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**Response
to
Draft National Aboriginal And Torres Strait Islander
Health Strategy**

**October 2001
Central Australian Aboriginal Congress Inc.**

Our Organisation

Central Australian Aboriginal Congress is one of the oldest Aboriginal community-controlled health organisations (ACCHOs) in Australia. Congress, initially called the Aboriginal Rights Council, formally emerged at a meeting of Aboriginal people in June 1973 in Alice Springs. Health was only one of many areas which the new organisation nominated for urgent attention. Its first activity was the ‘tent program’, providing desperately needed temporary shelter for people living in the so-called ‘fringe-camps’ of Alice Springs. In 1975, Congress established the first Aboriginal community-controlled health service in the region. From a small clinic staffed by one doctor and a few health workers-in-training, we have grown through the last three decades to offer a wide range of health and related services. Current programs and services include:

- a general medical clinic,
- an on-call 24-hour medical service,
- a dental clinic,
- a women’s medical clinic and birthing centre (Alukura),
- a men’s health program
- a social and emotional well-being centre,
- a child care centre,
- a community health program (including immunisation programs, child and infant health, frail aged and disabled program, nutrition education, diabetes, renal and eye clinics and a bush mobile service for outstations)
- a community transport service,
- a training ‘school’ for Aboriginal Health Workers (AHWs), and
- a research and policy development capacity which has a major impact on national Indigenous health debates.

The volume of work undertaken by these various section is enormous. For example, clinical consultations alone total more than 24,000 in a full year (1998 figures).

Congress has assisted many other communities in central Australian region to develop their own health services, including Papunya (Lyappa Congress, since disbanded), Utopia (Urapuntja H.S.), Pitjantjatjara homelands (Nganampa H.S.), Kintore (Pintubi Homelands HS), and Uluru (Multijulu H.S). CAAC also supported the development of ACCHOs in Tennant Creek, Katherine and Darwin. This was one aspect of its continuing advocacy role, campaigning for the extension and improvement of comprehensive community-controlled primary health care services¹ to communities suffering from many decades of neglect by the mainstream health care system. In this work, CAAC took part in the national peak bodies of the Aboriginal health movement, firstly NAIHO (National Aboriginal & Islander Health Organisation), then NACCHO (National Aboriginal Community-Controlled Health Organisation). In 1994, CAAC formalised its collaborative relationships with the other ACCHOs in the NT by helping to establish the Aboriginal Medical Services Alliance of the Northern Territory (AMSANT).

National Aboriginal Health Policy: A Brief Review

The Australian Constitution gives States primary responsibility for health, and the Commonwealth had no authority to legislate for Aboriginal people until after the Constitutional Referendum in 1967. In the thirty plus years since then, Commonwealth governments have tried to improve coordination in

¹ For Congress’ definition of primary health care services, see below.

Aboriginal health through development of national policy i.e. policy which commits all governments - state, territory and Commonwealth - to an agreed position and strategy.

The 1973 National Plan for Aboriginal Health aimed for the “improvement of the health of Australian Aborigines up to at least the level of non-Aboriginal Australians” within ten years. This was little more than a general statement of commitment.

In 1979, when it was clear that this objective was not going to be reached, a Commonwealth Government committee instead recommended that resources be put into providing basic public health facilities to communities, such as safe water supplies. The Aboriginal Public Health Improvement Program ran from 1981 to 1985. At the end of it, many Aboriginal communities still did not have these essential facilities.

In 1987 Commonwealth, State and Territory Ministers of Health and Aboriginal Affairs appointed a Working Party to develop a National Aboriginal Health Strategy. Congress made a substantial submission to the Working Party, as did many other Aboriginal organisations and communities, government departments, and health professional across Australia. The result was the March 1989 Report of the National Aboriginal Health Strategy Working Party. Government responded by setting up the Aboriginal Health Development Group, to plan implementation of the Strategy, while community and Aboriginal health organisation delegates set up their own group - the Community Advisory Group. Both groups delivered reports, in late 1989 / early 1990, but the Joint Ministers Forum only considered the Development Group's recommendations. The Forum's decisions became the new national policy setting, the National Aboriginal Health Strategy (NAHS).

In the early 1990s, RCIADIC and the Aboriginal Social Justice Commissioner undertook further extensive investigations into what was needed to fix Indigenous health. ATSIC, established in 1990, took over Commonwealth funding responsibility for implementing NAHS, but failed to do so. This was in part because they did not have the money required. Most health funds continued to go through state health systems, and the Tripartite Forums recommended by NAHS did not work. ATSIC also lacked health service expertise, and focused too narrowly on housing and infrastructure i.e. environmental health. There was little support for expansion and improvement of Aboriginal community-controlled primary health care services, even though they had been fundamental to NAHS. In 1994, an evaluation of NAHS, to which Congress also made a substantial submission,² said it had not been implemented.

Throughout the 1990s, community-controlled health services, with AMSANT doing much of the work, campaigned for Commonwealth to reorganise the way health service funding was provided. In 1995, they succeeded, and responsibility for the funding of Aboriginal health services transferred from ATSIC to the new Office of Aboriginal and Torres Strait Islander Health (OATSIH) within the Commonwealth Health Department. By the end of the decade, they also succeeded in accessing Commonwealth funding equivalent to Medicare, which funded private GPs to provide primary care, but which most Aboriginal people were barely accessing if at all. These new arrangements now include the State/Territory Aboriginal Health Forums, regional planning bodies such as CARIHPC, and a funding program utilising Commonwealth funding in part based on Medicare payment equivalents to roll out new primary health care services (PHCAP).

² Central Australian Aboriginal Congress. (1994). *Submission to the Review of the National Aboriginal Health Strategy* (Unpublished). Alice Springs: C.A.A.A.C.

In recognition of these major developments since 1990, and to take account of other recent reports impacting on health policy, including H.R.E.O.C.'s *Bringing Them Home*, and the House of Representatives report, *Health is Life*, the National Aboriginal and Torres Strait Islander Health Council has initiated a process to develop a new national strategy. This submission is our response to an extensive draft prepared by OATSIH staff for consultation and public comment.

The Congress Response

The remaining pages represent an analysis based on discussions held within Congress over the months since the Draft began to circulate. These discussions have included a workshop with our Cabinet, the governing body of the organisation, consisting of Aboriginal people elected at an AGM open to all Aboriginal people in Central Australia; meetings of the policy staff and senior management of the organisation; a general staff meeting; meetings within individual sections; some discussion with leaders of other ACCHOs in the NT and nationally; and a final Cabinet meeting to sign off on our submission. This process was recently assisted by a small grant from OATSIH to help us finalise our response.

Our response is in three parts. The first part sets out in point form our general comments, positive and negative, about the draft document, the process which produced it, and its extensive introductory sections setting out the history and evidence base on which the strategy is based. The second part of our response analyses in more detail Parts Two and Three of the draft, addressing the principles, goals, aims, key result areas and implementation responsibilities. The final section of our submission makes some recommendations regarding the process of turning the OATSIH draft into a final version for adoption by governments.

A. General Comments.

Positives

1. The decision to revise the national policy is a welcome one, more than justified by the big changes that have occurred in the decade since NAHS, and the draft provides a good starting point for discussing what should be in the new strategy.
2. It locates and summarises a lot of useful research, and in particular, acknowledges the role of colonisation in the production of ill-health and the importance of wider social determinants;
3. It attempts to develop a strategic approach with clearly-stated aims and measures for assessing progress towards them;
4. The strategy commits strongly to comprehensive PHC and particularly to ACCHOs;
5. It highlights the value of Framework Agreements, State & Territory Forums, and regional planning processes;
6. It commits to improving mainstream health services;
7. It clearly states a need for increased resources;
8. It emphasise evaluation and accountability, not just to government but to the Aboriginal community;
9. It calls for intersectoral collaboration to address the underlying causes of ill-health, and calls on the health sector to advocate for this

Negatives

10. The draft was written after submissions had been taken from government agencies, but not from the community-controlled sector, contradicting the tripartite Framework Agreement model it claims to support;

11. It is written in a very bureaucratic and convoluted style, lacking any real inspirational tone or sense of urgency;
12. It is more conservative, politically, than the 1989 NAHS, especially in its avoidance of land and sea rights issues, and its understated treatment of Indigenous rights in general;
13. The corollary is that it relies on a language and rhetoric more consistent with Liberal-National Party policy, especially 'mutual obligation' and responsibility, the playing down of rights, a tendency towards 'mainstreaming' and a subtle rejection of 'old-fashioned' models in favour of new 'partnerships';
14. The summary of existing research and other evidence is not done critically, thoroughly or rigorously, and is more a 'cut and paste' with something for everyone;
15. The summary also largely ignores the experience and writings which have emerged from the community-controlled sector in favour of published academic research and government inquiries;
16. The document talks too much about Aboriginal people as if they are the problem, or have the problem, and not enough about white society and its role in producing the problem through its policies and practices;
17. There is not much in the way of systematic analysis of what is actually happening now, nor is there any evaluation of NAHS and why it was not implemented;
18. It pays too much attention and gives too much credibility to the role of governments in achieving improvements, and not enough acknowledgement of the role of ACCHOs in forcing governments to act. While it acknowledges the importance of community leadership and capacity, this is abstracted from the day-to-day reality of developing and maintaining community-controlled organisations;
19. The 'line' through the document is not clear, in that the actions proposed do not clearly arise from the evidence presented;
20. There are no benchmarks against which progress towards the aims is to be measured eg it aims for reduced infant mortality, but does not say to what level, or by how much;
21. There is no clear commitment to closing the gap, to reducing the inequality between Indigenous and non-Indigenous health.

B. Response to Detailed Strategy and Implementation

Part Two. Setting the Agenda for the Future (Pp. 41-49)

This part of the document is in three sections. The first, *Developing a vision of a healthy future*, seeks to initiate discussion on common national priorities by providing several examples under the heading What would a healthy community look like?. Congress already has produced, in 1998, a model which incorporates many of the things set out here. It is attached, on the following page.

Principles

The next section in Part Two is a set of nine principles, which have been developed, it says, to guide national action. These principles have been stated better in other documents, and in fact, sections of the old NAHS have been reproduced. But some principles are not there, eg although the first principle is cultural security, there is no mention of land and sea rights, native title rights, protection of sites, or maintenance of languages. Para 261 talks of 'loss of culture', an unfortunate and inappropriate term. Cultures are not lost, they change, sometimes under unacceptable pressure from the dominant society, sometimes by choice. As mentioned in the introduction to this response, the draft, and particularly this section, should be rewritten within a rights-based approach. The rights of Aboriginal people, as Indigenous peoples and as citizens, need to be set out as the framework under which good health will be achieved. Self-determination is the fundamental right, or principle, yet in principle 8 it appears to

have been replaced by 'greater community and individual self-sufficiency'. This is a serious retreat from NAHS, and from RCIADIC. In this context, Congress reiterates what it said in its Submission to the Review of NAHS:

The best way for the health of our people to be improved is for our people *at a community level to control and deliver primary health care services*. Mainstream services, however 'appropriate', cannot deliver the necessary primary health care services that are essential to improving health³

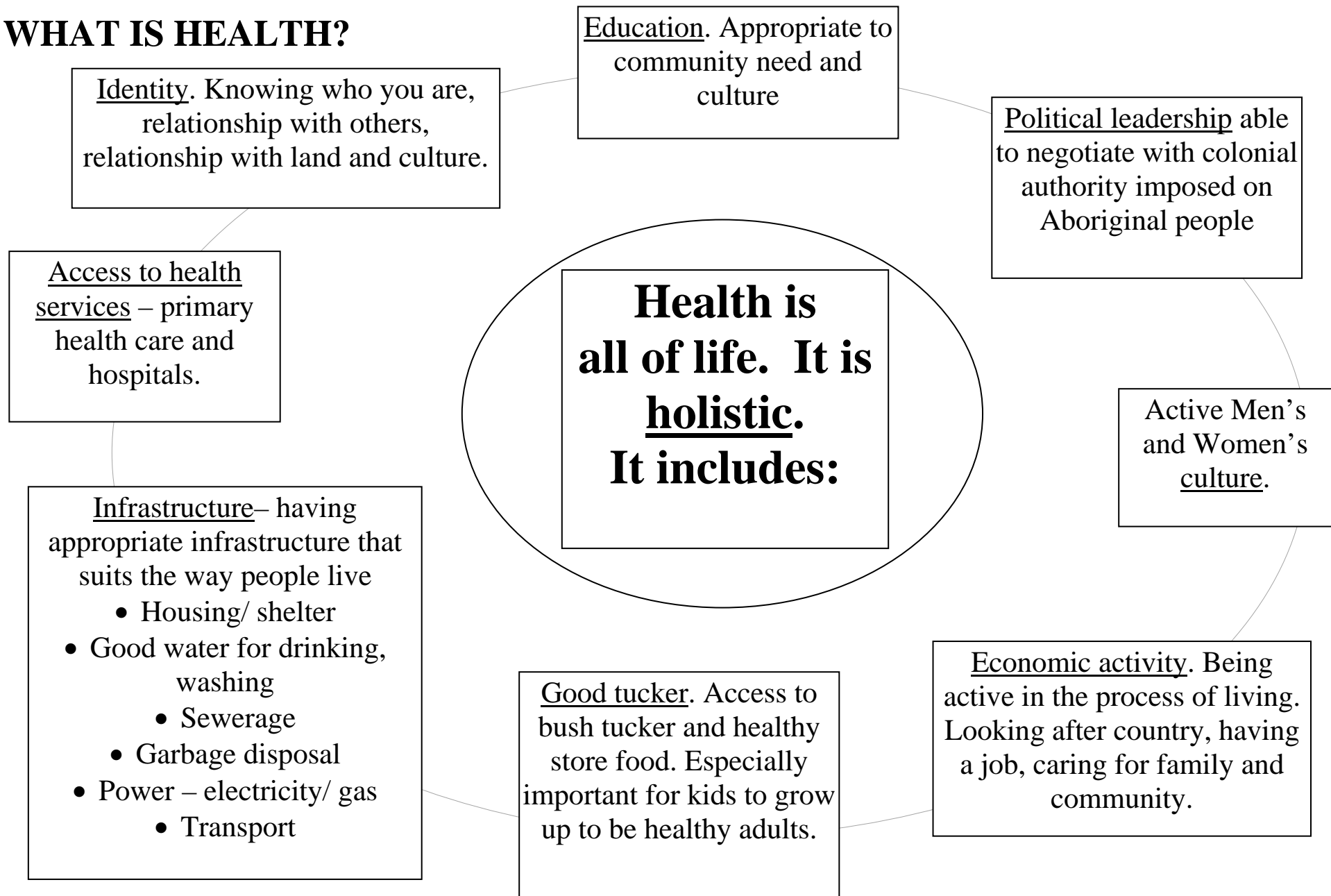
Goal & Aims

The final section of Part Two is the most important part of the document, since it sets out the national goal and aims of the strategy. The goal, it says, is that Aboriginal peoples enjoy a long and healthy life enriched by a strong living culture, dignity and justice. This will be achieved, it goes on to say, if mortality, morbidity and the prevalence of certain conditions are the focus, but really, these are more in the way of indicators. However, even if this is a useful way to establish the basic aims, there is one fundamental, glaring and inexcusable fault. Nowhere on this page does the strategy commit to any reduction in the gap between Aboriginal and non-Aboriginal health outcomes.

Congress submits that the national strategy must commit to reducing health inequalities between Indigenous and Non-Indigenous Australians, and that there should be clear benchmarks and time frames by which this will be achieved.

³ Central Australian Aboriginal Congress. (1994). *Submission to the Review of the National Aboriginal Health Strategy* (Unpublished). Alice Springs: C.A.A.A.C.

WHAT IS HEALTH?



Part Three. Implementation (Ref pp 51-101)

General comments

1. The Introduction (p53) says this section “translates the background information & agenda for the future into key activities to be undertaken *over the next few years...*” (Our emphasis). This needs to be rewritten, with a specific time frame for implementation set at the outset, to avoid procrastination and ensure accountability.
2. There needs to be some cross-referencing of the KRAs to the material in the first two parts, to demonstrate rather than simply assert the analytic and evidence base for these rather than other activities.
3. There is a major flaw in the structure overall of Part Three, in that it separates the “key activities” (called Key Result Areas) from implementation responsibilities. Lead agencies need to be specified for each result area, otherwise no one will have to take formal responsibility and accountability for carrying them out.
4. In the sections which follow which discuss some of the KRAs in detail, it will become clear that the overall policy ‘logic’ is overwhelmingly and unnecessarily complex, and the services of an experienced policy professional should be obtained to rewrite the document to overcome this.
5. When this is done, the order in which the KRAs appear should be revised, as follows:
 - a. National state and regional planning mechanisms and service delivery issues dealt with in KRA1 should be separated into two areas;
 - b. KRA3, which specifies the needs of ACCHOs, should be the first area of service delivery addressed, because comprehensive PHC is the foundation on which Aboriginal health improvements have to be built;
 - c. Other forms of primary care, and secondary and tertiary care, should follow on from this;
 - d. Workforce development, currently in KRA2, should be separated into pre-service training, which is an issue for the education sector, and in-service training, which is a core function of health services;
 - e. Buildings, equipment and infrastructure should be included within service planning;
 - f. Community capacity and health service capacity are not logically separate if community-control is the preferred model for service delivery, and Aboriginal involvement at all levels of service provision and planning is the goal

Key Result Area 1. Health Care Delivery Framework

There are five aims addressed by this KRA. At a planning level, this KRA sets out to ensure that:

- all planning processes *take account of* Aboriginal And Torres Strait Islander needs (our emphasis); and
- Aboriginal And Torres Strait Islander participation in planning increases.

At a service level, it sets out to

- increase quality and quantity of provision from all health care providers;
- “*move towards* funding based on need” (our emphasis); and
- increase coordination, partnerships and collaboration (but it does not say among whom).

These aims are addressed through a further 9 ‘Action Areas’, adding a further level of complexity to the ‘program logic’ of the policy model, especially since each ‘action area’ contains 3 or more further ‘dot points’ which are also sometimes broken down. In total, there are forty five (45) separate dot points or sub points in this one KRA.

There is also a list of 6 ‘indicators’ for assessing progress towards “these aims”, namely the five aims of KRA 1. But none of these PI’s actually measures the extent to which the first two aims have been met, other than at a regional or service level. The measure said to assess “quantity of service provision” is per capita expenditure on Indigenous people vis a vis the same figure for non-Aboriginal people – but since the former already exceeds the latter, what is the point? The issue is

by what factor it exceeds it, and this is nowhere specified, despite the expressed desire to “move towards” funding based on need. How slowly or how quickly this movement should occur needs to be specified, along with a methodology setting out formulas for needs based planning e.g. as have been used in relation to PHC only in the NT PHCAP program.

Given that these are the indicators by which the national health care delivery system will be held accountable for its performance in improving Aboriginal health, this is seriously deficient. It represents a far lower level of accountability than is demanded of the most impoverished and under-resourced community-controlled service; yet the national system spends billions of public health dollars each year.

Congress believes that this whole section needs to be redrafted, based on a much tighter and comprehensive analysis of strategic points of intervention in the national system, at each of the three levels, in relation both to planning and service delivery. It may be more useful to treat planning processes and structures separately from service delivery issues. As it is currently written, KRA 1 does not provide an adequate “Health Care Delivery Framework”, because it fails to prioritise comprehensive Aboriginal community-controlled primary health care services and their core functions as the centrepiece of that framework. In fact, the majority of points in relation to service delivery in this section refer to mainstream services. As government policy, NATSIHS should be careful not to perpetuate confusion on the part of governments about the differences between their policy setting and funding roles, and their roles as direct providers of services. The core of effective Aboriginal health care, the foundation on which other forms of primary care, as well as secondary and tertiary care, must be built, is universal access for Indigenous communities to comprehensive Aboriginal community-controlled primary health care services. The policy does in fact say this, but only at KRA3.

At a minimum, this first KRA needs to:

1. Commit to universal access for Indigenous communities to comprehensive Aboriginal community-controlled primary health care services;
2. Commit to the development of a national framework agreement, paralleling current state/territory agreements;
3. Increase the life of Framework Agreements from three to five years in next round;
4. Specify a way for ACHHOs, as the most experienced health leadership within the Aboriginal community, to have direct input or at least observer status at AHMAC, thereby preventing or at least making transparent the practice of state systems and/or the Commonwealth bypassing the National Aboriginal And Torres Strait Islander Health Council;
5. Specify a process through the national framework to resolve national resource allocation issues, including how to establish needs-based funding formulas beyond the primary care level;
6. Mandate and resource state and territory Aboriginal Health Forums to operate as advisory bodies in relation to:
 - a. Health Care Agreement negotiations between Commonwealth & State/Territories;
 - b. Public Health Partnership Agreements
7. Mandate and resource Aboriginal Health Forums to take advisory and monitoring roles in relation to all mainstream health service planning and provision in their jurisdictions;
8. Address service planning and delivery issues at a regional level, not just local (Action Area 2), for example by promoting the Central Australian Regional Indigenous Health Planning Committee (CARIHPC) as a best practice regional planning model, with working parties involving ‘non-core’ partners on specific issues e.g. substance abuse;
9. Place more focus on improving and monitoring provision of secondary and tertiary health services to Indigenous peoples e.g. monitoring ‘tertiary endpoints’;
10. Specify what programs and policies are needed to reform mainstream service (Action Area 3), including

- a. Aboriginal control over orientation of staff to provide more effective services, not just cross-cultural training, but specific orientation to Aboriginal health practice issues e.g. prevalence of ischaemic heart disease in young people;
 - b. Establishment of treatment protocols to ensure all professionals in the system address the special conditions and needs which Aboriginal clients may have
 - c. Universal adoption of hospital accreditation and quality assurance systems which incorporate of Aboriginal-specific standards.
11. Address the specific access issues for Aboriginal communities in rural and remote areas (Action Area 5) through
- a. Mandating and resourcing the AHFs and regional planning forums to monitor and coordinate implementation of NATSIHS with the Rural and Remote Health Strategy;
 - b. Acknowledging that “an appropriate range of services to rural and remote areas” (point 5, p 55) includes secondary and tertiary care systems, not just PHC;
 - c. Benchmarking minimum access levels to specialist services e.g. paediatrics, on a population basis;
 - d. Improving access to secondary and tertiary care through appropriate travel and transport services such as the Patient Assisted Travel Scheme, and accommodation assistance for patients and families who must travel to other centres for this care;
12. Under ‘Enhance coordination’ (Action Area 6)
- a. Rewrite the reference to Coordinated Care trials in the light of recent experience in the NT in relation to the Primary Health Care Access Program (PHCAP)
 - b. Include the point made above in relation to PHCAP; and
 - c. Promote models such as the one existing in Alice Springs whereby Health Service Liaison Meetings link ACCHOs to GPs, other health professionals, and the hospital for purpose of discharge planning and coordinated care.
13. Remove the references to cross cultural and other training (e.g. under AAs 3, 8 and 9) to KRA 2, to be dealt with more systematically as part of workforce development
14. Recognise the need for regional or zonal level services to be developed to support existing and new PHC services in communities;⁴
15. Make reference to the need for reform of the statutory framework in state and territory jurisdictions, including Public Health legislation, to make better provision for the specific needs of Aboriginal and Torres Strait Islander communities⁵;
16. Redraft and or remove entirely the sections on traditional medicine under Action Area Nine, in recognition of the inappropriateness – even offensiveness - of seeking to bring enormously diverse traditional cultural practices specific to regions and localities within the ambit of national policy without thorough and exhaustive consultations and negotiation conducted under the auspice of the national Aboriginal health leadership.
17. Provide under ‘Assessing Progress’ some additional measures to increase overall system accountability in relation to service provision and health outcomes eg.
- a. Number of service providers accredited in accordance with minimum standards;
 - b. Monitoring key tertiary endpoints such as rate of coronary angiography, percent of normal angiograms, renal transplantation rates, and years of survival post diagnosis for lung, breast and cervical cancer

Key Result Area 2. Building Health Service Capacity, including workforce

There are five aims under this KRA, covering

- Indigenous participation in the health workforce,

⁴ Boffa, J., & Weeramanthri, T. (2001). *Orienting health services and public health programs towards greater chronic disease control: a proposal for a network of zonal and regional public health services*. (Discussion paper prepared for the NT Aboriginal Health Forum, June 2001).

⁵ Aboriginal Medical Services Alliance Northern Territory (AMSANT). (2000). *Submission to the Review of the Public Health Act Discussion Paper*. Darwin: AMSANT.

- Increased training, protocols and guidelines for mainstream services,
- Increased sharing of information among services,
- Increased support for community boards and advisory groups, and
- Improved facilities and resources.

The logic and layout of this KRA is more confused than in KRA1, reflecting a lack of clarity about what constitutes Health Service Capacity. As with KRA 1, the number of levels continues to multiply – the first aim has four parts, giving in fact eight aims or goals. There are then eight action areas, of which the last three apply chiefly to facilities and resources. Within the Action Areas, there are over forty separate ‘dot points’ but despite this, several things mentioned in the aims are not operationalised in any specific Action Areas.

There is no apparent logic to the breakdown of the first five Action Areas. AA1 is to provide *support* to AHWs, while AA2 is to provide *education* to non-Indigenous health professionals and managers. AA3 seeks to increase participation of Indigenous people in the health sector, largely through education and training once again, but only mentions AHWs once. AA4 is about management training and support, to Boards and ACCHOs, and through regional structures that are inadequately specified. AA5 is again about education and training, in that it seeks to provide the “skills base to support new modes of delivery,” without saying what those “new models” might be, though a brief mention of “coordinating care” implies the authors might mean the Coordinated Care Trials. There are several references to “capacity” – of communities, of “health service managers”, of “Aboriginal And Torres Strait Islander health services,” and of “mainstream program managers”. However, the Draft has a separate KRA, KRA2 which deals with community-controlled health services, and another, KRA4, to deal specifically with community capacity. AA6& AA7 deal with buildings and equipment, but not adequately. AA8 is about Patient Information Systems, which are also picked up under KRA 7, Action Area 2, p86.

The section on Assessing Progress provides nine performance indicators, designed to assess Aboriginal And Torres Strait Islander workforce participation, changed practice by mainstream professionals and services, and progress on health services infrastructure. The participation measures are specific only in relation to ACCHOs, not other services, nor the bureaucracy. The education measures are both too broad – “graduates in ‘key health related fields’ and the non-AHW professions are too narrow – ‘doctors and nurses’. There is no indicator to measure progress towards the third aim, ie information sharing.

AA1. Provide support for AHWs

AHWs play a central role in improving Aboriginal health care and in Aboriginal health development. Given this draft of NATSIHS was written before the results of the National Review were in, this whole section now should be revised. In central Australia, AHWs have a clinical role, and pre-service and in-service training are both vitally important. AHWs’ continuing education and training needs have never been satisfactorily met, despite the fact that they are potentially the most stable and permanent component of the region’s PHC workforce, and the enormous value they add to regional health development. A decade of education institution-based AHW training has failed to produce a stable trained AHW workforce in the numbers required. Since the early 1990s, Congress and other ACCHOs have attempted to rectify this through:

- a. Becoming registered training providers in their own right so they can offer pre-service training courses which are more work-based; and
- b. Promoting the concept of a Training Unit dedicated to upgrading the skills of practicing AHWs and other PHC staff in the region.

Established in 1996, the Central Australian Remote Health Development Service (CARHDS),⁶ managed by the government and non-government PHC services themselves, began to fulfill the second function. The strategy must support this initiative, and consider its relevance to other regions.

Both strategies currently depend largely on non-Aboriginal health professionals to deliver the training, and the strategy should specify the need to support and resource senior AHWs to move into training and training coordination roles.

The basic point is that AHW education and training, both pre-service and in-service, entry-level or advanced, should be *work-based*. This was the model originally developed by ACCHOs in the 1970s and 1980s, before it was replaced with more education-institution based models (as happened also for nurses, for example). The new strategy needs to prioritise work-based learning models, and because these require active involvement from health services to work, the services have to be resourced to perform this function. The in-service element should be resourced with health funds, because it is a core function of PHC. Formal pre-service education and training qualifications require education-sector funding, though there is a case for some contribution from the health sector to ensure its needs receive priority over other sectors. Formal up-grading of qualifications e.g. postgraduate training, should be jointly funded.

A key issue in AHW education and training in this region is literacy and numeracy, especially in communities where English is not the first language, but also wherever there is a history of inadequate education provision, especially low participation and retention in secondary schooling. Relatively high literacy and numeracy standards are now built into national and NT customised AHW competency standards. This is a major issue, given that the retention rate to Year 10 is less than 10% in this region, and the average student in non-urban communities leaves school with English language literacy and numeracy equivalent to around Year 3 Primary School level. If health services are to play the major role in assisting AHWs to reach the national standards, they will need significant resourcing by ESL-trained adult educators to allow them to do so. This may best be done through regional training units such as CARHDS (previously CARHTU, see above). DETYAs Workplace English Language Literacy (WELL) program provides a potential source of support, allowing placement of tutors into workplaces.

Finally, it is incorrect to consider workforce development separately from issues of power and control. As a recent Review of CARHTU put it:

Best practice Aboriginal adult education (of which AHW training is a part) teaches us that Aboriginal community control must be central to all stages of training, from program design through curriculum development to delivery and assessment and evaluation. The relationships which trainers and participants develop are the key to successful training, and the use of Aboriginal trainers or co-trainers should be non-negotiable. Programs should reject the assimilationist ‘deficit’ model which tends to drive the national training reform agenda. AHW empowerment should be built into the program philosophy, and pedagogy needs to reflect this, not simply seek to transfer skills as defined and understood by non-Aboriginal professionals into Aboriginal heads and hands. This does not mean lower professional standards; training programs should be rigorously measured by their proven ability to raise AHWs industry-set competency levels, since technical expertise is at a premium. But to be effective, programs must also build the capacity of AHWs and their communities to assume greater responsibility for both their work and their training, involving them and their PHC services in training design and delivery. This means questions

⁶ At that stage, it was called the Central Australian Remote Health Training Unit (CARHTU).

of power and control, within services, within communities and within the industry as a whole, must constantly be addressed, through program content and delivery methods.⁷

These issues also serve to remind us that AHWs employed in PHC services operate most effectively inside a health team which includes other health professionals and community health boards all of whom are attuned to the specific health needs of the communities they serve. AHW training and support therefore needs to take place alongside and in an integrated way with training and development of these other key workers.

Regional planning of workforce development is one way to address this, and PHC services (and secondary and tertiary services) need to be resourced and supported to negotiate MOUs with education and training providers which provide a framework to address systematically the needs of all their employees, and of their community board members. Regional, state-based and national workforce development plans should also include strategies to develop in the medium to longer term a much greater number of Aboriginal nurses, allied health professionals and doctors – not as a substitute for AHWs, who have their own specific roles, but in addition to them.

Other professionals tend to have better resourced and organised professional associations to support their development, and AHWs have suffered for the lack of this infrastructure. The National Strategy should allocate resources to this issue.

KRA 3. Comprehensive community controlled primary health care services

It is the view of Congress that comprehensive Aboriginal community controlled primary health care services are the fundamental cornerstone of an effective national strategy, and so this is the most important part of the document to get right. In its current form, This KRA puts forward three aims, namely

- to maximise health outcomes by providing (not proving – a typo) effective comprehensive PHC service,
- to strengthen PHC services including preventative services and
- to maximise community participation and control.

This is not nearly precise enough. Community control has been dropped from the first two aims altogether, and ‘watered down’ to ‘participation and control’ in the third. The strategy should clearly aim:

- to strengthen and enhance existing Aboriginal community controlled primary health care services; and
- to establish sufficient new services to fulfil unmet need.

The draft goes on to suggest five action areas. The first seeks to ensure there is structural support for universal availability, through flexible regional, state/territory and national planning mechanisms, but this is not stated clearly. KRA1 has already dealt with these issues, and our comments under KRA1 also apply here. However, some additional points need to be made to ensure the strategy provides adequate support for the development of new comprehensive PHC services.

Firstly, reference needs to be made to PHCAP, which provides the national funding program for rolling out new PHC services. Secondly, a commitment to establish regional hub centres, to provide support to smaller services in their region, needs also to be specified. Thirdly, the regional planning processes under which the new services are rolled out also have to be resourced, with project officers preferably located within an existing service and accountable to both government and the

⁷ Boughton, B., Schofield, J., Warchivker, I., Lenthall, S., & Wakerman, J. (2000). *An Evaluation of the Central Australian Remote Health Training Unit. Final Report (Draft), June 2000* (Unpublished). Alice Springs: Menzies School of Health Research & Centre for Remote Health.

community through the state/territory forum. In some areas, these planning processes also require interpreters. Fourthly, the Rural Health Strategy and the Divisions program should also provide support, where appropriate, to the development of ACCHOS. The most fundamental point, however is that NACCHO and its State Affiliates – AMSANT in the NT – must be recognised and resourced to lead the process of comprehensive PHC service development.

The second Action Area seeks to increase comprehensiveness. As the Draft recognises, this requires us to define comprehensive PHC, but it is not good enough to say the strategy will include action to define the elements of a comprehensive PHC service. This definition needs to be agreed before the strategy is finalised, so all the parties know what they have committed to, given this KRA sets out to provide it. Congress submits that comprehensive PHC is based on the following principles, as set out in the Final Report of the Review of the Role of PHC in Health Promotion in Australia,

Improving Australia's health: The Role of Primary Health Care:

1. Collaborative networking between different PHC agencies working as a coordinated group conscious of a common purpose as well as with centrally based resource agencies.
2. Consumer and community involvement from the level of individual illness episodes through to health service management, and health policy development and planning.
3. A partnership with the secondary and tertiary sectors which respects the role that each sector plays within the health system and recognises the interdependence of the different levels of the system.
4. A balancing of health care priorities between the immediate needs of individual clients on the one hand and the longer term needs to change systems and structures in order to prevent illness (NCEPH 1992: 19-20).
- 5.

The definition should also refer to the international literature, and the way Aboriginal health services have developed this model over three decades. The Primary Health Care (PHC) sector is the part of the health care system which provides medical, public health and health promotion services with the community, in the community. But PHC also describes an approach to health care provision which developed from the struggles of popular and anti-colonial movements in the 1950s and 1960s, and was taken up in the early 1970s by the leadership of the Aboriginal community-controlled health movement. Comprehensive Primary Health Care services are the practical operations of the Aboriginal view of Holistic Health. This means that preventive care is incorporated into the clinic work of treating sick people. Decisions about what health programs are needed are made by community processes (ie horizontal) rather than from experts outside the community (vertical). It is the community dynamics that determine health service priorities. This model was codified at an international level at Alma Ata in 1978, and subsequently endorsed by the World Health Organisation (WHO) and the United Nations:

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

It is important that the strategy clearly rejects the tendency to reduce Primary Health Care to Primary Care, or Primary Medical Care. Primary Health Care includes *both* primary medical care

AND public health, and here we mean the ‘old’ and the ‘new’ public health.⁸ It must also clearly reject *selective* primary health care in favour of *comprehensive* primary health care. Congress submits that comprehensive Primary Health Care Services fulfill four basic or core functions:

1. **Clinical Care:** This includes treatment of sick people (Acute Care) as well as preventive care and the managements of people with chronic disease and disabilities (including the care of the frail aged). This includes both caring for people so that they feel better, as well as care that helps prevent both premature mortality and complications of these diseases.
2. **Social Preventive Programs** that require community action (agency) in order to be both effective and sustainable. These are essential to addressing issues that cannot be addressed through medical interventions and relate to many problems and people of different ages. However, they are particularly important to the problems of young people and their high mortality experience.
3. **Support services.** The sort of support required includes in-service training and orientation of staff; IT support; support for recruitment and staff issues; financial management support; and assistance with program development/ planning and evaluation. Where smaller community PHC services do not have the size to be able to provide some needed support in-house, it remains a core function and needs to be provided regionally.
4. **Policy & Advocacy.** Health services must be mandated to speak on behalf of both the service and the community and its health needs to government so that both policy and funding levels are addressed appropriately. This should include advocacy in relation to underlying issues which affect health, such as land rights, education, and economic development
- 5.

Finally, it should be clear from the above that a full understanding of primary health care also requires the strategy to define secondary and tertiary care, so that the relationships among the three sectors can be clearly articulated and delineated.

The third Action Area is Increase Financial Resources. It is laudable that the need for additional resources is recognised, but the size of the commitment and the time frame for its achievement should be specified.

AA4 is to support and enhance community control. While the link is made correctly to KRA2, there is no link to KRA 4, Building Community Capacity.

AA5 seeks to enhance skills and linkages with mainstream PHC workforce is not clear. Congress supports the development of partnerships with the Divisions program, through formal representation of ACCHOs on State Based Organisations and Divisions, and of NACCHO on the Australian Division of General Practice. Another important link not recognised in the draft is with the Public Health Association. The Draft should be rewritten to acknowledge the value of and provide resources to assist alliance building and partnerships between the ACCHOs, their state based organisations and NACCHO on the one hand, and a range of professional bodies and providers on the other, with the details to be decided by the relevant ACCHOs, according to regional needs.

The last dot point as it currently stands qualifies the otherwise unambiguous support given up to this point to comprehensive Aboriginal community controlled primary health care services. To correct this, all words after implemented should be removed.

⁸ “Public health has traditionally been concerned with regulating the provision of safe and adequate housing, water, sewage, and waste disposal as a means of prevention and control of infectious diseases. ..The New Public Health now acknowledges the importance of other social, economic and political factors in disease prevention. This approach includes a focus on population health, behaviour modification in a social context, community participation in policy and planning and an emphasis on social justice and equity.” Aboriginal Medical Services Alliance Northern Territory (AMSANT). (2000). *Submission to the Review of the Public Health Act Discussion Paper*. Darwin: AMSANT.

The P.I.s listed under Assessing Progress will need to be rewritten in the light of the above. Note especially the way primary care is conflated with primary health care in these PIs.

Congress also submits that examples of its own practice, as one of the oldest ACCHOs in Australia, should have been included in the best practice models attached to this KRA. In particular, in para 306, there is no recognition of the vital role played by CAAC in establishing the Central Australian Division of Primary Health Care. Moreover, if the Centre for Remote Health is acknowledged for its role in curriculum development and professional development, so too should the Central Australian Remote Health Development Service (previously CARHTU) of which CAAC is the Chair, and which is the recognised in-service provider for PHC services in this region, especially but not only for AHWs.

c. Conclusions and recommendation.

In the time we have allowed, it has not yet been possible to provide written responses to the remaining KRAs, the sections on implementation, or the material provided in the appendices. However, we believe that the material above demonstrates that significant work is required to bring the draft to a satisfactory form, before being considered suitable to go forward as a new national policy.

The most important thing we have demonstrated, we believe, is that the expertise for Aboriginal health policy development lies primarily within the Aboriginal community-controlled sector. Therefore, unless our sector is brought into the process of drafting the final version, the results will be unsatisfactory. This is not simply about consultation, or seeking our comments on drafts written by others. The ACCHOS must be at the table to negotiate the detail of the Strategy.

We therefore recommend that a new working party be formed, to revise the current draft, and that the ACCHOs be funded to meet on a state/territory and national basis to formulate their input and appoint representatives to a drafting group to prepare the next version.