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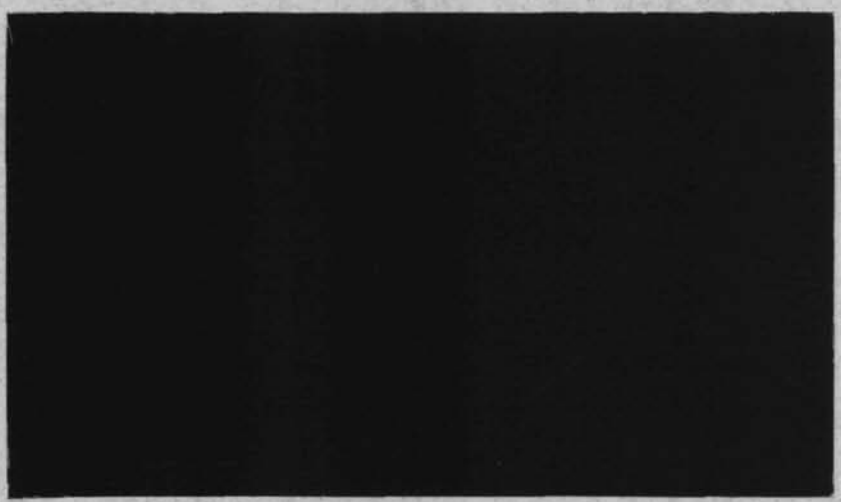

DISCUSSION PAPER

Aboriginal health and institutional reform within Australian federalism

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Director, CAEPR
The Australian National University
October 1996

ABSTRACT

This paper examines relationships between institutional reform within Australian federalism and Aboriginal health, both historically and in prospect. It begins with a brief historical analysis of government involvement in the general health arena within Australian federalism. It then provides a more extended historical account of government involvement in Aboriginal health and the emergence in the last 25 years of a group of important non-government players, the Aboriginal community-controlled health services. A more normative prescriptive analysis then follows, which identifies lessons from past experiences and enunciates principles for future action. These lessons and principles relate in particular to ideas about complexity and the need for greater role clarification and coordination in institutional arrangements for Aboriginal health. We argue for a view which in large part accepts this complexity and sees a need to draw organisations and their efforts into the Aboriginal health arena, rather than drive them out. We also, however, caution against drawing in *all* relevant organisations in related fields such as housing, education and infrastructure provision in the name of 'intersectoral collaboration'. A third argument suggests, perhaps counter intuitively, that measuring the success of institutional reform in Aboriginal health should to some extent be disarticulated from changes in substantive Aboriginal health status. A brief penultimate section of the paper looks at current general developments in the health arena. The conclusion of the paper identifies the key challenge and current opportunity for institutional reform within Australian federalism relating to Aboriginal health. This relates to the linking of responsibility sharing within Australian federalism and Aboriginal self-determination.

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Acronyms

ACCHSs	Aboriginal Community-Controlled Health Services
AHB	Aboriginal Health Branch
ATSIC	Aboriginal and Torres Strait Islander Commission
CDH	Commonwealth Department of Health
CDHFS	Commonwealth Department of Health and Family Services
CDHSH	Commonwealth Department of Human Services and Health
COAG	Council of Australian Governments
DAA	Department of Aboriginal Affairs
FCAATSI	Federal Council for the Advancement of Aborigines and Torres Strait Islanders
HRSCAA	House of Representatives Standing Committee on Aboriginal Affairs
NACCHO	National Aboriginal Community Controlled Health Organisation
NAHSWP	National Aboriginal Health Strategy Working Party
NT	Northern Territory
OATSIHS	Office of Aboriginal and Torres Strait Islander Health Services

Institutional arrangements for the provision of health care in the Australian federal system involve all levels of government and numerous non-government actors. Arrangements for Aboriginal health care provision are even more complex, involving not only general health organisations, programs and services, but also Aboriginal-specific ones. Given this complexity, it is perhaps not surprising that when public concern is periodically aroused about the persistent poor status of Aboriginal people's health, institutional arrangements do themselves often attract considerable attention and criticism. Are these institutional arrangements delivering health care to Aboriginal people in an appropriate and effective way, or could they be significantly improved? Is effort being directed where it is needed and suited, and is the complexity of arrangements within the federal system itself a problem?

This paper attempts to explore these and other questions about the linkages between Aboriginal health and institutional arrangements within Australian federalism. No attempt is made to engage in analysis outside the federal framework, since this is seen as the inevitable reality of Australian health care provision for the foreseeable future. Significant changes within the federal health care system have, however, occurred in the past and are continuing at present; and it is to the potential for reform within the federal system and its linkages with Aboriginal health that attention is directed.

We begin with a brief description of the history of government involvement in general health care provision within Australian federalism. We then provide a more detailed account of the history of government involvement in Aboriginal health and of the emergence in the last 25 years of a group of important non-government players - the Aboriginal community-controlled health services (ACCHSs). This history is followed by a more normative prescriptive analysis which attempts to identify lessons from past experience and principles for future action. The penultimate section of the paper considers the relevance of some current general developments in the health area. The conclusion then reiterates the general nature of both the challenge and the current opportunity for institutional reform in Aboriginal health within Australian federalism, referring in particular to ideas of responsibility sharing and self-determination.

Government involvement in health care: a brief history

At the time of federation in 1901, health care was an area of social responsibility left, constitutionally, primarily with the States. The Commonwealth was given a quarantine power, for which it legislated in 1908, and also, by force of circumstances, became involved fairly early on in some public health matters, such as infectious diseases. To administer

this involvement a Commonwealth Department of Health (CDH) was established in 1921. However, compared to the State departments of health which ran some hospitals, funded and regulated others and directly provided many other health services, the Commonwealth department was a smaller policy-oriented organisation operating at a level of remove from day-to-day health care servicing.[1]

During the 1940s, the Chifley Labor government attempted to involve the Commonwealth far more directly in health care provision. It attempted to establish a free national health service, staffed by salaried doctors, but was prevented from doing so both because of opposition from the medical profession and because of a lack of constitutional power. It did, however, succeed in passing a constitutional alteration which gave the Commonwealth a new head of power in the area of 'pharmaceutical, sickness and hospital benefits, medical and dental services (but not so as to authorize any form of civil conscription)' (Commonwealth of Australia Constitution Act, 51(xxiiiA)).[2]

Armed with this new constitutional power, and the ability under section 96 of the Constitution to make financial assistance to the States on 'such terms and conditions as the Parliament thinks fit', both the Chifley Labor government and subsequent Coalition governments began to develop a greater role for the Commonwealth in the health care area. This role, however, was primarily in health care funding rather than direct service provision. Indeed, by the 1960, the Commonwealth had become as significant a funder of health care services as the States, with each contributing about one-quarter of Australia's total recurrent health care expenditure (Butler 1991: 169). The Commonwealth's mechanisms for contributing this funding were essentially twofold; first, payment or reimbursement of fees for medical services or pharmaceuticals delivered by doctors or pharmacists to various categories of eligible individual, and second, health-related specific purpose grants to the States.

This pattern of Commonwealth involvement in health care funding was extended dramatically in the 1970s and 1980s through the introduction by Commonwealth Labor governments of the Medibank, and later Medicare, compulsory national health insurance schemes. As well as greatly extending, indeed universalising, individual eligibility for Commonwealth payment or reimbursement of fees for medical services and pharmaceuticals, these schemes also greatly increased Commonwealth involvement in health-related State grants. This was particularly so in the hospital funding area, where the Commonwealth agreed to make major grants towards the running costs of State hospitals on the condition that the States do away with public ward hospital charges and provide free public ward access to all.[3]

In recent years, as a result of these developments, the Commonwealth has been contributing almost half of total recurrent health care expenditure in Australia, while the contribution of the States (and Territories) has remained around one-quarter. Within this Commonwealth funding contribution, a little over half is in the form of payments for medical services and pharmaceuticals delivered to individuals on a fee for service basis and little less than half is in the form of health-related specific purpose State grants.[4]

By the 1990s, some aspects of these federal arrangements for health care funding and provision were being extensively criticised. Both Commonwealth and State participants seemed to agree that a weakness of the hospital funding grants was that they were historically based and not related to measures of hospital activity (see Bansemer 1991; Owens and Duckett 1991). Incentives for 'cost shifting' between the pre-funded public ward hospital sector and the fee-for-service health sector were also seen as a problem, as too were incentives for cost shifting between various narrowly-defined functional State grants programs (see Owens and Duckett 1991; Paterson 1995). Perhaps not surprisingly then, these health care arrangements have in the mid 1990s been given some attention by the Council of Australian Governments (COAG) in its attempts to promote both a more collaborative and cooperative style of Australian federalism and microeconomic reform (Duckett, Hogan and Southgate 1995). Ideas have emerged of hospital funding on the basis of 'case payments' for various 'diagnosis related groups' and of health services based on 'people-focussed ... streams of care', rather than multiple narrowly-focused functional programs (Paterson 1995; Duckett Hogan and Southgate 1995). These ideas are, however, still being developed and reform processes have not yet progressed far.[5] Established patterns of government involvement in health care funding and provision within Australian federalism remain largely intact; though there is clearly some impetus for further change now emerging.

Government involvement in Aboriginal health and the emergence of the ACCHS

In the Aboriginal health area, constitutional responsibility in the Australian federal system was, once again, initially left primarily with the States. From 1911, the Commonwealth developed a regional involvement in Aboriginal health through its administration of the Northern Territory (NT); but this was through its Territories rather than Health administrative system. From the 1930s and 1940s, the Commonwealth came under increasing pressure to expand its role in Aboriginal affairs. However, the presence of a specific exclusion relating to 'the aboriginal race in any State' in the Commonwealth's race power at section 51 (xxvi) of the Constitution

was often seen as an impediment to such greater involvement. In the 1950s, a movement grew up for the alteration of this constitutional provision, led by the Federal Council for the Advancement of Aborigines and Torres Strait Islanders (FCAATSI). In May 1967 a referendum for this alteration of the Constitution was successful and the Commonwealth's race power came to include Aborigines.

The clear expectation at the time of the 1967 referendum was that the Commonwealth would become far more actively involved in Aboriginal affairs, including Aboriginal health, on a national scale. Bandler, a black activist of the time, quotes *The Australian* newspaper of the time as follows:

> Strong pressure for Commonwealth help for Aborigines is certain to follow the sweeping vote on the Aboriginal issue in Saturday's referendum ... commentators said yesterday that the referendum vote gave the Government an overwhelming mandate to play a much greater role in Aboriginal affairs in the States. Some went so far as suggesting the creation of a new Department similar to the Repatriation Department to help in Aboriginal housing, health, education, employment and other problems associated with state government departments (*The Australian*, 29 May 1967 cited in Bandler 1989: 114).

The Coalition Commonwealth governments of the late 1960s and early 1970s did not go quite as far as these commentators were suggesting. They established a new Office of Aboriginal Affairs, rather than a department, and through it began making specific purpose grants to the States for 'Aboriginal advancement'. Health was one of four major functional areas identified for such grants and State government health departments began in the early 1970s to establish Aboriginal health units, or special services units, to receive and make use of these funds (see House of Representatives Standing Committee on Aboriginal Affairs (HRSCAA) 1979: 81-4; also Saggers and Gray 1991: 395-7).[6]

State grants for Aboriginal health were, in many ways, a fairly conservative Commonwealth response, given the mood of the late 1960s and early 1970s. A new politics was at that time emerging among Aboriginal people, which was increasingly calling for specifically Indigenous rights to land and group autonomy; in contrast to earlier calls for equal rights in areas such as wages, drinking, social security and the franchise. In this new politics, the States were seen as the established conservative interests in Aboriginal affairs; so directing money to them by way of specific purpose grants for Aboriginal health was not seen as particularly progressive. The more progressive image of the time was the province of a new breed of specifically Aboriginal community-controlled organisations which were beginning to emerge in the health area and many other policy and service areas as well; such as the Aboriginal Medical Service established in Redfern, Sydney in 1971 and the Victorian Aboriginal Health Service established around the same time. Although

these health services were at one level essentially small medical and dental clinics, at another level they were an important institutional manifestation of the politics of self-determination among Aborigines. They championed Aboriginal control and participation in both health care policy and service delivery and made strong claims for financial and other government support.[7]

When the Whitlam Labor Commonwealth government was elected in December 1972, its response to this new political mood among Aborigines was somewhat more substantial. It adopted 'self-determination' as the key term of Aboriginal affairs policy. It also established a fully-fledged Commonwealth Department of Aboriginal Affairs (DAA), a royal commission to examine possibilities for the granting of land rights to Aboriginal people and an elected National Aboriginal Consultative Committee. It continued to make specific purpose grants for Aboriginal advancement to the States in areas such as health, but also began making direct grants to the newly-emerging Aboriginal community organisations, such as the ACCHSs. This support for ACCHSs allowed their numbers and their share of expenditure from the Commonwealth's Aboriginal health program to begin to grow (see Table 1).

The Whitlam government also instructed CDH to develop a National Plan for Aboriginal health and to establish an Aboriginal Health Branch (AHB) within its Public Health Division. The National Plan, which was approved by the Commonwealth Minister for Health in March 1973, required the CDH to launch an immediate campaign 'to raise the standard of health of the Aborigines of Australia to the levels enjoyed by their fellow Australians', with the government 'aiming to achieve its goal at the end of ten years' (CDH 1973: 45). The CDH also, however, argued that 'practical responsibility' for Aboriginal health was 'shared' and that its own efforts could only 'attempt to knit together' those of others. Nevertheless, the AHB would, the CDH claimed, both 'stimulate a uniform, national approach' and encourage the 'active participation of Aborigines themselves' (CDH 1973: 5). It would also, the CDH claimed, 'provide a comprehensive nationally-oriented advisory service' and develop a 'close working relationship' with the DAA to ensure that 'all efforts' were 'co-ordinated and achieve maximum effectiveness' (CDH 1973: 46).

The Fraser Coalition Commonwealth government which came to power at the end of 1975 maintained virtually all the institutional changes that the Whitlam government had initiated in Aboriginal affairs. However, in the Aboriginal health area it soon became evident that these were not having the results hoped for. A report on Aboriginal health compiled by HRSCAA in 1979 suggested that the 'standard of health of Aborigines' was still 'far lower than that of the majority of Australians' and that 'little progress' had been made in 'raising' it (HRSCAA 1979: iii and 28).

Table 1. Health expenditure of Commonwealth Aboriginal Affairs portfolio, 1970-95.

Financial year	Grants to States $ million (A)	Grants to Aboriginal community organisations[a] $ million (B)	B as % of A+B	Number of ACCHSs funded
70/71	.64			
71/72	1.27	.04	3	
72/73	2.85	.10	3	
73/74	8.34	1.07	11	6
74/75	10.56	1.35	11	6
75/76	14.05	1.87	12	8
76/77	11.78	2.58	18	8
77/78	12.36	3.96	24	10
78/79	12.60	4.90	28	13
79/80	13.15	5.39	29	18
80/81	13.89	5.97	30	19
81/82	14.18	7.44	34	25
82/83	15.47	8.38	35	30
83/84	15.78	12.72	44	34
84/85	16.09	20.40	56	45
85/86	15.06	22.76	60	54
86/87	13.43	24.70	65	54
87/88[b]	12.94	24.13	65	62
88/89	11.85	26.89	69	64
89/90	10.93	27.65	72	66
90/91	6.50	35.68	85	87
91/92	5.95	37.15	86	92
92/93	3.36	44.51	93	92
93/94	0.99	53.74	98	96
94/95	1.11	68.06	98	96

a. The category of expenditure reported here is officially called grants for 'Aboriginal advancement'. It may include some elements of expenditure which do not flow entirely to Aboriginal community organisations. It may, therefore, be a slight over-representation of amounts of money flowing to Aboriginal community organisations, particularly in the early years.

b. A new category of 'substance abuse' appears to have been added to DAA financial records in this year. The reduction in health expenditure from 86-87 to 87-88 may, therefore, have been more apparent than real. If the 'substance abuse' category is included with health from 1987-88, the bottom of the table reads as follows:

87/88	12.96	28.12	68	68
88/89	12.11	31.33	72	72
89/90	11.69	31.98	73	73
90/91	7.10	41.53	85	85
91/92	5.99	42.17	88	88
92/93	3.73	57.40	94	94
93/94	.99	69.61	99	99
94/95	1.26	83.50	99	99

Source: Financial appendices of DAA and Aboriginal and Torres Strait Islander Commission (ATSIC) Annual Reports.

The HRSCAA argued that one reason for this lack of progress had been insufficient attention paid to the 'physical environmental' conditions in which Aboriginal people lived as a determinant of health status, but also insufficient attention to 'social' and 'cultural' factors relating to Aboriginal health (HRSCAA 1979: 37-74). It also made a strong call for 'increasing Aboriginal decision-making and involvement in health care' and argued that the evidence before it demonstrated that the 'focus of responsibility and decision-making in Aboriginal health still lies outside most communities' (HRSCAA 1979:111-114). Self-determination, it continued, implies that:

> Aboriginals should be given the opportunity to choose or design a health service which best suits their particular needs and available resources (HRSCAA 1979: 114).

This support for self-determination in Aboriginal health did not, however, translate into absolute Committee support for ACCHSs, as opposed to services provided by State (or Territory) health departments, in all situations. While the Committee was supportive of the ACCHSs and wanted to see their number and support for them increased, what it saw as 'fundamental' was that:

> Aboriginal communities have access to information concerning the full range of health care options from which they might choose (HRSCAA 1979: 114).

Where the HRSCAA was more overtly critical of the States was in relation to the funding of the Aboriginal health units within their health departments. It argued that the States had not accepted any 'financial responsibility for improving the health of Aboriginals as citizens of the State' (HRSCAA 1979: 79-80). The States had, as the HRSCAA saw it, simply availed themselves of Commonwealth funds on offer for Aboriginal health.

Perhaps what the 1979 HRSCAA report did not fully reveal was the sense of competition and even animosity which had by that time developed between the newly emerging ACCHSs and the Aboriginal health services of the State (and Territory) health departments. The ACCHSs saw the States as having been neglectful of services to Aboriginal people in the past and as having no right in the present to designated Commonwealth Aboriginal health expenditure (see, for example, Nathan and Japanangka 1983). The State and Territory health departments, on the other hand, sometimes saw the ACCHSs as amateurs or community activists who were insufficiently qualified to participate on equal terms in the highly professional area of health care policy and service delivery.

Some of this sense of competition and animosity was revealed in a confidential report prepared by the Department of Prime Minister and

Cabinet (DPMC) in late 1979 and early 1980, the *Program Effectiveness Review: Aboriginal Health*. Although never officially released, this report did receive some circulation and was reported on in the press (*The Canberra Times*, 25 February 1981). In it, the newly established national body of ACCHSs, the National Aboriginal and Islander Health Organisation (NAIHO), was quoted as arguing for a 'National Black Health Plan' which would more than double the number of ACCHSs in order to 'replace States Grants programs' (DPMC 1980: 36). The States, on the other hand, were seen as defending their efforts in Aboriginal health and their rights to the States grants program (DPMC 1980: 11). However, the DPMC report quoted a number of recent documents which seemed to throw some doubt on the level of State commitment to self-determination and community involvement in Aboriginal health. A 1977 Victorian Health Commission report was quoted as stating that:

> all planning and decision-making is the responsibility of the Health Department. However, as Aboriginals become more highly trained and involved in health matters it will become possible for the Aboriginal community to provide greater advice and consultation (DPMC 1980: 82).

A 1979 letter from the Queensland Premier to the Prime Minister commenting on the findings of the HRSCAA report on *Aboriginal Health* was quoted as stating that:

> the concept of a community basis for the design and delivery of health services is viewed with considerable concern. It is not considered that this concept makes provision for the professional expertise which is essential in decision-making in such areas (DPMC 1980: 83).

This letter was also quoted as stating that the 'principles termed self-management, self-sufficiency and Aboriginality are not so easily adjusted to the process that ensures good health' and that:

> It does not necessarily follow that programs popularly chosen by a community are necessarily what is required or in the best interest of that community (DPMC 1980: 83).

A 1979 letter from the Western Australian Premier to the Prime Minister commenting on the findings of the HRSCAA report was also quoted as stating that:

> The State Government cannot agree with the funding of Aboriginal medical services which are so costly, have no accountability, do not meet priority goals, are unstable and disrupt the State's organised structure and planning for Aboriginal health (DPMC 1980: 85-6).

Other States and the NT, most notably South Australia, were quoted in ways which indicated greater support for community involvement and self-determination in Aboriginal health. But the basis of a sense of competition

and animosity between the ACCHSs and the State and NT health departments was clear.

Another dimension of competition and animosity which the 1979 HRSCAA report did not fully reveal was one within the Commonwealth's administrative system between CDH and DAA. After establishing the AHB in 1973, the CDH had clearly found it difficult to develop any really significant role for itself in Aboriginal health. It felt that its professional expertise and links with the State health departments were not being adequately brought to bear and, more specifically, were not being utilised by the DAA in its administration of the Commonwealth's Aboriginal-specific health funding. The CDH came to believe that it should have primary responsibility for these Aboriginal health funds, and so have opportunities to tie in their allocation with broader health expertise and resource allocation processes. The DPMC report was inclined to agree with the CDH and recommended a phased transfer of the Commonwealth's Aboriginal health funds over three years (DPMC 1980: 15-7, 64-5, 71-2). The DPMC report also, however, sought to reaffirm the responsibility of the Minister for Aboriginal Affairs for the 'development ... of national policies directed to ... Aboriginal people, the administration of those polices, and the coordination of programs' (DPMC 1980: 69). Clearly there was a delicate balancing act being attempted here between increasing the role of the CDH in Aboriginal health expenditure without too greatly offending the DAA. The Fraser government declined to act on these recommendations of the DPMC report and so this tension within the Commonwealth's administrative apparatus between the CDH and the DAA remained unresolved.

In 1983, when the Hawke Labor Commonwealth government came to power these two dimensions of competition and animosity within the institutional arrangements of Aboriginal health were, if anything, still growing. The ACCHSs had increased their proportion of Commonwealth Aboriginal Affairs portfolio health program expenditure to about one-third and still wanted more (see Table 1). The CDH still felt that it should have custody of the Commonwealth's Aboriginal health expenditure, but the DAA believed equally firmly that it should retain the program. The CDH had become minorly involved in additional funding for some of the ACCHSs, for the 'salary costs of clinical staff' at a cost of some $1.9m per annum (CDH 1983: 31). If anything, however, this involvement had exacerbated tensions. In 1983, the CDH reported that this 'dual funding' arrangement was causing some 'difficulties' and a more 'logical approach', involving 'one government authority' was being suggested (CDH 1983: 32). In an attempt to resolve this tension and much to the CDH's dismay, in December 1984 the Hawke government decided to strip the CDH of its emerging funding role in relation to ACCHSs and transfer the role, along with four Aboriginal health staff positions, to the DAA (CDH 1985: 4, 47).

The CDH was, at the time, undergoing a major administrative restructuring, reducing it from 13 to five divisions, and one office which disappeared entirely was the AHB. The CDH saw itself as maintaining a 'professional advice' and 'policy' role in Aboriginal health, as well as some involvement in national Aboriginal health statistics issues, but without a discrete Aboriginal health office (CDH 1985: 47).

As a result of the December 1984 changes, the DAA came to have a fairly clear lead role in Aboriginal health within the Commonwealth's administrative system. To assist it develop this role, the DAA established a Commonwealth interdepartmental working group on Aboriginal health in 1985/86. Then in December 1987 a combined meeting of Commonwealth, State and NT Health and Aboriginal Affairs ministers decided to establish a broader working group to develop a National Aboriginal Health Strategy (NAHS) (DAA 1988: 46). Chaired by a representative of one of the ACCHSs, and with State, Territory, Commonwealth and other ACCHSs representation among its 19 members, over the next year this group produced a major report (National Aboriginal Health Strategy Working Party (NAHSWP) 1989).

The NAHSWP report emphasised a holistic concept of health among Aboriginal people and the benefits of Aboriginal community-control and participation in health care services. Because of this, it foresaw a major ongoing role for the ACCHSs and looked forward to their further growth and development (NAHSWP 1989: ix-xviii). The NAHSWP report was also highly critical of the allocation of government 'responsibilities' in Aboriginal health between different levels and departments of government and called for greater efforts to both 'define' and 'coordinate' these responsibilities and for greater 'intersectoral collaboration' (NAHSWP 1989: 35-40, 102-114). To advance these ideas, the report recommended the establishment of a Council of Aboriginal Health which would be a 'standing committee' of both the Health and Aboriginal Affairs national ministerial councils. The Council would involve Commonwealth, State/Territory and ACCHSs representatives, would meet quarterly and report to joint annual meetings of the ministerial councils (NAHSWP 1989:36-9). The report also recommended that similar 'tripartite forums' be established at the level of individual States and Territories in order to 'resolve issues relating to intersectoral collaboration within the State and Territory' (NAHSWP 1989: 40). It also recommended the establishment of an enhanced Office of Aboriginal Health within the newly emerging Aboriginal and Torres Strait Islander Commission (ATSIC), which looked set to take over the role of the Commonwealth's DAA (NAHSWP 1989: 39).

In March 1989, the NAHSWP report was presented to a second joint meeting of Commonwealth, State and Territory Ministers for Aboriginal

Affairs and Health. Initial responses were consensual in their support. However, as matters proceeded, consensus soon broke down.

To take the NAHSWP report further, a development group was established which included only one ACCHSs representative alongside Commonwealth, State and Territory government representatives. This immediately put the ACCHSs offside and an attempt to draw them back in, through a separate community advisory group, was only partly successful. The two groups produced separate implementation reports with some notable strategic differences (Aboriginal Health Development Group 1989; Community Advisory Group 1990). Then only one of these reports, that of the development group, was submitted to a third joint meeting of the Commonwealth and State/Territory Aboriginal Affairs and Health ministers in June 1990.

This June 1990 joint ministerial meeting endorsed the work of the development group and, in turn, of the NAHSWP. The NAHS became official government policy and moves were begun towards implementing its major recommendations. The national Council of Aboriginal Health was to be established and so too were its counterpart State and Territory level tripartite forums. The Office of Aboriginal Health within ATSIC was to be enhanced and an ATSIC Commissioner specifically designated as having health responsibilities.

In December 1990 the Commonwealth Ministers for Health and Aboriginal Affairs announced a budgetary commitment to the NAHS of $232 million over five years. The Commonwealth's intention was also, however, to secure broadly matching expenditure from the States and Territories through formal Aboriginal health agreements. This was seen by the Commonwealth as in line with the outcome of the Special Premiers Conference of October 1990 and its commitment to a 'closer partnership' between the Commonwealth and State/Territory levels of government within Australian federalism.[8]

Eliciting formal agreements and matching expenditure from the States and Territories proved a difficult process. During 1991, various elements of the ATSIC structure became frustrated with the process, seeing it as unnecessarily restricting their own utilisation of the Commonwealth's designated NAHS funds. Nevertheless interim agreements were made for 1991-92 identifying $43.2m of 'new effort' by the States and Territories in Aboriginal health (Gordon 1994: 28). In 1992, however, the ATSIC Board of Commissioners determined that Commonwealth NAHS funds would henceforth be allocated on the advice of ATSIC regional councils directly to ACCHSs and that this would occur independently of the further pursuit of agreements with the States and Territories relating to Aboriginal health. The negotiation of such agreements was to be referred to the Council of

Aboriginal Health. The Council was also to address the issue of Aboriginal health 'goals and targets' which were supposed in some way to underlie these agreements and on which some preliminary work had recently been done (Wronski and Smallwood nd). However the Council had only just been convened and how it would operate was still rather uncertain.

By 1992-93, many ACCHSs were beginning to express considerable dissatisfaction with the implementation of the NAHS. One reason for this was the rather tardy establishment of the Council of Aboriginal Health and its counterpart State/Territory tripartite forums. Another reason for dissatisfaction was that the vast majority of the Commonwealth's promised NAHS funds - some $171 million of the projected $232 million over the five year period - was not to flow to the ACCHSs, but to Aboriginal community organisations involved in housing provision and infrastructure (Gordon 1994: 18). This in part derived from the emphasis on holism, intersectoral collaboration and the importance of 'health systems infrastructure', as well as health services, to Aboriginal health in the NAHSWP report (NAHSWP 1989: 59-101). However, despite their support for these ideas, the ACCHSs were less than happy about having such a large portion of the NAHS budget directed outside the health services sector.

A further and related reason for dissatisfaction on the part of the ACCHSs was their perception that in gaining access to funding primarily through ATSIC and its newly-emerging regional council structure, they were increasingly being drawn into invidious competition for resources with other Aboriginal community-controlled organisations. The ACCHSs did not generally perceive that they were faring well in this process and began to resent it. They began to think seriously about the possibility of having their funding program removed from ATSIC and transferred to the Commonwealth's health portfolio, which was by late 1993 part of the new Commonwealth Department of Human Services and Health (CDHSH) with an annual budget of around $17 billion; some 20 times the size of ATSIC's (CDHSH 1994: 3). Indeed in September 1993, meeting as the National Aboriginal Community Controlled Health Organisation (NACCHO), the ACCHSs passed a resolution explicitly stating that they wanted such a transfer to occur. The ACCHSs had now become major critics of ATSIC, its Office of Aboriginal Health and its implementation of the NAHS.

1994 was a significant year for institutional arrangements in Aboriginal health. It began with one of those outbreaks of public attention and concern about Aboriginal health which periodically arise in Australian public life and ended with the publication of a damning official evaluation of the NAHS. In between, public debate was focused on Aboriginal health in a manner and to an extent seldom previously seen.

The outbreak of public attention and concern began in January 1994 when the then Commonwealth Minister for Human Services and Health, Graham Richardson, visited a number of Aboriginal communities in northern Australia and suggested that living conditions in some of these communities were 'appalling' and would 'barely be tolerated in a war-ravaged African nation'. He argued that existing funding of matters relating to Aboriginal health from a variety of Commonwealth, State and Territory sources was 'uncoordinated' and an 'extraordinarily wasteful and stupid way to do business'. Richardson claimed he was going to 'do something' to 'clear up the mess' (*The Canberra Times*: 21 January 1994).[9]

Two months later Richardson retired from federal politics, but before he did he established a new Office of Aboriginal and Torres Strait Health Services (OATSIHS) within CDHSH. He also made a bid for the new Office to take over ATSIC's Aboriginal health program, promising increased funding as well. ATSIC, however, resisted the move and CDHSH and the new Commonwealth Minister for Human Services and Health, Carmen Lawrence, failed to convince the Expenditure Review Committee of Cabinet of the merits of the change during the 1994 budget process. However an extra $25 million over five years was identified for Aboriginal health in the 1994 Commonwealth budget and was to be allocated by a joint health planning committee of both CDHSH and ATSIC. CDHSH now had some program involvement in Aboriginal health funding and continued to make appointments to its new OATSIHS. It also continued to come under pressure from the ACCHSs and NACCHO to persist with its bid to take over Aboriginal health funding from ATSIC (see, for example, Anderson 1994; Bartlett and Legge 1994).

During the latter half of 1994 an official committee, comprising two NACCHO members, four elected ATSIC representatives, Commonwealth and NT government officials and a health academic, undertook an evaluation of the NAHS. Their major finding was that the NAHS 'was never effectively implemented' (Gordon 1994: 3).

One element of this lack of implementation was that the Council of Aboriginal Health, the key national tripartite forum, had 'lacked political support from Commonwealth and State/Territory Ministers and ATSIC' (Gordon 1994: 3). The Council had not been convened until 1992 and had met only four times by October 1993.[10] At its fourth meeting, partly reflecting ACCHSs and NACCHO representation within it, the Council had passed a resolution that Aboriginal health funding be transferred from ATSIC to the CDHSH (Gordon 1994: 31). From then on the Office of Aboriginal Health within ATSIC failed to convene any further meetings of the Council. The Council, and particularly its ACCHSs and NACCHO representatives, had lost faith in ATSIC and now ATSIC and its Office of Aboriginal Health were losing interest in the Council.

It was not just ATSIC, however, which had lost interest and failed to support the Council of Aboriginal Health. The joint forum of Commonwealth and State/Territory Aboriginal Affairs and Health ministers, of which the Council was supposed to be a standing committee, had not met at all since the June 1990 meeting at which it had endorsed the work of the development group and the NAHS. Commonwealth, State and Territory ministers also seemed to have lost interest in Aboriginal health and the Council was left without the ongoing linkages to them that it needed.

Another finding of the NAHS evaluation was that after the 1992 ATSIC Board decision to allocate Commonwealth NAHS funds without pursuing formal agreements with the States and Territories seeking matching expenditure, 'no subsequent agreements were negotiated' (Gordon 1994: 28). This was despite the fact that one of the early outcomes of the COAG processes had been the signing by all levels of Australian government in December 1992 of a general *National Commitment to Improved Outcomes in the Delivery of Programs and Services for Aboriginal Peoples and Torres Strait Islanders* which also foreshadowed the making of more specific bilateral agreements in areas such as health (COAG 1992: 10-11) The NAHS evaluation committee also found that work on Aboriginal health 'goals and targets' had not been significantly progressed either (Gordon 1994: 29). Neither finding was perhaps surprising, given the state of the Council of Aboriginal Health, to which the tasks had been referred.

With such a damning evaluation of the NAHS being produced in late 1994, it was perhaps inevitable that in 1995 there would be significant changes to institutional arrangements relating to Aboriginal health.[11] The impetus for change was, in may ways, the ACCHSs growing dissatisfaction with ATSIC and its role in the inadequate implementation of the NAHS. The ACCHSs were becoming more and more committed to the idea that the Commonwealth Aboriginal health program, through which they were primarily funded, should be transferred to the CDHSH. ACCHSs pressure for this change was unremitting and, in the context of the 1995/96 Commonwealth budget, was finally successful. The ATSIC health program and its substance abuse program, with a combined 1994/95 expenditure of $84.76m (see Table 1), were transferred to the OATSIHS within the CDHSH from July 1995. ATSIC resisted this administrative transfer to the end. However the dissatisfaction and persistence of the ACCHSs was such that it was, in some ways, inevitable. The ACCHSs wanted their funding outside ATSIC and were not going to give up till that was the case.

As part of the inter-organisational politics of effecting this transfer, in the latter half of 1995 ATSIC did, however, successfully negotiate a Memorandum of Understanding with the Commonwealth Minister and Department of Human Services and Health regarding its ongoing

involvement in health matters. This established that 'principles' of 'holistic ... health', 'community control and participation' and 'intersectoral collaboration', drawn from the NAHS, would 'guide the development and implementation' of Aboriginal health programs (ATSIC Chairperson and Commonwealth Minister of State for Human Services and Health (CMSHSH) 1995:1). It also set out a 'framework for cooperation' between ATSIC and CDHSH which provided for ATSIC to have ongoing involvement in Aboriginal health planning at regional, State/Territory and national levels and through both its elected and administrative arms (ATSIC Chairperson and CMSHSH 1995: 2). ATSIC's continuing role in 'environmental health matters' was also re-affirmed, as too were its 'statutory responsibilities' to 'monitor' and 'advise ... on the coordination' of all Commonwealth programs for Aboriginals and Torres Strait Islander peoples (ATSIC Chairperson and CMSHSH 1995: 3-4). ATSIC's ongoing role in Aboriginal health matters was being clearly acknowledged, even though it had lost the Commonwealth Aboriginal-specific program expenditure. In many ways this was a highly desirable outcome for ATSIC, since it was assured of ongoing involvement, without itself having to bear the sole responsibility for program ownership and health status outcomes.

The OATSIHS, meanwhile, was setting about getting to know its newly acquired constituency of ACCHSs. Its approach was fairly gentle and gradualist. A 'rebasing' exercise was begun, which was an attempt by the CDHSH to get to know how the ACCHSs ran and were funded; not just from the former ATSIC sources but from other sources as well. Some minor funding increases were offered relating to matters such as training and professional development of ACCHSs staff, while more general planning exercises also gradually got underway. It was, however, pretty much 'business as usual' for the ACCHSs.

The institutional reformist energies of the OATSIHS, during late 1995 and early 1996, appeared to be more directed to relations with the States and Territories, than to relations with the ACCHSs. OATSIHS re-invigorated the idea of formal bilateral Aboriginal health agreements with each State and Territory in line with the 1992 multilateral COAG *National Commitment* and began pursuing such agreements quite vigorously (COAG 1992). The agreements being pursued were, however, more 'framework' statements than detailed plans. They attempted to establish ongoing 'joint planning processes' which would involve local NACCHO and ATSIC representatives as well as Commonwealth and State/Territory health departments (see South Australian Minister for Health et al. 1996: 3.4-3.7).[12] Unlike the agreements sought in 1991, these new agreements did not ask the States and Territories to match Commonwealth funding; although they did ask them to 'identify and publicly report' their own 'current levels of funding' for Aboriginal health both in 'mainstream' and 'specific' services and also to commit themselves to an 'increase' in those

'current levels of resources' (see South Australian Minister for Health et al. 1996: 3.1). In the process of negotiation, these agreements also moved from being bilateral, to trilateral or even quadrilateral agreements; since as well as the Commonwealth and State/Territory ministers for health becoming signatories, both the ATSIC chairperson and in some cases a State or Territory-based ACCHSs representative also looked to becoming signatories. As such, the agreements appear to be establishing tripartite, or even quadripartite forums and processes in each State and Territory repeating hopefully in more successful form one of the ideas of the NAHS.[13] As of August 1996, three of these agreements had been signed and the other five looked set to be signed in the near future.

One final institutional development under the new OATSIHS regime has been the establishment of a new national Aboriginal and Torres Strait Islander Health Council. Membership includes eight NACCHO representatives, three ATSIC Commissioners, a representative of the Torres Strait Regional Authority, an Australian Medical Association representative and a National Health and Medical Research Council representative. It met for the first time in June 1996.[14]

In the wake of the election of the Howard Coalition Commonwealth government in March 1996, and the renaming of the CDHSH as the Commonwealth Department of Health and Family Services (CDHFS), a number of more general developments in the health area of potential relevance to institutional arrangements for Aboriginal health are also beginning to take shape. More, perhaps, needs to be said about these. However, at this point, it may be useful to reflect more critically on this history of government involvement in Aboriginal health and the emergence of the ACCHSs in order to suggest what lessons might be drawn from past experience and principles enunciated for future action.

Lessons and principles

One of the more striking aspects of this history of government involvement in Aboriginal health and the emergence of the ACCHSs is the constant criticism directed at the complexity of institutional arrangements and the need for greater coordination and role clarification. While there is no denying institutional complexity and the legitimacy of these concerns, the call to reduce complexity and for greater coordination and role clarification can be deceptively simple and consensual. It can obscure the extent to which there are in fact substantial areas of disagreement among the various actors involved in Aboriginal health over who should be doing what, where and how. In such circumstances, talk about clarifying and coordinating roles can become a respectable code for fairly blunt exercises in inter-organisational politics. It can at times be little more than an attempt to

prevail in disagreements and to drive out of the Aboriginal health arena organisations which harbour opposing views and interests.

In 1983-84, for example, it seemed reasonable and unexceptional to complain of 'dual funding' arrangements in Aboriginal health at the Commonwealth level and to call for a 'more logical approach' involving 'one government authority' (CDH 1983: 32). The ultimate consequence of this call for coordination and role clarification was, however, effectively to drive out, or at least greatly marginalise, the CDH from the Aboriginal health arena for some years to come. The DAA's and later ATSIC's role as the lead Commonwealth agency in Aboriginal health in the late 1980s and early 1990s was certainly clear and there was no problem of coordination. But the overall Commonwealth effort in Aboriginal health was perhaps not as effective as it might have been had the CDH been more involved.

In 1995, by contrast, when Commonwealth funding for Aboriginal-specific health programs moved from ATSIC to CDHSH, the language of role clarification and coordination does not appear to have been used to drive out ATSIC from the Aboriginal health arena. Indeed the experience between the CDHSH and ATSIC in negotiating their Memorandum of Understanding in the latter half of 1995 would appear to be a fairly genuine attempt to clarify organisational roles, while acknowledging more generally that both organisations have important and different contributions to make in Aboriginal health. Thus, talk about coordinating and clarifying roles can be useful, but it can also obscure what are in fact fairly blunt exercises in inter-organisational politics.

Underlying talk about coordination and role clarification, there is a somewhat larger issue concerning institutional complexity and organisational involvement in Aboriginal health. The common view is that institutional arrangements relating to Aboriginal health are unnecessarily complex and that there is a need for some significant clearing of the organisational landscape. A contrary view, however, is that to a large extent the complexity of institutional arrangements in Aboriginal health reflects the complexity of the issue being addressed. Aboriginal people's health is affected by numerous inter-related factors which relate to the roles and responsibilities of numerous government, and also non-government, organisations. For a concerted and effective effort in Aboriginal health to emerge, large numbers of these organisations need to be drawn in to the Aboriginal health arena and linked in appropriate ways one to another. On this view, the need is not for a clearing of the organisational landscape but for its enhancement; a further bringing in of organisational players with useful resources and expertise, an increase in resources and the creation of better linkages. This contrary view, we would argue, deserves greater consideration.

The need to draw in and enhance organisational efforts, rather than drive organisations out, relates also to the other ongoing dimension of organisational tension in Aboriginal health over recent years; that between the ACCHSs and the Aboriginal health units of the State and Territory Health Departments. The ACCHSs are now well established and have articulated a strong philosophy of self-determination in Aboriginal health to support their claims for involvement. The ACCHSs need, unquestionably, to be further supported and in pursuing this objective it is necessary to facilitate the development of more effective linkages between these organisations and the broader health arena. Their participation in the NAHSWP was a useful step in this direction, as too was the idea, if not so much the actuality, of subsequent tripartite Aboriginal health forums. ACCHSs involvement in the current round of State/Territory-based Aboriginal health agreement making and the foreshadowed joint planning processes and structures is also encouraging. It suggests that the central role of the ACCHSs' in Aboriginal health is gradually being recognised. It is clearly now unacceptable for either State or Territory health departments, or any one else in the Aboriginal health arena, to treat the ACCHSs as anything less than full partners and crucial participants. Certainly comments like those quoted earlier from the Victorian Health Commission and the Western Australia and Queensland Premiers in the late 1970s, which expressed reservations about Aboriginal involvement in health planning processes, were unhelpful in their day and need not to be repeated. Fortunately there is some evidence to suggest that the State and Territory health departments have moved in this direction over recent years, though they could still move further.

The State and Territory health departments need also to more effectively discharge their responsibilities within the Aboriginal health arena. This may require some accommodation and encouragement. However, these organisations still directly contribute one-quarter of all health expenditure in Australia and are responsible for the actual expenditure of a good bit more as well. They provide and regulate both major hospital and other health service facilities. They simply cannot be done without. The challenge is not to drive these organisations out of Aboriginal health, but to make them ever more responsive to Aboriginal health needs and ideas of Aboriginal self-determination in *all* health service activities. What, for example, does and can Aboriginal self-determination mean in the acute care public hospital setting, which the States and Territories so clearly dominate? How, further, can this be linked with ideas about Aboriginal self-determination in the primary care area, where the ACCHSs are more active but the State and Territory health departments still also play some role?

There is still clearly considerable potential for tension and disagreement between the State and Territory health departments and the ACCHSs over

various aspects of their approaches to Aboriginal health care. One of the crucial roles that the CDHFS and its OATSIHS may be able to play in the future is, potentially, to mediate and lessen such tensions. The Commonwealth's advantage here is that it's health administration operates largely at one remove from day to day health servicing and that it has a major interest in both the ACCHSs and State/Territory health systems. It funds and supports both to a very significant degree and has a substantial interest in both effectively engaging with Aboriginal health issues. OATSIHS should, however, seek to avoid a situation, such as occurred in the 1970s and 1980s, where the ACCHSs and the State/Territory health departments appeared to be competing for Commonwealth Aboriginal health dollars (see Table 1). This fuelled the tensions between the ACCHSs and the State/Territory departments and it is perhaps no coincidence that these tensions have only begun to lessen in recent years as the ACCHSs have come to receive virtually all Commonwealth Aboriginal-specific health funding, while the State and Territory Aboriginal health units have been forced to draw their funds from elsewhere (see Table 1). OATSIHS has become involved in some small scale funding of State/Territory health departments to elicit particular developments in the ongoing processes of making Aboriginal health agreements with the States and Territories. However, OATSIHS should guard against such funding becoming entrenched or large scale, so as to avoid the perception of competition for funds between the ACCHSs and the States/Territories. Fortunately, this appears to be the direction in which the OATSIHS is moving.

OATSIHS's role in relation to the ACCHSs is clearly very important. The basis of this relationship is, of course, funding, which will need to be continued and in time increased. However, the relationship could potentially offer far more than funding. It could provide the ACCHSs with an entry point to the resources and expertise of the larger Commonwealth health system. This is something which the former Office of Aboriginal Health within ATSIC could not provide the ACCHSs, because of its lack of sufficient health administration expertise and linkages. This lack may in fact have been behind some of the souring of relations between the ATSIC Office and the ACCHSs. The ACCHSs often felt the ATSIC Office had no health expertise and was as a consequence making inappropriate demands of them; such as the collection of inappropriate health performance indicators (see Anderson and Brady 1995). It is to be hoped that OATSIHS's relationship with the ACCHSs does not suffer similar problems and that OATSIHS uses its position within the Commonwealth's health administration to the advantage of the ACCHSs. The 'rebasing' exercise in which OATSIHS has engaged the ACCHSs in the last year has already shown that as a group they obtain about 40 per cent of their financial resources from sources other than the Commonwealth Aboriginal-specific health program. With the encouragement and mentoring of knowledgeable health bureaucrats within OATSIHS, this

proportion could certainly increase, providing the ACCHSs with both greater resources and to some extent greater independence.

Having argued that the institutional need in Aboriginal health may be to draw in and link organisational efforts and resources, rather than drive them out in the name of reducing complexity, clarifying roles and increasing coordination, we now wish to argue that one of the lessons of past experience relates to the limits and dangers of focusing too heavily on drawing in *all* relevant organisations and efforts in the name of 'intersectoral collaboration'. As used in the NAHSWP report, intersectoral collaboration meant at least two quite different things. On the one hand, it meant collaboration across various parts of the health services industry; between the ACCHSs, hospitals, other community health providers and the State, Territory and Commonwealth health departments. On the other hand, it meant collaboration between health services and other service areas, such as education, housing, and infrastructure. The rationale for this was unimpeachable. It related to the argument that, as the NAHSWP put it, Aboriginal health depends as much on 'health systems infrastructure' as it does on health services provision (NAHSWP 1989: 59-84). However, as the implementation of the NAHS during its first five years demonstrated, the danger of this argument is that it may in fact dissipate reform effort and resources directed to Aboriginal health. The ACCHSs lost faith in the implementation of the NAHS partly because it ended up directing so many of its resources to housing and infrastructure and not to health services. What ought to have been an opportunity for reform in the health services sector ended up, in large part, being captured by the housing and infrastructure sector of ATSIC in the name of intersectoral collaboration. Whatever its virtues, intersectoral collaboration should not give other players in other sectors first call on Aboriginal health services resources and reform efforts. Institutional reform in Aboriginal health must seek first and foremost to enhance resources and efforts *within* the health sector. Only secondarily should it seek to ensure that other sectors, such as housing, infrastructure and education, are operating in ways which support health efforts. Intersectoral collaboration, in this latter sense, needs to be approached rather cautiously.

One further lesson to be drawn from past experience and elaborated as a principle for future action relates to the avoidance of crisis-driven policy cycles and the need to maintain momentum for reform beyond the occasional easy consensus. The 1994 outbreak of concern and controversy over Aboriginal health was not unique. It reflects something of a crisis syndrome in much public policy making. When a crisis is occasionally perceived in a particular subject area of social concern, a flurry of policy activity often ensues and, in many instances, a consensus on the need for policy action is arrived at. This consensus is, however, often rather easy and somewhat misleading. The sense of crisis makes it unacceptable not to

join the call to action. Yet in time, the sense of crisis is bound to dissipate and a sense of complacency, or inattention to the subject area, is bound to return (Hogwood 1987). As this occurs, consensus and the momentum for reform may well disappear if not carefully managed. The question, then, for Aboriginal health as for other policy areas, is how to maintain a momentum for institutional and policy reform over time when the occasional sense of crisis inevitably recedes.

One suggestion we would proffer is that reform efforts need, at least to some extent, to be disarticulated from substantive changes in Aboriginal health status. This may seem counter intuitive, in that the push for reform is ostensibly driven by a concern for improving Aboriginal health status. Yet changes in Aboriginal health status are unlikely to emerge in time scales of one, two or even five years; the sorts of time scales in which political processes and participants often seek results from institutional reform. In these circumstances, using Aboriginal health status changes as measures of the success, or otherwise, of institutional reform in Aboriginal health can be very unhelpful. At best assessments of institutional reform are likely to be neutral. At worst they are likely to be negative and lead to premature abandonment of institutional reforms on the grounds that they have not had demonstrable effects.

What the benchmarks should be for measuring the success, or otherwise, of institutional reform in Aboriginal health, if Aboriginal health status per se is not to be used, is no easy question. There are, we would argue however, some processual measures which can be used to qualitatively assess the success of reform efforts. One, for example, is whether all relevant participants are being kept in the reform process and are expressing some ownership of it. Another might be whether all participants are continuing to acknowledge the important roles of others and feel that others are also acknowledging their roles. These are, in a sense, measures of whether the easy consensus of the crisis is being sustained and developed on a longer term basis. They also relate to our argument about the need to draw in organisations and their efforts to the Aboriginal health arena, rather than drive them out. Another possible more substantive measure of success is the types and amounts of resources which organisations are identifying as being devoted to Aboriginal health issues. Although resources are not themselves a measure of success, organisational capacity to identify them does demonstrate some ongoing awareness and commitment. This in itself is an important goal of institutional reform and could be taken considerably further. The development of more critical debates about what might constitute an 'equitable' allocation of resources to Aboriginal health, not only through Aboriginal-specific programs but also through mainstream programs such as Medicare, would be particularly helpful (Mooney 1996).[15] So the task of assessing institutional reform, without requiring of it

unrealistic short term changes in substantive Aboriginal health status is not impossible, although certainly it is quite difficult.

Current general developments

Since coming to power in March 1996, the Howard Coalition Commonwealth government has begun to place its own mark on reform processes in the health arena. In the 1996/97 budget, for example, it introduced tax rebates claimable against private health insurance expenses in an attempt to lessen demands on public ward hospital systems (Wooldridge 1996: 2). The new government has also pushed along the COAG reform process in health, suggesting in particular that health-related specific purpose grants to the States and Territories be greatly reduced in number and perhaps, in conjunction with the negotiation of new public health agreements with the States and Territories, even transferred to an 'identified grants' stream within general purpose Commonwealth revenue sharing (COAG 1996: 3).

The relevance of the first of these developments, the tax rebates, to Aboriginal health is probably marginal. Few Aboriginal people are likely to be in a position to take out private health insurance. There is the slight prospect, however, that a lessening of pressure on Commonwealth, State and Territory health budgets may flow from an increase in private insurance moneys coming into the health system and that this may in turn open up some new room for manoeuvre within public sector health funding. The potential for this should not, however, be overstated. The relevance to Aboriginal health of the second development, the pushing along of the COAG health processes, may however be more substantial and is worthy of some further discussion.

Along with many involved at the service delivery level within the community health system, the ACCHSs have long complained that narrowly focused specific purpose programs are not well suited to their broad, flexible primary health orientation. Such programs are seen as restricting community health operations and priorities, and as requiring inordinate administrative effort (see, for example, Bartlett and Legge 1994). Yet the Commonwealth specific purpose payments system has in many ways encouraged the proliferation of such programs over the years. As perceptions of new or changing health problems have emerged, the Commonwealth response has often been to add a specific purpose payment addressing the issue. In 1996 the Commonwealth Department of Finance's catalogue of specific purpose payments identified no less than 23 in the health area directed in some instances to matters as narrowly defined as cervical cancer screening, artificial limbs and magnetic resonance imaging (see Department of Finance 1996). While this may enable the Commonwealth to promote very specific developments in health services,

it must certainly also have its costs. The administrative processes of both accessing and later acquitting funds from these narrowly focused programs must inevitably be both tedious and onerous. Hence the idea of broader, more general Commonwealth public health funding may well be as attractive to the ACCHSs as to other community health service providers and to the States and Territories. This may be particularly so if, as appears to be emerging, there is some substantial cross-referencing between the new Aboriginal health agreements in each State and Territory and the proposed general public health agreements which would underlie such a financing shift. Indeed such cross-referencing would be a useful way of embedding the Aboriginal health agreements in broader health sector funding processes, which at the moment they are not.

One other notable development under the Howard Coalition Commonwealth government has been the maintenance of funding levels in the Aboriginal-specific health programs of the OATSIHS in the 1996/97 budget. While funding maintenance may not sound much of an achievement in an area of such acute need as Aboriginal health, in a context of significant budgetary cuts in other areas, including in ATSIC, it was indeed notable. The challenge, however, may arise from the Howard government's declared intention to fund an additional 35 Aboriginal health services from this only slightly increasing level of funding over the next three years (Wooldridge 1996: 4). Such an addition will clearly only be able to be sustained if OATSIHS helps its existing constituency of ACCHSs, as well as some of the new ACCHCs, to find funds in the health system beyond the limited Aboriginal-specific pool. OATSHIS's guidance and assistance to the ACCHSs in this process may well prove a significant test of their relationships. Trust in these relationships could potentially be enhanced, but equally it could falter. Again much is still to be worked through in this area of institutional reform.

Challenge and opportunity, responsibility sharing and self-determination: a concluding comment

Linking Aboriginal health and institutional reform within Australian federalism is clearly a major challenge for the whole Australian nation. In part this challenge arises from the need to interweave in institutional arrangements for Aboriginal health two rather disparate sets of ideas. One of these sets of ideas is responsibility sharing within the Australian federal system, while the other is Aboriginal self-determination.

Responsibility sharing is a crucial element of Australia's highly concurrent style of federalism. While the notion has great collaborative potential, it also has the potential to fall far short of cooperative ideals amidst inter-governmental and inter-organisational conflict. To a large extent the

history of government involvement in Aboriginal health and the emergence of the ACCHSs does involve such falling short. Responsibility has in the past sometimes been avoided and disputed, rather than willingly taken up and shared. But this has not always been the case. There have been more positive developments and there can be more in the future. Responsibility sharing can be made to work. Indeed, in the realpolitik of Australian federalism, there is no other realistic way forward.

Self-determination has in the last 30 years become the philosophical bedrock of Aboriginal organisation and action. It is a philosophy which calls on governments to put aside the directive regulation which characterised their involvement with Aboriginal people in the past and also calls on Aboriginal people to take action in changing the conditions of their own lives (Anderson 1994). Aboriginal self-determination in health, as in other spheres, should not be read as an opportunity for governmental disengagement. Aboriginal people's efforts need to be supported by appropriate resources and expertise, which perhaps only governments can provide. This support must, however, be provided in ways which respect Aboriginal people and organisations as full partners in the process. Aboriginal participation and priorities need to be seriously and concertedly addressed. This, it appears to us, is the crucial challenge in linking Aboriginal health and institutional reform within Australian federalism, linking Aboriginal self-determination with wide spread responsibility sharing.

Though the extent of this challenge for Australian federalism should not be underestimated, it should also be recognised that in the last two years a rare opportunity for progress has emerged. This opportunity has arisen largely as a result of the transfer of the Commonwealth's Aboriginal-specific health funding program from ATSIC to CDHFS. This transfer has allowed long standing tensions in the institutional arrangements of Aboriginal health to be temporarily relieved, not only between these two Commonwealth portfolios, but also between the ACCHSs and ATSIC and the State and Territory health departments. Whether this lessening of tension will persist and be converted into a greater sense of cooperative responsibility sharing between these organisations over the longer term only time will tell. The OATSIHS within the CDHFS has made a credible start in its handling of relations within the arena both with the ACCHSs, with ATSIC and with the State and Territory health departments. It can only be hoped that these more cooperative relationships continue and that the current opportunity for institutional reform in Aboriginal health within Australian federalism is not let slip away. Such a development would indeed be fitting as Australian federalism approaches its centenary.

Notes

1. From 1915 the Commonwealth did become involved in the direct provisions of health services to war veterans. This, however, was for a long time done through the Department of Repatriation, rather than the Department of Health, and remained largely separate from Commonwealth involvement in health care for the general population (see Lloyd and Rees 1994).

2. The inclusion of this last phrase in the Commonwealth's new head of constitutional power was a major concession to the opposition of the medical profession to plans like that of the Chifley government (see Sax 1984: 55).

3. This pattern of Commonwealth involvement, instigated by Labor, was partly dismantled by the Fraser Coalition government from 1975 to 1983 (see Gray 1984; Sax 1984; Butler 1991). This dismantling, however, proved temporary.

4. Some recent figures are as follows. The Australian Institute of Health and Welfare (1994: 122-5) calculated that in 1992-93 total recurrent health expenditure in Australia was $34.3 billion, or 8.5% of Gross Domestic Product. The Commonwealth accounted for $15.1 billion of this, the States, Territories and local governments $8.1 billion and private expenditure $11.1 billion. Other sources give a break down of a slightly lesser figure for Commonwealth contributions as follows: $6 billion for medicare benefits, $2 billion for pharmaceutical benefits (see Commonwealth Department of Human Services and Health 1995) and $5.7 billion for health-related specific purpose grants to the States and Territories (see Department of Finance 1996).

5. For comparison with other policy areas which have been given attention by COAG (see Carroll and Painter 1995).

6. The other areas identified for grants were housing, education and employment and vocational training (see Commonwealth Parliamentary Debates, House of Representatives, 11 September 1969: 1240-9).

7. The mood of the times among Aboriginal people is well captured in Gilbert (1973). One of the defining moments of this new politics was the establishment of the Aboriginal Embassy on the lawns of Parliament House in Canberra on 26 January 1972. Another lesser known manifestation was a divisive debate within FCAATSI at its Easter 1970 conference over membership and voting rights within the organisation. Previously the membership had been predominantly sympathetic whites, but a move now emerged for restricting executive membership and voting rights to people of Aboriginal and Torres Strait Islander descent (see Bandler 1989; Burgmann 1993: 31-4).

8. For an account of the October 1990 Special Premiers Conference and events leading up to it see Fletcher and Walsh 1991. Subsequent Special Premiers Conferences pursuing this closer partnership became COAG from May 1992.

9. Richardson acknowledged, with his customary exaggeration, that 'a million politicians have promised all that in the past 100 years', but argued that now it had 'come time to do something'. Cartoonist, Geoff Pryor was less sanguine about the difference between Richardson and previous politicians (*The Canberra Times* 22 January 1994).

10. The Council had in fact been reviewed after only two meetings (see Codd 1993).

11. Another signal event of 1994 was that the Aboriginal and Torres Strait Islander Social Justice Commissioner, Michael Dodson, devoted a large portion of his report for the year to Indigenous Health. His argument was that the state of Indigenous people's health in Australia was 'an abuse of human rights' and a

'breach' of Australia's 'obligations at international law'. He also, however, argued that there was 'comprehensive support within Australia' for improving Indigenous health and that there was often 'bewilderment as to why nothing appears to change'. His analysis of this lack of change related to different 'perspectives'; localised, holistic Indigenous perspectives versus centralised fragmented bureaucratic perspectives. He argued for genuine, localised community planning supported and resourced by government agencies. While this analysis went 'well beyond arguing about which administrative arm of government should be in charge of Indigenous health', Dodson did clearly see it as unacceptable that Commonwealth funding of ACCHSs had been left to ATSIC, with CDHSH making 'negligible contributions'. He argued that it was 'untenable' for Commonwealth departments to 'shift all responsibility' to ATSIC for 'Aboriginal problems', believing that a 'combined strategy which utilises existing ATSIC structures, existing community-level structures ... and existing programmes of mainstream service providers could achieve the desired results' (Aboriginal and Torres Strait Islander Social Justice Commissioner 1995: 99-175).

12. The Agreement being quoted here is the South Australian agreement. Though we have not seen them, we are led to believe that the agreements applying to the other States and Territories are very similar.

13. The South Australian Agreement does in fact formally establish an ongoing quadripartite forum called the South Australian Aboriginal Health Partnership.

14. The proposed terms of reference for this Council are to advise the Commonwealth on:

> strategies for the Commonwealth to improve health outcomes for Aboriginal and Torres Strait Islander peoples, including Indigenous specific and mainstream programs administered by States and Territories, and the Commonwealth directly;
> and ways to improve cross-sectoral linkages and coordination with environmental health programs and other health programs.

14. The NAHS evaluation suggested that equity of resource allocation to Aboriginal health should be thought of in terms of 'equal access to equal care appropriate to need' (Gordon 1994: 2). More work needs to be done on these sorts of ideas. Some more specific relevant work currently underway within the Health Insurance Commission relates to geographic differences in the use made of Medicare, particularly low usage of this health funding source in remote areas with proportionately large Aboriginal populations.

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