

Governments, Responsibilities & Aboriginal Health

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In this presentation:

- Consider key concepts
- Briefly survey relevant evidence
- Consider the implications for policy and strategy



Key Concepts

- ◆ **“Health”** is a value – not an absolute outcome, or an absolute state; it is a process
 - ◆ It often reflects our notions of an idealised state of being
 - ◆ Our measures presume particular approaches to valuing ‘health’
 - ◆ Different perspective, implicitly and explicitly value health differently (biomedical, policy, Indigenous, legal etc)



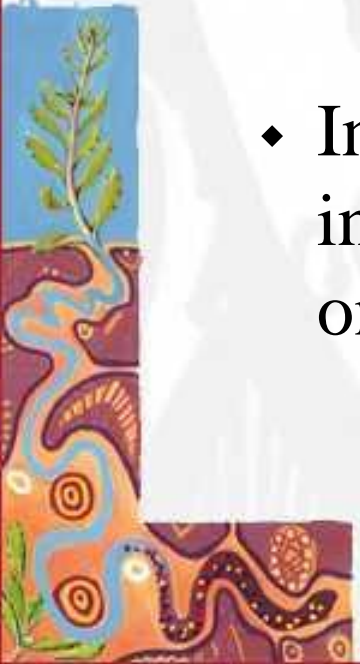
Key Concepts

- ◆ The position we take in arguing about the role of governments in health
 - ◆ Depends critically on the value we attach to health
 - ◆ & the our understanding, and values, about the role of the state in achieving health.



Key Concepts

- ◆ Governments have a role in
 - ◆ Minimising human suffering
 - ◆ In reducing the distribution of health inequalities, and the impact of such inequalities on disadvantaged populations.



Evidence

Comparative International Studies:

- ◆ Settler Colonial Countries: New Zealand, Canada, United States of America, Australia.
- ◆ Defined as (per Tessa Morris Suzuki):

A particular colonial formation with the key characteristics of the dispossession of Indigenous peoples and appropriation of their land, natural and/or cultural resources; as well as the ongoing management of the colonised people within the politico-legal structures of the settler colonial state.

Evidence

Comparative International Studies:

- ♦ Similar histories & contemporary social context they have different long term trends in health status.
- ♦ Over the 12 years 1985-1996, the all causes mortality rate for Indigenous Australian fell by 9% (cf 26% for All Australians) (cf. Maoris 45% over the period 1974-1994 &. Native Americans in US 25% from 1974-1992).
- ♦ For the period 1990-1994, the Australian Indigenous all cause rate was 1.9 times the Maori rate, 2.4 times the US Native American rate, and 3.2 times the all Australian rate.

Evidence

Comparative International Studies:

- ◆ Why significant differences in trend?:
 - ◆ Subtle differences in the historical and social pattern of colonialism
 - ◆ Political: treaties, voting rights, political participation
 - ◆ Economic: forms of economic incorporation
 - ◆ Colonial institutions: relative emphasis on education, health etc.

Evidence

Comparative International Studies:

- ◆ Kunitz proposes three key factors in the American system that have contributed to the effectiveness of the Indian Health Service.
 - ◆ Indian health has been federally administered;
 - ◆ Relative political stability of the Indian health service compared to other domains of Indian Affairs;
 - ◆ An integrated service providing primary, secondary and some tertiary care, environmental health programs, public health nursing, health education, and substance abuse and mental health services

Evidence

Medically Amenable Mortality and Morbidity

Population level health outcomes – when PHC services:

- ♦ integrate population health activities and clinical care (vaccine programs, chronic disease management programs);
- ♦ co-ordinate effectively across barriers between levels of care (antenatal programs);
- ♦ Intervene effectively in the activity of other ‘institutions’ to reduce exposure to risk (liquor licensing; ?food supply programs)

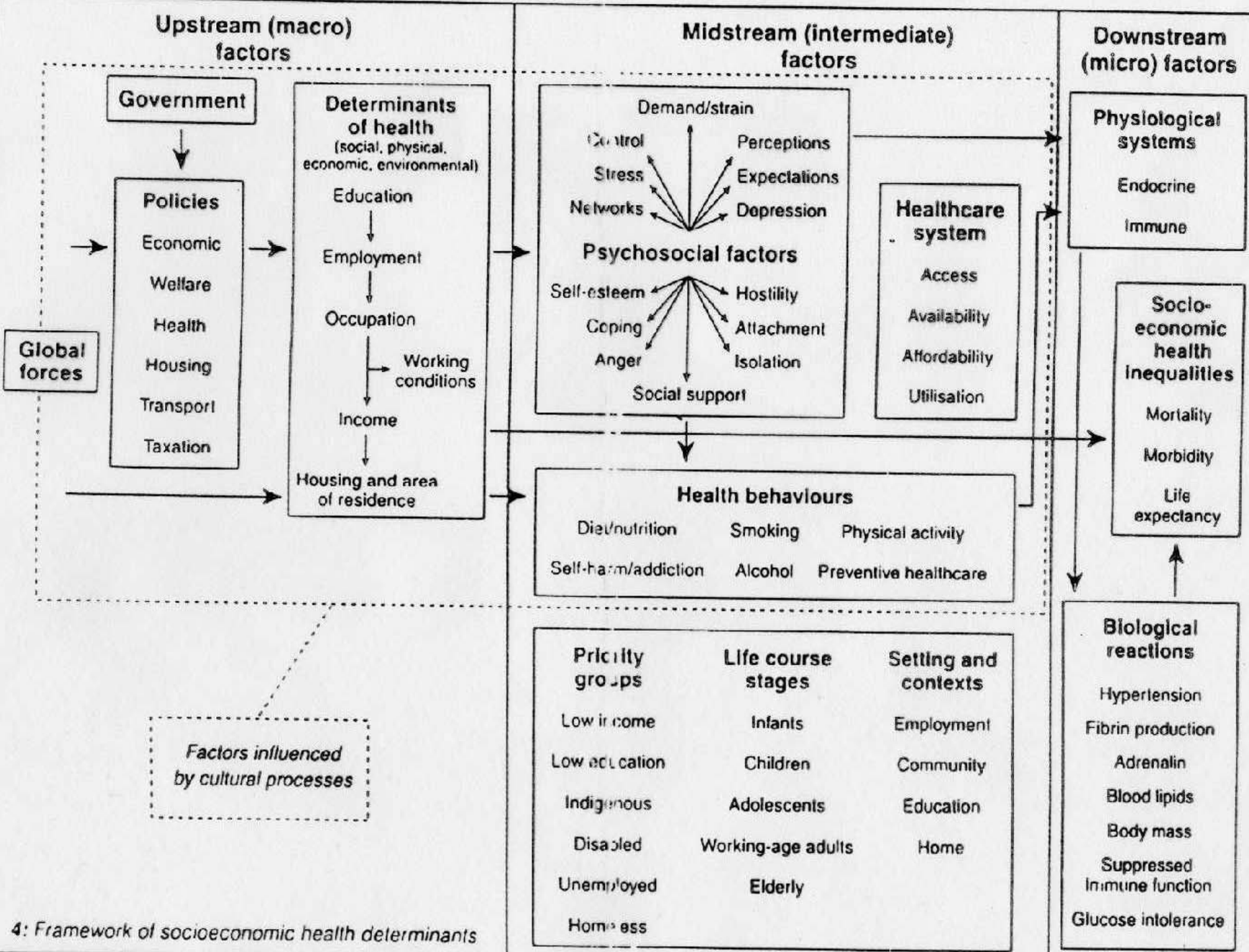
Evidence

Medically Amenable Mortality and Morbidity

- ◆ Service capacity is critical (especially PHC);
- ◆ Organisation (coordination), management and linkage of services critical
- ◆ Government capacity to influence the development of coordinated services and well linked services limited:
 - ◆ Funding relationship and effective policy tools
 - ◆ Federal structure of the Australian health system

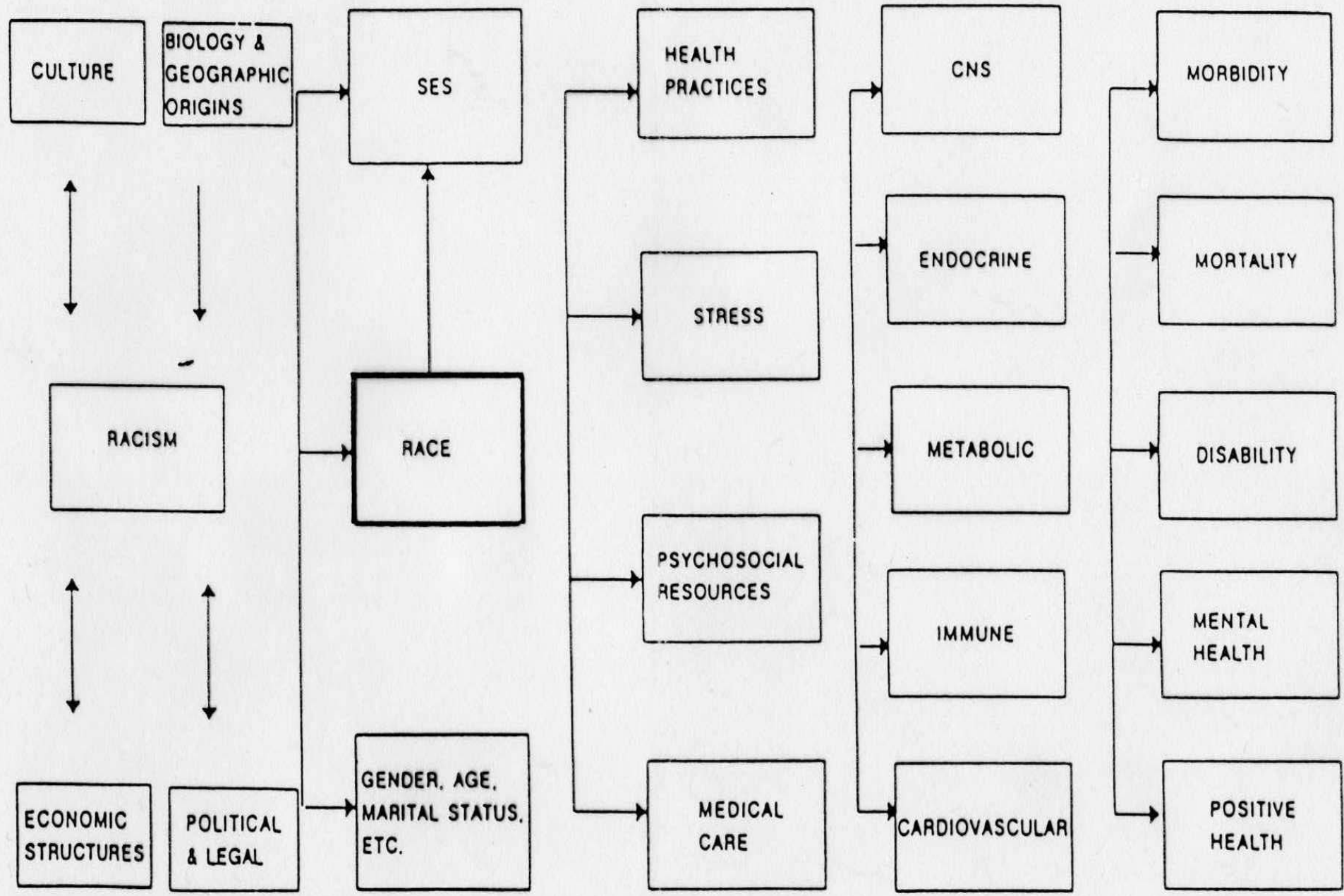
Evidence

- ◆ Many social determinants of health lie outside the direct strategy influence of health portfolio - education, housing, employment etc. Health sector has a role in organising and advocating for health effective policy
- ◆ Health sector plays a direct role in population health outcomes
- ◆ Evidence from social epidemiology – inequalities are socially produced



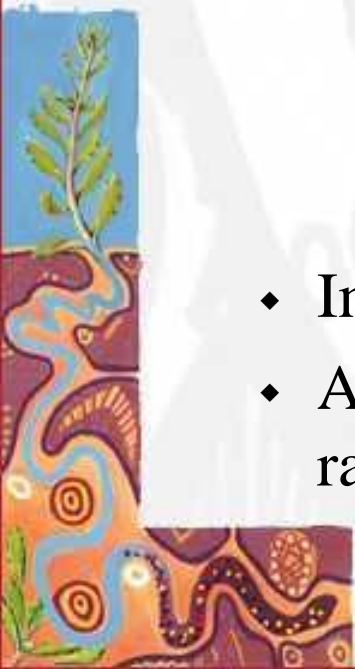
4: Framework of socioeconomic health determinants

BASIC CAUSES → SOCIAL STATUS → SURFACE CAUSES → BIOLOGICAL PROCESSES → HEALTH STATUS



Accountabilities

- ◆ If the role of government interventions is to reduce the burden of and maximise population health gain:
 - ◆ Develop the capacity of the health system to produce health gain
 - ◆ Through a federal structure
 - ◆ In collaboration and partnership with Indigenous communities
 - ◆ Implement effective inter-sectoral strategies
 - ◆ Actively promote and develop a socially inclusive, non-racist social climate



Accountabilities

- ◆ Health Service Capacity:
 - ◆ Financing reform, workforce development, aligning organisation and delivery of service delivery
 - ◆ Consider health expenditure:
 - ◆ 1998/99
 - ◆ 1.22:1 overall expenditure
 - ◆ MBS & PBS 0.37:1
 - ◆ 1.27:1 primary care expenditure
 - ◆ 2.07:1 acute care

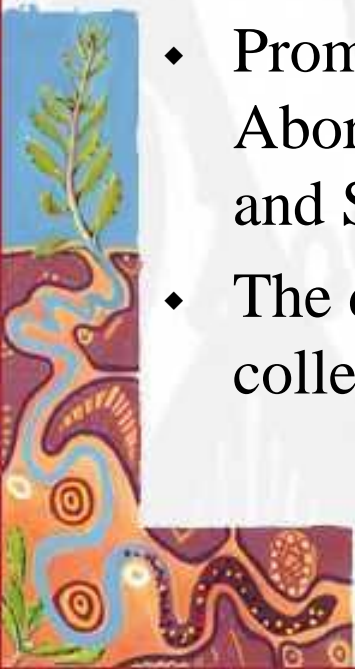
Accountabilities

- ◆ Through a federal structure: Framework Agreements (multi-sectoral, intergovernmental). From 1998-
 - ◆ Improving access to both mainstream and Aboriginal and Torres Strait Islander specific health and health related programs which reflect the level of need.
 - ◆ Increasing the level of resources allocated to reflect the higher level of need of Aboriginal and Torres Strait Islander peoples, including within mainstream services, and transparent and regular reporting for all services and programs.

Accountabilities

Framework Agreements cont'd

- ◆ Joint planning processes, which will inform the allocation of resources
- ◆ Promoting greater accountability in relation to outcomes in Aboriginal health and wellbeing across all Commonwealth and State Government funded organisations
- ◆ The development of a coordinated approach to the collection and use of data



Accountabilities

National Health Performance Management Framework

- ◆ Tier One: Health conditions; Human function; Life expectancy and wellbeing; Deaths
- ◆ Tier Two: Environmental factors; Socioeconomic factors; Community capacity; Health behaviours; Person-related factors
- ◆ Tier Three: Effective; Appropriate; Efficient; Responsive; Accessible; Safe; Continuous; Capable; Sustainable



Accountabilities

- ◆ Through institutional processes and service delivery that enhances Aboriginal participation and control
 - ◆ Aboriginal Community Controlled Health Services
 - ◆ Partnership processes in policy development; planning
- ◆ Inter-sectoral strategy
 - ◆ Effect of government interventions?
 - ◆ Impact of ATSIC abolition
 - ◆ ?

Health Policy and Rights

- ◆ The link depends on the broader politics
- ◆ Policy constructs such as “need” or “equity” are critically to forging links between policy discourse and health rights discourse
- ◆ Link between the values that underlie rights and the regulation of health system accreditation & performance
- ◆ Values are contested.
- ◆ Realisation of rights requires participatory processes

Government Responsibilities & Aboriginal Health

- ◆ Governments do have responsibilities in Aboriginal health
 - ◆ These are shared
 - ◆ These are contested
 - ◆ Should both focus on equity and need as financing principles; alleviation of suffering and reducing inequalities
 - ◆ Participatory process
 - ◆ Treaties:
 - ◆ Underscore participatory process
 - ◆ Direct impact on the social production of inequalities if they result in changed social and political position of Indigenous peoples