A comprehensive health care system is required so that all policies have a greater chance of being implemented comprehensively and equitably. This research has generated a number of lessons for building a robust health care system. There is a need to build the learning capacity of organisations; create a more equitable health care system; connect and integrate different parts of the health care system; and monitor performance.

Statement of authorship

Numerous steps were involved in producing this thesis including the development of the research questions, designing the study, conducting and transcribing the interviews, the analysis and the reporting within this document. The author was responsible for all aspects of this thesis.

This thesis has not been submitted for the award of any degree or diploma in any other tertiary institution.

No other person’s work has been used without due acknowledgement in the main text of the thesis.

All research procedures reported in this thesis were approved by the relevant Ethics Committees.

Preface

While working as a Program Manager on a major research project exploring the rate of diabetes among Aboriginal people living in urban areas, I was both concerned and curious. The persisting inequitable rates of morbidity and mortality among Aboriginal Australians compared to non-Aboriginal Australians were of concern. Having recently moved from Sydney to Darwin I was curious about Aboriginal affairs and the Northern Territory.

My original plan was to conduct a randomised control trial of a diabetes intervention for Aboriginal Australians living in urban areas. There was compelling evidence that interventions, targeting people at risk of diabetes, are an effective way of delaying the onset of the disease (1-6). Designing an intervention specifically for Aboriginal people living in urban settings may have been of some benefit. However, Aboriginal Australians are a diverse group of people. It is unlikely that there would be one single intervention that would be suitable for all Aboriginal Australians. In addition, the process of engagement and community development, together with empowerment, employment and connectedness provide much of the benefit that stems from designing interventions. I was unsure whether designing another intervention was the best contribution that I could make.

In this context of uncertainty, I came across a book entitled: From the Bush to the Store: Diabetes, Everyday Life and the Critique of Health Services in Two Remote Northern Territory Communities (7). The book presented a range of issues connected to diabetes and explored Aboriginal views of ill health and well-being. Within the book I came across this quote:

> ‘Many of the Aboriginal people consulted during this project are, to put it bluntly, fed up with the circularity and inconsistency of health intervention strategies. They are also fed up with the continually recycled rhetoric of 'culturally appropriate intervention'. Health bureaucracies are seen as continually 'reinventing the wheel', so to speak, by engaging in an ongoing process of instituting, abandoning and then reinstituting essentially similar intervention strategies within particular communities. These complaints relate to wider issues to do with the comparative lack of 'institutional memory' within health bureaucracies and organisations in the Northern Territory, the high turnover of health personnel, and a culture of 'short-term' project planning within the health field.’ (7) p.43

The author, Kim Humphrey, identified a range of issues regarding the nature of interventions. These comments resonated strongly with my own concerns. Having worked as a project officer I was aware of the issues of sustainability. Projects only seemed to function for as long as a dedicated project officer was working on them. After reading Humphrey’s work it seemed to me that the problem was not that the health care system could not develop high quality interventions. Rather the underlying problem was that the health system was not able to sustain interventions, regardless of their success and ability to improve Aboriginal health. The health care system had formed a pattern of developing, abandoning and reinventing interventions regardless of the performance or benefits of that intervention. This repetitious cycle of interventions pointed to an opportunity to explore ways to improve the performance and capacity of the health care system to be better able to meet the needs of Aboriginal Australians.

At the same time as seeing the potential to make a useful contribution by exploring the strengths and weaknesses of the system, I was also aware that Aboriginal people have been the subject of much research. As a non-Aboriginal Australian I felt more comfortable exploring the performance of the health care system than focusing on the rates of diabetes among Aboriginal people and identifying strategies to encourage healthy behaviors.

Perhaps the greatest influence on my decision to focus on the health care system, rather than on Aboriginal people, stemmed from my experience as a white middle class Australian. It seemed incredible to me, that at age 28, being brought up and educated in Australia, and having lived in Australia most of my life, I only had a very limited understanding of the history and needs of Aboriginal Australians. If an educated member of mainstream Australian society stumbles by chance across the injustices faced by Aboriginal Australians, then it may also be possible that those systems that operate within a western framework such as health, education, and law can also be unaware of the needs of Aboriginal Australians. There may be circumstances that draw attention to the needs of Aboriginal Australians at particular points in time, and these systems may then be able to tinker with programs and services to make them more accessible to Aboriginal Australians. But this often occurs by chance and through advocacy, and often after the fact. For example, mainstream programs such as Medicare and the Pharmaceutical Benefits Scheme were not designed specifically with Aboriginal populations in mind. Laudably, changes have been made to these programs to make them more accessible to Aboriginal Australians. However changing programs to better meet the needs of Aboriginal Australians takes many years. For many Aboriginal Australians this process results in delayed access to mainstream programs and therefore further marginalises Aboriginal Australians from their non-Aboriginal counterparts.

By highlighting the health care system's contribution to persisting high rates of Aboriginal mortality and morbidity, it may be possible to identify how to reengineer the system to better meet the needs of Aboriginal Australians.

This is the perspective from which this research was conducted.

Acknowledgements

An array of factors leads someone into deciding to undertake a PhD, and another set of determinants allow a person to complete this journey. This makes it difficult to know who to thank first and from what point in my life. Because while in many ways I have found doing a PhD a solo exercise, there is no way that I could have completed this research on my own. There are a number of people who provided opportunities, support, and advice for which I feel incredibly lucky and grateful.

On reflection I decided it was appropriate that I start with my mum – Elizabeth Lloyd. Because without her strength, grace, wit and goodness I would be the shadow of the person that was required to emerge through this journey of trying to complete a PhD. To her I will always be indebted for so many reasons and in so many ways.

To Dad – Denis Mahony – who provided a helping hand every step of the way. Thank you for always being willing to help, and for your honest, critical and insightful feedback. I trusted Dad with initial drafts and am grateful that even after seeing my work in its infancy and at its worst, he still encouraged me to persevere.

I felt privileged and lucky that such clever and inspiring people agreed to supervise me. Marilyn Wise always reminded me to conduct my research in accordance with my values. Under Marilyn’s supervision I had enough scope to find things out for myself and the opportunity to discuss ideas. Marilyn’s respectful and graceful way of providing honest feedback provided me with an opportunity to learn and sufficient confidence to continue. Without Tarun Weeramanthri expecting the most from me and insisting that I improve my writing, this thesis and my research would not have reached the required standard. Tarun always reminded me of the importance of conducting applied research that was constructive, fair and helpful to those practitioners working in the health care system.

Many people at Menzies School of Health Research provided a welcoming hand at times that it was needed most.

Professor Joan Cunningham provided consistent, regular and practical advice. Without Joan’s offer of employment I would never have moved to Darwin to work in Aboriginal health. And without Joan’s continuing support I would never have decided to stay in Darwin and embark on a PhD. Since March 2003, Joan has been extremely generous in providing technical research advice, moral support and career counseling.

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TABLE OF CONTENTS

Appendices

Glossary of Abbreviations

Aboriginal	For the purposes of this thesis the term Aboriginal is used respectfully to refer to Aboriginal and Torres Strait Islander people
ACCHS	Aboriginal Community Controlled Health Service
AIHW	Australian Institute of Health and Welfare
AMSANT	Aboriginal Medical Services Alliance Northern Territory
ATSIC	Aboriginal and Torres Strait Islander Commission
HbA1C	Glycosylated hemoglobin is a form of hemoglobin used primarily to identify the plasma glucose concentration over prolonged periods of time. A high HbA1C (above 6.5%) represents poor glucose control in patients over an extended period.
HIC	Health Insurance Commission
PBS	Pharmaceutical Benefits Scheme
PCDS	Northern Territory Preventable Chronic Disease Strategy
Medicare	Australia’s national health insurance program
NAHS	National Aboriginal Health Strategy
NT	Northern Territory
NT DHCS	Northern Territory Department of Health and Community Services
NHMRC	National Health and Medical Research Council
OATSIH	Commonwealth Office of Aboriginal and Torres Strait Islander Health

Section 1

Introduction and background

The aim of this section of the thesis is to set the scene in which the research occurred. The factors that prompted study into the implementation of Aboriginal health policy are described. The literature on the performance of the health care system in meeting the needs of Aboriginal Australia is presented, and the theories on the policy process are examined. This body of work provides the foundation on which this research is built.

Chapter 1

Why is this research important?

‘A strange rhetorical paradox is enveloping the health of Aboriginal Australians’ (8) p 1. It is well known and widely reported that Aboriginal Australians are sicker and, on average, die much earlier than non-Aboriginal Australians (9-11). There have been over three decades of inquiries, policies, programs and reviews into the health of Aboriginal Australians (12). However, there have been only limited changes in terms of health outcomes.

The lack of progress in reducing the gap in health and life expectancy between Aboriginal and non-Aboriginal Australians points to the need for all sectors, including the health sector, to examine their structures, processes, policies and services and to identify and adopt the changes that are necessary to improve Aboriginal health outcomes.

The aim of this chapter is to explain why it is important to research health system contributions to improving Aboriginal health, and to outline the reasons behind the specific focus on how Aboriginal health policy is implemented.

Reasons for researching health system contributions to Aboriginal health

Four major influences prompted this research: persisting inequitable rates of mortality and morbidity among Aboriginal Australians; a history of inappropriate Aboriginal health research; a poor track record in administering Aboriginal affairs; and the legacy of colonisation.

Aboriginal mortality and morbidity

Australian Aboriginal people have an average life expectancy seventeen years shorter than that of non-Aboriginal Australians, and have experienced higher rates of morbidity across their life span (13). Over the period 1999-2003 Aboriginal people died at almost three times the rate of non-Aboriginal people. The three leading causes of death were diseases of the circulatory systems, injury and cancer (9). Chronic diseases are now the major causes of early adult deaths in the Australian Aboriginal population (14). Death rates for diabetes are between 7 and 20 times as high as the rates in the non-Aboriginal population (14). Aboriginal communities experience high levels of both infectious and chronic disease. Therefore the burden of disease in some Aboriginal communities is similar to that of many developing countries (15). Many of these illnesses are preventable.

There are examples of gradual improvements in health status for Aboriginal Australians on some key indicators. For example, there have been improvements in infant mortality and in immunisation rates (9) and in some areas, such as deaths caused by circulatory disease, the rate of increase in mortality has slowed (16). For example in 2006, Thomas reported that the increase in death rates for chronic disease among Aboriginal people in the Northern Territory was slowing (17). This demonstrates that Aboriginal health can improve, and with sustained and increased effort further gains can be made.

High levels of mortality and morbidity among Aboriginal Australians have been explained by adverse socioeconomic conditions such as lower incomes, poorer educational outcomes, lower rates of employment, lower rates of home ownership and overcrowding and poor housing (15). Aboriginal Australians face a disproportionate number of adverse social conditions. In Appendix 1 the core determinants of Aboriginal health are described in greater detail. These underlying determinants of chronic disease demonstrate that all sectors, not just health, have a role to play in preventing chronic disease. Often the health care sector is seen as solely responsible for high rates of mortality and morbidity. While the health sector has a responsibility for preventing the incidence and reducing the prevalence and complications from chronic diseases, many actions can be taken by other sectors to prevent the onset of chronic disease across populations. The health sector must work with other sectors in order to achieve many of its goals.

The health sector has found it challenging to respond to the particular cultural and socioeconomic circumstances of its Aboriginal peoples, and to the wider demands of reducing the incidence and prevalence of chronic disease across the whole population. The health care system in Australia was established to treat infectious diseases and non-Aboriginal Australians rather than Aboriginal Australians with high rates of chronic disease (18). Even though socioeconomic factors are significant determinants of health, the health workforce presently does not have the skills required to work with other sectors to address the socioeconomic determinants. The current health system operating across Australia has been slow to respond to the growing evidence of the need for reform – of its structures, priorities, decision-making processes and service delivery – to ensure that it is contributing effectively and efficiently to improving the health of the Aboriginal population, and to reducing the incidence and prevalence of chronic disease more broadly.

In addition to persisting high rates of mortality and morbidity, Aboriginal Australians suffer a history of inappropriate Aboriginal health research (19).

The history of Aboriginal health research

In Australia there is a legacy of inappropriate Aboriginal health research (20-22). This legacy has generated high levels of Aboriginal communities' distrust of research and researchers. In the excerpt below Tuhiwai Smith outlines a common, international understanding and experience of Indigenous health research:

> *'Research... continues relentlessly and brings with it a new wave of exploration, discovery, exploitation and appropriation. Researchers enter communities armed with goodwill in their front pockets and patents in their back pockets, they bring medicine into villages and extract blood for genetic analysis. No matter how appalling their behaviours, how insensitive and offensive their personal actions may be, their acts and intentions are always justified as being for the 'good of mankind'. Research of this nature on Indigenous peoples is still justified by the ends rather than the means, particularly if the Indigenous peoples concerned can still be positioned as ignorant and undeveloped (savages).'* (19) p. 24-25

In addition to the inappropriate research processes described above, the focus of Aboriginal health research has also been found to be inappropriate. Since the 1970s Aboriginal health research, in Australia, has focused mainly on describing rates of disease or behavioural determinants of health (20-22). This focus is telling. It contributes to a misconception that Aboriginal Australians are somehow responsible for their own disadvantage.

Steps have been taken to conduct Aboriginal health research in an improved and more empowering manner. Since the 1980s, reforms have been made to Aboriginal health research. The National Health and Medical Research Council (NHMRC) established guidelines for ethical conduct in Aboriginal and Torres Strait Islander Health Research (21). The guidelines have a dual purpose. They are intended to assist researchers during the conception, design and conduct of research, and to guide Human Research Ethics Committees when considering research proposals. The values that underpin these guidelines and therefore form the basis of this research are: spirit and integrity, reciprocity, respect, equality, survival and protection, and responsibility (23). Of these six values, the spirit and integrity principle may be seen as the integral component. The spirit and integrity value is intended to bind all the values together and reflect the fact that the present and the future are bound up in the past.

The value of reciprocity requires the researcher to demonstrate a benefit to the community. Benefits may stem from the research process, as well as the outcomes of the research. There is an increasing shift in Aboriginal health research to ensure that immediate benefits from the research process are directed to Aboriginal communities. Potential benefits may include employment on the research project and increased community knowledge and awareness of health conditions or determinants. Initiatives, such as the NHMRC guidelines, represent a shift in the research paradigm to ensure that are immediate and direct benefits for Aboriginal people.

The history of inappropriate research has had lasting effects on the culture and climate of Aboriginal health research. Despite recent changes to the way research is conducted, further work is required to ensure power is shared between the Aboriginal community, researchers and the health care system. Therefore Aboriginal health research is precarious territory for white middle class Australians (21;24).

Rather than the dominant approach of describing disease rates among Aboriginal populations, it became apparent that there was an opportunity to make a useful and different contribution to Aboriginal health by researching the strengths and weaknesses of the health care system. Despite a history of conducting substantial amounts of Aboriginal health research, little of this has focused on the system's contribution to persisting rates of mortality and morbidity among Aboriginal Australians. Focusing on health system contributions is an important and relatively unexplored area of research. Turning the focus of research on to the health care system, rather than on Aboriginal communities, meant that this research would not replicate the history of inappropriate Aboriginal health research.

Australia's performance in administering Aboriginal affairs

To establish the research territory and highlight patterns in Aboriginal affairs in Australia, the history of administration and policies was reviewed. This review found there have been four main policy themes in the history of Aboriginal affairs in Australia. They include segregation, assimilation, self determination and mutual obligation.

The period from 1820 to 1900 was characterised by major Aboriginal population decreases and a policy of segregation. Epidemics of introduced diseases, starvation resulting from destruction of native flora and fauna, setting out poisoned flour, and the deliberate killing of Aboriginal Australians by settlers - all resulted in major population decreases. As an example, by 1890 the Aboriginal population of Queensland had decreased from an estimated 120,000 to 32,000 (25).

In 1937 a policy of assimilation was adopted. Its aim was: 'all Aborigines shall attain the same manner of living as other Australians, enjoying the same rights and privileges, accepting the same responsibilities, observing the same customs, and being influenced by the same beliefs, hopes and loyalties' (25). Aboriginal missions had been created in the 1870s in response to international pressure and issues of urban drift; these missions were used to enforce separation. Thus the stolen generation was created and terrible psychological and social legacies have been left among Aboriginal communities and people, and there is a serious lack of trust in government that continues into the present day (26;27).

In the early to mid-1900s the state and territory governments, together with the churches, controlled all aspects of Aboriginal life (28). However a referendum in 1967 gave the Commonwealth the right to pass laws regarding Aboriginal Australians. Two clauses in the Federal Constitution that discriminated against Aboriginal Australians were changed: Section 127 which excluded Aboriginal Australians of full descent from national census counts; and Section 51 XXVI which prohibited the Federal government from passing laws regulating to Aboriginal Australians living in the Australian states (25).

Self determination was the policy adopted at the federal level in 1972 (25). The principle of 'self determination of peoples' had been prominently stated in the United Nations Charter of 1945, the UN General Assembly Declaration on the Granting of Independence to Colonial Countries of 1960, and the UN International Covenants on Civil and Political

Rights and Economic, Social and Cultural Rights of 1966 (29). The Whitlam Labor Commonwealth government adopted self determination as the key term of Australian Aboriginal affairs policy and by doing so brought Australia more in line with international law.

In 1990 the Aboriginal and Torres Strait Islander Commission (ATSIC) was created. ATSIC was one of the significant initiatives and mechanisms to be established under the auspice of the self determination policy (30). For the first time in post-colonial Australian history, Aboriginal people had a national organisation comprised of elected representatives. However, the year 2004 saw the abolition of ATSIC by the Federal government. Its abolition, rather than reform, was seen as another breach of trust on the part of government (31).

In its place a policy theme of shared responsibility and mutual obligation was adopted by government. Under these new arrangements Indigenous Coordination Centers were created. These multi-agency units are managed by the Office of Indigenous Policy Coordination in the Department of Families, Community Services and Indigenous Affairs. Their role is to facilitate the establishment of shared responsibility agreements between governments and Indigenous communities (32).

The new arrangements for the administration of Aboriginal affairs have multiple components. Most notable among the new arrangements are the transfer of Aboriginal specific programs to mainstream government departments and agencies and the creation of a government appointed 12 member National Indigenous Council, whose role is to advise a Ministerial Taskforce (32).

The Aboriginal and Torres Strait Islander Social Justice Commissioner's report in 2004 raised two concerns with the new arrangements. Firstly, the new arrangements are based on administrative procedures, not legislative reform. This allows the government greater flexibility in how they are implemented. It also makes the new arrangements less transparent and more difficult to scrutinise. Secondly, their introduction did not require the abolition of ATSIC. Addressing the goals of ensuring better whole of government coordination, and improving the accountability and accessibility of mainstream programs that are part of the mutual obligation policy, could have been achieved without abolishing ATSIC (32).

Reviewing the major policies in Aboriginal affairs shows that many attempts have been made to improve the circumstances of Aboriginal Australians. It is not that nothing has been done. On the contrary, many policies and reports have been developed. There are concerns about the extent to which these policies were developed in collaboration with the people they were intended to serve. In addition, it is not clear whether or not these policies have been monitored and evaluated, and if so, whether this information was used to change practice.

In order to explore more closely the impact and contributions reports have made on the health status of Aboriginal Australians, the researcher decided to review the implementation of five national reports on Aboriginal affairs. These reports were chosen due to their prominence, national focus and relative accessibility. They include the 1979 House of Representatives Standing Committee on Aboriginal Affairs; the 1989 National Aboriginal Health Strategy; the 1991 Royal Commission into Aboriginal Deaths in Custody; the 2000 House of Representatives Standing Committee on Family and Community Affairs Inquiry into Indigenous Health; and the 2003 National Strategic Framework for Aboriginal and Torres Strait Islander Health.

Reviewing these national reports revealed a number of long standing barriers to effectively managing Aboriginal affairs. For example, there were multiple calls for national responsibility for Aboriginal affairs (or the need to coordinate responsibility between the Commonwealth and states), adequate resources and flexible funding arrangements, and improved access to mainstream services for Aboriginal Australians. This may demonstrate either the persisting nature of these barriers or that limited emphasis has been placed on the implementation of these recommendations.

The number of policy initiatives that were available to select from was evidence that many attempts have been made to improve the circumstances of Aboriginal Australians. However, rather than contributing to improving Aboriginal health status these efforts paint a picture of a largely ineffective cycle of policies and reports. The accumulation of a cycle of reporting and recommending, without ensuring actions, constituted a track record of good intentions being thwarted by limitations of the administration process. This cycle has been reported as early as 1979 in the House of Representatives Standing Committee on Aboriginal Affairs report on Aboriginal health (33).

> *'When innumerable reports on the poor health state of Aboriginal health are released there are expressions of shock or surprise and outraged cries for immediate action. However, the reports appear to have no real impact and the appalling state of Aboriginal health is soon forgotten until another report is released.'* (33) p. iii

In 1994, Gardiner-Garden examined the contribution of the Commonwealth government to the health status of Aboriginal Australians. He reported that between late 1992 and mid 1994, there were a least seven national reports. Gardiner-Garden noted the persisting high rates of Aboriginal mortality and morbidity, the frequency of reports and reviews, and the cycle of developing policy without impacting on the functioning of health services or on the health of Aboriginal Australians. He recommended, that in order to break the cycle of reporting and inaction, greater attention be placed on monitoring the implementation of recommendations (28).

This cycle has continued through to the National Strategic Framework for Aboriginal and Torres Strait Islander Health published in 2003 (34).

The persistence of this cycle of consultation, reporting and recommendations, combined with raised expectations on the part of Aboriginal communities, followed by inadequate action and investment by the responsible agencies, was the stimulus to explore policy development and implementation processes, in an effort to find ways to break the cycle. This cycle represents, over time, a failure of the Australian government and Australian society more broadly, to protect and promote the rights of Aboriginal Australians. This may be partially explained by the legacy of the Australian colonisation process.

Legacy of colonisation

In Aboriginal affairs, people often refer to the legacy of colonisation. The phrase 'legacy of colonisation' appears to be used in multiple ways. It may refer to the huge population losses due to starvation and disease, or to a history of the dominant culture imposing its policies and practices on Aboriginal people. For the purposes of this research the legacy of colonisation refers to the ways the colonisation process influences how Aboriginal people are perceived by the broader Australian population. This process is so subtle but all-pervasive, that non-Aboriginal Australians are often unaware of their own views, let alone where they come from or how they impact on the health and well being of Aboriginal Australians.

In 1788, the vastly different social systems of Aboriginal and non-Aboriginal Australians came into conflict. Aboriginal people were semi-nomadic, had well-developed social and economic structures and policies, and had a thorough understanding of the environment. Speaking more than 700 languages, the sophistication of Aboriginal culture, policy and practices had led to their being one of the longest surviving of any population groups – with some evidence pointing to their occupation of the land for more than 40,000 years. The new Australians were largely marines and convicted criminals and had come from an urbanised society on the point of an industrial revolution. The colonisers chose to view Australia as 'unoccupied land' using the policy of 'terra nullius' to justify their subsequent processes of shifting Aboriginal people from their lands and denying them the use of their language, and breaking down the social structures. The colonisation process segregated and marginalised Aboriginal people from mainstream society and then later tried to impose dominant values on Aboriginal people (13;25;35). Dispossession and marginalisation were instrumental to the process of Australian land settlement. But perhaps the greatest travesty was the confusion and indecision that surrounded the status and rights of Aboriginal Australians within the new Australian colonies. This confusion and indecision resulted in relatively frequent changes in policy without evaluation or reflection. This legacy of colonisation still remains part of Australia's social fabric and continues to disempower and marginalise Aboriginal people (13).

The legacy of colonisation may be seen as a form of institutionalised racism. When most people think of racism, they think of acts of prejudice and discrimination (which may manifest as a lack of respect, a failure to communicate the range of options available to patients, or suspicion). However, these acts are more accurately described as personally mediated racism. A more insidious form of racism that is especially relevant to the legacy of colonisation is institutionalised racism. This form of racism is characterised by historical injustices and inaction in the face of need, and includes structural barriers to accessing services such as those ingrained in law or customs of organisations (36). It is reinforced by the fact that the majority of people in the population are, albeit unwitting, beneficiaries of the current laws and customs, making it very difficult to bring about change given the enormous disparity in the size of the Aboriginal and non-Aboriginal populations in Australia.

In 2007, the legacy of colonisation continues to permeate aspects of government relations with the Aboriginal community, and non-Aboriginal people's reactions and interactions with Aboriginal Australians. It affects the way non-Aboriginal people view and understand Aboriginal Australians, and also how Aboriginal people view non-Aboriginal Australians. Despite the far reaching effects, the legacy of colonisation remains unnoticed and poorly understood by most Australians, and therefore unchanged.

Why implementation?

The history of excluding Aboriginal Australians from political and social decision making has meant that health services have evolved without long-standing reference to the cultural and linguistic requirements of Aboriginal Australians. However, in the last decade there is evidence of gradual improvements in Aboriginal infant mortality and in immunisation rates (9), demonstrating that the health sector is capable of having a direct effect on improving health outcomes of Aboriginal Australians.

Due to decades of persistent advocacy on the part of Aboriginal people, of some health professionals, and the Aboriginal self determination movement, the health sector across Australia has begun to develop evidence based health policy that is more reflective of the cultural and life circumstances of communities (37). This improved approach to policy development has meant that some health policies in Australia now reflect, more precisely, the steps that are needed to improve Aboriginal health (8). The 1989 National Aboriginal Health Strategy (NAHS) is a notable milestone in the history of Aboriginal affairs for two reasons. Firstly, because for the first time there was consensus among the Commonwealth and state and territory governments and the Aboriginal community on what was required to improve Aboriginal health. Secondly, because an evaluation of the NAHS found that it was never effectively implemented (38). More recently, there has been increasing recognition by health policy makers of the need for a culturally-specific, comprehensive and integrated approach, particularly in relation to chronic diseases (39).

However, improvements in policy goals and policy development have not necessarily been reflected in policy implementation. There is considerable experience in Australia suggesting that implementation is a separate and urgent problem. A preliminary investigation of the literature on Aboriginal health, Aboriginal affairs and policy revealed a need to understand the implementation of Aboriginal health policy by the health care system. It pointed to the need for research to understand the facilitators and barriers to the implementation of Aboriginal health policy.

An overview of the research

Two research questions were formed. Firstly, what are the facilitators and barriers to the implementation of Aboriginal health policy? Secondly, what are the initial actions required to improve the capacity of the health sector to implement health policy intended to improve Aboriginal health.

Understanding the implementation of Aboriginal health policy does not fit within the boundaries of one discipline. The theory and experience underpinning the implementation of Aboriginal health policy needs to access the fields of public health, political science and management. A public health framework was applied to this research because it provides an overarching framework that utilised multiple theories without being limited to an in-depth examination of one model.

This research employed qualitative research methods. At its broadest point, qualitative research may be defined as any kind of research that relies on methods other than statistical procedures or other means of quantification (40). However, this definition does not adequately describe the range of methods, concepts and perspectives that comprise qualitative work. In addition, the definition does not capture the inherent characteristics of qualitative research, nor the reasons for using qualitative research methods. In essence, qualitative research is characterised by an ability to provide a deep understanding of social phenomena. This deep understanding comes from the ability of qualitative research to examine phenomena in context and to draw on multiple methods in an attempt to gain insight and rich understanding (41;42).

The implementation of the Northern Territory Preventable Chronic Disease Strategy (PCDS) by the health system in the Northern Territory was selected as a case study to explore the pathways, facilitators and barriers to policy implementation by a complex health system. Particular attention was paid to the facilitators and barriers to implementing the policy with and for the Aboriginal population of the Northern Territory.

Four reasons prompted this choice. PCDS is a live policy that had been implemented for five years; it was developed using the World Health Organization's recommendations on developing an integrated health sector approach to the prevention and treatment of non-communicable diseases; its development followed the capacity building processes described in the Northern Territory Public Health Strategy and therefore was developed in a culturally appropriate way to target the priority issue of chronic disease; and it was developed for the entire population of the Northern Territory while recognising the specific needs of Aboriginal people who comprise 29% of the Northern Territory population (43).

PCDS was developed in 1997 and endorsed as core business by the Northern Territory Department of Health Community Services in 1999. However, the only new funding available for implementation was special funding through the Pharmaceutical Benefits Scheme S100 program in 2001. A requirement of this funding was that funds be spent in remote Aboriginal communities. Despite the initial intention that the policy be implemented across the whole of the NT population, therefore, the funding options meant that, in the implementation phase, it was essentially, an Aboriginal health policy.

Thirty-five in-depth semi-structured interviews were conducted with policy officers, policy directors, service providers and researchers in the Northern Territory. Service providers include Aboriginal Health Workers, doctors, nurses, and health services managers. Participants were employed by either Aboriginal community controlled health services, Northern Territory government health services, or local government health services.

This research was based on an interpretative view. Therefore, while collecting the data, conducting the analysis and interpreting the findings, emphasis was placed on divergence in meaning and the co-construction of views and perspectives. The inquiry lens for this research follows the tradition of critical theory. First developed by a group of German scholars in the 1920s, critical theory is defined as being concerned with justice and with the ways that elements of society interact to construct a social system (44). Elements may include a combination of factors such as race, class, gender, education and religion (45). Critical researchers see research as a means of empowering the oppressed and to this end pay particular attention to dominant values within the field of study (46). Critical theory researchers are expected to 'enter into an investigation with their assumptions on the table, so no one is confused concerning the epistemological and political baggage they bring with them to the research site' (45) p. 292. They are upfront about their concern for social justice.

An intention of this research is to improve the capacity of the health care system to implement Aboriginal health policy and therefore improve Aboriginal health. Particular emphasis was placed on gaining insights and identifying ways to improve the performance of the health care system in meeting the needs of Aboriginal Australians and to avoid the trap of blaming, discrediting or attacking the health care system. For this reason – wanting to make a useful contribution rather than providing a critique of government – it was decided to seek supervision in the domains of both academia and government. The primary supervisor was the Executive Director for the Australian Centre for Health Promotion, based at the University of Sydney, and the co-supervisor was the Chief Health Officer of the Northern Territory Department of Health and Community Services. The supervisory partnership brought together perspectives on policy from theoretical and practical grounds, national and Northern Territory perspectives. The opportunities for synergies across these settings were enabled largely through a joint supervisors' teleconference that was held between the supervisors and the student on a quarterly basis.

In addition to the supervision arrangements, the student made a conscious effort to regularly feed back initial findings to health services, government and research communities. Thirteen presentations were conducted during the candidature. In addition the student was involved in the evaluation of PCDS, and research findings were made available to the evaluators.

An overview of the thesis

The thesis is divided into five main sections. The first section provides the introduction to the study and establishes the context for the research question. Chapter 2 sets the scene for the research by describing the Australian health care system and its relevance to Aboriginal Australians. The literature on the performance of the health care system in meeting the needs of Aboriginal Australians is explored and theories within the political science, management and public health literature on the policy process are examined.

The second section deals with the theory and practice of undertaking social science research. In this section, the research design and specific methods used in the study are introduced. In addition the methods used to collect and analyse the data are outlined.

The third section of the thesis comprises Chapters 4-6. The aim of this section of the thesis is to identify the factors that influenced the changes to the original and evidence-based Northern Territory Preventable Chronic Disease Strategy. Chapter 4 includes a description of the PCDS in its original form and an exploration of how PCDS changed as it was implemented in different regions of the Northern Territory. Chapter 5 looks at the role of the health workforce in facilitating and constraining the implementation of Aboriginal health policy. Chapter 6 examines the role of professional values and the system culture in facilitating and constraining the implementation of Aboriginal health policy.

Chapters 7 and 8 comprise the fourth section of the thesis. While this section continues to describe findings emerging from the research, there is a shift in focus. The section shifts from examining policy and how it is modified as it is implemented, to examining the capacity of the health care system to respond to policy ideas. The aims of Chapter 7 are to explore the reasons that inadequate resources are invested in Aboriginal health, and to outline the implications of inadequate resourcing for meeting the health needs of Aboriginal Australians. Chapter 8 explores ways to enhance the management capacity of the health care system to implement Aboriginal health policy more effectively.

Chapter 9 represents the fifth and final section of the thesis. It begins by reviewing the findings presented in Chapters 4-8 in light of research questions posed at the outset of the research. It then discusses the actions that are required to improve the capacity of the health care system to implement Aboriginal health policy.

Chapter 2

Setting the scene

There are three parts to this chapter. Firstly by way of background, the Australian health care system is described, the ways in which Aboriginal people access health care in Australia are explored, the Northern Territory health care system is outlined, and the Aboriginal health workforce is described. Secondly, previous research that has been conducted on the performance of the Australian health care system in meeting the needs of Aboriginal Australians is discussed. An examination of this research points to a need to explore how Aboriginal health policy is implemented as a separate and urgent problem within the Australian health care system. Thirdly, the political science perspective on how policy is developed and implemented is presented, and the concept of implementation for the purposes of this research is outlined.

The Australian health care system

Health care services in Australia are responsible for providing comprehensive health care at primary, secondary and tertiary levels. They are responsible for protecting and promoting health, and preventing illness, injury and disability. Health care services in Australia include hospital and nursing home services; private community based health services (such as general practitioners and some medical specialists); public health services that are responsible for surveillance, and population-wide interventions to protect and improve the health of the population; and other specific services such as drug and alcohol services, ambulance and other health transport facilities (47).

The Australian health care system is characterised by a complicated mixture of government and private initiatives with financial responsibilities being divided between the state and territory governments, and the Commonwealth government. The appropriate division of responsibility between the two levels of government is a major policy issue. While there is general consensus around the broader powers and responsibilities of government, there is less consensus on the boundaries of those responsibilities and whether or not they are adequately fulfilled.

The Commonwealth government dominates the funding of health care, mainly through Medicare, the national health insurance program, and has responsibilities covering the Pharmaceutical Benefits Scheme (PBS) and financial support for high level residential care, medical services, and for health research (47;48). Medicare is a tax-based system of payment, intended to enable all citizens access to high quality medical care regardless of ability to pay at the point of service. The intention of PBS is to reduce the cost of pharmaceuticals at point of sale. The Health Insurance Commission is a statutory authority, established by the Commonwealth to administer Medicare and the PBS. The Australian Institute of Health and Welfare was established to collect health related statistics and to undertake research on health status. The Commonwealth also provides hospital and medical services to eligible veterans.

State and territory governments have strong legal and financial powers, especially over public hospitals, and provide a range of health services including the transport of patients and community health services (47;48).

Cost containment is a major issue for state and territory governments. The arrangement of health services in each state and territory is different. Functions such as the administration of primary and community health services, environmental health protection in areas such as food safety, and water quality control, waste disposal and occupational health and safety are sometimes the responsibility of local government. State and territory psychiatric, geriatric and mental hospitals receive almost all of their funding from state and territory governments, which normally have direct responsibility for the administration of these institutions. The states and territories also administer an extensive system of registration requirements for health professionals (47).

Aboriginal people's access to health care

In the Australian health care system, Aboriginal people access care through a variety of services. These services include mainstream, publicly funded health services that span primary and tertiary care (primary health care centres and hospitals), Aboriginal community controlled health services which mainly provide primary health care and some specialist care, and through private health care providers such as general practitioners.

In theory, mainstream publicly funded health services are expected to be responsive to the needs of all Australians, including Aboriginal Australians (49). In practice, despite principles of universal access, many Aboriginal people are excluded from accessing many mainstream services in Australia (50-52). Steps have been taken to identify and address structural, cultural and communication barriers to meeting the health needs of Aboriginal people. While some progress has been made, such as changes to Medicare and Pharmaceutical Benefits Scheme to allow greater access to these funding schemes for remote Aboriginal populations, more work is required in this area. Some of the barriers that continue to restrict the access of Aboriginal Australians to quality health care in Australia include miscommunication and lack of communication between non-Aboriginal health care providers and Aboriginal patients; mistrust of the mainstream health care system by Aboriginal people; and poor understanding by some non-Aboriginal health professionals of the impact of their own cultures on the way in which they provide health care (36;53). Aboriginal community controlled health services were established to address some of these barriers to effective service provision. But Aboriginal community controlled services are not available to all communities or people, although where they have been established, they constitute a significant component of the health care system for Aboriginal Australians.

The demographics of the Northern Territory and the structure and organisation of the Northern Territory health care system are briefly described in the paragraphs below.

The Northern Territory health care system

The challenges of meeting the health needs of its Aboriginal residents are increased by the unique demographics of the Northern Territory (NT). In 2001, the Australian Bureau of Statistics reported that less than 200,000 people were living in the NT. This population is spread over more than 1.3 million square kilometers. In the NT the majority of the population lives in urban areas. Almost 60% of the NT population lives in the three major urban centres of Darwin, Palmerston and Alice Springs. This leaves approximately 40% of the population living in rural or remote towns and communities, including Katherine and Tennant Creek. In 2000 approximately 90, 000 people were found to be living in Darwin and Palmerston, while some regions such as South Alligator were sparsely populated with less than 800 people (54).

Twenty nine percent of people who live in the NT are Aboriginal (9;10). In the NT, 81 percent of Aboriginal people live in remote communities. This is different to the national picture where 30 percent of Aboriginal people live in major cities, 43 percent in regional areas, and 27 percent in remote areas (9).

The NT is divided into five health regions. Each region has a public hospital and a number of community health services. The hospitals provide inpatient, outpatient, and emergency services (55). In total, there are 80 remote community health services in the NT. Most are staffed by resident nurses and Aboriginal Health Workers with regular visits from a general practitioner, although some of the larger communities have resident general practitioners. Remote communities also have access to visiting specialist outreach services. Health services vary in size, capacity and funding arrangements. Some of these remote community health services are funded by the NT Department of Health and Community Services, others by the NT Government through grants to local councils or health boards, while Aboriginal community controlled health services are funded by the Commonwealth Department of Health and Ageing and managed by a dedicated health board (56).

Who constitutes the Aboriginal health workforce?

Despite the fact that 29% of people who live in the NT are Aboriginal, the composition of the health workforce is overwhelmingly non-Aboriginal. Aboriginal Health Workers are the most commonly employed Aboriginal health professionals although there are some Aboriginal nurses, doctors, and a very small number of Aboriginal allied health professionals (57;58). As well, there is a growing number of Aboriginal policy officers, service managers and directors. But the composition of the health professional workforce continues to be overwhelmingly non-Aboriginal.

The high levels of chronic and acute disease and injuries experienced by Aboriginal people and communities, compared with non Aboriginal residents of the Northern

Territory, mean that all health professionals in the health sector work extensively with Aboriginal clients or patients. All members of the health workforce have significant levels of responsibility for the delivery of programs and services to Aboriginal clients and patients and, in the context of this research, for the implementation of policy. Within the workforce Aboriginal Health Workers play a critical role in the delivery of community-based health care and preventive programs (35).

The roles of Aboriginal Health Workers have changed over time. In the 1950s, Aboriginal people were employed as medical assistants in leprosy hospitals in the Northern Territory (59). In Central Australia in the mid-1990s, eight roles were identified for Aboriginal Health Workers. These roles ranged from maintaining traditional health, cultural brokerage, health education and promotion, environmental health, community care, administration and management, policy development and program planning, to clinical care (60).

In 2003, the National Aboriginal Community Controlled Health Organisations (NACCHO) held a meeting to clarify a national definition of an Aboriginal Health Worker. Two definitions emerged from this process. Firstly, Aboriginal Health Workers were described as Aboriginal people who work within a holistic primary health care framework as determined by the local community. Secondly, Aboriginal Health Workers were described as applying cultural and community insights to ensure culturally safe practice, managing health problems in the Aboriginal primary care and community setting, undertaking population health activities, functioning as an advocate and broker of change, and as an integral member of an Aboriginal primary health care team (58). These two definitions reflect a degree of confusion and debate surrounding the diverse roles of Aboriginal Health Workers. In theory the roles of Aboriginal Health Workers have grown exponentially from medical assistants and cultural brokers with a clinical focus, to a range of other roles in health promotion, community development, management and policy development. In practice, the roles of Aboriginal Health Workers vary depending on the culture and priorities of their community and workplace.

Now the Australian health care system has been described, attention is turned to previous research on the performance of the Australian health care system.

Previous research on the performance of the Australian health care system in meeting the needs of Aboriginal Australians

Aboriginal health research has repeatedly demonstrated inequitably high rates of mortality and morbidity among Aboriginal Australians compared to non-Aboriginal Australians. Less research has focused on how Aboriginal health policies are implemented. This part of the literature review begins from this latter perspective.

Bartlett and Legge are two of only a few authors in Australia who have raised concerns about system contributions to the persisting rates of mortality and morbidity among Aboriginal Australians. In 1994 Bartlett and Legge produced a report entitled ‘Beyond the Maze: Proposals for more effective administration of Aboriginal health programs’ (61). In there report they make a number of important points.

A lack of cross cultural skills among health professionals is often cited as creating barriers to Aboriginal Australians accessing heath care services. However Bartlett and Legge found that stereotypes of Aboriginal Australians reinforce the colonial legacy. This legacy acts as the major barrier to Aboriginal Australians accessing health care. Australia's failure to formally recognise its past creates ongoing discrimination that reinforces the past practices of missionaries and colonialists.

Secondly, Bartlett and Legge found that administrative and political failures have created new obstacles in the development of an effective health service for Aboriginal people. Factors such as inadequate resources for Aboriginal health are seen as directly leading to inadequate primary health care services. The authors argue that the Aboriginal community controlled sector is under-funded and unsupported, with respect to research and evaluation skills, leadership and professional development and information resources.

Bartlett and Legge describe a fragmented health care system where different components in the system are working in competing paradigms. This contested space creates structural barriers to planning and coordination; incorporating Aboriginal voices in Aboriginal health policy; and to intersectorial collaboration (61).

The Bartlett and Legge report represented a paradigm shift in the Aboriginal health literature. The persisting rates of Aboriginal illness are reframed from blaming Aboriginal people for their own illness (due to unhealthy behaviors such as alcoholism) to highlighting the implications of government actions and drawing attention to the health care system's responsibility for Aboriginal health.

Gardiner-Garden, who was referred to in the previous chapter, raised concerns about the health care system's contribution to the persisting rates of mortality and morbidity among Aboriginal Australians. Gardiner-Garden reviewed the Commonwealth government's involvement in Aboriginal health from 1972 to 1994. Between late 1992 and mid 1994 he found seven national reports on Aboriginal health issues. Paradoxically, some of these reports recommended that recommendations from previous reports be implemented. Gardiner-Garden describes a cycle of developing reports and policy without implementing the recommendations. He refers to the persisting high rates of Aboriginal mortality and morbidity, the frequency of reports and reviews, and the cycle of developing policy without having an impact on the functioning of health services or on the health of Aboriginal Australians. In order to break the cycle of reporting and inaction, Gardiner recommends that greater attention be placed on monitoring implementation of recommendations and acting upon many of the practical suggestions that have been made over the years (28).

Ian Anderson is an Aboriginal academic whose work focuses on Aboriginal health policy in Australia and internationally. Anderson's research and commentary on Aboriginal health policy is widely published (8;11;20;31;62-66). His review of the implementation of the National Aboriginal Health Strategy (8) is particularly relevant to this research.

The National Aboriginal Health Strategy is described as an important milestone in the history of Aboriginal health, because it represented, for the first time, consensus between Aboriginal communities, Commonwealth and state and territory governments on strategic directions for Aboriginal health (8). However an evaluation in 1994, five years after it was implemented, found that it was grossly under funded, there was a lack of accountability, the Aboriginal and Torres Strait Islander Commission (ATSIC) was used as a scapegoat, and that the National Council of Aboriginal Health – established to oversee the implementation of the National Aboriginal Health Strategy – lacked political support (8;38).

The major barrier to implementation appeared to be the fact that the responsibility for the National Aboriginal Health Strategy changed as it was implemented. The Commonwealth, state and territory governments and communities reached consensus on priorities for Aboriginal health, but by default, the implementation of the National Aboriginal Health Strategy became the sole responsibility of ATSIC. Additional barriers included a requirement that Commonwealth funds be tied to the provision of state and territory funds. These negotiations led to long delays and proved fruitless. No formal agreements were reached and interim arrangements were put in place. The Commonwealth funds which were eventually provided for the implementation of the National Aboriginal Health Strategy were absorbed into the ATSIC primary health care budget. ATSIC failed to develop and implement useful program performance information. There was continuing confusion about the role of Aboriginal health services, especially in relation to the mainstream health sector (8).

Anderson’s analysis of these barriers found that rhetorical commitment does not result in meaningful action. There are differences between commitments made at executive levels of government and the complexity of processes needed to sustain institutional reform. Aboriginal health is only one of a number of competing priorities. The failure to implement exists within a systemic context of poor relations between Aboriginal people and the state, and formidable issues with the structure of the Australian health care system. But perhaps the most compelling concern is that the barriers to implementing the National Aboriginal Health Strategy are not new. There are ‘uncomfortable echoes’ with prior attempts to develop policy. The failure to implement amplifies the impact of other faltering Commonwealth policy initiatives – such as the implementation of the recommendations of the Royal Commission into Aboriginal deaths in custody (8).

Based on these three key analyses, it is possible to identify some factors influencing the implementation of Aboriginal health policy. It appears that effective implementation relies on genuine commitment to the policy idea across the health care system; widespread responsibility for implementation; improved relations between the government and Aboriginal Australia; improvement to the structure of the health care system; respect and planning for the complex processes associated with generating the change that is required to implement a policy idea; timely provision of quarantined resources; and monitoring program performance. Meeting these criteria will be a formidable task. An added barrier is the history of faltering policy initiatives, perceptions of a chronic history of failing to implement policy, and the degree of cynicism that exists. An examination of the political science literature may provide some insight here. If more was understood about the policy process and the nature of implementation then some of the more subtle factors that influence the success or failure of policy might be revealed.

How is policy developed?

In the political science literature, most discussion on policy tends to gravitate towards understanding why certain problems become policies and why others do not. In the public health literature, discussion on policy tends to focus on getting evidence into policy (67;68). Less emphasis has been placed on what happens to a policy once it has been developed.

The examination of the political science literature begins with a brief outline of the policy models that have been compiled to describe the process of policy development. Policy is a concept that theorists and researchers have debated for centuries. These debates have proceeded through a number of distinct phases where certain models have been prominent. Rational decision making, incrementalism, Kingdon's policy streams and the advocacy coalition framework are some of the major models of policy development.

Rational decision making (69;70)

Policies are seen to involve a linear progression towards predetermined goals in the rational decision making model of policy development. The aim of the policy development process is to find solutions that best match goals, based on assessment of evidence. Under this model, there are a number of steps in the policy development process. Firstly, goals are defined, then what is needed to achieve those goals is explored and alternatives are considered in terms of costs and benefits. However the rational decision making model does not always reflect reality. The model fails to recognise that people do not always clarify their goals, are not rational all of the time and may drift in and out of the policy process. The rational decision making model fails to emphasise the importance of political power and contested values in the policy process, and that the role of policy makers may be to provide a set of options to government rather than to identify solutions.

Incrementalism (69;71)

Rather than taking each problem in new light, decision makers take what they currently do as a given. They then make small incremental adjustments to current actions and behavior. The incrementalism model for understanding policy development is seen to make the problems seem more manageable. The major advantage of this model is that it is not necessary for all partners to have the same goals. However, policy development does not always work in an incremental way. In many cases there is a sudden flurry of interest and a proposal suddenly takes off.

Kingdon's policy streams (69)

Kingdon's policy streams see policy problems, solutions and the national context as three separate streams that run in parallel rather than as intersecting issues that influence one another. At crucial points these parallel streams couple, creating a window of opportunity for change. In this model, timing is central to policy development. The major limitation of this model is that it does not explicitly pay significant attention to building alliances or forming coalitions.

Advocacy coalition framework (72;73).

Under this model policy, is understood in terms of collective action over a decade or more. Coalitions form among individuals and institutions who share a common set of policy beliefs and these coalitions are the vehicle for change. The focus of this framework is on individuals and organisations who seek to influence public policy on a particular issue or area, for example researchers, policy analysts, interest groups and administrative agencies.

An overview of some of the major models of policy development demonstrates that the process of policy development is dynamic, complex and intricate. Because the agenda setting process is so intensive and difficult, it is often seen by policy officers as the final step in the process. Agenda setting, however, is only the beginning of the policy process. Implementation is often seen as the responsibility of operational areas of the health care system and therefore is 'handed over' to services to implement (74). Viewing the policy process in this disconnected way undermines both the likely benefits of the policy idea and the relationship between the central and operational areas of the health care system. While some literature points to the need to involve implementers in the policy design process (75), this reads as if it has been suggested as a courteous act rather than being based on a robust understanding of the policy process as evolutionary and dynamic, and therefore relying on trust, respect and partnership.

Lin explains that policy development is not an organised and systematic process, and policy is not a single decision. Policy may be more accurately understood as 'a web of decisions that take place and evolve over time' (68) p.5.

In the next section of this chapter, attention is turned from the policy process to defining and seeking to understand the concept of implementation. But in directing attention to implementation specifically, the intention is not to reinforce the incorrect assumption that the stages of the policy process can be separated in practice and divided up to different parts of the health care system. What can be divided in theory cannot necessarily be separated in practice. While implementation has been discussed in separate sections in this chapter, in reality policy development and implementation are overlapping endeavours.

What is implementation?

Many people lament the failure to put good evidence-based ideas into practice. Prominent among these examples of ‘implementation failure’ is that more than two and a half centuries passed from the first demonstration that citrus fruits prevent scurvy until citrus was mandated in the British merchant marine. This happened despite the importance of the issue and the unambiguous evidence supplied by controlled experiments (76).

There is a tendency to assume that the failure arises at the point of implementation rather than earlier in the policy process. While people often express their frustrations, rarely do the discussions explore why this phenomenon occurs. This combination tends to foster cynicism rather than insight or inspiration for change. While a limited amount of research has focused on the implementation of Aboriginal health policy, some important theoretical work in the political science and management literature sheds light on the phenomenon of implementation.

The term implementation is sometimes used to refer to the act of putting policy into practice (74). At other times implementation refers to a set of methods to encourage others to adopt a policy idea (75;77). For the purposes of this research implementation may be defined broadly as when and how policy decisions are translated into action (75;78). Implementation is more than the dissemination of information; it is an ongoing process rather than a one off event.

In 2005, Fixen et al conducted a systematic review of the implementation literature (75). This review produced 743 citations – 20 of these were identified as experimental studies and two were identified as meta-analyses of experimental studies. A number of stages of implementation were identified from the systematic review process. These stages of implementation include exploration and adoption, program installation, initial implementation, full operation, innovation, and sustainability. Exploration and adoption involves accessing information, mobilising support and assessing the potential barriers to implementation. Ideally, at the end of this first stage of implementation there will be an implementation plan with tasks and a timeframe. Program installation requires structural supports such as human resources and reporting frameworks. Initial implementation may be best described as the awkward stage, because this is where a change in skills, organisational capacity or culture is required. Full operation occurs once new learning is integrated into everyday practice. The innovation stage provides an opportunity to refine or expand practices. The final stage is sustainability; the aim here is continued effectiveness in a changing world (75).

deLeon describes three generations of policy implementation research (79). The first generation consisted of case study analyses that tended to focus on where policies were not implemented. They did little to generate theory but they brought the complexity of policy implementation to light. The second generation was consciously theoretical and assumed a top down perspective. However there was also an alternative second generation approach that considered implementation from a bottom-up orientation (79).

In a top down approach, as the name suggests, policy is driven by government organisations and departments. Often there are many organisations and departments involved at different levels in the system; making linkages across these departments is fundamental to effective implementation (80). The focus in a top down approach tends to be on the best way to move a policy proposal to fruition. It assumes the existence of a prime mover or leader and emphasis is placed on communicating what needs to be done, rather than listening. A top down approach is prone to unduly optimistic expectations (79). In a bottom up approach, otherwise know as backward mapping, policies are developed by those in close proximity to where the problem lies (81). Backward mapping assumes that the closer one is to the sources of the problem the greater the ability to influence it. Problem solving relies on maximising discretion and decision making at the level of the problem. Control is dispersed, policy makers can only indirectly influence those working at the level of implementation (82). deLeon argues that policy implementation has been practiced as a top-down phenomenon and that its study and practice would be much better served were its practitioners to adopt a more participatory and more directly democratic orientation (79).

The third generation of policy implementation research that deLeon describes recognises that different conditions might require different implementation strategies. The most important observations emerging from this generation of implementation research is that there is no single best implementation strategy, that the appropriate strategy is very much contextual in terms of what are the contingencies surrounding the policy issues, and how they can be best addressed in terms of implementation (79).

In the literature, many factors are highlighted as important to the successful implementation of policy. They include political commitment and leadership (83); resources (74;83); specific policy objectives (74;75); structural arrangements and administrative capacity (75); leadership within organisations (78;84); dedicated staff responsible for implementation (75); feedback and communication (75); engagement with other organisations (85); continuous monitoring and evaluation (85); and community and stakeholder participation (75).

All of the above mentioned lessons are built on a vertical understanding of implementation where policy emerges fully formed. As sensible and pragmatic as the initial description of implementation is, it does not go far enough in highlighting the dynamic nature of implementation, or the evolving nature of the policy development process. Seeing policies as plans that need enforcement is based on a management framework. Under this framework, implementation is seen as a technical exercise. This understanding of implementation does not sufficiently reflect the entire phenomenon of implementation.

Wildavsky presents a different way of understanding implementation (86). He sees policies as ideas that evolve. Wildavsky explains that there will never be a scenario where all aims are met in every jurisdiction. The implementation of ideas is a context dependent exercise and is more subtle than the monitoring of aims can capture. Wildavsky states that the application of ideas will have different interpretations in different areas.

Implementation may best be described as the struggle over the realisation of ideas (86;87). Lewis defines an idea as the outcome of imagining or conceiving of something (88). Imagining something occurs in a context. Because a context is influenced by history, values and relationships, ideas may be seen as value-laden and inherently political (as opposed to technical). Ideas are not static; rather they evolve over enduring interactions and time. Therefore it is not surprising that ideas have the capacity to change and to produce unpredictable outcomes. Ideas are at the centre of policy and the policy process, therefore it may be best to think of policy as a living system rather than as a technical machine (88).

Policies are continuously transformed by implementing actions. These actions simultaneously alter resources and objectives. At each point, in the policy process new circumstances arise that allow different potentials in policy ideas to be actualised. When one acts to implement a policy; one acts to change it (86).

The notion of control appears to be central in understanding barriers to the implementation of policy in a top down model. Implementing a policy that has been designed by others located at a higher point in the hierarchy – where mandates are sent downwards and resource enabling implementation trickle down – often meets resistance. Organisations which receive policies in this nature often feel resistance because there is no ownership or control over the idea. Engagement with organisations which are responsible for implementation is essential to avoid resistance. Shared control and ownership are a critical determinant of the implementation process (89).

Understanding implementation as part of an evolutionary policy process draws upon the political science literature. Given that ideas evolve depending on the circumstances that arise, the context in which policies are developed and implemented play an important role in shaping ideas. Therefore the management literature was explored in order to further understand how organisations learn, and therefore under what conditions might they best generate, respond to and enact policy ideas.

Argyris and Schon argue that people have mental maps which they use to guide them on how to act in situations (90). Argyris and Schon present two theories to demonstrate that there is a split between theory and action. There are theories that are implicit in one’s actions (theories in use) and those that people speak of to others (espoused theory). Theories in use are the theories that can be implied by behaviour. Espoused theories are the theories that people know or describe about themselves. People tend to value their own behaviour by their intentions and they judge other people’s behaviour by its outcomes (91).

Individual, group and organisational behaviour and actions are complex and determined by a range of interrelated factors. This complexity pervades the way people and organisations learn. Therefore it is possible to apply the concepts of theories in use and espoused theory to organisational learning.

Learning involves the detection and correction of error. Single loop learning is said to be present when goals, values, frameworks, and strategies are taken for granted. Double loop learning involves questioning the role of framing and learning systems which underlie actual goals and strategies (91). In other words, single loop learning occurs at a superficial level because single loop learning takes problems at face value, and thinks about what needs to be changed to avoid those problems in the future or to respond differently to those problems when they are arise again. Double loop learning, on the other hand, questions the underlying goals of an organisation and considers whether or not the organisation is acting in accordance with their priorities.

It is possible to understand organisational learning in terms of the way people and organisations construct maps. According to Argyris (90;92) for organisational learning to occur, discoveries and evaluations must be embedded in organisational memory. If it is not encoded in the images that organisations have and the maps they construct with others, then individuals within organisations may have learned but the organisation itself may not have done so. In other words, it is possible to apply the concepts of theories in use and espoused theory in the context of organisational behaviour and learning. This knowledge is necessary in understanding how organisations might realign themselves and change their organisational practices in order to enact a policy idea (91).

Implications

Depending on which model people ascribe to, and whether grounded in the discipline of political science or management, different insights about the policy process will be revealed. But regardless of individual frameworks for understanding the policy process, it is clear that an ability to implement a policy relies on an ability to learn. Implementing a policy relies on the incorporation and adaptation of ideas into health services' core business. In order to implement policy ideas effectively, an organisation needs to know how to prioritise the most important ideas and identify processes required to realise the ideas in practice. This may involve consulting with the board, the population or the staff, or a combination of the above, or in some instances it may involve an executive decision.

Regardless of how policy ideas are adopted, the need to endorse an idea is an important stage in the policy process. In addition and perhaps most importantly, there is a need to reorient practices, structures and processes to ensure that the context for implementing an idea is set and will support the adaptation of that idea. In all of these scenarios, organisations need to learn about the science behind the idea, the relative benefit of adopting the idea, as well as learning how to apply the idea in the organisation's core business.

In a top down model the people and organisations involved in the development of the idea need to learn how to engage implementers in the policy development processes, or they need to learn how to support implementers to adopt that idea effectively. Implementers on the other hand need to learn how to prioritise which ideas are critical and which ones are beyond the capacity of the health service.

Essentially implementation appears to be about the ability to prioritise and control one's own workload. This will be difficult in health services whose core business is to treat patients and where there are widespread staff shortages. Nevertheless, implementation relies on an ability to learn how to work more effectively – to innovate, become more efficient and effective – to develop higher quality services. Clearly these improvements cannot all occur at once so good judgment is requirement – this too needs to be learned.

The connection between learning and implementation has been made before. Browne and Wildavsky argue that different levels or organisations can learn different things at different times (93). And what you learn depends on what you are interested in and therefore what questions you ask. For example, a hierarchy is interested in who makes decisions and the market is interested in the effective use of resources. Change is the idea behind implementation – this means that continually changing the objectives of the policy is as important as changing the plan for how to meet those objectives. This is why implementation is dynamic – organisations learn what objectives to prefer, as well as how to achieve those objectives.

Learning to learn becomes important and is also known as the double loop process. A non-learning organisation repeats the same error infinitely. A single loop learning organisation detects error, discovers the sources and then comes up with the strategies for its correction. Double loop learning creates a context for organisational change (90;94). Continuous change through learning, ongoing self evaluation and self development become the goal.

The structure of an organisation can influence what they are set up to learn. Hierarchies want to learn about who is entitled to have what by reason of status; markets about how to maximise total results; collegiums[1] about the equalisation of outcomes. Hierarchies evaluate to make certain proper procedures are followed; collegiums analyse from the vantage point of the worst off (93).

Organisations are more than instruments, they are bundles of desires with competing interests and shifting boundaries (95;96). They encapsulate ways of life as well as modes of achievements. It is not clear which combination of organisational structures are optimal under which conditions for diverse purposes – but there is a universal aim that is important here – that is one of multi-organisational learning. Rather than focusing on the best structure to implement policy, it might be more helpful for organisations to focus on their capacity for learning. However, if organisations learn in isolation, this may lead to divergence and a greater likelihood of organisations misunderstanding one another. Therefore a process of multi-organisational learning is required. In other words, the process of organisations learning together is more likely to facilitate a well-connected health care system.

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[1] a group where each member has equal power and authority

Conclusion

A review of the literature on the performance of the health care system in meeting the needs of Aboriginal Australians found that limited research has focused on the performance of the health care system. The research that has been conducted has demonstrated that the health care system has failed to adequately address the health of Aboriginal Australians. It identified the implementation of Aboriginal health policy as a separate and urgent problem. In addition, the literature review suggested that political science and management theory may assist the health care system to implement Aboriginal health policy more effectively.

The health care system is set up to treat patients presenting with acute illnesses, and the majority of the workforce is clinically trained. Therefore the health care system tends to focus on the health and behaviour of patients rather than on organisational performance. While there have been improvements in developing Aboriginal health policy in an inclusive and evidenced based way, little is known about how Aboriginal health policy is implemented. This review identified an urgent need to explore the implementation of Aboriginal health policy. An exploration of the political science and management theory provided some insight into the complexity of the policy process and identified the evolving nature of policy ideas and the importance of learning to successful policy implementation.

Section 2

Study design and methods

This section introduces the research design and specific methods used in this study. The chapter begins by explaining that a qualitative approach was adopted for this research. The methods used to collect and analyse data are outlined as are the various ethical issues which were considered in the course of the study. The section concludes by noting that the values of spirit and integrity, reciprocity, respect, equality, survival and protection, and responsibility underpinned this study, and more importantly were key principles in the success of the project.

Chapter 3

How was this research conducted?

Introduction

Qualitative research methods were employed to gain an in-depth understanding of the barriers and facilitators to the implementation of Aboriginal health policy. Because an in-depth rather than a broad overview was sought, it was decided to conduct a case study to provide a bounded context in which to identify and understand the implementation of Aboriginal health policy. The researcher had a particular concern for social justice and therefore the lens of critical theory was used to frame this inquiry. However, before further details of the research framework are described, an outline of qualitative research methods is provided.

What is qualitative research?

Qualitative research may be defined as:

> ‘a situated activity that locates the observer in the world. It consists of a set of interpretive, material practices that make the world visible. The practices transform the world. They turn the world into a series of representations, including field notes, interviews, conversations, photographs, recordings, and memos to the self. At this level, qualitative research involves an interpretive, naturalistic approach to the world. This means that qualitative researchers study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them’ (42) p. 3.

Qualitative researchers are concerned with knowledge and the quest for a greater understanding of society. However qualitative researchers bring unique and individual perspectives to the research that they conduct. What qualitative researchers see, learn and interpret is not universal; what is seen is shaped by the researchers’ values, beliefs and culture.

The two main perspectives of qualitative researchers are reported widely in the literature (41;42;44-46;97-101). Firstly there are a group of qualitative researchers who are referred to as positivists. These positivist qualitative researchers aim to create a ‘pure’ interview: one that is conducted in a sterilised context and comes as close as possible to providing a ‘mirror reflection’ of the reality that exists in the social world. Social constructionists on the other hand, suggest that knowledge about a reality is ‘out there’ in the social world. In other words, this second group of qualitative researchers’ believe that ‘truth’ is not a universal concept. Under a social constructionist frame of reference, an interview is seen as context specific. An interview is believed to meet the demands of an interaction between the interviewer and the interviewee and can be seen as nothing more or nothing less (102).

These two broad perspectives on the main types of qualitative researchers reveal that there is no single or accepted way of doing qualitative research. Researchers bring their own perspective on the world to their research. The researchers’ worldview comprises a basic set of beliefs that combine to provide an interpretive lens and framework in which to understand the research (42).

How qualitative research is conducted depends on an interaction of a range of factors. Prominent among these influences are the researchers’ ontology, epistemology and the purposes and goals of the research. Ontology may be defined as what can be known about the social world (101) or the nature of reality (42). Epistemology refers to ways of knowing and what is perceived as legitimate knowledge (101). Axiology is concerned with morals, values and ethics. Researchers need to express and make transparent their values and ethics so that the reader may identify the values and biases that the researcher may bring to the research (44).

The researcher felt that rich descriptions and multiple perspectives were needed to understand the nature and complexity of implementation. Therefore qualitative methods were chosen as the most appropriate method to understand the implementation of Aboriginal health policy.

The researcher’s perspective

For the purposes of this study the researcher describes herself as a critical realist. She believes that an external reality exists independent of one’s beliefs and understanding. However, because reality is only knowable through the human mind and socially constructed meanings, the researcher believes that the researcher and the social world interact and impact on each other. At the same time as respecting the interaction between the social world and the researcher, the researcher also strives for empathic neutrality and to acknowledge, look for and respect different values and ways of understanding the world. The researcher believes that research cannot be value free and therefore researchers should make their assumptions transparent. This epistemology is known as interpretivism.

In keeping with the tradition of interpretivism, efforts have been made throughout the research to highlight the researcher’s perspective that informs this research. For example in the preface of this thesis time was taken to explain the personal experiences of the researcher that contributed to this research focusing on the health system contributions to persisting high rates of Aboriginal mortality and morbidity. In addition, while collecting the data, conducting the analysis and interpreting the findings, emphasis was placed on divergence in meaning and the co-construction of views and perspectives as explained in the data analysis section of this chapter.

Throughout the research process emphasis was placed on feeding back the initial findings to participants and academic colleagues. This appraisal process was followed to build the quality and rigour of the research. As discussed later in this chapter, over eleven presentations were made to health service providers, academics and policy officers. In addition, the final draft of the thesis was read by an Aboriginal academic college. These strategies were employed to ensure the research was both respectfully presented and of high academic standard.

The framework of this research

The inquiry lens for this research follows the tradition of critical theory. First developed by a group of German scholars in the 1920s (44) critical theory is defined as being concerned with issues of power and justice and with the ways that elements of society interact to construct a social system. Elements may include a combination of factors such as race, class, gender, education and religion (45). Critical researchers see research as a means of empowering the oppressed and to this end pay particular attention to dominant values and power within the field of study (46). Critical theory researchers are expected to 'enter into an investigation with their assumptions on the table, so no one is confused concerning the epistemological and political baggage they bring with them to the research site' (45) p. 292. They are upfront about their concern for social justice.

An instrumental case study was the research framework used in this research. According to Creswell (1998), a case study may be defined as an exploration of a bounded context over time and through detailed, in-depth data collection involving multiple sources of information rich in context (44).

There are two main approaches to case studies. One method is directed by Yin and encompasses a formulaic and positivist approach to case study research and focuses on design and methods (103). The other major author is Stake whose emphasis is on the 'art' of case study research. Stake describes three main types of case studies: intrinsic, instrumental and collective. In an intrinsic case study the particular policy or program is chosen because it holds particular or unusual interest. In an instrumental case study the case is examined to provide insight into a broader issue or phenomenon. The case is of secondary interest, it plays a supportive role and facilitates an understanding of a particular phenomenon. A collective case study includes multiple cases. There might be either intrinsic or instrumental cases but the defining feature is that the researcher examines several cases (44;104;105).

This research is based on Stake's approach to case study research. He describes case study research not as a methodological choice but as a choice of what is to be studied, and views a case study as both a process of inquiry about the case and the product of that inquiry (104). In this research, the Northern Territory Preventable Chronic Disease

Strategy (PCDS) was chosen as an instrumental case study to understand how Aboriginal health policy is implemented.

In the following section of this chapter the PCDS is briefly described. A more detailed description of PCDS can be found in Chapter 4 of this thesis.

Brief description of the Northern Territory Preventable Chronic Disease Strategy

PCDS focused on five chronic diseases that share common risk factors such as smoking and obesity. The chronic diseases included in PCDS are: diabetes; ischemic heart disease; hypertension; renal disease; and chronic airway disease. The incidence and prevalence of these chronic diseases among the Aboriginal population are significantly higher than in the non-Aboriginal population (9;15). These diseases share underlying behavioural risks factors, such as: smoking, being overweight, low sense of personal control, and low birth weight. These risks are much greater among the Aboriginal population (15).

PCDS was developed to reduce the incidence and prevalence of chronic diseases across the whole population of the Northern Territory. PCDS comprised three approaches: primary prevention, early detection and better management of chronic disease. The primary prevention approach focuses on addressing underlying determinants of health as well as lifestyle modification. The primary prevention approach recognises there is a relationship between income, social class, social inequality and adverse health outcomes in adulthood. More than half the people who have diabetes are not aware of their condition. Early detection allows for earlier intervention which is likely to delay the onset and reduce the incidence of complications. Better management has been shown to reduce complications. Better management relies on the creation of systems to provide ongoing rather than acute and episodic care. PCDS has been described in greater detail in a separate paper (43).

The philosophical and technical reasons for choosing PCDS as a case study for this research are briefly described below. The PCDS is a live policy that had been implemented for five years. It was developed using the World Health Organization’s recommendations on developing an integrated health sector approach to the prevention and treatment of non-communicable diseases. In addition, the development of PCDS followed the capacity building processes described in the Northern Territory Public Health Strategy. Therefore the researcher was assured that the PCDS was developed in a culturally appropriate way to target the priority issue of chronic disease, and the researcher was confident that the quality of the policy could be assured. Emphasis could then be placed on understanding changes that occur to policies during implementation, rather than as a result of the development of a poor quality policy.

Study design

Thirty five in-depth interviews were conducted to understand how PCDS was implemented. While the in-depth interviews were the main data collection methods used in this research, multiple sources were drawn upon to provide rich insight into the nature of implementation. Strategies such as reviewing formal documents on PCDS and taking note of observations in a research diary were also included in the study design. Informally triangulating what interviewees reported with the researcher's observations and official documentation on PCDS, allowed for a deeper understanding of the complexity of implementation to be generated through this research.

Participant selection

Participants were selected purposively following the key principles of sampling as described by Curtis et al (106). A list of stakeholders, and where possible people instrumental in the development and implementation of PCDS, was drawn up. Attention was placed on ensuring a range of perspectives were considered across the different professional groups and levels in the system, at the central policy level and the health services delivery level of the health sector. Emphasis was placed on including a diverse range of voices in community health services rather than covering all regions of the Northern Territory. The interviews were held with nurses, doctors, managers and Aboriginal Health Workers within the one community.

Policy officers, policy directors, service providers and researchers in the Northern Territory participated in this research. Service providers include: Aboriginal Health Workers, doctors, nurses, and managers. Participants were employed by either Aboriginal community controlled health services, Northern Territory government health services, or local government health services.

Twenty percent (7/35) of interviewees were Aboriginal. Aboriginal interviewees worked as health service managers (n=3), Aboriginal health workers (n=2), a research officer, and a policy officer. Of the seven Aboriginal interviewees, five were trained as Aboriginal health workers.

The majority of interviewees has a professional background in either medicine or nursing (n=23). Five of the interviewees had worked as Aboriginal health workers, three in allied health, three in fields outside health, one as a project officer, and one interviewee trained as both a nurse and a teacher. The health sector is dominated by people trained as nurses and doctors. See Table 1 for a list of interviewees by current positions, Aboriginal status, professional background, and organisational funding arrangement.

Table 1: Characteristics of interviewees (n=35)		
	N	%
Current position		
Aboriginal Health Worker	2	**6**
Doctor	8	**23**
Manager	6	**17**
Nurse	4	**11**
Policy Director	3	**9**
Policy Officer	8	**23**
Researcher	4	**11**
Aboriginal Status		
Aboriginal	7	**20**
Non-Aboriginal	28	**80**
Professional background		
Aboriginal Health Worker	5	**14**
Allied Health	3	**9**
Doctor	11	**31**
Nurse	12	**34**
Other	4	**11**
Funding arrangement		
ACCHS	6	**17**
NT Government	21	**60**
Local government (grant in aid)	4	**11**
Non Government Organisation	**4**	**11**

Collection of data

All potential participants were telephoned by the primary researcher and sent a letter to invite them to participate in the research. Only one organisation declined to participate given other research commitments. An information sheet was provided and written consent was obtained from all participants prior to interview. Copies of the information sheet and consent form are attached as appendices 3 and 4. The interviews occurred at the participants' place of work – in Darwin, or Alice Springs or in remote Aboriginal communities several hundred kilometres from the major urban centres of the Northern Territory.

Semi-structured in-depth interviews were conducted with thirty-five participants. All interviews were conducted by the primary researcher. An interview prompt was used. A copy of the interview prompt sheet is attached as Appendix 5. Participants were asked to describe how they were involved in the PCDS or in preventing or managing chronic disease; factors that supported the implementation of PCDS; barriers to implementation of PCDS; how to recognise success; and how to recognise success for Aboriginal people. The duration of the interviews was between thirty and ninety minutes.

During the interviews the primary researcher encouraged the interviewee to talk. The primary researcher made a conscious effort to keep her own opinions and beliefs to herself and facilitate discussion without challenging the interviewees' opinion. Time was spent prior to the interview building up the relationship with a general discussion before asking the research questions. In this way the primary researcher eased her way into the interview. She began by asking participants to give a brief overview of their professional background and how long they had been in the Northern Territory. This allowed the interviewees to commence the interview by talking about their experiences with confidence. The primary researcher tried to present herself as someone who was 'neither firmly entrenched in the mainstream nor too far at any particular margin' (102) p. 104.

Data management

Thirty four of the interviews were recorded and then transcribed. One interview was not recorded, but detailed notes were taken. All participants were sent a copy of their transcript (or notes from the interview when not recorded) for verification and comment.

The primary researcher made detailed notes on the transcripts. This allowed the identification of emerging issues and to highlight patterns in the information being collected.

Once all interviews had been conducted, interview transcripts and notes were entered into QSR NVivo, a computer software package that assists in managing qualitative data.

Data analysis

Some qualitative researchers describe interpretation as an art (107). Others argues that qualitative analysis involves both creativity and rigor (108;109). Creativity is needed to present information in an engaging and insightful way. Rigor relies on a systematic approach, thoroughness, and a clear description of process.

There are a number of different traditions in qualitative analysis. There are also varying definitions of each these traditions. For example, content analysis has been defined as organising content into themes; thematic analysis also fits into that broad definition. The difference lies in when and how codes are identified. With content analysis categories are identified prior to coding, whereas with thematic analysis codes are identified from patterns and themes in the data (107). Green et al describe three traditions: thematic content analysis; grounded theory; and framework analysis. It is interesting to note that content and thematic analysis have been combined into one category. Grounded theory is described as discovering theory from the data and involving a cyclical process of collecting data, analysing it, developing codes, further sampling, and more analysis and so on, until saturation is reached. Framework analysis is described as classifying data within a thematic framework (109). Definitions of some of the different traditions are set out in Appendix 6. The term grounded theory is often misrepresented (109). Grounded theory is a research method rather than a technique of data analysis.

In this research, interviews were coded and analysed using thematic analysis. The themes used in analysis were derived primarily from the data and through sequential analysis.

Three main coding procedures were used. These included open coding, axial coding and selective coding. Open coding involved comparison between events, actions and interactions. The researcher took apart each idea and reconceptualised it, giving it a new name that was seen to represent a broader phenomenon. Axial coding occurred once categories and relationships were developed. These codes were more rigorously specified and connections were made between categories and subcategories. The codes were scrutinised during this process to ensure that each code was fully elaborated and delineated. Next, selective coding was used to map the links between all the codes. A central code was identified to provide a theoretical point of integration for the research (107).

Open coding, largely involved data management because emphasis was placed on sorting and synthesising the data. Firstly each interview was broadly coded on QSR NVivo. Then each broad code was pasted into a word table with three columns. The first column housed the interview text, the second column included notes that summarised the main points being made in the interview text, and the third column was used to develop axial codes.

Selective coding was conducted with pencil and paper in a research journal. In the centre of the page the main code was listed, such as barriers or supports to the implementation of Aboriginal health policy. A balloon was drawn around the main code. Then the sub codes were written around the main code. Clusters formed around particular codes. Many of the sub codes were similar across the main codes. For example the workforce, responsibility for health, funding and leadership and management were all discussed as both a support to implementation, and as a barrier to implementation. Therefore the codes were remapped using themes that emerged from the interviewees' comments, rather than the themes that were derived from the interview prompts.

There were three levels to the interpretation process. Firstly, the researcher attempted to understand the points that the participants raised. Secondly, there was a crucial common sense understanding where the researcher used general knowledge about the context of statements to place them in a wider arena. Thirdly, theoretical understanding (or evidence, or literature) where the interpretation was placed in the broader literature (108).

To strengthen the validity of the analysis, interview themes were compared to the original PCDS framework and to the national and international literature. This was done to strengthen the validity of the research by identifying how the perspectives of the participants compared to, or differed from the literature.

The analysis process was not linear. Rather, there was a constant need to go back to the interviews and to go back to the literature. This process relied on thinking conceptually and an ability to link concepts and identify the underlying issues without speculating beyond the research question or findings.

Presentation of the data

The data are presented in a descriptive way and are illustrated with verbatim quotes. This method was chosen to present the data in its full richness and to capture the participants' reality.

During the analysis it became apparent that people from similar occupational backgrounds tended to share common views. Therefore there was a need to describe particular professional groups. However the process of labeling professional groups as similar is problematic because it increases the risk of generating stereotypes and not being mindful of individuality and heterogeneity among people within professions. However patterns did emerge and it was important to describe this in the research. The intention was to describe patterns, not to express a pejorative view.

Ethics

In the past, the type of Aboriginal health research that has been conducted in Australia has been one of the barriers to improving Aboriginal health. Aboriginal health research has been described as exploitative. In some cases unethical research practices were justified by arguments for the greater good of the community. Therefore it is not surprising that research has been considered a dirty word among some Aboriginal people (19;21).

A number of underlying assumptions that inform research practice have been seen as unacceptable to Aboriginal people and problematic in making a useful contribution to improving Aboriginal health. Tuhiwai-Smith argues that western research brings a cultural orientation – a different conceptualisation of such things as time, space and subjectivity, and different and competing theories of knowledge (110).

One of the implications of the dominance of the western research framework is a tendency to conduct descriptive research rather than intervention studies. A review of Aboriginal publications in Australia, New Zealand and Canada, published in 2006 revealed that there is an over reliance on descriptive research (111). This is especially problematic if one considers who benefits from descriptive research and at what point. Anderson aptly states that it is the researched not the researchers who should be the primary beneficiaries of any inquiry (20). In Australia – in Aboriginal health research – this has not been the case. As a non-Aboriginal Australian researching Aboriginal health, the researcher was keenly aware and at times paralysed by the fact that Aboriginal health research is a contested and ethically treacherous space (24).

Since the 1980s Aboriginal health research has undergone reform that led the National Health and Medical Research Council (NHMRC) to establish guidelines for ethical conduct in Aboriginal and Torres Strait Islander Health Research (21). The NHMRC guidelines were endorsed in 2003 and are intended to provide guidance to researchers during the conception, design and conduct of the research. And perhaps more importantly and influentially, the Human Research Ethics Committees consider proposals for research in light of the values and ethics included in these guidelines. The values that underpin these guidelines and therefore are the basis of this research are: spirit and integrity, reciprocity, respect, equality, survival and protection and responsibility (23).

Ethical Aboriginal health research, like all concepts can be seen from many angles. The advent of the 2003 draft values and ethics in Aboriginal and Torres Strait Islander Health research, replaced the NHMRCs original guidelines from 1991. The 2003 guidelines represented a shift in focus from emphasising legal processes to define and enforce consent, to emphasising values that should underpin research. In the 2003 version of the guidelines, ethical conduct is focused on repositioning research to consider the point at which research benefits Aboriginal people and the ethical implications of research, rather than focusing on confidentiality for individual participants.

Initiatives such as the 2003 NHMRC guidelines represent a shift in the paradigm of research to ensure that there are immediate and direct benefits for Aboriginal people. Anderson suggests three ways to understand the benefits stemming from Aboriginal health research. Firstly there are immediate benefits. For example the skills of Aboriginal Health Workers may be enhanced through the research process. Or as a result of the research there may be raised community awareness of a health problem, or treatment of an individual with a disease. Secondly there are direct consequences of research that emerge from the data collected, the results of analyses, and the impacts of published material, and new intervention strategies designed as a result of the research project. Finally Anderson refers to delayed benefits. This is when the application of research findings depends on further developments in interventions or conceptual models (20).

The practical response to these guidelines and the application and relevance to this research is outlined below.

Of the six values that lie at the heart of the guidelines, spirit and integrity may be seen as the glue that binds and links all the values together. The spirit and integrity value is intended to reflect the fact that the present and the future are bound up in the past. Integrity is defined as behaviour which maintains the coherence of Aboriginal culture. The key to upholding integrity in Aboriginal health research is to not impose a western research framework that threatens or undermines the coherence of Aboriginal culture.

The value of reciprocity requires the researcher to demonstrate a benefit to the community. It is possible to distinguish between benefits stemming from the process of research and benefits stemming from the outcomes of research. There is an increasing shift in Aboriginal health research to ensure that immediate benefits from the research process are directed to the Aboriginal community. Potential benefits may include employment on the research project, and increased community knowledge and awareness of health conditions or determinants.

Given the bias towards describing rates of disease among Aboriginal populations combined with the relative dearth of health system research, and given that the researcher is a non-Aboriginal Australian, it was decided that it was important and useful to focus on the health system as the subject of this research. Therefore the community of interest for this research included the Northern Territory health care system; health services; health professionals; policy officers, and Aboriginal Australians living in the Northern Territory. The values that underpin the NHMRC guidelines were applied to researching the Northern Territory health care system and all of its stakeholders.

In the spirit of reciprocity a number of presentation of the research aims, methods and findings were conducted throughout the candidacy. Four presentations were held in 2005, seven in 2006 and to date, two presentations have been held in 2007 with more planned later in the year. These presentations are listed in Appendix 1.

Respect for human dignity and work is an important characteristic of relationships between people. A respectful relationship is based on trust. The researcher was conscious of ensuring that Aboriginal perspectives were incorporated into the design and analysis of the process. This was achieved through consultation and discussion with colleagues and friends who are Aboriginal and by stratifying the interview sample to ensure that the perspectives of Aboriginal people were reflected in the research.

Equality was an important principle that was upheld throughout the research. Care was taken to ensure a range of perspectives in the interviews, in terms of the different professions interviewed and in terms of the geographical location across the Northern Territory. Perspectives were sought from rural and remote locations and from the Top End of the Northern Territory and Central Australia. In addition, care was taken during analysis to consider the implications of the research findings in terms of each professional group. For example, in Chapter 4 this research recommends a greater role for Aboriginal Health Workers in chronic disease interventions, through the implementation of the primary prevention arm of PCDS.

The researcher's responsibility to cause no harm during the research process or as a result of the research outcomes, was taken seriously. Care was taken to negotiate sensitive issues. The researcher was conscious not to make judgments about those working in Aboriginal health policy or to imply that those working in Aboriginal health policy were performing poorly. The emphasis of the research is on the system and how the collective rewards particular behaviours, and that agents of the system work within the incentives, rewards and penalties of the health care system's culture. Attention was placed on looking at ways to improve the capacity of the health care system to implement Aboriginal health policy – not to discredit it or provide a critical review.

The researcher was committed to reflective practice. Detailed notebooks were kept during the period of her studies. She recorded details of meetings, conversations, observations, her response to conferences and general reflections. These notes were used extensively to interpret findings, to conduct the analysis and to write this thesis.

The research had high level support from the Northern Territory Department of Health and Community Services and was seen as a collaborative exercise that reinforced the intention to conduct informative and constructive research. The student researcher had two supervisors providing complementary expertise across the policy and academic environments. One supervisor is the Chief Health Officer of the Northern Territory Department of Health and Community Services, and the other supervisor is a leading policy and health promotion academic from the University of Sydney.

Throughout the research process emphasis was placed on maintaining communication and relationships with those working in chronic disease within the health care system. The researcher was acutely aware of who was benefiting from the research and at what point. The PCDS was being evaluated at the same time as this research was being conducted and the findings from this research were shared with the evaluators and was seen to provide some evaluative feedback and input into the evaluation process.

Building the trust between the researcher and the researched facilitated honest and open interviews and, more importantly, provided the foundation for the successful uptake of the research findings. The health care system was involved in the research design, data collection and analysis. A communicative and collaborative approach was undertaken and a concerted effort was made to build and maintain two way communication throughout the research process. While writing up the findings, the researcher recognised that these findings would be presented to those working in the health care system. Therefore in writing up the results from this research, care was taken to be fair, honest and diplomatic. Undertaking a collaborative approach and building trust between the researcher and those involved in chronic disease in the Northern Territory, meant that the Northern Territory health care system was interested in hearing the findings from the research and in discussing their implications.

This research was approved by the Top End and the Central Australian Human Research Ethics Committees.

Conclusion

As a non-Aboriginal Australian conducting Aboriginal health research, the researcher was acutely aware of the need for this study to make a positive contribution to the Northern Territory health care system, service providers, policy officers, the Aboriginal community and the research community more broadly. The success of this study relied on a considered and reflective approach to the research process in keeping with the values of spirit and integrity, reciprocity, respect, equality, survival and protection, and responsibility as outlined in the NHMRC guidelines for conducting Aboriginal and Torres Strait Islander research.

In the following five chapters of this thesis the findings emerging from the research are presented.

Section 3

How is Aboriginal health policy implemented?

This section of the thesis presents the first part of the findings emerging from the research. The intention of the research was to understand how Aboriginal health policy is implemented by a complex health system. An examination of the Northern Territory Preventable Chronic Disease Strategy revealed that it changed as it was implemented. The PCDS is used differently by different organisations, demonstrating that there is an interaction between the policy framework and the context in which policies are received.

This section of the thesis will explore the factors that influenced the changes to the original, evidence-based Northern Territory Preventable Chronic Disease Strategy.

Three chapters comprise this part of the thesis. Chapter 4 describes the implementation of the PCDS and explains why PCDS was chosen as a case study of the implementation of Aboriginal health policy. Chapters 5 and 6 explore in detail two themes emerging from the research: the role of the health workforce in facilitating and constraining implementation, and the roles of professional values and system culture in the implementation of Aboriginal health policy.

In this section of the thesis emphasis is placed on demonstrating the dynamic ways that policies change as they are implemented.

Chapter 4

The Northern Territory Preventable Chronic Disease Strategy: An instrumental case study

Introduction

The Northern Territory Preventable Chronic Disease Strategy (PCDS) was chosen as an instrumental case study to understand how Aboriginal health policy is implemented. An overview of the PCDS it its original form reveals that PCDS evolved over time and across regions throughout the Northern Territory. There are three components to this chapter. The first includes an explanation of why PCDS was chosen as a case study of the implementation of Aboriginal health policy. The PCDS is described in the second component, and the third explores how PCDS changed as it was implemented and how PCDS was used differently across the levels of the health care system and across regions of the Northern Territory.

Why choose the PCDS as a case study of implementing Aboriginal health policy?

PCDS was developed in response to a growing rate of chronic disease among the population of the Northern Territory and concerns about the capacity of the health care system, particularly in remote communities, to respond to the increasing burden of chronic disease. Evidence of effective services and programs to prevent and treat chronic disease, and community knowledge (from both Aboriginal and non-Aboriginal community members) were drawn upon to create the PCDS.

In essence, the PCDS provided an organised approach to preventing and managing a group of related chronic diseases. The PCDS represented a comprehensive and high quality policy that was intended to guide health service planning and delivery across the Northern Territory. It was to be implemented by existing health services.

The high regard for PCDS was widespread. For example in the excerpt from one of the participants, PCDS was likened to a great revolution:

> *'When we arrived in the NT in 2001, we thought of the PCDS as a kind of philosophical / intellectual event which would unite all health care workers in the Great Cause of banishing chronic disease. In this context, the 1999 the*

> *Preventable Chronic Diseases Strategy could be seen as the great Communist revolution, with everyone working for the same cause: to cure and prevent chronic disease with all of life, healthy mums, healthy babies, etc.'* Doctor

In another example the PCDS was described as a common sense approach that was able to unravel complex interrelated determinants of health into a visionary strategy that included practical ways to address chronic disease:

> *'PCDS was common sense. One of its great strengths was unraveling the complex interrelationships between tobacco and nutrition, and birth weight and kidney disease – all that sort of complexity was a bowl of spaghetti to the people who were trying to work out what we do about all of this. And so when it was set down in that Strategy* [PCDS] *it suddenly became doable.* Policy Director

The PCDS has been adopted in other jurisdictions in Australia and, as one of the researchers interviewed as part of this study describes: *'The Northern Territory PCDS has been the blue print for the national PCDS strategy.'*

The widespread high regard for PCDS meant that when examining the implementation of PCDS the quality of the policy could be assured. Therefore by taking PCDS as a case study to explore policy implementation, it was possible to examine the quality and impact of the implementation processes as a discrete component of the policy cycle. Confidence in the quality of the policy idea created the space required to examine the strengths and weaknesses and the barriers and supports to implementation.

What is Aboriginal policy?

While the PCDS was developed for the entire population of the Northern Territory, particular attention was placed on the specific circumstances and higher rates of chronic disease among Aboriginal people. In the Northern Territory 29% of the population is Aboriginal. In the excerpt below a participant explains why Aboriginal health is seen as core business of the health department and as an integral component of the PCDS:

> *'Predominantly* [the development of the PCDS was] *driven by people working in Indigenous health. And because Indigenous people are over represented in the health statistics and in the health system, people said like it or lump it Aboriginal health has to be part of our core business… PCDS was developed in consultation with the people who it was going to affect – and that is obviously Indigenous people both as clients and as workforce. I think that is something that is certainly a feature of the NT – the fact that Indigenous health has to be the core business because you're talking about a third of the population.'* Researcher

The PCDS represented a new generation of policy that was not equity neutral. During its development PCDS took into account the particular needs of Aboriginal populations and was founded on the knowledge that Aboriginal people suffer a greater burden of chronic disease. So while on the one hand the PCDS may be described as a generic policy on chronic disease that made specific reference to Aboriginal populations, it is also true that the PCDS was a policy founded on principles of equity and social justice.

However there were changes to PCDS as it was implemented. As described further along in this chapter, the requirements of funding stipulated that funds allocated to PCDS be spent in remote Aboriginal communities. Therefore during its implementation PCDS focused mostly on remote Aboriginal communities and essentially became an Aboriginal health policy.

Therefore in this thesis the PCDS is thought of as an Aboriginal health policy. However, the author recognises that it is difficult to precisely define what constitutes Aboriginal health policy. One may start by describing Aboriginal health policy as a policy that is developed explicitly for and with Aboriginal Australians. However, in addition there is a general perception that Aboriginal health policy is developed exclusively for Aboriginal Australians. Under this definition the PCDS may not be seen as an Aboriginal health policy because it was developed for the entire population of the Northern Territory.

A description of the PCDS

In 1997, PCDS was developed by the Northern Territory Department of Health and Community Services in consultation with Aboriginal community controlled sector, and non government organisations and with explicit reference to the scientific literature. Its aim was to reduce the incidence and prevalence of chronic diseases across the population of the Northern Territory. The PCDS focuses on five common chronic diseases. These diseases are diabetes; ischemic heart disease; hypertension; renal disease; and chronic airway disease. Each of these diseases shared underlying risks, such as smoking, being overweight, low sense of control, and low birth weight.

The idea behind PCDS was to develop an integrated evidence based framework to prevent and control these common chronic diseases. The strategy arose as a result of recognition that the major burden of disease among the population of the Northern Territory had shifted from communicable diseases to chronic diseases. The shift in focus is profound for a health system because chronic diseases are, by definition prolonged, and require patients and their families to take a significant level of responsibility for the treatment and on-going management of their conditions. Furthermore, chronic diseases are more clearly the result of the interaction between people and their social, economic, and physical environments. The role of ‘primary prevention’ is, therefore, more obvious in relation to non-communicable diseases.

The PCDS provided the evidence base and a framework for the management and prevention of chronic diseases, and as such, was an important and much needed strategy. The health system had been set up to diagnose and treat communicable diseases – the PCDS provided guidance for the changes that were needed in order to enable the system to contribute significantly to the reduction in the incidence and prevalence of chronic diseases.

The PCDS included three approaches to preventing and managing chronic disease: better management, early detection and primary prevention. Better management relies on the creation of a system to provide ongoing rather than acute and episodic care. Early detection allows for earlier intervention which is likely to delay the onset and reduce the incidence of complications. The primary prevention approach focuses on addressing underlying determinants of health as well as lifestyle modifications. The primary prevention approach recognises there is a relationship between income, social class, social inequality and adverse health outcomes in adulthood.

The ten year objective for the PCDS was to reduce the projected incidence of the five common diseases (diabetes, ischemic heart disease, hypertension, renal disease, chronic airway disease). The three year objective was to reduce the projected impact such as hospitalisations and deaths from chronic disease.

The PCDS framework and a timeline of the events comprising the development and the implementation of PCDS are included as Appendix 7.

After being developed in 1997, the PCDS was endorsed as core business of the Northern Territory Department of Health and Community Services in 1999. During this period implementation involved champions of PCDS explaining the details of PCDS and promoting the benefits of the framework that underpinned PCDS. While the arguments presented in PCDS are compelling, and the increasing burden of chronic disease was a significant concern, without systematic and structural supports within overstretched health services, achieving change proved to be onerous and enormously difficult.

In 1999, responsibility for PCDS shifted from the Public Health Division to the Primary Health Care Division of the Northern Territory Department of Health and Community Services. This decision to change the location of organisational responsibility for PCDS between divisions was undertaken to encourage closer links between central office and regional health services. By incorporating PCDS as part of the Primary Health Care Division it was believed that the PCDS might be more likely to be seen as the core business of the Primary Health Care Division rather than an additional or external project. Engaging the primary health care workforce was seen as essential to the implementation of PCDS. Responsibility for implementing the PCDS was seen as resting with operational areas (43).

However, PCDS evolved as it was implemented. Changes to PCDS during implementation were influenced by two main factors – how the PCDS was funded and the role of professional groups in the health care system. These are now described.

What factors influenced the implementation of PCDS?

Arguably the most significant event in the implementation of PCDS was receiving substantive funding in 2002. The process of acquiring these funds is described in the paragraphs below.

Funding

In 2001 special funding was made available to facilitate the implementation of PCDS through the Pharmaceutical Benefits Scheme (PBS) Section 100 (S100) program.

S100 of the National Health Act 1953 was originally intended to allow the Commonwealth to provide medications outside the normal mechanisms of the PBS. Under S100 the Minister may make special arrangements so that an adequate supply of special pharmaceutical products are available to persons who are living in isolated areas; or who are receiving medical treatment in such circumstances that pharmaceutical benefits cannot be conveniently or efficiently supplied or are inadequate for that medical treatment.

A memorandum of understanding was signed between the Commonwealth and the Northern Territory Government that extended the PBS to all communities in remote areas where there were no pharmacies. The memorandum of understanding required that the new Commonwealth S100 payments would not be used to replace or reduce the Northern Territory government’s expenditure on remote Aboriginal health. Prior to this arrangement the Northern Territory Government had been supplying medications to remote Aboriginal community. Therefore changes to the S100 arrangement enabled the redistribution of funds within remote health services. Funds that had previously been spent on medicines were then able to be allocated to other areas of need.

In 2002, after much negotiation in the Northern Territory Department of Health and Community Services it was proposed that the major proportion of S100, $2.35 million per annum, be devoted to remote area implementation of the Northern Territory Preventable Chronic Disease Strategy and Quality Use of Medicine Programs. This was to be monitored by regular meetings with the Northern Territory Aboriginal Health Forum. The annual savings from S100 became the main source of ongoing funding for PCDS activities.

The way in which S100 funds were able to be used for funding PCDS was broadly known throughout the Northern Territory health care system. The process is aptly explained by one of the participants:

> *‘Section 100 is primarily about delivering pharmaceuticals to remote Aboriginal people. The Territory was already spending money on all those pharmacy services prior to Section 100 existing… part of the agreement was that funding would continue to be available once the Section 100 agreement was signed. The Territory wasn’t supposed to withdraw that money* [from remote Aboriginal

> communities]*… Part of the money was able to be used for funding PCDS.'* Doctor

A requirement of this Commonwealth funding stipulated that funds that the Northern Territory government had previously spent on medications to remote Aboriginal communities remain in remote Aboriginal communities but could be spent in other areas of health care. These funds were allocated to the implementation of PCDS. The funding arrangement was the most visible factor that led to the PCDS becoming essentially an Aboriginal health policy.

The role of professional groups in the health care system

Professional groups in the health care system had a substantial influence on the implementation of PCDS. In its original form, the PCDS included three equally important approaches of primary prevention, early detection and better management. However, during implementation, the better management of chronic disease became the principal approach of PCDS. While the fundamental reasons behind these changes to the three approaches of PCDS are less tangible than the influence of funding, the effects are powerful.

Respondents explain the shift in focus to better management according to ethics, pragmatism, diminished capacity of remote health services, and the power and commitment of certain professional groups. Ethics are a relevant concern here because a number of respondents felt that focusing on early detection of chronic disease would be unethical if services were not equipped to treat and manage the new diagnoses. One participant offered pragmatism as an explanation for the refocus. It was felt that when tackling an issue as complex and large as chronic disease, there was a need to start somewhere. Better management became the starting point. However, the pragmatic explanation, in isolation from other explanations, loses credibility when many participants indicated that remote health staff and services were not equipped to deal with the increasing burden of chronic disease. This concern about remote health service capacity appeared to be the fundamental driving reason for focusing on the better management of chronic disease.

As described by one participant, remote health management and staff were seen as being overwhelmed by chronic disease:

> *'Remote staff were overwhelmed and paralysed by the extent of chronic disease in the community, therefore the priority was to put in supports to make the task of managing chronic disease achievable.'* Policy Director

However, in addition, a number of participants commented that district medical officers were highly influential across the health care system and in the development and implementation of PCDS:

> *'Having a group of highly respected, brilliant, long-term, Territory-based public health physicians that have grown primarily out of a group of DMOs* [district

> medical officer] *who really didn't accept an emergency general practitioner function as their sole purpose in life… they've thought deeply about what they have experienced and they have had a major system-wide impact on how we do business: partly through writing the Strategy* [PCDS] *and partly through living it.'* Policy Director

Members of this professional group are clinically trained and therefore more likely to have skills in clinic based activities such as the treatment and management of chronic disease rather than the skills required for primary prevention approaches.

While less explicit, the change of PCDS from three main strategies to focusing mainly on better management was determined by a significant factor. In the health care system the treatment of patients and other clinic-based activity are seen as core business. While in theory prevention is seen as important, the health care system is not set up for and therefore is less skilled in community-based activity.

The acquisition of funding and the dominance of clinical training within the workforce influenced the evolution of the PCDS. However, these modifications to PCDS are only part of the story. PCDS was used differently in central and operational areas of the health care system.

How PCDS was used in different regions in the Northern Territory

The central and regional parts of the health care system used the PCDS for very different purposes. The central level used PCDS to lobby for funding in competition with acute care, while at the regional level the PCDS evolved into various types of chronic disease programs.

Before exploring how PCDS was used across the central and regional parts of the Northern Territory, the reasons why change is especially difficult in resource poor contexts, and the factors that are required to generate change are introduced. These concepts are explored in greater detail in chapter 8 of this thesis. The context in which PCDS was received has limited resources and is facing increasing demand. Some health services have been described as being '*stretched like a drum'*. As described by one of the participants below, it is especially difficult for health professionals to change practice in circumstances where health services are over extended:

> *'it is easier just to do more of what you're used to doing, rather than think about how to do this differently'* Doctor

If a health professional is required to spend his or her day catching up on tasks from the day before, or responding to patients who present at the health service, then it is difficult to create the space required to think proactively about how to do things differently.

In addition to policies being received in resource-poor contexts, the nature of change is complex, time consuming and challenging. In the excerpt below a participant describes the multiple steps involved in implementing a policy idea:

> *'there is a process of you actually have to have the idea, you have to work out how you're gong to implement the idea and you have to get the change happening. And that is the critically difficult step. And then you have to monitor to make sure that the change is happening, and that doesn't happen very often, and then you have to sort of tinker a bit. But you have to not tinker too much, because otherwise you never get the change embedded.'* Doctor

Implementing policy relies on change. This research has found that change relies on the ability to set aside time to think about and plan for the change process. In addition there is a need for a high level of expertise and respect for the change process. When there are only a limited number of health professionals operating in a context with increasing demands, it is difficult to undertake this change process. Additional resources, expertise and support are required to engender and maintain change, regardless of how good the policy idea might be. People working at the central policy level play an important role in securing these resources and providing support to the health services.

Central policy level

This research revealed that the health professionals working at the central policy level had two main roles in the implementation of the PCDS. Firstly, health professionals used the PCDS as a resource to lobby for additional funds to be allocated to addressing the increasing burden of chronic disease. As described by one of the participants, the PCDS proved to be a very effective resource in lobbying for funding of chronic disease programs:

> *'Since we have had the* [Preventable] *Chronic Disease Strategy, whenever there has been an opportunity to make recommendations around funding we have pulled out that strategy and we've slapped it on the table and we've said remember this? This is what you have committed to, this is what you believe in, this is what we are all working towards, and so here is the next thing on the list that hasn't got any money. It might be maternal and child health or whatever… So one of those rare opportunities we have to direct government around money was when the Commonwealth agreed to fund PBS listed drugs in remote health.'* Policy Director

Secondly, health professionals working at the central policy level play an important role in supporting the regional level of the health care system to implement PCDS. There is a perception among many service providers that chronic disease work was initiated with direct, hands on support from town. The support involved staff from the central policy level going to the regional health service to generate a list of people with high blood glucose; the provision of guidelines and staff education on how to manage chronic disease and screen for complications. In the example below a health service manager describes how staff from the central policy level assisted in the development of their patient recall system:

> *'We really didn't have a list of diabetics, didn't even have a profile in the community, of who are the diabetics, who are the hypertensive people, all those*

> *sorts of things. So they came out and they set that up, they gave us education and they gave us guidelines on what to do. It was more in the way of following these people up from a medical perspective, of doing the appropriate tests and assessments on chronic disease patients, and things like that. Then once we got into the swing of doing that, then we started* [with the help of people from central office] *getting more ideas of what sort of education we should be doing with these people* [chronic disease patients].*'* Manager

Regional health service level

Despite the acquisition of funds and central office providing support to regional areas, there were variations in chronic disease program across regions. Many different types of chronic disease programs are operating at the regional level of the health care system. In this part of the chapter the three types of regional chronic disease programs are described.

Community A: A remote community with PCDS funding

In a remote community Aboriginal health service, a chronic disease nurse and a chronic disease Aboriginal Health Worker are employed in dedicated chronic disease positions funded through the Preventable Chronic Disease Program. While the positions are based in one particular remote health service, they are responsible for four communities in the region. They visit one of these communities once a week and they visit the other two communities on a monthly basis. In this region the chronic disease work is set up as a specialised program rather than as core business or routine work in the health service. Establishing a program for chronic disease is seen as important because a program provides a structure to ensure that time is dedicated to chronic disease, and protects against acute care consuming the work of the health service.

In the excerpt below the chronic disease nurse describes the day to day responsibilities of their regional Preventable Chronic Disease Program:

> *'Basically we are involved in it by keeping the* [patient recall] *card system going. We aim to see a diabetic or hypertensive patient every three months. We do just general obs, diabetics have a HbA1c done every three months, a blood test that gives us a picture of what their sugar levels have been over the last two months. But we also use all those opportunities of seeing those people, to doing some brief interventions, talking to them about their medication, making sure they understand what each tablet is for, why it is important to take it, encouraging them to take it, encouraging them to get their dossette's* [medication box] *filled up. If they're not happy with the tablets maybe we need to sit down and find out what the problem is. Basically we believe the more people understand about what is wrong with them and what their medications are doing the better compliance I think we get, so we get better outcomes.'* Nurse

Prior to the creation of the Preventable Chronic Disease Program in this region the health service were only seeing 16 patients for their chronic disease review per month. At the time of the interview the chronic disease team were seeing approximately 33 to 35 patients per month and were aiming to increase this to see 50 patients for their chronic disease review per month.

A large component of the role of the dedicated chronic disease positions involves working with other health service staff to ensure that chronic disease patients are managed well. The chronic disease staff aims to support other health providers to opportunistically monitor patients' chronic disease when they present at the health service for an unrelated matter.

A step by step account of how the chronic disease positions aim to facilitate opportunistic monitoring is described below:

> *'The progress notes are what we write on every day, so if someone is due for a chronic disease review, we write in the progress notes. Just put the dates the chronic disease review was due. If they're due for any bloods or urine for pathology we write out a pathology form, we don't have to do that, but if we write it out, it saves the clinic staff, who might see that patient, wading through the books to work out what they're due for. So we're trying to make it user friendly, for the clinic staff who happen to see that patient. As well as it is much quicker for the patient when they come in. There is a chronic disease care plan that has to be filled out as well. We always make sure that the chronic disease care plan is sitting ready, we indicate just with a lead pencil what needs to be done, if their due for their fluvax or their pneumovax we highlight that as well.'* Nurse

The central elements of the chronic disease program in Community A are to provide a system to ensure that chronic disease patients receive regular chronic disease checks and that their medications are monitored. Two dedicated chronic disease positions establish systems and processes to facilitate all clinical staff in effectively managing chronic disease patients.

Community B: An urban Aboriginal community controlled health service

A chronic disease program in an urban Aboriginal community controlled health service focuses on the early detection and better management of chronic disease. The priorities in this health service are community leadership and quality assurance mechanisms. Therefore the development and monitoring of the chronic disease program occurs with the advice and approval of the community board and the program relies on a quality improvement process. Patient files are audited and feedback is given to individual practitioners on their management of patients with chronic disease and their screening rates.

While there are many elements to the program, most strategies are the responsibility of the health service, and while individual practitioners have responsibilities in this program, their activities are supported by the health service. For example, the early detection of the chronic disease component of the program involves practitioners carrying out adult health checks. The health service monitors chronic disease detection rates by practitioner, and each health care practitioner receives feedback on their screening rates compared to other practitioners.

The health service has established a patient recall safety net. Patients with a chronic disease who have not accessed the service in the last six months are followed up and invited to go to the health service for a chronic disease review. This element of the program is seen as efficient because the program only targets those chronic disease patients who have not attended the health service and therefore are likely to be having difficulties managing their disease. This recall safety net is supported by a chronic disease outreach program.

Community C: A remote community health service with no PCDS funding

The emphasis in Community C is on the better management and early detection of chronic disease. However, Community C is a remote community health service where there is no additional funding or grants to support the chronic disease program. Despite a lack of funding, the service conducts three monthly chronic disease reviews and an annual screening for chronic disease. The process developing these strategies was incremental. For example screening for chronic disease started with the ‘at risk’ population – patients over 55 years of age, then the 45 to 55 year old cohort were screened. After these population groups were screened the annual sexual health screen was expanded to include chronic disease checks. There are no dedicated chronic disease positions. In this program the priority is to see acute care patients. While many of the providers are starting to develop care plans, time constraints are seen as a barrier to writing chronic disease plans.

Analysis of the regional chronic disease programs

An analysis of three chronic disease programs reveals that the type and size of chronic disease programs differ across regions. Regional health services have different levels of capacity and their own priorities; these two factors combine to influence their ability to implement PCDS, and the type of chronic disease program that is developed. This research has found that regional chronic disease programs are shaped by the structure and priorities of their organisation. In Community A emphasis is on clinical work. Attention is placed on ensuring that files and medications are kept up-to-date. A quality improvement approach is adopted in Community B because that is one of the health service priorities. In Community B, the chronic disease program is integrated into core business of the service and is supported by management practices such as quality assurance. Emphasis is on supporting providers to do their jobs well and providing data to inform the management and screening of patients. In Community C no additional funding or support was available to facilitate the implementation of the PCDS. Despite this the health service still manages to conduct three monthly chronic disease reviews as part of their core service. In addition, Community C commenced screening their population for chronic diseases – starting from the most at risk health service first. Community C shows a high level of commitment and fortitude. Despite being under resourced, substantial efforts have been made to provide for the needs of chronic disease patients. The priority in Community C is acute care but effectively managing patients with chronic disease is also seen as core business and attempts have been made to ensure chronic disease patients receive the care they need.

The extent to which the strategies suggested in PCDS have been adopted in different communities depends on the resources and capacity. The fact that there are a range of chronic disease programs operating is influenced by the priorities and interests of the health services. Implementation at the regional level is shaped by both the ability and priorities in each particular community.

In one sense, the variations at the regional level are positive because they indicate that the PCDS has been adapted to local circumstances. However, on another level these variations may reflect pre-existing inequity in the health care system. Some health services had fewer resources when the PCDS was introduced, and therefore may not have been able to use the policy to achieve the same benefits from the PCDS as other, better resourced regions.

The way PCDS has been implemented is different than had been intended by its authors. The variations in the goals and resources of the components of the health system that were responsible for its implementation are reflected both in 'what' was implemented and in 'how'. However, none of the manifestations of the PCDS are as comprehensive as the original PCDS document.

The relationship between central and regional levels of the Northern Territory health care system

Despite the central level of the health care system playing a fundamental role in the development of PCDS and the establishment of chronic disease programs in some regional health services, there are negative aspects to the relationship between central and operational levels of the health care system. Some health services reported feeling that 'sometimes policy is imposed' on their organisations. In the excerpt below one participant describes policies published by the Northern Territory Department of Health and Community Services as glossy magazines:

> *'I think they* [The Northern Territory Department of Health and Community Services] *put out very nice glossy magazines. They've put out some very nice commercial things like you know, we're doing it right in the bush and community stuff and our vision for the next five years and everything. People have really done some hard work in thinking what these things are going to be, then they send it out. But nobody says how, what's the best way to implement that in your community. You're not given any guidance on how to interpret these broader policy sort of things that people get. Then individual policy formation, there's no consultation.* Manager

When asked what happens to these policies from central policy level when they arrive at the regional health service, the manager explains that they are placed in a filing cabinet:

> *'Isn't that a dreadful thing to say, but no the reality is a lot of it is so up here* [theoretical], *there are no strategies in it and I don't have time to sit down and think about ok how are we going to implement this particular one.'* Manager

When asking participants in central office about the tension between central policy arm of the health system and service delivery in regional areas, a policy director explained that the tension is '*normal – that is just life. It is always like that.'* Interestingly the policy director went on to explain, from a personal point of view, the transition from working in regional areas to working in policy at a central level:

> *'I will tell you what is hard though. It is really hard to make the transition. I made the transition when I went into high level management, left project management and did high level management. The transition from advocate* - [as an advocate] *if you haven't got what you need it is someone else's fault so you can just thump the table and say someone should give it to me, whatever 'it' is. Someone should do it! And then when you become the person responsible for juggling the resources, you know, you can't adopt that, it is just such a luxurious position to be in to be able to say well someone else has got that money somewhere they are just aren't giving it to us. It just isn't there. You know, there is no money tree out the back of Health House to pluck it off. We have got thousands of advocates in the Territory, thousands of them. That's why the* [PCDS] *Strategy is quite precious to people like me because it really is a very concrete tool that you can take to lobby for money.'* Policy Director

These comments demonstrate that even though the central and regional levels of the health care system are working toward the same goal of preventing and managing chronic disease, they work in different ways. These differences can mean that in some instances the pressures faced by each level of the health care system are not well understood by one another and this can lead to conflict.

Discussion

This research demonstrated that PCDS changed in two main ways as it was implemented. Firstly, there was a change in focus from targeting the entire population of the Northern Territory to principally focusing on Aboriginal people living in remote communities. Secondly, there was a change in focus from three approaches to preventing and managing chronic disease to focusing largely on the better management and to a lesser extent focusing on the early detection of chronic diseases.

PCDS was used in different ways at central and regional levels in the health care system. This is an important point because it demonstrates that while all members of the health care system may be working towards the same aim, the path is different at different levels of the health care system. But the fact that PCDS is used differently by different parts of the system is not broadly acknowledged. Therefore other people's roles are not necessarily widely understood or appreciated. This can create conflicts between different parts of the health care system.

At the central level, one of the key roles of policy directors is seen as lobbying for funds, while others focus on providing support to regional areas. In the regional levels of the health care system, emphasis is placed on meeting patient and population needs, and the central level of government is seen as having a role in providing resources and support. However, these expectations are rarely met as the health care system is stretched due to limited resources and increasing demands. This creates tension between central and operational areas of the health care system and a degree of misunderstanding of each others' pressures and roles. There is a disconnect among parts of the system which are ultimately working towards the same goal through very different means.

There is an inequity in terms of what the system does – who receives high quality care – and what the system is – which parts of the system cannot make best use of the policy idea. An examination of three regional chronic disease programs reveals that implementation occurs differently in different regions. The characteristics of the program depend upon the level of resources, skills, interests and concerns in each community. The interaction between the original policy idea and the context in which it is received is dynamic. This regional variation may be viewed positively because it demonstrates that policies are adapted according to regional circumstances, and it also demonstrates that implementation is dynamic and that people use and benefit from policies in different and sometimes unexpected ways. But the downside is that this process may be inequitable because certain jurisdictions have fewer resources and therefore are less able to get the most from innovative policy ideas such as the PCDS.

The culmination of an inability of the system, and agents of the system in some instances, to understand the perspective and role of other parts of the system, and an ongoing inequity among and within and across some organisations, leads to a fragmented health care system.

Participants offer some explanations for the changes to PCDS as it was implemented. An examination of the political science and management literature in concert with further analysis of participant interviews reveals further interrelated and systemic factors that influenced changes to PCDS during it implementation. These factors include the composition of the workforce, the values of health professionals and the dominant culture of the health care system, the legacy of under resourcing of primary health care for Aboriginal Australians and the subsequent value and symbolic representation associated with the granting of funds, and the management capacity of the health care system to respond to policy ideas. These underlying, powerful but largely undetected factors are explored in greater detail in subsequent chapters.

Conclusion

Research into the implementation of PCDS revealed that it was not implemented seamlessly across all components of the health care system at the same time. Nor were all components of PCDS implemented by each part of the health care system. Policies evolve as they are implemented.

The implication of this finding is that is may be pertinent to proactively determine the essential aspects of policy ideas that need to be implemented first. Stakeholders can no longer expect all aspects of policy to be implemented, rather they need to be prepared to negotiate and compromise. By identifying the deal breakers in policy ideas, stakeholders will be in a better position to advocate what is essential in the policy idea, and to avoid policy reactively evolving solely according to the strengths and weaknesses in the health care system.

Chapter 5

Changing shape: workforce and the implementation of Aboriginal health policy

Research was conducted to explore the extent to which a specific Aboriginal health policy, the Northern Territory Preventable Chronic Disease Strategy (PCDS), was implemented by the health sector in Australia's Northern Territory. The capacity of the health workforce emerged as a major factor influencing the implementation of PCDS. This chapter explores the role the of the health workforce in facilitating and constraining the implementation of Aboriginal health policy.

As described in Chapter 4, the PCDS was developed as a universal and targeted policy intended for the entire Northern Territory population. It incorporated three major approaches to reduce the incidence and prevalence of chronic disease: primary prevention; early detection; and better management for the people with chronic disease. The research found that PCDS changed as it was implemented. Instead of a 'universal focus' the policy was implemented most fully in remote Aboriginal communities. And instead of a balanced program of activities across the three 'approaches' the great majority of implementation initiatives were focused on refining the systems and methods of early detection and better management. In comparison, there was limited emphasis given to implementing the primary prevention approach that was also a major arm of the policy. These changes were influenced by the new financial resources that became available for implementation, and by the capacity of the workforce and their employing organisations.

A number of implications may be drawn from the change in focus that occurred during the implementation of PCDS. Aboriginal health policies are not implemented seamlessly across all components of the health care system at the same time. Policies evolve as they are implemented. The ways in which these ideas evolve are influenced by the context in which they are received. Decisions about which aspect of policy are implemented were not determined by evidence of population needs. Rather the workforce implements those aspects of the policy that most closely matched their existing knowledge and skills.

Interviewees identified a number of barriers and facilitators, within the workforce, that influenced the implementation of PCDS.

Barriers to the implementation of the policy

Interviewees identified four major reasons why it had proven difficult to implement all aspects of the PCDS. Interviewees reported that there were too few health professionals employed to meet the demands of providing acute and chronic care, and that there were too few Aboriginal health professionals, in particular. In addition, interviewees reported that the Aboriginal Health Workers are 'under supported' in their roles and that there are high levels of self perpetuating staff turnover throughout the health care system.

Nearly all interviewees stated that there are too few service providers employed in the health sector. Given the high level of demand for acute care as well as for chronic care, almost all interviewees identified the lack of dedicated chronic disease positions: doctors, Aboriginal Health Workers and to a lesser extent allied health professionals as a major barrier to the implementation of the PCDS.

Many interviewees commented on the need to increase the number and proportion of Aboriginal people employed as health professionals in the workforce. The cultural and local knowledge, skills, experience, and community connectedness, combined with clinical and population health knowledge, were viewed as essential to the effective implementation of the PCDS and, over time, to the achievement of positive health outcomes.

There was a strongly held perception among many of the interviewees that the Aboriginal Health Workers who are employed are 'under supported'. There were multiple dimensions to 'under support'.

In the first place, some interviewees pointed to the exclusion of the Aboriginal Health Workers from the policy development and implementation processes. One participant, for example, explained that consultation is ad hoc and limited:

> '[Aboriginal Health Workers are] *asked to have input but rarely asked if they fully understand what the policy means, and in terms of implementing a lot of those policies you only see bits and pieces of it, you only have small involvement.'* Manager

Many interviewees also reported that Aboriginal Health Workers work under greater pressure from their families and the community generally than the non-Aboriginal health professionals, but that they receive less professional and practical support. In the following quote an Aboriginal Health Worker describes being given inadequate housing:

> *'I don't get a lot of support… I have got a child ten months old and I've got a partner and we are staying in a small flat, she is starting to walk, and the flats are really small. We need a house to grow a family. You need a house not a flat; especially because it has just got two rooms. One room has got a kitchen, lounge and laundry and the other room has the toilet, shower and bedroom.'* Aboriginal Health Worker

According to some interviewees there is a lack of inter professional respect between Aboriginal Health Workers and nurses. This is caused in part by disparities in the amounts and level of professional development and practical support available to nurses and Aboriginal Health Workers. These disparities have been reinforced by the steps taken to implement the PCDS so that it seems, at least, that nurses have received a greater proportion of the PCDS-specific training than have the Aboriginal Health Workers.

One interviewee viewed the lack of champions in the bureaucracy as being responsible for the limited support available to Aboriginal Health Workers and ultimately, for the loss of Aboriginal Health Workers from the workforce:

> *'There aren't any champions for Aboriginal Health Workers in the bureaucracy, not that I can see. No one is speaking out and saying, look, we can't afford to lose these people. It is almost being seen to be written out of the script but I can't see how we can progress without them.'* Manager

Nearly all interviewees mentioned high staff turnover as a barrier to implementing PCDS. In the following example a participant describes the extent of staff turnover in one of the health services:

> *'And in the last year, we've had nine nurses go through one of the positions… So that kind of churn in the staffing really makes it very hard to maintain your chronic disease programs… We haven't been successful in finding someone who can come for more than a short time.'* Doctor

The participants reported high staff turnover as an indicator of the capacity of the remote health workforce. In the following example a participant explains that high staff turnover is occurring across the health system. Constant and widespread high staff turnover suggests that the capacity of the health care workforce is compromised:

> *'We have a constant turnover of both grass roots staff and executive members.* Policy Director

Participants pointed to the implications of high staff turnover. High staff turn over does not enable health professionals in the field to build the trusting relationships they need to have with policy officers, and the staff turnover also erodes communities' trust of health professionals and of the health services generally. High staff turnover is also seen as a barrier to building a strategic focus within health services and the health system and to sustaining chronic disease programs. There is also a perception that high staff turnover acts as a barrier to employing people with experience.

In the following quote a telling example of the far reaching implications of high staff turnover at the management level is described:

> *'What a group of health workers and Indigenous staff tried to do was to think about how can we have communities set the direction for the way our services can be delivered. We ran a number of workshops… a representative member came to the management team table and gave some direction around how to do better*

> *service delivery… So this was the kind of process which was really, really quite challenging, and innovative, and participatory in that people can look at how their services could be better delivered so they had some engagement of that. And that was going really quite well and then we had a change in management… this is not the way we are going to work, so it falls over, everybody goes back to the way it was and then you try to pick up the pieces yet again.'* Policy Officer

This study found that high staff turnover erodes trust throughout the different levels of the health care system and undermines the potential for a strategic focus. High staff turnover perpetuates further staff turn over which compounds the problem, and therefore can be seen as a systemic, self-perpetuating barrier to implementation.

What facilitated the implementation of PCDS?

The respondents also identified several actions that had facilitated or supported the implementation of the PCDS through their organisation within the health sector. Some individual health services had been able to secure additional funding through the PCDS and had used it to employ new staff in dedicated chronic disease positions, and to provide professional development for staff to strengthen their skills in the management of chronic disease in Aboriginal communities. The commitment of and support from health service managers was identified, too, as having facilitated the implementation of the PCDS.

The additional staff were employed in positions ranging from policy directors and policy officers to service providers across the urban and remote locations of the Northern Territory. The benefits of employing additional health professionals were especially noted, with nearly all interviewees commenting on the value of having additional staff. This is not surprising given that insufficient numbers of staff was so frequently viewed as a barrier to the implementation of the PCDS.

PCDS also brought with it additional training in chronic disease diagnosis and management. Some participants perceived the new training as an important facilitator because they (or their staff) needed new skills to manage chronic disease. According to one policy officer good training support is now available and appreciated:

> *'We've got good training, training support which is terrific really nowadays'.* Policy Officer

Respondents reported that additional staff and training were necessary to ensure that their services had the capacity to carry out the work of the PCDS, but that they were not sufficient, on their own. They pointed out that the implementation of the policy also depended on support and commitment from health service managers, and on structural support that saw the creation of dedicated chronic disease positions.

As authoritatively stated by one policy officer, obtaining the support of the health service manager is paramount:

> *'When you look at where the chronic disease program is working well, it is usually where the clinic manager* [health service manager] *is really supportive.'* Policy Officer

Respondents pointed out that the commitment and support of health service managers is instrumental in making chronic disease a priority among the competing and unrelenting demands faced by health services. This research found wide variation in health service managers' commitment to the implementation of the PCDS policy, and hence in the priority given to chronic disease management or prevention in each of the health services.

Most interviewees perceived that dedicated chronic disease positions were needed to develop and maintain effective chronic disease programs. The roles of dedicated chronic disease positions include establishing systems and processes such as recall and reminder systems, and spending additional time educating and supporting at-risk patients. According to one health service manager the additional time dedicated chronic disease staff were able to spend with chronic disease patients was especially valued:

> *'With having those staff dedicated to chronic disease, they are able to spend more time with the clients, they are able to go back and see them every day, whereas if you're relying on the acute clinical staff to do that, they get tied up with people with coughs and colds.'* Manager

But even when staff were employed in dedicated chronic disease positions, it seemed that they are often required to work in acute care and that they are not given sufficient quarantined time for their chronic disease management work. One of the doctors who was interviewed, describes a norm in health services where all staff are expected to assist in treating acute care patients:

> *'Every health centre has an acute workload and there is an extra expectation which is almost universal, that all staff will participate in dealing with an acute workload, and as a result, even the staff members who are nominally employed by the Preventable Chronic Disease Program don't get anything like the amount of time that would be necessary to actually do that job'*. Doctor

One of the implications of such a norm is that the new roles of dedicated chronic disease positions can create tensions between dedicated chronic disease and acute care staff. Below a health services manager describes the circumstances in which such tension can arise:

> *'Sometimes if they* [working in the chronic disease positions] *feel the clinic is really busy and if they are sitting and doing paper work or updating the cards* [recall system] *then they often feel from the other staff, that are working clinically, are thinking 'how come you can sit and do that when we're busy?'* Manager

A researcher describes a tendency among dedicated chronic disease staff to retreat to working in an acute care model under such pressures:

> *'… one of the difficulties is that it is easy for people who have trained clinically to retreat back to that model.'* Researcher

The two principal factors that appear to influence the amount of time that staff in dedicated chronic disease positions can dedicate to their roles are the size of the health service and health service managers' commitment to chronic disease. The larger the health service the greater capacity for specialisation. The more committed a manager the more likely a health service will be able to allow chronic disease staff to be 'taken off line' to carry out their chronic disease management roles.

The goals of policy and the roles and skills of the workforce

Interviewees reported that although the PCDS included a strong, evidence-based primary prevention component, the health workforce responsible for the policy's implementation was overwhelmingly clinically-trained. Furthermore, the workforce had been employed in clinical roles, and had not been provided with the necessary training to enable them to acquire the knowledge, skills or experience necessary to implement the primary prevention and early detection arms of the PCDS. Nor was it clear that their job descriptions had been changed to reflect the revised roles that were, implicitly at least, expected of them by the policy.

One participant expressed a view that this gap between the current roles required by the health system, and the skills and experience of the current workforce will take some time to eliminate:

> *'I think we are always going to have this contradiction between what we know, what I think generally is well accepted by public health people as what is necessary, but not having the workforce or the resources to really implement it.'* Researcher

Some nurses expressed frustration at this. They accepted that patient education, as well as treatment, is their responsibility, but felt that they were continually being given advice on the importance of conducting patient education rather than the skills of how to educate effectively:

> *'The other thing with getting out and doing some education is… how to actually do education programs. It is not something that I have done a huge amount of… And I think we are being told what is needed, but not how to do it.'* Nurse

All the Aboriginal Health Workers who were interviewed expressed frustration, too. They felt they were tied to working in clinical roles within the health services, although they recognised that if they were to be able to implement programs to prevent the incidence of chronic disease they would need to work in the community:

> *'I think we need more health promotion in the community, we've got to get out of the clinic. That is a big issue.'* Aboriginal Health Worker

Many interviewees, but especially Aboriginal Health Workers, emphasised that reducing the incidence of chronic disease will require actions to address the broader determinants of health:

> *'Well if we want to stop or slow the chronic disease… or new diagnosis, we have to go for the smaller things first I think. If we want to stop like kidney failures and stuff like that, then we'd have to stop skin infections. Where does it all start up? Same with hypertension or diabetes. Get the shop to sell a lot more healthier food. Or make healthier food cheaper than the popular sweet food.'* Aboriginal Health Worker

There is a mismatch between the goals of the policy and the skills of the workforce. This mismatch can undermine the capacity of evidence based policies to achieve their aims. However, an awareness of this mismatch and the development of novel strategies during implementation would provide an opportunity to strengthen aspects of the workforce in a proactive and equitable way through the implementation of policy. In other words, the current tendency for dominant aspects of the workforce to shape policy and therefore gain additional skills during implementation may be reorganised through proactive planning and consideration of which aspects of the workforce would benefit from the implementation of policy.

Discussion

There were variations in the extent to which the PCDS was implemented by the wide range of health services that make up the Northern Territory health sector. The research highlighted the fact that the components of the policy that were most closely aligned to the existing roles, strengths and experiences of the health workforce - such as treatment and clinical care - tended to be implemented first. This meant, in practice, that the focus of the early policy implementation initiatives was on improving chronic disease management. In turn, this meant that new staff positions and professional development associated with the PCDS implementation were more likely to be in clinical areas than in population health areas.

Although the policy was intended to change and expand the current practice of existing health services, it did not include a program or funding to enable the existing system to change its structures, processes or services. In any organisation, if new work is to be carried out, it is necessary to change current systems and processes to support the proposed changes. In this case, the intention was to shift the focus of essentially clinical health services toward a population-health approach. This would mean combining targeted self-management for patients with diagnosed chronic disease with universal, community-based preventive programs, to address the social determinants of chronic disease and to enable early diagnosis and intervention. This would also require changes in service goals and priorities, in roles and work practices, in the skills of staff, and in all the support systems – medical records, follow-up and reporting systems, and in staff development and career opportunities.

Such reorientation of already stretched health services is not a trivial undertaking. The community demands for acute care, the pressures experienced by staff to respond to acute care demands, the dissonance between the knowledge, skills and experience of staff and those needed to implement the new policy, the high staff turnover, and the limited financial and human resources all mean that the system is under strain.

The workforce required to effectively implement policy

A skilled workforce whose roles are congruent with achieving policy goals is critical to the effective implementation of Aboriginal health policy. A policy idea, such as the primary prevention of chronic disease, cannot be implemented if the policy does not include strengthening the primary prevention workforce in its vision.

This research revealed the need for significant changes in the composition, roles, and organisational support available to the health professional workforce if a policy such as the PCDS is to be implemented fully. The research also indicated that when such changes were not integrated into the policy implementation phase, the policy was only partially implemented. Staff selected those parts of the policy that fitted most closely with existing practice, and were not able to implement those parts of the policy that required significant changes in roles and practice.

There is a need for additional service providers, for greater representation of Aboriginal health professionals in the workforce, to better support Aboriginal Health Workers, and to decrease high levels of staff turnover that exist throughout the health care system. High staff turnover serves to erode trust and undermine the sustainability of interventions.

There was a perception, among some participants, that there is a lack of staff trained in community development and that some service providers lack skills in providing brief interventions. However, according to all Aboriginal Health Workers interviewed, addressing the social determinants of health and community development were seen as the most important aspects to improving Aboriginal health. The issue may be that the sections of the workforce committed to primary prevention are disempowered, or that primary prevention skills do not exist within dominant aspects of the health workforce, such as medicine and nursing.

Enabling Aboriginal Health Workers would allow the primary prevention arm of PCDS to be implemented. Aboriginal Health Workers expressed interest in working in the community, rather than in the clinic, and in addressing the broader determinants of health. The latter may involve, for example, developing strategies to overcome an unhealthy food supply in remote communities, and overcrowding in houses.

Aboriginal people in the health workforce

It is notable that, despite the significant cultural and linguistic divide between Aboriginal and non-Aboriginal Australians and between Aboriginal and non-Aboriginal health professionals, and often between Aboriginal patients and non-Aboriginal health professionals, few of the respondents mentioned this as a barrier to the implementation of the PCDS. The fact that the health professional workforce is still, in 2007, overwhelmingly non-Aboriginal is of major concern – both because it reflects the limited educational and career opportunities that have been available to Aboriginal peoples, and because without the leadership, experiences, and community connectedness of an Aboriginal health professional workforce, the health system continues to struggle to meet the health care needs of its Aboriginal patients, and to work effectively to establish healthy communities.

Although it is widely acknowledged that Aboriginal Health Workers play a significant clinical and cultural role in the delivery of clinical health care in the Northern Territory, this research revealed that there were few Aboriginal Health Workers employed as service managers, or as program coordinators or leaders. Despite long-standing advocacy on the part of Aboriginal Health Workers and Aboriginal communities there was no evidence in this study of increases in the power of Aboriginal Health Workers within the health sector, and little evidence of greater respect being accorded them for their work by other health professionals.

The implementation stage of the PCDS included no guidance or assistance for health services to review the roles of all staff, including the Aboriginal Health Workers, to implement changes in job descriptions and priorities. Nor was there any specific professional development offered to Aboriginal Health Workers to strengthen their knowledge and skills in community-based health promotion and to implement activities to improve the food supply, engage communities in regular physical activity, or to implement smoke free policies in communities.

The relationship between the workforce and capacity to improve Aboriginal health

There have been some novel attempts to improve Aboriginal health through medical education (112;113). These approaches are based on the principle that if Aboriginal health is included in undergraduate medical curriculum then there is a greater likelihood of developing Aboriginal friendly, or culturally safe mainstream services. For an example of Aboriginal friendly curriculum visit the Onemda VicHealth Koori Health Unit website at: http://www.onemda.unimelb.edu.au/teaching/cdams.html.

Despite considerable attempts to support the development of the Aboriginal health workforce at federal, state and territory levels (49;59;114;115), Aboriginal people continue to be under represented in the health workforce overall (57), and particularly in higher level positions (38;49). Adequate Aboriginal representation at all levels of the health workforce is essential to the effective, efficient implementation of health policy such as the PCDS and, ultimately to improving the health of Aboriginal people.

In addition to the critical role of Aboriginal Health Workers in the health workforce to ensure the cultural, linguistic and practical relevance of health care and population health services, the health sector offers real career opportunities for Aboriginal people. This is not new or softly spoken evidence. On the contrary, employing Aboriginal people in the health workforce was a prominent recommendation in the 1989 National Aboriginal Health Strategy (116). The fact that in more than a decade so little progress has been made points to the need for sustained, persistent effort on the part of the health sector and of the education sector.

The relationship between policy goals, the composition of the workforce and implementation

The PCDS was a major initiative of the Northern Territory Health service – an effort to use evidence-based policy to guide the clinical and population health services and programs offered by the health sector, and to achieve, in particular, improved Aboriginal and Torres Strait Islander health outcomes.

However, responsibility for policy implementation rested with each of the component health services in the Northern Territory health sector. The first deviation from the policy's intention was caused by the receipt of dedicated funds to support implementation in remote communities only. This was welcome in the sense that it meant there was a clear, well-resourced focus on working with Aboriginal communities, principally. But it meant that there was limited, universal action taken by the health sector as a whole – isolating the work of individual health services in remote locations and reducing the momentum that may have emerged from a more substantial implementation initiative.

Policy implementation in practice, became the responsibility of individual health service managers and health professional staff. From the three approaches that were proposed in the policy, the approach that most closely fitted the current pattern of service delivery overall, and that most closely aligned with the existing organisational capacity of the services, was implemented. The job descriptions, reporting mechanisms, records and follow-up systems for primary prevention and early detection approaches appeared to remain mostly unchanged. Priorities and resources continued to be invested, principally, in chronic disease management. And the approach that was selected also fitted most closely, with the knowledge, skills and experience of the health professional staff. This meant that, in effect, only one of three approaches included in the policy could be said to have been implemented fully.

This research affirmed the extent to which the composition, professional preparation, and ongoing professional development of the health workforce plays a role in shaping the implementation of health policy. In the absence of specific organisational change to ensure that the structures, systems and processes used by any health service 'fit' the demands of implementing a given policy, it is clear that implementation will be shaped, instead, by the existing organisational structures and by the strengths and weaknesses of the existing workforce.

Conclusion

Improving Aboriginal and Torres Strait Islander health relies on the implementation of culturally-determined health policy over a sustained period (62). Implementing such policy relies on responsive health services, delivering evidence-based clinical care and population health programs. This is easier said than done.

There are limitations in the organisation and staffing of the current health sector that shape the implementation of health policy. In this case study, this meant that only one of three approaches outlined in the policy was implemented. The research found that those components of the policy that were implemented had been selected because they fitted most closely the current systems and services being offered by the health sector, and that were most readily adopted by the existing workforce – which is, primarily, clinical. The capacity of the health professionals working in a complex health system to change their goals, the focus and methods of their work, and to build the knowledge and skills they need is limited, unless there is a significant investment by the health sector at the time of releasing a new policy.

This research found that there was a mismatch between evidence for preventing chronic disease and the current composition and roles of the workforce. Implementing the primary prevention arm of PCDS could be done in ways that build the capacity of Aboriginal Health Workers. This would have mutual, far reaching and important benefits for the community, as well as addressing the longstanding issue of needing to better support Aboriginal Health Workers.

The health care system has begun to develop evidence based health policies that are more reflective of the cultural and life circumstances of Aboriginal communities. PCDS is an example of such a policy. The challenge now lies in maximising the benefits of this improved approach by comprehensively implementing policy. If implementation is determined by the current strengths or dominant aspects of the health care system then capacity for change will be undermined. Successful implementation relies on restructuring organisations to give Aboriginal Health Workers and health professionals greater power in determining implementation priorities, and in ongoing investment in undergraduate education and professional development of all health providers and policy officers and directors.

In the following chapter the roles of professional values and system culture and their influence on the implementation of PCDS are explored.

Chapter 6

The roles of professional values and system culture in the implementation of Aboriginal health policy

The culture of the health care system and the personal and professional values among health professionals are explored in this chapter. The purpose is to consider how the culture of a mainstream health care system and the values of health professionals influence the extent to which Aboriginal health policy is implemented.

Culture permeates all aspects of society and has been defined as a complex whole which includes knowledge, belief, art, morals, law, custom, and any other habits acquired as a members of society (117). Cultures are never static, they continue to develop and evolve. In Aboriginal health the term culture may be used to refer to Aboriginal culture and non-Aboriginal culture in an Australian context. Or it may be used to describe the culture of the health care system. Or it may be used to refer to the cultures belonging to different professional groups such as Aboriginal Health Workers, nurses and doctors. All of these cultures and sub cultures reflect Australian values and contexts. They have far reaching effects on the type of policies developed and the extent to which they are implemented, and therefore the capacity of the health care system to meet the needs of Aboriginal Australians.

Despite the far reaching influence culture has on actions, more often than not the influences of a dominant mainstream culture are not formally recognised or at the fore of most peoples' minds (118). For example, it is not common for people to critique the role that the culture of the health care system or their own professional values have on how they define health problems, and shape their expectations and understanding of patient circumstances. In most situations it is easier to critique the culture of others – of patients or other professional groups- rather than one's own culture.

The PCDS included three major components of primary prevention, early detection and better management. As described in Chapter 4, it was intended and expected that each of the three major components would be implemented equally although not, necessarily, simultaneously. In practice, however, the research revealed that this did not happen. Instead, across the Northern Territory, the better management component was implemented by many health services and the early detection component was implemented to a lesser extent. The primary prevention component received substantially less attention. PCDS changed as it was implemented.

The influence of professional values and system culture on the implementation of PCDS

This research found that among the factors influencing the implementation of the PCDS, the professional and personal values of the workforce and the organisational culture of the health system both influenced and were influenced by the policy.

Many different professions work in the Northern Territory health system. Most of these professions are 'clinical'. Their primary role is to diagnose, treat, and manage diseases and injuries in individual patients or clients who present to the health system. The Aboriginal Health Workers, who have clinical training, often fulfill a diverse range of roles such as health promotion, social work and community brokerage.

The research confirmed what other research has found, that within the health sector, the medical profession dominates decision-making about system-wide priorities and resources, and about individual patient care (119;120). In the Northern Territory, nurses have significant decision-making powers in the many communities that do not have a resident medial officer. The values of these two professional groups, therefore, predominated in the implementation of the PCDS. The implementation of the primary prevention component of PCDS required public health and health promotion knowledge and expertise if it was to be implemented fully. However, although the Aboriginal Health Workers have valuable knowledge and skills in this area, they were not accorded sufficient power to influence decision making on priorities and resources, and hence exercised limited influence on the components of the PCDS that were implemented.

Different professions: different values

In response to questions about barriers to managing chronic disease, interviewees expressed a range of values about who and what is responsible for Aboriginal health. Aboriginal Health Workers, nurses and doctors viewed the 'health problems' differently, identified different 'causes' and expressed different perspectives on what actions need to be taken to address the problems effectively.

Aboriginal Health Workers saw the difficulties that health services have in addressing underlying determinants of health as a major barrier to improving Aboriginal health. For example, one Aboriginal Health Worker explains a situation where a child keeps presenting to the clinic with sores: '*This household, kids keep coming in with sores. Scabies and you treat the kids and they go home and a month later they will come back with scabies or sores again.* When asked why there is a problem with this particular house the health worker explains: '*Well it is overcrowded. It has got dogs around.'*

When asked what needs to happen if children kept presenting with the same problem the health worker explained: '*You'd have to treat the whole house, which usually happens. But you need to have a look at the house. Who out of the house is getting income? Who is getting paid? Who is working? What is happening to the kids during the day? Are they going to school or aren't they? Is the house kept tidy? How many people are living* *there? But even if you do find all that out there is nothing you can do if it is overcrowded because there are no other houses to split that house up.'*

Nurses, on the other hand, expressed the view that professional boundaries among the various health professionals and between the health professionals and community members were uncertain and hence, a barrier to improving Aboriginal health. They saw the need for services to develop an integrated set of responsibilities to enable them to provide effective health care. The following comment emphasises the concerns about different perspectives on responsibilities for Aboriginal health:

> *'A clinic can only do so much, we can show where there are problems but you can't actually change things happening out there, the* [food supplied through the] *store or peoples attitudes* [to healthy behaviors]. *They might like to just sit around gambling all day, or they might want to smoke.'* Nurse

Miscommunication was identified by some participants as a barrier to effectively sharing responsibility for Aboriginal health. There is a perception that Aboriginal Australians and non-Aboriginal Australians have different communication styles:

> *'Some people say, yes, yes, yes and then do no, no, no. They say I am interested, you say well take those tablets then and then* [they are thrown] *in the bin or garden as you go out. Not everybody votes with their mouth. Some people make themselves scarce when you're looking for them… that's just a mechanism that Aboriginal people use, whereas we might just say we don't want to go.'* Nurse

In another comment a nurse states the following: *'I think we worry more about their health than they do'*. This statement suggests that some nurses feel a degree of frustration towards Aboriginal peoples' behavior and reaction to their health status and cultural and social circumstances. The comment may be indicative of a situation where some health professionals project their concerns and approaches to health on to Aboriginal patients and communities. It may also reflect a history in the health care system of over emphasising patient compliance with medication or treatment regimes, and of drawing attention away from the circumstances that influence patients' health, service provider responsibility and government responsibility (121;122).

Some of the doctors interviewed also discussed the boundaries between responsibilities for health, but there were great variations in their perspectives.

Interactions between individual values and professional values

In addition to the values that appear to underpin different professional groups, individuals within each profession bring a personal set of values to their work. Such values are likely to differ on the basis of age, gender or social class. For example, in response to questions about the implementation of policy on managing chronic disease, three different doctors expressed three very different understandings of what actions were required and by whom. The particular issue raised was that of patient compliance.

In Example A the doctor expressed a great deal of insight into and empathy with the circumstances of Aboriginal people and sees that patients can fully comply with treatment only when it 'fits' their circumstances. The doctor reflects on the fact that the circumstances of each of his patients with chronic disease are diverse and sees one of the responsibilities of doctors as tailoring care according to patient needs.

In Example B, the doctor perceives that Aboriginal patients are non-compliant because they are not committed to their health. Other potential explanations for not taking the medications were not explored. The doctor expressed little empathy for how a twenty five year old patient with multiple medical conditions might be feeling. There was no mention of the patient's social or economic circumstances, or the potential impact her circumstances might have on her care. The doctor sees taking the medications as the responsibility of the patients, but that the nurses have a role in supervising.

A third doctor, in Example C, emphasised the responsibilities of the health service rather than the responsibilities of the patient. Recall systems are an important tool available to health services and health professionals to assist in managing patients with chronic disease, by reminding health professionals and patients when regular checks such as blood pressure and blood glucose levels are due. The doctor in Example C suggests that recall systems can be used as a safety net rather than as a management tool. This approach empowers the patient to take responsibility and make decisions about their own health and health care, and at the same time focuses on the responsibility of the health service to meet the needs of its at-risk patients. The model suggests that over managing or micro managing can be harmful for patients and centers the control of the chronic disease with the health service; it suggested that doctor-patient behavior is intertwined in a complex relationship.

Example A

'I think one of the principles of primary health care is providing appropriate care, which needs to be tailored to the needs of the particular individual. Now the circumstances of each Aboriginal patient are quite different. Some of the patients for example are living pretty much the lifestyle of working class or lower middle class white people in our society. They have houses, they have proper cupboards and safe places to keep medicines. They have an appropriate number of people living in the house, and they don't have chaos reigning. And at the other end of the spectrum you've got people living without any housing, living in the open with a chronic disease. So in the one circumstance you've got people who are quite capable of going to a pharmacy and collecting prescriptions and having a whole lot of boxes of tablets and taking them at the appropriate times at home. And they've got the literacy skills to do so. And at the other end, you've got people who are illiterate with impaired eyesight living in circumstances where on any particularly day the police or the wardens may come and move them on down the river or whatever and they may lose all their possessions at any time - because if they go shopping someone may collect up their possessions and put them in the rubbish bin. And you've got everything in between, so you need to be sensitive to where people are at.' Doctor

Example B

'The main barriers are compliance from the patients. Education is extraordinarily difficult. For example, had a women the other day aged 25, had mitral valve replacement, two months ago, she has systemic lupus erythematosus, which is nasty, nasty disease, for which she is on steroids. She's got asthma, she's got pneumonia, she was given powerful antibiotic, intravenously for 7 days. When I saw her last week, I suggested that that wasn't going to be of any benefit if we were to continue. And I suggested another antibiotic... I suggested she take it, one twice a day, she was to start Wednesday afternoon, have one Wednesday night as well, have one Thursday morning. I rang the clinic on Thursday and said how is she, because she was almost suitable to be evacuated. Oh she hasn't started them yet. That surprised me, because I though the staff in the clinic would have given them to her, at least initially. They had impressed on to her that she had to take them, but she couldn't be bothered'. Doctor

Example C

'We've got what we call: a recall safety net… we wait six months and print a list then of all patients, from our health service with chronic disease who haven't been here in the last six months, and then we go and visit them. And talk to them, and find out why, and try and get them to re-engage in the health service… Also the other problem that we really had to get on top of, doctors here started using the medications… as a way of getting patients to come back. So they'd [the doctors] *only give someone four weeks of tablets and they'd say I want to see* [the patient] *them in four weeks, and so they'd only write the script for four weeks. And that meant that when patients didn't come back, they didn't get their tablets either. And we've got* [doctors] *them to accept they should be writing, like for most people. And if they decide we're too busy, they can't be bothered waiting to see the doctor, at least they are still taking their tablets. So the control had to be taken off the health professional.'* Doctor

These examples reflect the difference that various personal values make to the approaches to treatment and care that are offered by different professionals – although each is implementing the same treatment and management policy. It also demonstrates that personal values and professional values may not align.

Even within professions, differences in values can reflect differences in training. Recent graduate training is likely to be very different to training received 30 years ago. The doctors whose quotes were included in the above mentioned examples were all men of a generally similar age and training, although the doctor in example B was ten years older, and had less experience working in the Northern Territory than the other two doctors. This suggests that experience in working with Aboriginal communities, organisations and patients can lead to a shift in values and hence, to a difference in the implementation of clinical policy.

In the health care system there are likely to be a range of professional and personal values. Some of these values will align with the goals of particular policies such as the PCDS, and other will not. Identifying individuals and professional groups who are most likely to be ‘early adopters’ of policy ideas may facilitate the initial stages of policy implementation (76;123). However, attention needs to be paid to inequity. If there is not a basic level of capacity in some health services and among particular professional groups, this approach of utilising early adopters may result in the implementation of aspects of policy ideas, but it may not build the capacity of the health care workforce equitably, or according to population needs.

The culture within the health care system

One of the aims of the PCDS was to introduce a new way of treating and managing patients with chronic diseases. This necessitated a shift in the culture of the health care system away from reactively treating patients that ‘walk in the door’ to working in a systematic way and following up patients proactively and routinely. As aptly described by one participant, changing the culture of health services is a difficult and time consuming task.

> *‘I think we have only turned the corner of changing the culture in remote clinics since about 2000, 2001. Because prior to that there was a lot of resistance from a lot of the older remote nurses and health workers to the idea that your job was to run these systems and go out and chase people for follow up. And before that there was very much a culture of you treated what walked in the door. And it is not until you do an audit and you show that someone with diabetes has attended the clinic 50 times during the year and they haven’t had a blood pressure or a blood test done, that you can sort of win people over and say well maybe you need to have some other approach to this because your opportunistic care methods are not working. Because that diabetic will always come in at 9am on Monday morning when the clinic is jam packed and you’re always going to say can you come back on Wednesday and we’ll do your blood test and they are never going to come, unless you go out and invite them in on Wednesday. So that culture has shifted.’* Doctor

This cultural shift suggests that the better management component of PCDS has been implemented and gives insight into the mechanisms of culture change within the health care system. The abovementioned quote illustrates that multiple steps are required to change the culture of the health care system. Strategies that are particularly useful include: audits and the provision of other evidence that describe the problem; systems such as quality improvement processes, or recall safety net, to support patients and health professions in meeting their responsibilities; and leadership that articulates and creates commitment for new values and beliefs.

A potent message emerging from the interviews was that focusing on patients’ compliance with medication and treatment overemphasises patient responsibility and draws attention away from the circumstances that influence patients’ health, service provider responsibility and government responsibility.

> *'The limitations of compliance being seen solely as patients' responsibility are that it enters into the dangerous territory of victim blaming, it doesn't account for other significant factors such as living conditions, it doesn't account for service provider responsibility such as the extent to which service providers involve patients and patient circumstances in treatment plans, and it doesn't consider the responsibility of government to provide accessible health services and whether or not this responsibility is met.'* Doctor

This research found evidence of a cultural shift in the allocation of responsibility for the health of patients – moving from a single focus on patient responsibility to a more comprehensive focus on the responsibilities of health professionals, services and governments. Patients can take responsibility for only one component of their treatment and on-going management – and can do so only with the active support of the other components of the health care system (124;125).

Discussion

The PCDS provided an evidence-based 'template' for the health system and for health professionals to use to improve the management of chronic disease. However, the implementation of the policy is undertaken by doctors, nurses, allied health professionals and Aboriginal Health Workers, who view the 'health problems' and their 'causes' differently and who have different personal and professional perspectives on what action needs to be taken. Despite the unifying values that are inculcated through professional training, there are also diverse values within professional groups – which may be linked with age, gender, social class or experience. The values make a difference to the analysis of problems, to the selection of solutions, and to the evaluation of progress assessed by each of the health professions and health professionals involved. This section of the chapter considers the implications of these findings, and makes a number of recommendations for utilising and influencing the values of health professionals and the culture of the health care system to improve the capacity of the health care system in the implementation of Aboriginal health policy.

Differences in viewpoints

This research has found that not all values have equal merit in the health care system at all times. Particular values may dominate the application of particular policies or evidence-based templates. This research has also found that particular values may dominate in different settings. For example the values of doctors and nurses may dominate in the health service setting, the values of policy directors may dominate in bureaucratic settings, and the values of Aboriginal Health Workers may be more likely to dominate in community settings.

Personal and professional values are not necessarily consistent with the intentions of policy makers, and certain aspects of policy are more closely aligned to particular professional values and to the acute care emphasis in the health care system. For example, better management and early detection strategies for chronic disease are based on clinical activity and therefore are more closely aligned with dominant aspects of the health care system. Primary prevention, on the other hand, involves working in the community and with different sectors and requires a different set of skills and knowledge. Policy values that do not align with the existing culture of the health care system or dominant professional values will be more difficult to implement.

The health care system has a history of excluding perspectives at particular stages of the policy process. For example, members of the health care system who work in operational areas are often required to implement policy ideas, yet those working in operational areas are often excluded from providing input during the initial stages of policy development. In another example, Aboriginal Health Workers' concerns are often implicitly marginalised within the process of selecting the priorities for policy implementation within health services. Many Aboriginal Health Workers are concerned about primary prevention and community-based health promotion. Because the health care system is dominated by clinical professions the decision making process tends to favor interventions that are most closely aligned to interventions based in the clinic.

This finding reinforces the importance of developing and maintaining connections across the policy and service provision levels of the health system (126). Involving service providers in policy development, and policy officers and directors in implementation is an important foundation in developing a comprehensive policy that has the greatest likelihood of being implemented effectively.

Interactions between culture and policy

In theory, policy intends to bring about change in practice. This may require a change in the culture of the health care system and in the values of health professionals. However, in practice, it appears that the influence between culture and policy is multidirectional and multifaceted.

On one level the existing culture of the health care system and the values of health professionals influence what aspects of policy are implemented. PCDS changed as it was implemented from including the components of better management, early detection and primary prevention, to focusing mainly on better management. Strategies for better management were enhanced and less attention than was expected by the policy was placed on early detection, and primary prevention.

On another level, policy has the potential to influence the culture of the health care system and the values of health professionals. Aspects of policy that are implemented affect the culture of the health care system and health professional values. For example the changes in practice that were required as part of the better management of chronic disease did influence the culture and the values of those responsible for implementation. This research found that the culture of the health care system in remote Aboriginal communities had changed from treating patients who presented at the clinic to systematically managing patients with chronic disease.

The relationship between the culture of the health care system and policy is dynamic: culture changes policy as it is implemented, and policy that is effectively implemented changes the culture of the health care system.

The value and nature of change

According to Iles et al. there are many types of change. Planned change is deliberate and the result of conscious reasoning. Emergent change arises from influences such as the political climate and the influence of different interest groups. Episodic change involves the replacement of one strategy with another. Continuous change is ongoing, evolving and cumulative (127).

More often than not implementation decisions are made implicitly through the influence of the dominant culture and professional values. This change process may be seen as emergent. Leaving decisions about which aspects of policy are implemented first to the dominant culture of the health care system and values of health professions will make change slower, more diffuse and patchy. It may mean that change occurs according to the history of the health care system and the preferences of dominant professional groups, rather than the needs of the population the policy intended to serve. It may also contribute to a lack of coordination among health professional groups and this may work against generating a team and collaborative environment.

The health care system now values the development of evidence based and inclusive Aboriginal health policies. However, this research has demonstrated that policies change as they are implemented. The process of implementation appears to be partially planned and partially reactive. A comprehensive evidence based strategy for addressing chronic disease was developed in an inclusive way. The implementation process was partially reactive because it was shaped by a range of factors such as the dominant values of health professionals and the acute care culture within the health care system. This research suggests that the implementation of PCDS was influenced by the strengths and weaknesses of the health care system, rather than a considered and proactive evidence based process.

Effectively implementing Aboriginal health policy in Australia will rely on moving from emergent change mechanisms to facilitating a combination of planned and continuous change (127).

Conclusions

This research has demonstrated that the culture of a health care system is dynamic, powerful and self reinforcing. On the one hand, the culture of the health care system and health professional values determine which aspects of policy are implemented. This can limit the potential for change. On the other hand, aspects of policy that are implemented affect the culture of the health care system and health professional values. This suggests that culture can be an ally. Strategies for culture change can be embraced as a tool for generating behavior change among health professionals.

Understanding complex problems and developing comprehensive solutions relies on a process that facilitates consideration of a mix of voices at all stages of the policy process. It often difficult to be conscious of one's own and collective values, and the influence they have on the way in which health problems are perceived, and how different health professional groups come together in the health care system to decide what actions are taken first. Generating a process that will support more reflective practice among all health professionals will support the development of a more responsive health care system that is more accessible to Aboriginal Australians (128;129).

A collaborative process that facilitates the consideration of multiple perspectives is required to overcome the limitations of what people see. While incorporating multiple perspectives is the aim, ultimately it is likely that some views will dominate. Therefore a proactive approach is required to ensure that marginalised voices are considered in a tapestry of perspectives.

Incorporating multiple professional values throughout the implementation process relies on a fundamental shift from seeing implementation as the dissemination of information, to understanding that implementation involves a reorientation of work and organisations to facilitate the establishment of new practices (123). Strategies for culture change might, for example, begin with a practical demonstration of the problem through the generation of information from audits of patient records (130). Other important strategies are likely to involve communicating new purposes (131), restructuring responsibility (123;131), professional development and training, and goal setting, monitoring and evaluation (131).

Policies that are considerably different to the current culture or dominant professional values rely on substantial planning to facilitate change. This will require a step by step implementation process that is founded on the principle that implementation of policy is much more than the dissemination of information; it involves the engineering of culture change.

There are multiple stakeholders and complex pressures in the Australian health care system. This makes change extraordinarily difficult (127) but not impossible. Changing the culture of organisations and systems can be facilitated through the creation of learning organisations. These concepts are discussed in Chapters 8 and 9.

In the previous three chapters, the way that policy changes as it is implemented and how these changes undermine the quality of an evidence-based and stakeholder-informed policy are described. In the following two chapters, rather than emphasising how policy changes, the focus shifts to the context in which policy are received. A comprehensive health care system is required so that all policies have a greater chance of being implemented comprehensively and equitably.

Section 4

The context in which policies are received

This section of the thesis continues to present findings emerging from the research, but there is a fundamental shift in emphasis. Attention is redirected from exploring how policy changes as it is implemented, to examining the context in which policies are received. Emphasis is placed on the ability of the health care system to respond to policy ideas.

There are two chapters in this section of the thesis. Chapter 7 explores whether or not there are sufficient resources invested in Aboriginal health and examines the effects of funding arrangements and processes on the ability of the health care system to implement policy ideas. Chapter 7 reveals there are a number of long-standing and perverse incentives operating in the health care system. These perverse incentives lead to a situation where the acquisition of funding may be seen as a success in its own right. This is problematic because it is not the acquisition of funding that improves Aboriginal health, it is what that funding allows a health system or an organisation or a community to do. In order to avoid the common trap of seeing funding as a success in its own right, it was decided to focus on the factors required to improve Aboriginal health. It is recommended that the performance of the health care system be evaluated according to principles of quality, efficiency, effectiveness, acceptability and equity.

Chapter 8 explores ways to enhance the management capacity of the health care system to implement Aboriginal health policy more effectively. Incorporating new policy ideas into core business is a complicated process with many far reaching and sometimes unexpected implications. A basic level of management capacity is required if these complex processes are to be enacted. In the previous chapter it is argued that the performance of the health care system be evaluated to highlight areas of success and gaps in performance. While evaluating performance is an important undertaking in its own right, it needs to be underpinned by sufficient management capacity. If performance goals are to be met, then management processes that allow organisations and systems to learn from their experiences are required.

Chapter 7

The resourcing of Aboriginal health

Introduction

A case study of the Northern Territory Preventable Chronic Disease Strategy (PCDS) revealed that policies change and adapt during implementation. Often policy changes are shaped according to dominant aspects of the health care system rather than according to population need. When the implementation process is reactive it can undermine the quality of an evidence-based and stakeholder informed policy. So far in this thesis the dynamic ways that the PCDS changed as it is implemented have been examined. Now in this chapter there is a shift in focus from examining how policy changes as it is implemented to focusing on the context in which policies are received and examining the capacity of the health care system to respond to policy ideas.

As the title suggests, this chapter examines the resourcing[2] of Aboriginal health. The intention of this chapter is to explore the impact that resourcing has on the capacity of the health care system to respond to policy ideas. The resourcing of Aboriginal health emerged as a major theme in this research. On the one hand, the allocation of funding to PCDS enabled its implementation and directed attention to addressing chronic disease in remote Aboriginal communities. However, a lack of resources for Aboriginal health is seen to diminish the capacity of the health care system. Diminished capacity is problematic for implementation. A basic level of infrastructure and capacity is required to be able to respond to new policy ideas. In addition, organisational practices and procedures need to be reoriented as part of the implementation process. Diminished capacity within the health care system undermines this multilevel implementation process.

There has been much debate in Australia on the resourcing of Aboriginal health. There has been a tendency in these debates to discuss the inappropriate use of resources in

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[2] The terms funding and resources are often used interchangeably. While the terms are related, they in fact reflect different phenomena. Funding may be defined as a supply of money for a project, an individual or an organisation. Resources on the other hand, relate more broadly to access to a supply of support or aid. Resources might exist in the form of access to equipment or expertise. Both funding and resources are important ingredients within a range of factors required to build the capacity of the health care system.

Aboriginal health. There is a common perception among the broader Australian population that 'governments have poured huge amounts of taxpayers' money into Aboriginal health, to no avail' (50) p. 12.

A punitive focus on the use of resources is different to examining the provision of resources and exploring the ways in which the supply of resources may influence the ability of the health care system to meet the needs of Aboriginal Australians. By and large the dominant focus on whether or not the use of resources for Aboriginal health has been appropriate has occurred to the exclusion of other important issues. In particular, whether or not there are sufficient resources, or whether the supply of resources is efficient and effective; or the link between the appropriate and adequate supply of resources and the capacity of the health care system to meet the needs of Aboriginal Australians.

Worrying about the perception that funds spent on Aboriginal health are wasted is destructive in terms of reconciliation and building relationships between Aboriginal and non-Aboriginal Australians. It directs attention away from examining the performance of the health care system in meeting the needs of Aboriginal Australians, and more specifically, whether or not spending on Aboriginal health is effective and efficient.

The premise of this chapter is that without adequate resources there will be diminished capacity across the health care system to respond to policy ideas. Therefore attention is now placed on examining whether or not there are sufficient resources for Aboriginal health.

Are there sufficient resources for Aboriginal health?

The widespread belief about excessive funding of Aboriginal health has also permeated some aspects of the health literature. For example a textbook on the Australian health care system stated:

> '[Aboriginal health inequities exist] *despite the disproportionately large dollar amounts specifically provided to that sector of the community over numerous years.'* (132) p. 9.

In 1998, in order to establish whether or not there were adequate resources spent on Aboriginal health, the Australian Institute for Health and Welfare conducted a review of Commonwealth, state and private expenditure on Aboriginal health. This review revealed that per capita health expenditure for and by Aboriginal people was only about eight percent higher than health expenditure for other Australians (50;133).

In 2001, a subsequent review by the Australian Institute for Health and Welfare found that for every dollar spent on non-Aboriginal Australians, $1.18 was spent on Aboriginal Australians. It would be difficult to argue compellingly that this difference constitutes 'disproportionately large dollar amounts' especially when one considers the increased burden of disease suffered by Aboriginal Australians (134). Sicker populations require greater financial investment. For example, asthma and diabetes patients who require hospitalisation use six times the average PBS and hospital resources than other Australians (65). The 2001 review, by the Australian Institute of Health and Welfare, also found that over the period 2001-2002 and 1998-1999, relatively less expenditure was spent on Aboriginal people compared to non-Aboriginal people (134). This relative difference in health expenditure is explained by faster expenditure growth on types of health services which Aboriginal people use less, such as those funded through private health insurance.

When determining an adequate amount of resources to support the health of Aboriginal Australians, many factors need to be taken into account. These include the burden of illness and co-morbidities, geographical distribution, and the structures and services required to ensure effective and high quality health service provision. In addition, it is also important to consider whether or not funds are allocated appropriately.

Understanding the allocation of resources is complicated. The majority of health care funds are spent on secondary health care (in hospitals) rather than primary health care (in the community). However, many participants in this research argued that if there was a robust primary health care service in place there would be less demand on hospital services. In addition, Australians who utilise hospital services would not be as sick or as advanced in their disease, and therefore would require less expensive care, and would have a longer and better quality of life. The allocation of resources to hospital versus primary health care services is an issue that is important to both Aboriginal and non-Aboriginal Australians. However, given that Aboriginal Australians suffer a great burden of illness the implications for Aboriginal Australians are more pronounced.

The Australian Institute of Health and Welfare review revealed that the allocation of resources to health care were different for Aboriginal compared to non-Aboriginal Australians. Aboriginal Australians had relatively higher expenditure on community and public health services, patient transport, public hospital services, mental health services, government administration and research. There was relatively lower expenditure on Medicare, PBS, residential aged care, privately funded health care services, such as doctors in private practice and private hospitals and dentists (65;134).

The Australian Institute of Health and Welfare reviews on the expenditure on Aboriginal health clearly show there are inadequate resources for Aboriginal health.

However, attempts have been made to improve the funding structures for Aboriginal health, and the process for allocation of resources for Aboriginal health is evolving. For example, some work has been conducted to identify options for formulating equitable funding ratios for Aboriginal health, based on disease burden and disadvantage (135). The Aboriginal coordinated care trials and the Primary Health Care Access Program used multiples of mainstream Medicare and the Pharmaceutical Benefits Scheme. In addition the Top End and Central Australian planning studies included workforce ratios for Aboriginal health on which per capita resourcing needs could be calculated.

However, there is a need for this to occur at a faster pace and on a larger scale.

There are two aims for the remaining sections of this chapter. The first is to explore the causes of inadequate resources being available for Aboriginal health. The second is to outline the symbolic and pragmatic implications of inadequate resources being available to meet the health needs of Aboriginal Australians.

Factors that contribute to the under resourcing of Aboriginal health

Three factors emerged as contributing to the under resourcing of Aboriginal health. They include inefficient funding arrangements, mainstream programs being inappropriate for Aboriginal Australians, and competing interests determining the allocation of resources.

The funding relationship between the Commonwealth and state and territory governments

Many participants in this research expressed frustration about the funding arrangements for Aboriginal health. In order to provide background information to participant comments, a description of the financial arrangements of the Australian health care system is outlined in Box 1.

Box 1: The financial arrangements of the Australian health care system

Financial responsibilities for the Australian health care system are divided between state and territory governments and the Commonwealth government.

State and territory governments have strong legal and financial powers, especially over public hospitals, and provide a range of health services including the transport of patients and community health services (47;48). Psychiatric, geriatric and mental hospitals receive almost all of their funding from state and territory governments which normally have direct responsibility for the administration of these institutions. The states and territories also administer an extensive system of registration requirements for health professionals (47).

Functions such as the administration of primary and community health services, environmental health protection (food safety and water quality control) are sometimes the responsibility of local government.

Financial arrangements in each state and territory are different. However, the same complex funding formula is used to estimate costs to deliver health care. These funds are granted through the Commonwealth and State and Territory health care agreements. Cost containment is always a major issue for state and territory governments because funds are allocated according to an estimation of projected costs rather than actual costs incurred.

The Commonwealth government dominates the funding of health care mainly through Medicare, the national health insurance program, and has responsibilities spanning the Pharmaceutical Benefits Scheme (PBS) and financial support for high level residential care, medical services, and for health research (47;48).

The funding relationship between the Commonwealth and state and territory governments is portrayed by participants as inflexible, cumbersome and inefficient.

In theory, the Commonwealth has major responsibility for Aboriginal primary health care. The Commonwealth funds Aboriginal primary health care through the Office of Aboriginal and Torres Strait Islander Health (OATSIH) as well as through mainstream funding such as Medicare and the PBS. Currently, OATSIH has no systematic way of allocating health funding to communities. Aboriginal communities, especially those in remote areas, cannot get equitable access to Medicare due to different service delivery models and workforce shortages. The Northern Territory Government therefore complements Commonwealth funding with significant direct primary health care funding and service delivery. The dual funding of primary health care between the Commonwealth and the Northern Territory Government complicates the whole picture and allows for 'buck passing' between the Commonwealth and the Northern Territory over respective responsibilities.

An example of the manifestation of the Commonwealth and state funding arrangements is outlined in an excerpt below. Here a doctor describes a situation where the Northern Territory Government was penalised in the Commonwealth-state funding agreements for paying for pharmaceuticals in remote Aboriginal communities:

> *'The Territory used to spend money on pharmacy services for remote Aboriginal people, but no other state government was buying drugs for their people. The Territory was actually being penalised under the Commonwealth-State funding arrangements for spending above others. There was an assumption that all states were equal and that calculation of expenditure was averaged and any state that spent above the average, within certain parameters, in a certain area were penalised for doing that. So if Victoria spent more on roads than anybody else they were penalised for that. They were assumed to have more money for roads than they needed so they got less roads funding. In the Northern Territory because we spent so much more on primary health care, we were actually penalised for that. Because we were spending on primary health care we got less money for health because it was assumed that we had money to spare. There wasn't any adjustment made by the Commonwealth Grants Commission to realise that there were no other providers and no alternatives.'* Doctor

In the example above, complicated and inflexible funding arrangements contribute to an under resourcing of primary health care by the Commonwealth government to the Northern Territory. Another effect of these funding arrangements can be seen at the operational level. In the example below a doctor describes the difficulty that an individual health service faces when seeking additional resources to provide health services.

> *'We've had a long process of negotiating with funding bodies to get more resources… Part of our difficulty is we are half funded by OATSIH and not seen as a fully fledged community controlled health service. We are incorporated under the community government council which means that we can't be a full*

> *member of AMSANT* [Aboriginal Medical Services Alliance Northern Territory] *and therefore have slightly dubious status with OATSIH as a community controlled health service. AMSANT demands that to be a full member you have to be separately incorporated and so we are on some lists for some things for OATSIH and we're off other lists. I have never managed to get anyone to explain what and why, and what implications it has. Occasionally we are left out of things because of that… We are in an anomalous situation because of the incorporation and because of the fact that we were a grant-in-aid health service with money from Territory Health to the Mission and then handed over to the local government council.'* Doctor

Many participants in this research described the Commonwealth-state funding arrangements as inefficient and as undermining the capacity of governments and individual organisations to provide health services to Aboriginal Australians. It is difficult to access information on how funding decisions are made, therefore it is not possible to substantiate or contradict these claims. The fact that it is difficult to get information on how funding decisions are made is telling in itself. In an area full of opinions there is a dearth of facts. There is a need for greater transparency and access to the allocation of funds and evaluation on whether the process has been effective.

Do mainstream services meet the needs of Aboriginal Australians?

There is an expectation that mainstream publicly funded health services will be responsive to the needs of Aboriginal people (49). Aboriginal people can access care in three ways. Firstly through mainstream publicly funded health services, secondly through private providers such as general practitioners, and finally through Aboriginal community controlled health services. However in practice, evidence suggests that mainstream health services do not always meet the needs of Aboriginal Australians.

In response to questions about barriers to implementing chronic disease programs, participants identified the inapplicability of mainstream programs, such as Medicare in the context of Aboriginal health, as a major hindrance. Some participants highlighted specific examples in chronic disease where the incentives to improve chronic disease management in mainstream general practice work against the effective delivery of health care in remote Aboriginal communities. The staffing arrangements are different in remote Aboriginal communities and rely heavily on Aboriginal Health Workers and nurses, not just general practitioners. However, until recently only doctors were able to claim payments from Medicare for undertaking adult health checks. In the example below one of the participants describes this situation and explains how it works against the effective delivery of health care in remote Aboriginal communities.

> *'Most patients are having their adult health checks but they are being done by the Aboriginal Health Workers and the nurses. And it is only the people with abnormalities that are referred to the doctor for screening and yet if a doctor saw all of those people having adult health checks then you'd probably be able to afford another three doctors, so there is a bit of self defeating negativity in there'.* Doctor

The mainstream process of funding adult health checks did not recognise the contribution being made by Aboriginal Health Workers and nurses in remote Aboriginal communities. As a result, the mainstream funding of adult health checks can be seen as establishing perverse incentives that undermined Aboriginal Health Workers and nurses triaging patients to ensure that doctors had sufficient time to see the sickest patients. It is not clear whether or not the funding disincentives actually changed practice in an undesirable way; or whether practice remained appropriate to needs, despite limited access to funding. It is clear that it is frustrating for service providers to be operating in a system that doesn't make sense and is working against efficiently meeting the health needs of Aboriginal Australians.

An examination of the literature supports these participants' comments and reveals that there is a history of structural barriers in the health care system that prevents mainstream services from meeting the needs of Aboriginal Australians (50-52). There has been a significant under spend in Medicare and PBS items for Aboriginal Australians. In 2003 the Health Insurance Commission commissioned research to determine Aboriginal people's access to Medicare and the PBS. The major finding of the research was that Medicare and the PBS are exemplary health funding systems which well serve the general community, but that Aboriginal people everywhere face considerable barriers which impede their full access to both Medicare and PBS (136).

This research demonstrates that many mainstream services are not available to Aboriginal Australians. It has not been possible for example to access Medicare if there is no doctor in the community, and by the same token it has not been possible to access PBS if there is no pharmacy (137). In addition Medicare can only be accessed with a unique, personal Medicare number. This is secured through a process of enrolment which was developed largely on the assumption that new registrants are immigrants. Many Aboriginal people however, have historically relied on services offered to them by the state and territory governments, and have never required registration. Others have faced obstacles linked to transience or problems with identification (138).

Policies that are designed for the Australian population are generally ineffective for remote Aboriginal communities. The process of establishing national programs and funding incentives in the health care system for the mainstream population, without considering the needs of Aboriginal Australians, is inequitable. It is laudable that adjustments have since been made to make national programs and funding incentives accessible to Aboriginal Australians in remote areas – though there is a time lag. But in light of the higher rates of illness in remote Aboriginal communities, at best this process is inefficient, and at worst, negligent.

More recently, decades after Medicare and PBS have been operating, steps have been taken to address the under spend on Aboriginal people. In response to the finding of the research commissioned by the Health Insurance Commission, the PBS reviewed the supply of medicines to remote Aboriginal communities.

Changes have been made to make the organisation of Medicare and PBS more appropriate and accessible to Aboriginal Australians. These changes have meant that providers other than doctors (i.e. Aboriginal Health Workers) are able to claim payments from Medicare, and that pharmacueticals are now able to be ordered in bulk and supplied as needed to patients on site. The usual co-payment associated with PBS medicine is not charged and the pharmacist remuneration structure is different (139).

Complicated and cumbersome financial arrangements and the development of mainstream policies without explicit consideration of the needs of Aboriginal Australians mean that the mainstream health care system does not always meet the needs of Aboriginal Australians. There is an urgent need to establish and maintain more effective funding arrangements for Aboriginal health. But this will be a difficult and complicated task. And ultimate responsibility for these funding arrangements, and therefore responsibility for the change process, remains unclear.

Having acknowledged the limitations of the Australian health care system for Aboriginal Australians, it is also important to note that attempts have been made to make the funding arrangement and mainstream policies more appropriate for Aboriginal Australians. These alterations and modifications are commendable. But the time lag between the development of the policies, the realisation and acknowledgement of the problems and the establishment of modifications is significant. During this time many Aboriginal Australians are not accessing mainstream services and therefore are disadvantaged.

What factors influence the allocation of resources?

Despite the common misconception among some health professionals and other Australians that funding in the health care system is allocated according to community need, the reality is that funding decisions are influenced by a variety of factors, ranging from historical influences to political imperatives. A number of participants expressed frustration at the point that funding decisions are made according to political imperatives rather than moral, economic or social arguments.

In the following quote, a participant uses economic and moral rationales to argue for additional funding for Aboriginal health. The participant presumes that because health needs are not met, that decisions must be based on political imperatives rather than according to need:

> *'Take a child who can't hear properly by the time they go to school. Think of the cost of one person who cannot hear properly through their school years. What happens to them? They don't learn properly, they either withdraw, they may become aggressive, they don't form proper relationships, they don't get jobs when they get out of school. Cost that out over a lifetime of one person. In some communities just about half the kids can't hear properly, or can't hear functionally. So how could you not be pouring lots of resources into that? I don't get it. The only thing I can think of is it is not a political imperative to do that. And I think part of the reason is that Aboriginal people are not able to advocate strongly for those issues in the political process, they can't get a response to that concern and after a period of time that level of ear disease becomes the norm. People just get used to it and don't really expect anything else. So we are really*

> *caught there. We require the integrity in governments to address that and I don't think in those terms we've got it… I think most people really want improvements in Aboriginal health but what are they prepared to do and commit to achieve that? I mean John Howard wants improved Aboriginal health but what is he prepared to put into it or politically risk for it is a question that is worthy of asking.'* Manager

The polemical comment above uses both economic and moral factors as fundamental reasons to support further funding and attention towards addressing the underlying determinants of Aboriginal health. This comment highlights that the costs of Aboriginal health can be viewed according to immediate versus long term costs, economic versus social costs, and social costs versus political costs. In this contested domain, it appears that political costs take precedence.

Many participants across all levels of the health care system cited a lack of political imperative to improve Aboriginal health as the major underlying reason for inadequate resources. Many firmly stated that there are no votes to be won by improving Aboriginal health and therefore there is no political imperative to generating efforts in this area.

> *'Aboriginal health always loses out because there are no votes in Aboriginal health… The key political conundrum in Australia this decade is how we get government to take leadership on this and say well look there are no votes in this* [funding Aboriginal health] *but we're doing it because it is a good thing to do. And the current government has an ideology that it doesn't even want to take it there at the national level. The ALP Northern Territory Government has some ideology around supporting this but is constrained by their slim electoral margin, they can't be too radical. You know it is really hard I think.'* Doctor

If a lack of political imperative is one of the fundamental causes for inadequate resources being spent on Aboriginal health, then one of the strategies to increase funding for Aboriginal health and for sectors, such as education, that contribute to addressing the underlying determinants of health, may be to reorient the political system so that Aboriginal Australians have a stronger voice in the political process.

An issue that was not raised among participants, but is likely to have a major influence on the allocation of resources for Aboriginal health, is the role of vested interests in determining the priorities for health care and therefore the allocation of resources.

Duckett (1992) delineates between the interests of organisations, health professionals and patients within the health care system (140). Duckett argues that organisations are concerned about cost control; health care providers are concerned about the quality of care and freedom of professional judgment; and patients are concerned about access to care and freedom of choice. If one considers that health care represents a significant proportion of the Australian economy, 9.3% of GDP in Australia (141); and many Australians earn their income from the provision of health services; and that changes to the health care system are likely to affect the number of providers and how much they are paid – it is not surprising that there is vigorous debate from affected interests (142).

There are contests for resource allocation and control within the health care system and this contest determines where funding is supplied. While moral, economic or even political arguments may be made within this competitive environment, the contest is ultimately one of power.

The three major reasons for having inadequate resources for Aboriginal health can be linked to a fragmented health care system. There are structural barriers to long term funding that emerge from the Commonwealth-state funding divide. The processes of mainstream policy development in health care often occurs without the specific needs of Aboriginal Australians in mind, and therefore are often inappropriate for Aboriginal Australians. While alterations to make mainstream policies more appropriate to Aboriginal Australians occur, they do so in subsequent years and even decades. This process is inefficient and inequitable. Contests among vested interests determine the priorities of the health care system and therefore the allocation of resources. Contests are ultimately about power across different levels in the health care system, and are rarely an evidence based examination of the health care needs of a population. These contests contribute to an under resourcing of Aboriginal health, because the voice of Aboriginal health in the health care system lacks power.

Implications of inadequate resources

There are three main implications of supplying inadequate resources to Aboriginal health. Firstly, inadequate resources for Aboriginal health contribute to diminished capacity. Implementing a policy idea relies on the existence of a basic level of infrastructure and capacity within individual health services and across the health care system. Secondly, inadequate resources for Aboriginal health are seen as contributing to a short term funding scenario. In this scenario additional funding suddenly becomes available and this process works against systemic building of the capacity of the health care system to meet the needs of Aboriginal Australians. Thirdly, the acquisition of funding to facilitate the implementation of a policy idea can be seen as an achievement in its own right, without necessarily being linked to how that funding is utilised.

The relationship between the provision of resources and the capacity of the health care system to meet the needs of Aboriginal Australians

Many participants commented that historically there has been less capacity within the primary care services for Aboriginal Australians compared to the capacity that exists within primary care services for mainstream Australia. Primary care services for Aboriginal Australians are required to provide a greater range of culturally appropriate services than mainstream services, but due to structural barriers such as the organisation of Medicare and PBS, they in fact have access to fewer resources. This creates a situation of double jeopardy where the organisations that are required to provide more are actually given less. To improve Aboriginal health, comprehensive primary health care services are required to provide in-depth, culturally appropriate care. However these very services have historically been given less resources and therefore have had diminished capacity. As highlighted in the comment below, a number of participants were conscious of under resourcing in primary health care and saw this as a major barrier to the implementation of Aboriginal health policy such as the PCDS:

> *'The limitation of the PCDS is the chronic under resourcing in primary health care. When you're expecting people who are less well resourced than the mainstream to actually do more…'* Doctor

Therefore rather than additional funding being required to support the implementation of individual policies, the central issue becomes one of diminished capacity within the health care system. Respondents were concerned that some primary health care services are struggling to provide key services. This results in the implementation of programs such as PCDS being seen as less immediate and a lower priority concern. The following comment by a policy officer demonstrates insight into the pressures faced by some service providers in some remote Aboriginal communities, and the impact this has on the ability to implement new policies such as PCDS:

> *'So when we talk about preventable chronic disease, the capacity of the remote health team and remote health workforce is so diminished that PCDS is the last thing on their agenda. And I am talking about serious, serious things… traumatised nurses being called out, after being on call all night dealing with a death, called to attend a fire where two children were burnt to death. The next morning drives two and a half hours to deal with a grieving community, with no back up. We can't put that sort of pressure on people. And there we are dithering around the edges with PCDS saying increase your well persons' check and let's do some screening and why haven't you done your reviews.'* Policy Officer

The extent to which Aboriginal health is appropriately resourced is highly contentious. As outlined in the introduction to this chapter, there is a common myth that Aboriginal health is over resourced when, in fact, historically Aboriginal Australians received less health care resources than non-Aboriginal Australians. This has especially been the case in terms of access to primary health care services rather than tertiary care. Steps have been taken to address the funding inequity, particular at the primary health care level, and as a result there have been recent increases in funding rates for the health of Aboriginal Australians. In the example below one participant describes the improvement in funding parity and sees this as the basis for improving Aboriginal health:

> *'Aboriginal people were being funded at about one third the rate of non-Aboriginal people, when Aboriginal people have somewhere between 150% and 200% of the disease burden. So there is obviously disproportion there. Even just by bringing Aboriginal health funding to sort of parity, or just beyond parity meant that we still weren't resourcing it enough but we were resourcing it about three times better than it had been resourced already, which is a start'*. Doctor

Policies can only be as effective as the context in which they are received, and therefore adequate resources are an important precursor to being able to implement policy. If there is diminished capacity in health services, then the effectiveness of policies will be compromised.

Short-term funding

More often than not, funding is suddenly made available and there is a concerted but short term effort to think how to best make use of those funds. A policy officer describes this process and is frustrated by the ad hoc funding process but also the implications for how that funding is used:

> *'the policy director will ring up and say there is money available, think, think, think, the wheels start turning… there is $100,000 available let's whack a project officer in there. I mean we are creating jobs for more white middle class project officers.'* Policy Officer

This funding process is seen as encouraging the health care system to employ project officers for a limited period of time on a specific project, rather than contributing to the systematic building of the capacity of the health care workforce.

In another example, a participant describes their process of obtaining funding and discusses how this funding process encourages organisations to fall into a short term funding cycle. This cycle is seen as diminishing rather than building the capacity of the health care system:

> *'As part of the strategy of getting OATSIH funding they gave us money to do a needs assessment and planning exercise, from that it was expected that we would then have a strategic plan and we would apply for funds, which would include a three year program for chronic disease work. But we never completed our strategic plan because our health committee fell apart. We identified a number of needs but both the manager and I said it is not appropriate for us to put in a gamin* [pretend/fake] *plan as has been done in many other Aboriginal communities. You get a consultant in, they write something up that looks you beaut, you get the money and then you go to implement it and then a year or two down the track it all falls over because it didn't actually genuinely have a community understanding of what was going on… I wasn't personally going to be involved with doing it again, so then from being flavor of the month with Commonwealth health we became the bad boys because we didn't go through playing the game. So money was held out and dangled there and then withdrawn. But we didn't want to get into short term funding scenario because then you worry about withdrawing services at the end.'* Doctor

Short-term funding undermines the capacity of the health care system. It encourages a reactive rather than a planned approach, which tends to result in short-term and incomplete solutions rather than comprehensive solutions, which build the capacity of the health care system as well as improving the health of the population.

The value of funding

The acquisition of $2.35 million dollars in recurrent funding was seen as fundamentally supporting the implementation of PCDS. The provision of funds was seen by participants to represent institutional will and to bring recognition and authority to chronic disease and Aboriginal health.

The negotiation process for the allocation of the S100 funds was said to be highly competitive. As explained by a policy director below, arguments and rationales for funding were made based on the merit of each program, as well as in comparison to other policy ideas:

> *'I was on the Departmental Executive when that* [the opportunity for funding] *came up and myself and several other executive members… put up a real fight in Executive to have all of that money devoted to implementing the Chronic Disease Strategy in remote areas. And everyone had other ideas about how it could be used: it could plug the patient travel gaps, and it could fund this or that development of software, and there were lots of clever ideas about how else it might be used but I think because the strategy was so logical, simple, and undeniable, and reliable, the strategy won. And so Cabinet approved that we would spend our Section 100 monies on the PCDS.'* Policy Director

The case study on the funding of the PCDS reveals that the allocation of funds is a competitive process. On the one hand, high levels of competition are likely to increase in a stretched and under resourced environment that is faced with continual and often increasing costs. On the other hand, the process may be especially competitive because funding symbolises recognition, acknowledgment and status within the health care system.

Many respondents commented that the funding of PCDS represented a shift in thinking in the health care system. The health care system has a history of using new money to cover existing expenses emerging from acute care requirements, such as patient travel costs. Funding PCDS represents a change in the allocation of new money. Funding a new program that would work proactively to reduce the increasing burden of disease, and therefore reduce or minimise a large increase in future health care costs associated with the rising incidence of chronic disease and its complications, represents a significant shift in thinking.

A critical success factor in funding PCDS appears to be the fact that a policy existed, and that this policy included both compelling arguments for addressing chronic disease, but also tangible strategies for action. In addition, there were people around the decision making table in positions of authority who were able to effectively argue for the merits of addressing chronic disease.

The recognition and authority that funding symbolises is seen as especially important for chronic disease programs within the health care system, because there is a history of preoccupation with infectious diseases. Relatively less attention has been placed on chronic disease. A number of policy directors noted the recognition that stemmed from the funding of PCDS. As aptly described by one policy officer, the funding of PCDS brought attention to the financial costs associated with the increasing incidence of chronic disease:

> *'I guess when the strategy* [PCDS] *came along, there was very little intentional investment in chronic disease. And there was very little understanding among policy people who made decisions about money, that chronic disease was actually a consumer of resources and that it was what was causing people to die'.* Policy Director

There has been a history of high levels of funding being allocated to protecting the population against potential threats such as 'exciting infectious diseases' rather than funding 'real' but perceived as less urgent or dramatic threats such as diabetes and other chronic diseases within the health care system:

> *'Royal Darwin Hospital has just gotten many millions of dollars for trauma and that is what people are much more interested in, exciting infectious diseases like SARS and bird flu and chemical warfare, and things like that, than they are in what the real threat to their health is which is diabetes and so on.'* Policy Director

These comments suggest that funding is linked to status and recognition of institutional will. And more specifically, that funding of chronic disease is seen as representing a shift of thinking in the health care system – of planning for emerging disease rather than using additional funds to prop up funding in the dominant area of acute care. Therefore, due to the symbolic power of funding, it is not surprising that funding is seen as a success in its own right, as opposed to a means to an end. There was less attention placed on how funding is used or how organisations might become more effective in carrying out their core business. The practical ramifications of funding such as the ability to employ staff and provide more comprehensive health services were not prominent among the participants' comments.

Improving Aboriginal health relies on examining the effectiveness of work processes and identifying where there are opportunities for improvements. If effort is centered on obtaining more funding rather than changing the way core business is conducted, then the capacity to improve the health care system may be compromised. In an extreme scenario, funding could be sought and received without changing the work of the health care system. Seeing funding as the ultimate goal is problematic because it diverts attention away from building the capacity of the health care system to better meet the needs of Aboriginal people.

There is a need to have an eye to both – to secure funding and to improve the way that core business is conducted.

Policy people may see securing funding as the ultimate goal of their own work. They may look to operational areas to implement policy ideas. This research has demonstrated thinking in this way will be unproductive. The worth of funding is diminished if it is not used to build the capacity of the health care system to improve its practices.

Discussion

Whether lamenting insufficient resources or marveling at the ability to secure funds to facilitate the implementation of the Northern Territory Preventable Chronic Disease Strategy (PCDS), resources emerged as an important theme when examining the capacity of the health care system to respond to policy ideas. Not surprisingly, the provision of funds was highly valued among participants and seen as an important support to implementation. However, participants also explained that the way in which funds are distributed has far reaching effects in overall capacity and the ability of the health care system to undergo a process of sustainable development.

The funding of PCDS showed that in some cases the acquisition of funding emerges from a series of opportunities, rather than a systematic approach to funding innovative policy ideas within Aboriginal health. Lobbying for funds is described as a highly competitive process. Success relies on additional funds being available; having a high quality evidence based strategy with compelling arguments for focusing on a specific disease; and strategies to address the disease facing population groups. Perhaps the most important ingredient was having people in positions of authority and supportive of PCDS at the decision making table.

Inadequate resources for Aboriginal health undermine policy implementation in two main ways. Firstly, inadequate resources undermine the potential to generate support for and commitment to implementing the aims of the policy. Secondly, inadequate resources undermine the capacity of the health care system to adopt innovative ideas and to reflect on the effectiveness of their work.

The inadequate resourcing of Aboriginal health is caused by a number of long standing and entrenched perverse incentives operating in the health care system. This has created a formidable situation in the health care system that challenges its capacity to improve Aboriginal health. This research found that funding decisions are often made according to political imperatives and vested interests, rather than according to community needs. In addition, policies designed for the Australian population are usually formulated without considering the needs of Aboriginal Australians, and therefore are generally less effective for remote Aboriginal communities. Commonwealth-state funding arrangements are inefficient and diminish the capacity of the health care system, and there is an entrenched culture of short term and ad hoc funding arrangements. The cumulative effect of these structural barriers is that adequate and appropriate funding of Aboriginal health is not assured. This undermines the capacity of the health care system to meet the needs of Aboriginal people and therefore improve Aboriginal health. There is an important need to clarify and measure the funding responsibilities of the health care system, and to manage and monitor these responsibilities to ensure that they are met.

Policies are designed and implemented within a fragmented health care system where there are multiple structural barriers to the efficient and effective funding of Aboriginal health. This research found that funding is often seen as a success in its own right and disconnected from how those funds are used. Therefore, in order to avoid this common trap, it was decided to focus on the factors that are required to improve Aboriginal health. To this end it is recommended that the performance of the health care system be evaluated according to its principles of quality, efficiency, acceptability, and equity. These principles are adapted from the second edition of Duckett's text on the Australian health care system (143).

Quality is important in terms of system design. Poor quality care can result from poor continuity of care across hospital and primary health care settings. Some difficulties in continuity of care can be attributed to the different Commonwealth and state and territory financial arrangements. There are three aspects to an *efficient* health care system. Factors such as multiple reporting requirements cause technical inefficiencies. The extent to which a system is able to adapt to change is known as dynamic efficiency. Allocative efficiency is concerned with ensuring the best allocation of resources to yield the best possible outcomes. *Acceptability* of the health care system is considered from the perspective of patients, communities and providers. But it is difficult to disentangle the financial and professional interests of the providers from the interests of consumers and the system as a whole. *Effectiveness* of the health care system can be measured in terms process and outcomes. The latter would consider the ability of the health care system to prevent the incidence and reduce the prevalence of chronic disease. A process measure may examine factors such as increased attendance by Aboriginal people to health services, and an increase in the frequency of chronic disease checks. *Equity* may be measured in two ways: in terms of access to care and also in terms of outcomes of care or health status.

Evaluating the performance of the health care system according to the principles of quality, efficiency, acceptability, effectiveness and equity will allow for multiple benefits. Firstly, an evaluation of this type will create space for more sophisticated discussions about expenditure and Aboriginal access to health care that enables attention to be placed on improving capacity rather than diverting attention and efforts from the cycle of obtaining and accounting for funds (65). Secondly, focusing on these principles will encourage a longer term perspective in strengthening the capacity of the health care system. This process will avoid the common trap of short term funding and scenarios where organisations lobby for their concerns, disease and body parts in a reactive system. Thirdly, it will be possible to facilitate an expanded use of health expenditure information as a means of monitoring health service delivery and access to health services. According to the Australian Institute of Health and Welfare, health expenditure information is one means of investigating health service delivery and the levels of access to health services, and identifying where improvements can be made (134).

Conclusion

Policy is an important mechanism in improving the work of the Australian health care system. The capacity of the entire health care system to contribute to policy development and implement policy ideas is fundamental to improving Aboriginal health. Given the increased burden of disease and inequities in life expectancy between Aboriginal and non-Aboriginal Australians, there has been a history of inadequate funds being allocated to Aboriginal people in Australia. This situation contributes to a scenario of diminished capacity in some health services and government departments. This has contributed to funding being seen as an achievement in its own right and not necessarily inextricably connected to how those funds are used. This undermines the implementation of evidence based policy ideas.

In Australia, there has been a history of myths that generated extensive rhetoric of overspending on Aboriginal Australians, and blame being placed on Aboriginal Australians for wastage of funds and persisting illness. This ill-informed view is both destructive and incorrect. There is a history of inadequate resourcing of Aboriginal health, partially through structural barriers that stem from not considering Aboriginal Australians in the development of funding incentives and mainstream policies. And partially a failure of the health care system to evaluate its own performance according to the extent to which it meets the needs of Aboriginal Australians. These mistakes ought to be acknowledged and addressed as the first step towards reorienting the health care system according to principles of quality, efficiency, acceptability, and equity.

The premise of this chapter is that inadequate resources for Aboriginal health result in diminished capacity across the health care system to respond to policy ideas. Inadequate resources result from the cumbersome allocation of resources rather than simply the amount of resources provided to Aboriginal health. It is hoped that by shedding light on the causes and implications of inadequate resources, there will be greater awareness and attention placed on evaluating the performance of the health care system, to ensure adequate resources are made available for Aboriginal health, and to systematically build the capacity of the health care system to meet the needs of Aboriginal Australians. Much of this work, however, is beyond the control of individuals and organisations within the health care system. It is not within the health care system's control to restructure funding arrangements and culture. Therefore the next chapter in the thesis explores ways to enhance the management capacity of the health care system to respond to policy ideas. It is believed that building management capacity can occur despite the fact that in some areas of the health care system there are diminished resources for the health of Aboriginal Australians. In addition, it is felt that, in contrast to the funding arrangements and culture, it is within the health care system's control, and within the control of the organisations that comprise the health care system, to create learning environments. In the longer term it may be possible to advocate for changes to funding arrangements and influence the evolution of the health care system.

Chapter 8

Management capacity required to respond to policy ideas in the health care system

Introduction and background

A case study of the implementation of the Northern Territory Preventable Chronic Disease Strategy (PCDS) revealed that the PCDS framework has been used by the health system in multiple and distinct ways. The various applications of PCDS demonstrate that there is an interaction between the policy idea and the context in which new policies are received. If there is limited capacity in the context, then implementation will be difficult.

This chapter is based on the premise that strengthening the management[3] capacity of the health care system will strengthen the quality of policies as they are implemented. A robust health care system will be better able to respond to and adapt policy ideas in a comprehensive way.

The term capacity will be used throughout this chapter to refer to the level of management capacity that is required for an organisation or a system to respond to and adopt and adapt a new policy idea. This definition of capacity is based on the premise that in order for an organisation to innovate or implement a policy idea there needs to be sufficient space to move into a new area. If an organisation is already overstretched at

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[3] The term management is used in many ways in the health care system, including, but not limited to, the management of patients with chronic disease, the management of individual chronic disease programs, the managers of individual health services, the health department, or senior bureaucrats and decisions makers. For the purposes of this chapter the term management refers to the systems and processes that support the operation and functioning of the health care sector. Leadership is seen as an important and unique component of management where emphasis goes beyond functioning, to focus on supporting the development, improvement and enhancement of the health sector. Leadership is seen as an individual and collective capacity and as an interaction between leaders, followers and context (144;145). Leadership is instrumental to facilitating organisational and cultural change and emerged as a prominent theme among participant comments.

the time the new policy idea is introduced, it is difficult to attend to day-to-day business and there will be insufficient time and ability to reflect on current practice and to identify ways to improve the operation of the organisation. For example, if a health service dedicates most of its time to seeing patients, it may be difficult to conduct a review of patient records to determine who are the chronic disease patients and who are due to have their blood pressure checked. New systems and processes can be established to make work more efficient, but an adequate amount of time, expertise and planning is required in order to establish (or modify) the required systems. The need to create the space to move into a new area pertains to other disciplines and professions too. For example, if an academic has a full-time lecturing load it will be difficult to find time to conduct research.

A framework to determine an organisation's readiness to innovate

Greenhalgh et al (2004) published a conceptual model for considering the implementation of innovations in health service delivery and organisation (123). This model is based on a systematic review of 213 empirical research studies and includes nine components. While the entire model is comprehensive and informative, its application is beyond the scope of this research. However, one component in particular – system antecedents for innovation – is especially relevant to this chapter. System antecedents for innovation incorporate three essential elements: structural determinants, absorptive capacity for new knowledge, and a receptive context for change.

As the name suggests, structural determinants demonstrate that certain structures allow organisations to implement changes in policy or practice more readily. For example, if an organisation is large, mature, functionally differentiated and specialised, or if decision making is decentralised and there are resources available to channel into new projects – then that organisation will be more likely to adopt innovations. Despite the significance of these structural determinants, and the fact that they are consistently associated with organisational innovativeness – together they only account for less than fifteen percent of the variation among comparable organisations. Therefore, changing the structure of an organisation alone is not sufficient to enhance the capacity of the organisation to respond to innovative ideas and to implement policy. Greenhalgh et al (2004) also point out that the relationship between structural determinants and innovativeness is moderated by additional factors, such as how radical the innovation is compared to the existing core business and culture of that organisation.

The second prerequisite for implementation within the health care system is an absorptive capacity for new knowledge. Greenhalgh et al (2004) are referring to a systematic ability to identify, interpret and reframe new knowledge into an organisation's existing knowledge base and to put this reframed knowledge to appropriate use. For example, if a policy is received by an organisation, critical thinking is required for that organisation to take what is stated in the policy and apply those ideas to its own setting. Organisations will need to consider whether or not any of the ideas articulated in the policy document apply to the core business of the organisation, or if the ideas apply to an area that the organisation has identified as a priority. In order for organisations to develop this ability to critically assess policy ideas in terms of their relevance to existing work and future priorities, or as Greenhalgh et al (2004) articulate ‘absorptive capacity for new knowledge’, they have to have reached a stage of development and maturity. This maturity may manifest in a number of ways. For example, organisations may have created a culture of learning, or enjoy proactive leadership that is directed towards sharing knowledge across the organisation. It is important to note that the knowledge that underpins the development of absorptive capacity is not objective, given or static – rather the knowledge is socially constructed and continually negotiated. The ability of an organisation to generate absorptive capacity for new knowledge is underpinned by broader and more easily recognised management concepts such as organisational change.

The extent to which an organisation and a health care system are receptive to change is the third prerequisite for implementation included in the Greenhalgh model. There are a number of organisational features that have been independently associated with its ability to embrace new ideas and face the concept of change. These organisational features that combine to create a receptive context include strong leadership; a clear strategic vision; good managerial relations; visionary staff in pivotal positions; a climate that is conducive to risk taking; and effective data capture systems. The leadership component is seen as especially helpful in breaking out of norms in large well established organisations. An organisation’s receptiveness to change is also underpinned by the concept of learning organisations in the management literature. Peter Senge coined the phrase learning organisations, and with this demonstrated that organisations learn in unique and different ways. The fundamental ingredient for learning is the ability of an organisation to question why things are done they way they are, and to challenge and change the norms of the health care system (146;147).

These abovementioned prerequisites for implementation provide a useful framework in which to assess how amenable the health care organisation is to innovation and change.

In addition to organisational features mentioned in the paragraphs above, system features also have a pronounced impact on the ability of organisations and the health care system to implement policy. A health care system may be defined as a set of connected or independent parts that are bound by a common purpose. The health care system is complex because of the great number of interconnections within and among small care systems (148). According to Sterman, who applied complexity theory framework to understand why the health care system finds it difficult to adopt evidence, found that systems have a number of recognisable characteristics. Systems are constantly changing; tightly coupled (that is everything in the system is connected – the actors in a system interact strongly with one another); nonlinear (effect is rarely proportional to cause); history-dependent; self organising (systems arise spontaneously from their internal structure); adaptive and evolving; characterised by trade-offs; counter intuitive (there is a tendency to look for causes near the events we seek to explain – our attention is drawn to the symptoms of difficulty rather than the underlying cause); and policy resistant (the complexity of the systems in which we are embedded overwhelms our ability to understand them). The result is that many seemingly obvious solutions to problems fail or actually worsen the situation (149).

The purpose of this chapter

The aim of this chapter is to identify ways to enhance the management capacity of the health care system to implement policy more effectively. Participants in the study reported that leadership and engagement with health services managers were important supports to implementation. On the other hand, having more policy ideas than capacity to implement them was identified as a barrier to implementation.

In addition to the Greenhalgh et al (2004) model, the findings emerging from the study illuminate further barriers to, and facilitators of, implementation and provide points of reference when examining the broader political science and management literature. In this chapter, participant comments are considered in light of the literature on leadership, management and the policy process. The literature is drawn upon as a way of creating a new intellectual space in which to understand implementation.

Now the framework for understanding the management capacity required for the implementation of policy has been described, participants' comments on management capacity required for implementation are presented.

Defining and enhancing leadership

Many participants identified leadership as one of the most important supports for the implementation of PCDS. Leadership was portrayed in terms of individual leaders and attributes. In the following example a policy officer describes leadership as key to implementation:

> *'Probably a really key thing is to have… leaders, that believe* [in PCDS] *and understand it, to lead it, you know. X is that kind of personality you need, because without those personalities you can do a hit and miss, you just wouldn't have the impact. So I think that is the other important factor with that you've got to have the calibre of leadership'.* Policy Officer

The quote suggests that the personality and commitment of people in key positions is seen as especially important in facilitating the implementation of policy.

Most of the identified leaders were doctors who were committed to Aboriginal health and a public health approach. As previously noted in Chapter 4, one policy director applauded a group of doctors for their role in PCDS:

> *'I think having some highly respected, brilliant, long term – Territory* [based] *public health physicians has been critical. And they have grown, primarily out of a group of District Medical Officers who really didn't accept, you know, an emergency GP function as their sole purpose in life. They've come here, they've thought deeply about what they have experienced. And they have had a major system wide impact on how we do business. Partly through writing the Strategy and partly through living it, you know. They would have to be the most important, I think. You know, a group of people who provided leadership.'* Policy Director

The incumbents of the Community Physician and the Director of the Preventable Chronic Disease Program posts within the Northern Territory Department of Health and Community Services were seen as inspirational and fundamental to the success of PCDS. Attributes that were admired include: looking laterally, working collaboratively with non-government organisations, passion, persistence and long-term commitment. There is a perception that the drivers of the PCDS have been involved in Aboriginal health for a long time and are involved in multiple policies and programs. This creates synergies and a critical mass of activity to improve chronic disease. For example, the Program Director for the Preventable Chronic Disease Program was also one of the editors of the clinical practice guidelines for working in remote Aboriginal communities.

While participants mainly saw leadership according to individual attributes of people in pivotal positions, the literature reveals that there are multiple forms of leadership. Definitions of leadership have been compiled into the box below to give an indication of the complex ways in which leadership may be understood and may operate.

Box 1: Definitions of leadership

Leadership is highly valued within the health care system because it is seen as producing change and movement. Leadership is able to generate change by building a vision and strategy, and by aligning, communicating, motivating and inspiring people to change and develop (150).

Individual heroes – The traditional, hierarchical view of leadership assumes that leaders are people who occupy a position of authority and to whom we often ascribe some form of greatness. In this model, most people within the system are powerless and lack vision and cannot master change without being led (146;150;151).

Charismatic leadership – Charismatic leaders are defined as individuals who contain a capacity to generate excitement about and enthusiasm for and loyalty to missions. In this model, leaders are seen as powerful and this power stems from their ability to generate compelling visions. One of the problems with this type of leadership is that a single person cannot sustain the magic over long periods (152).

Adaptive leadership – Under this definition leadership is seen as transcending the individual and as being a fundamental component of effective systems. System relationships are not defined by hierarchy, but according to interactions among a range of people and networks. In this model leadership is seen as a complex dynamic process that emerges between people and ideas. Adaptive leadership is an interactive event in which knowledge, action preferences and behaviors change, thereby provoking an organisation to become more adaptive. Under this definition leadership occurs when interacting agents generate adaptive outcomes. It is seen as the product of interaction, tension and exchange. This definition provides a pathway for respecting diversity – not only through its formal emphasis on heterogeneity, but also because cultural respect is much easier to cultivate through one on one interactions (151).

Transformational leadership – The emphasis in this definition is on the ability of leaders to communicate and inspire other people. Leaders are expected to create working environments that are conducive to creative thinking, and encourage connectedness among people within an organisation, or agents across a system (153).

Shared leadership – This modern view of leadership recognises the importance of viewing issues from multiple perspectives. Every team member is bounded by their own mental models. Incorporating multiple perspectives enables teams, and therefore organisations, to expand the boundaries of their mental models and to consider the long-term consequences of actions across the organisation and community (149).

Limitations in how leadership is portrayed

The term leadership is often used synonymously with the term management. The implication is that leadership is incorrectly seen as a position in the hierarchy of the health care system. However an examination of the literature reveals that it may be more helpful to see leadership as a collective of people who build the capacity of organisations, and sustain the process of change required for organisations to shape their own future (154;155). The roles of leaders are beyond that of charismatic decision makers. The roles include an ability to build a shared vision, bring to the surface and challenge prevailing assumptions, and to foster more systemic patterns of thinking (156).

Despite many participants valuing leadership and seeing it as a fundamental support to implementing policy, it is also important to recognise that there are limitations to the way leadership is portrayed. Most participants tended to portray leaders as heroes with passion and drive. Leaders who have passion and drive are especially valued because these attributes are seen as fundamental to achieving organisational and behavioural change. However passion and drive are not general concepts, rather they are specifically tied to particular interests. It is unlikely that leaders are passionate about everything at all times, they are likely to have particular interests and therefore effective leadership depends on there being a match between the individual leader's area of interest and the policy idea.

Defining leadership according to individual attributes directs attention away from collective responsibility and diverse ways to enhance the organisational capacity of the health care system. It also directs attention away from the positional power that leaders have at their disposal, and the extent to which they have the responsibility and authority or control over the decisions that are essential to the introduction and implementation of new policy ideas into an organisation. How to build leadership within the health care system was not discussed by participants.

Why an agreed definition of leadership is required

Presently there is a paradoxical situation where, on the one hand, leadership is seen as necessary for implementation of health policy but, on the other hand, leadership is poorly defined and understood by participants compared to the knowledge that exists in the literature. So the very concept that is seen as important to implementing policy is currently lacking.

Without an agreed definition of what leadership is, or an agreed understanding of where leaders are required, it is difficult to build leadership within the health care system. Different definitions will lead to different responses; for example if leadership is innate and personality dependent, then getting the right people for positions is crucial. If leadership can be harnessed, then the formation of structures and the provision of resources become important and necessary commitments.

The type of leadership required to build management capacity

Leadership may best be seen as growing from an ability to generate a vision for the future while clearly seeing the current reality. This type of leadership requires input from a diverse range of people across the health care system.

Senge describes three types of interrelated leaders. Firstly, Senge refers to local line leaders. This type of leader has sufficient authority to undertake changes in the way work is organised. Managers of health services might be described as local line leaders. Secondly, there are internal networkers who operate across social networks and therefore are not limited by the boundaries of organisations. Internal networkers are seen as leaders because of their ability to share new ideas and innovative practices. Finally, there are executive leaders who have overall responsibility for organisational performance, but less ability to influence work processes because they are removed from day-to-day responsibilities. One of the key roles of executive leaders is to create an environment of innovation and knowledge generation (154). Successful leadership processes will generate capacity throughout and across organisations.

Multiple definitions and different types of leadership reveal that leadership is required throughout the health care system. In the Aboriginal health workforce, leadership is required that includes the Aboriginal people working as health professionals across the health care system, among managers of health services, among policy officers, and senior executives. There is a need for leadership within the Aboriginal community controlled sector, in the NT Department of Health and Community Services, within the general practice sector, and through member organisations such as the Public Health Association of Australia.

One of the ways to build management capacity for implementation is to broaden understanding of the different types of leadership required within and across organisations for policy to be implemented effectively.

Broader understanding the policy process

Generating program and policy ideas is one of the main mechanisms the health care system uses to try and improve Aboriginal health. There is a perception among many participants that more policies are being developed to address, specifically, the health of Aboriginal residents of the NT, and that those policies are meeting the best practice standards of cultural specificity and respect, and of effective population health and clinical care. However, there was also a widespread perception among many participants that there are more policy ideas than there is capacity to implement policy within health services.

Having more policy ideas than capacity to implement within the health care system is seen as problematic for two reasons.

Firstly, improving Aboriginal health relies on changing the practice of an existing system – not just on developing ideas. The following quote suggests that a fundamental challenge in improving Aboriginal health lies in an ability to develop management systems and process to support the transition from a policy idea to practice.

> ‘*What we’ve found at our health service is it is fine to have an idea, it* [the challenge] *is how do you apply that idea, in practice, in the context of this health service.’* Doctor

Secondly, the imbalance between ideas and capacity is perceived to work against the ability of the health care system to improve Aboriginal health. Multiple ideas and strategies are seen to compete with one another to draw on the limited resources that exist within health services.

Many services providers expressed feelings of dissatisfaction with their relationship with central office. In the following example a doctor explains the resentment felt by some service providers working in remote communities:

> *‘People feel that there are a lot of people visiting communities who tell them what to do these days. And they would feel better able to manage that if they were on top of their jobs. But because their jobs are so out of control they are all over worked, they feel like they need help to catch up, rather than to be told how to do their jobs better.’* Doctor

In another example, a manager describes policies as arriving in the post as ‘glossy brochures’ and complains that little emphasis is placed on implementing these policies:

> *‘Very nice glossy brochures... things like you know, we’re doing it right in the bush and community stuff and our vision for the next five years. People have really done some hard work in thinking what these things are going to be, then they send it out. But nobody says how: what’s the best way to implement that in your community? You’re not given any guidance on how to interpret these broader policy sort of things that people get.’* Manager

These examples demonstrate tensions between central and operational areas of the health care system and highlight a need to improve the relationship between service providers and policy officers. The tensions appear to be underpinned by a fragmented health care system and diminished primary health care infrastructure – all of which generate structural barriers to implementing policy.

The phenomenon of having more ideas than capacity was raised by service providers rather than policy officers, and it was expressed in a way that suggests too many ideas may reflect an underlying issue of a disconnect between central and operational components of the health care system. Rather than the issue solely being a question of having too little management capacity within health services, an additional and underlying influence appears to be the fact that policies are developed and implemented within a disconnected health care system.

Beyond a top down approach to the policy process

Participants' comments suggest that the dominant approach of the health care system is to develop policies and programs centrally and then attempt to implement them in health services. A number of frustrations emerged under this top-down model. In a top-down approach policies are seen as the intention of government, and organisations are seen as mere instruments of policy implementation (126;157). The major problem with this interpretation is that it offers a highly simplistic and misleading depiction that underestimates the complexities and the importance of the relationship within and across organisations. Decision making processes, how problems are defined and perceived, the location of power and responsibility and resource allocation are all highly contested within the health care system. These processes are incredibly dynamic and can shift suddenly with changing governments or chief executive officers.

The relationships between organisations and policy are also complex and multifaceted. Some of the major influences that are overlooked in a top-down approach to the policy process include: the role of service providers who take on a mediating position between the promises of a policy and what is actually performed; the fact that many health professions work in the health care system and each has a body of rules and knowledge that is independent of those dictated by the policy or the management of the organisation; politics are inherent in service design and policy directives; and there is scope for differing interpretations of what a policy means (157). A top down approach fails to recognise the complexities of these relationships.

A bottom-up approach to the policy process provides an alternate view. In a bottom-up approach policy is seen emerging from the actions of individual practitioners, and the focus is on service providers and health care services and their interactions rather than the policy idea (74).

The term 'street level bureaucrats' was coined by Michael Lipsky and is useful in providing another perspective on the role of service providers in the policy process. Street level bureaucrats are the front line deliverers of programs and include professions such as nurses, Aboriginal Health Workers and doctors. They are the 'agents of the system' who grant access to government services and programs (82). Street level bureaucrats are seen as exercising discretion in decisions about citizens and their access to services. The individual actions of street level bureaucracy add up to agency behavior. Discretion is necessary in health service care because individual situations are often too complicated to reduce to one program.

Understanding the role of street level bureaucrats is important because it questions the assumption that information flows with authority from higher to lower levels in government (158) and it highlights the paradoxical framework that service providers work in. The role of street level bureaucrats is to respond to individual client needs in a bureaucratic structure that is more oriented to population based needs (159).

The intention here is to highlight the complexities of the relationships within and across organisations and the difficulties associated with seeing one organisation as responsible for policy development and the other as responsible for implementation. In reality the roles, interactions and relationships are far more complex than implied by the dominant paradigm: the top-down approach.

New ways to define implementation

As discussed in Chapter 2, policy implementation is dynamic and multifaceted. Under a top-down model, policies are often inappropriately seen as plans needing enforcement. If a plan is seen as a tool in the hands of the implementer, the tool is limited. It can only produce certain results under appropriate circumstances. Wildavsky argues that policy is more appropriately seen as an idea that evolves through a process of enduring interactions (86). Wildavsky explains that problems are defined and redefined through the process of attempting to draft acceptable solutions. Under this definition, implementation involves framing questions and finding answers. Analysts become creators as well as implementers of policy. Knowing how to implement relies on the craft of adopting the right rule at the right moment, as events unfold, in order to bring out one potential result over many others.

Therefore implementation may best be described as the struggle over the realisation of ideas (86;87). Having an idea is one thing. Making the idea happen is another thing entirely. An idea is the name given to the outcome of imagining or conceiving of something. Imagining something occurs in a context and this context is influenced by history, values and relationships. Therefore ideas may be seen as loaded – as value-based and inherently political (as opposed to technical). Ideas are not static; rather they evolve over enduring interactions and time. Therefore it is not surprising that ideas have the capacity to change and to produce unpredictable outcomes (88). As Lewis argues, ideas are at the centre of policy and the policy process, and therefore it may be best to think of policy as a living system rather than as a technical machine (88).

Policies are continuously transformed during the process of implementation. These actions can even alter the objectives. New circumstances arise at each point of the policy process that allow different potentials in policy ideas to be actualised. When an organisation or a system acts to implement a policy, it acts to change the policy idea. When one thinks of implementation as an evolutionary process, then it becomes apparent that a policy in its original form will never be able to predict its own consequences, because at each stage of the policy process new circumstances arise and the policy evolves and changes during implementation in response to these new circumstances (86). Policies will never be able to fully contain or predict their own consequences.

Different frameworks for understanding the policy process highlight different problems and solutions for implementation, and emphasise different gaps, needs and opportunities within the health care system.

In summary, this research found a broader understanding of the policy process is required to allow new solutions to emerge and appropriate capacity to be built among and across organisations within the health care system. However, participant comments also indicate that there are more ideas in the health care system, than there is capacity to implement these ideas. This is partially attributed to the policy process operating in a disconnected health care system. In the health care system there is a dominant assumption of a top down approach to the policy process. This assumed approach does not reflect the complexity of the policy process and therefore limits the exploration of solutions. This research found that policies are ideas that evolve, and therefore implementation is much more than a technical exercise. A broader definition is required that reflects the dynamic and evolving nature of policy. Participants' comments about the need to develop management capacity and infrastructure within health care services are discussed in the following section of this chapter.

The infrastructure and management capacity required to implement Aboriginal health policy

Many participants in this research indicated that a basic level of infrastructure is required to implement policy ideas. This basic level of infrastructure does not always exist in Aboriginal health services. The previous chapter on the resourcing of Aboriginal health indicated that funding arrangements and the relationship between the Commonwealth and state and territory governments create perverse incentives and undermine the adequate resourcing of Aboriginal health.

In the example below, a participant argues that these funds may be more effectively used if a project officer was employed to build systems and processes within health services to assist health care providers in managing patients with chronic disease, and to support health providers to practice according to best practice guidelines. By developing infrastructure, such as a patient recall system, the service will be enhanced and this will result in patients having better access to care. This is very different to educating health care providers as to the treatment requirements for patients with diabetic renal disease.

> *'the only way that the Preventable Chronic Disease Strategy can work is through assuming the existence of comprehensive primary health infrastructure… Sure all patients with diabetic renal disease should be on ACE inhibitors; and all patients with rheumatic heart disease and AF should be on Warfarin and Aspirin and they're all in the* [PCDS] *Strategy, but the infrastructure to deliver that is completely dependent on the health service infrastructure as to whether you're achieving that or not'* Doctor

In the health care sector there has been a tendency to use funding to develop health education programs where project officers or nurses are employed on a contract basis to provide, for example, health education and chronic disease awareness services to

Aboriginal communities. While many of these programs have been extremely effective, the sustainability of this work remains an issue. The participant below believes that employing staff to build the capacity of the system is far more efficient than employing health promoters or chronic disease educators to work directly with patients.

> '[Employing staff] *has been a huge catalyst for a massive change within a whole health service, which then affects 10 GPs, 15 health workers. The way that everyone practices has been influenced by these system developments within a health service. Compared to, you could invest the money in a couple of health promoters or a couple of chronic disease educators. And so the main game has to be getting the health service oriented so that everything that they do is focused around chronic disease.'* Doctor

The previous chapter reminds us of the underlying and pervasive influence of inadequate resources for Aboriginal health, and the effect that has on implementation. In addition, the above mentioned example highlights that in some instances the limited funds that are available may be used inappropriately or inefficiently – for short term education projects rather that establishing processes or infrastructure to improve the quality of health care services over the longer term. It is important for health services to develop a basic level of infrastructure and capacity so they will be better placed to provide core services and to respond to policy ideas.

The role of middle level managers

A number of policy officers emphasised the importance of working with health service managers in the implementation of PCDS. There was a perception among many policy officers that policies were most effectively implemented when there was philosophical alignment between the policy and the personal philosophies of the health service managers. In the following example a policy officer describes the importance of working with health service managers:

> *'The clinic* [health service] *managers, they have their forum that is held in Darwin, every three months. And I have been trying to get on the program. I think one of the things we really need to do is, is to do a lot more work with the clinic* [health service] *managers. When you look at where the chronic disease program is working well, it is usually where the clinic* [health service] *manager is really supportive and it's like: where the clinic* [health service] *manager is supportive of women's health, then women's health works well. So it is really dependent on clinic* [health service] *managers. So that is where I am trying to target some efforts now, to get the clinic* [health service] *managers on side and to understanding what difference* [PCDS] *will make... I'd like them to get them to have a better understanding of the chronic disease strategy and the impact that it can have on their workload. Because there is some anecdotal evidence that where people do address their chronic disease patients well, then they're on call cuts back, and their workload becomes less. But it is moving from there* [acute care] *to there* [chronic disease] *that is really hard.'* Policy Officer

It is clear from the example above that the policy officer values the impact health service managers can have on the implementation of PCDS. It appears that gaining health service managers' support for a policy idea is an important step towards implementing a policy idea. In Chapter 4, it was argued that people apply their own solutions to a policy idea. People and organisations interpret and adopt policies according to the context in which they are working. Personal experience, professional background and training influences which aspects of policy are of interest and worthy of the effort required to adopt them. While middle level managers are in pivotal positions for enacting policy ideas, these positions are not the only factor that builds management capacity. As described in the discussion section of this chapter, it is important not to overemphasise the role of middle level managers, or wrongly assume that working with middle level managers is sufficient in building the management capacity of organisations.

This research has found that a basic level of management capacity is required to adopt a policy idea. There is a need to create a space within day to day responsibilities to be able to move into a new area, or think about the application of an innovation within an organisational setting. People and organisations have their own particular interests and concerns. In some cases these interests will match the aims of the policy, or the aims of the policy can be reframed to be seen as in keeping with the individual or organisation's concerns. In other cases this may be more difficult. But essentially the main point is that people will reshape policies in order to fit with their own solutions. This results in a tendency to overemphasise the role of middle level mangers because they have the capacity to change the way work is organised. But over emphasising the role of middle level managers overshadows the need to develop adaptive and shared leadership across the health care system, and does not respect the complexity of the health care system.

Types of management capacity required for implementation

Participants made a number of suggestions for how to improve the capacity of the health care system to implement policy. While most service providers would agree on the need to build capacity within health services, there are different perspectives among service providers on how to build that capacity.

According to an Aboriginal Health Worker, improving Aboriginal health relies on improving the listening capacity of the government and the health system.

> *'I reckon if the government or whoever is in health, if they want to do something about anything, if they are really serious they should come and talk to the health workers or to the people and get our ideas on how we can stop it because we are right in the center of it.'* Aboriginal Health Worker

In another example a doctor expresses a need for a change management process:

> Change is described as *'an iterative process… you do a little change, you monitor the effect and then you do the next change and you monitor the effect, and then you do the next change and you monitor the effect. So it is just a series of little steps rather than showing people the top of the ladder and saying jump.'* Doctor

According to another participant, multiple program areas that quarantine time and attention for specific conditions or groups of people are needed:

> *'My ideal situation would be to have some acute clinical staff, that just did acute clinical, and then to have staff that just worked on the women's health, on men's health. If the Department are totally dedicated to providing best practice health promotion and screening and follow up and all of that and preventive care, then you would need to divide each area up, like they have with the chronic disease here, and have the time to screen the men, educate the men, have the program running semi independently to the acute stuff. See it is very hard for the staff when the acute stuff keeps coming through the door to still manage the other program areas, and still be expected to do health promotion. I mean how many jobs can we have? The acute stuff won't stop coming through the door until we get more health promotion, and that might, I don't see that will change any time shorter than a 5 to 10 year period.'* Manager

These diverse perspectives among service providers on how to build the capacity of the health care system to implement policy, suggest that there is no single model of effective management. Instead certain organisations or individuals within organisations may prefer different organisational structures and processes. Perspectives may vary according to a range of factors, including, but not limited to the decision maker's professional background, the demographics of the population and personal preference. The existence of diverse perspectives provides a reminder that people and organisations have their own and often very different solutions to building management capacity. A well developed and comprehensive policy will be applied differently in different settings and will have many different interpretations and manifestations. A high level of flexibility is required to implement a policy idea – there is a need for negotiation and compromise if ideas developed centrally are to be useful and applied in regional settings.

Discussion

This research found that shared leadership, a broader understanding of the policy process generally, and implementation in particular, reflecting on the roles of middle managers, and respecting that organisations are at varying stages of development, are all required to identify ways to enhance the management capacity of the health care system.

Leadership

Leadership was highly valued in the health care system and was seen as an essential ingredient in the implementation of Aboriginal health policy. However it was common for participants to equate leadership with people in positions of authority. If leadership is ascribed to a privileged few then it suggests that leadership is viewed as a personal attribute, and not as something that can be built and sustained across the health care system. There may be an undercurrent of disempowerment that buoys the individual notion of leadership. A broader definition of leadership is necessary, to see leadership as a collective of people who build the capacity of organisations to sustain the change required for organisations to shape their own future. Leadership may be best seen as growing from an ability to generate a vision for the future while clearly seeing the current reality. This type of leadership requires input from a diverse range of people across the health care system.

The literature reveals many definitions of leadership. For example transformational leadership is required to create a working environment that encourages connectedness among people and creative thinking. In another example, shared leadership emphasises the importance of viewing issues from multiple perspectives. These definitions provide a good basis from which to consider the types of leadership that are required within organisations and across the health care system. It is unlikely that one person has all these skills, or that the multiple functions of leadership can be generated by one person.

This research has demonstrated that leadership is much more than a person in authority. Leadership is an event that is supported by an ability to identify and challenge underlying norms and values, and to undertake a systematic and long term approach to creating an environment that is responsive to innovation and change. Knowledge and skills in implementation rely on generating shared leadership throughout the health care system where individuals, organisations and the systems develop the ability to reflect on their own practice, respect the contribution and position of others and to make judgment decisions and stand by them. These are skills that are learned rather than acquired – and exist in points of time or certain circumstances rather than existing all of the time and in all scenarios.

Understanding the many forms of leadership and its collective and interactive nature provides an important foundation to building organisational capacity for change and an ability to respond to innovations.

Broader understanding of the policy process

This research has demonstrated that there is more than one way to understand implementation. If, as is common in a top down model of the policy process, policies are seen as plans that are to be adopted uniformly across all parts of a system by a process of enforcement, then implementation becomes a technical exercise. Therefore management and program planning skills are necessary for successful implementation. If implementation is seen as part of an evolutionary process, where policies are continually redesigned, then analytical skills are required. In the evolutionary model, new circumstances arise in each stage of policy implementation. These new circumstances allow implementers to actualise different potentials of the policy idea (86). Understanding implementation as an evolutionary process offers an alternative to dominant assumptions about implementation and implementation failure.

This research has found that the PCDS changed and evolved as it was implemented. And further, that what was implemented was determined by the interaction between ideas and the context in which they are received.

Every time an idea is discussed it changes according to the nature of the interaction. Most people for example, will say different things to different people depending on their personality, the reaction of the person they are speaking to, or depending on how they know that person, where they met them, or how they are dressed and so on. Ideas are the same; they change depending on who receives them. Ideas evolve through a dynamic interaction with their environment. Implementation is dynamic; it is about negotiation and compromise. Often this occurs at a subconscious level and therefore is taken for granted.

The adoption of an idea also draws upon espoused values and beliefs; these usually manifest dynamically as assertions or strategies. Ideas do not speak for themselves. Rather successful implementation relies on an ability to expose and illuminate issues. For example, it becomes important to consider how best to frame the policy in order to encourage uptake. Negotiation and compromise play an important role here. Do organisations have skills in negotiation and are they able to reflect on their ability to negotiate? These are important attributes within an organisation because the application of a policy idea relies on judgment, respect, negotiation and compromise. At this point it is important to remember that individuals, organisations and systems all operate in context. Each organisation can establish processes and structures to facilitate more effective implementation. It is not just up to individuals to negotiate and compromise. There is a relationship between people's ability to do their job and the level of organisational support they receive. Organisational support can come in the form of a culture that is supportive of, and rewards innovation.

Roles of middle level managers

Middle level managers have been described as the crucial link between policy and practice. They are influenced by policies from the top down and recommendations from bottom-up. While middle level managers are the point at which many ideas need to be reframed into the goals of the organisation or strategic plan, and where the change needs to be endorsed and instigated, it is important not to over burden these pivotal positions. The challenge we are left with is how do we support managers in their decision making without reinforcing narrow definitions of the policy process and of leadership?

At this point it is important to reflect back on the multiple definitions of leadership, because this is where the importance of shared leadership, transformational and adaptive leadership come into their own. Middle level managers have sufficient authority and capacity to undertake changes in the way work is organised but they are not required to make all the decisions themselves – their roles are more diverse than that. Middle level managers are expected to create working environments that are conductive to creative thinking and encourage connectedness among people within an organisation and with the community. They are not expected to do all the creative thinking on their own. It is also true that middle level managers work in a context of limited resources and increasing expectations. There are both sicker populations requiring access to health services, and greater expectations on how work should be organised.

There is a danger that middle level managers will be seen as a short term solution to improving the ability of the health care system to implement policy. This type of thinking does not adequately reflect the complexity of implementing Aboriginal health policy. Factors such as the under resourcing of Aboriginal health, and the need to reconsider the way in which work is organised and whose knowledge is legitimate in the health care system is beyond the responsibility and control of middle level managers. Seeing middle level managers as largely responsible for implementation is likely to create further problems in the health care system, rather than improve the capacity of the health care system to implement Aboriginal health policy.

Rather than sharing the responsibility for implementation, this research found that policy officers often tried to persuade middle level managers to adopt policy ideas. Effective implementation relies on the entire health care system working in partnership to identify problems and systematically working together in teams to identify solutions or ways of managing predicaments. This type of work relies on adequate time and resources, legitimisation of the process and the commitment of teams. It is by no means a small undertaking.

While middle level managers provide a crucial link between policy and practice, they are not the only factor that influences the implementation of Aboriginal health policy. Overemphasising the role, and therefore the responsibility of middle level managers can serve to reinforce narrow definitions of the policy process and leadership. A longer term and complementary solution would involve affirmative redistribution of the workforce (more Aboriginal Health Workers, enactment of broader roles, more Aboriginal nurses, doctors, etc.); and transformation of the health care system (transform norms, values, reconsider whose knowledge is legitimate).

Organisations and the health care system are at varying stages of development

While there have been some major advances in building the capacity of organisations for change, this research showed that the system antecedents for innovation, as outlined in the Greenhalgh et al (2004) model, have not been comprehensively and equitably met in the Northern Territory health care system. Organisations within the health care system are at varying stages of development. While in some areas there are visionary staff in pivotal positions, in other areas there are a limited number of staff and many long-standing vacancies.

There are multiple reasons why there is not a steady base of proactive leadership that generates shared knowledge within each and across all organisations. There are for example, inadequate funding arrangements and considerable workforce shortages. Organisations are not sufficiently large, mature, functionally differentiated and specialised. They do not have sufficient slack in resources to channel into new interventions. Given the demographics of the Northern Territory, this finding is not surprising. The geographical spread and relatively small but relatively sicker population make providing health care in this region especially challenging.

Only some organisations are able to identify new knowledge that stems from policy ideas, and only a smaller number of organisations are able to interpret and reframe this knowledge into their existing knowledge base. While there are improvements in capacity – particularly in the better management of patients with chronic disease through the implementation of PCDS – these improvements have occurred opportunistically, rather than systematically and equitably across the health care system. This realisation suggests the underlying issue in the implementation of Aboriginal health policy, and thereby the system's ability to improve Aboriginal health, is not a failure to implement a policy idea *per se*, but rather a need to examine and comprehensively and equitably build the capacity of health services to effectively deliver core services, and respond to policy ideas. More importantly, the system needs to consider equity implications while developing the capacity of the health care system.

Ways to build management capacity

Building management capacity in the health care sector is a formidable task. Given the level of diversity in how health services are structured, it is difficult to come up with a standard way to develop capacity. In addition, change is inherently difficult - the culture of the health care system is deeply entrenched, there are multiple stakeholders, and there are complex pressures in the environment (127). However, the literature provides a useful way forward. The management literature was explored to identify some alternative models for building management capacity within the health care system.

Concepts such as learning organisations feature in the management literature (94;146;156;160-164). There are five characteristics of learning organisations. The first, systems thinking, views actions as connected or belonging to patterns rather than individual events. Actions are examined in context and seen to take years to fully play out their effects on each other. The second, personal mastery, involves individual proficiency and commitment to lifelong learning. This characteristic is based on the premise that an organisation's capacity for learning can be no greater than that of its members. The third, mental models, recognises that one of the roles of learning organisations is to identify and challenge individual and organisational assumptions. The fourth, shared vision, involves moving beyond an individual vision or charismatic leaders to generating a shared picture of the future. The final characteristic is team learning, which allows groups of people to discover insights that are not attainable individually. Teams are seen as the fundamental learning units within organisations (146).

The literature on learning organisations demonstrates that organisations learn in different ways, but there is a tendency to ask how the same things can be done better and to make changes within existing organisational norms. The key to developing learning organisations is to question why things are done the way they are and to challenge and change the norms of the system. This is often referred to as double-loop learning (91;165;166).

The management literature suggests that developing the capacity of the health care system needs to occur as an entire system rather than as isolated parts (149), and in addition there is a need to examine the organisation of the health care system. What are the processes through which decisions are made? Who determines the goals of the health care system? Who distributes and exercises power and authority? How is behavior organised? Who decides the rules and responsibilities? Who has influence and decides how decision makers are held accountable? A poorly organised system can impede or entirely obstruct the implementation of policy. Conversely, establishing an appropriate system from the outset will allow policy to be implemented more fully. As Greenhalgh found in her systematic review, improving the structure of organisations and the health care system is important but not sufficient. Other factors such as an ability to recognise and reshape new knowledge within organisations are equally important.

In addition, the literature on learning organisations reveals that building management capacity within the health care sector relies on tangible beginnings, such as identifying current practices and definitions of leadership and exploring broader definitions and processes. Success is iterative and relies on an ability to learn from change by using lessons from initial steps to inform the next steps.

Conclusion

To implement Aboriginal health policy effectively there is a need to enhance the management capacity of the health care system. It is possible to build management capacity within organisations and across the health care system. Incorporating multiple perspectives into the decision making process is required to build management capacity comprehensively and equitably.

This research has found that rather than capturing the multiple and diverse perspectives within the health care system, the system is disconnected and only some voices are seen as legitimate at certain points and circumstances. For example, community voices are not always legitimate in the hospital setting and government perspectives are not always legitimate in the community setting. In addition, and perhaps more importantly, incorporating Aboriginal perspectives throughout the policy process is not ensured, or even prioritised within many organisations and across the health care system. While trust exists in some relationships, trust is not guaranteed throughout the health care system. Formal mechanisms and opportunities for team learning, that prioritises Aboriginal perspectives, are necessary to build relationships and trust, which provide the foundation to incorporate multiple perspectives within organisational and system decision making.

For organisations to innovate, they require a basic level of capacity and infrastructure to deliver core services; structures and processes for incorporating multiple perspectives in responding to new knowledge; strong multi perspective teams; and shared leadership throughout the organisation and across the health care system.

However, care must be taken not to focus on organisational capacity at the exclusion of other important factors that contribute to the implementation of policy. Overemphasising organisational capacity to innovate and change has the potential to overshadow, for example, an examination of the performance of the health care system. Both organisational capacity and a mechanism to examine and reflect on the performance of the health care system are required, if there are to be giant strides in improving effectiveness of the health care system for Aboriginal Australians.

Section 5

Discussion and conclusions

Chapter 9

What has this research revealed about the implementation of Aboriginal health policy?

This chapter discusses the findings presented in the previous four chapters in light of the research questions posed at the outset of the research.

As explained in Chapters 1 and 2, the health care system was set up in a period when Aboriginal people were excluded from mainstream society and services. Therefore while in theory, mainstream publicly funded services and policies are expected to be responsive to the needs of all Australians, including Aboriginal Australians, in practice there is a lack of Aboriginal input and insight into many aspects of the health care system. For example, as described in Chapter 5, despite strong arguments and multiple efforts, there are insufficient numbers of Aboriginal Australians employed in the workforce. This can make Aboriginal people invisible within the health care system, which in turn can compromise Aboriginal Australians' access to mainstream health services.

When reflecting on the findings in this concluding chapter, particular attention has been directed to ensuring that these reflections are not blind to the pre-existing inequities in the health care system. Therefore in this chapter, where possible, an effort has been made to distinguish between policy implementation issues generally, and the implementation of Aboriginal health policy in particular.

This thesis examined the facilitators and barriers to the implementation of Aboriginal health policy; and identified initial actions required to improve the capacity of the health care sector to implement health policy intended to improve Aboriginal health. Rather than simply listing and responding to the facilitators and barriers to implementation in this chapter, it was decided it would be more appropriate to create a set of criteria that could be used to guide effective health policy implementation, in general, and Aboriginal health policy implementation in particular.

Criteria for effective implementation of Aboriginal health policy

The findings reported in this thesis have been appraised by the researcher and synthesised to result in ten criteria for the effective implementation of Aboriginal health policy. The first criterion identifies the need for a broader understanding of the nature of policy implementation. This is the foundation on which all criteria are based. Only once a revised understanding of the nature of implementation is accepted, can the broader implications for the policy process and system contributions be explored. Contrary to what is often assumed by those working in the health care system, this thesis has demonstrated that policies are not plans that need to be enforced. Policies are more accurately understood as ideas that evolve. The ways in which these ideas evolve are influenced by the context in which they are received. This has particular implications for Aboriginal health policies that are implemented in a mainstream health care system that does not routinely incorporate Aboriginal perspectives into policy decision making. The broader understanding of the nature of implementation, implicit in this research, generates a number of implications for health professionals and the health care system. These implications may be seen from two angles. There are implications for the implementation of individual policy ideas and there are implications for the health care system.

The second criterion for effective implementation identifies the need to decide proactively who ought to be involved in policy decision making, and at what point in the policy process. This research found that by deciding who is involved in the policy decision making process, organisations are in effect deciding which aspects of policy will be implemented. Not all aspects of policy can be implemented perfectly at once. Therefore the third criterion for effective implementation is to identify the deal breakers in negotiations about which aspects of policy are implemented.

Because policy is often introducing new ideas and practices to existing systems, it is possible, and even necessary, during implementation, to find ways to build the capacity of health services. For example, the implementation of a policy idea might require the development of an information system that tracks patients who are due for chronic disease checks. This information system may be used in other ways by the health service to provide an efficient means of keeping track of other health checks that are required. This is the fourth criterion. Tracking what happens to a policy idea is the fifth criterion. Rather than monitoring the effectiveness of a policy according to whether or not the policy met its original aims, it may be more telling to monitor processes such as who adopted the policy idea, and how that idea changed during implementation.

The sixth criterion represents a shift from facilitating the comprehensive implementation of individual policy ideas, to building a more equitable health care system so that all policy ideas have a greater chance of being implemented fairly and comprehensively. An equitable health care system that is efficiently resourced and appropriately incorporates Aboriginal perspectives is required to implement Aboriginal health policy comprehensively and effectively. The seventh criterion prioritises the need to reform the mainstream health care system to become equitable.

To implement policy, organisations need to be prepared to respond to new knowledge and generate change (123). A culture of learning is required to respond to policy ideas and initiate, learn from and sustain change. Therefore the eighth criterion for effective implementation is to generate learning organisations. Building learning organisations and thereby facilitating effective implementation relies on a quality health care system.

The ninth criterion emphasises the need to connect different parts of the health care system. This criterion reinforces that systems are living things and that therefore policies, organisations, and systems are continually reinvented.

Criteria ten focuses on performance. The need to monitor the performance of the heath care system emerged as an important finding for this research. Monitoring the performance of the health care system ought to consider the quality of health care and system design; efficiency in reporting requirements; efficiency of funding processes; an ability to instigate and maintain change, the acceptability of the health care system from the perspectives of Aboriginal Australians; and most importantly in building a health care system that prioritises equity. Each of these criteria for the effective implementation of Aboriginal health policy is described in detail in the paragraphs below.

Implications for the implementation of individual policy ideas

Criterion 1: Facilitate a broader and more comprehensive understanding of the nature of implementation

Contrary to what is often assumed by those working in the health care system, policies are not plans that need to be enforced. This research has demonstrated that policies may be better understood as ideas that evolve. Every time an idea is discussed it changes according to the nature of the interaction and the setting in which it is received. Negotiation and compromise become important factors in the implementation process.

Policy ideas do not speak for themselves. Organisations need to learn about the science behind the idea, the relative benefit of adopting the idea, as well as learning how to apply the idea in the organisation's core business. As shown in Chapter 8, if an organisation is to implement a policy idea, there is a need to reorient practices, structures and processes to ensure that the context for implementation will support the adoption of that idea.

As highlighted in Chapter 4, policies are used differently by different parts of the health care system, for example the central level of the health care system used PCDS to lobby for funding for chronic disease in competition with acute care, whereas PCDS was used by regional levels of the health care system to assist in the management of chronic disease, albeit differently across regions. This is because the settings in different parts of the health care system are diverse, and policy is shaped during implementation according to the context in which it is received. This finding emphasises the role the health care system plays in shaping policy ideas, and highlights the need to build a more robust and equitable health care system for Aboriginal Australians.

Insufficient Aboriginal insight and participation within the mainstream health care system creates pre existing system inequities in meeting the needs of Aboriginal Australians. This means that even when policies are developed in partnership with the Aboriginal population, during implementation, the policy will evolve according to a health care system that does not routinely include Aboriginal perspectives in decision making. This will undermine the good work of the policy development process. Acknowledgement of this important and far reaching inequity, is an important first step to changing practice.

The next step may involve affirmative action, to ensure Aboriginal perspectives are sought during implementation decision making. For this to occur, implementation decisions need to be explicit and proactive, rather than implicit and reactive, and require more Aboriginal Australians to be employed within the health care system.

Criterion 2: Proactively discern who needs to be involved in policy decision making and at what point

It is now more common for policies to be developed in an evidence based and consultative way. It is widely expected that multiple stakeholders will be involved in the development of policy ideas (167). Because policy evolves as it is implemented, this expectation of inclusiveness needs to be extended throughout the policy process.

Involving multiple stakeholders in decision making throughout the policy process will require commitment, structural changes, a reorientation of expectations, an overview of the benefits of inclusive policy implementation versus the costs, examples of good processes and strategies to follow, and monitoring whether policy has been implemented inclusively. As found in Chapter 6, incorporating multiple perspectives will require a culture change in the way the health care system and organisations operate. Structures and processes will need to be established to ensure Aboriginal perspectives are heard and acted upon, and to ensure that the nature of involvement is one of partnership and shared decision making, rather than simply asking for input or information and consultation.

Establishing a systematic process that equitably incorporates a range of stakeholder perspectives is a fundamental prerequisite to comprehensively implementing policy. This is not a small undertaking. It requires a shift in the way policy is currently implemented and, therefore shifts in the organisation and allocation of roles and responsibilities are required. If it is not possible to include a range of perspectives, at the very least it is important to recognise that by deciding who is included in the decision making process, one is in fact prioritising what aspects of a policy will be implemented.

Middle level managers are seen as especially important in the implementation process because they have sufficient authority and capacity to undertake changes in the way work is organised. However there is a danger in overburdening these pivotal positions. Middle level managers are expected to create working environments that are conducive to creative thinking and encourage connectedness among people within an organisation and with the community. While middle level managers provide a critical link between policy and practice, overemphasising the role and responsibility of middle level managers can reinforce narrow definitions of the policy process and leadership.

This research has demonstrated that leadership is much more than a person in authority. Leadership is an event that is supported by an ability to identify and challenge underlying norms and values. Many types of leaders need to be involved in the policy process. It is unlikely that one person has all the skills that are required to provide leadership on the different aspects of implementing a policy idea. Transformational leadership is required to create a working environment that encourages connectedness among people and creative thinking. Aboriginal leadership is required to ensure that Aboriginal perspectives and priorities are well represented in the health care system. Employing Aboriginal people in senior positions, within the health care system, is one way of ensuring Aboriginal values are included as part of the policy decision making process.

Criterion 3: Identify the deal breakers in negotiations about which aspects of policy are implemented

As demonstrated in Chapter 4, it is not possible to implement all aspects of policy at once. Therefore decisions need to be made about which aspects of policy need to be implemented first. To ensure that decisions about policy implementation are made according to population need rather than the strengths and weaknesses of the health care system, it is important to identify the essential and fundamental aspects of policy ideas.

In determining the essential aspects of policy ideas, stakeholders need to be prepared to negotiate and compromise. By identifying the deal breakers, stakeholders will be in a better position to advocate what is essential in the policy idea. Part of the skill of negotiation is an ability to expose and illuminate issues in a way that emphasises their importance and benefits across a range of professions, organisations and population groups. In addition, knowing what is essential to other stakeholders is important. There may be an opportunity to advocate collaboratively to address common concerns.

The application of a policy idea relies on judgment, respect, negotiation and compromise. It is not just up to individuals to negotiate and compromise. The analysis of leadership in Chapter 8 pointed to the relationship between people’s ability to do their job and the level of organisational support they receive. Organisational support can come in the form of a culture that is supportive of and rewards innovation.

Criterion 4: During implementation find ways to build the capacity of health services

In addition to improving the health of the population, policies provide an opportunity to build the capacity of the health care system. Chapter 5, which examined the role of the workforce in shaping implementation, argued that it may be possible to explore which professional groups benefit from the implementation of a particular policy idea. Taking PCDS as an example, Aboriginal Health Workers are more likely to benefit from the implementation of the primary prevention strategies because they have greater interest in addressing the broader determinants of health. Whereas nurses and doctors are more likely to benefit if the better management strategy is implemented. They are likely to develop skills in ongoing treatment in a clinic environment, rather than skills acquired from working in the community. It is also possible to build the capacity of organisations to respond to new knowledge and to be able to initiate change. For example, organisations may build quality improvement processes while developing strategies for the better management of chronic disease (130).

Criterion 5: Track what happens to a policy idea

Often policies are monitored to identify the extent to which the original aims are met. Given that policy evolves as it is implemented it may be more telling to monitor processes such as who used the policy idea in the health care system (i.e. policy directors or service providers, or which organisation) or whose voices were heard, or what evidence was used to inform decision making.

Implications for building a robust health care system

When most people think about improving the implementation of policy they focus on the policy itself. However, policies change as they are implemented according to the strengths and weaknesses of the health care system. Therefore it is very important to consider how to build the capacity of the health care system. The health care system shapes all policies as they are developed and implemented, therefore building the capacity of the health care system will have lasting benefits.

As indicated earlier in this chapter, there is often an assumption that the needs of Aboriginal Australians are automatically encompassed within the mainstream health care system. This assumption does not ensure that policies meet the needs of Aboriginal Australians and can mean that Aboriginal people are invisible within the health care system. Therefore a critical criterion in building a robust health care system is to ensure that the structures, processes, resources, policies and services that comprise the Australian health care system are, themselves equitable within the system and that they focus on the achievement of equitable health outcomes.

Criterion 6: Build an equitable health care system

A health care system that is structured equitably is a social determinant of health in its own right. This is partly because having access to health care allows opportunities for prevention, early detection and ongoing management of chronic conditions. Equity of access to health care is a central concern in Australia and internationally. One of the major influences of inequity of access derives from how the health care system is structured. However there are inequities in how the health care system is structured. If the system is set up in ways that are inequitable, and if policy changes and evolves as it is implemented according to the strengths or weaknesses of the health care system, then any inequities in the health care system will be reinforced and reproduced as policies are implemented. In other words, the strong aspects of the system will get stronger, and the weak aspects of the health care system will remain untouched. An equitable health care system is required to ensure the base from which policy ideas are shaped is equitable.

Building the capacity of individual organisations and providing sufficient resources are important prerequisites to building a robust health care system. Chapter 7 found there is a legacy of under spending on Aboriginal health. Chapter 5 found there is also a legacy of not employing sufficient numbers of Aboriginal people in the health workforce. Chapter 8 found another legacy of not including Aboriginal views in decision making. These structural flaws can generate further inequities as policies are redesigned and evolved. If Aboriginal perspectives are not heard in the health care system then it is unlikely that these perspectives will be heard during implementation. The health care system is set up in a largely western framework and therefore the needs of Aboriginal Australians are not always at the forefront of the decision making process. Western cultural hegemony across most parts of the health care system means that it is easy to assume western ways of understanding. This is why both Aboriginal and non-Aboriginal views need to be at the decision making table.

If there is diminished capacity within Aboriginal health services then these services will have less ability to respond to and therefore benefit from policy ideas. Health services for Aboriginal Australians are of varying quality and size across urban and remote communities. There are different funding sources and different reporting requirements. For example, there are Aboriginal community controlled health services that are funded through the Commonwealth government and there are health services that are funded and run by the Northern Territory Department of Health and Community Services. The quality of health services for Aboriginal Australians is not guaranteed.

As a basic standard, there is a need for all health service organisations across the health care system to have sufficient resources and capacity to be able to create their own innovations and respond to external policy ideas. There is a need to have processes in place to enable organisations to initiate and maintain the change process and monitor its effectiveness.

The demographics of the Northern Territory and the financial arrangements provide a challenging context in which to build the capacity of the health care system in an equitable way that is responsive to the needs of Aboriginal Australians. However there are the foundations of knowledge in the literature and there are a number of extraordinarily committed and dedicated staff.

Criterion 7: Aboriginalise the health care system

As described in the criterion above, building a well resourced health care system with strong management capacity are important components of an equitable health care system. However alone they are not sufficient. Creating a more responsive health care system for Aboriginal Australians, relies on establishing structures and processes within the mainstream health care system to ensure that Aboriginal views and perspectives are routinely incorporated into the policy process.

The health care system was not established with Aboriginal world views, aspirations, knowledge and needs at its heart, and hence adaptation is needed to bring the health care system in to line with the community it serves. Furthermore, there has not been nearly enough investment in bringing Aboriginal people into leadership roles or into management positions, so that there has been no ‘day-to-day’ exchange of ideas to help transform the policy to suit local contexts. For Aboriginal health policy to be implemented comprehensively and equitably there is a need to Aboriginalise the mainstream health care system.

One of the mechanisms to Aboriginalise the health care system should be to build the learning capacity of organisations in a way that incorporates Aboriginal perspectives in the learning process.

Criterion 8: Build the learning capacity of organisations

As outlined by Greenhalgh et al (2004), in order to implement policy, organisations need to be prepared to respond to new knowledge and initiate change (123).

A culture of learning is required to respond to policy ideas and initiate, learn from and sustain change. Systems thinking, personal mastery, mental models, shared vision and team learning are the five characteristics of learning organisations. Learning organisations see actions as connected and as taking years for actions to fully play out their effects on each other. An organisation's capacity for learning can be no greater than that of its members, and therefore personal mastery is required for learning. Learning organisations identify and challenge individual and organisational assumptions, have a shared vision, and see teams as the fundamental learning units within organisations (146). In order to implement Aboriginal health policy comprehensively there is a need to prioritise Aboriginal perspectives in the learning process.

Greenhalgh et al (2004) provide some practical steps for building organisational capacity. For organisations to respond to policy ideas, they need to be structured in a way that allows them to implement change to a policy more readily. For example, organisations may need to be sufficiently mature and differentiated to be able to channel resources into new projects. There may be a need to decentralise decision making. Organisations also require a capacity to absorb new knowledge. To be able to identify, interpret and reframe new evidence into an organisation's existing knowledge base and put this information to appropriate use. In addition, organisations need to be receptive to change. This requires visionary staff in pivotal positions, a climate that is conducive to risk taking, and effective data capture systems (123).

As a starting point, organisations need to have sufficient space and capacity to be able to move beyond core business and think about the most appropriate structure for their organisations and how to respond to new knowledge and initiate change. As shown in Chapter 7, creating this space is partly about providing sufficient resources in an efficient way. However, no matter how small an organisation there are a range of strategies that may be applied to improve the functioning and processes of that organisation.

Criterion 9: Connect different parts of the health care system

As shown in Chapter 8, health systems are constantly changing, tightly coupled, nonlinear, history-dependent, self organising, adaptive and evolving, characterised by trade offs, counter intuitive and policy resistant. Systems may be most accurately understood as living things rather than structured machines (149).

There are many examples of disconnections across the health care system. For example, there are disconnects between policy and operational areas, among health professions, between Aboriginal and mainstream Australian perspectives, between services and the community. Part of the reason for these disconnects is that capacity is often developed in isolation, rather than across the entire system. If organisations develop in isolation they are likely to generate greater divergence, and therefore greater misunderstandings about the functions and expectations of different parts of the system are likely to emerge. This process is likely to further fragment an already fragmented system. In addition, the fact that the system is tightly coupled means that an action in one part of the system is likely to have flow-on effects in other parts of the system. Challenging shared norms and learning the same lessons will help generate greater understanding and collegiality across the different parts of the system. There is a need to utilise systems thinking when building organisational capacity to avoid further fragmentation to the health care system.

There is some literature that outlines steps involved in responding to new policy ideas within organisations, and that suggests how to build the management capacity of organisations. Less research in health services has focused on how to facilitate learning across the health care system.

The very nature of systems makes change difficult. But not impossible. Because work occurs in a complex system, shared leadership and systems thinking are required to instigate change.

Systems thinking views actions as connected and belonging to patterns and cycles rather than according to individual events. In this context, actions are seen as taking years to fully play out their effects (146). Systems thinking is an iterative learning process in which a reductionist, narrow, short-run and static view of the world is replaced with a holistic, broad, long-term dynamic view where policies, organisations and systems are continually reinvented (149).

Adopting systems thinking fits neatly with an evolutionary definition of the implementation process. However there are inequities in the health care system that make it difficult for the health care system to meet the needs of Aboriginal Australians. This research found there are a range of factors that make the health care system unprepared to adopt Aboriginal health policy. There is a need for greater resources, recognition and development of multiple types of leadership and management skills. The main underlying barrier to implementing Aboriginal health policy is that the system has not been established by and with the people it is intending to serve. There are no mechanisms to ensure that the policy ideas contained in the PCDS are going to be discussed and negotiated among all stakeholders as equals throughout the policy process.

Criterion 10: Monitor the performance of the health care system

Monitoring of the health care system should pay particular attention to the quality of health care and system design; efficiency in reporting requirements, efficiency in the ability to adapt to change, and efficiency in ensuring the best allocation of resources to yield the best possible outcomes; acceptability of the health care system from the perspective of Aboriginal Australians; effectiveness of the health care system in preventing the incidence and reducing the prevalence of chronic disease; and prioritisation of equity.

An equitable health care system is one that results in equitable outcomes of care, including health status, but also values equity in terms of access to care and ensuring that Aboriginal people are recognised and valued in the health care system. Only by meeting these criteria will the health care system be effective in meeting the needs of Aboriginal Australians.

While monitoring the performance of the health care system, it will be important to use multiple perspectives to identify what the health care system does well for Aboriginal people and what it does poorly; to draw on the concept of allocative efficiency to investigate whether the health services that are offered to Aboriginal people are appropriate, or whether money may be better allocated to other parts of the system. For example, would some of the money allocated to patient travel, be better spent on screening all patients for chronic disease, or to provide support for after school programs? By monitoring progress it will be possible to acknowledge and celebrate when improvements are made. This would avoid the common tendency to problematise Aboriginal health.

The literature outlined in Chapter 2 revealed there is widespread concern about a lack of genuine long term commitment to improving Aboriginal health. This commitment failure creates a scenario that privileges short term solutions and quick fixes. Therefore monitoring the performance of the health care system in meeting the needs of Aboriginal Australians would need to address the level of genuine commitment and therefore long term solutions enacted to improve Aboriginal health. This emphasises the need for Aboriginal Australians to be part of a team of people involved in monitoring the performance of the health care system in meeting the needs of Aboriginal Australians.

Reflections on the research

This part of the chapter discusses the strengths and limitations of the research process and the strengths and limitations of the research findings.

Strengths and limitations of the research process

There were a number of strengths and weaknesses of the research process. The main purpose of the research was to examine the implementation of a health policy by a ‘mainstream’ health system to a primarily Aboriginal population. The focus of the research was therefore on the perspectives of the professional staff working in the health sector – both Aboriginal and non-Aboriginal professionals, who were invited to provide their perspectives on the factors that facilitated or posed barriers to policy implementation.

The logic of the research was based on the assumption that, unless the health sector is able to develop and implement evidence-based health policy effectively and efficiently, it is unlikely that Aboriginal health status can improve. A strength of this research was that the PCDS is a live strategy that has been implemented for five years through much of the Northern Territory health system. In addition, a range of health professionals working in policy and service provision were interviewed through this research, so that a range of rich perspectives on the factors facilitating and constraining the implementation of PCDS was obtained.

The aim was to conduct applied research. Therefore a number of steps were taken to ensure the research remained connected with the PCDS and those working in chronic disease. Particular strategies such as providing input to the evaluation of PCDS, and having the Chief Health Officer acting as a supervisor for this research, meant that structures were in place to stay connected. In addition, ongoing contact between the researcher and those working in chronic disease in the Northern Territory meant that the researcher was always conscious of the need to make a useful contribution, and of the need to provide fair and constructive analysis. The researcher often asked herself how this information might be received by those working in the system. Attention was placed on how best to convey information rather than changing the nature of the information that was provided.

This applied research process underpinned the success of this research. It meant that the research is relevant and rich because many people were involved in the research and it also meant that the system was interested in hearing the findings from this research as evidenced by the number of presentations given to research stakeholders (see Appendix 2).

Due to funding and time constraints there was a limit to how many people could be interviewed. It was felt that it was more important to understand a range of in-depth views among service providers and policy officers in the Northern Territory, than to ensure broader representation across the vast geographical regions of the Northern Territory.

Despite a history of conducting substantial amounts of Aboriginal health research, little research has focused on understanding the system contributions to persisting rates of chronic disease. It is for this reason that people working in the health care system were seen as the priority focus of the research. Although Aboriginal community members are the recipients of the health service and therefore have an important contribution to make, there was a need to limit the scope if the research was to be conducted in-depth.

If more funding and time were available it may have been interesting to compare the implementation of PCDS with the implementation of other Aboriginal chronic disease programs across Australia, to establish patterns in implementation of Aboriginal health policy generally, as well as issues specific to implementation of Aboriginal health policy in the Northern Territory.

Strengths and limitations of the research findings

The PCDS was a novel policy idea that was developed in a consultative process and was based on available evidence. The quality of the PCDS may have meant that in this research some of the essential elements of PCDS may have been overlooked. For example, it may be absolutely necessary to quarantine funds for policy implementation. However because funds for PCDS were quarantined, this crucial aspect to the successful implementation of PCDS may have been taken for granted. The researcher may not have paid enough attention to the need to quarantine funds within the criteria for effective implementation.

It is interesting that when making recommendations for more effective implementation there is a strong tendency to gravitate towards stating what needs to happen rather than how change might occur. This however, may be a failing of human nature. It is much easier to suggest what needs to occur rather than how (76). Clichés such as ‘the devil is in the detail’ and ‘easier said than done’ ring true in this research too.

In 1997, Anderson argued that genuine and widespread commitment across the health care system is required for implementation (8). In order to move beyond identifying where changes in the health care system are needed and what changes ought to be made, commitment is required. The importance of commitment underpins the need to identify how to build the capacity of the health care system.

Meeting the criteria for implementation will be a formidable task. An added barrier is the perceived history of faltering policy initiatives to which Anderson refers. The widespread perception of a failure to implement Aboriginal health policy has created a strong degree of cynicism within the health care system. The greatest detriment of cynicism is that it masks other ways of understanding the phenomenon. So taking implementation as an example, if more was understood about the policy process and the nature of implementation then some of the more subtle facts that influence the success or failure of policies might be revealed.

The health care system and its agents will need to avoid the tendency for a quick fix or easy solution. But in a democracy, where governments need to win elections, there will be a powerful incentive for short term wins in the health care system. The system needs to learn how to respond to this pressure in a constructive way. To identify ways these ‘windows of opportunity’ might be used to build a better system, or alternatively – how these knee jerk reactions might be avoided with grace and maturity.

In a PhD thesis it is not possible to include everything of relevance and interest. If more time and resources were available it may have been worthwhile to explore notions of power. A greater understanding of the nature of power in decision making and within the health care system may provide further insights into the nature of policy implementation and the nature of innovation and change within the health care system.

The extent to which a case study on the implementation of the Northern Territory Preventable Chronic Disease Strategy can be applied elsewhere is worthy of further consideration. Two points arise when thinking about the broader application of the case study. First, what is the extent to which a case study conducted in the Northern Territory holds relevance for elsewhere in Australia? Secondly can a case study about a mainstream health policy that is largely applied in Aboriginal health offer lessons for general mainstream health policy or Aboriginal specific health policy? While an effort was made in Chapter 9 to distinguish between policy implementation issues generally, and the implementation of Aboriginal health policy in particular, further research is required to understand the nature of implementation in other settings and contexts.

Recommendations for how to implement policy

One of the tools that might be developed to generate a broader understanding of the nature of the policy implementation process would be to develop a guide book for implementation. The guidebook could be written for health service providers, policy officers, health students, community organisations, and non government organisations. The focus of the guidebook would be on the nature of implementation and would include a number of suggestions or values to consider when trying to implement an innovation or policy idea.

There are a number of important points to remember about the implementation of Aboriginal health policy. Communicating these points on their own will be insufficient in challenging assumptions about the implementation process and in generating change.

Ultimately in Australia there is a need to highlight examples of success – milestones of effective implementation. Once examples of successful implementation are highlighted, it may be easier to identify what we are aiming for and what system changes are required as a priority in being able to more effectively and equitably implement Aboriginal health policy. It will be important to remember that developing stand alone policies is not the solution to improving Aboriginal health. Policies can only be as effective as the systems and organisations that create and are required to implement them.

There is also a need to ensure that multiple criteria for effective implementation are fulfilled. This will build momentum for change, and create opportunities to reinforce and complement the benefits of meeting each criterion. For example, if Aboriginal health policy in particular is to be implemented comprehensively within the mainstream health care system, the seventh criterion, to Aboriginalise the mainstream health care system, needs to be fulfilled. One of the mechanisms to incorporate Aboriginal perspectives is to ensure that the tenth criterion, monitoring of the performance of the health care system, involves Aboriginal perspectives and input.

Recommendations for future research

First and foremost this research revealed the need for further research to identify how to build the capacity of the health care system to become more equitable in the distribution of resources and in the representation of Aboriginal views.

As described in Chapter 2, Bartlett and Legge, Gardiner-Garden and Anderson make important contributions to understanding how governments and the health system contribute to persisting high rates of Aboriginal morbidity and mortality. This work points to a failure of the health care system in protecting the rights and meeting the needs of some Aboriginal Australians, and is helpful in drawing attention to the health care system's responsibility for Aboriginal health. But when providing a critique of the health care system, there is a danger of emphasising problems without offering solutions. Duckett argues that an ideal health system would be patient centered, ensure high quality care is available to all people in a timely fashion, well integrated, accessible, dynamic and respectful of patient autonomy (168). This work provides a useful starting point in developing criteria for an effective health care system, however substantially more research is required, with a specific focus on Aboriginal health, to identify ways to increase the capacity of governments and the mainstream health care system to improve Aboriginal health.

Research is required to identify ways to monitor the performance of the health care system according to the quality of health care services provided and the quality of the health care system's design. For example, are the resources in the health care system equitably distributed and are Aboriginal perspectives adequately represented? However, rather than simply highlighting the strengths and weaknesses of the health care system, or describing a scenario where there are many reports and inquiries but little change in practice, there is a need to consult the political science and management literature. This will identify new ways to understand and address long standing problems associated with performance of the health care system.

Given that there are a number of financial and structural constraints in the Australian health care system, there is the potential to test the extent to which financial incentives and structures might facilitate the effective implementation of Aboriginal health policy. Popular sentiments suggest that financial incentives are important but there is no evidence yet available to illustrate the influence that financial incentives have on the effective implementation of Aboriginal health policy. This would be an important area for further research.

In Chapter 7, the interviewees suggested that political imperatives take precedence and explain the lack of policy action in Aboriginal health. It is also suggested that a greater Aboriginal voice in the political process may alter the nature of this dynamic. The question about whether having an Aboriginal voice would alter the political imperatives is a testable proposition that is worth of further study.

There is an opportunity and need to conduct comparative research on the implementation of Aboriginal health policy. It would be useful to conduct comparative research with other Australian jurisdictions, about Aboriginal health and/or chronic disease, or comparing Aboriginal-specific policy with mainstream health policy adapted to Aboriginal communities. In conducting further research it is important to remember that researching health system contributions to Aboriginal health relies on an applied research process. It would be unethical to conduct this research without involving those the study is intending to assist. Researchers have a responsibility to acquire new knowledge but they also have a responsibility to ensure that that knowledge is accessible to the people it is intended to serve. Findings solutions is not enough. There is a need to build relationships between researchers and policy officers and health service providers.

Concluding remarks

There is a widespread perception that the health care system fails to implement Aboriginal health policy. This cynical view is unhelpful. It does not generate discussion about ways that it might be possible to more effectively implement policy or improve the health of Aboriginal Australians. It only serves to generate a culture of highlighting problems and allocating blame.

The case study on the implementation of PCDS revealed that policies change as they are implemented. The composition of the workforce and the values and culture of the health care system influence which aspects of policy are implemented. By understanding the changing nature of policies, it is possible to see the impact that the capacity of the health care system has on its ability to respond to policy ideas.

This research found the primary prevention arm of the PCDS needs to be implemented more comprehensively. This will require the development of structures and processes that incorporate Aboriginal perspectives in the implementation decision making, and the creation of new positions that will need to work outside the traditional boundaries of the health services. Positions such as community development workers and intersectoral collaborators will be required to enact many of the strategies in the primary prevention arm of PCDS. In addition to implementing the primary prevention arm of PCDS, there is a need to prioritise Aboriginal perspectives in decision making. There has been a history of implicitly excluding Aboriginal perspectives from policy decision making and throughout the health care system. This unconsciously renders the specific needs of Aboriginal Australians invisible.

The implications of this research, for the implementation of Aboriginal health policy more broadly, are relevant at two levels. This research has shown that, prior and during implementation, certain steps are required to enhance the effectiveness and equity with which policy ideas are implemented. When implementing policy it will be important to proactively discern who needs to be involved in the policy decision-making process and at what point; identify the deal breakers in negotiations about which aspects of policy are implemented; find ways to build the capacity of health services during implementation; and monitor the evolution of policy ideas. In addition, a robust health care system needs to be built. Developing stand alone policies is not the solution to improving Aboriginal health. A comprehensive health care system is required so that all policies have a greater chance of being implemented comprehensively and equitably. This research has generated a number of lessons for building a robust health care system. There is a need to build the learning capacity of organisations; create a more equitable health care system; connect and integrate different parts of the health care system; and monitor performance.

Many of the findings and implications of this research apply to policy implementation generally. What is specific about Aboriginal health policy in particular, is that the mainstream system is not set up in a way that automatically or routinely incorporates Aboriginal perspectives into decision making. Often, this occurs at a subconscious level, and therefore, the implications are rarely acknowledged and reflected upon. This is especially problematic for the implementation of Aboriginal health policy, because Aboriginal health policies evolve according to the strengths and weakness of the mainstream health care system. Therefore, the system level inequities that exclude Aboriginal Australians from policy decision making, tend to be self reinforcing and further disadvantage Aboriginal Australians.

In the short term, three main actions are required to improve the capacity of the health care system to implement Aboriginal health policy. Firstly, there is a need for a more sophisticated understanding of political science and policy implementation among service providers and policy officers. A shift in dominant thinking that perceives policies as plans that need enforcement to seeing policies as ideas that evolve according to the strengths and weaknesses of the health care system is required. Secondly, there is a need to refocus efforts from developing new evidence-based policy ideas, to building the capacity of the health care to be responsive to Aboriginal Australians' health needs, and to be evolutionary, self-reflective and consciously different from the current system's legacy of colonisation. A robust health care system will be able to more effectively respond to policy ideas and innovations in an efficient and equitable way that prioritises the perspectives of Aboriginal Australians. Finally, the health care system and the Aboriginal population need to build on and look for examples of successful implementation. Examples of success may emerge from the performance monitoring process. Highlighting examples of successful implementation will deliver clarity of purpose and incentive. Through these actions it may be possible to see greater improvements in Aboriginal health.

It is well known and widely reported that Aboriginal Australians are sicker than non-Aboriginal Australians and on average, die much earlier than their non-Aboriginal counterparts. There have been over three decades of inquiries, policies, programs and reviews in the health of Aboriginal Australians. However, there have only been limited changes in terms of health outcomes. Understanding the evolving nature of policy and building a more equitable health care system that can create and respond to new knowledge, that can initiate change and monitor its progress and can reflect on its own performance, is what is required to overcome the 'strange rhetorical paradox [that] is enveloping the health of Aboriginal Australians' (8) p. 1.

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Appendices

Appendix 1: Determinants of Aboriginal health in Australia

Appendix 2: Resultant publications, presentations and awards

Appendix 3: Information sheet

Appendix 4: Consent form

Appendix 5: Interview questions prompt sheet

Appendix 6: A selection of traditions in qualitative analysis

Appendix 7: The PCDS framework and timeline of events

Appendix 1 Determinants of Aboriginal health in Australia

Table 1: Summary of the health determinants and status of Aboriginal people in Australia (9;169)

Factors	**Aboriginal health determinants and status**
Employment	In 2002 Aboriginal adults were more than twice as likely to be unemployed (13%) than non Aboriginal adults (4.6%)
Education	Higher levels of education are associated with better health outcomes. In 2002, Aboriginal people were less than half as likely as non-Aboriginal people to have completed a post-secondary qualification of certificate level. In 2004, Aboriginal students were around half as likely to continue to year 12 as non-Aboriginal students.
Housing	In 2002, 9% of Aboriginal households in Australia were living in overcrowded conditions. The highest rate of overcrowding occurred in households that were renting from Aboriginal or mainstream community providers (34%). Twenty four percent of Aboriginal people rent from state or territory housing authorities.

Health risk factors	In 2002, 49% of the Aboriginal population aged 15 years or over smoked on a daily basis. Fifteen percent reported consuming alcohol at risky or high risk levels in the last 12 months. Fifty one percent had not participated in sport or physical recreation activities during this period. Twenty four percent reported being a victim of physical or threatened violence.
Mortality	Over the period 1999-2003 Aboriginal people died at almost three times the rate of non-Aboriginal people. The three leading causes of death were diseases of the circulatory systems, injury and cancer.

Appendix 2 Resultant publications, presentations and awards

2007

Publications

Lloyd J, Wise M, Weeramanthri T**.** Changing shape: workforce and the implementation of Aboriginal health policy. *Australian Health Review* (accepted for publication).

Lloyd J, Wise M, Weeramanthri T. The implementation of Aboriginal health policy by a mainstream health system: the roles of professional values and system culture. *Social Science and Medicine* (under review).

Presentations

Lloyd J. *Re-orienting the Australian health care system to implement Aboriginal health policy.* Presented at the IUHPE World Conference on Health Promotion and Health Education, Vancouver, Canada, June 2007.

Lloyd J. *Implementing Aboriginal health policy: the role of the workforce and values and beliefs in generating change.* Presented at Health Policy Researchers Group NSW, Australian Health Policy Institute, University of Sydney, February 2007.

Awards

2007 Cross Cultural Public Health Research Award, Faculty of Medicine, University of Sydney

The award is made annually by the Dean of the Faculty of Medicine at The University of Sydney to a candidate for the degrees of Master (by research), PhD, MD, or professional doctorate in public health in the School of Public Health, The University of Sydney, or at the University of Western Sydney, to support research on public health issues affecting Indigenous Australians or refugees or recently arrived migrant to Australia.

Value: $5000

2006

Presentations

Lloyd J, Wise M, Weeramanthri T. *How do beliefs influence the implementation of Aboriginal health policy?* Presented at the Cooperative Research Centre for Aboriginal Health Symposium, Adelaide November 2006.

Lloyd J. *Qualitative methods and analysis used to understand how Aboriginal health policy is implemented.* Presented at Qualitative Health Research Collaboration, University of Sydney, November 2006.

Lloyd J, Wise M, Weeramanthri T**.** *Is Aboriginal health policy implemented?* Presented at the Emerging Health Policy Research Conference, University of Sydney, October 2006.

Lloyd J, Wise M, Weeramanthri T**.** *Changing shape: workforce and the implementation of Aboriginal health policy*. Presented at the Health is everyone's business… everybody's choice? Darwin, NT, September 2006.

Lloyd J, Wise M, Weeramathri T**.** *Is Aboriginal health policy implemented?* Presented at the International Society for Health and Equity Conference, Adelaide, September 2006.

Lloyd J. *Implementation of Aboriginal health policy: A case study of the Preventable Chronic Disease Strategy.* Presented at the Preventable Chronic Disease Program Workshop, Charles Darwin University, July 2006.

Lloyd J. *The implementation of the Northern Territory Preventable Chronic Disease Strategy.* Presented at the Dry Season Seminar Services, Department of Health and Community Services Northern Territory, June 2006.

2005

Lloyd J. *Implementing PCDS: method and preliminary findings.* Presented to the Evaluation Committee of the Northern Territory Preventable Chronic Disease Strategy, November 2005.

Lloyd J. *Understanding Aboriginal health policy as a determinant of health.* Presented at the Monday Seminar Series, Menzies School of Health Research, Darwin, NT, December 2005

Lloyd J. *Aboriginal health interventions: crucial success factors*. Lecture at the Social Determinants of Indigenous Health Short Course, Menzies School of Health Research, Darwin, NT, June 2005

Lloyd J. *The cycle of Aboriginal health projects: are interventions making you sick?* Poster at the World Health Promotion Conference, Melbourne, VIC, March 2004

Appendix 3 Participant information sheet

Implementing Aboriginal Health Policy in Australia

Information Sheet

Aboriginal people are sicker and die around twenty years earlier than non-Aboriginal Australians. The federal and state governments have been trying to improve the health of Aboriginal people. A number of committees have been formed and reports written describing problems in Aboriginal communities and range of solutions have been discussed. Unfortunately despite this effort and attention, particularly over the last thirty years, there have been no marked improvements in life expectancy. Aboriginal people are still sicker and die earlier than non-Aboriginal Australians.

This project is looking at effectiveness of the mainstream health system rather than an Aboriginal population or community. The idea is that if we have a better understanding of how policy works and some of the incentives and pressures faced by those working in the mainstream health system we might be able to identify ways to improve things. Please note the intention is to understand and improve the implementation of policy, NOT to discredit the system.

The aims of this study are to:

- Provide an initial assessment of perspectives on how the implementation stage in the policy process works;
- Investigate factors that influence the extent to which Aboriginal health policy is implemented;
- Understand and explain the interactions and relationships between those people and organisations responsible for policy development and those responsible for policy implementation of Aboriginal and Torres Strait Islander health policy in Australia; and
- Identify initial actions that will improve the capacity of the health sector to implement health policy intended to improve Aboriginal and Torres Strait Islander health.

You are invited to participate in this study. Forty people who are involved in Aboriginal health policy in Australia have been selected to be interviewed. Some examples of who we want to talk to are: researchers, people working for the health department, and people delivering services. You will be asked about your experiences of the implementation of the NT Preventable Chronic Disease Strategy. The length of the interview will depend on the time you have available, but we will try to limit interviews to no more than an hour.

All information provided is strictly confidential. Recorded interviews will be stored in a locked filing cabinet at Menzies School of Health Research for five years. A copy of the written transcript will be sent to you for your corrections and approval (if you agree to participate but prefer not to be taped, notes that include key points from the interview, will replace the transcript and will be sent to you for approval). Electronic transcripts (and notes) will be stored on password protected files and all names will be removed and replaced with a deidentified code. Only the principal researcher will have access to this locked filing cabinet and electronic files. Draft findings will also be sent to you for your comment and to ensure findings are presented in a constructive way.

Participation is voluntary and you have the right to withdraw material at any time.

This study is being conducted by Jane Lloyd, towards her PhD, under the supervision of Ms Marilyn Wise from the University of Sydney and Dr Tarun Weeramanthri from Menzies School of Health Research. This study has been submitted to the Human Research Committee of NT Department of Health and Community Services and Menzies School of Health Research. If you have any concerns or complaints about the conduct of this research study you can contact the Committee Secretary, Linda Ward on 8922 7922.

If you have any general questions or comments regarding this study please feel free to contact Jane Lloyd on 08 8922 8196 or via email on janel@menzies.edu.au

Thank you for your time and consideration of this study. Please note this letter is for you to keep.

Researcher signed ………………………………..

Printed name ……………………………………. Date ………………………………..

Appendix 4 Consent form

Implementing Aboriginal health policy in Australia

I agree to participate in a taped interview. As proposed, and I understand that:

- All due care will be taken to protect my identity.
- All information collected for this project will be kept in a secure and lockable cabinet for at least 5 years.
- If I am interviewed, I will be sent a copy of the interview transcript (or notes if the interview is not recorded), when it is available. I then have two months to approve or partially approve the transcript (or notes) for use, after which time it will be assumed the transcript is approved for use.
- A thesis will be written at the completion of the project.
- The research findings of the project may be presented at conferences, seminars, and in academic journals.
- I can say ‘no’ to participating, and I may withdraw from the project at any time.
- If I am interviewed, I will be sent a copy of the draft findings for comment.
- I can contact Jane Lloyd at any time on 8922 8196 for further information about the project.

I understand the purpose of this research project and agree to the points made on this consent form.

Participant signed ………………………………..

Printed name …………………………………....   Date ……………………..

Witness signed ………………………………..

Printed name …………………………………….   Date ……………………..

Contact details (requested for follow up and to verify analysis and interpretation)

……………………………………………………………………………………………
……………………………………………………………………………………………

If you have any concerns or complaints about the this project, you can phone the Top End Human Research Ethics Committee Secretary, Linda Ward on 8922 7922.

Appendix 5 Interview questions prompt sheet

The purpose of this interview is to understand many perspectives on how implementation happens, or doesn't happen, through a case study of the NT Preventable Chronic Disease Strategy (PCDS). Check time availability.

1. Tell me a bit about yourself?

(Prompt: professional background; how long have you been working in the Territory and on Chronic Disease)

2. Please describe how you are involved in the PCDS.

3. How is PCDS implemented?

(Prompts: how were decisions made, who were the leaders, what resources were provided to whom and where did the resources come from, how long did it take, what parts were critical? Also prompt regarding operational areas role in implementation. To what extent do:

- operational areas include PCDS goals in their business plans;
- health service providers prioritize the prevention and management of chronic disease in their daily work plans
- take account of prior initiatives such as the Nutrition, Tobacco, or Alcohol strategy?)

4. What are the supports for implementation?

5. What are the barriers to implementation?

6. How are Aboriginal and Torres Strait Islander people specifically targeted in this strategy?

7. How will we know if the PCDS has been a success?

(Prompt some of the anticipated benefits include:

- at the system level - greater integration across primary and acute care, over the life span; and across determinants of health;
- in terms of capacity building – guideline development, recall systems, care plans;
- in terms of service provision – greater access
- health outcomes)

8. How will we know if the PCDS has been a success for Aboriginal and Torres Strait Islander people?

9. Who else do you suggest I should talk to?

Appendix 6 A selection of traditions in qualitative analysis

Author/s	Content analysis	Thematic analysis	Discourse analysis	Grounded theory	Other
Rice & Ezzy 2002 (107)	Identify categories prior to coding.	Patterns and categories emerge from the data.	Not included.	Patterns and categories emerge from the data.	Not included.
Green & Thorogood 2004 (109)	Analyse content into themes. The aim is to report key elements of interviewees accounts.	Not included.	Not included.	Discover theory from the data. Involves a cyclical process of collecting data, analysing it, developing coding, further sampling, more analysis and so on until saturation is reached.	Framework analysis: classifying data within a thematic framework. This involves familiarisation; thematic analysis; indexing; and charting.
Spencer, Ritchie et al 2003 (108)	Content and context of data are analysed.	Not included.	Concerned with the way knowledge is produced	Develop theory from the data, as opposed to developing data from a theoretical framework. Categories are saturated.	Policy and evaluation analysis. Providing information about the context for policies, and how to maximise the effectiveness of their delivery.

Gribich 1999 (170)	Enumerative: recurrence of particular aspects.	Not included.	Investigative: analysis searchers beyond the works to uncover power struggles, history, myths and language.	Iterative: themes are highlighted along the way and become part of ongoing investigations.	Subjective: researcher’s subjective experiences are inseparable from the analysis.

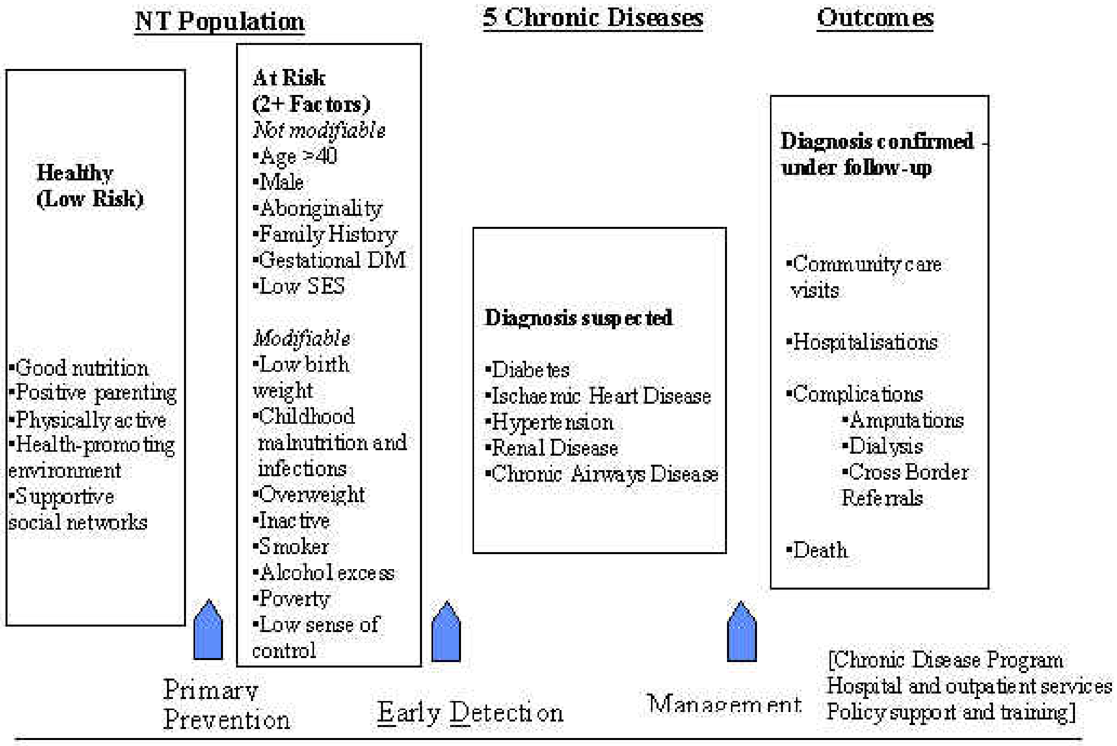
Appendix 7 The PCDS framework and timeline of events

The PCDS framework is based on a life course approach that encompasses antenatal, childhood and adult influences on the development of chronic disease. This framework recognises that many of the modifiable risk factors for chronic disease occur during antenatal care, childhood and in adulthood. This is an important revelation because it demonstrates that the health care system may intervene at many points over ones life course. Despite common assumptions, it is not just in adulthood that one needs to be conscious of preventing chronic disease. The point of intervention depends upon ones stage of life and the point at which one is at over the illness trajectory.

In the second column in the framework risk factors for chronic disease are described as either modifiable or non-modifiable. A modifiable risk factor is one that can be changed such as smoking. A non-modifiable risk factor is one that cannot be changed such as a family history of chronic disease. If an individual has a non-modifiable risk factor then changing the modifiable risk factor becomes even more important.

In addition to the framework, PCDS included a number of best buys. These best buys were recommendation on effective strategies and points in which to address chronic disease. The best buys for addressing chronic disease were identified from the evidence base and they include: child and maternal health; underlying determinants such as alleviating poverty, promoting a sense of control and self care and improving food supply; lifestyle modification (stop smoking, loose weight and exercise); early detection and early treatment; and best practice management in order to prevent the complications of diabetes such as kidney disease.

The framework of the Northern Territory Preventable Chronic Disease Strategy



Source: Northern Territory Department of Health and Community Services

A timeline of the development and implementation of PCDS

Year	Action
1996	• Creation of a Top End Community Physician position focusing on chronic disease
1997	• Formation of Chronic Disease Working Party to respond to renal failure and chronic disease • Coordinated Care Trials funded. Outputs relevant to PCDS include the creation of guidelines for chronic disease and a computerised patient recall system • Development of the PCDS
1999	• PCDS became part of core business of the NT Department of Health and Community Services. PCDS received 928K in new funds • Responsibility for PCDS shifted from public health to primary health care to encourage closer links with service providers
2001	• The Preventable Chronic Disease Program was created to implement the PCDS. • Physician appointed to manage the Top End Preventable Chronic Disease Program • Four chronic disease positions were created for Maningrida, Wadeye, Milingimbi and Ramingining. By 2004 there were chronic disease coordinator positions in most of the Major Top End communities. • Commenced formal assessment of health service activities

2002	• Major portion of s100 funds allocated to Preventable Chronic Disease Strategy and quality use of medicine programs – approximately $2.35 million per annum • Employed PCDS coordinators in Central Australia • Better management of chronic disease named as one of five community health centre priorities and written into business plans against which reporting is required
2003	• NT Department of Health and Community Services restructure. The Preventable Chronic Disease Strategy is included as a program and as part of the Health Development and Oral Health Branch. • Established new positions: community nurse and Aboriginal Health Worker in one remote community and a coordinator position in the Katherine region. • Roll out and maintenance of systems – recall, use of guidelines and care plans.
2005	• Commenced the evaluation of the Preventable Chronic Disease Strategy