INDIGENOUS HEALTH

CSIRO PUBLISHING

Australian Health Review, 2013, 37, 232–238
http://dx.doi.org/10.1071/AH12186

Feature

Does Australia have the appropriate health reform agenda to close the gap in Indigenous health?

Ronald Donato[1,3] PhD, Senior Lecturer

Leonie Segal[2] PhD, Professor

[1]School of Commerce and Centre for Regulation and Market Analysis, GPO Box 2471, Adelaide, SA 5001, Australia.
[2]Health Economics and Social Policy Group, School of Nursing and Midwifery, University of South Australia, GPO Box 2471, Adelaide, SA 5001, Australia. Email: leonie.segal@unisa.edu.au
[3]Corresponding author. Email: ronald.donato@unisa.edu.au

Abstract. This paper provides an analysis of the national Indigenous reform strategy – known as *Closing the Gap* – in the context of broader health system reforms underway to assess whether current attempts at addressing Indigenous disadvantage are likely to be successful. Drawing upon economic theory and empirical evidence, the paper analyses key structural features necessary for securing system performance gains capable of reducing health disparities. Conceptual and empirical attention is given to the features of comprehensive primary healthcare, which encompasses the social determinants impacting on Indigenous health. An important structural prerequisite for securing genuine improvements in health outcomes is the unifying of all funding and policy responsibilities for comprehensive primary healthcare for Indigenous Australians within a single jurisdictional framework. This would provide the basis for implementing several key mutually reinforcing components necessary for enhancing primary healthcare system performance. The announcement to introduce a long-term health equality plan in partnership with Aboriginal people represents a promising development and may provide the window of opportunity needed for implementing structural reforms to primary healthcare.

What is known about the topic? Notwithstanding the intention of previous policies, considerable health disparity exists between Indigenous and non-Indigenous Australians. Australia has now embarked on its most ambitious national Indigenous health reform strategy, but there has been little academic analysis of whether such reforms are capable of eliminating health disadvantage for Aboriginal people.
What does the paper add? This paper provides a critical analysis of Indigenous health reforms to assess whether such policy initiatives are likely to be successful and outlines key structural changes to primary healthcare system arrangements that are necessary to secure genuine system performance gains and improve health outcomes for Indigenous Australians.
What are the implications for practitioners? For policymakers, the need to establish genuine partnership and engagement between Aboriginal people and the Australian government in pursuing a national Indigenous reform agenda is of critical importance. The establishment of the National Congress of Australia's First Peoples provides the opportunity for policymakers to give special status to Indigenous Australians in health policy development and create the institutional breakthrough necessary for effecting primary healthcare system change.

Received 7 June 2012, accepted 10 September 2012, published online 1 February 2013

Introduction

Compared with non-Indigenous Australians, Aboriginal people die at much younger ages, have more disability and experience reduced quality of life because of ill health.[1] Over the period 1999–2003, 75% of Indigenous males and 65% of Indigenous females died before the age of 65 compared with only 26% of non-Indigenous males and 16% of non-Indigenous females.[2] The burden of disease and injury in the Indigenous population is around two and half times that of the general population with chronic diseases accounting for 80% of the mortality gap between Indigenous and other Australians aged 35–74 years.[3,4]

There is a considerable body of international evidence which highlights that disparities in health owe much to contemporary structural and social factors embodied in what are termed the 'social determinants' of health.[5] Access to healthcare and difference in lifestyles (e.g. smoking, alcohol misuse) are important determinants of health inequalities but so are the circumstances in which people are born, grow, live and age and the extent to which they have control over these circumstances.[6] For Indigenous Australians, considerable evidence has now accumulated which recognises that deeper causative social, environmental and economic factors are contributing to poor Indigenous health status.[7] These factors include psychosocial (such as dispossession, racism and life stresses); economic (such as income and employment); education (such as literacy/numeracy, school attendance and completion levels); community capacity (such as family

functionality, safety, and criminal justice system contact); and the physical environment (such as poor and overcrowded housing and inadequate transport).[8,9]

Locating important causative factors of health and ill health outside the health system presents major challenges to health policy and government policy more generally, as a range of measures is required that extend beyond the conventional boundaries of the health sector itself.[8,10] To this end, primary healthcare (PHC) is recognised as central not just to dealing directly with chronic disease but also for providing a multidisciplinary framework that can interface with other sectoral domains and tackle Indigenous disadvantage.[5,6] Australia is currently in the process of implementing health system reform including changes to PHC, as well as implementing its most ambitious Indigenous health policy aimed at closing the gap in health inequality. This paper provides an analysis of the federal government's most recent Indigenous health policy initiatives in the context of broader health reform to assess whether current attempts at addressing Indigenous disadvantage are likely to be successful.

Importance of primary healthcare in addressing Indigenous health inequality

Accumulated international evidence indicates that a strong focus on PHC is important to improving health outcomes, reducing health inequalities and controlling national health system costs.[5,11,12] PHC is considered crucial to dealing with the growing burden of chronic diseases through prevention, early detection and more effective management of such conditions. Increasing resources to primary healthcare and ensuring better access may offset some of the deleterious effects of socioeconomic disadvantage and inequality.[11] When access to primary care is compromised those who are more disadvantaged are more likely to present for care later and sicker and consequently diagnosis and intervention are delayed and disease processes advance more quickly, thereby increasing mortality.

The WHO, in its 1978 Alma Ata declaration and as reaffirmed in its 2008 report, has given explicit focus to the underlying social determinants of health and consequently broadened the traditional definition of primary healthcare to encompass what is known as comprehensive PHC. Here, PHC is not confined to an episodic biomedical paradigm of treating ill health but instead represents a broader socioenvironmental perspective of health, with an emphasis on providing multidisciplinary care, supporting community empowerment and a focus on prevention, health promotion and inter-sectoral collaboration.[5,13]

Although the definition of PHC and its underlying philosophical principles has been contested in the Australian context, over the past decade there has been a shift, at least in policy intent, towards the need to pursue a comprehensive PHC model approach.[13,14] To date however, comprehensive PHC has not been practised in any extensive way in Australia, with some elements only evident in the Aboriginal Community Controlled Health Services (ACCHS) – the Indigenous-specific health sector (discussed later).[13,15]

International studies reveal that just as primary healthcare has improved health of populations in general, better access to primary healthcare has also improved outcomes for Indigenous populations.[7,16] In the case of Australia, there is now recognition that the poor performance in alleviating Indigenous health inequality is, in part, the result of inadequate investment in primary healthcare given the very high burden of morbidity and mortality experienced by Indigenous Australians.[17,18] Health expenditure per capita excluding hospital services, in 2008–09, was only 12% higher for Aboriginal people and in 2006–07 was 5% *lower* for Indigenous Australians than for the rest of the population.[19,20] The higher per capita hospital expenditure for Indigenous Australians, which is 2.4 times higher than the general population, serves to obscure the level of underfunding in primary health services and calls into question the efficiency of resource allocation across health sector boundaries. Studies conducted over the past decade have estimated that the level of spending on PHC services for Aboriginal people is less than half the level required, given the burden of illness.[18,21]

Despite attempts over the past decade to improve PHC in Australia there is general acknowledgement that a limit has been reached regarding what can be achieved through a piecemeal approach and that more fundamental structural reforms is required.[15,22–24] In particular, it is widely recognised that the fragmented funding arrangements and differing jurisdictional responsibilities between state and Commonwealth governments have contributed to poor collaboration between GP and allied and community services and has represented a considerable barrier to the delivery of coordinated multidisciplinary care.[25,26] Researchers have argued that key structural reforms to PHC in Australia are required that centre on unifying the funding arrangements of PHC as a necessary prerequisite, combined with the devolution of fund-holding and purchasing responsibilities to regionally based primary care organisations.[27] It is useful to consider Indigenous health policy in the context of the structural problems currently facing the Australian health system and the recent healthcare reforms aimed at addressing these.

Indigenous health policy and current Australian health system reforms

National Indigenous health reform – Closing the Gap *strategy*

In 2008, the Council of Australian Governments (COAG) signed a national partnership agreement involving a $4.6 billion package, which committed both tiers of government to enhancing Indigenous health and wellbeing.[28] The agreement is unique in that for the first time specific targets and time frames were incorporated into the policy framework. The specific targets include: closing the life expectancy gap within a generation; halving infant mortality rate gaps within a decade; halving the gap in reading, writing and numeracy achievements within a decade; halving the gap in year 12 attainment by 2020; and halving the differential unemployment outcome between Indigenous and non-Indigenous Australians. Recognising the significance of the broader social determinants impacting on Indigenous disadvantage, the agreement is framed around seven building blocks recognised as supporting the reforms against the COAG targets. These building blocks are: early childhood, schooling, health, economic participation, healthy homes, safe communities, and governance and leadership.

With regard to health, COAG has committed up to $1.6 billion, through a National Partnership Agreement over 4 years to close

the gap in life expectancy with the Commonwealth committing $800 million through its Indigenous Chronic Disease Package (ICDP). Implemented in July 2009, the ICDP aims to provide significant new funding for preventative health, with a focus on promoting healthy lifestyle; support for more coordinated and patient-focussed primary healthcare in both Indigenous-specific and mainstream general practices; and an expanded Indigenous health workforce, and increased training support in Indigenous health services.[29,30] Under a National Partnership Agreement, State governments will contribute additional funding matching the Commonwealth's contribution of around $800 million.

The Federal government will also fund either directly or via distribution to state governments, a total of $2.8 billion of the $3 billion committed to four other National Partnership agreements that underpin the seven building blocks of the *Closing the Gap* strategy. The additional funding commitments are to: improve Indigenous early childhood development ($565 million); create sustainable Indigenous employment opportunities ($223 million); reform housing and infrastructure arrangements in remote communities ($1.9 billion); and improve delivery of services in designated remote priority locations ($291 million).[28]

Notwithstanding the 'unprecedented level' of cooperation and coordination needed to deliver on the COAG commitments[30] the underlying structural features associated with system funding and jurisdictional responsibilities for Indigenous healthcare remain largely unaltered. The Commonwealth government continues to be responsible for the same set of programs, each still within their own funding silos, notably primary and secondary care services funded under Medicare Australia, aged care, Indigenous employment programs, tertiary study allowances, and Aboriginal Controlled Health Services. State and territory governments, with Commonwealth funding support, continue to have primary responsibilities for the delivery of education, public housing, police, public hospitals and community health. Given the concerns over the structural features of the Australian health system and the limitation this imposes on its capacity to secure performance improvements, understanding broader system reforms currently underway becomes important in analysing whether *Closing the Gap* is likely to be able to address Indigenous disadvantage.

Current Australian health system reform

It is widely recognised that the division of responsibilities between Commonwealth and state governments has resulted in a fragmented and uncoordinated health system structure. Several reviews have identified that existing structural arrangements have contributed to waste, duplication and cost shifting between jurisdictions with separate institutional 'silos' around funding and service provision creating significant barriers to individuals receiving integrated healthcare, with the optimal mix of service components.[25,26] Current attempts at reforming the Australian health system commenced with the National Health and Hospital Reform Commission (NHHRC), which reported to the Australian government in late 2009. The NHHRC report reiterated the conclusions of previous major health system reviews, that performance improvements are unlikely to be achieved without structural reforms to the funding and jurisdictional responsibilities of the Australian health system.[25] The report identified the need for 'one health system' and recommended the Commonwealth take over all funding and policy responsibilities for primary care and progressively become the dominant funder of hospital inpatient services. State governments would continue their role as provider of services, as under existing arrangements. Moreover, recognising the special circumstances of Indigenous disadvantage, the NHHRC recommended that all health funding for Indigenous Australians be aggregated and a single National Aboriginal Health Authority be established and have responsibility for the commissioning of the full range of health services.

In response to the NHHRC report, the federal government in 2010 released the *National Health and Hospital Network* (NHHN) report, which supported the Commonwealth takeover of all funding and policy responsibility for PHC and lead responsibility for hospital services.[31] However the government report did not support the recommendation of unifying all Indigenous healthcare funding within a single authority. Moreover, following state government(s) resistance to some components of the NHHN agreement, a revised document known as the COAG National Health Reform Agreement (NHRA) was negotiated and subsequently adopted in August 2011, and now represents the health reform agenda to be implemented. Under the NHRA arrangements, the federal government's role with regards to PHC was relegated from taking over full responsibility, as originally emphasised in both the NHHRC and the government's NHHN reports, to one of taking 'lead' responsibility for system funding and policy development and working in 'partnership' with state governments.[32] Furthermore, the federal government's position regarding public hospital funding was also diminished from a 'dominant' funder to a 'partner' with state governments. Thus under current health system reforms, there were to be no structural changes to health system arrangements, with funding to be directed to health services based on pre-existing professional and program boundaries.

One element associated with PHC that remained within the government's revised NHRA package is the establishment of a network of independent primary healthcare organisations known as 'Medicare Locals'. These new organisational structures were to build on existing Divisions of General Practice. They are tasked with working closely with other primary healthcare providers, as well as with hospital and aged care services to improve access and foster service integration. However, there is no change in structural factors to support this role. In the absence of single fundholding and third party purchasing capabilities, Medicare Locals do not have the incentive structure or mechanisms for promoting integration, continuity of care or a more efficient multidisciplinary health service mix, let alone pursue a comprehensive people-centred approach to primary healthcare.[22]

The relatively diluted nature of health system reforms being implemented under the NHRA package in turn impacts on Indigenous health policy and the capacity to achieve major improvements in the health of Aboriginal Australians. Whilst *Closing the Gap* represents the most extensive national Indigenous health policy development to date, there is a lack of articulation with the broader health system reform currently being pursued. No specific attention was given to Indigenous disadvantage within the NHRA package and consequently it is unclear how Medicare Locals are expected to identify and address gaps in access to PHC services for Indigenous Australians. Importantly,

by not pursuing a single funding system structure for Indigenous health, the capacity to engage in comprehensive PHC and a cross-portfolio approach in a way that attempts to tackle the underlying causative socioeconomic and environmental factors contributing to ill health is undermined. Current arrangements compromise the ability to fully capitalise on 'what works' in improving Indigenous health outcomes. Attention turns to this issue.

Indigenous health – 'what works'

With regards to 'what works' in Indigenous health, much of the empirical evidence, both internationally and in Australia, has been confined to specific programs or interventions, with limited studies reporting on the linkage between health system model approaches and health outcomes.[33]

Recent empirical evidence from Canada regarding Indigenous communities living on-reserve in Manitoba found that the greater degree of community control over PHC services, the lower the rate of hospitalisations for Ambulatory Care Sensitive (ACSC) conditions.[33] Those communities who entered into transfer agreements for control of PHC services showed lower hospital admissions than did those who did not and the reductions in hospitalisation rates were sustained overtime. At a more specific level, with regards to suicide prevention, Canadian research evidence suggests that the degree of community control is directly linked to better mental health and general wellbeing.[34] In the US, recent studies identify the improvement in health outcomes of native Americans as arising from a combination of mutually supportive structural elements facilitated by having funding and policy responsibilities under the single jurisdiction of the Indian Health Service (IHS).[7,16] The reduction in health disparities is attributed to an increase in the total level of resourcing, the widescale introduction of quality assurance processes supported by a nationally coordinated IT and innovation system, and the active engagement of the local community in health service decision making, which is underpinned within a single accountability and funding system.[16] Research highlights that the comparative success of the US in reducing life expectancy gap between Indigenous and non-Indigenous populations is linked to the comprehensiveness of PHC services provided through the IHS and the integrative nature of PHC services provided in collaboration with greater tribal self-determination[35,36].

Several reviews have been undertaken in Australia exploring the evidence of effectiveness of individual programs and interventions that have been implemented aimed at improving Indigenous heath. For instance, over the past decade the Office for Aboriginal and Torres Strait Islander Health commissioned several reviews including: a summary of the literature on achievements in Indigenous health,[37] a review of the evidence of effective interventions shown to have positive impacts on selected social and environmental factors relevant to Indigenous health,[38] and a review of the evidence of PHC services contributing to Indigenous health improvements.[7] A common theme emerging from these extensive reviews regarding 'what works' was the crucial importance of community engagement, ownership and control over particular programs and interventions. Underpinning such arrangements and representing necessary components to the 'success' of particular strategies were adequate and secure funding sources with flexibility to meet identified community needs; collaborative and multidisciplinary team approaches; Indigenous workforce and skills base development; and community capacity building including leadership and governance.

More recently, the Productivity Commission[39] in its report to COAG on progress to date in *Closing the Gap* provided a summary on the 'things that work' in having some positive impact on COAG targets and identified several 'success factors' that included: cooperative approaches between Indigenous people and government; community involvement in program design and decision making – a bottom-up rather than top-down approach; good governance at organisation, community and government levels; and ongoing government support in the form of human, physical and financial resources.[39] Similarly, the Australian Institute of Health and Welfare (AIHW) and the Australian Institute of Family Studies (AIFS) through its jointly managed repository of evidence-based research undertook a recent review of empirical studies published in peer review journals which identified several key factors as contributing to 'what works'. These included: community involvement and engagement; adequate resources; respect for local culture; development of partnerships, collaboration and shared leadership; and development of social capital.[40]

Empirical evidence provides support for the importance of community engagement, control and empowerment in defining 'what works' in Indigenous health and an essential component in efforts to address Indigenous disadvantage. What is also clear is that at the system level, effective community engagement requires a supportive structural environment in terms of funding and delivery models, capacity building and clinical governance, and quality assurance processes. To this end, the Aboriginal Community Controlled Health Services sector represents an important component of a PHC system structure, and a brief overview of this sector is outlined.

Aboriginal Community Controlled Health Services (ACCHS)

Indigenous Australians access PHC services through a complex blend of mainstream services and an Indigenous-specific sector (i.e. ACCHS). ACCHS are multifunctional community organisations that seek to follow an integrated primary healthcare model, with a philosophical approach of community control, cultural appropriateness of services and a holistic view of health as its foundation.[41] First established in the 1970s, ACCHS have pioneered the development of health services that are strongly engaged with their communities, and have sought to increase access to a broad range of PHC services and to advocate on behalf of their communities around the broader determinants of health.[42] There are around 150 ACCHS in Australia, ranging from large comprehensive primary care centres in urban areas to small clinics and outreach services in very remote communities. In 2010 ACCHS were funded through a myriad of programs, with the Commonwealth government contributing 73% of total funding and the state governments contributing the remainder.

Since Indigenous per capita expenditure on mainstream PHC services is around two-thirds of the mean expenditure of non-Indigenous Australians the Indigenous-specific sector has an important role to play alongside conventional PHC services. Differences in cultural norms, the small 'market' size of the

Indigenous population and its dispersion across remote regions, limit the extent to which mainstream services are able to fully meet the unique needs of all Aboriginal people.[18] Moreover, as already outlined, empirical evidence highlights the importance of community engagement, empowerment and control as prerequisites to initiating 'things that work' in enhancing Aboriginal health. To this end, services provided through ACCHS represent a key component within the PHC framework. Thus efforts to increase the accessibility to comprehensive PHC for Aboriginal Australians require expanding the capacity of both mainstream services *and* the Indigenous-specific health sector as the first does not generally address the cultural needs and engagement of the population and the second does not necessarily have capabilities across the full spectrum of primary care services and competencies.[18,41]

Whilst there are some initiatives underway to expand community control in some states, the funding of ACCHS remains complex, uncertain and fragmented, with the sector dependent upon a short-term contractual funding base, which is often proposal-driven involving high administrative costs.[43,44] Moreover, the fragmented nature of jurisdictional responsibilities in PHC means that the ACCHS sector is not formally coordinated with mainstream PHC services. Reforms aimed at enhancing PHC for Indigenous Australians need to address the dichotomous situation governing the two sectors.

Structural reforms: unifying funding and policy responsibilities for PHC

Economic theory provides conceptual support for the establishment of single funding arrangements and devolved purchasing responsibilities of PHC services to a single fundholder.[27,45] Such an approach provides the incentives and framework for promoting local priority setting reflecting a better alignment of health services with the health needs of the population, better coordination with other portfolios impacting on health, and stronger community engagement. The greater the range of services included in a needs-based funding model, the greater the ability to substitute across service programs and professional boundaries and provide an optimum mix of services in the most cost efficient manner.[45] International evidence highlights the importance of single jurisdictional responsibility for Indigenous health in facilitating the development of comprehensive PHC which encompasses a multidisciplinary collaborative approach and strong community engagement.[16,33]

In Australia, the failure of current health reforms to deal with the structural problems of the Australian health system, in particular unifying the funding responsibilities for PHC under a single jurisdiction, compromises the capacity for *Closing the Gap* to realise major system performance improvements. Funding silos based along professional, service and institutional boundaries remain and therefore so do the barriers to the development of a collaborative, multidisciplinary and integrated approach to the delivery of comprehensive PHC services. For Indigenous Australians, not pursuing structural reforms carries additional significance given the added fragmentation in PHC due to the presence of both mainstream and Indigenous-specific sectors funded by two tiers of government and the greater need for community engagement and empowerment given the significance of the social determinants impacting on Indigenous health. Peak body Indigenous organisations have been critical of the lack of genuine engagement and partnership with and participation by Aboriginal peoples in the formulation of the *Closing the Gap* strategy and the lack of coordinated support given to the recognition of ACCHS as key providers of comprehensive PHC services.[46]

Establishing a single fundholding PHC model for Indigenous Australians, funded through a needs-adjusted capitated formula, lays the foundation for incorporating and facilitating an array of mutually supportive components necessary for enhancing PHC system performance capable of addressing Indigenous disadvantage. Such arrangements enable primary care organisations to engage in needs assessment for their defined populations and to identify the range and mix of services required that best address those needs. Moreover, the capitated funding approach establishes the incentive structure to substitute across service programs and professional boundaries and provide greater coordination and integration of services to maximise health outcomes. Importantly, a single fundholding framework offers the scope to expand the role of ACCHS and for the sector to more effectively coordinate with mainstream PHC services in a way to meet the complex requirements of the Indigenous population. It also provides the mechanism to incorporate community input and engagement, and to engage in multi-sector collaboration that encompasses the broader social determinants that intersect PHC, such as family support and early childhood development programs. To this end, greater impetus is therefore given to: developing clinical governance and quality assurance processes supported by IT infrastructure; building workforce capacity, governance and leadership capabilities for ACCHS; and in articulating Indigenous PHC reforms with broader health system reforms already underway. In all, structural reforms to system financing are necessary for the development of a comprehensive PHC system which is multidisciplinary and collaborative in focus, has the responsiveness and flexibility to meet the needs and aspirations of the Indigenous community, and the capacity to coordinate with other policy domains influencing the social determinants of health.

Whilst institutional resistance seems to have stymied financing reforms to PHC for the general population, implementing structural reforms to PHC as it applies to the Indigenous population cohort appears feasible. Here, the precedent for implementing structural reforms to health system funding has already been established for the Australian veteran population. The special status of the Australian war veteran population enabled substantive structural system reforms to take place within the Department of Veteran Affairs (DVA) during the 1990s, which saw it become the only publicly funded organisation with funding responsibility for all aspects of health and aged services. These structural reforms to funding have enabled DVA to purchase healthcare for its veteran population across a broad mix of services, from both public and private sectors including medical and allied health, which best meet the particular needs of its defined population group.[47] Although the delivery system architecture required for addressing the specific needs of Indigenous Australians is different to that required for the veteran population, it is the special status given to a particular population group that is the germane issue here, as it can create the institutional pre-conditions necessary for implementing structural financing reforms.

To this end, the establishment of the National Congress of Australia's First People in July 2011 and the subsequent announcement by the federal government in November 2011 to develop a long-term Health Equality Plan in partnership with the Congress may provide the impetus needed to pursue structural change. Recognising the special status of Indigenous Australians in health policy development could provide the institutional breakthrough needed for unifying funding and policy responsibilities for PHC under the single jurisdiction of the Commonwealth government.

Conclusion

Comprehensive PHC is central to managing the growing burden of chronic disease and addressing socioeconomic and environmental factors affecting health, through a greater emphasis on a collaborative multidisciplinary approach to health and wellbeing. The historical underfunding of primary healthcare services for Indigenous Australians relative to need, together with the fragmented nature in jurisdictional responsibilities of the Australian health system and the multiplicity of programs, have contributed to the very poor health outcomes of Aboriginal Australians. Importantly, the absence of genuine partnership and engagement between Aboriginal people and the Australian government in formulating either the *Closing the Gap* strategy or the broader health system reforms underway compromises the capacity of current strategies to achieve their goals.

Whilst additional funding under the *Closing the Gap* agreement may result in some improvement in Indigenous health, the necessary shift in system performance capable of genuinely closing the gap in health inequality is unlikely to be achieved without core structural changes. The weight of empirical evidence in Australia supports the value of community engagement, ownership and empowerment in program success in Aboriginal health, underpinned by a supportive, flexible and comprehensive system of funding. To this end, unifying all funding and policy responsibilities for comprehensive PHC and incorporating both mainstream and ACCHS sectors within an integrated fundholding framework provides the strategic basis for improving health outcomes for Indigenous Australians. Such structural reforms provide the incentive mechanism and driver for enhancing the capacity and governance of ACCHS and its interface with mainstream PHC services, substituting across services and professional boundaries, and engaging in multi-sector collaboration that encompasses the social determinants influencing Indigenous health.

To date there has been little engagement with Aboriginal people in the formulation, development and ownership of the national Indigenous health reform strategy. The announcement by the federal government of its intention to develop a long-term Health Equality Plan in partnership with the newly established National Congress of Australia's First Peoples, represents a positive move towards Indigenous engagement and empowerment. These developments may provide a window of opportunity for giving special status to the Indigenous population in a way that already exists with the Australian veteran population, where fundholding and policy responsibilities for health services are controlled under one program. Such recognition would create the pre-conditions necessary for overcoming institutional barriers and establish the basis for implementing structural reforms to PHC and potentially secure system performance gains capable of closing the gap in Indigenous health inequality.

Competing Interests

The authors declare they have no competing interests.

References

1 Australian Institute of Health and Welfare. Australia's Health 2010. Canberra: AIHW; 2010.

2 Australian Institute of Health and Welfare. Indigenous health: age at death. Canberra: AIHW; 2012.]. Available at http://aihw.gov.au/mortality-indigenous/#age [verified 1 April 2012]

3 Vos T, Barket B, Stanely L, Lopez A. The burden of disease and injury in Aboriginal and Torres Strait Islander peoples 2003. Brisbane School of Population Health, University of Queensland; 2007.

4 Australian Institute of Health and Welfare. Contribution of chronic disease to the gap in adult mortality between Aboriginal and Torres Strait Islander and other Australians. Canberra: AIHW; 2011.

5 World Health Organization. Closing the gap in a generation: health equity through actions on the social determinants of health. Geneva: WHO; 2008.

6 Marmot M. Social determinants and the health of Indigenous Australians. *Med J Aust* 2011; 194(10): 512–3.

7 Griew R, Tilton E, Cox N, Thomas, D. The link between primary health care and health outcomes for Aboriginal and Torres Strait Islander Australians. Sydney: Robert Griew Consulting; 2008.

8 Carson B, Dunbar T, Chenal R, Bailie R, editors. Social determinants of indigenous health. Sydney: Allen and Unwin; 2007.

9 Australian Institute of Health and Welfare. The health and welfare of Australia's Aboriginal and Torres Strait Islander people: an overview 2011. Canberra: AIHW; 2011.

10 Ring I. A 'whole of government' approach needed on Indigenous health. *Aust N Z J Public Health* 1998; 22(6): 639–40. doi:10.1111/j.1467-842X.1998.tb01460.x

11 Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. *Milbank Q* 2005; 83: 457–502. doi:10.1111/j.1468-0009.2005.00409.x

12 Macinko J, Starfield B, Shi L. The contribution of primary care systems to health outcomes within Organization for Economic Cooperation and Development (OECD) countries, 1970–1998. *J Health Serv Res* 2003; 38: 831–65. doi:10.1111/1475-6773.00149

13 Hurley C, Baum F, Johns J, Labonte R. Comprehensive primary health care in Australia: findings from a narrative review of the literature. *Australas Med J* 2010; 1(2): 147–52.

14 Commonwealth of Australia. Building a 21st century primary health care system: Australia's first national primary health care strategy. Canberra: Commonwealth of Australia; 2010.

15 Wakerman J, Humphreys J, Wells R, Kuipers P, Entwistle P, Jones J. Primary health care delivery models in rural and remote Australia – a systematic review. *BMC Health Serv Res* 2008; 8: 276. doi:10.1186/1472-6963-8-276

16 Sequist T, Cullen T, Acton K. Indian Health Service innovations have helped reduce health disparities affecting American Indian and Alaskan Native people. *Health Aff* 2011; 30(10): 1965–73. doi:10.1377/hlthaff.2011.0630

17 Commonwealth of Australia. Closing the Gap: Prime Minister's report 2011. Canberra: Commonwealth of Australia; 2011.

18 Dwyer J, Silburn K, Wilson G. National Strategies for improving Indigenous health and health care. Aboriginal and Torres Strait Islander Primary Health Care Review: consultant report no.1. Canberra: Commonwealth of Australia; 2004.

19 Australian Institute of Health and Welfare. Expenditure on health for Aboriginal and Torres Strait Islanders people for 2008–09. Canberra: AIHW; 2011.
20 Australian Institute of Health and Welfare. Expenditure on health for Aboriginal and Torres Strait Islanders people for 2006–07. Canberra: AIHW; 2009.
21 Eagar K, Gordon R. Access and equity – the funding required to close the gap in Aboriginal and Islander health in far north Queensland. Centre for Health Services Development, University of Wollongong; 2008.
22 Segal L, Dalziel K, Donato R. Economics-informed policy can drive better health but there will be few gains without structural change. *Dialogue* 2011; 30(2): 44–50.
23 Powell-Davies G, Williams A, Larsen K, Perkins D, Roland M, Harris M. Coordinating primary health care an analysis of the outcomes of a systematic review. *Med J Aust* 2008; 188(8): S65–8.
24 Naccarella L, Southern D, Furler J, Scott A, Prosser L, Young D, *et al*. Primary care funding and organisational policy options and implications: a narrative review of evidence from five comparator countries. *Med J Aust* 2008; 188(8): S73–6.
25 National Health and Hospitals Reform Commission. A healthier future for all Australians: final report 2009. Canberra: NHHRC; 2009.
26 Commonwealth of Australia. The blame game: report on the inquiry into health funding. House of Representatives Standing Committee on Health and Ageing. Canberra: Commonwealth of Australia; 2006.
27 Donato R, Segal L. The economics of primary health care reform in Australia - towards single fundholding through development of primary care organisations. *Aust N Z J Public Health* 2010; 34(6): 613–9. doi:10.1111/j.1753-6405.2010.00622.x
28 Commonwealth of Australia. *Closing the gap on Indigenous disadvantage: the challenge for Australia*. Canberra: Commonwealth of Australia; 2009.
29 Commonwealth of Australia. Closing the Gap: the Indigenous chronic disease package in 2009–2010. Canberra: Commonwealth of Australia; 2010.
30 Council of Australian Governments. National Indigenous Reform Agreement (Closing the Gap). Canberra: COAG; 2009.
31 Commonwealth of Australia. A national health and hospitals network for Australia's future. Canberra: Commonwealth of Australia; 2010.
32 Council of Australian Governments. National Health Reform Agreement. Canberra: COAG; 2011.
33 Lavoie J, Forget E, Prakash T, Dahl M, Martens P, O'Neil J. Have improvements in on-reserve health services and initiatives promoting community control improved First Nation's health in Manitoba? *Soc Sci Med* 2010; 71: 717–24. doi:10.1016/j.socscimed.2010.04.037
34 Chandler M, Lalonde C. Cultural continuity as a hedge against suicide in Canada's First Nations. *Transcult Psychiatry* 1998; 35: 191–219. doi:10.1177/136346159803500202
35 Bramley D, Hebert P, Tuzzio L, Chassin M. Disparities in Indigenous health: a cross-country comparison between New Zealand and the United States. *Am J Public Health* 2005; 95(5): 844–50.
36 Cornell S, Kalt J. American Indian self-determination: the political economy of a policy that works. Harvard Kennedy School, RWP10–043. Cambridge, MA: Harvard Kennedy School; 2010. Available at http://dash.harvard.edu/handle/1/4553307 [verified 5 March 2012].
37 Burns J, Thomson N, Brooks J, Burrow S, Kirov E, McGougan B, Valenti A. Describing an iceberg from a glimpse of its tip: a summary of the literature on achievements in Aboriginal and Torres Strait Islander health. Perth (Australia): Australian Indigenous Health *info* Net; 2002.
38 Black A. Evidence of effective interventions to improve the social and environment factors impacting on health. Office for Aboriginal and Torres Strait Islander Health. Canberra: Commonwealth of Australia; 2007.
39 Productivity Commission. Overcoming Indigenous disadvantage: key indicators 2009. Canberra: Productivity Commission; 2011.
40 Australian Institute of Health and Welfare; Australian Institute of Family Studies. What works to overcome Indigenous disadvantage: key learnings and gaps in the evidence. Canberra: AIHW and Melbourne: AIFS; 2011.
41 Baeza J, Lewis J. Indigenous health organizations in Australia connections and capacity. *Int J Health Serv* 2010; 40(4): 719–42. doi:10.2190/HS.40.4.i
42 Bartlett B, Boffa J. The impact of Aboriginal community controlled health service advocacy on Aboriginal health policy. *Aust J Primary Health* 2005; 11(2): 53–61. doi:10.1071/PY05022
43 Dwyer J, Lavoie J, O'Donnell K, Marlina U, Sullivan P. Contracting for Indigenous health care: towards mutual accountability. *Aust J Publ Admin* 2011; 70(1): 34–46. doi:10.1111/j.1467-8500.2011.00715.x
44 Martini A, Marlina U, Dwyer J, Lavoie J, O'Donnell K, Sullivan P. Aboriginal community controlled health service funding: report to the sector 2011. Melbourne (AUST); The Lowitja Institute; 2011.
45 Segal L, Donato R, Richardson J, Peacock S. Strengths and limitations of competitive versus non-competitive models of integrated capitated fundholding. *J Health Serv Res Policy* 2002; 7(Suppl 1): 56–64. doi:10.1258/135581902320176485
46 Steering Committee for Indigenous Health Equality. Shadow report: on Australian Government's progress towards closing the gap in life expectancy between Indigenous and non-Indigenous Australians. Close the Gap Steering Committee for Indigenous Health Equality; 2011. Available at http://resources.oxfam.org.au/pages/view.php?ref=593 [verified 1 February 2012]
47 Lyon K. They said it couldn't be done: contracting for Veteran's hospital care in Australia. In: Bloom A, editor. Health reform in Australia and New Zealand. South Melbourne: Oxford University Press; 2000.