



How Aboriginal Health Policy is Implemented

Jane Lloyd, Marilyn Wise, and Tarun Weeramanthri

Menzies School of Health Research, University of Sydney
and Department of Health and Community Services
Northern Territory

Aim

To identify facilitators and barriers to the implementation of the NT Preventable Chronic Disease Strategy

The NT Preventable Chronic Disease Strategy

- Shift from communicable
- Five common chronic disease:
 - Diabetes
 - Ischemic heart disease
 - Hypertension
 - Renal disease
 - Chronic airways disease.
- Share underlying risk factors.

NT Population

**Healthy
(Low Risk)**

- Good nutrition
- Positive parenting
- Physically active
- Health-promoting environment
- Supportive social networks

**At Risk
(2+ Factors)**
Not modifiable

- Age >40
- Male
- Aboriginality
- Family History
- Gestational DM
- Low SES

Modifiable

- Low birth weight
- Childhood malnutrition and infections
- Overweight
- Inactive
- Smoker
- Alcohol excess
- Poverty
- Low sense of control

Primary
Prevention

5 Chronic Diseases

Diagnosis suspected

- Diabetes
- Ischaemic Heart Disease
- Hypertension
- Renal Disease
- Chronic Airways Disease

Early Detection

Outcomes

Diagnosis confirmed under follow-up

- Community care visits
- Hospitalisations
- Complications
 - Amputations
 - Dialysis
 - Cross Border Referrals
- Death

Management

[Chronic Disease Program
Hospital and outpatient services
Policy support and training]

Method

- 35 in-depth semi structured interviews
- policy directors and policy officers (11)
- service providers including:
 - Aboriginal Health Workers (2)
 - doctors (8)
 - nurses (4)
 - managers (6)
- researchers and non-government organisations (4)

Findings

- Implementation of PCDS was influenced by:
 - workforce
 - funding
 - leadership and management
 - culture, ideology, and perceptions of roles and responsibilities for health.

Workforce factors that have facilitated the implementation of PCDS

- Additional service providers
- Training in chronic disease
- Commitment from the manager
- Dedicated chronic disease positions

‘With having those staff dedicated to chronic disease, they are able to spend more time with the clients, they are able to go back and see them every day, whereas if you’re relying on the acute clinical staff to do that, they get tied up with people with coughs and colds.’ Manager

But there is still a way to go...

- Dedicated chronic disease positions not given quarantined time to work on chronic disease
- Tendency for chronic disease staff to work in acute care

What's needed to facilitate the implementation of PCDS?

- **Work in the community setting**
- **Focus on the broader determinants of health**

'Well if we want to stop or slow the chronic disease... or new diagnosis, we have to go for the smaller things first I think. If we want to stop like kidney failures and stuff like that, then we'd have to stop skin infections. Where does it all start up? Same with hypertension or diabetes. Get the shop to sell a lot more healthier food. Or make healthier food cheaper than the popular sweet food.' Aboriginal Health Worker

System-level barriers to implementing PCDS

- Insufficient numbers of service providers
- Insufficient representation of Aboriginal people in the workforce
- ‘Under supporting’ Aboriginal Health Workers

‘I don’t get a lot of support... I have got a child ten months and I’ve got a partner and we are staying in a small flat, she is starting to walk, and the flats are really small. We need a house to grow a family. You need a house not a flat. Especially because it has just got two rooms. One room has got a kitchen, lounge and laundry and the other room has the toilet, shower and bedroom.’ Aboriginal Health Worker

System-level barriers to implementing PCDS

- High staff turn over throughout the system
- Mismatch between evidence and workforce capability

How workforce influences the implementation of PCDS

- PCDS evolved and devolved as it was implemented, through a process of collective negotiation
- Parts of PCDS continue to be developed and refined (better management and early detection) while others received less attention (primary prevention)
- Aspects of PCDS that are implemented (i.e. focus on better management) are influenced by the strengths of the workforce
- What is implemented affects the workforce. Capacity is built among the dominant parts of the workforce (nursing and medicine, rather than Aboriginal Health Workers)
- Raises questions about the capacity of the health workforce to do things differently.

How policy makers can refine PCDS implementation?

- Establish systems and processes to ensure the primary prevention arm of PCDS is implemented.
- Consider how Aboriginal Health Workers might be enabled through this process.

Implications for policy

Addressing system level workforce barriers will have lasting benefits for PCDS, and other policies, and for equity among professions in the health workforce.