Strengthening the link between policy formulation and implementation of Indigenous health policy directions

Anna Matthews, Lisa R Jackson Pulver and Ian T Ring

Abstract

This study aimed to understand the problems within the Indigenous health policy process in Australia and how weaknesses in the process impact on policy implementation. Using semi-structured questions, 23 key stakeholders in the policy-making process were interviewed. Three main themes dominated; a need for increased Indigenous involvement in policy formulation at the senior Australian Government level, increased participation of Indigenous community-controlled health organisations in the policy-making process and, most importantly, ensuring that policies have the necessary resources for their implementation. The emergence of these specific themes demonstrated weaknesses in policy process from the formulation stage onward. Tackling these would, according to our informants, significantly enhance the effectiveness of the policy process and contribute to further improvement of the health of Indigenous Australians.

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What is known about the topic?

Research has repeatedly highlighted the poor health of Indigenous Australians compared with their non-Indigenous counterparts. Despite an abundance of health policies to tackle this inequality, there has been relatively little improvement. Little has been written about the policy process for Aboriginal health, and even less about the implementation of health policies.

What does this paper add?

This research describes the process for development of policies and the relationship between policy development and policy implementation, with a specific focus on chronic disease policy as this is the largest cause of excess deaths in Indigenous Australians.

What are the implications for practitioners?

There is an immense feeling of frustration among practitioners because they experience the effects of the current inadequacies in policy formulation and implementation. Specific guidance is offered to practitioners through quotes from Indigenous Australians who speak of their experiences in mainstream health services. These informants, through sharing their experience, suggest that practitioners and health service staff could examine their attitudes towards Indigenous Australians and understand better the shared history of the continent we all now share.

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EVIDENCE SHOWS THAT Indigenous Australians experience a significantly higher morbidity and mortality across the disease spectrum compared with non-Indigenous Australians.[1] In the period 1996–2001 Indigenous life expectancy was 59 years for males and 65 for females; 18 and 17 years below the country's average life expectancy of 77 years for males and 82 years for females.[2] These figures vary from area to area, however, and in one shire in New South Wales the average age of death recorded for Aboriginal males is 33 years.[2]

The poor health of Indigenous Australians is largely the result of adult mortality, with Indigenous Australians from 30 years onwards having death rates five times higher than their non-Indigenous counterparts.[3] Four main conditions

account for almost 70% of these excess deaths; these are circulatory disease, injury, respiratory illness and diabetes.[3] As a population, Indigenous people have higher rates of chronic disease than the non-Indigenous population, with an earlier age of onset.[4]

The disease burden of Indigenous peoples is a global concern[5] and many developed countries, such as America and New Zealand have made significant gains in Indigenous health over recent years.[6] However, in stark contrast to this, there has been relatively little progress in improving the health of Indigenous Australians, although the most recent official statistics suggest some recent improvement.[1,7]

The disease pattern and history of Indigenous Australians is not unique except that, unlike the experience of Maori in New Zealand or the Indigenous populations in both the United States and Canada, there has never been a formal treaty between Indigenous Australians and the colonisers of Australia.[8] It has been argued that the absence of a treaty with Indigenous Australians is causally associated with their poor health and social disadvantage.[8] This argument is supported by the fact that treaties, no matter how loosely worded or abused have appeared to play a significant and useful role in the development of health services, and in social and economic issues, for the Indigenous peoples of New Zealand, the US and Canada.[9]

Australia, however, has proved itself capable of doing well with health service and delivery for the non-Indigenous population, spending 9.5% of its gross national product on health,[10] and has an excellent record in confronting complex issues such as AIDS and cancers in women.[1] Therefore, why is such a competent country failing when it comes to the health of its first peoples?

Background

Since the 1967 referendum* that enabled the Commonwealth Government to act in Indigenous affairs, there has been 30 years of National policy making concerning the health of Indigenous Australians.[11] Yet, despite this, an Aboriginal or Torres Strait Islander child born in Australia today can expect to live up to 20 years less than non-Indigenous Australians.[11]
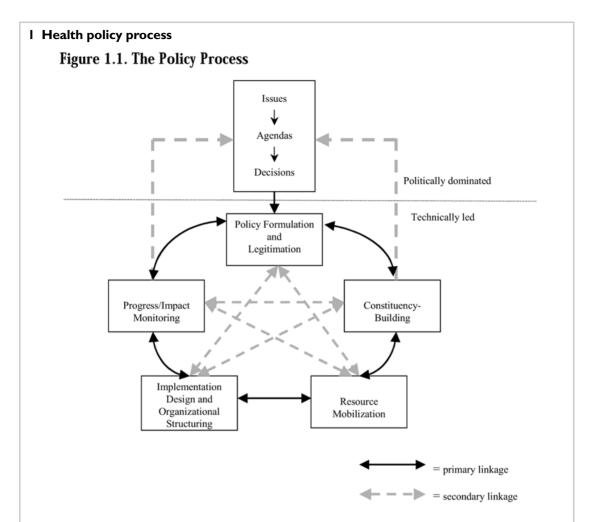
A timeline detailing national Indigenous health policy production since 1967 has been produced by the Australian Indigenous HealthInfoNet.[12] This timeline is indicative of the abundance of national policies being developed to improve Indigenous health, and if policy production was an indicator of good health, Aboriginal and Torres Strait Islander people would be among the healthiest in the world.[3]

Box 1 illustrates the theoretical health policy-making process.[13] Resource mobilisation and implementation of the policy accounts for a large proportion of this process, and if formulation and implementation become divorced in this process it can be argued that policies become merely symbolic.

Hence, as implementation is an integral part of the policy-making process, problems or failure in implementation can be argued to be as much a consequence of flaws in the policy-formulation process, including inadequate problem definition or policy design, as they are due to specific administration problems.[14] This argument is relevant to policy making in Australia today, as from a detailed literature review and examination of the abundance of Australian health policy production in the last 30 years it is apparent that producing policies does not appear to be problematic, however, the rolling out and implementing of policies does. Hence, this research focuses on the problem of policy implementation.

The policy making process also consists of theoretical conceptual steps, which dissect and examine more practically the process illustrated in the Box. For example, how are issues identified, what evidence is used and what values are incorporated when deciding which policies to formulate? With regard to the constituency building step of the policy process; which groups

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* The result of the 1967 referendum made two changes to the Australian Constitution. The first was to allow the Commonwealth to make laws for all Australians through amending s51 of the constitution where people of the 'Aboriginal race in any state' were excluded; and secondly to include Aboriginal people in the population of Australia for the purposes of Commonwealth funding grants to states and territories by repealing s127 of the constitution.

I Health policy process

Figure 1.1. The Policy Process

From: Scribner S, Brinkerhoff D. Introduction to the Toolkit and the Policy Process. In: Policy Toolkit for Strengthening Health Sector Reform.[13] Used by permission.

are policies disseminated to and how does this occur? How is ownership of a policy generated amongst a constituency? How are resources mobilized, finances sought and plans rolled out within the implementation stage? Finally, how are policies monitored and evaluated? Who is responsible for this and what evaluation tools do they utilise?[15] Therefore, this research is focused around the health policy process and the conceptual steps within it in order to answer the question which can be divided into three components, the first of which allowed us to explore

with government and organisational informants how policy directions are formulated with regard to chronic disease: what are the up and coming priorities, who is involved in this process, and what factors influence prioritisation of policy directions? Once the first component was answered, we were then able to focus on the second and third components of the question: the implementation of policies, including any potential barriers to implementation; and how the link between policy formulation and implementation could be improved.

It can be argued that the gap in life expectancy between Indigenous and non-Indigenous Australians cannot be closed without a reduction in the high burden of chronic disease, which, as the major cause of death and excess death in Indigenous Australians, was the focus of this research.

Methods

Twenty-three stakeholders were interviewed, to gain a variety of perspectives from seven interview groups:

- Commonwealth government: five interviewees from the Minister of Health's office and the Office of Aboriginal and Torres Strait Islander Health. One interviewee within this group was an Indigenous Australian.
- State/territory government: four interviewees from Queensland Health, New South Wales Department of Health and Cape York Health Council. Three interviewees from this group were Indigenous Australians.
- Indigenous peak bodies (IPBs): three interviewees from the Australian Indigenous Doctors' Association (AIDA) and the National Aboriginal Community Controlled Health Organisation. All interviewees in this group were Indigenous Australians.
- Non-government organisations: two interviewees from the Australian Medical Association (AMA) and the Australian Bureau of Statistics. Neither of these interviewees were Indigenous Australians.
- Researchers: three researchers from the National Centre for Epidemiology and Population Health and the Koori Health Research Centre, University of Melbourne.
- Public Health: two interviewees from Queensland Public Health, both of whom were non-Indigenous Australians.
- Community Controlled Health Organisations (CCHO's): three managers from a Canberra Aboriginal Medical Service (AMS) and a Cairns AMS; one clinician from a Canberra AMS. All interviewees bar one from this group were Indigenous Australians.

The interviews were semi-structured around four principal questions:

- What is your role within Indigenous health?
- What are the top three policy directions, with regard to Indigenous chronic disease, for your organisation in the next 10 years?
- What are your views on the debate around implementation of policies?
- What do you feel can be done to improve the link between policy formulation and implementation?

Asking participants their role gave context to the interview. Identifying the top three policy directions for the next 10 years focused the interview around the question of how directions were formulated and what influences led to this policy direction. As much debate in Australia is currently focusing around the implementation of policies, interviewees' views around this were explored, in addition to other issues which they may have felt impeded the policy-making process. The interview then focused on the future by discovering what participants felt could be done to improve the link between formulation and implementation. This challenged the interviewee to not only identify barriers but also to think about how, realistically, the barriers could be tackled and removed.

These questions covered most aspects of the policy-making process; identification of needed policy direction, policy formulation, implementation and evaluation of how the policy process could be improved. The interviews were manually transcribed and thematic analysis conducted with an inductive approach used to tabulate responses to the principal questions.

These tables were examined to identify patterns in the responses between different interview groups. The tables were also used to quantify the dominant themes. They also helped to identify similarities and differences in responses between the different interview groups, which could be related to the different demographics within each group.

Ethics

This research project received ethical approval from Leeds University. There was no contact with patients or community leaders; every interviewee

was a professional working in the field of Indigenous health and policy making. Each interview gave recorded consent and every attempt has been made to maintain confidentiality of the individual interviewees.

Findings

The main themes are presented in this section and the different views of the interviewees compared. The quotes provided are from the interviews and are verbatim.

What are the top three policy directions with regard to chronic disease, for your organisation in the next ten years?

Comprehensive primary health care

At the Commonwealth level there was a focus on increasing access to comprehensive primary care by harnessing mainstream services, as one non-Commonwealth interviewee observed:

> There is a very complicated moment in Indigenous health going on and that is that there is a pressure at a Commonwealth level to return to a kind of mainstream approach to health ... the argument is that we've thrown loads of money at Aboriginal health and it hasn't made a difference, we've funded Aboriginal Community Controlled Services and it hasn't made a difference — we may as well put the money back into the mainstream services.

This demonstrates a belief of many interviewees that the lack of resources and support given by the Commonwealth Government to AMS's illustrates a lack of enthusiasm and belief in their effectiveness. However, a Commonwealth interviewee noted that many Indigenous people are unwilling to access mainstream services and the role of AMS's was recognised:

> They just don't feel culturally safe going into mainstream services. And once again white people don't understand because they just do it routinely and assume that everyone else does too ... there's not much

sympathy for it but it's a very real thing and that's why we've ended up with a range of Aboriginal Medical services in urban areas as well.

Interviewees from IPBs and the service delivery level were strongly in favour of focusing and building upon AMS's as a policy direction and feel they increase access to health care for Indigenous Australians and create a feeling of community control which cannot be found in mainstream health services:

> Community control by definition belongs to the community, so by form and structure people don't have to make that sort of psychological censorship to go from being Indigenous people into becoming the appropriate patient in a mainstream service, whereas in community controlled services they can just be themselves.

Hence from the findings regarding comprehensive health care it is evident that there is a divide in opinions between the Commonwealth government, IPBs and the service delivery level with regard to the environment in which Indigenous health policies should be implemented.

Social determinants of health

Improving the social determinants of health was cited as a priority by interviewees from all levels apart from the Commonwealth, which is interesting, as social determinants have been shown to be an integral part of comprehensive health care.[16] One interviewee touched on this:

> ... there is a reluctance to really grapple with social determinant issues, because they are extremely costly to deal with. So there is a temptation on the part of policy people to medicalise social problems. Why? Because you can then say that you have taken care of it and if it fails you can say we gave it a shot but it hasn't helped.

Some interviewees felt that for Indigenous health to improve, social determinants must be tackled before increasing clinical services, whereas others felt that increasing clinical serv-

ices should be the priority. The 2005 Social Justice report[17] demonstrated a significant gap in social determinants such as education, housing etc. between the Indigenous and non-Indigenous Australian populations and therefore they cannot be discounted as having an impact on Indigenous Australians' health. Hence, most interviewees felt a balanced approach was needed:

> . . . when you look at Indigenous health there's a holistic approach which means that to deal with health you deal with the social environment as well . . . we could have the best health system in the world, we can fix them up, deal with their diabetes but if they go back into the same environment then their problems will re-occur.

Community control

Community control as a policy direction was only cited by Indigenous interviewees and encompasses the idea that Indigenous communities should have control and input with regard to policy formulation and the services that they are offered. This would allow policies to be contextual and tailored to communities' needs.

> . . . you've got to do it in the context of Indigenous society — so you can start where their mindset is; what's important to them and what they want to do.

Indigenous interviewees also emphasised that policies have to be considered in the context of not only Indigenous communities but also in the context of Australian society. Therefore, not having differing standards for different groups within society with regard to health risk behaviour:

> I don't think we should be blaming social determinants or people for smoking and drinking, after all coronary care units are full of fat, middle-class white people who are considering having their second coronary bypass and we don't think about closing down coronary care units. So the same should apply for Indigenous commu-

nities and I think that's an important context to think of these things in.

What are your views on the debate around the implementation of policies?

Resources

An increase in funding for Indigenous health was not indicated by any interviewees as a future policy direction. However, over half of the interviewees cited a lack of resources as a barrier to effective policy implementation. This was not, however, widely cited at a Commonwealth or state/territory government level.

The responses which were given by interviewees at government level regarding resources —

> . . . in health and in chronic disease in particular the implementation has probably been pretty effective in that money has flowed in to the system, we have quite a good system in place for giving that money out to the community sector.

> The amount of money spent on Indigenous health is quite high . . . so much has been spent for so little gain.

were in contrast to those given by interviewees at other levels.

> Numerous reports are proving what the under-spend is in Aboriginal health and it just seems indefensible for these areas to not be better funded.

> I think the Australian policy environment or arena has been characterised by policy that was developed without any funding, without any commitment really to funding . . .

It is perhaps not surprising that there is a difference in opinions between these two groups, as one provides the resources and one receives them. However, the AMA[18] suggests that the gap in spending in relation to need is still high, and perhaps this is why gains appear small.

Top-down policy making

> The reason for not seeing the outcomes of the policies at a service delivery level is because a

lot of the policy making in Australia is actually done in a top-down approach.

This comment from one interviewee is a reflection of an opinion shared by many interviewees, particularly those not in government. There is strong feeling that Indigenous policy formulation occurs without an understanding of the context within which Indigenous health services are delivered. This relates to the previous findings regarding community control in the policy making environment, as, if this was more apparent, then policy formulation would have an increased bottom-up approach.

> Indigenous policy is developed by people in Canberra who live in the glass towers, who don't know anything that's going on on the ground but make these policies based on their biases that affect their understanding ... when it gets to be implemented on the ground it doesn't work because it doesn't take into account the uniqueness of the communities or the geographical locations.

An interviewee from the government also acknowledged lack of understanding as a problem in the implementation of policies but did not link this to a lack of Indigenous representation at a policy formulation level:

> There are massive communication difficulties and once again these things are not apparent but clearly, there is no real interchange and there is no real understanding.

Top-down policy making is closely related to a lack of Indigenous representation in the formulation of policies.

> I think there are flaws in the policies from the start because if I'm in a community and say "What are your priorities?" they wouldn't be the same as those of people sitting in Canberra. It's just that there's that gap between how good policies are grounded and should be developed by priorities that are generated by the community.

> When you look at Indigenous health it's usually white, middle-class females that make these policies up. There are no Aborig-

inal people with experience in working in a community that are a part of developing those policies.

Structure of government

Within Indigenous health care there are different arrangements surrounding the administration of programs compared with mainstream health services, as illustrated by the following interviewee:

> ... the Commonwealth is primarily a financer of the health system — it doesn't run programs or administer programs and that's the constitution. With the exception of Aboriginal health — they run Aboriginal health services. But the states are primarily for the provision and the delivery of health systems.

Due to this arrangement there is a lack of responsibility taken by either Commonwealth or state/territory governments regarding Indigenous health, leading to constant buck passing between the two.

> ... it's grey enough for the football, the black political football and ultimately our kid's lives and access to health care, to get kicked around between the Commonwealth and states.

> So it gets passed around and around so no one has to deal with it or sometimes they put it in the too hard basket so we'll all just skim over it.

This arrangement also leads to national policy making which often does not translate to the individual states. Health policy for non-Indigenous Australians is governed by the state and territory government which can tailor to their individual populations and also therefore take responsibility for formulation.

What do you feel can be done to improve the link between policy formulation and policy implementation?

Consultation

As a means of improving the link between Indigenous policy formulation and implementation,

increased consultation with Indigenous communities and services was mentioned by interviewees from all levels of the policy process.

> Creating and nurturing links between Indigenous communities and policy makers — that's the vital link.

> ...we need better ways of engaging with Indigenous people as opposed to organisations. Our links to communities are not as good as they could be ... stronger advocacy and representative structures for our service provision centre would help with implementation.

An Indigenous interviewee felt that to improve communication between the Commonwealth and Indigenous communities, a representative structure is needed, not just consultation:

> ... you need a national presence; in terms of governance you need a national presence for Indigenous people, especially in Parliament when decisions are made.

However, a view was expressed that it is not a priority for the Australian Government to have a representative structure for Indigenous Australians, as the previous Indigenous elected representative structure, the Aboriginal and Torres Strait Islander Commission (ATSIC), was abolished in 2004, despite recommendations to reform rather than abolish ATSIC by the United Nations Commission on Human Rights.[19]

Political will and commitment
Interviewees from IPBs felt that to improve the link between policy formulation and implementation there needs to be increased political will, motivation and commitment.

> ... they [governments] need commitment, to take off their paternalistic hat and listen to what is coming back up from communities and services.

> We need the right bureaucrats who are motivated and can work out ways of pushing things through the system to get things done. So I think we need more of those

people rather than people who cover themselves by writing bland policies.

It was, however, recognised that this can be very difficult and that bureaucracy can often be a hindrance:

> ... even when people set out with good intentions it gets diverted with processes and interpretation ... the system dilutes good intentions and by the time it gets back to the community, nothing's happened.

Resources
Interviewees from Indigenous peak bodies feel that to have effective implementation of policies it is necessary to have the appropriate resources to do so.

> In policy formulation dollars need to be put behind the implementation plan. If there isn't then it's not going to get implemented.

> ... there needs to be an injection of funds and people say the whole thing is not about money but money would sure help, so we would be calling for an extra $500 million per year just to bring it up to par to the health of the average Australian.

However, a government interviewee felt that a sudden injection of funds would be unwise and that the capacity of services needs to be built up first:

> The major issue at the moment is not that there's not sufficient funds being spent on Indigenous issues, it's building up the capacity so that money being spent is well spent, that it has an effect, it's evaluated and you could do quality improvement on it.

The following comment from an interviewee summarises the main feelings among IPBs and CCHOs about how the policy process would ideally marry the formulation and implementation process.

> The policies don't always make sense but you've got to live with that and try and work with it. So in an ideal world we'd have evidence base behind the proposal that you

put up to government, government would take this as a policy priority and put the money in at the front end and we reckon you know $400 million is going to make an impact on this issue, we're going to roll it out — not just for a 4-year budget cycle — but we're going to make a long-term commitment and we'll see it through longitudinally for three generations and we will have an ongoing evaluation and we will evaluate every 5 years in a systematic way. And that would be great policy and policy implementation, and we'll do it with the affected community, you know, there will be a consumer focus; we'll set up a system that's a strong voice from the service user and that's considered good process. But that's just non-existent, it's non-existent.

Discussion

One theme from the interviews that ran throughout was the disconnection between responses given by the Commonwealth Government compared with those given by the IPBs and CCHOs. This divide could be due to the disconnection between policy makers and the service delivery level or it may be due to the fact that everyone interviewed at the national government level bar one was a non-Indigenous Australian, while every interviewee bar one from IPBs and CCHOs was an Indigenous Australian. Hence, the disconnection appears to be due to the notable lack of Indigenous representation at the Commonwealth level.

Many interviewees feel this lack of representation hinders the policy-making process, with regard to policies being formulated in the context of community priorities and the environment in which policies will be implemented. An increased representation of Indigenous Australians in the Commonwealth would immediately give context to policy making.

The issue of Indigenous representation is a theme throughout all the principal questions; community control as a policy direction, top-down policy making as a barrier, and increased consultation as a future improvement. This issue

was focused on heavily by Indigenous interviewees, with little acknowledgement of the issue by Commonwealth interviewees. However, most Commonwealth interviewees focused on increasing consultation with communities and services as a future improvement. There was no focus, however, on increasing the number of Indigenous people working at a Commonwealth level by Commonwealth interviewees.

When Commonwealth interviewees were asked specifically about the lack of Indigenous representation at a Commonwealth level they acknowledged that it was a problem but worried that there would be difficulty in finding qualified Indigenous staff. This demonstrates how interlinked Indigenous health issues are. As many interviewees commented, there is a need for a whole-of-government approach to tackle not only health but the social determinants of health, including education, both of which will affect the health of Indigenous communities and require more Indigenous policy makers and health professionals. However, no Commonwealth interviewees cited tackling the social determinants of health as a priority for the future.

It seemed to be a struggle between interviewees as to the importance of the link between health and social determinants. This struggle has been recognised in other pieces of research, as some see the cause of poor health as only an issue of material deprivation (eg, poor housing, lack of education etc),[20] whereas others view it as a combination of material deprivation and psycho-social stressors, related to stress, alienation, discrimination and lack of control.[20] This mirrors findings from Michael Marmot's Whitehall study where it was found that those in a population who had little control over their lives were discriminated against, were deprived of a clean, safe environment in which to live, lacked opportunities for education and tended to have poorer health, particularly in relation to chronic disease[21] — all of which relate to Indigenous Australians today.

Throughout the interviews it became apparent that the closer the interviewee was to the service delivery level the more frustrated they were that

significant improvements were not being made in Indigenous health. When asked about the lack of urgency at the Commonwealth level and the frustration at a service delivery level, one Commonwealth interviewee replied:

> They have to see it everyday ... Indigenous health workers have a deep emotional tie to their work and due to the importance of their community to them they can't just switch off when they go home — that must be exhausting.

It was also apparent that due to the lack of Indigenous representation at a Commonwealth level non-Indigenous Commonwealth interviewees do not feel personally and directly affected and therefore do not share the urgency expressed by Indigenous interviewees.

The other theme which presented itself was resources. The majority of Commonwealth interviewees, although not recognising resources as a barrier to policy implementation, did see resources as an area for future improvement. This was mostly in the manner of streamlining funding arrangements and building up the capacity of services so they are more capable to receive an increase in funding. No Commonwealth interviewee suggested an injection of resources as a future improvement.

In 2004, the AMA reported that the gap between spending on Indigenous health and actual need was continuing to widen and stood at $460 million per year.[18] Indigenous Australians have low levels of access to, and use of, health services such as Medicare and the Pharmaceutical Benefits Scheme (PBS).[†,18] These schemes are the main funding mechanism for primary care from the Commonwealth.[3] Indigenous Australians,

despite being three times as sick, access these services at one-third the rate of the non-Indigenous population.[22] Therefore, with inspection of expenditure data it becomes evident that current spending is not relative to need and, as many interviewees observed, inadequate resources are a significant barrier to policy implementation.

Despite the abundance of Indigenous health policies produced at a national level, there is not a specific chronic disease policy for Indigenous Australians. There is a National Chronic Disease Strategy[23] which mentions the chronic disease problems faced by Indigenous Australians but gives little specificity as to how these should be tackled. The National Strategy for Heart, Stroke and Vascular Health[24] also outlines strategies for tackling chronic disease with regard to Indigenous Australians. While these strategies demonstrate good intent, the way in which they will be implemented has not been documented; with no mention of who will implement them, any form of timeline and no mention of resources.

When asked about this, Commonwealth interviewees referred to the Healthy for Life Strategy.[25] This is an excellent strategy, but mainly focuses on improving chronic disease by concentrating on maternal and child health services to increase the birth weight of Indigenous babies, which has been linked to a reduction in the risk of developing chronic disease.[26] However, there will be a time lag before these results will be seen, and with the lack of a specific Indigenous Chronic Disease Strategy it leads to the question: Is enough being done for those with the precursors for, or suffering from, chronic disease at the moment?

Commonwealth interviewees avoided answering the question, "Do you feel an Indigenous chronic disease policy is needed?" Instead, they referred to other programs which tackled specific areas of chronic disease. One Commonwealth interviewee that did comment on a national policy indicated it may not translate; this is an interesting statement as it was not made with regard to any other national Indigenous policy. An interviewee from the state government level, however, felt that many existing national Indigenous health policies actually do not translate to

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† The Australian Government's funding of the health system includes three major national subsidy schemes: Medicare, the Pharmaceutical Benefits Scheme (PBS) and the 30% private health insurance rebate.
Medicare and the PBS subsidise all Australian citizens' payments for medical services and for a high proportion of prescription medicines, as well as specified dental and optometry services. The Australian Government also funds a 30% rebate of private insurance, to support people's choice to take up and retain private insurance.

all communities and therefore felt that the same mistake should not be repeated, but rather each state and territory government should take responsibility for formulating and implementing a tailored chronic disease policy.

This study has taken responses and opinions from all levels of the policy-making process to gain a variety of perspectives regarding the formulation and implementation of Indigenous health policies, which provides an insightful contribution to the literature surrounding this topic. Although it provides broad representation, it does lack an interview with the Office of Indigenous Policy Coordination.

Conclusion

This study examined how Indigenous health policy directions for chronic disease are formulated and asked what can be done to strengthen the link between formulation and implementation. This provided insight into where the problems within the policy process in Australia were occurring, with regard to Indigenous health, and how the link between policy formulation and implementation could be improved. Three main themes ran throughout the interviews:

- Indigenous representation at all levels
- Community control
- Appropriate and sustainable resources.

Lack of Indigenous representation at a policy-making level was regarded by many interviewees as a barrier to formulating policy directions within the context of Indigenous communities' priorities and culture. It was also demonstrated by the disconnection between responses from the Commonwealth interviewees compared with those from IPBs or CCHOs. Therefore, increased Indigenous representation was cited as an improvement for the future, as increased Indigenous representation at the policy level would lead to more community control and context in the policy process.

Another main theme was that of resources. On examination of health expenditure data it became obvious that Indigenous health care and pro-

grams under the Commonwealth's direct control were under-funded relative to actual need. The implementation of policies becomes almost impossible if there are inadequate resources, including staff at the service delivery level. Also, formulating policies which have no money attached to them indicates a lack of will to implement them and leads to the formulation of policies which are symbolic in nature and ineffective on the ground.

With regard to chronic disease there needs to be a focus on increasing Indigenous Australians' access to culturally appropriate comprehensive primary care and to pharmaceuticals through the PBS. However, many interviewees believe that a national chronic disease policy also needs to be formulated to clearly set out how the Australian government actually plans funded implementation strategies to tackle the high rates of chronic disease suffered by Indigenous Australians today.

From the findings in this research it appears that for this policy to be effective there needs to be Indigenous representation, an effective implementation plan that enables states to tailor the national policy, clear timeframes and adequate resources; all of which should be established from the formulation stage.

The current debate in Australia is around the abundance of national Indigenous health policies that have produced little or poor implementation. This research has reinforced that policy implementation and evaluation is an integral part of the policy process and should be considered from the formulation stage. The government of Australia can move away from symbolic policy making and hasten the improvement of the health of its first peoples. This will require a drastic overhaul in the policy and implementation process, but without this it appears that progress in reducing the gap between the health of Indigenous Australians and the rest of the population is likely to continue at its current inadequate level.

Acknowledgement of country

Australia is the only place in the world where Indigenous Australians belong. There is no place in Australia where this is not true.

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Competing interests

The authors declare that they have no competing interests.

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Australian Health Review call for student papers

The Australian Healthcare and Hospitals Association (AHHA) and the *Australian Health Review* (AHR) invite university students to submit a paper for consideration for the 2008 AHR Student Paper Awards, comprising an undergraduate and a postgraduate award. The purpose of these Awards is to support and encourage excellence in health policy and management research and writing at undergraduate and postgraduate levels. Submissions will be accepted for consideration until 31 April 2009. The papers must meet the following criteria:

1. The primary author of a submitted paper must be an undergraduate or postgraduate student at an Australian or New Zealand university in 2008. Additional authors other than the primary author may include other undergraduate students and the faculty mentor or supervisor.

2. Only original papers (not published or accepted for publication elsewhere) will be accepted. (Oral or poster presentations with printed abstracts do not count as published papers.)

3. Papers should be 1000–3500 words and be prepared according to the guidelines for authors of *AHR*.

4. All entries require a sponsoring statement from a university supervisor who attests: (a) that the supervisor has read the manuscript and (b) that the planning, execution, and writing of the manuscript represent primarily the work of the student(s).

The papers will be reviewed by a sub-committee of the Editorial Board of *AHR*, using the following four criteria:

- Justification for the paper
- Subject mastery and originality
- Logical organisation
- Relevance to health policy and management in Australia and New Zealand.

The Award winning undergraduate and postgraduate papers will be published in Issue 33(4) of *AHR* and the authors will be recognised at the 2009 AHHA National Congress.

Sandra G Leggat
Editor *Australian Health Review*

Prue Power
Executive Director Australian Healthcare and Hospitals Association