

# Planning, Implementation and Effectiveness in Indigenous Health Reform

**Final Report**

May 2015

Margaret Kelaher  
Hana Sabanovic  
Camille La Brooy  
Mark Lock  
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Although the painting currently hangs vertically, the work was painted so it could be displayed either vertically or horizontally to acknowledge that Aboriginal and Torres Strait Islander peoples have had to continually adapt in many ways, when participating in policy development and for Indigenous health reform. The work recognises the basic needs and concerns for Aboriginal and Torres Strait Islander peoples at all levels, including maintaining access to traditional, fresh and healthy foods; to clean running water; to shelter and affordable housing; to education and employment opportunities; and to representation in the legal and political system and the striving for self-governance.



In this painting, the yellow background represents the sun for growth and the promise of a bright future. The red/ochre lines connect people with community, acknowledge and respect traditional song lines and embrace future pathways. The green digging stick symbols represent the gathering food and combined knowledge and developing new equal partnerships. The gold circles lying across most communities represent inclusion and collaboration in policy development and health reform at all levels. The white witchetty grubs represent gathering food, staying strong in culture and community values. The blue symbols represent water and the promise of refreshing new models that support and work earnestly, towards self-governance. The green circular symbols inside each community represent meeting on equal ground. The white oval and rectangle shapes represent communities and the diversity and adaptability of each community and act as an important reminder that many communities have already been — and at times, inappropriately — governed by non-Indigenous people, government agencies and service providers which often tried to implement ineffective models. Last, but not least, the black coolamons laying across (most) communities represent babies, new life and new futures and these new beginnings are underpinned and supported by culturally effective and culturally safe collaborative governance models, that acknowledge, respect, encourage and support diverse culture and cultural needs.

**Sandra Kaye Angus (Wiradjuri, b. 1954)**

***Gudy Murun (Wiradjuri)***

***Songs and Life or Song Lines and Sustaining Our Nation, 2010***

**Acrylic on canvas**

**60cm x 90cm**

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the  
**Lowitja**  
Institute

Australia's National Institute for Aboriginal and  
Torres Strait Islander Health Research



THE UNIVERSITY OF  
MELBOURNE

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ISBN 978-1-921889-36-3

First published in July 2015

This work is published and disseminated as part of the activities of The Lowitja Institute, Australia's national institute for Aboriginal and Torres Strait Islander health research, incorporating the Lowitja Institute Aboriginal and Torres Strait Islander Health CRC, a collaborative partnership partly funded by the Cooperative Research Centre Program of the Australian Government Department of Industry and Science.

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**Managing editor:** Cristina Lochert

**Copy editor:** Cathy Edmonds

**For citation:** Kelaher, M., Sabanovic, H., La Brooy, C., Lock, M., Uddin, S. & Brown, L. 2014, *Planning, Implementation and Effectiveness in Indigenous Health Reform*, The Lowitja Institute, Melbourne.

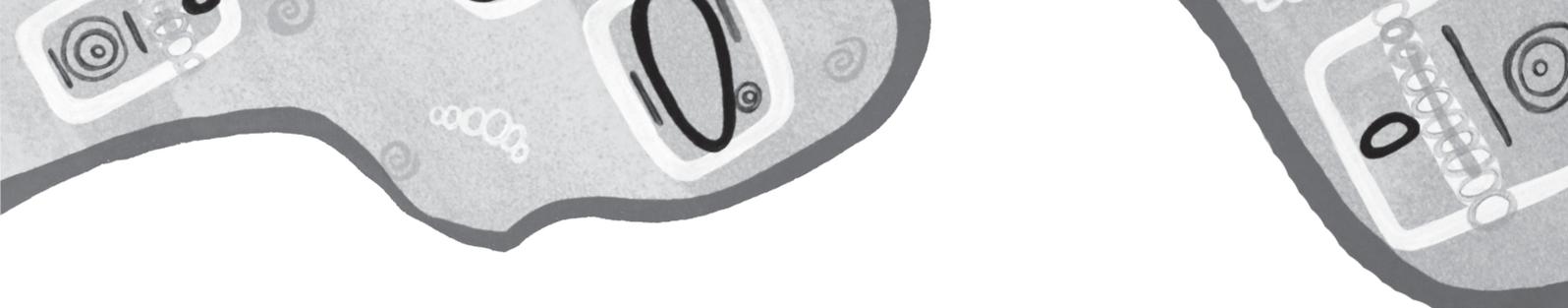
**Design and layout:** Inprint Design

**Definition:** 'Aboriginal and Torres Strait Islander people' is used to refer to Australian Indigenous people. The term 'Aboriginal' is sometimes used for consistency with original sources.



**Australian Government**  
**Department of Industry and Science**

**Business**  
Cooperative Research  
Centres Programme



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# Acknowledgments

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The research team acknowledges the support and participation of the numerous contributors involved in the research. Thank you to all who generously gave their time to participate, and share their knowledge and experience, in the various stages of this project.

We would particularly like to thank members of the following bodies:

- Kimberley Regional Aboriginal Health Planning Forum
- Yamatji (Midwest) Regional Aboriginal Health Planning Forum
- Goldfields Regional Aboriginal Health Planning Forum
- Pilbara Regional Aboriginal Health Planning Forum
- South Metropolitan Area Aboriginal Health Action Group
- Armadale, Bentley, Fremantle, Rockingham/ Kwinana and Peel Group District Aboriginal Health Action Groups
- Western Australian Statewide Aboriginal Health Planning Forum
- Western Australian Aboriginal Health Planning Forum
- Victorian Advisory Council on Koori Health Closing the Gap Sub-Committee
- Hume Region Closing the Health Gap Steering Committee
- Lower Hume Project Working Group
- Central Hume Project Working Group
- Hume Region Young Women's Health Project Working Group
- Southern Metropolitan Region Closing the Health Gap Committee
- Urban South Reference Group
- Frankston/Mornington Peninsula Reference Group
- Local Aboriginal Community Partnership Reference Group
- Loddon Mallee Region Closing the Health Gap Regional Advisory Committee
- Mildura Aboriginal Service Area Partnership Group
- Bendigo Aboriginal Service Area Partnership Group
- Echuca Aboriginal Service Area Partnership Group
- Eastern Metropolitan Region Executive Group
- Barwon South Western Region Closing the Health Gap Advisory Committee
- Gippsland Closing the Health Gap Advisory Committee
- East Gippsland Sub-regional Consortium
- Central and West Gippsland Sub-regional Consortium.

The research team also thanks the members of our project reference group and all those who participated in our quality assurance workshop organised by the Lowitja Institute.

## Project reference group

The project reference group was established to help refine the scope, focus and design of the study, identify key stakeholders and potential sites for research, and to provide input into both the content and methodology used in the project. It comprised representatives from the following organisations with insight and experience in Aboriginal and Torres Strait Islander health and policy:

- Aboriginal Health Council of Western Australia
- Commonwealth Department of Health and Ageing and Office of Aboriginal and Torres Strait Islander Health

- National Aboriginal Community Controlled Health Organisation
- Victorian Aboriginal Community Controlled Health Organisation
- Victorian Department of Health, Aboriginal Health Branch
- Western Australian Country Health Service
- Western Australian General Practice Network.

## Research team

Members of the research team who contributed to this report include:

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- Dr Mark Lock
- Dr Shahadat Uddin
- Mohammad Khan
- Mr Arif Khan
- Dr Jasmina Brankovich
- Mr Ron Gidgup
- Professor Lawrence Brown.

# Abbreviations

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<b>ACCHO</b>	Aboriginal Community Controlled Health Organisation
<b>CEO</b>	Chief Executive Officer
<b>COAG</b>	Council of Australian Governments
<b>DH</b>	Department of Health (Victoria)
<b>DoHA</b>	Department of Health and Ageing (Commonwealth Government)
<b>IHNPA</b>	Indigenous Health National Partnership Agreement
<b>LIN</b>	Local Indigenous Network
<b>NIRA</b>	National Indigenous Reform Agreement
<b>OATSIH</b>	Office of Aboriginal and Torres Strait Islander Health
<b>PIE</b>	Planning, Implementation and Effectiveness in Indigenous Health Reform



# Executive summary

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The idea that engaging Aboriginal and Torres Strait Islander people and organisations in the planning and governance of interventions to improve their health will lead to greater benefits is one of the most fundamental concepts in Aboriginal and Torres Strait Islander health and a core tenet of the Aboriginal community-controlled health sector. This is supported by growing evidence that providing increased voice to vulnerable or disenfranchised populations is important to improving health equity at a number of levels [1]. This embryonic literature suggests that how governing bodies involve the community in their processes can have a significant impact on their ability to improve health equity.

The Planning, Implementation and Effectiveness in Indigenous Health Reform (PIE) project, funded by the Lowitja Institute and the Australian Research Council, carried out by the University of Melbourne, arose from concerns by Aboriginal and Torres Strait Islander people that despite the importance of participation and investment in collaborative governance, little research focused on capturing current practice and identifying best practice is being done. The advent of the National Indigenous Reform Agreement (NIRA) [2] and the Indigenous Health National Partnership Agreements (IHNPAs) [3, 4] has led to further development/application of collaborative approaches to governance through committees and forums at national, State and regional levels. The activities associated with these committees and forums are referred to throughout this report as collaborative governance.

This report focuses on building the evidence base around best practice based on case studies of collaborative governance in relation to the NIRA. The report addresses:

1. the processes through which Aboriginal and Torres Strait Islander community members and organisations are involved in governance
2. the impact of their engagement on decisions and relationships with others
3. the aspects of engagement that are associated with:
  - a. greater satisfaction with the process
  - b. greater confidence in implementation
  - c. improvements in access to health services.

## Key findings and recommendations

Overall, the findings of the PIE project suggest that the incorporation of Aboriginal and Torres Strait Islander communities and organisations in regional planning plays an important role in improving health equity. Achieving this requires strong links between Aboriginal and Torres Strait Islander organisations and mainstream organisations and among Aboriginal and Torres Strait Islander organisations. The study makes an important contribution to understanding the processes through which the incorporation of disenfranchised groups into governance might contribute to health equity. It highlights the potential role of social networks in the processes.

The study also provides empirical evidence of the links between engagement in governance and the effectiveness of implementation, the achievement of health benefit, and satisfaction with the processes. In doing so, it confirms one of the longest standing and central tenets in Aboriginal and Torres Strait Islander health—the importance of engaging Aboriginal and Torres Strait Islander people in the planning, governance and delivery of programs to improve their health.

The incorporation of Aboriginal and Torres Strait Islander communities and organisations in governance plays an important role in improving satisfaction with planning processes and the

outcomes of health programs, including access to health assessments and prevention of avoidable hospitalisations. This suggests three main recommendations, which can be found overleaf.

**Recommendation 1:** The incorporation of Aboriginal and Torres Strait Islander communities and organisations in the governance of health programs should be further supported and developed.

**Recommendation 2:** Governance processes should include mechanisms to ensure that perspectives of Aboriginal and Torres Strait Islander participants are valued and inform decision making.

**Recommendation 3:** Future interventions should consider where relationships between organisations need further strengthening and should develop strategies/activities to achieve this.

The implementation of the IHNPAs was associated with a significant shift in power from central government to regional forums, which comprised local health service providers and community groups. Regional forums, for the most part, provided an effective platform to involve Aboriginal and Torres Strait Islander people and organisations in governance. The results showed that the inter-organisational networks formed in the context of these forums influenced improvements in access to health services as a result of the IHNPAs. Two further recommendations are associated with this.

**Recommendation 4:** Support for the role of regional forums with the continuation of regional approaches to planning and funding for secretariats should be continued.

**Recommendation 5:** The equity of processes to select projects for funding in order to ensure an optimal regional service mix should be improved. Measures to achieve this should include:

- a. providing support in proposal development
- b. ensuring that data on performance is considered in decision making
- c. identifying ways in which potentially competing organisations can work together.

A number of complexities were involved in co-ordinating IHNPA activities across national, state and regional levels. Working with tripartite forums was seen as an effective mechanism to offer state-wide and national solutions to advance Aboriginal and Torres Strait Islander health. A strong feeling that regional forums were under-utilised as a mechanism for co-ordination and communication was also apparent and led to a further recommendation.

**Recommendation 6:** State-level (tripartite) and regional planning forums should be used as a means to improve communication and co-ordination between different programs.



# Introduction

---

The meaningful participation of Aboriginal and Torres Strait Islander<sup>1</sup> people in the development and implementation of policy and programs aimed at improving their health is a central value that is reflected in the principles of community control and reverberates through policy documents. Despite this, very little research focuses on capturing current practice and identifying best practice in processes to engage Aboriginal and Torres Strait Islander people in the planning, implementation and evaluation of health programs.

This was highlighted in 2007 when the Council of Australian Governments (COAG) agreed to a partnership between all levels of government to work with Aboriginal and Torres Strait Islander people and their communities to close the gap on Indigenous disadvantage. This included a commitment to closing the life expectancy gap between Aboriginal and Torres Strait Islander people and non-Indigenous Australians within a generation; halving the mortality gap for children under the age of five within a decade; and halving the gap in reading, writing and numeracy within a decade. On 13 February 2008 then Prime Minister Kevin Rudd made a formal apology to the Aboriginal and Torres Strait Islander people of Australia for the suffering caused by the mistreatment and forced removal of children. The health components of these outcomes were to be addressed by two IHNPA's: the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes [3] and the National Partnership Agreement on Indigenous Early Childhood Development [4]. These initiatives collectively represent an investment of more than \$2 billion.

The IHNPA's emphasised both the importance of including Aboriginal and Torres Strait Islander

people in developing solutions in health care and the importance of increasing the responsiveness of mainstream health services to the needs of Aboriginal and Torres Strait Islander people. Despite these measures, no recommendations concerned best practice or key performance indicators that were to be met in either area. The absence of clear guidance was one of the key tensions associated with the otherwise welcome investment of the IHNPA's.

The Planning, Implementation and Effectiveness in Indigenous Health Reform (PIE) project was conducted between 2010 and 2013 by the University of Melbourne and sponsored by the Lowitja Institute and the Australian Research Council. The project developed a framework to evaluate the engagement of Aboriginal and Torres Strait Islander people in policy and program development for the IHNPA's and assessed the impacts of this engagement on policy, programs and the implementation of the IHNPA's.

This report develops the evidence base to inform best practice guidelines and key performance indicators for the engagement of Aboriginal and Torres Strait Islander people in collaborative governance. Its recommendations will help inform policy makers, health services, and Aboriginal and Torres Strait Islander communities.

The aims of the PIE project were to identify:

1. the processes through which Aboriginal and Torres Strait Islander community members and organisations are involved in governance
2. the impact of their engagement on decisions and relationships with others
3. the aspects of engagement that are associated with:
  - a. greater satisfaction with the process
  - b. greater confidence in implementation
  - c. improvements in access to health services.

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<sup>1</sup> Aboriginal and Torres Strait Islander people is used to refer to Australian Indigenous people. The term 'Aboriginal' is sometimes used for consistency with original sources.



# Background

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*In order to address health inequities, and inequitable conditions of daily living, it is necessary to address inequities... in the way society is organized... To achieve that requires more than strengthened government—it requires strengthened governance: legitimacy, space, and support for civil society, for an accountable private sector, and for people across society to agree public interests and reinvest in the value of collective action. In a globalized world, the need for governance dedicated to equity applies equally from the community level to global institutions. [5]*

There is growing evidence that providing increased voice to vulnerable or disenfranchised populations is important to improving health equity at a number of levels [1]. A systematic review of the literature on the influence of the political context on health equity at a national level found that the only factor consistently associated with improvements was the political incorporation of formerly subordinated groups—an association was found in six out of seven studies [1]. Research on place-based initiatives has demonstrated that the quality of local governance is associated with better outcomes even when taking variation in the projects delivered into account [6–8], although this finding varies depending on the context of the program.

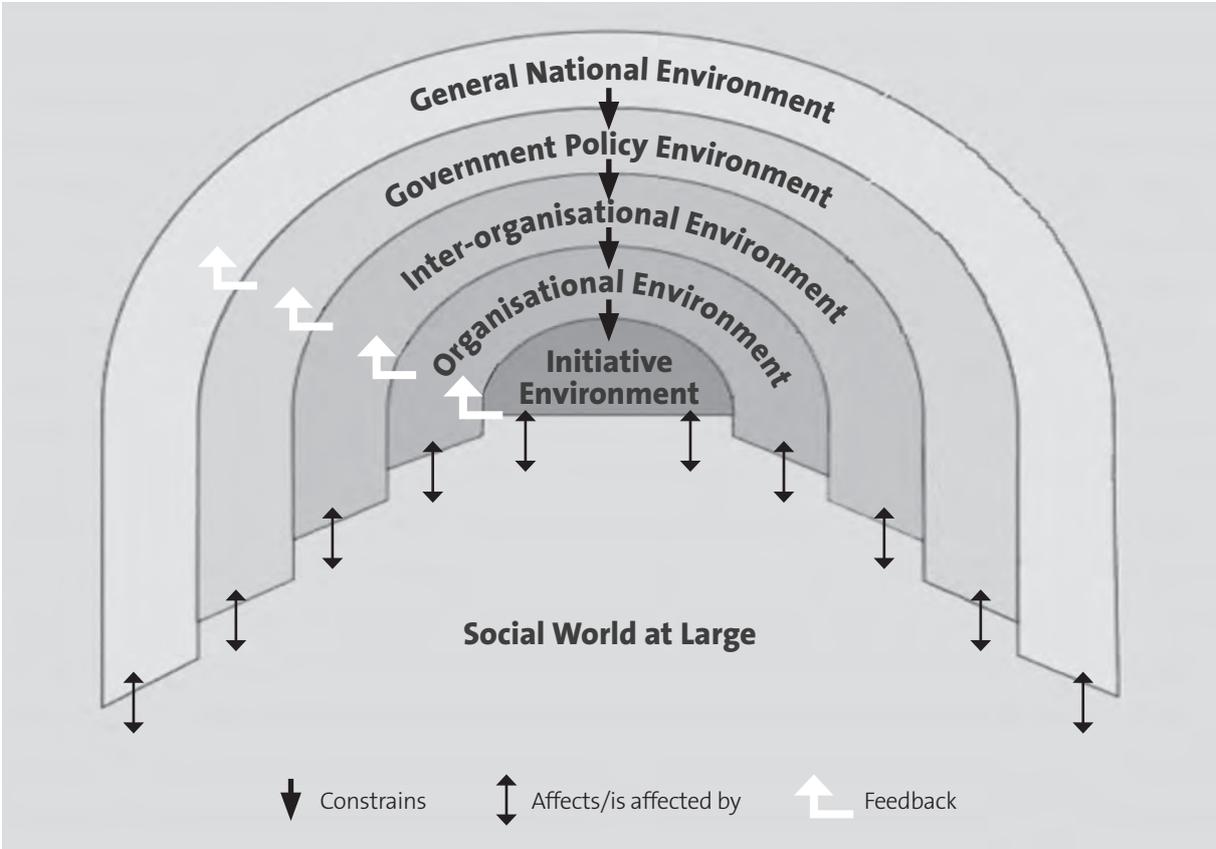
Despite an increasing recognition of the importance of governance, much of the research linking models of governance to better performance does not examine the pathways via which this occurs [9]. There is growing consensus that a more nuanced analysis of power in collaborative governance models is crucial to understanding how they might create an environment for improved health care. Phillips et al. [9], in a systematic review of primary care, acknowledge that Aboriginal and Torres Strait Islander health is at the ‘vanguard’ of developing new models of governance because of the need for accountability to community in terms of the quality of services provided. The advent of the National Indigenous Reform Agreement (NIRA) [2] and the IHNPA [3, 4] has led to further development/

application of collaborative approaches to governance through committees and forums at national, State and regional levels. The activities associated with these committees and forums are referred to throughout this report as collaborative governance.

Within various countries, the integration of top-down and bottom-up approaches in policy development has been viewed as a key mechanism to make policy and institutions more inclusive of citizens and more responsive to their needs [10]. The governance of programs associated with the NIRA is embedded in complex national, policy, inter-organisational and local environments (Figure 1).

At a national level, overarching agreements are delivered by a range of Commonwealth and State and Territory government departments. This process is overseen at State and Territory level by planning committees, including tripartite Aboriginal and Torres Strait Islander health forums and, in some cases, regional planning committees. The approach to collaborative governance, the balance of power between regional and other stakeholders, and the composition of committees varies between and within agreements and jurisdictions. It has been argued that difficulty in balancing the needs and priorities of stakeholders at different levels has been a major contributor to mixed results in joined-up initiatives [6-11]. However, there has been very little focus on how these processes could be improved.

Figure 1: A generic model of nested environments for local Initiatives



Source [12: p. 2884]

Evaluations have tended to judge success in terms of whether the interventions have achieved defined outcomes, but tended to overlook the process of reaching these outcomes. This has occurred because theory around participation has not pervaded evaluation frameworks. Nelson and Wright [13] describe participation as progressing from ‘instrumental’ to ‘transformative’, depending on the rationale associated with participation. In instrumental participation, collaborative governance and other types of participation are seen simply as a means to achieve particular policy outcomes. In transformative participation, collaborative governance is seen as an end in itself, as well as a means to achieve certain outcomes. Transformative participation is associated with shifts in decision-making power, whereas instrumental participation is not. In health policy the discussion around participation has a transformative perspective but approaches to the study of these processes have not evolved to keep pace.

The NIRA initiatives have been associated with clear shifts in resources and decision-making power; that is, the point of participation would seem to be transformative. However, the performance benchmarks are more suggestive of an instrumental approach. For example, despite the principles stated in the NIRA and the amount of time and energy devoted to establishing collaborative governance, there are no benchmarks that evaluate the engagement of Indigenous people and the process of making Indigenous health ‘everyone’s business’. Modern conceptions of responsibility in government require that all programs are outcomes orientated and it would be naive to suggest otherwise; however, governance is a clear contributor to program quality. Developing this key area of knowledge in a policy environment of unprecedented change is the primary focus of the PIE project.

## Key documents and terms

Three key government policies form the background to the PIE project:

- the National Indigenous Reform Agreement [2]
- the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes [3]
- the National Partnership Agreement on Indigenous Early Childhood Development [4]

The NIRA frames the task of Closing the Gap in Indigenous disadvantage. It sets out the objectives, outcomes, outputs, performance indicators and performance benchmarks agreed by COAG.

The six COAG Closing the Gap targets outlined in the NIRA are:

- to close the gap in life expectancy within a generation
- to halve the gap in mortality rates for Indigenous children under five within a decade
- to ensure all Indigenous four-year-olds in remote communities have access to early childhood education within five years
- to halve the gap in reading, writing and numeracy achievements for Indigenous children within a decade
- to halve the gap for Indigenous students in year 12 equivalent attainment by 2020
- to halve the gap in employment outcomes between Indigenous and non-Indigenous Australians within a decade.

The NIRA also provides the framework that links together National Agreements and National

Partnership agreements which address specific elements of the reform. The two IHNPAs—the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes [3] and the National Partnership Agreement on Indigenous Early Childhood Development [4]—are included in the agreements outlined in the NIRA.

National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes [3] fall under the following five priority areas:

- tackling smoking
- healthy transition to adulthood
- making Indigenous health everyone's business
- primary health care services that can deliver
- fixing the gaps and improving the patient journey.

National Partnership Agreement on Indigenous Early Childhood Development [4] program areas include:

- Element One: Early childhood service integration – Children and family centres
- Element Two: Antenatal care, pre-pregnancy and teenage sexual and reproductive health
- Element Three: Increase access to, and use of, maternal and child health services by Indigenous families.

The regional planning forums, which are the focus of this report, are responsible for the delivery of the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes and Elements Two and Three of the National Partnership Agreement on Indigenous Early Childhood Development.



# Methods

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The approach to the PIE study involved seven key stages:

1. development of a research framework
2. establishment of a project reference group
3. ethics approval and consent process
4. collection of interview and survey data from forum members
5. analysis
6. regional reporting and feedback
7. final report and recommendations.

The research framework and the methodology underwent a quality assurance process convened by the Lowitja Institute. The Lowitja Institute brought together key stakeholders from government, health departments, Aboriginal Community Controlled Health Organisations (ACCHOs) and the Aboriginal and Torres Strait Islander community to provide input on the development of the project, the methodology and the associated process of consultation.

## Literature review

A literature review was conducted in order to ensure that key concepts associated with best practice to ensure meaningful participation in the planning, implementation and governance of programs to improve health equity were represented in the research framework. The databases searched included Academic Search Premier (EBSCO), APAFT: Australian Public Affairs – Full Text (Informit), Expanded Academic ASAP (Gale), JSTOR, Ovid (Medline) and ISI Web of Science. The search terms used included power, policy process, planning, governance, public/citizen participation or stakeholder engagement and health. The search covered the period from 1990 to 2011 although seminal research conducted before this period is also included. In addition, the literature

on deliberative democracy was reviewed to identify concepts that might be useful in informing the research framework.

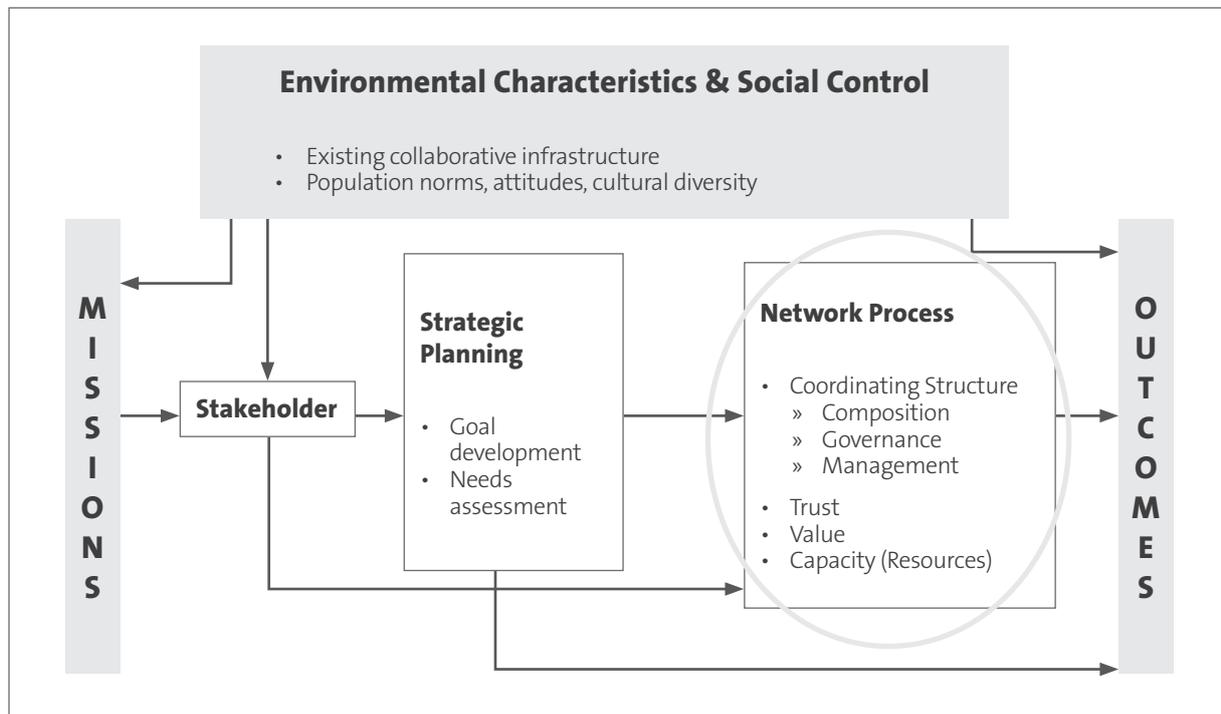
The literature review suggested two key ways in which the participation of the community in planning and program development processes is conceptualised. The first way is in terms of the extent to which the community has power to authorise decisions. For example, in Arnstein's classic framework [14], community participation is seen as going through a series of stages from non-participation and tokenism to some degree of community power. The second way is by conceptualising community participation in terms of the point of the planning and policy process in which participation occurs [15]. Participation in policy making is not characterised in absolute terms but rather in terms of its appropriateness to the policy problem. Although this approach more accurately reflects the policy-making environment, it does raise the issue of who decides what kind of participation is necessary and when. Models of best practice need to incorporate both approaches.

A number of models have been developed to inform best practice around community engagement in planning. These typically embed the planning process in a governance structure that includes community and other stakeholders. For example, Varda et al. [16] includes five stages: goal development, community needs assessment, gap identification, priority setting and resource inventory. Although these protocols are useful for understanding whether community has been engaged at different stages of the planning process, they do little to inform understanding of the quality of engagement. Varda et al. [16] adds to conventional understandings of planning by adding dynamic network approaches to the understanding of power as shown in Figure 2 (overleaf). This introduces the idea that power is located not only in the people/organisations involved themselves or by their presence or absence alone but by the social

processes that bind them together in the planning processes. This addition of network processes provides a clear link between approaches to planning

literature and theory around what constitutes power in participatory processes.

**Figure 2: The role of network processes in planning**



Source [16, p. E6]

## Research framework

The research framework incorporates both approaches to conceptualising participation [14, 15], social network process [16] and theory concerning how social processes modify and reinforce each other [17]. The research framework outlines indicators to measure different aspects of how participants are conferred with power in the

context of governance (Table 1). The framework encompasses all aspects of the process from representation to implementation. Consistent with the literature, the framework addresses who is included, the process of deciding what is to be achieved and the structure that determines how it is to be implemented [18].

**Table 1: Framework for evaluating participation in governance**

<b>Aspects of governance</b>	
<b>Who is involved?</b>	
<b>Representation</b>	<b>Indicators</b>
Community representation	% community representatives % community organisations represented
Legitimacy of representation	Selection process Constituency (formal/informal) of representatives Recognition of legitimacy within the forum
<b>What is to be achieved?</b>	
<b>Planning processes</b>	
Strategic planning processes	Reporting/consultation Assessment of community needs and priorities Review of community health status Focus of change Review of existing resources and activities [19]
<b>Shared goals</b>	
Shared understanding of purpose	Terms of reference Role within the planning cycle Consistency of terms of reference, and Acceptance/understanding of terms of reference and role within forum [20]
<b>How will it be implemented?</b>	
<b>Process decision making</b>	
Identification of strategies and goals	Engagement in preference-shaping [21]
Prioritisation	Engagement in agenda-setting [21] and 'non-decision making' [22]
Decision making	Patterns of influence [19, 23, 24]
Access to resources	Resource allocation
Diffusion of innovation	Formal and informal network ties [16, 23]

## Ethics approval

The PIE project was approved by the human research ethics committee at the University of Melbourne and the Western Australian Aboriginal Health Information and Ethics Forum. State and Territory tripartite forums in Victoria and Western Australia endorsed the collection of study data. Tripartite forums consisted of representatives from State government, federal government and the Aboriginal community-controlled health sector. Each forum identified representatives to sit on the project

reference group, which played an active role in refining the scope, focus and design of the project. Project reference group members identified regional case studies for the project.

There were two levels of informed consent in the project. First, consent to participate was sought from each forum before contacting members of the forum. Second, informed consent was sought from each member as to who should be approached to participate.

## Sample

The sample for this study included State-level forums and case studies based on health regions [25, 26] (nine in Victoria and seven in Western Australia). In Western Australian, regions included the South Metropolitan area, Kimberley, Pilbara, Goldfields and Midwest. Victorian case study regions were Barwon-South West, Gippsland, Loddon Mallee, Hume, Southern Metropolitan and Eastern Metropolitan.

Interviews and surveys were conducted with members of the forums in case study areas. Organisations rather than individuals were the unit of analysis for the study. In terms of organisational representation, the response rate was 77 per cent in Victoria and 71 per cent in Western Australia. Table 2 outlines the characteristics of the organisations included in the sample and their relationships with other organisations in the forum.

**Table 2: Sample characteristics**

Variables	Values	% (n = 188)
State	Western Australia	33.0
	Victoria	67.0
Remoteness	Urban	27.9
	Rural	57.6
	Remote	14.5
Aboriginal organisation	Yes	25.5
	No	74.5
Links	Aboriginal to Aboriginal	8.8
	Aboriginal to mainstream	14.0
	Mainstream to Aboriginal	22.7
	Mainstream to mainstream	54.5

## Interviews and surveys

The processes associated with governance were assessed using two main data sources:

- interviews to examine the process of planning and governing IHNPA activity
- social network survey data.

These data were linked with health services data in order to assess outcomes.

Interviews and surveys were conducted with the members of the forums representing their organisations. The interviews were semi-structured, with questions focusing on:

- the composition of the forum
- involvement in strategic planning processes
- the extent to which goals and values were shared among the members, particularly between Aboriginal and Torres Strait Islander and mainstream organisations

- the process of decision-making
- successes
- areas for improvement, as well as key learnings.

Social network data were entered directly into a specifically developed computer survey program that linked to a Microsoft Access database. This approach was used to minimise the load on participants by enabling them to only answer detailed questions about organisations they had links to and by creating a seamless transition between questions about different organisations and levels of governance. The survey asked participants about the forums with which they were involved and about their relationships with other organisations in that forum. The study focused on the networks formed between organisations in terms of:

- frequency of contact
- the importance attributed to the relationship
- the effort required to maintain the relationship.

The survey also asked organisations about their satisfaction with the governance processes in which they were involved and the likelihood that the plans developed would be successfully implemented.

Interviews were recorded and survey responses were entered directly on the computer.

Data on the composition of forums was coded in terms of the percentage of Aboriginal and Torres Strait Islander organisations and percentage of Aboriginal and Torres Strait Islander community representatives.

Three measures of health service uptake were used:

- Aboriginal and Torres Strait Islander health assessments offered through Medicare
- potentially avoidable hospitalisations
- State-based child health assessments.

These measures were selected because they are important indicators of changes in care to improve the early detection, diagnosis and intervention for common and treatable conditions that cause high morbidity and early mortality. They are also areas that have historically been a major area of disparity between Aboriginal and Torres Strait Islander and non-Indigenous Australians [27, 28].

## Analysis

The interview data were analysed thematically using a template based on the research framework. Specifically, transcripts of the interviews were coded to:

- examine the participation of Aboriginal and Torres Strait Islander community/organisations in planning
- identify key relationships between participating organisations
- identify the extent to which key values are shared
- understand the role of these organisations in relation to planning processes.

Emergent themes that we had not accounted for in our coding were also identified through this process.

Logistic regression was used to examine the relationship between the representation of Aboriginal and Torres Strait Islander community/organisations

on the forums and satisfaction with the process and the perceived likelihood that the planned project would be implemented. It was used to also examine the relationships between organisations within forums using the survey data and the regional uptake of Aboriginal and Torres Strait Islander health assessments and child health assessments and potentially preventable hospitalisations for chronic and acute conditions. The independent variables included time before and after the IHNPA, State (Victoria, Western Australia), percentage of the forum comprising Aboriginal and Torres Strait Islander organisation representatives, percentage of the forum from the Aboriginal and Torres Strait Islander community, and links between Aboriginal and Torres Strait Islander and mainstream organisations. Two analyses were conducted to examine inter-organisational networks based on the frequency that organisations worked together and the importance they placed on each relationship. The analyses controlled for remoteness (major cities, inner and outer regional, remote and very remote).

## Case studies and forums

The federal government and the seven State and Territory governments jointly deliver the IHNPA. The PIE project included two State case studies, Victoria and Western Australia. Victoria, the smallest of the mainland States, is 227,416 square kilometres in area and has no remote areas [29]. Western Australia is the largest State in Australia (2,529,875 square kilometres) and the second-largest State/province/national region in the world [29]. Seven per cent of Australia's Aboriginal people live in Victoria and 13 per cent live in Western Australia [30]. The percentage of the population that is Aboriginal is 1 per cent and 3 per cent respectively for Victoria and Western Australia [30].

Victoria and Western Australia were selected as case studies because they encapsulate the full range of areas (urban, rural, remote) where Aboriginal Australians live. More importantly, Victoria and Western Australia both chose to manage their contribution to the IHNPA through regional planning forums that were responsible for the planning, implementation and governance

of the IHNPA activities created in accordance with corresponding service boundaries of the regional health department branches.

Victorian and Western Australian forums comprised local ACCHOs, health departments and mainstream health providers. Some forums included representation from the Aboriginal and Torres Strait Islander community and other relevant Aboriginal and Torres Strait Islander and mainstream organisations. All Victorian forums had representation from Aboriginal and Torres Strait Islander community members. Western Australian forums, on the other hand, for the most part comprised only organisational representatives.

In Victoria, forums were co-chaired by an ACCHO representative and the director of the regional health department branch. In Western Australia, forums were usually chaired by an ACCHO. Both States had a rotating chair policy among the Aboriginal and Torres Strait Islander members. The processes for developing and approving plans were similar in both Victoria and Western Australia. Individual organisations within forums developed proposals, there was an internal cull process, a local plan was developed and then the budget was approved by the State health department. However, in Victoria the forums knew their allocated budget, and the role of the health department was to provide advice and ensure adherence with the guidelines. Priority setting was done at a forum level. In contrast, Western Australian forums did not know how much money would be allocated to their regions, and decisions about which components of the plans to fund were made by the State health department.

In total, there were 29 forums in Victoria, representing 148 organisations, and 21 in Western Australia, representing 127 organisations (note: organisations were usually represented on forums by more than one person). All the regional planning forums had representation from the community-controlled sector. In those regions where there were no ACCHOs, Aboriginal and Torres Strait Islander people were engaged in the process directly as community representatives on the forums. However, the majority of respondents were representatives of mainstream service provider organisations.

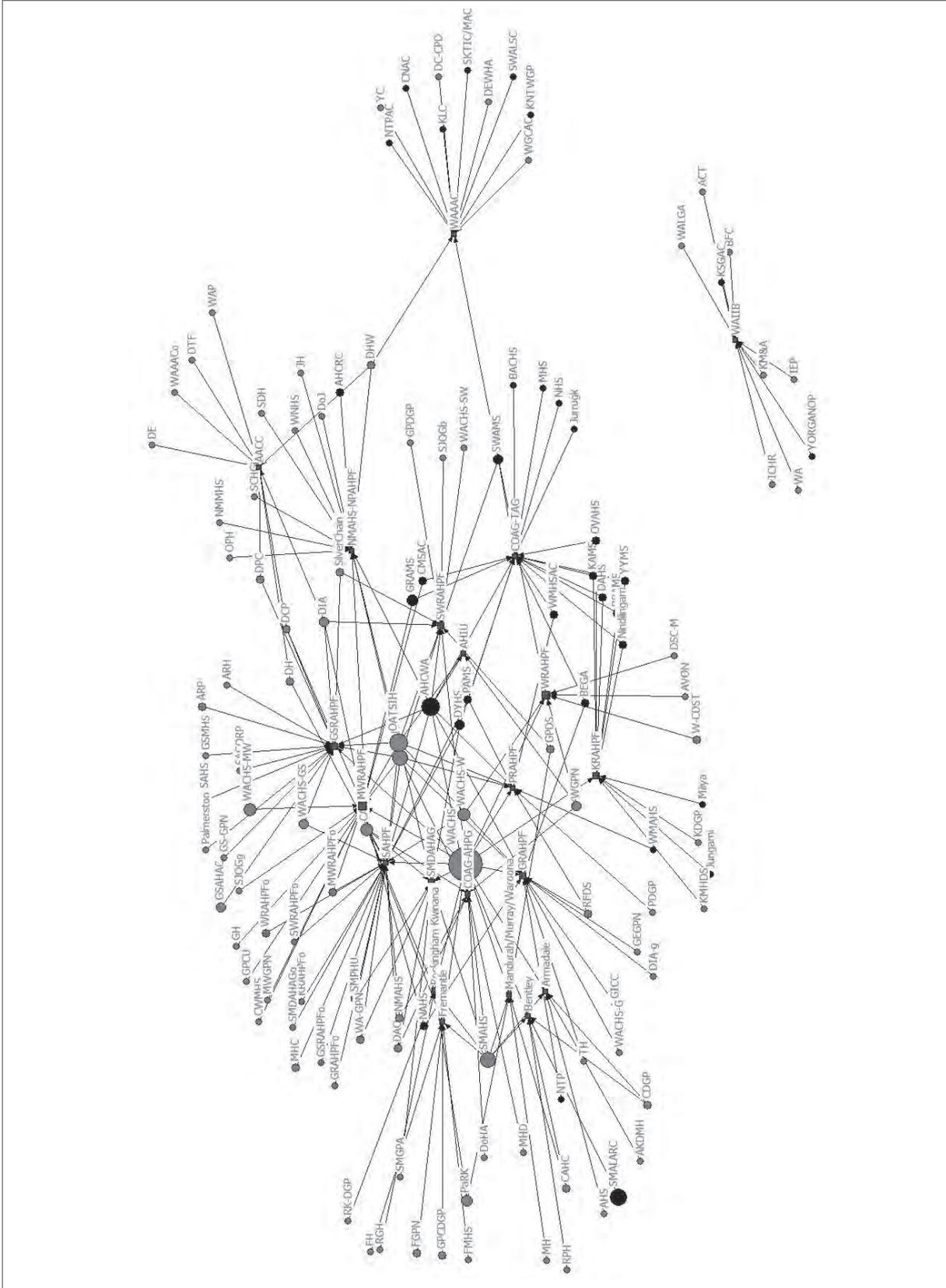
Aboriginal and Torres Strait Islander community/organisations made up 29 per cent and 21 per cent of the forum members in Victoria and Western Australia respectively. All forums, their composition and co-membership links were mapped and analysed.

Figures 3 and 4 show the structure of the forums in Victoria and Western Australia—the forums, the member organisations of each and the links between the forums. The size of the marker representing each organisation shows the extent to which it is connected. They highlight the complexity of the ways in which collaborative governance in Aboriginal and Torres Strait Islander health is structured. The figures show that in both States there are a relatively small number of highly connected organisations and forums at the centre, and a large number of organisations with a small number of connections at the periphery (density = 8% in Western Australia and density = 5% in Victoria). The core organisations in both States were the Office of Aboriginal and Torres Strait Islander Health, State health departments and peak organisations for ACCHOs. These network graphs reinforce the importance of tripartite forums as central connecting agencies in Aboriginal and Torres Strait Islander health within States. This was strongly reinforced by interview data that showed the engagement of tripartite forums added a sense of legitimacy to the planning and governance processes. In Western Australia, the tripartite forum was expanded to include the peak organisation for Medicare Locals, which appeared to improve the centrality in Western Australia compared to Victoria, where no such expansion occurred.

There was a higher level of co-membership in Western Australia because of a mid-level committee that had membership from all the regional forums. This committee provided an important mechanism for information sharing and also for corrections of scale. Corrections of scale occur when a problem observed in a number of regions can be addressed at a State level. Conversely, local solutions can be found for more idiosyncratic issues.



Figure 4: Collaborative governance networks in Western Australia—links between forums and organisations





Overall, although the health sector was relatively well connected, there was little evidence of connection across sectors. This is most clearly shown in Figure 4 (p. 14), where there is little connection between the Western Australian Indigenous Implementation Board and the network of health regional planning forums. This is highlighted in Figure 5 (p. 15) which shows co-memberships. Developing intersectoral connections may be an important priority for the future.

## Limitations

In this report we make a *prima facie* case for governance and associated social processes to have a role in improving health equity. In doing so, we simplify some very complex social processes. The analysis focuses on the links themselves rather than network indices. Although there is value in this generalised approach, it should be considered a complement to, rather than an alternative for, detailed network analysis of the forums (for example, statistical models for social networks).

This report examines collaborative governance in the context of a national policy initiative that precluded both experimental and quasi-experimental designs. However, variation in the performance of different regional forums is used as a way to better understand the role of governance in health equity.



# Results of interviews and surveys

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## Responses from the forums

Collaborative governance resulted in greater engagement by the mainstream sector and Aboriginal and Torres Strait Islander communities. This development was welcomed and valued by most respondents, particularly those who recognised the need for greater collaboration and integration if better health outcomes are to be achieved.

*There's a recognition that more than one group can provide [input] and together we can cumulatively provide a good service, that we're both important to each other. And we're both important for the good of the Indigenous community. (Mainstream service provider respondent)*

In both jurisdictions there was agreement that attendance by executive-level management was important because their role placed them in a position to influence the operating culture within their own organisations. Essentially this was because the planning forums

*are not incorporated bodies. They can't make any kind of resolution on behalf of everybody, because they're not an entity, you know. What they can do is make recommendations of how things should be, and then each organisation has to take that up with their own boards, who will then ratify it or not, but one would assume that if it's a good idea and it's worthwhile, that we are in the business of having better outcomes for health for Aboriginal people, that we would follow through and accept that those ideas are good. (Aboriginal service provider respondent)*

It was also beneficial for the position of Chair to be held by someone in a leading position within the policy-making environment because it was the Chair's role to pass on the planning forum's recommendations to the funders.

The following interview extract exemplifies this:

*If the Chair agrees to pass up that recommendation, that means that they endorse it, and if the Chair is a key person within...DH [Department of Health, Victoria] or DoHA [Department of Health and Ageing, Commonwealth Government], that's good for the members. So from a strategic point of view, from the membership point of view, I would like that to be a funder. (Mainstream service provider respondent)*

In both jurisdictions there were tensions around the breadth of engagement of the forums. Some respondents felt that there should be greater intersectoral engagement in order to help the forums more effectively address the social determinants of health. However, others felt there was a need to keep the focus of forums and their membership firmly on health service provision in order to maximise their effectiveness in this area. Balancing this tension required the ability to reconfigure the forums to address changing needs. For example, the Kimberley forum decided to reduce its membership to include service providers only in order to sharpen the focus on providing better health services. At the same time, working groups were often convened to address particular issues and could involve a broader range of stakeholders including policy makers.

Another means of dealing with this tension was to structure the forums to have a core group and a peripheral group of members, where only the core members had decision-making power.

*And again a primary health care provider is core. The government aspect then actually became advisory, not core. So they didn't have a voting power. So they are putting information in but the primary health care teams are the ones that — the health providers are the ones that actually make decisions which we think is the go. (Aboriginal service provider respondent)*

As indicated earlier, community representation on planning forums in both Western Australia and Victoria was generally provided through ACCHOs, but a notable exception was in the major urban areas, where the Aboriginal and Torres Strait Islander community is less clearly defined and is more likely to consist of people from diverse kinship groups, many of whom would not be considered as the traditional owners of the lands on which they live.

Boxes A and B illustrate differences in the composition and establishment of forums in rural/remote areas compared to urban areas. In the Midwest, Western Australia (Box A), the structure is relatively simple, with a single committee based on key organisations in the area. In contrast, in Southern Metropolitan, Victoria (Box B, p. 20), a considerable process was required to establish the committee, and there were multiple levels and higher levels of community engagement.

### Box A: Case study—Midwest region, Western Australia

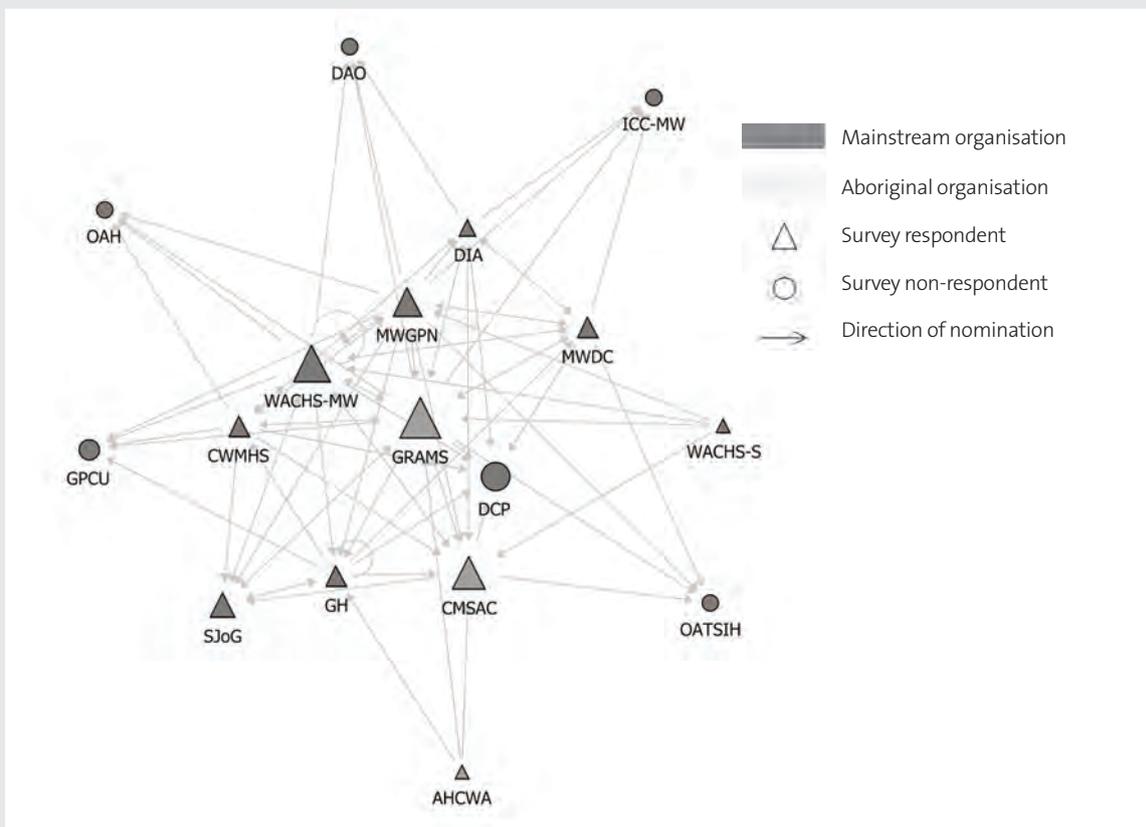
The Yamatji (Midwest) Regional Aboriginal Health Planning Forum has a broad membership base that is not strictly restricted to health service providers. Figure A1 shows the member organisations. The forum has strong representation from the management of the four core service providers in the region—West Australian Country Health Service Midwest (WACHS-MW), Geraldton Regional Aboriginal Medical Service (GRAMS), Carnarvon Medical Service Aboriginal Corporation (CMSAC) and Midwest General Practice Network (MWGPN)—as well as other health organisations. This facilitates productive discussions about which service providers are best placed to deliver which programs:

*We sit down and talk about who is best placed to deliver. So, for example, WACHS has the best capacity to deliver allied health programs at the moment. So they should do that. It might not always be that way but at the moment that is the way to go. We have other strengths and we do those programs. (Aboriginal service provider)*

Figure A1 suggests that the relations between the organisations in the Midwest hinge on these four core service providers from a co-ordination hub in the middle of the network. The star shape created by their spatial distribution results because the organisations at the 'points' have been nominated as contacts by just two or three of the closest organisations to them but not the others. However, all the relationships between the organisations suggest a network where power and influence are not highly concentrated. This is a network that consists of people who are powerful in their own organisations in a network where power is shared. This contributes to highly effective collaborative governance.

Box A cont...

Figure A1: Network of organisations that work together in the Midwest forum



Acronym	Name	Acronym	Name
AHCWA*	Aboriginal Health Council of Western Australia	ICC-MW	Indigenous Coordination Centre
CMSAC*	Carnarvon Medical Service Aboriginal Corporation	MWGPN	Midwest General Practice Network
CWMHS	Central West Mental Health Service	MWDC	Midwest Development Commission
DAO	Drug and Alcohol Office	OAH	Office of Aboriginal Health
DCP	Department of Child Protection	OATSIH	Office of Aboriginal and Torres Strait Islander Health
DIA	Department of Indigenous Affairs	SJoG	St John of God Hospital
GH	Geraldton Hospital	WACHS-MW	West Australian Country Health Service—Midwest
GPCU	Gascoyne Primary Care Unit	WACHS-S	West Australian Country Health Service—State
GRAMS*	Geraldton Regional Aboriginal Medical Service		

\*ACCHOs

## Box B: Case study—Southern Metropolitan region, Victoria

The Southern Metropolitan region of Melbourne is home to a very diverse and rapidly growing Aboriginal and Torres Strait Islander population that comprises 14 per cent of the total Victorian Aboriginal and Torres Strait Islander population. Three local government areas within the region are in the top 20 for the largest number of people aged 0–24 years. Additionally, the Aboriginal and Torres Strait Islander population in the City of Casey grew at the highest rate in metropolitan Melbourne in the years immediately preceding the commencement of the IHNPA. Although the population may be large, it is geographically dispersed and very fragmented and it has access to only two ACCHOs within the region itself, one of which is a State-wide specialist service. This created a challenge for the Southern Metropolitan Department of Health branch because

*people didn't know where community was... [The first step in the process was therefore to] bring the community together because that was really lacking... and it was basically door knocking community people to get them involved. (Department of Health respondent)*

Once the community became involved in the process, it was proposed that a local planning and implementation structure was required in the region because

*the Aboriginal communities in each area... [were] completely different, their needs were different, the services available in the local area were different and so they wanted to be in charge of their own destiny locally. (Department of Health respondent)*

Three local reference groups were established using the four Local Indigenous Networks in the region as a reference point: the Urban South network, which covers St Kilda and the inner south; the Hastings network; and the Frankston and Mornington Peninsula network. For the Casey, Dandenong and Cardinia areas, localised planning was made possible by using a pre-existing Local Aboriginal Community Partnership, whose membership was altered to make it more applicable to the IHNPA.

*The concept of the local reference groups evolved from the contribution of members of the committee, so community members, in particular, emphasised the need for that local reference point and so as a result... we developed the idea, basically you've got to go and talk to the local communities and do that throughout the life of that initiative, and so as a result of that we developed the concept of (a) the consultation with the Local Indigenous Networks and then (b) the local reference groups. (Department of Health respondent)*

The establishment of these site-based reference groups has enabled the diverse communities in the region to meet and discuss their needs and priorities. This has enabled community input into the planning process and respondents agreed that the establishment of these groups has been a major achievement and key strength of planning process in the region.

There was no systematic process to determine fair and appropriate representation of Aboriginal and Torres Strait Islander community members on the forums, particularly in urban regions where the size or distribution of the Aboriginal and Torres Strait Islander population is, in some instances, not even known. Community representatives tended to be drawn from pre-existing networks, such as the Local Indigenous Networks (LINs) or community activist groups. Although this partly reflects the tight timeframes, it also indicates the need for a longer discussion about appropriate participation in different areas.

Some respondents were critical that, in most cases, the Aboriginal and Torres Strait Islander members on these planning forums tended to be Aboriginal Health Workers, Aboriginal Liaison Officers or other Aboriginal and Torres Strait Islander staff of member organisations. This was felt to be an issue because they were essentially expected to undertake two roles at the table and this was thought to be an unrealistic expectation that could potentially lead to a conflict of interest:

*We had a number of people that were on the... [planning forum] or attended it, who were Aboriginal or Torres Strait [Islander, but] they came as professionals representing organisations. They didn't come as a community member. And that is one area that I think that we assumed they would have two roles, and I think that's wrong.*  
(Mainstream service provider respondent)

It was also noted that it was difficult to get consistent attendance at meetings because of competing demands on community members' time. This raised another important issue, namely the extent to which community members were able to make informed decisions, given the large volumes of preparatory reading provided prior to meetings. This is an important issue, especially in areas that rely on these people for community input in decision making. However, in some regions

*there's limited Aboriginal staff that have the confidence to go to meetings because they feel like they get pinpointed with anything that's to do with Aborigines'. (Mainstream service provider respondent)*

In contrast, in more remote areas communities were more clearly defined and politicised, with established

mechanisms for advocacy and accountability already in place through the community-controlled sector. In remote areas the question of how a community is defined and who comprises it was not seen to be an issue. Members of planning forums in these more remote regions, such as the Pilbara or the Kimberley, predominantly felt that appropriate community engagement in the planning process was achieved through the involvement of ACCHOs:

*The Pilbara Aboriginal Community Health Service, their board is made up of representation from the four Western District communities, so a representative of their board in theory does represent the Western District community, communities.*  
(Mainstream service provider respondent)

Although respondents generally shared this view, they also noted community involvement through ACCHO representation had its own drawbacks and that, partially, it was also a matter of necessity, given the vastness and remoteness of these regions and the high cost, both in time and money, that travelling to planning forum meetings entailed. One drawback concerned the integrity of people representing the community because, in a competitive funding environment, ACCHOs may have interests that differ from the interests of the community they represent. In some instances this was dealt with by having community representatives sit alongside organisational representatives.

*Only if you've got people such as myself that have listened to their boards, and say, right, we've got a strategic plan, this is what the board wants, put that strategic plan on the table, then it's not a white person standing up, a white fella standing up in front of a group of people, it's me just putting the document on the table to say this is where our group of Aboriginal people want to go. That's different. Now, not everyone comes to the table with that approach.* (Aboriginal service provider respondent)

Box C (overleaf) describes the Kimberley forum in Western Australia. This forum was unique among the case studies because the majority of its members were Aboriginal and Torres Strait Islander. This contributed to a significantly different governance environment.

## Box C: Case study—Kimberley region, Western Australia

Unlike urban areas with diverse and often fragmented Aboriginal and Torres Strait Islander communities, communities in the remote regions are much more clearly defined and politicised, with established mechanisms in place for advocacy and planning. These existing arrangements have made it easier to engage with communities in the COAG planning process in these regions. The Kimberley region in Western Australia is a case in point. Among the case study regions, the Kimberley region has the highest proportion of Aboriginal and Torres Strait Islander people in the population, estimated at 40 per cent of the total population according to the latest census data available, and many have been politically active for a long time. This is evident in the large number of ACCHOs in this region and the strong working relationships they have with each other and with the mainstream sector, and Kimberley Regional Aboriginal Health Planning Forum respondents were confident that the member ACCHOs, with their boards and membership base, are representative of the Aboriginal and Torres Strait Islander people and their communities in the Kimberley. Moreover, the representatives from these community-controlled organisations tend to be Aboriginal and Torres Strait Islander people from the Kimberley themselves. Respondents from the Kimberley felt that community participation in the Kimberley is therefore not something that needs to be formalised, considering that

*you don't have to go and have a special meeting or special effort all the time to get Indigenous input because the regional manager is an Indigenous person... (Mainstream service provider respondent)*

The Kimberley Regional Aboriginal Health Planning Forum was the only planning forum included in the case studies whose membership comprised more ACCHOs than mainstream services. We interviewed 14 forum members and we know that the outstanding organisations are also ACCHOs. The composition of the forum therefore reflected the Aboriginal and Torres Strait Islander distribution of the overall population, which effectively meant that

*[more than] 50 per cent of the people attending the planning forums are Aboriginal... and, you know, we all work with the Aboriginal communities, for Aboriginal health and you can't do that successfully unless you actually are... communicating... with the communities, doing consulting with the communities, so I think the voice is very loudly heard... Because I think they are very heavily represented. (Aboriginal service provider respondent)*

## What is to be achieved?

### *Shared goals*

Overwhelmingly, respondents had a shared understanding of the goals of the planning forums they attended. The clearly expressed main aim of the planning forums was to improve health outcomes for Aboriginal and Torres Strait Islander people within the confines of the framework set out in the IHNPA. As such, planning forums were seen as an opportunity for collaboration among service providers to work together towards a more coordinated approach to the planning and delivery of primary health care services in the regions. Perhaps more importantly, they created a platform for dialogue with communities, giving them a voice in the policy-making process so that local needs could be identified and locally appropriate solutions developed to address these needs. The appointment of an Aboriginal person in the position of chair or co-chair promoted and underlined the importance

of this objective. It also highlighted the government's commitment to working in partnership with Aboriginal and Torres Strait Islander communities.

*I think the Department [has] put a lot of faith in the Steering Committee, which is excellent. I've heard that feedback by the Aboriginal representatives is that they feel really appreciative... of the space... the department [has] given them to make decisions and make project plans, and to bring that back to a table where they're sitting around... Aboriginal peers making decisions... Looking at self-determination and self-determined principles was really important [and a] critical part of how we needed to go about this. We needed... transparency for anyone else that might come into the picture later... [about] how those projects actually came to fruition. (Department of Health respondent)*

Box D highlights the importance of valuing Aboriginal perspectives by ensuring that leadership roles in forums are held by participants from ACCHOs or the community.

### Box D: Aboriginal chairs

Planning forums were influenced by their leadership and respondents emphasised that it was important that an Aboriginal person chaired the meetings. This was mandated at State-level. Aside from being a symbol of respect and commitment to partnership, chairs did influence members' perceptions of the aims of the planning forums.

Two interview extracts illustrate this:

*Having a senior role to play on the committee... is something that's really respectful of Aboriginal people and in particular ACCHOs... So I'm the co-Chair of the committee [alongside] the [DH] director of the region. So symbolically it's a respectful thing to do. It's not just about me personally, it's ACCHOs holding the seat. (Aboriginal service provider respondent)*

*The people at the table are mainstream... 'I'm the doctor, I'm the nurse, I'm the midwife... I know what is best. Don't need a community person telling me what to do.' It's a different way of thinking and I don't know how that would break down. I... thought once... that it'd be good for some of the people who sit on forums where there isn't an... [ACCHO] to actually go out into the regions and just sit on a forum where the chair is under the CEO [chief executive officer] or the chairperson of the... [ACCHO] and just see how it works, because it does work differently. You know the community and what the community wants, that's a priority and it's the forum's job to work towards that... Whereas with... some of the forums I've been to, where there isn't an... [ACCHO] the focus isn't a lot on what the community wants. It's workers funded to do this job. Are we meeting our outcomes? (Aboriginal service provider respondent)*

Furthermore, and perhaps because of this, it may have also had an impact on the rate of attendance by community representatives at meetings. Because it signified respect towards Aboriginal people, it also created a more welcoming environment for community representatives to have a say.

Tensions among forum members mainly stemmed from differences of opinion about how to best achieve a forum's aims and who was best placed to deliver a program. Perhaps unsurprisingly, some competition surfaced along boundaries between the mainstream services and the community-controlled sector, particularly because of the emphasis placed on a holistic view of health. Respondents noted that the advantage of ACCHOs was that their services are based around the needs of the clients as opposed to an expectation that clients should conform to how they operate. This was in contrast to the mainstream sector, which does not have the flexibility to tailor services specifically to the needs of Aboriginal and Torres Strait Islander people. This raised concerns among Aboriginal and Torres Strait Islander respondents that Aboriginal and Torres Strait Islander clients would not receive care appropriate to their needs through programs delivered by the mainstream sector, especially considering that

*if you are providing services to Aboriginal people, they feel a lot more comfortable if it's an Aboriginal*

*person that is delivering the service to them'.  
(Aboriginal service provider respondent)*

However, competition between Aboriginal and Torres Strait Islander organisations was also a significant issue.

*Competition squabbles around who could—who would be best placed to deliver services, who should be delivering service. People saying they can do everything and they can't really demonstrate competencies for them doing everything. And therefore the service on the ground wouldn't be what it should be. (Aboriginal service provider respondent)*

Resolving these issues was often difficult because forums had no objective data on past investment and past performance of services.

Box E highlights the importance of building the capacity of mainstream services to address the needs of Aboriginal and Torres Strait Islander people when the ability to choose services at an ACCHO is constrained.

## Box E: Making Aboriginal health everybody's business

The IHNPAs recognise the importance of increasing the responsiveness of mainstream health care services to meet the needs of Aboriginal and Torres Strait Islander people. Two COAG priority areas in the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes [3] specifically address this: 'Making Aboriginal health everybody's business' and 'Primary health care services that can deliver'. This was seen as being particularly important in those regions where ACCHOs were not easily accessible; it was just as important to ensure that people needing secondary care received it in a culturally appropriate way. Also, not all Aboriginal and Torres Strait Islander people choose to visit an ACCHO for their health care needs.

*If you look at what people say... are the difficulties that they encounter, well, if you talk to community members they'll talk about getting lost in the system, not knowing what's supposed to be happening next, not knowing who they're supposed to be seeing, not knowing when their next appointment is, no one following them up, being discharged and no one following them up... if we talk to service providers, they will actually talk about similar issues, they might use different language but they're often talking about the same things, which is the siloed way in which organisations operate, the lack of communication between different bits of the health system, the difficulty in knowing what's happened to a referral once you've made it.*

*And so there's a recognition that you've got to create the pathways to enable people to get good health care, and then in terms of improving the patient journey, it's very much what your experience is then of going down those pathways, so we'd see it as very much... an intrinsically linked and connected set of initiatives. And some of that is about being able to support people whilst they're trying to manage those pathways, and the patient journey is difficult because the service is disconnected. So there is things that we need to do to improve the service system, to make it more connected... (Aboriginal service provider respondent)*

Across the regions the outcomes of the planning process have had a tremendous impact on how the mainstream sector responds to the needs of Aboriginal and Torres Strait Islander people in catchment areas differently:

*Traditionally it was widely recognised that we needed to do more but I think we were doing what we did in isolation.* (Mainstream service provider respondent)

Initiatives to increase cultural awareness have included training packages, staff exchanges between mainstream health service providers and ACCHOs, the creation of greater numbers of Aboriginal-specific positions and spin-offs from the planning process, such as the involvement of Aboriginal and Torres Strait Islander people on the advisory boards of major urban and rural hospitals.

*It's about that inclusion of the Aboriginal culture within the way that we operate and that can be both structurally within our organisation... but also it is inclusive of the way that we engage both with individuals and with families to identify what they see as their needs and what do they see as their wants and aspirations for the future.* (Mainstream service provider respondent)

*They [consumers] appreciate the fact that non-Aboriginal settings have good cultural awareness and a good responsive service. So those are the things that really motivate the committee to keep on going. So having that common set of service standards across the various settings, having staff who understand the cultural needs of Aboriginal people and will respond in the most helpful way. They're really the most [important] things that have come out of it.* (Mainstream service provider respondent)

However, although everyone involved listed such outcomes as major achievements and milestones in Aboriginal and Torres Strait Islander health, it was also pointed out that

*[if] we want to change the landscape, [if] we want to make things different... [so that] no matter where the Aboriginal person went they always got a quality service, [this needs to become standard practice].* (Mainstream service provider)

It also needs to be incorporated into how organisations operate and not something delivered merely on a voluntary basis and usually only to those organisations participating in the IHNPA process. As one respondent noted:

*Why would you do Closing the Gap projects if it wasn't going to change the way we did business?* (Mainstream service provider respondent).

## Planning

In all instances the key focus of the planning forums surveyed was the planning and implementation of the IHNPA. Respondents were pleased that the IHNPA had raised the profile of Aboriginal and Torres Strait Islander health and placed it firmly on the political agenda. Nevertheless, some respondents felt the approach was too top-down and restrictive because it did not leave room to address priority issues identified by the community. Respondents from previous planning forums felt that the IHNPA process had overshadowed the broader objectives that they had sought to

achieve, and that it had taken over their agenda and dominated the discussion with what 'both the Commonwealth and the COAG... had decided' (Aboriginal service provider respondent):

*Some planning forum members were keen to have, to develop, a regional plan that reflected the reality on the ground, so not to focus on the priority areas that the government said, so they did want to be able to provide a picture that reflected exactly what the Aboriginal health issues, gaps, statistics, research, policy, everything that was relative. They wanted to be able to do that. They wanted more time.* (Aboriginal service provider respondent)

Others did not raise this as an issue because they saw that

*all of the National Partnership Agreement focus areas were... areas of need... so all of them fit in. So we knew that these areas are all priority areas. So it just complimented what we knew already.*  
(Mainstream service provider respondent)

The quality and extent of planning processes varied across the regions due to a rush to implementation. The application of State-level deadlines constrained the abilities of regional forums to effectively engage with communities. This was particularly true of newly established forums. In some areas, this initial lack of engagement contributed to a sense of disenfranchisement from the planning process, which carried with it repercussions for the remainder of the life span of the initiatives proposed.

*If we go back a bit, what happened in our region was... all of a sudden it was landed on the regions... with no real warning and no understanding of what was coming. All of a sudden it was a task that had to be done...* (Aboriginal service provider respondent)

Community consultation processes varied and in most instances planning forums explored a number of different avenues through which this could take place. As indicated earlier, some planning forums relied on ACCHO representatives for community input; others felt that it was appropriate for ACCHOs to consult with communities because they were already embedded within them. In the regions lacking an ACCHO or a discernible community group, the planning forums had to employ other strategies. Given the time constraints, many planning forums employed an external consultant to carry out this work. In a few instances, the planning forums were unsatisfied with the work produced by the consultants; this created more work for them and was observed to have stalled the process in these regions.

*I can't speak for what happened within each of the ACCHOs, but from my observation, because of the timeline of the particular planning process I would say that the majority of the CEOs from the ACCHOs used their particular knowledge and understanding*

*of... the burden of disease within their communities, and that knowledge having come through firsthand observation of where they were delivering services and... what services they were delivering. Which obviously left a number of gaps, you know, what you would do if you were doing it properly. And we've got to come to a new approach to—with the way we do health services planning, but it has much more of a population health basis to it.* (Aboriginal service provider respondent)

Among service provider respondents, community input was cited as one of the most valuable aspects of participating in the planning process for the IHNPA and one of its key strengths. This was particularly true of planning forums that had direct representation from community. However, concerns were raised among participants over the extent of community members' understanding of the IHNPA process or its parameters, and that

*at those types of forums or conferences, they speak in high language so people don't understand anyway.* (Aboriginal service provider respondent)

Tensions arising during the planning process often appeared to stem from an oversight or lack of acknowledgment of existing arrangements in place for Aboriginal and Torres Strait Islander health in the regions. An often raised concern was that the IHNPA planning process added new layers of complexity, created multiple points of accountability and failed to utilise existing expertise, and that this was done at the expense of the everyday business of agencies.

*There was a view that attendance at the forum distracted from the ACCHO's core business as it has always been (and should be) the recognised lead service for Aboriginal health. The health service's role in the forum was not clear and that generally our expertise in service provision to Aboriginal people, management and technical assessment of programs had not been sought.* (Aboriginal service provider respondent)

Box F highlights the planning process in the Hume region in Victoria, where there was a focus on taking a population health approach and encouraging community engagement.

## Box F: Case study—project working groups, Hume region, Victoria

The planning process in the Hume region and its associated governance structure was explicitly designed to increase opportunities for community involvement in the process, particularly in those areas of the region where service gaps were identified in the initial stages of planning. The planning was done in a number of stages and involved the establishment of an overarching planning forum, project working groups and associated reference groups, each a platform for dialogue and a conduit for community voice in policy making.

Five project working groups were established in the region, one for each priority area for action included in the Hume IHNPA Implementation Plan. One priority area was to identify the health needs and to develop health service delivery models for the Aboriginal and Torres Strait Islander communities living in the Central Hume and Lower Hume Primary Care Partnership catchment areas. This was included in the plan as a priority area in order to ensure that underrepresented communities in the region would benefit from the IHNPA. As one respondent explained:

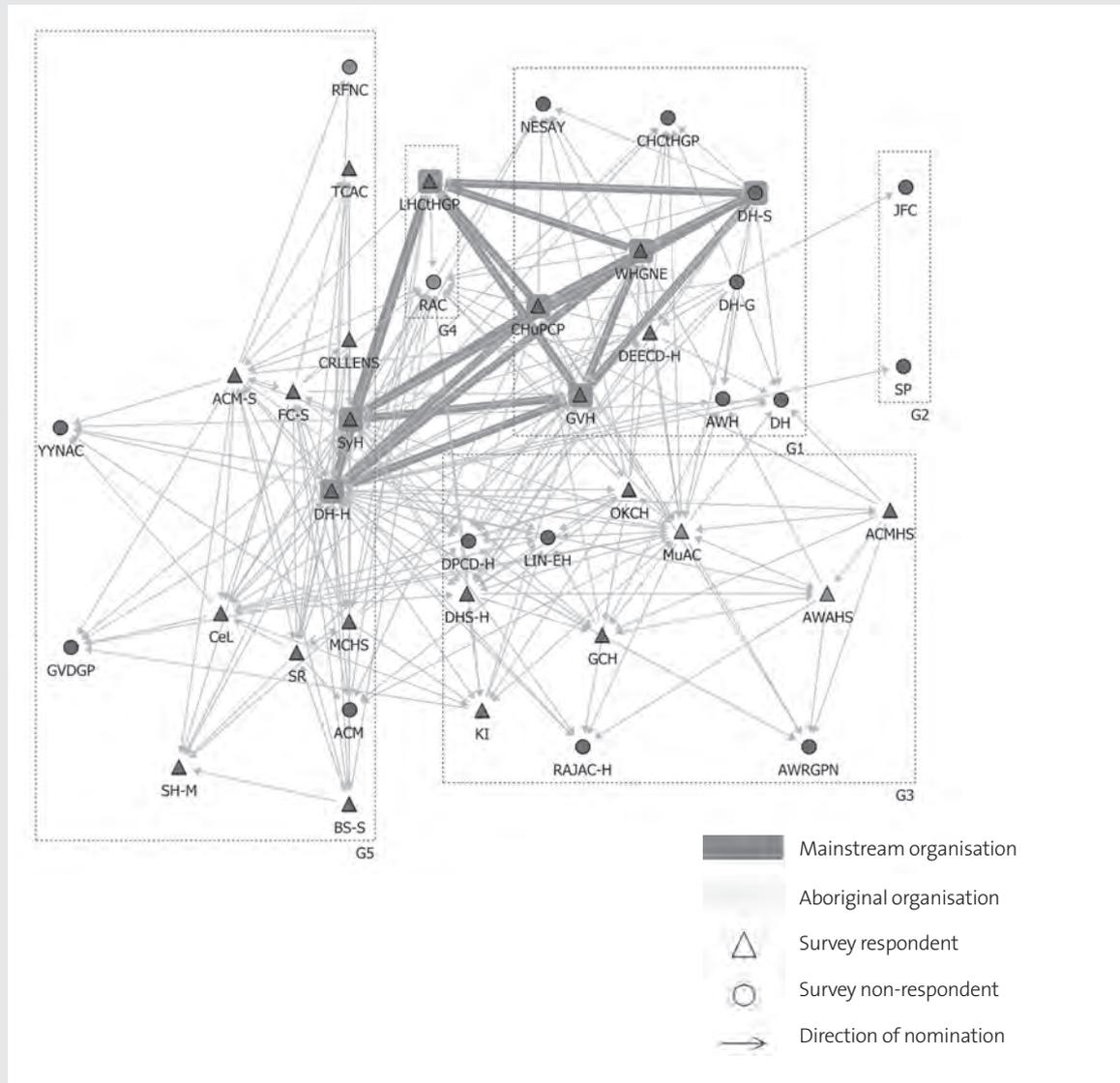
*They wanted to make sure that these were services that weren't going to be Shepparton or Wodonga focused... because [that's] where the services are already at. It was making sure that they were engaging in those small community pockets... because it's very isolated you don't get numbers and sometimes there's no networks out there. (Aboriginal service provider respondent)*

The Lower Hume and Central Hume project working groups each employed a project officer to carry out the work required for the groups to achieve their stated aims and also established a project reference group (consisting of members of the local community) to provide advice. They were linked to the overarching Hume regional planning forum directly via cross-membership by their project sponsor (the organisation that auspices the funds for that project) and received executive support from the IHNPA Partnership Manager. Three IHNPA Partnership Manager positions were created and based at Rumbalara Aboriginal Co-Operative, Mungabareena Aboriginal Corporation and the Department of Health, Hume region (DH-H).

The social network data gathered for the Hume region illustrates the pattern of relationships between the organisations involved in the delivery of the IHNPA through the project working groups (Figure F1 overleaf). Analysis of network cohesion can be used to indicate how close organisations are to each other as measured by the frequency of contact between them (referred to as interlinks). Depending on the size of the network, cohesion can be used to determine whether it contains subgroups and what their characteristics are by comparison. For example, information can travel between organisations more efficiently if they are close to one another compared to organisations that are far apart.

Applying this measure to the data collected in the Hume region reveals five subgroups (G1–G5, as indicated by the dotted lines). These groups have emerged from the analysis because of their ties to each other in Figure F1. Although the groups shown do not strictly correspond to the five projects they also show a strong tendency to sort by geography. The links highlighted in yellow show how each auspice agency is closely linked to both DH-H and the project worker; for example, DH-H, Seymour Health (SyH) and the Lower Hume the IHNPA Project Officer (LHCTHGP) Mungabareena and Rumbalara are central in the figure, as would be expected, because these organisations are where the IHNPA Partnership Managers are based.

Figure F1: Network of organisations that work together in the Hume forum



Acronym	Organisation
<b>Lower Hume project</b>	
LHCtHGP	Lower Hume Closing the Health Gap Project (via Project Officer)
DH-H	Department of Health, Hume region
SyH	Seymour Health (auspice agency)
TCAC	Taungurong Clans Aboriginal Corporation
RAC	Rumbalara Aboriginal Cooperative (Partnership Manager)
MCHS	Mitchell Community Health Service
CRLLENS	Central Ranges LLENS
CEL	Centrelink
DPCD-H	Department of Planning and Community Development, Hume region

GVH	Goulburn Valley Health
FC-S	Family Care Seymour
DPCD-H	Department of Planning and Community Development, Hume region
BS-S	Barry Street Seymour
SR	Seymour Renewal
TCAC	Taungurong Clans Aboriginal Corporation
ACM-S	Aboriginal Community Member – Seymour
<b>Central Hume project</b>	
CHCtHGP	Central Hume Closing the Health Gap Project (via Project Officer)
CHuPCP	Central Hume Primary Care Partnership (auspice agency)
OKCH	Ovens and King Community Health
DH-H	Department of Health, Hume region (Partnership Manager)
DPCD-H	Department of Planning and Community Development, Hume region
DEECD-H	Department of Education and Early Childhood Development Hume Region
ACM	Aboriginal Community Member
<b>Others</b>	
JFC	Juliet Frizzell Consulting
SP	Shepparton Partnerships
G1	Group 1
G2	Group 2
G3	Group 3
G4	Group 4
G5	Group 5

This view was shared by ACCHOs and mainstream service organisations, and a number of community respondents also raised this as an issue and drawback of the IHNPA.

*I think the whole thing has been pushed upon our community... which is a typical government... way of doing things. So an instance comes to mind where there was no real support in terms of health care pathways and tackling smoking, for instance, and now there is a lot... 'Oh, Closing the Gap initiative. Bang, here's all these dollars, bang, set up all these brand new committees, in that there is already existing committees, they have to go by the wayside, here's the new ones, here's the money, you've got three years to do something, we want results and see you later'... I don't think it's really taking into account our community. Just because something is there [doesn't mean] we will take it up or run with it... it takes time. (Aboriginal service provider respondent)*

Hence, while large sums of money are invested in creating new ways of doing business, existing resources are often overlooked. For example, smaller ACCHOs lacking the resource capacity to attend planning forum meetings were unable to partake in the opportunities that the IHNPA presented and were marginalised by the process, while larger agencies, which could afford to invest more time and effort into the process, were rewarded. This meant that existing patterns in funding tended to be reinforced through the IHNPA.

*The single biggest thing that will make a difference, I reckon, in Aboriginal health in remote communities is building the corporate governance capacity, making sure it's good community-controlled governance, it's good corporate governance. So... things like we don't have an HR [Human Resources (manager)]... we don't have a Corporate Services manager.*

*So imagine in any corporation, you've got your manager or your CEO, you've got your clinical staff and program people that do all the services, and then in the middle you're supposed to have... some sort of middle management like corporate services, HR. We don't have that to do, you know, everything from policies and procedures, all the business around recruitment, workforce development... this is the stuff that's really the meat on the bone, because if you don't have a strong corporate governance, you're not going to be able to... manage effectively the external accountability requirements in dealing with governments and whatever—basically all stakeholders—so you've got to have good administration, good HR, good recruitment, good workforce development, good corporate services, and it all requires people and personnel to manage. That would be, to me, capacity building. I know a lot of people don't like the term, but it's such an important issue for regional engagement.*

*Planning at a regional level is all well and good, but if you haven't got strong organisations to receive funds, equip them effectively and roll out programs and services, then no planning, no policy in the world, is going to make a difference. (Aboriginal service provider respondent)*

Further to this, another respondent stated:

*We missed out on COAG funding entirely because we weren't at the table when the funds were distributed. To me that is the single big issue. If you're not at the table—you don't have the capacity to get there—then you can miss out on some of these key government investments in Aboriginal health... (Aboriginal service provider respondent)*

### **Managing complexity**

The delivery of the IHNPA's required the Commonwealth and State governments to work together to deliver the programs. Lack of co-ordination between the Commonwealth and the States was an issue that was raised in Victoria and Western Australia by respondents from all sectors. There was also clear consensus that the responsibility for ensuring that the appropriate infrastructure exists rests with State and Territory health departments and the Commonwealth Department of Health and Ageing (DoHA).

*So DoHA is well within [its] right to say, well, that's Victoria and it should be Victoria who does that. Victoria says, well, no, you're talking about DoHA programs, they should be providing a template for co-ordination to happen. So this is the passing the buck thing, no one wants to step into the case, because it'll cost money. It will involve redesigning programs, at both ends, in order for them to interface properly. And at the moment that's interface by force but not by design. And that work is really important to happen. (Aboriginal service provider respondent)*

This lack of co-ordination between the different government departments was most acutely felt at the regional level, where there is

*a little bit of a competing agenda between the kinds of things that the Commonwealth are trying to achieve and the kinds of things the Victorian Government are trying to achieve. (Aboriginal service provider respondent)*

This was especially pertinent in regions that were experiencing difficulties resolving differences in expectations between programs. For example:

*If I was to say there's one thing that's hindered us the most, [it] is the fact that we've still got multiple levels of government funding Aboriginal health, and I think that is confusing the system at a really fundamental level. I think the quicker we can get to a single Aboriginal health fund in a community... and a single Aboriginal health plan for a community, the better. (Mainstream service provider respondent)*

Lack of co-ordination was perceived as a limiting factor in the success of the IHNPA's and was

*actually crippling a great opportunity of what we could have seen for the best investment of Aboriginal health dollars that were ever announced by a Prime Minister. (Mainstream service provider)*

In both Victoria and Western Australia there were very functional relationships between the Office of Aboriginal and Torres Strait Islander Health (OATSIH) and relevant health departments. However, two key sources of tension existed. First, OATSIH did not have the resources to engage with regional planning forums. Respondents expressed disappointment at the fact that OATSIH was bypassing an opportunity

to hold a collective dialogue with all the key stakeholders involved in the IHNPA initiative at the regional level, including the organisations funded through them. This limited the capacity of forums to co-ordinate and integrate different government programs. As one participant stated:

*I never saw the program contract manager the whole time and that was 12 months... And it's quite disappointing and disgusting, if you ask me, especially daily contract management... I understand that the contract managers should be involved, in the regional planning and stuff like this,*

*and in such a good regional planning forum, it's not like they have any reason not to be involved. I can't understand. They're actually missing out. (Aboriginal service provider respondent)*

State OATSIH staff also felt that greater regional engagement was desirable, but they also noted that the forums were a State-level initiative that did not consider the level of resources available in other organisations.

Box G outlines capacity building requirements at each IHNPA level.

## Box G: Capacity building requirements

The need to invest in local capacity building was echoed by respondents in Victoria and Western Australia. Forum members noted that this was required at all levels if the IHNPA were to succeed. At the individual level, capacity building was seen as a means of empowerment that could help Aboriginal and Torres Strait Islander people have a voice in policy making. At the organisational level, capacity building was pertinent to the delivery of quality care. Respondents from remote areas noted that investing in programs to build up the skills of existing staff could contribute to continuity of care for patients and make services less reliant on visiting specialists:

*When I first came here they used to bring up white counsellors from wherever and it takes them so long to develop a relationship with the clients. The clients half the time never really trust them. They take off. They never stay because it's harsh living conditions up here... So it's a much better way, training up people. (Aboriginal service provider respondent)*

Investment in capacity building was therefore also deemed to be important to the delivery of the IHNPA. The programs that organisations delivered often reflected the extent of their resource and staff capacity and skills sets, and a few respondents expressed frustration that this amounted to a missed opportunity to make greater strides towards Closing the Gap:

*I've said 'aspirational' a number of times today, but I thought this was an opportunity for us to really set some hard targets, to do something about... dental health, have very concrete outcomes for local communities, even if we were focusing on kids in Koori schools at years prep to three, for example, having dental health checks and engaging in treatment. But instead, what ended up happening is we took sort of soft options and easy wins in my view. Let's get people playing football with you in a football jumper. (Mainstream service provider respondent)*

Most importantly, lack of capacity prevented participation in the IHNPA process. Those who were unable to participate or attend and articulate their needs or advocate for the people or communities they represented, lost out in the process:

*My view... is ultimately everybody in the region and everybody State-wide needs to address that issue: if communities, if populations, don't have good representation at the planning forum or at State, at planning processes, then it's really up to agencies to make sure, like OATSIH and other groups, to say, okay... let's get the capacity in place so they can be at the forums, and that will be the biggest single impediment to closing the gap. (Aboriginal service provider respondent)*

At the State-wide level, both in Western Australia and Victoria, members of the planning forums expressed some frustration regarding the inability of OATSIH State office staff to influence policy. As one participant expressed it:

*They are an observer, not so much because they're not there, because the State office can only be an observer in any given situation, because they're not really anywhere near there. Now the question is, do they even feedback what they hear at the committee? I am not too sure... they are so far removed from Canberra... How much influence these people have is a big question. (Aboriginal service provider respondent)*

Although respondents almost universally described their relationship with the OATSIH State office as strong, this relationship was viewed primarily as one of information exchange rather than as an effective mechanism to enhance the co-ordination of programs.

*And there's... this classic business playing out at the moment where we're funding Tobacco Action Workers in some communities. We know the Commonwealth is going to, at some point, fund Tobacco Action Workers in some community somewhere but trying to bring these two things together in a structured fashion to try and achieve the best outcome is really difficult. (Mainstream service provider respondent)*

*You've got OATSIH rolling this bit out and then you got Tobacco rolling this bit out and neither of them speak to each other... (Aboriginal service provider respondent)*

This meant that when co-ordination did occur, it occurred at the local level. The planning forums provided a platform for communication for service providers to discuss the issues that constrained their ability to achieve their goals and to collegially work out solutions. However, this role often required additional resources:

*What's helped the process? I think that it's been helped by... our region having a co-ordinator... I think most of the other regions got somebody in to consult. We don't have a consultant. Consultants write up beautiful little plans [but]... we just said*

*we need someone to co-ordinate it, keep it moving, someone that's independent of the organisations, and not necessarily independent from the department, but somebody that can help with [establishing consensus]... (Mainstream service provider respondent)*

### **Decision-making processes**

The decision-making process was consensus based in most forums. Most planning forums privileged the views of Aboriginal and Torres Strait Islander people and organisations through their procedures (for example, by having Aboriginal chairs). This was important in order to ensure that Aboriginal and Torres Strait Islander views were not overwhelmed by the non-Indigenous majority. Respondents noted that success in health planning is

*about being inclusive and having that procedural fairness and getting the feedback and getting people locally to develop ideas, it's all about empowering. (Mainstream service provider respondent)*

The Gippsland planning forum in Victoria, for example, had a specific clause in its terms of reference to

*build in an underlying principle that Aboriginal community control is important here. (Aboriginal service provider respondent)*

This was reflected in a strong preference to invest funds with ACCHOs because

*there's a desire to be in control of resources at a local level then also you can actually make sure that something happens for your community. (Aboriginal service provider respondent)*

And also

*that the power belongs to the Indigenous organisations to implement these projects. (Aboriginal service provider respondent)*

Reaching consensus often involved much deliberation and at times delayed the progress of planning, particularly for the newly established forums. A number of tensions existed at this stage of the process, including with the process of coming to a decision. Community representatives were often eager to see

programs commence and to spur on the decision-making process. Consistent representation was, therefore, important and some forums only permitted substitute members

*as long as they have the authority to discuss, agree and make commitments on behalf of their organisation.* (Mainstream service provider respondent)

This is important because

*unless the whole mob is there a decision can't be made.* (Aboriginal service provider respondent)

This created challenges, particularly in urban areas where the community was difficult to define.

*I mean, when you go to, say, for a meeting here in Dandenong, that's a huge Aboriginal population, and you'd see less than half a dozen people sitting around the table wanting to make decisions on Aboriginal programs and issues in the area, I have issues with that. And I've told them. I understand that St Kilda LNs is very strong, purely because of the Aboriginal people involved there. Frankston, every time you go to one of those they are at different places so there's no continuity around the LNs, even in terms of having a continuous chairperson, a one-time chair.* (Mainstream service provider respondent)

There was greater variability in decision-making processes in Victorian forums than in Western Australian forums. This may be because Victorian forums knew what their budgets were and decided which projects would be funded. In Western Australia decisions about the budget for each area and the projects to be included were made at a State-level after regional plans were submitted. All sectors were represented in the State-level decision-making process. However, some respondents were disappointed by the lack of control at the regional level:

*Let's not pretend people have influence in the outcome if they don't.* (Aboriginal service provider respondent)

*We set up our State planning forum which had chairs from each of the regional forums and a matrix was developed about how the plans were going to be assessed... and how we were going to allocate the dollars and we said to them then, that*

*if you wanted a fair process, you had to have a [representative] from [the Aboriginal Health Council of Western Australia] and a [representative] from the Commonwealth, be involved in the review process of the regional plans, otherwise it wouldn't be... transparent. That we would be trusting the State to make all the decisions. I guess... you could say there was... 'fors' and 'againsts' how they assessed some of the regional plans. I mean, some of the regional forums weren't happy about the way it was done. However, at the end of the day, we were, we probably came out in a stronger position.* (Department of Health respondent)

Planning forums that were well established and had an agenda beyond the timeframe of the IHNPA's approached this process from a more empowered position because of a collectively held

*commitment and... belief that these forums are worth their weight.* (Aboriginal service provider respondent)

A good example of this is the Kimberley Regional Aboriginal Health Planning Forum (see Box C, p. 22). As noted earlier, this forum predominantly comprises ACCHO representatives and the 'weight of numbers' this lends the forum has proven to be advantageous when negotiating with the Western Australian Country Health Service over resource allocation. As one forum respondent highlighted:

*The biggest thing for us is the Mental Health dollars... that we had a huge win, a huge say in that. Well, there was 22 million out of a 117 million that the State Health Department had. There was 22 million that was quarantined for mental health. And they had already decided... what that 22 million dollars was going to be spent on... we disagreed and we said, 'No'... We stuck, you know, and we stuck our heels in and said, 'No, this is not good enough...'* (Aboriginal service provider respondent)

Other forums also sought to get around the parameters of the IHNPA's by tweaking the expected program outcomes to better fit the funding streams under the five priority areas for action approved by COAG. The following case illustrates this well:

*If you took all that [prescriptive stuff] out of it and just looked at the outcomes that you wanted, it was*

really easy to trim back the quantitative stuff rather than the qualitative stuff. So if you were going to... for instance, look at patient journey stuff... We looked at that and we thought, hang on, we can actually dovetail the outcomes to patient journey that we originally [suggested] with our patient transport because for us it's a major issue... [To] see an obstetrician when you're living in Puntukurnu... or Jigalong, you've got to come into a Newman and get a bus to Port Hedland and the bus only goes one day a week. So then you've got to wait till the next appointment which could be the following Monday and our strike rate of people actually turning up to appointments was about 30%. So now we actually bring people in in a bus of their own... and we'll enhance that and have transport going directly to Hedland but whilst that sounds a lot to do, its overcoming really huge barriers... so with our patient journey money... whilst we didn't get enough money to do this... we can actually do this if we use a bit of

that money from there and shift it around a bit. So the level of flexibility is probably a lot greater than we first anticipated. It's starting to be a good line. (Aboriginal service provider respondent)

In Victorian and Western Australia, smaller working groups or subcommittees were often created to work on specific issues and provide feedback to the committee as a means of spurring on the decision-making process. The Kimberley Regional Aboriginal Planning Forum utilised its standing subcommittees of people working within specific subsectors to make decisions from 'the ground up'.

Box H highlights the decision-making process in Barwon-South Western in Victoria. This forum, although consisting predominantly of mainstream organisations, assigned the power to make decision to the ACCHOs in the region.

## Box H: Case study—Barwon-South Western region, Victoria

In Victoria, the Barwon-South Western region planning forum was unique in terms of its decision-making process. It had a formal arrangement in place in its terms of reference that stated that decision making was the responsibility of the Chief Executive Officers (CEOs) of the member ACCHOs. Among the ACCHO CEOs the process was consensus based:

*It's like the absolute reverse of how Aboriginal organisations have existed for the last however many years... So it's now the Aboriginal organisations making the decisions, and the mainstream having to take it rather than the other way around, and I think that's absolutely the way it should be, and that's subjective but I think... that is just the critical factor.* (Aboriginal service provider respondent)

This structurally embedded decision-making arrangement did not hinder the ability of the other organisations to contribute to the process. Most respondents agreed that this arrangement worked well. The process by which projects were chosen for inclusion was described as being 'very democratic' and inclusive. All members were given the opportunity to put forward their ideas, and to comment and state their opinions, and they each had input into the projects being carried out.

The decisions of the CEOs were informed through consultation with the communities they service. One ACCHO, for example, created its project proposal based on feedback from the community, which highlighted an apprehension to use the local hospital for acute medical care. Consultation was conducted through community lunches, community information days, information via a newsletter and by asking people to respond to a questionnaire about the issues that could be addressed through the IHNPA.

The social network data gathered for the region reflects the impact of this arrangement over a number of indicators and this is illustrated in Figure H1. Eight respondents in the Barwon-South Western region made 66 links to 21 organisations. In the figure, triangles show the respondents, blue shows the ACCHOs and the direction of nomination is indicated by arrow heads.

Figure H1: Network of organisations that work together in Barwon-South Western

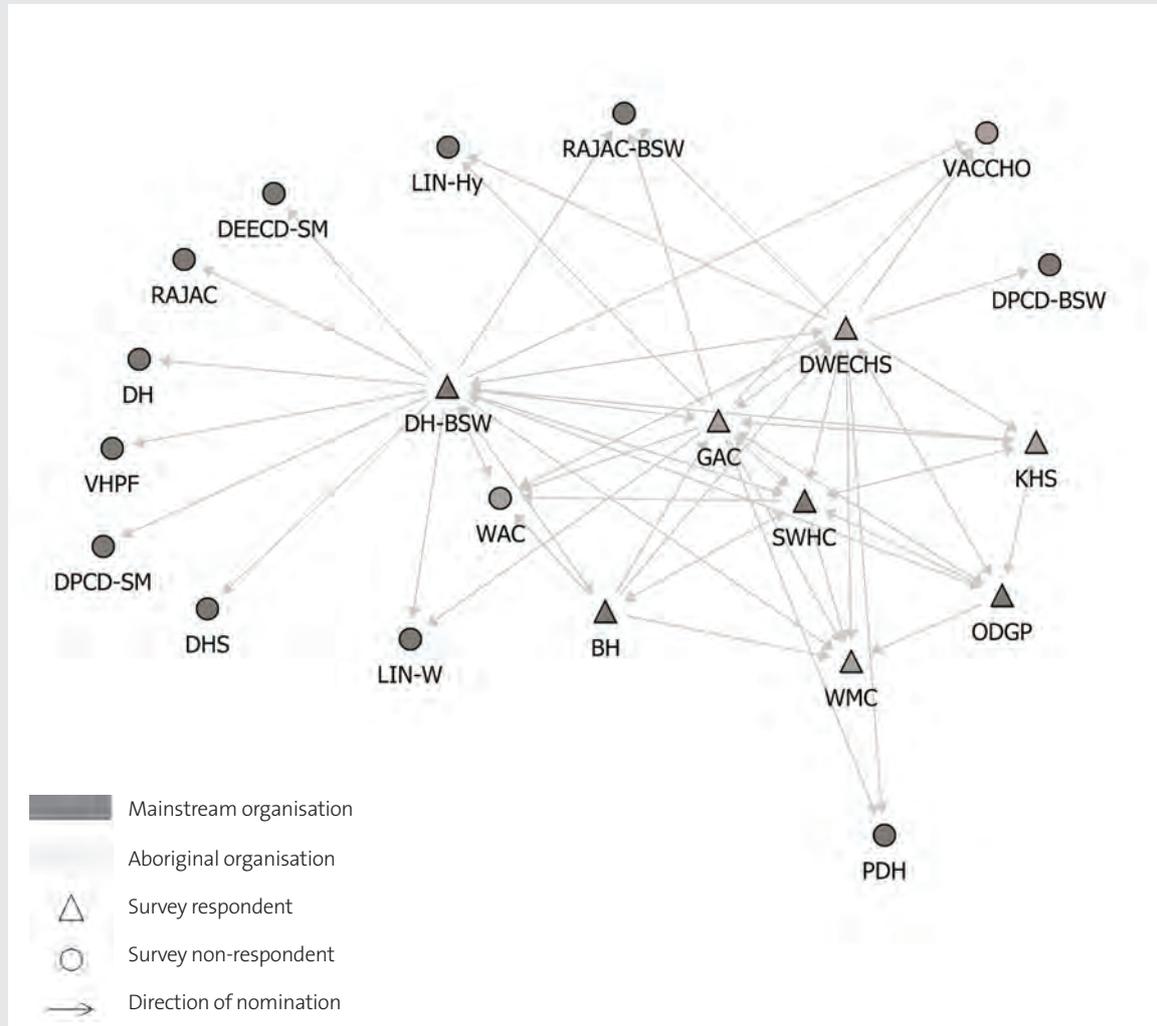


Figure H1 displays an uneven distribution of nominations clustered around the five ACCHOs in the region: Dhauwurd Wurrung Elderly & Community Health Service Inc. (DWECHS), Gunditjmara Aboriginal Corporation (GAC), Kirrae Health Services (KHS), Wathaurong Aboriginal Co-operative (WAC) and Windamara Aboriginal Corporation (WMC).

The clustering of the ACCHOs indicates they contacted each other much more frequently than they contacted the other organisations. Another group of organisations, nominated by the Department of Health Barwon-South Western (DH-BSW), can be seen on the left of the diagram. The position of DH-BSW indicates its role as 'gatekeeper' in terms of sharing of information and co-ordination of the IHNPA's in the region.

Degree centrality is a measure of prominence (in-degree centrality) and influence (out-degree centrality). The higher an organisation's score for these measures, the more centrally located it is on the degree centrality sociogram. In Figure H2 (overleaf), the organisations found towards the centre of the sociogram are the 'block' of ACCHOs and their degree centrality scores are relatively evenly distributed (Table H1 overleaf), which suggests that there is no single 'most' prominent organisation among them.

Figure H2: Degree centrality, Barwon-South Western

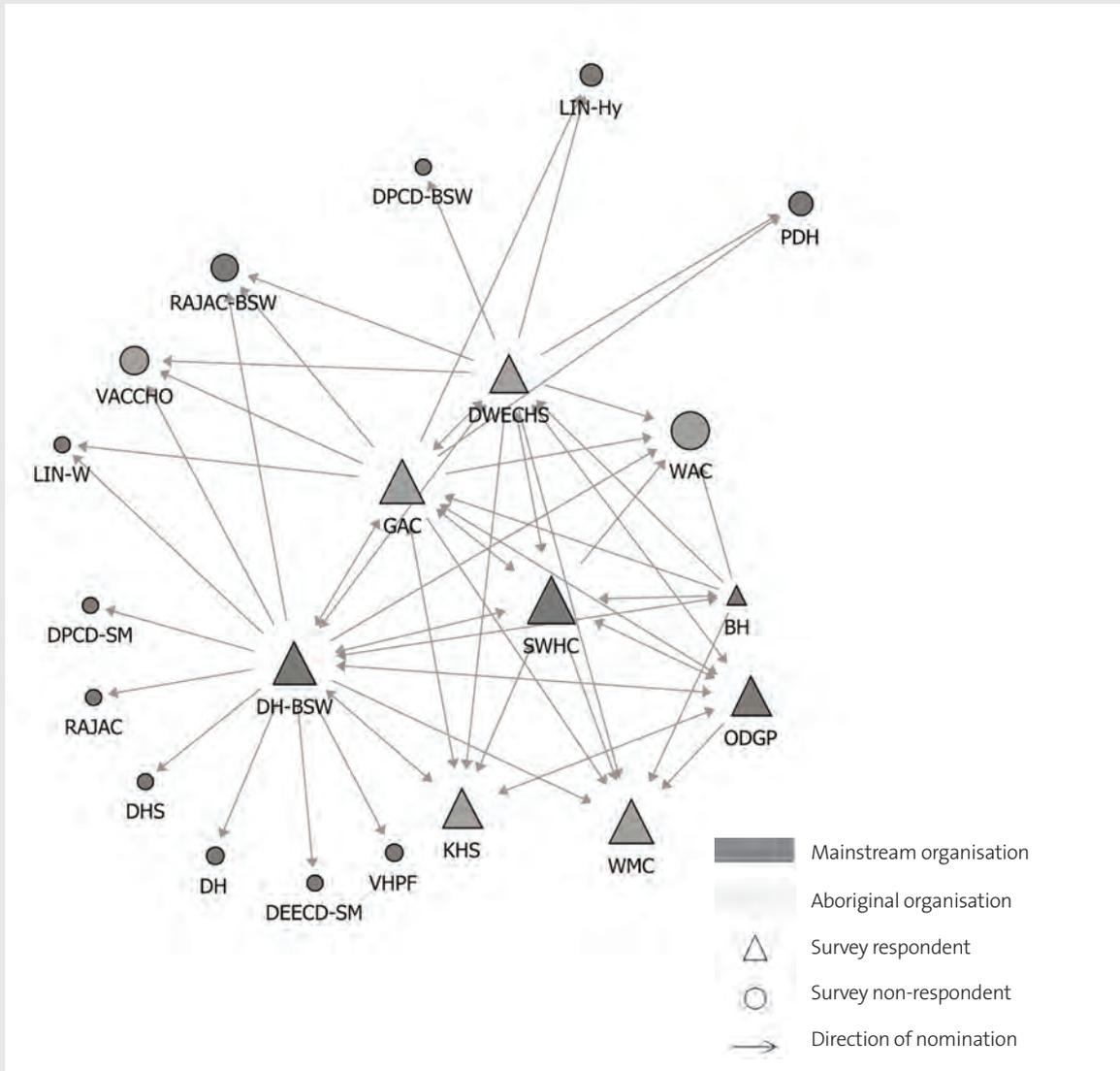


Table H1: Barwon-South Western degree centrality indices (abridged)

Contact	In-degree centrality	Out-degree centrality
WMC	0.30	0.00
GAC	0.30	0.60
WAC	0.25	0.00
KHS	0.25	0.20
DWECHS	0.25	0.60

# Results of data analysis

Overall, the regional planning forums provided an effective means to engage Aboriginal and Torres Strait Islander people and organisations in planning and governance. The forums were attuned to privileging the views of Aboriginal and Torres Strait Islander people and organisations, and represented a significant shift in decision making from State level to regional level. Table 3 shows a summary of performance against the evaluation framework. There were a number of ways in which the planning processes could be improved, particularly around the

processes for proposing and selecting programs, the provision of information around performance, and the interface between State and Commonwealth programs. Despite these limitations, most participants agreed that the planning and governance platform provided by the forums was a significant advance on previous arrangements, and endorsed their continued funding and development. Almost all participants felt that the funding of a secretariat was crucial to maintain the achievements of the forums. Ongoing funding has been provided in both case study States.

**Table 3: Indicator framework for power in planning processes**

Aspects of governance	Indicators	Method	Findings
<b>Who is involved?</b>			
Aboriginal representation	% Aboriginal representatives % Aboriginal organisations represented	Document review Interview	100% of the planning forums surveyed in Western Australia and Victoria had representation from Aboriginal organisations/community. These constituted 25% of all participants.  Tensions around most appropriate means of community engagement.
Representation of people with expertise in delivering Aboriginal programs	% planning forum members with expertise % Aboriginal planning forum members with expertise	Interview	100% of the planning forums surveyed in Western Australia and Victoria had representation of people with expertise in delivering Aboriginal programs.
Legitimacy of representation	Selection process Constituency (formal/informal) of representatives Recognition of legitimacy within the planning forum	Interview Network analysis Interview	Forum membership in all instances comprised service providers eligible to deliver programs to Aboriginal people and their communities. Aboriginal representation through ACCHOs was considered appropriate. Concerns about the breadth of the engagement for other organisations.  Tensions around legitimacy of process for engaging community. Direct community participation was desired and sought after, particularly in Victoria.

Table 3 cont...

Aspects of governance	Indicators	Method	Findings
<b>What is to be achieved?</b>			
Shared understanding of purpose	Terms of reference Role within the planning cycle Consistency of terms of reference and role with NIRA/IHNPA Acceptance/ understanding of Terms of reference and role within planning forum [20]	Document review Interview	The purpose of the planning forums was to provide a co-ordinated approach to the planning and delivery of health programs to improve the health and wellbeing outcomes of the Aboriginal and Torres Strait Islander populations in the regions and to collaborate on implementing the agreed health priorities, strategies and initiatives that are consistent with the regional implementation plan.  Among the respondents there was a shared understanding of purpose of the regional planning forums and their role within the broader IHNPA framework. However, this role was difficult to execute because of Commonwealth programs offered in the regions but without working in a co-ordinated way.
Strategic planning processes	Assessment of community needs and priorities Review of community health status Focus of change Review of existing resources and activities [19]	Interview	All regional planning forums conducted a scoping exercise to determine the priorities in each region. This generally entailed a series of steps including reporting/consultation, assessment of community needs and priorities, review of community health status, and review of existing resources and activities taking place. However, there was very little data about performance rather than activity.  Rush to implementation meant that the process was compromised both in terms of enabling considered decision making and in terms of enhancing the ability of organisations to compete on equal terms.
<b>How will it be implemented?</b>			
Identification of strategies and goals	Engagement in preference-shaping [21]	Interview	Aboriginal and Torres Strait Islander people were involved in the decision-making process around the identification of strategies and goals, either indirectly through the consultation processes employed by the individual planning forums or directly through their involvement on the planning forums.
Prioritisation	Engagement in agenda-setting [21] and 'non-decision making' [22]	Interview	Prioritisation of regionally identified goals identified through the needs assessment process was done in accordance with the IHNPA five priority areas. These did not always coincide with local priorities.
Decision making	Patterns of influence [19, 23, 24]	Interview	Aboriginal and Torres Strait Islander people were involved in the decision-making process, either through direct participation or indirectly through ACCHO representatives.

Table 3 cont...

Aspects of governance	Indicators	Method	Findings
Access to resources	Resources allocation	Document review Interview	In Victoria the allocation of resources varied across the regions and it was distributed on a per capita basis. One drawback of this was that regions lacking the infrastructure for the roll-out of the IHNPA programs, and that had dispersed Aboriginal and Torres Strait Islander populations, were disadvantaged by this because they had to invest a large portion of the funds towards setting up the infrastructure for the delivery of programs. Within the regions, resource allocation was determined by regional planning forums with the help of the regional Department of Health branch. In Western Australia implementation plans were put together by planning forums in each region. However, decisions over the aspects of the plans that would be funded were made at a State level by a smaller working group of the Western Australian Aboriginal Health Planning Forum.
Diffusion of innovation	Connectivity [16] In-degree centrality [23]	Network analysis	Overall, the most central organisations reflected the tripartite structure with strong connections between State, OATSIH and the community-controlled health sector.  Social network data indicates that ACCHOs were highly connected and prominent across all regions. This suggests that they are influential agents in the planning process. The Department of Health, Victoria and the Western Australian Country Health Service branches, particularly the regional branches, were also influential.

## Impact of engagement on decisions and relationships with others

Figure 6 (overleaf) shows the number of links between organisations by priority areas. The areas reflect both the IHNPA in Aboriginal and Torres Strait Islander health outcomes and in child health. Overall, around 50 per cent of the links were between mainstream organisations and 10 per cent were between Aboriginal organisations; 15 per cent were from Aboriginal organisations to mainstream organisations and 25 per cent were from mainstream organisations to Aboriginal organisations. Aboriginal organisations were more connected than would be expected if all

organisations in the network had an equal chance of being connected to any other. However, mainstream organisations make an important contribution to the network.

The areas that reflected the highest level of collaboration were making Aboriginal and Torres Strait Islander health everyone's business, service delivery and improving the patient journey. This is not surprising because the aim of these priority areas was to improve collaboration and co-ordination between services. The areas with the lowest numbers of links were child health and maternal health. This is largely because of lower numbers of links between mainstream organisations in child health and maternal health.

Figure 6: Priority area networks for Aboriginal and mainstream organisations

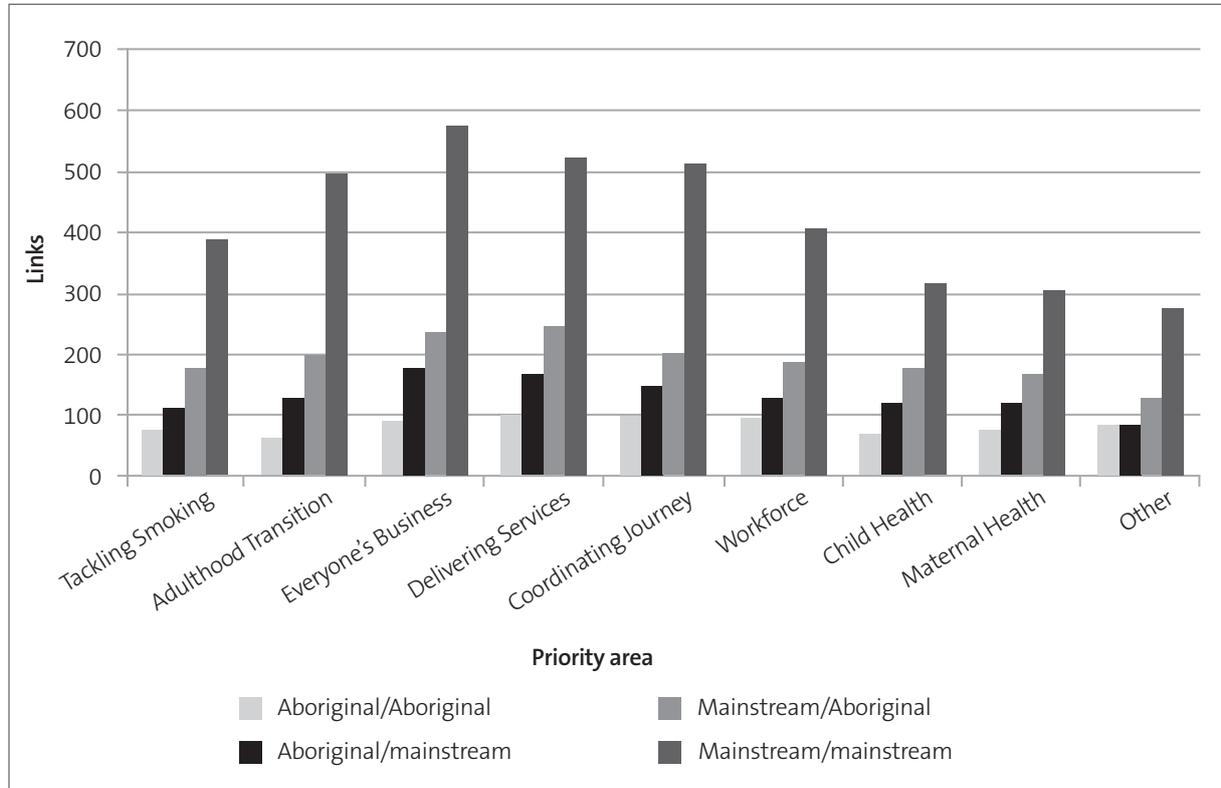
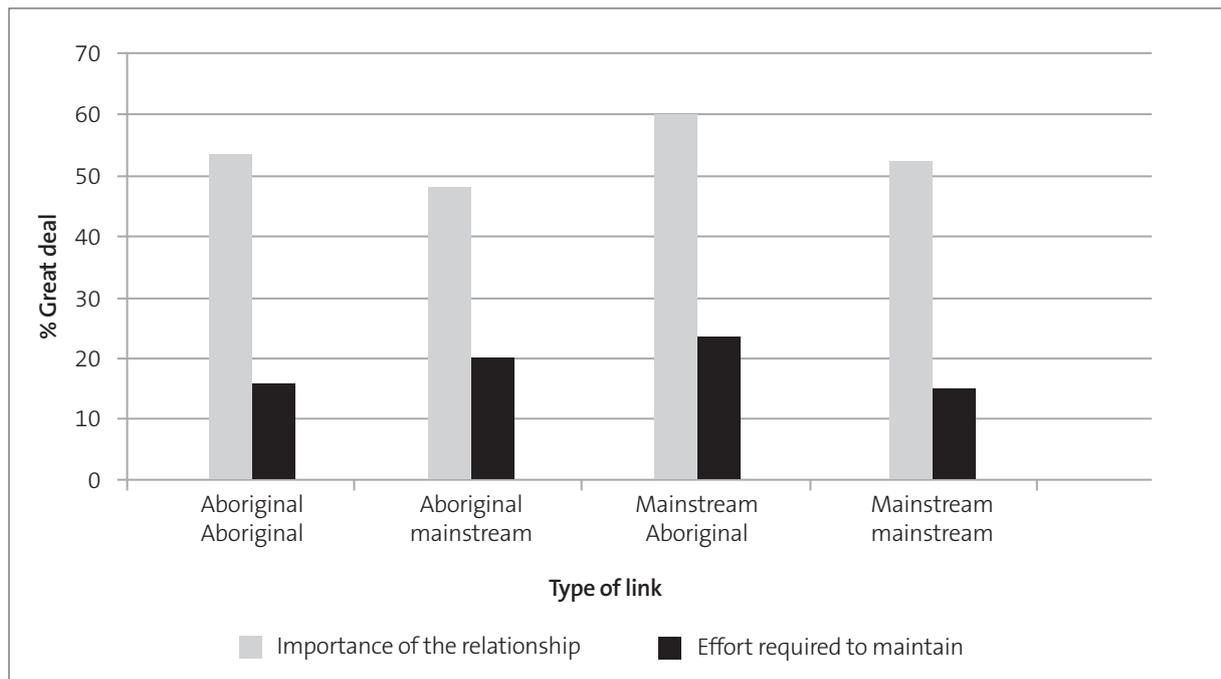


Figure 7: Importance and effort required to maintain networks for Aboriginal and mainstream organisations



Mainstream organisations rated their links with Aboriginal organisations as more important and requiring more effort to maintain than their links with mainstream organisations (Figure 7). Aboriginal organisations rated their links with Aboriginal organisations as more important than their relationships with mainstream organisations. However, Aboriginal organisations also found that their relationships with mainstream organisations required more effort to maintain. The analysis examining the relationship between different types of links and improvements in access to health services also suggests that these two kinds of links are very important.

## Impact of engagement on the process, implementation and improvements in access to health services

### *Satisfaction and confidence in implementation*

The odds of being satisfied/very satisfied/completely satisfied with the forum process increased with the percentage of Aboriginal organisations involved in the forums once jurisdiction and remoteness were controlled for. There was no association between the percentage of community members involved in the forums and satisfaction.

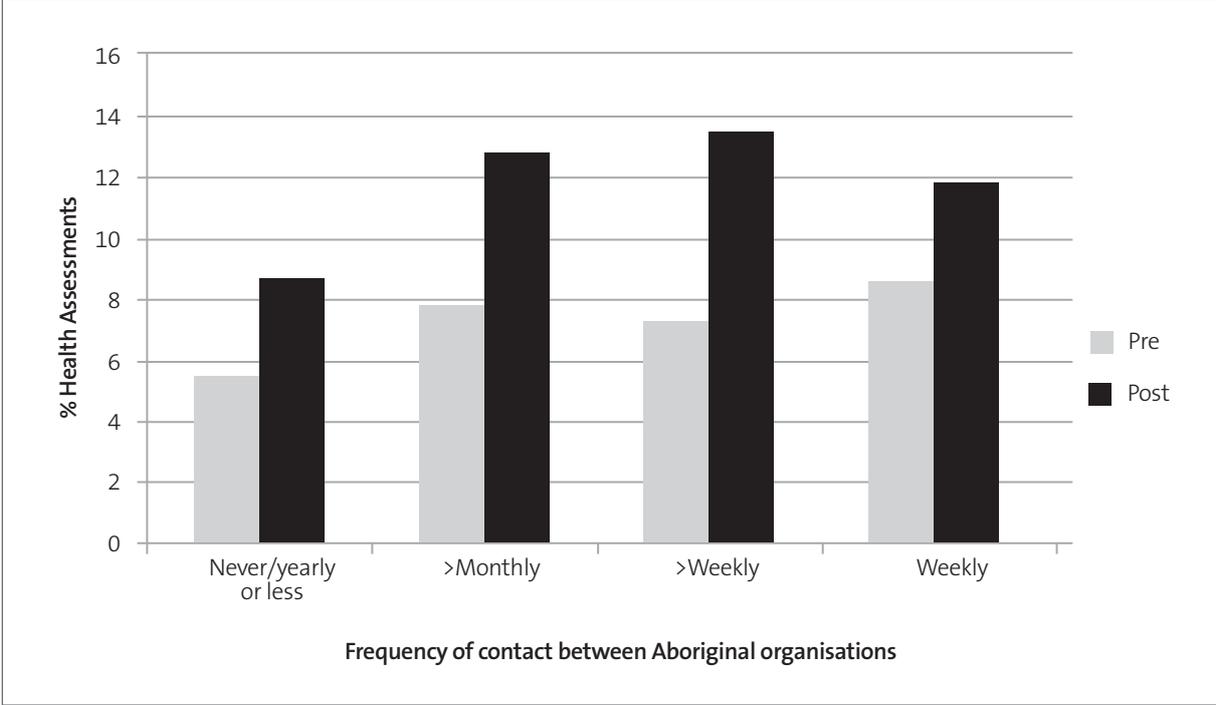
### *Health assessments*

The level of health assessments overall increased as a result of the IHNPA from around 8.9 per cent per year to 10.8 per cent per year, although there was substantial variation between regions.

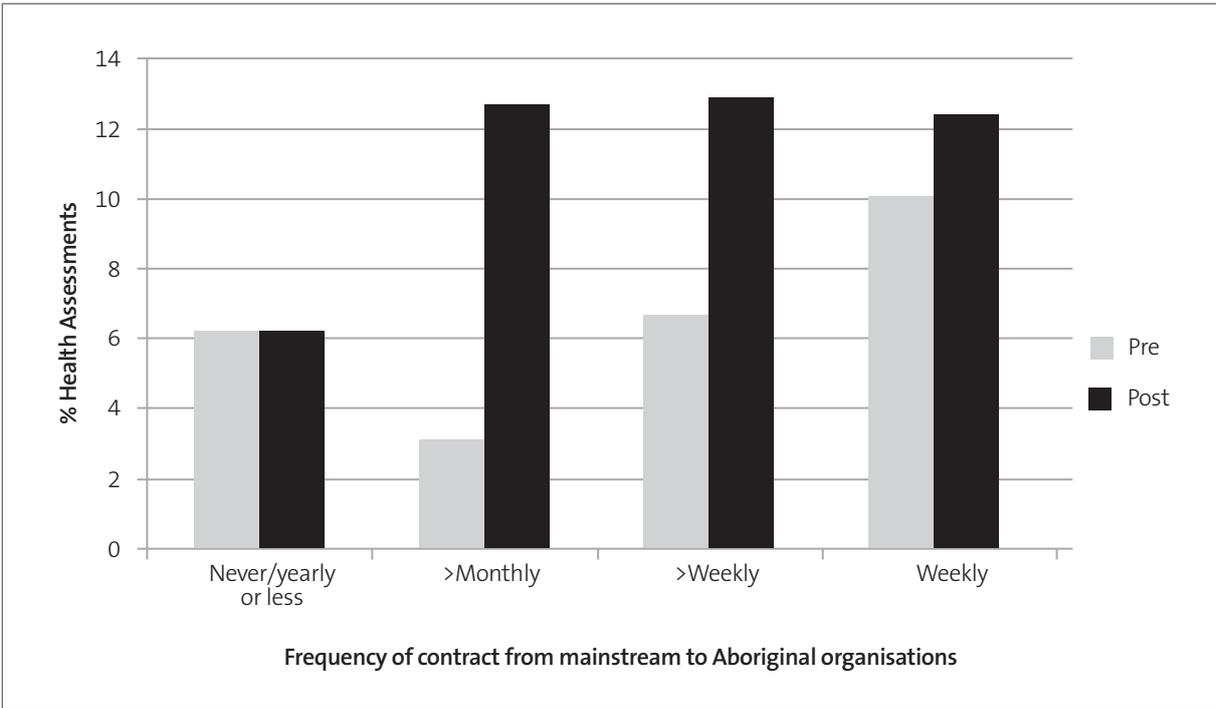
Higher rates of health assessments overall were associated with more frequent links between mainstream organisations and from Aboriginal organisations to mainstream organisations. Changes as a result of the IHNPA increased as a result of the frequency of contact between Aboriginal organisations. Figure 8 (overleaf) shows that in regions where organisations had no or annual contact, there was a lower level of change than in regions where there was a higher level of contact. There was a similar pattern for frequency of contact between mainstream and Aboriginal organisations (see Figure 9 overleaf).

Higher rates of health assessments overall were associated with greater importance being placed on links between mainstream organisations and from Aboriginal organisations to mainstream organisations. Figures 10 and 11 (p. 43) show that the level of change in the uptake of health assessments was associated with the importance placed on links between Aboriginal organisations and the links from mainstream to Aboriginal organisations.

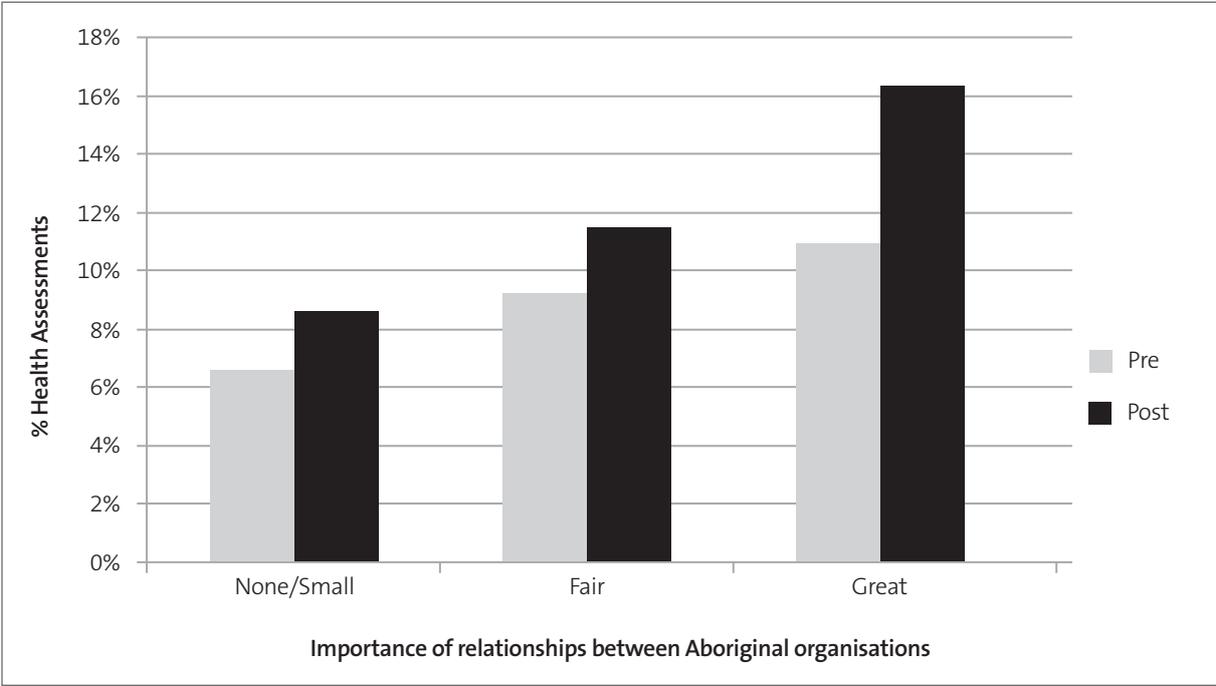
**Figure 8: Frequency of contact networks for Aboriginal organisations and the uptake of health assessments pre and post the IHNPAs**



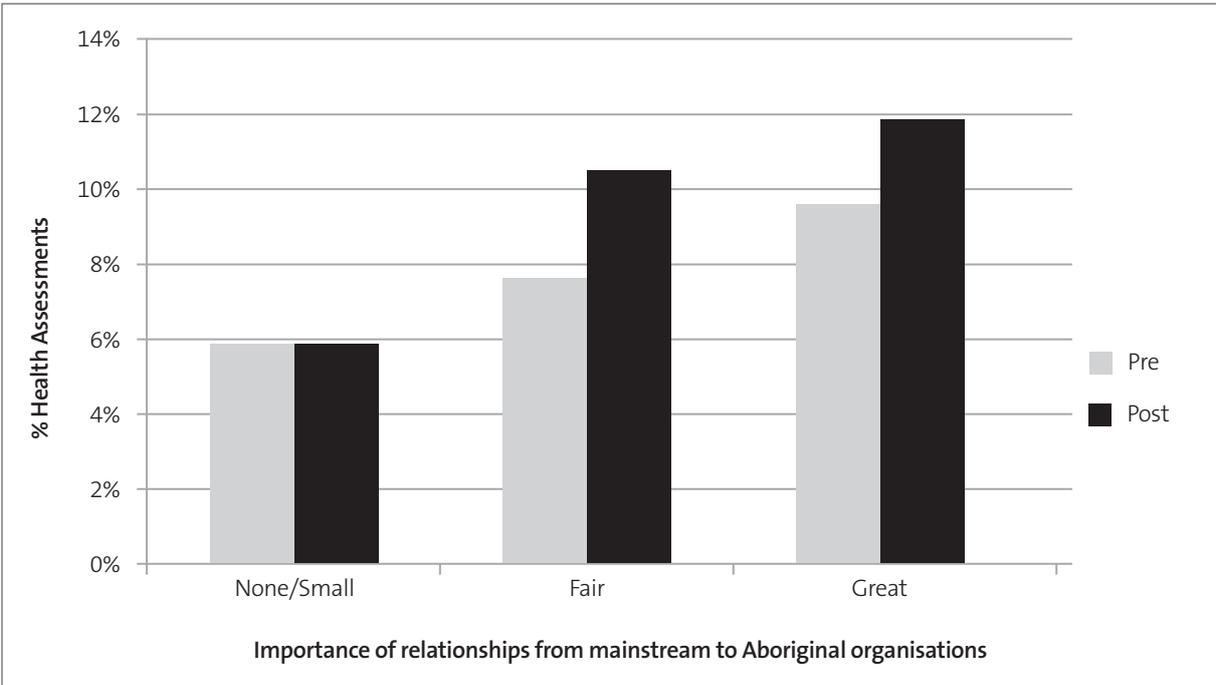
**Figure 9: Frequency of contact networks from mainstream organisations to Aboriginal organisations and the uptake of health assessments pre and post the IHNPAs**



**Figure 10: Importance of networks for Aboriginal organisations and the uptake of health assessments pre and post the IHNPAs**



**Figure 11: Importance of contact networks from mainstream organisations to Aboriginal organisations and the uptake of health assessments pre and post the IHNPAs**

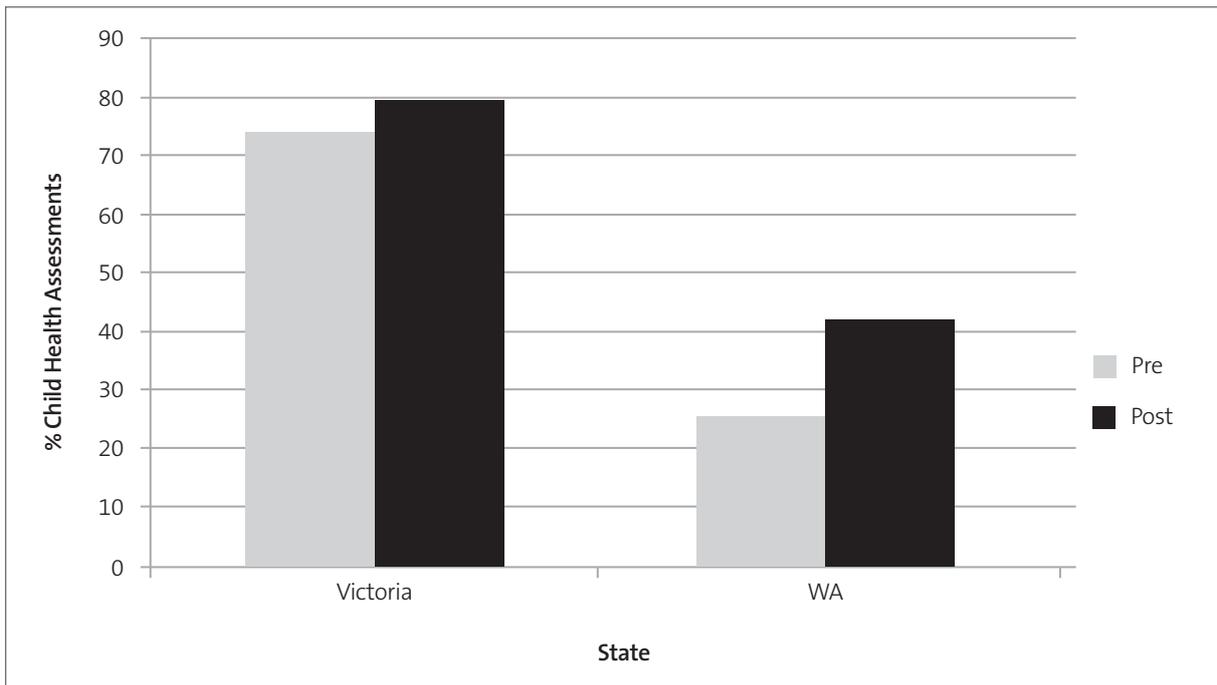


### Child health assessments

The percentage of children receiving appropriate health assessments increased from 44.3% to 58.2% as a result of the IHNPA. The percentage of children receiving health assessments was much higher in Victoria (77.1%) than in Western Australia (34.0%),

although this may be because different methods were used to estimate the population. The percentage change in child health assessments as a result of the IHNPA was higher in Western Australia than Victoria (Figure 12).

Figure 12: Uptake of child health assessments pre and post the IHNPA in Western Australia and Victoria



Higher rates of child health assessments overall were associated with more frequent links between Aboriginal organisations and from mainstream organisations to Aboriginal organisations. Changes as a result of the IHNPA increased as the frequency of contact between Aboriginal organisations and mainstream organisations increased. Figure 13 shows that in regions where organisations had no or annual

contact, there was a lower level of change than in regions where there was a higher level of contact. There was a similar pattern for frequency of contact between mainstream organisations (Figure 14).

The pattern of results for the importance network was very similar to the frequency network, although there was less variability in importance ratings.

Figure 13: Frequency of contact networks for Aboriginal organisations to mainstream organisations and the uptake of health assessments pre and post the IHNPA

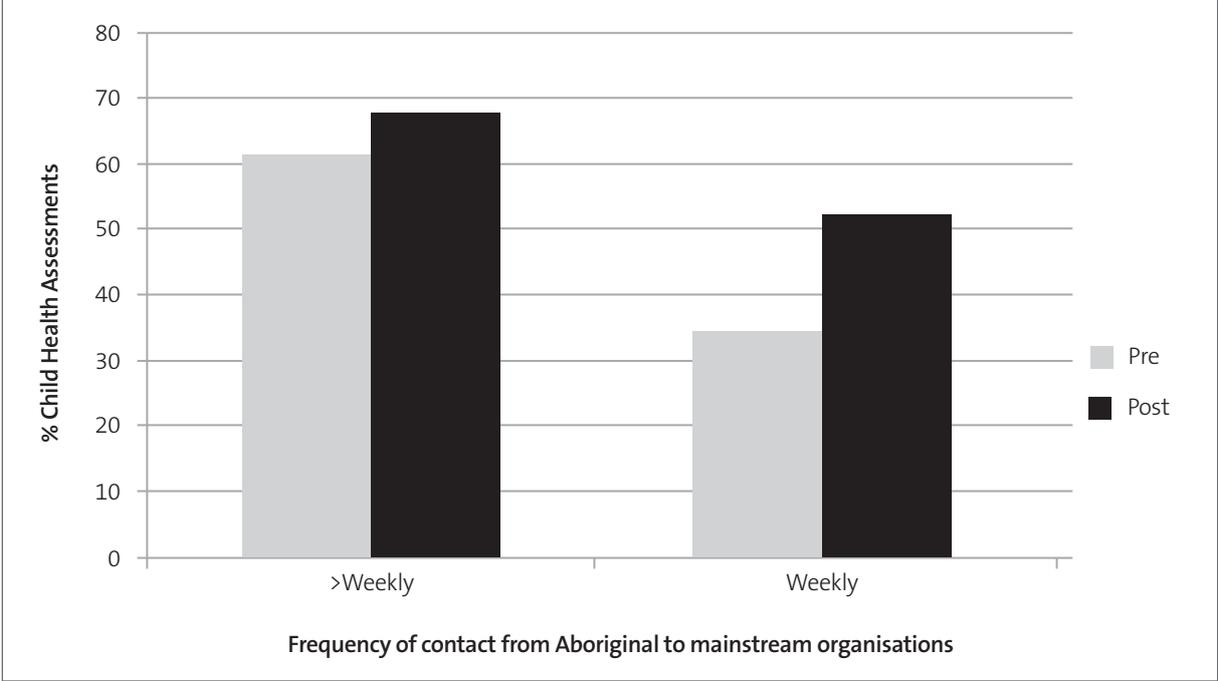
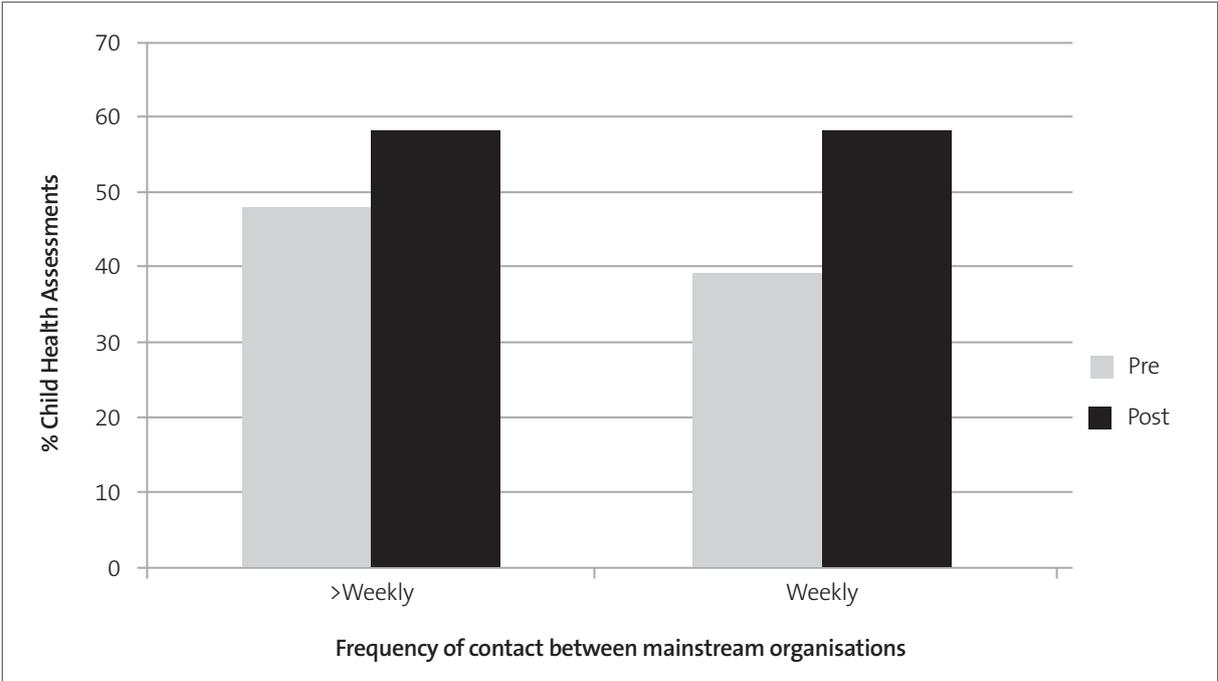


Figure 14: Frequency of contact networks from mainstream organisations to Aboriginal organisations and the uptake of health assessments pre and post the IHNPA



### Potentially preventable hospitalisations

The percentage of potentially preventable hospital admissions for chronic disease decreased from 2.5 per cent in 2009 to 1.9 per cent in 2012, but with a high level of variability between regions. There was no evidence of any influence of frequency or importance networks on potentially preventable hospitalisations.

In regions where there was a higher frequency of Aboriginal organisations working with each other and mainstream organisations working with Aboriginal organisations, there were lower levels of potentially preventable hospitalisations for chronic conditions. Likewise, in regions where the frequency of Aboriginal organisations working with mainstream organisations and of mainstream organisations working with each other were higher, there were higher levels of potentially preventable hospitalisations. In regions where the frequency of working with Aboriginal organisations was higher, potentially preventable hospitalisations were more likely to decrease post the IHNPA.

The pattern of results for the importance network was similar to the frequency network. For the network around the effort required to maintain relationships, potentially preventable hospitalisations were higher in areas where greater effort was required to maintain relationships from mainstream to Aboriginal organisations and between mainstream organisations.

The pattern of results was the same for acute conditions and for chronic conditions, except that there were no significant effects of the effort network.

Overall, the results suggest that even taking into account confounding factors such as State, remoteness and level of representation, the networks between organisations were important determinants of the effectiveness of the IHNPA. The relationships that contributed to better performance overall and change as a result of the IHNPA varied depending on the type of health outcomes (Table 4). For health assessments, increased uptake overall was predicted by relationships with mainstream organisations, but change as a result of the IHNPA was a function of relationships with Aboriginal organisations (Table 4). However, the opposite was true for child health assessments (Table 4). In contrast, relationships between Aboriginal organisations were predictors of lower potentially preventable hospitalisations for chronic and acute conditions (Table 4). Relationships from Aboriginal to mainstream organisations were also associated with lower potentially preventable hospitalisations post-IHNPA (Table 4). The results highlight the importance of the relationship between mainstream and Aboriginal organisations in improving health service use and uptake for Aboriginal people but they also suggest the importance of relationships between Aboriginal organisations.

**Table 4: Link types and health outcomes by network types**

	Increased health assessments		Increased child health assessments		Lower potentially preventable hospitalisations*	
	Frequency	Importance	Frequency	Importance	Frequency	Importance
<b>Overall</b>						
Aboriginal Aboriginal			✓	✓	✓	✓
Aboriginal mainstream	✓	✓				
Mainstream Aboriginal			✓	✓	✓	✓
Mainstream mainstream	✓	✓				
<b>Health changes from 2009–2012</b>						
Aboriginal Aboriginal	✓	✓		✓	✓	✓
Aboriginal mainstream	✓	✓	✓	✓		
Mainstream Aboriginal	✓	✓				
Mainstream mainstream			✓	✓		

\*significant effects in the effort network are not included because these were only significant for potentially preventable hospitalisations for chronic conditions



# Conclusion

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The idea that engaging Aboriginal and Torres Strait Islander people and organisations in the planning and governance of interventions to improve their health will lead to greater benefits is one of the most fundamental concepts in Aboriginal and Torres Strait Islander health and a core tenet of the Aboriginal community-controlled health sector. It is supported by international literature showing that giving an increased voice to vulnerable or disenfranchised populations is important to improving health equity [1]. There is much evidence demonstrating the adverse impacts of not engaging Aboriginal and Torres Strait Islander people in governance. However, very little empirical evidence shows the links between engagement in governance and satisfaction with the processes, implementation and benefit. This study is the first to provide such evidence.

## Processes through which Aboriginal and Torres Strait Islander community members and organisations are involved in governance

The implementation of the IHNPAs was associated with a significant shift in power from central government to regional forums comprising local health service providers and community groups. The engagement of Aboriginal and Torres Strait Islander people and organisations was highly valued in the forums. The results show that the inter-organisational networks formed in the context of these forums influenced improvements in access to health services as a result of the IHNPAs. The links associated with improving uptake were those from mainstream organisations to Aboriginal organisations and those between Aboriginal organisations. The findings add further support to evidence suggesting that the incorporation of minority groups into governance is an important strategy in improving health equity. More

importantly, it demonstrates that representation alone is not enough—rather, the relationships between organisations are critical to eliciting change.

Most regional forums created an environment where there was appropriate engagement of Aboriginal and Torres Strait Islander community/organisations in each phase of planning and governance and where participants were able to engage equally in governance processes. These are critical features that support meaningful participation in governance processes [29–31]. Almost all participants supported their continuation and highlighted the importance of a funded secretariat for effective functioning.

Aboriginal and Torres Strait Islander community members and organisations remained a minority on forums; however, they were privileged through the processes involved in planning and governance. There was also, for the most part, a clear recognition of the important contribution that Aboriginal and Torres Strait Islander participants were making. This helped establish the legitimacy of the process for Aboriginal and mainstream health service participants alike. Forums where Aboriginal and Torres Strait Islander community/organisations were more engaged in the process tended to be more effective in eliciting health service change.

The major constraint to equal participation in the forums was caused by a political imperative to rush to implementation. This caused a collapsing of the timelines for the development of project proposals and the selection of these proposals for inclusion in plans. Larger organisations were more likely than smaller organisations to have the resources to prepare proposals, whereas community members were reliant on others to write them. The legitimacy of the process was compromised by the fact that the selection process was often not endorsed by all forum members.

Participants universally saw competition within the forums as negative. These concerns tended to fall into three major categories. First, there were concerns that competition adversely affected relationships within the forums. Second, there were concerns that the best services did not always win in competitive processes. Creating an environment where health services compete to provide services to groups they formerly eschewed may have benefits in terms of equity of access to health services if they are actually delivered. However, such an environment could also be an impediment to working together to make the best collective decisions. Third, in a small number of situations, resources were provided to one organisation but support was expected from another. These issues may be resolved by providing support so that organisations are able to participate equally in the selection process, ensuring that data on performance is considered in decision making and perhaps identifying ways in which potentially competing organisations can work together.

The other major set of issues that inhibited the performance of the regional forums was around the articulation between Commonwealth, State and regional activities. In both States included in the case studies, Western Australia and Victoria, there were issues around negotiating the complexities of matching IHNPA-defined priorities with regional needs. These occurred when regional priorities fell outside the guidelines of what could be funded, when State-level programs were not meeting local need or when there were other State-level impediments to delivering programs. In Western Australia all the regional forums were represented on State-level forums with representation from the Commonwealth, the State, and State peak bodies for general practice and ACCHOs. This provided the possibility of discussing problems, identifying whether problems were a State-level or regional issue, and enabling corrections of scale where required. For example, in some communities in Western Australia there is complete reliance on public housing because there is no private rental market. This created a barrier to recruiting Aboriginal and Torres Strait Islander staff in a number of regions because their salaries would place them over the income threshold for public housing. The issue was resolved

through negotiations between State departments with responsibility for health and housing. In Victoria there was no mid-level forum. However, the selection of projects in the regional plans happened at a regional level and there was an overall policy to preferentially fund high-performing local programs over State-led programs. Both these approaches helped reduce tensions between State and regional priorities.

There were also challenges associated with working in a space where programs were being rolled out at national and State, as well as regional, levels—sometimes with little co-ordination or even communication. Almost universally, joint planning through the tripartite forums was seen as an effective and worthwhile approach to co-ordination. This now well-established mechanism has the potential to streamline different government programs and reduce disparities and service gaps and offer State-wide and national solutions to advance Aboriginal and Torres Strait Islander health. In both States when the framework<sup>2</sup> partners worked together it created a shift from adversarial relationships to more constructive approaches in which problems were jointly identified and managed.

The complexities of managing regional, State and Commonwealth programs was seen as a barrier to progress in many regions. The regional forums were a state process. Although OATSIH Staff members were represented on the forums, supporting these processes was challenging because it was not always seen as part of core OATSIH business and there was a lack of a regional presence to discuss issues and concerns and a lack of continuity. In both States regional forum members described their relationships with OATSIH's State office as strong and positive. However, these relationships were seen only as an

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2 The signatories of the framework agreements in each State and Territory are the Australian Government, the relevant State/Territory governments, the Aboriginal community-controlled health sector, the Aboriginal and Torres Strait Islander Commission (prior to 30 June 2004), and the Torres Strait Regional Authority [32]. Framework agreements have been in place for nearly 20 years and were the primary vehicle for ensuring collaboration in resource allocation, joint planning, and priority setting for service delivery between key stakeholders in Indigenous health within each state and territory. In most States the framework agreements have remained active during the period of the National Partnership Agreements.

opportunity to exchange information horizontally and not as a mechanism through which influence or communication occurred vertically. The key messages from our interviews were that the regional structure in place could be better utilised to reach and inform stakeholders collectively of what is taking place across the region and nationally and how it will affect them. Conducted on a consistent basis, Commonwealth engagement with regional forums could help nurture better and closer relationships with funded service providers. Moreover, the regional planning forums could provide an avenue through which to streamline ad hoc administration of programs and create a more co-ordinated environment, thereby minimising discrepancies created by disjointed policy making among the government departments.

## Impact of engagement on the process, implementation and improvements in access to health services

This study provides empirical support for the idea that the participation of disenfranchised populations in governance plays an important role in improving health equity. This is an important finding given that there is little existing evidence demonstrating the effectiveness of governance in primary health care [9]. Inter-organisational networks formed in the context of regional forums were associated with improved uptake of Aboriginal and Torres Strait Islander health assessments and child health assessments. Inter-organisational networks were also important in reducing the number of potentially preventable hospitalisations.

The links between mainstream and Aboriginal organisations were critical to determining the impacts of the forum on health improvements. However, an unanticipated finding from this data was that the relationships between the Aboriginal organisations themselves are also important and may be an important factor in reducing competition. Both the qualitative and quantitative data suggest that forums might be most effective in reducing health disparities when they privilege the relationships with Aboriginal and Torres Strait

Islander community and organisations, and when mainstream organisations develop partnerships with Aboriginal organisations.

The relationships that contributed to better performance overall and change as a result of the IHNPAs varied depending on the type of health outcomes. For health assessments, increased uptake overall was predicted by relationships with mainstream organisations but change as a result of the IHNPAs was a function of relationships with Aboriginal organisations. Relationships between Aboriginal organisations were predictors of lower potentially preventable hospitalisations for chronic and acute conditions. Relationships between Aboriginal organisations were also associated with decreases in potentially preventable hospitalisations post the IHNPAs. For both health assessments and potentially preventable hospitalisations, the frequency with which Aboriginal organisations worked with each other and the importance placed on these relationships were associated with positive change post the IHNPAs. Health assessments and potentially preventable hospitalisations are both associated with primary care co-ordination and showed similar patterns.

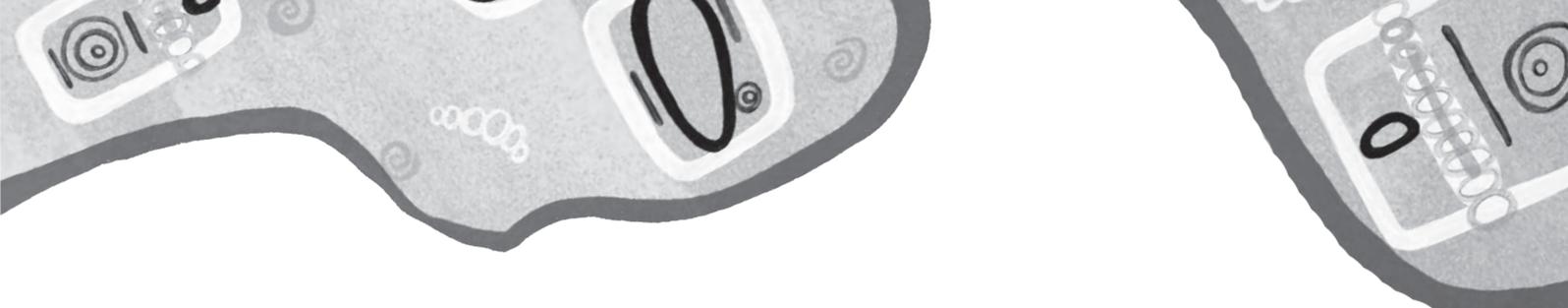
For child health assessments, increased uptake overall was predicted by relationships with Aboriginal organisations but change as a result of the IHNPAs was a function of relationships with Aboriginal organisations. This may reflect differences in the delivery of child health assessments through maternal and child health clinics/nurses rather than through the regular primary care system. The differences in results across health outcomes suggest a need to consider which relationships need to be strengthened in relation to each priority area.

Taken together, the data suggest that regional forums reflected a genuine shift in power from State government to the Aboriginal organisations and community members who participated. For Aboriginal organisations, the welfare of Aboriginal and Torres Strait Islander people has always been their core business. For most mainstream organisations, however, explicitly considering how to provide better quality of care to Aboriginal and

Torres Strait Islander people has only recently been on their agenda [26]. The data suggest that where mainstream organisations worked frequently with Aboriginal organisations and saw these relationships as important, positive results ensued.

The analyses focusing on the frequency of working together and the importance of relationships suggested that not only are links between mainstream and Aboriginal organisations important but also those between Aboriginal organisations. The qualitative data suggested that the success of both types of relationships was pivotal in the success of the forums. In the context of the current

health reform there has been much emphasis on the need for mainstream organisations to improve the way they work with Aboriginal and Torres Strait Islander communities and organisations [26]. Our data suggest that there would also be a benefit in investing in developing better ways for Aboriginal organisations to work with each other.



# Recommendations

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Overall, the findings suggest that the incorporation of Aboriginal and Torres Strait Islander communities and organisations in regional planning plays an important role in improving health equity. Achieving this requires strong links between Aboriginal organisations and mainstream organisations and between Aboriginal organisations. The study makes an important contribution to understanding the processes through which the incorporation of disenfranchised groups into governance might contribute to health equity. It has highlighted the potential role of social networks in the processes. Furthermore, it has advanced the understanding of the relationship between governance and outcomes in primary care.

The incorporation of Aboriginal and Torres Strait Islander communities and organisations in governance plays an important role in improving satisfaction with planning processes and the outcomes of health programs. This suggests three main recommendations, and further emanating from these.

**Recommendation 1:** The incorporation of Aboriginal and Torres Strait Islander communities and organisations in the governance of health programs should be further supported and developed.

**Recommendation 2:** Governance processes should include mechanisms to ensure that perspectives of Aboriginal and Torres Strait Islander participants are valued and inform decision making.

**Recommendation 3:** Future interventions should consider where relationships between organisations need further strengthening and should develop strategies/activities to achieve this.

The implementation of the IHNPA was associated with a significant shift in power from central

government to regional forums comprising local health service providers and community groups. Regional forums, for the most part, provided an effective platform to involve Aboriginal and Torres Strait Islander people and organisations in governance. The results show that the inter-organisational networks formed in the context of these forums influenced improvements in access to health services as a result of the IHNPA. Two further recommendations are associated with this.

**Recommendation 4:** Support for the role of regional forums with the continuation of regional approaches to planning and funding for secretariats should be continued.

**Recommendation 5:** The equity of processes to select projects for funding in order to ensure an optimal regional service mix should be improved. Measures to achieve this should include:

- a providing support in proposal development
- b ensuring that data on performance is considered in decision making
- c identifying ways in which potentially competing organisations can work together.

A number of complexities were involved in co-ordinating IHNPA activities across national, State and regional levels. Working with tripartite forums was seen as an effective mechanism to offer State-wide and national solutions to advance Aboriginal and Torres Strait Islander health. A strong feeling that regional forums were under-utilised as a mechanism for co-ordination and communication was also apparent and led to a further recommendation.

**Recommendation 6:** State-level (tripartite) and regional planning forums should be used as a means to improve communication and co-ordination between different programs.



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