“Best Buys” & “Trained Monkeys”

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Concepts and Issues in Aboriginal health policy

- Aboriginal health and social disadvantage is well documented and unequivocal
- Australian governments, and Australian health institutional structures all profess a high level of commitment to addressing Aboriginal health inequalities
- There is a general consensus about the range of appropriate strategies (health and non-health sector)
- There remain critical and unresolved policy dilemmas that are fundamental to the implementation of strategy

Concepts and Issues in Aboriginal health policy

- 1967 Referendum - deletion of race clauses
- 1968 Commonwealth Aboriginal Health Program
- 1971 First Aboriginal Medical Service (Redfern)
- 1989 National Aboriginal Health Strategy
- 1995 transfer of responsibility for health from ATSIC to Commonwealth Health - OATSIH(S)
- 2002 Australian Health Ministers Advisory Council – Workforce Strategy
- 2003 National Aboriginal and Torres Strait Islander Strategic Framework in Health

Concepts and Issues in Aboriginal health policy

- Some of these submerged tensions are revealed in the policy banter that is integrated in the discourse about Aboriginal health.
- The context is semi-ironic and even derisory – but it reveals critical intellectual tensions.
  - **Best Buys**
  - **Trained Monkeys**

“Best Buys”

- 1998–99 $1,245 million (2.6% of health expenditure for all Australians) was spent on health services for Aboriginal and Torres Strait Islander people.

- Equivalent to $3,065 per person, compared with the $2,518 per person estimated to have been spent for non-Indigenous people, a ratio of 1.22:1.

- For each dollar spent on health services for non-Indigenous Australians, $1.22 was spent on health services for Indigenous people.
(AIHW 2001)

"Best Buys"

- Expenditure on Indigenous people in public hospitals was twice as much per person (a ratio of 2.07:1)
- Comparative analysis of Ambulatory Sensitive DRGS (Stamp et al 1998) with data from Western Australia, Northern Territory, New South Wales and Queensland - rate of admission was between 1.7-11 times higher than for non-Aboriginal patients
- Ong and Weeramanthri (2000) delays in presentation of AMI were significantly greater for rural and urban Aboriginal people and non-Aboriginal people living in rural areas relative to urban non-Aboriginal people.

“Best Buys”

- Relative Expenditure on primary care services was calculated as 1.27:1 (AIHW 2001).
- Indigenous specific primary health care expenditure (Commonwealth funding for Aboriginal Community Controlled Health Services, State and Territory government funding of Indigenous specific primary health care services) only partly compensates for lower expenditure through the Medical Benefit Scheme and Pharmaceutical Benefits Scheme.

“Best Buys”

- **Relatively Higher Expenditure** on Aboriginal and Torres Strait Islander people in relation to community and public health services, patient transport, public hospital services, mental health services government administration and research.
- **Relatively Lower Expenditure** with respect to the Medical Benefits Scheme, Pharmaceutical Benefits Scheme, residential aged care, and privately funded health care services (such as doctors in private practice, private hospitals, dentists and other privately funded allied heath professionals).

"Best Buys"

- **Needs based funding** needs to consider
- **Cost Relativities**:
  - Burden of illness and co-morbidities
  - Geographic distribution (higher price differentials and diseconomies of scale as a result of higher proportion of the population in rural/remote regions)
  - Requirement for specific delivery structures/arrangement to ensure effectiveness or quality

"Best Buys"

- Sick populations require greater financial investments
- Asthma and diabetes patients who require hospitalisation use 6 times the average MGS PBS and hospital resources
- Per capita health care expenditure increases with co-morbidities (2 conditions – 6 times; 3 conditions – 10 times; 5 conditions – 16 times)
- Coordinated care trials demonstrated increase utilisation of resources for a relatively 'sicker' population

"Best Buys"

- Does health care impact on population health outcomes?
- Traditional model of health transition strongly influenced by studies of the demographic transition in industrialising Britain
- McKeown: argued that improvements in housing, environmental infrastructure; possibly nutrition and improved economic status were key causes

"Best Buys"

- Significant difficulties in the application of this model to Indigenous populations

- The mortality decline in Nth American and New Zealand occurred after the treatment revolution for infectious diseases
- Contemporary evidence regarding medically amenable mortality and morbidity demonstrates the population level impact of health care

"Best Buys"

- Reduced prevalence and incidence of communicable diseases that are susceptible to immunisation programs
- Reduced complications of chronic disease through effective chronic disease management programs
- Improved maternal and child health outcomes (such as birth-weight) through the implementation of a culturally appropriate antenatal programs
- Reduction in social and environmental risks through effective local public health advocacy such as through changes to liquor licensing regulations

“Best Buys”

- But whilst primary health care might be represented as a ‘best buy’: its effectiveness requires a system-wide investment in change:

- **Example One:** Vaccine programs and chronic disease management programs integrate population health activities and primary clinical care services by linking screening and recall services (a population health activity) with primary clinical care (commonly undertaken by general practitioners) and oppurtunistic screening and immunisation.

"Best Buys"

- **Example Two:** Antenatal programs link services provided by general practitioners and other primary health care workers with those provided by hospital based birthing services requiring coordination across organisational structures.

- **Example Three**: Public health strategies (such as alcohol regulation, or food supply programs) that are implemented through non-health structures require advocacy of local primary health care services with agencies such as local government, liquor licensing authorities or the local store

“Best Buys”

- **Health care is not done to people**.
- The application of health technologies may produce health outcomes in populations or individuals, depending how they are incorporated into peoples daily lives.
- Active participation.
- Don’t purchase health outcomes.

“Best Buys”

- Relative value of health care investment vis a vis non-health sector investment.
- Put money into housing or health?
- Impact of program investment, in health or other sectors, will depend on the baseline
- Relatively little empirical data
- Most of our models are determinant, not, impact oriented.

“Best Buys”

- FALSE Choice
- The allocation of resources for Aboriginal programs is **mostly** from within the sector specific allocations. That is Aboriginal health investments are competing with other investments in the health sector.
- Health care services have the potential to ameloriate the suffering of individuals & improve the health outcomes of communities.

“Trained Monkeys”

- If the resources of health is developed through informed negotiation between health care providers and Aboriginal people what qualities are needed?
- Technocrat blind the cultural and social context of the patient they are treating? Trained Monkeys delivering a technology? Or??
- What is the role of Aboriginal people in such a health system?

"Trained Monkeys"

- Indigenous characteristics of the health workforce:
  - 0.7% of health occupation workforce in 2001 (population proportion 2.4%) if exclude Aboriginal health workers (otherwise 0.9%)
  - Health occupations greater than 1% included environmental health workers (3.5%) primary product inspector (2.0%), nursing assistant (2.0%), medical administrators (1.6%), ambulance officer (1.4%), personal care assistant (1.4%) and admissions clerk (1.1%). **All others less than one percent**

“Trained Monkeys”

- Analysis of trends (95-97) in Indigenous participation in health sciences education (higher education sector): graduations trending up; graduations trending down.
- For 1999-2000 Indigenous graduates in health sciences consisted of health support (41%); nursing (33%).
- In 1999 113 students completed health related undergraduate courses (1.0% of total); numbers of Indigenous students enrolling in and completing g health and welfare courses has declined since 1997-98

“Trained Monkeys”

- Why are Indigenisation of the health workforce critical to strategies to improve the effectiveness and quality of the health system:
  - Not all graduates will be involved in the direct delivery of health care to Aboriginal Australians
  - Some will be involved in policy, research and administration
  - Others will pursue mainstream careers but will potentially play a critical role in the development of community **leadership and reform in mainstream systems**

"Trained Monkeys"

- Both Indigenous and non-Aboriginal health professionals involved in the delivery of health care to Aboriginal peoples are required to:
  - Critically engage with Aboriginal clients, understand their priorities and perspectives
  - Modify their practice accordingly

- **Compliance is a function of a relationship**

Conclusion

- **“Best Buys” and “Trained Monkeys”**

- Reflect a technocratic or mechanistic view of health care linked to a economic paradigm of production and consumption
- They falsely imply choice and divert our attention from the need for systemic institutional reform
- Need to communicate a more sophisticated approach to Aboriginal health strategy.