

Changing shape: workforce and the implementation of Aboriginal health policy

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Abstract

Thirty-five interviews were conducted in a case study on the implementation of the Northern Territory Preventable Chronic Disease Strategy (PCDS) to explore the role of the health workforce in the implementation of Aboriginal health policy. There was a tendency for the workforce to implement those aspects of the policy that drew on existing skills in treatment and management and to avoid or delay implementation that required the acquisition of new skills in primary prevention. Factors that facilitated the implementation of the PCDS included the addition of new resources, employment of additional staff, training, increased commitment from managers, and the creation of dedicated chronic disease positions. Factors impeding implementation included insufficient numbers of service providers, too little support for current Aboriginal Health Workers, and high staff turnover.

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“A STRANGE RHETORICAL paradox is enveloping the health of Aboriginal Australians”.¹ 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.^{2–4} There have

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What is known about the topic?

The development of Aboriginal-led, evidence-based policy is vital to the future of Aboriginal health. Although there is evidence identifying the steps in developing effective public policy, there is less evidence to guide implementation.

What does this paper add?

The aspects of a health policy that are most likely to be implemented by health organisations are those that coincide most closely with the strengths of the workforce.

What are the implications for practitioners?

The study confirms the need to restructure organisations to give Aboriginal Health Workers and other health professionals greater power in determining implementation priorities and for ongoing investment in the professional development necessary to enable policy implementation.

been over three decades of inquiries, policies, programs and reviews into the health of Aboriginal Australians.⁵ However, there have been only limited changes in 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 development of Aboriginal-led, evidence-based policy is vital to the future of Aboriginal health. Although there is a considerable body of evidence identifying the steps in developing effective public policy, there is less evidence to guide implementation. There is considerable experience in Australia that suggests implementation is a

* For the purposes of this paper the term Aboriginal is used respectfully to refer to Aboriginal and Torres Strait Islander peoples.

separate, urgent problem. The evaluation of the National Aboriginal Health Strategy found that it was never effectively implemented;⁶ the same finding has applied to other major policy interventions such as “Bringing them Home” or the Royal Commission into Black Deaths in Custody.

Research was conducted to explore the extent to which a specific Aboriginal health policy was implemented by the health sector in one Australian jurisdiction with a view to identifying ways to enhance the capacity of the sector to implement Aboriginal health policy more effectively. This paper explores the role of the health workforce in the implementation of Aboriginal health policy.

Background

In the Australian health system Aboriginal people access care through mainstream publicly funded health services, Aboriginal community-controlled health services, and through private health care providers such as general practitioners. Health services are responsible for health care, for protecting and promoting health, and preventing illness, injury and disability. In theory, mainstream publicly funded health services are expected to be responsive to the needs of Aboriginal Australians.⁷ In practice, despite principles of universal access, many structural, cultural and communication barriers exclude Aboriginal people from accessing many mainstream services in Australia.^{8,9} Aboriginal community-controlled health services were established to address some of the barriers to effective service provision, and, while not available to all communities or people, constitute a significant component of the health care system for Aboriginal Australians.

The Aboriginal health workforce

In the Northern Territory, 29% of the population is Aboriginal. In spite of this, the health workforce continues to be 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.^{10,11} As well,

there is a growing number of Aboriginal policy officers, and service managers and directors. 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.

The health workforce in this paper refers to all health professionals and does not distinguish them by culture, language, or by their employing organisations (which include Aboriginal community-controlled organisations, hospitals, general practices, and community health services). The workforce may be based in urban, rural or remote communities, or provide outreach services. All members of the health workforce have significant levels of responsibility for the delivery of programs and services to Aboriginal clients and patients. Aboriginal Health Workers have a critical role in the delivery of community-based health care and preventive programs¹² and, by extension, in the implementation of health policy.

The roles of Aboriginal Health Workers

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.¹³ In Central Australia in the mid-1990s, eight roles of Aboriginal Health Workers 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.¹⁴

In 2003 the National Aboriginal Community Controlled Health Organisation (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 by

self and others, managing presenting 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.¹¹ These two definitions reflected the 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.

Methods

The study was approved by the Top End and Central Australian Human Research Ethics Committees.

The case study

The implementation of the Northern Territory Preventable Chronic Disease Strategy (PCDS) was selected as a case study to explore the pathways, facilitators of and barriers to policy implementation in a complex health system, with particular attention to the Aboriginal population of the Northern Territory. The PCDS was chosen as a case study because it had been implemented for 5 years; it was developed using the World Health Organization's recommendations on an integrated health sector approach to the prevention and treatment of non-communicable diseases; it followed the capacity building processes in the Northern Territory Public Health Strategy in a culturally appropriate way; and it was developed for the entire population of the Northern Territory, while recognising the specific needs of Aboriginal people.

The PCDS focused on five chronic diseases: diabetes; ischemic heart disease; hypertension; renal disease; and chronic airway disease. The incidence and prevalence of these chronic dis-

eases among the Aboriginal population are significantly higher than in the non-Aboriginal population. These diseases share underlying behavioural risk factors, such as: smoking, being overweight, low sense of personal control, and low birth weight. These risks are much greater among the Aboriginal population. The PCDS comprised three approaches: primary prevention, early detection and better management of chronic disease. The primary prevention approach focused on addressing underlying determinants of health, as well as lifestyle modification. More than half the people who have diabetes are not aware of their condition and early detection allows for earlier intervention which is likely to delay the onset and reduce complications. Better management relies on a system to provide ongoing rather than acute and episodic care. PCDS has been described in greater detail in a separate paper.¹⁵

The policy was developed in 1997 to reduce the incidence and prevalence of chronic diseases across the Northern Territory, and endorsed as core business of the Northern Territory Department of Health and Community Services in 1999. Implementation was limited until special funding was made available through the Pharmaceutical Benefits Scheme (PBS) Section 100 program in 2001. Changes to Section 100 allowed the Commonwealth to fund PBS medications even when there was no private pharmacy. Previously, the Northern Territory Government paid for medications for remote Aboriginal communities, and this change required that funds previously spent on medications for remote Aboriginal communities had to remain in the communities but could be spent in other areas of health care. This meant that in its implementation phase the PCDS became essentially an Aboriginal health policy.

Participant selection

Purposive sampling was used to select participants from a list of people and organisations involved in the development and implementation of the PCDS in the Northern Territory. The selection aimed to obtain a range of perspectives from the workforce across all levels of the health

system in the Northern Territory, such as central policy (ie, Northern Territory Department of Health and Community Services), health service delivery organisations and different professional groups.

Data collection

All potential participants were telephoned by the primary researcher and sent a letter inviting them to participate in the research. Only one organisation declined to participate given other research commitments. Written consent was obtained from all participants before interview. The interviews occurred at the participant's places 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 35 participants. An interview prompt was used. Participants were asked to describe how they were involved in the PCDS; factors that supported the implementation; barriers to implementation; how to recognise success; and how to recognise success for Aboriginal people. The interviews were between 30 and 90 minutes. 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 majority of interviewees had a professional background in either medicine or nursing ($n = 23$). Five of the interviewees were trained as Aboriginal Health Workers, three in allied health, three in fields outside health, one as a project officer, and one interviewee had trained as both a nurse and a teacher.

Analysis

Interview transcripts and notes were entered into NVivo qualitative software (Qualitative Solutions and Research International, Melbourne, Vic.) and analysed using thematic analysis through sequential analysis. To strengthen the validity, we compared the interview themes to the original PCDS

framework and to the Aboriginal health workforce literature. Two keywords were used in the literature review: "Aboriginal health" and "workforce". Expanded Academic Press, ATSI Health, and CINAHL were searched for articles from 1996 to 2006.

Findings

The implementation of the PCDS varied depending on the professional training, the roles and the self-defined strengths and weaknesses of the workforce, and the extent of the organisational support received for implementation. All respondents had played some role in implementation, although the focus and intensity of the work varied significantly.

Implementation and policy change

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. Implementation of the policy was influenced by the financial resources that became available for implementation, and by the capacity of the workforce and their employing organisations. 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 majority of implementation initiatives focused on refining the systems and methods of early detection and better management. Primary prevention was also a major arm of the policy but was given limited emphasis. Decisions about which aspect of policy were implemented were not determined by population needs; rather, the workforce implemented those aspects of the policy that most closely matched their existing knowledge and skills.

The composition of the workforce also influenced the professional development to support implementation, with more professional develop-

ment opportunities for the medical and nursing workforces, and limited professional development for the Aboriginal Health Workers who were both keen to undertake primary preventive initiatives and best placed to do so in community settings. This suggested that while the policy implementation built capacity, it implicitly and unconsciously favoured the development of specific professions.

Barriers to implementation

Interviewees identified four major reasons why it had proven difficult to implement all aspects of the PCDS. There were too few health professionals employed to meet the demands of providing acute and chronic care, and too few Aboriginal health professionals, in particular. In addition, the Aboriginal Health Workers were “undersupported” in their roles, with high levels of self-perpetuating staff turnover throughout the health care system.

Aboriginal Health Workers were excluded from the policy development and implementation processes. One participant explained that consultation was 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 received less professional and practical support. In the following quote an Aboriginal Health Worker described 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 interprofessional 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, reinforced by the PCDS implementation where nurses received a greater proportion of the PCDS-specific training than 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. The following quote provides an example of the extent of staff turnover in some 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*

High staff turnover does not enable health professionals to build the trusting relationships they need to have with policy officers and erodes communities' trust of health professionals and of the health services generally. High staff turnover was seen as a barrier to building a strategic focus within health services and to sustaining chronic disease programs, and acted as a barrier to employing people with experience.

In the following quote a rich 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*

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. The cultural and local knowledge, skills, experience, and community connectedness, combined with clinical and population health knowledge and skills were viewed as essential to the effective implementation of the PCDS and, over time, to the achievement of positive health outcomes.

What facilitated implementation?

Some individual health services secured additional funding through the PCDS and used it to employ new staff in dedicated chronic disease positions, and to provide professional development for staff in the management of chronic disease in Aboriginal communities. The commitment of and support from health service managers was identified as facilitating implementation. Nearly all interviewees commented on the value of additional staff.

The PCDS also brought additional training in chronic disease diagnosis and management. Some participants perceived the training as an important facilitator because they (or their staff) needed new skills to manage chronic disease. 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. 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 was 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 positions were needed to develop and maintain effective chronic disease programs. These roles included 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 spent 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, they were often required to work in acute care and were not given sufficient, quarantined time for chronic disease management work. One of the doctors described a norm in health services where all staff were 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 is that the new roles 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, [that they] 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 size of the health service and the health service managers' commitment to chronic disease appeared to influence the amount of time that staff in dedicated chronic disease positions could dedicate to their roles. The larger the health service the greater capacity for specialisation. The more committed a manager, the more likely a health service will allow chronic disease staff to be "taken off line" to carry out their chronic disease management roles.

Policy goals and the workforce

Interviewees reported that although the PCDS included a strong, evidence-based primary prevention component, the health workforce responsible for the implementation was overwhelmingly clinically trained. Furthermore, the workforce had been employed in clinical roles, and had not been provided with the necessary training 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 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 expressed frustration. They felt they were tied to 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*

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 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 that the focus of the early policy implementation initiatives was on improving chronic disease management. In turn, new staff positions and professional development associated with the PCDS implementation were more likely to be in clinical areas than in population health.

Although the policy was intended to change and expand the current practice of existing health services, it did not include funding to enable the existing system to change structures, processes or services. In this case, the intention was to shift the focus of essentially clinical health services toward a population health approach — 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 enable early diagnosis and intervention. This would 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 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 human resources all meant that the system was under strain.

The workforce required to effectively implement policy

A skilled workforce whose roles are congruent with achieving policy goals is critical to effective implementation of Aboriginal health policy. As well, evidence to improve population health does not speak for itself. A policy idea cannot be implemented if the policy does not include strengthening the 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, 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 that required significant changes in roles and practice.

We also found a need for greater representation of Aboriginal health professionals in the workforce, to better support Aboriginal Health Workers and to decrease the high levels of staff turnover that erode trust and undermine the sustainability of interventions. There was a perception 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.

Enabling Aboriginal Health Workers would allow the primary prevention arm of the PCDS to be implemented. Aboriginal Health Workers were keen to work in the community, rather than in the clinic, and to focus on the broader determinants of health, such as affordably healthy food supply in remote communities and overcrowding in houses.

Aboriginal people in the health workforce

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 — because it reflects the limited educational and career opportunities 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 establish healthy communities.

Although it is widely acknowledged that Aboriginal Health Workers play a significant clinical and cultural role in the delivery of 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 of increases in the power of Aboriginal Health Workers and little evidence of greater respect being accorded them by other health professionals.

The implementation stage of the PCDS included no guidance for health services to review the roles of staff, including the Aboriginal Health Workers, to implement changes in job descriptions and priorities. Nor was there any specific professional development offered to Ab-

original 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.^{16,17} These approaches are based on the principle that if Aboriginal health is included in the undergraduate medical curriculum then there is a greater likelihood of developing Aboriginal-friendly or culturally safe mainstream services.

Despite considerable attempts to support the development of the Aboriginal health workforce at federal, state and territory levels,^{7,13,18,19} Aboriginal people continue to be under-represented in the health workforce,¹⁰ and particularly in higher level positions.^{6,7} 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.²⁰ 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 and education sectors.

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

The PCDS was a major initiative of the Northern Territory Department of Health and Community Services — an effort to use evidence-based

policy to guide the health services and programs, and to achieve, in particular, improved Aboriginal 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 and staff skills, 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. 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 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.

Strengths and weaknesses of this research

There were a number of strengths and weaknesses of this research. The main purpose of the research was to examine the implementation of a health policy by a “mainstream” health system with the goal of developing an evidence-based approach to reducing the incidence and prevalence of chronic disease in 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 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 5 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 the PCDS was obtained.

The main weakness was that Aboriginal communities and community members were not interviewed as part of this research. 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 but less reliable insights across central offices, health services, and community groups in rural and remote areas.

Despite a history of Aboriginal health research, little research has focused on understanding the health care system's 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 have an important contribution to make, there was a need to limit the scope if the research was to be conducted comprehensively.

Conclusion

The health of Aboriginal and Torres Strait Islander peoples can improve only when culturally-determined health policy is implemented over a sustained period by responsive, community-led health services delivering evidence-based clinical care and population health programs. However, 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. Those components of the policy that were implemented were 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 the 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. The 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.

Showcasing an example of an effective and comprehensive implementation of Aboriginal health policy will be an important milestone in the history of Aboriginal affairs. This is what is required to overcome the “strange rhetorical paradox ... enveloping the health of Aboriginal Australians”¹ and to make giant strides towards improving Aboriginal health.

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Competing interests

The authors declare that they have no competing interests.

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