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Discussion Paper

Performance indicators for Aboriginal Health Services

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SERIES NOTE

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- identify and analyse the factors affecting Aboriginal and Torres Strait Islander participation in the labour force; and
- assist in the development of government strategies aimed at raising the level of Aboriginal and Torres Strait Islander participation in the labour market.

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Professor Jon Altman
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ABSTRACT

Performance indicators, which are simply variables that help to measure change, have been highly contentious in the area of Aboriginal health. This discussion paper focuses on the introduction of performance indicators for Aboriginal Health Services by the former Department of Aboriginal Affairs and subsequent attempts by the Aboriginal and Torres Strait Islander Commission (ATSIC) to implement their collection. This paper addresses some of the difficulties implicit in the way in which performance indicators have been linked to funding allocations, and the difficulties experienced by Aboriginal community-controlled health services in providing the data requested. Often the data requested in the past have not been relevant either to monitoring performance, or to assessing health status. The paper examines conceptual problems associated with indicators, and makes overall policy recommendations.

Acknowledgments

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Foreword

Early in 1994, due to an unexpected staff resignation, the Centre for Aboriginal Economic Policy Research (CAEPR) had some discretionary resources for visiting fellowships. At that time a vibrant policy debate raged, especially in the popular media, about the reasons for the continuing poor health status of indigenous Australians despite apparent considerable program effort. I decided that this was a policy issue replete with economic policy implications, both directly, in terms of the economic question about the most effective option to expend scarce health dollars for maximum outcomes, and also indirectly in terms of the unquestionable linkages between health status, labour force status and, ultimately, economic status. CAEPR staff had also undertaken research both on evaluating outcomes from special programs and on the relative efficacy of special versus mainstream programs for indigenous Australians. The health policy debate fitted squarely into this context.

I initially approached Maggie Brady, Visiting Research Fellow at the Australian Institute of Aboriginal and Torres Strait Islander Studies to visit CAEPR. Maggie is a renowned researcher on the causes and consequences of alcohol and substance abuse among indigenous Australians; over the years, she had undertaken considerable field research, primarily as an anthropologist, in many remote Aboriginal communities. Maggie accepted this invitation and visited CAEPR for three months from July to September. Simultaneously, I approached Ian Anderson, Chief Executive Officer of the Victorian Aboriginal Health Service, and a medical practioner, to visit CAEPR. Owing to other commitments, including part-time postgraduate studies in anthropology at La Trobe University, Ian was not able to visit CAEPR for a prolonged period. Instead, he visited Canberra on three separate occasions to collaborate with Maggie.

While Ian and Maggie were with CAEPR the interagency review of the National Aboriginal Health Strategy launched in 1989, began. The research presented in this discussion paper is the revised version of a submission made by them jointly to the review. All too often such submissions are neither subjected to peer review nor published. The CAEPR Discussion Paper series provides an avenue for this important piece of research to be disseminated to a wider audience. Further research on indigenous health policy will be published by CAEPR later in the year.

Jon Altman
Series Editor
April 1995

Introduction

> It must be remembered that Aboriginal people suffer the poorest level of health of any identifiable group of Australians. This situation demands far-sighted and negotiated policies, objectives and strategies and demands that evaluation of Aboriginal health care services be professionally researched and performed, and carried out in a spirit of trust and cooperation.
>
> (Moodie 1987: 13)

This paper examines the background and present context of government attempts to evaluate progress towards improving Aboriginal health and the use of performance indicators as part of monitoring health processes. Performance indicators, introduced at many levels of government at a time when 'management by objectives' was adopted in Australia in the late 1980s, have remained an area of confusion within Aboriginal health. Why they are needed, how they are established and the uses to which indicators are put have all been subject to a high level of debate and dissension. This paper aims to examine the reasons for this as well as discussing what a 'performance indicator' is, and what it means.

Performance indicators are variables which help to measure change. For example, the World Health Organisation (WHO) stated that with the ideal to attain health for all by the year 2000, member states need to know what progress they are making towards this goal and to this end need to introduce a systematic monitoring and evaluation process and develop indicators of progress (WHO 1981: 10).

The issue of program evaluation can evoke profoundly polarised views. In the highly politicised environment of Aboriginal health, performance indicators have at times been highly contentious. This in itself is not surprising - performance indicators tend to focus contested claims for resources. Implicit in the construction and use of these indicators are ideological assumptions about the objectives that underlie resource allocation processes in Aboriginal health. Consequently, tying this form of performance evaluation to funding cycles often exacerbates an already highly inflamed situation.

International influences

There are two broad trajectories that have had an underlying, and at times contradictory, effect on the process of evaluating and indicating progress in Aboriginal health in Australia, which have influenced the management of government funds at a federal level, and impacted on the direction of health policies in this country.

The first of these was the pledge in the early 1980s by member states of WHO to participate in the Global Strategy for health for all by the year 2000 sufficient to 'permit people to lead a socially and economically productive life'. Integral to this process was the need for indicators of progress and change in health status which would contribute in a positive way to governments' own self-assessment. Performance evaluation in this context is broadly oriented to measuring the distribution of health and health care resources between nations, and within nation states. The goal of performance indicators is to measure the extent to which such changes in distribution have occurred.

The second key trajectory has been the introduction of 'management by objectives' in western industrialised countries, which has come to incorporate program budgeting (Barrett 1992). WHO itself, in conjunction with the Global Strategy, developed guidelines for what it termed a 'managerial process' for health development. This involves a continuous process of programming by objectives and budgeting by programs. The Department of Finance, in promoting the introduction of program budgeting within the Australian public service stated that the development of indicators should focus on questions of:

i efficiency, which is the relationship between the inputs and outputs;

ii effectiveness, which is the extent to which the impacts of a program's output (that is its outcome) meet its objectives (Department of Finance 1985: 1).

The necessary components of this process include policy formulation, long and medium-term programs, program budgeting and evaluation. Program budgeting, endorsed by WHO as the means of managing its own worldwide programs, is a process of identifying objectives or targets and translating these into the costs required for their achievement. That objectives have to be identified means that priorities have to be established, and this is usually done in the process of developing policies.

In the deployment of performance evaluation for Commonwealth-targeted Aboriginal health programs these two distinct influences have tended to overlay each other. The redistributive and managerialist approaches share a common interest in efficiency and outcomes. However, measures of performance oriented towards evaluating efficiency and effectiveness tend to presume that resource inputs are a given, whilst re-distributive measures presume the level of resources in the Aboriginal health sector are inadequate. This leads to a lack of clarity as to which process has policy priority. To what extent will outcomes be enhanced by driving the dollar further, or to what extent is it necessary to increase current resource outlays in Aboriginal health? In the end, this tension is insoluble without a clear statement of policy principles.

It is the parallel and sometimes converging course of these two influences - one an internationally agreed global target (health for all by the year 2000), the other a method for governments to link costs to objectives and evaluate progress towards those objectives - that constitutes an underlying theme for this discussion paper.

We focus our comments on the implementation of performance indicators for the Commonwealth-funded community-controlled Aboriginal Health Services (AHS). In part this story needs to be contextualised with a brief history of relationships between AHS and the state. After considering the more specific history of the introduction of performance indicators, we discuss some of the difficulties community agencies have in providing such data. Finally, we consider some of the conceptual problems that have an impact on the effective deployment of such performance measures.

Aboriginal Health Services and the state

In 1971 members of the Aboriginal community of Redfern, Sydney, took action to create a health service for their community. This service, like the Victorian Aboriginal Health Service which commenced operation shortly after, was initially run on a voluntary basis. After some months of operation both services were given a grant from the then very new Commonwealth Department of Aboriginal Affairs (DAA). The events of this period revolutionised the delivery of health care to Aboriginal people. There are now over 90 such organisations across Australia, funded by the Aboriginal and Torres Strait Islander Commission (ATSIC), DAA's successor, or by a mix of ATSIC and State-derived funds. In this section it is our intention to briefly review the history of the formation of Commonwealth-funded Aboriginal community-controlled health services; their relations with the state (in particular the Commonwealth); their current functions and mechanisms of funding.

A detailed history of the administration of AHS funding would need to take account of their development within the context of both Australian federalism and the ongoing transformation of Australia's internal colonial relations. The history of Aboriginal health service provision is littered with many examples of State and Commonwealth-funded programs either competing directly for clients, or at least operating parallel to each other (Saggers and Gray 1991; Nathan and Japanangka 1983; Robbins 1993; Kunitz 1994). At times, conflict between different systems of administration has crystallised into competing ideological positions, with the Commonwealth championing self-management strategies against recalcitrant states such as Queensland which until the 1980s steadfastly maintained an assimilationist position and provided little in the way of funding (Kunitz 1994). In the Northern Territory and Western Australia, assimilationist health servicing policies were modified in the 1980s and 1990s to incorporate the rhetoric of community control. Nevertheless, while some departmental personnel are genuinely supportive of such policies, the assertion of community control has been used, in some cases, as an excuse for cost-cutting in which the State or Territory hands over inadequate funds to a community (resulting in inadequate services) and leaving them to deal with the result. With no clear delineation of responsibilities, even obvious gaps in the delivery of services to Aboriginal communities can remain unfilled, as different sectors of government abdicate their own responsibilities in favour of other agencies. At times the existence of other agencies or levels of government becomes a *raison d'être* for inaction, and for underspending on Aboriginal citizens (Altman and Sanders 1995).

What is generally uncontested within the context of Commonwealth-Aboriginal community relations is the need for Aboriginal self-determination. What *is* contested are the meanings and practices that should cohere around this principle. As a principle of policy, 'self-determination' signified a shift in the form of regulation and surveillance of Aboriginal life. It opened a social space into which Aboriginal action could occur without the supervision of the Aboriginal welfare system. However, as a principle of political action self-determination signifies a 'more general principle of action of Aboriginal people and their communities, especially in relation to non-Aboriginal institutions and society' (Anderson 1994). The differences are often subtle, but nevertheless important. The assertion of Aboriginal autonomy as a principle of political action is bound to lead to political conflict with any system of regulation.

There has been at times resistance within the Commonwealth Aboriginal affairs bureaucracy to the imposition of mechanisms of rationality. Particularly in the early days of the DAA, there was a 'basic conflict ... between the ideal of "quick and positive response" and the reality of Treasury regulations and audit requirements' (Bennett, citing Gray 1989: 95-96). It should be noted that 'evidence of premature transfer of funds, the setting of salaries without checking of public service guidelines, the advancing of funds without authority and the unauthorised purchase of supplies', suggests that departmental operations in the late 1970s were affected by more than just an ideological position about the urgency of need in Aboriginal Australia (Bennett 1989: 95).

The DAA throughout its history was at the periphery of the Commonwealth bureaucratic apparatus. This position insulated the department from some of the earlier incursions of economic rationalism into the Commonwealth system of public administration (Pusey 1991). Even ATSIC, as a statutory authority remains quite peripheral to the machinations of the Commonwealth apparatus. The low status of Aboriginal affairs has also meant that the DAA tended to inherit some remarkably ineffectual government ministers (Bennett 1989). Nevertheless, despite an early culture of 'getting the job done', the later development of the DAA was marked by increasing centralisation of activities, and increasing adherence to bureaucratic regimes. The introduction of program budgeting in 1989 completed the transition to a new culture of managerial rationality.

AHS emerged through the 1970s as the Aboriginal movement exploited the liberalisation of policy on Aboriginal affairs. As organisations, the AHS were community initiatives into which Aboriginal values and practices were incorporated. For example, the particular importance placed on kin relationships has resulted in the creation of organisational structures in which the boundaries between private and public social spheres are considerably blurred.

There are two fundamental qualities inherent in the approach promoted by the community-controlled health services. The first is the two-way skills transfer process between (usually) non-Aboriginal professional staff and Aboriginal health workers which is seen as integral to effective program delivery. Secondly, the principle of self-determination is embedded in the organisational operation of the services, as well as being a principle of health care practice (Anderson 1994). For this and other reasons, the impact of AHS in the communities they service is far more complex than that of a service provision agency and their clients. AHS, operating effectively, can become strategic sites for community development (Bartlett and Legge 1994).

As initiatives founded on the idea of community control the idea of community accountability is central to their operation. Nevertheless, the meanings and practices attached to the idea of community accountability are distinct, although not entirely unrelated, to corresponding bureaucratic notions. The best examples of conflicting ideas of accountability centre on the use of government grant funds to support community members in times of crisis. Whilst an Aboriginal administrator may see that it is their responsibility to pay for the petrol so that an aunty or uncle can attend a distant funeral, such action places the community organisation in breach of grant conditions unless the conditions of grant allow for this type of expenditure. In this circumstance the administrator may be acting responsibly in a community context, but irresponsibly from the point of view of the funding agency.

There is no national consensus among key stakeholders regarding the division of funding and administrative responsibilities for the core functions of AHS. In part this is a consequence of the submission-driven basis for AHS funding. Resource allocation is based on the strength and persuasiveness of the argument presented by the local agency, rather than by reaching consensus on the appropriate range of core functions which the Commonwealth funds. Many AHS receive a mix of funding from the State and the Commonwealth. However, the nature of the mix depends more on historical circumstance than any rational design.

It would be nonsensical, however, to take the position that all AHS should deliver the same range of programs in the same manner. This would ignore the diversity of Aboriginal circumstance and undermine the ability of local organisations to respond flexibly and creatively to the contingencies of local variables. Rather than proscriptively choosing the necessary functions of an AHS, it should be possible through consensus with key stakeholders, to determine the range of possible program initiatives that the Commonwealth will fund. This does require greater clarity about the division of funding responsibilities between the various possible agencies, and between the Commonwealth and the States, and this is an intractable problem area for the Commonwealth. Nevertheless, the health service delivery issue constitutes a prime example of the urgent need for working protocols to be established between Commonwealth, State and other agencies.

Despite the lack of clarity in resource allocation policy, AHS have evolved across the nation to provide a broadly consistent range of services. These include: primary clinical care, some secondary (or specialist) clinical services, child immunisation and developmental surveillance programs, dental services, education and skill development programs, health promotion/public health programs and research activities. Local factors or needs have shaped the range of programs at the local level. Equally potent has been the circumstance of history: the efficacy of local politicians and AHS staff; the responsiveness of that particular State government; and the quality of the relationship between that organisation and the Commonwealth Aboriginal affairs bureaucracy.

Indicators of the distribution of health and of health care

The WHO has provided its member states with a framework for monitoring progress towards the goal of 'health for all by the year 2000' which is intended to assist countries to develop indicators of progress. However, indicators are also needed to illustrate differences in health situations within countries, in order to reflect progress towards closing the gap between those who 'have health' and those who do not. This, WHO states, is a fundamental principle for the selection and use of indicators relating to primary health care (WHO 1981: 12).

WHO proposes four categories of indicators at a macro level:

i health policy indicators
ii social and economic indicators
iii indicators of the provision of health care
iv indicators of health status and quality of life

It is perhaps significant that the first set of indicators suggested by WHO (health policy indicators) are what it refers to as 'indicators of political commitment', and these should, WHO suggests, be demonstrated initially by a high-level commitment to a policy statement or health charter. 'The seriousness of political commitment, can only be measured by the extent to which socially relevant development strategies such as primary health care are actually being implemented' (WHO 1981: 18). The allocation of adequate financial resources is considered by WHO to be a prime indicator of political commitment to strategies such as health for all. WHO considers that it is necessary to have indicators relating to the degree of equity of distribution of financial resources, for example, to know the proportion and geographical distribution of the populations who do not have access to clean water or primary health care services. The formation of national goals and targets is an important element of a strategic approach to achieving equity in health (that is equal access to equal care appropriate to need) and health care.

So how does Australia measure up against these internationally identified criteria of political commitment to improve health? While its health policy performance concerning the total population is good in terms of Aboriginal health there is still no Aboriginal health policy at a national level, and neither is there an endorsed set of priorities, goals and targets for Aboriginal health (Department of Community Services and Health 1988; Department of Health, Housing and Community Services 1993). The document which comes closest is the National Aboriginal Health Strategy (NAHS) Working Party report. While this document, with $232m funding to implement the strategy, was intended to produce measurable outcomes, it did not nominate goals or articulate a policy in it's 1989 report (NAHS Working Party 1989). An additional committee had to be set up to advise on the structural arrangements recommended in the NAHS (Aboriginal Health Development Group 1989). Consequently, as part of the Commonwealth Government's Better Health Program, two consultants (a medical professional and an Aboriginal health professional) were engaged by the Commonwealth Department of Health in 1990 to compile a document on goals and targets in Aboriginal health.

By June 1991 the draft goals and targets had been drawn up and around 700 copies were distributed across the country for comment and feedback (Wronski and Smallwood n.d.). Only 27 responses were received. The draft set of goals and targets subsequently became the subject of disagreement between the States and Territories, tripartite forums, the Council for Aboriginal Health and Aboriginal community-controlled organisations, and as a result have never been fully endorsed (Gordon 1994). Nevertheless, some State governments are using the draft as it was intended by the authors, as 'milestones' against which health services could monitor their progress. The interim set of goals and targets has an ambivalent place in the process of evaluating the NAHS. In effect, there are no accepted, nationally agreed-upon criteria against which to evaluate the NAHS, nor Aboriginal health as a whole. The evaluation report states baldly, 'There were no effective accountability mechanisms implemented by either the Commonwealth or by the States and Territories to measure progress' (Gordon 1994: 11).

The introduction of program budgeting and DAA

Despite its somewhat institutionally peripheral position within the Commonwealth public service, Aboriginal affairs administration was by no means completely insulated from the moves to transform the culture of Australian public administrative systems. The program management and budgeting initiative has been a major element of budget reforms introduced by the Commonwealth Government since 1984 (Barrett 1992: 3). Program budgeting, the setting of objectives and measurement of performance against them, was a formal part of the Government's financial processes by the late 1980s. The financial management improvement program, one part of this overall strategy, 'with its focus on better resource management through clearer objectives and enhanced information systems to assist evaluation of these objectives, was aimed particularly at managers in the line agencies' (Williams 1993: 40). Throughout this process, central agencies such as the Commonwealth Department of Finance have redefined their role to centralise the importance of evaluating program performance and assisting departments to improve their financial management (Williams 1993). These reforms had been influenced by overseas initiatives in the government and private sectors, and organisations such as WHO, which stressed 'management by objectives' (Barrett 1992: 4). Ministers and departments were asked in late 1987 to prepare evaluation plans, and by 1989 all Commonwealth departments had introduced program budgeting to enable the Government 'to better focus on the objectives and achievements of programs' (DAA 1989).

In the case of Aboriginal health, it was true that prior to this, evaluation had been haphazard to the extent that the 1979 House of Representatives Standing Committee on Aboriginal Affairs (HRSCAA) report on Aboriginal health observed that 'in the absence of definitive information the Committee has not been able to make a judgment on the effectiveness of any of the various health programs discussed in this report'. It went on to recommend that suitable criteria should be established 'so that standardised information can be collated and that funds be provided for this purpose where programs are funded by the government' (HRSCAA 1979: 109).

As a result of these policy changes throughout the Commonwealth, DAA circulated a draft document in December 1986 entitled 'Performance Indicators - Aboriginal Health Services' which produced heated discussion among AHS. Several AHS undertook detailed analyses of the DAA document, making suggestions for changes. The overall response of the Aboriginal health sector, expressed through their umbrella organisation at the time, the National Aboriginal and Islander Health Organisation

(NAIHO), was hostile; NAIHO interpreted the performance indicators as an 'intrusion by the DAA' (NAIHO 1987: 9). More specifically, NAIHO objections to the 1986 performance indicators were as follows:

i the inappropriateness of DAA formulating priorities in health
ii the absence of a national Aboriginal health policy, aims or objectives (thus measuring outcomes against a non-existent yardstick)
iii *tying funding to quantifiable health improvements*
iv emphasis on empirical over-interpretive data as indicators
v unprofessional and uninformed selection of indicators.

In 1987 letters were sent to AHS requiring them to submit six monthly throughput indicators to DAA. These were as follows:

i monthly total of consultations with doctors
ii monthly total of consultations with sisters
iii monthly total of consultations with Aboriginal health workers at the health service and at homes
iv number of educational and preventive programs conducted during the month
v number of people who attended these programs
vi monthly total of consultations with dentist (where available).

NAIHO argued that DAA was not the appropriate body to be formulating priorities in Aboriginal health: 'the imposition of a series of pre-determined performance indicators shall in effect amount to the establishment of de facto priorities for a particular service' (NAIHO 1987: 9). There were simply no detailed policies or objectives on which to base the indicators other than the global objective to 'raise the standard of Aboriginal health to that of the Australian community generally'.

Another major concern to emerge was the proposition to tie funding to quantifiable changes in health status. This was highlighted by the unfortunate experience of the Aboriginal Medical Service in Walgett, New South Wales which was offered funding in November 1986 on condition that it accomplish certain improvements in health status by 1988. These improvements included reducing hospital admissions (by 20 per cent), and the incidence of diabetes and sexually transmitted diseases (by 10 per cent). While it appears that these unrealistic and impossible demands made on an Aboriginal health service was an atypical event involving an inexperienced DAA officer, Moodie used the example to effect as part of a critique of the handling of the performance indicators issue on the part of DAA (Moodie 1989).

By 1989, the last DAA Program Budgeting Manual reiterated that ongoing funding was tied to the provision of performance data by grant recipients, and these were divided into national and project level information (DAA

1989). Grant recipients were required to report six monthly and provide data on the following performance indicators:

i National level: births; deaths; morbidity rates for different diseases; hospitalisation rates; immunisation rates; infant mortality rates;
ii Project level: client population; number of consultations by doctor, nurse, Aboriginal health worker, others; prevalence rates for significant ill health conditions; immunisation rates (dental if appropriate).

The collection of these data was the beginning of a planned reporting process whereby regional, state and central offices were, in turn, to accumulate the data from the initial reports, and then transform them into a performance report to the Secretary of DAA, the Minister and Parliament.

The initial mishandling of the introduction of performance indicators in Aboriginal health by the DAA was unfortunate, for it antagonised the Aboriginal health sector, whose cooperation was crucial to their successful implementation. The hostility towards 'measuring performance' has lasted for many years, and explains the subsequent difficulties in gaining national Aboriginal endorsement of other government initiatives, such as the establishment of national goals and targets for Aboriginal health. It is worth noting that when the Commonwealth introduced its program evaluation strategy, many agencies expressed concern that the strategy would reimpose a form of central oversight that was 'contrary to the spirit of devolution of control, a centrepiece of the government's public management reforms' (Barrett 1992: 18). One defender of this process has argued that this was not the intention and it has not eventuated. Nevertheless, Australia does appear to have placed 'a greater emphasis on institutionalising the link between evaluation and the budget than other nations' (Barrett 1992: 17).

ATSIC and the National Aboriginal Health Strategy

There has been a gap in the development of Aboriginal health policy-making mechanisms which has implications for performance evaluation. Effective policy development is a strategic means of establishing principles of action and in this context must engage all the key stakeholders. The lack of a national Aboriginal health policy apparatus has also jeopardised the implementation of the NAHS, including the establishment of national goals and targets, and performance indicators.

The release of the NAHS Working Party report in 1989 coincided with the legislative program to create ATSIC. One of the key recommendations within the NAHS Working Party report was for a strategic approach to improved coordination of resource allocation and policy development in Aboriginal health. As such the NAHS Working Party recommended the creation of tripartite forums at a State and Commonwealth level, which drew membership from the State and Commonwealth sectors and from Aboriginal communities. Unfortunately, the creation of ATSIC with its own in-built consultative mechanisms was not anticipated in this approach to improving intersectoral collaboration (Codd 1993: 16; Bartlett and Legge 1994). ATSIC subsumed the role of the DAA, which at the Commonwealth level gave it the lead role in implementing the Council for Aboriginal Health (the national tripartite forum); as well as the responsibility for providing the Council with necessary secretariat support (the Office of Aboriginal Health).

The Council for Aboriginal Health met twice following a two-year delay in its formation, at which stage it was reviewed at the instigation of the Ministers for Aboriginal Affairs and Health, Housing and Community Services. This unilateral action from the Commonwealth alienated non-Commonwealth stakeholders (Codd 1993: introduction). Nevertheless, the Codd review recommended the continuing operation of the Council for Aboriginal Health, with slightly modified terms of reference. These terms of reference included the monitoring of the implementation of the NAHS, as well as developing national Aboriginal health policies. The review was delivered in March 1993. The Council has not met since.

The failure of ATSIC to operationalise the Council for Aboriginal Health thus undermined the sustained development of Aboriginal health policy. ATSIC's own consultative structure does not in any way compensate for this lack. The Regional Councils of ATSIC are essentially funding allocation bodies and have little scope for policy development. The Board of Commissioners does not necessarily include anyone with experience of health service delivery. The National Aboriginal Community Controlled Health Organisation (NACCHO), the successor to NAIHO, has no resources to meet under its own volition. Finally, until very recently, there have been no formal links between ATSIC and the other key Commonwealth agency - the Department of Human Services and Health (DHSH). The recently formed Joint Planning Committee for Aboriginal Health Services (which has NACCHO, ATSIC, DHSH, and National Health and Medical Research Centre (NHMRC) representation) is primarily a funding-allocation apparatus (for additional Commonwealth monies available in 1994-95) and has no collaborative policy-oriented functions. Given that improved intersectoral collaboration was a key component of the NAHS this has been a key deficiency in the implementation of the strategy.

ATSIC and health performance indicators

ATSIC has a responsibility under section 7 of it's Act to 'monitor the effectiveness of programs, including those conducted by bodies other than

ATSIC'. In the first two years of ATSIC's operations, 1990-92, grant agreements continued to utilise the old DAA throughput measures. In 1992-93 ATSIC sent out the manual in which the 'local' program performance indicators were inadvertently omitted, leaving only the 'national' performance indicators being requested from health services. Once the mistake was discovered, letters were sent out asking people to ignore them; but several health services sent in these inappropriate data anyway. These data (including births and deaths, infant mortality rates) are only useable epidemiologically when collected from much larger population groups. A population with between five and ten births a year cannot sensibly provide figures on an 'infant mortality rate'. In 1992-93, some AHS sent in indicators according to the incorrect 'national' guidelines; others ignored them (as instructed by ATSIC); and others negotiated new performance indicators of their own with regional offices.

The error highlights a key problem with the identification of performance indicators by ATSIC and by DAA before it; namely, neither ATSIC nor DAA have ever been the sole actors in the provision of health services or programs to Aborigines, as is the case with other key services such as housing, education and employment. They have always been supplementary to (or in some cases substituting for) existing services provided through States; even if ATSIC is the primary funder of an Aboriginal community-controlled health service, such a service only provides primary health care, and has limited impact on secondary health care such as hospital treatment and access to other tiers of health care. This means that, like its predecessor, ATSIC cannot be held responsible for Aboriginal health status in general, and any indicators of performance that it can collect will always, of necessity, be only partial indicators.

The 1993-94 ATSIC Program Policy and Guidelines Statements continue to list the 'national' performance indicators, while noting optimistically that they are under review as a result of the implementation of the NAHS and partly due to ATSIC's ongoing evaluation processes. ATSIC also noted at this time that with the introduction of the National Aboriginal and Torres Strait Islander Health Goals and Targets 'more information will be available to examine the success or otherwise of the policies and programs developed as a result of the Strategy'. With the creation of an Office of Aboriginal and Torres Strait Islander Health Services in DHSH following the 1994-95 budget, it is expected that this office will take on board the negotiations for the creation of these goals and targets.

The ATSIC Operational Plan for 1993-94 provides a little more information, also mentioning that the program performance indicators are in the process of being developed but adding that once formulated, they will focus on the following:

i the number of people accessing ATSIC funding programs;
ii community participation in and control over health programs;

iii the training undertaken to ensure the appropriate service provision;
iv monitoring of key activities, such as health promotion and prevention, immunisation, screening and surveillance.

Some of these suggested indicators concern the provision of health care, which are very different from indicators linked to health status and indeed the Operational Plan for 1993-94 notes for the first time that the 'vital statistics' on births and deaths, morbidity, hospitalisation, immunisation and infant mortality will be provided by the Australian Institute of Health and Welfare. This suggests that a decision has finally been made that it would be inappropriate for ATSIC to ask small AHS to collect and submit such information.

According to the Daffen Report commissioned by ATSIC, there is at present 'no matrix in place to collect, collate or analyse published Performance Indicators' (Daffen 1994: 136). No new performance indicators have been identified. The 1994 Funding Procedures Manual does not specify the performance indicators that accompany letters of offer, the space is left blank: at present AHS can identify these for themselves, presumably in negotiation with ATSIC regional offices. In short, the process of formulating useful health indicators is not yet resolved. Neither has it been resolved exactly what performance the indicators are assessing: funding efficiency, staff effectiveness, number of clients or prevalence of illness, which are all indicative of different types of activities and services. There has not yet been a selection and refinement of indicators to satisfy the differing requirements of financial accountability, provision and effectiveness of service, and progress towards specific goals. Neither has there been any support provided to AHS (either advice or funding) to assist them in formulating their own objectives and internal evaluations.

At present the data on progress reporting and performance indicators are sent by AHS to regional offices of ATSIC, who in turn write a report with a profile of each community, a report on activities covering every component of ATSIC programs (population profile, number and type of programs and so on). These go to State offices, where a state-wide overview of information is compiled and sent to Canberra where the Health Policy Section should ideally compile a national picture. In practice, this has not been possible because of the poor standard of data collected so far. Central office is aware that there are difficulties in data collection at the local level, with inadequate human and computer resources.

Available indicators and progress reports are sent by the ATSIC branch to the Office of Evaluation and Audit (OEA), to Senate Estimates Committee and are used for the ATSIC Annual Report. The OEA in ATSIC has the responsibility to regularly evaluate and audit the operations of the Commission and is accountable to Parliament, but also to Aboriginal and Torres Strait Islander people through reports to the Commission. The

Office has given broad evaluative activities a much greater focus than was previously the case in either DAA or the Aboriginal Development Corporation (ADC) (Dillon 1992: 96). It conducts two forms of audit: focus audits of programs, which are oriented to efficiency, and evaluations; to date 90 per cent of OEA's recommendations have been endorsed (Daffen 1994: 89). The Office has undertaken an internal (confidential) evaluation of ATSIC's health section, and some of their findings were contributed to the evaluation of the NAHS in 1994.

The view from the ground

Early performance indicator requests resulted in health services compiling tables noting the monthly totals for presentations in categories such as cardiovascular, respiratory, diabetes, trauma or skin. But, as one AHS administrator noted, 'It is not possible from the available figures to assess in what areas improvement has occurred or whether this improvement will be sustained' (Koteka 1988). However, the same health service was able to measure a drop in outpatient consultations as well as alcohol related injuries at one stage, and suggest reasons why this had occurred. Health service administrators often made additional notes when they sent in their performance indicators, commenting on the numbers of births as opposed to deaths, pointing out the fundamental constraints on health improvement due to STD and diabetes rates, or pertinent observations on health status. They reveal a level of frustration with the expectation that a small health service can deliver on health outcomes which largely remain outside their jurisdiction:

> from the morbidity figures the population of both communities are rather unhealthy. This is not surprising in view of the poor hygiene and living conditions, poor nutrition, abuse of alcohol and volatile substances, lack of understanding and acceptance of some of the causes of diseases and their methods of prevention and control. These contributing factors to ill health could be overcome provided there is community determination and a will to improve. No matter how good a health service is provided, we will have little impact on the health of the people if these basic issues are not resolved (Koteka 1988: 4).

Unrealistic outcome measures have the less than useful effect of highlighting the enormity of the task to what are often small, under-resourced health services. These apparently 'poor' outcomes can then be used by the bureaucracy to imply that some services are not doing a good enough job.

Health services have received no feedback on the performance indicators they submit (either before or after the commencement of ATSIC), or on the more personal comments that may be sent in by individual health administrators. This reinforces the widespread view that performance indicators have been instigated for purely financial accounting purposes, rather than to encourage some collaborative evaluation exercise which would be helpful to the AHS.

It has been noted by the researchers that some regional officers of ATSIC have urged health services to 'just put anything down' in order to satisfy the requirements. A new draft Aboriginal Health Strategy for South Australia presents, as an imaginary negative case study, what has been the real-life situation of AHS sending in their performance indicators:

> The funding body doesn't comment, except on late submission, and the statistics are virtually meaningless without comparison and analysis to identify and ascertain reasons for trends. They are unrelated to statewide goals or strategies. They are activity statistics suggesting staff work hard but do not indicate whether or not health is improving ... It is onerous for services to collect meaningless statistics which disappear into a 'bureaucratic void'. It is also a poor basis for evaluation (Aboriginal Health Council of South Australia 1994: 66).

The 1993-94 financial year saw the continuation of confusion regarding the performance information required from AHS. Ensuring that AHS provide performance indicator data is a regional office function. Regional offices are generally under-staffed, have a high staff turnover and do not employ staff who necessarily have any experience of health service delivery. AHS continue to be required to provide information on what DAA officers initially construed as national performance data. In addition, some AHS have also provided data previously required by the DAA which related to the number of active files and the number of consultations performed by doctors, health workers and nurses. Some agencies were also asked to provide a narrative description of program activities. It is very difficult for AHS administrators to operate effectively in an environment in which their prime funding agency cannot introduce some consistency to the most routine aspects of the funding/grant acquittal process.

In its document on the development of indicators, the WHO acknowledges that the question of selectivity of indicators is crucial, particularly for developing countries where health services are rarely adequate to permit routine information collection. 'It is still very difficult', the document observes, 'to get the information where it matters most - at the community-level' (WHO 1981: 7).

WHO identified some of the issues that arise from local community-level collections:

> In the field of health, routine health service data are an essential source of information on disease-specific morbidity and mortality, on certain measurements of children, and on the various activities carried out by the health services. This information, obtained from ongoing programmes, is relatively cheap and easy to collect and analyse. It is, however, incomplete and often inaccurate, especially when those responsible for collecting it at the periphery are not taught how to use it themselves; are overburdened with so much form-filling that this activity seriously interferes with their service functions; have no feedback or see no relevance in collecting the information; or are generally unsupervised. There is another drawback when the data collected are not oriented towards particular problems to be solved or tasks to be fulfilled. The record systems of health services are often kept for administrative purposes rather than for monitoring,

> which means that data on required denominators are not available - for example the population at risk or the population to be covered by a particular service (WHO 1981: 16).

The 'success' of health services in meeting the needs of their clients, and fulfilling administrative requirements for their funding agencies is determined by a wide range of factors including the skills of clinic staff; the rate of staff turnover; the relationship between the health service and other community staff (store, office etc.) or organisations; and the influence of fluctuating community problems. The quality and severity of these problems vary according to socio-historical context, and geographical location. However, it does mean that even simple administrative tasks can be at times extraordinarily difficult.

Conceptual problems: what performance indicators are appropriate?

The current performance indicators requested by ATSIC are a mixture of outcome and throughput or process measures. Before considering some of the conceptual difficulties in developing appropriate performance indicators for ATSIC's health and community development program it is worthwhile returning to the Department of Finance documents which outline the conceptual basis for the use of performance indicators within program budgeting:

> It is important to emphasise, however, that the role of performance indicators is to *inform judgements rather than to replace them.* It is not required or expected that any one indicator, or even set of indicators, will provide a definitive measure of program accomplishment. Rather their role is in *indicating,* or focusing attention on, relevant areas to identify corrective action (by individual program managers, the responsible Minister, or the Government, as appropriate) might be required or where more intensive evaluation is needed (Department of Finance 1985: 2 original emphasis).

Performance indicators are only one part of the evaluation of program activity. They do not replace the need for internal organisational review, nor intensive externally driven evaluation. However, it would appear that a number of evaluative processes have been collapsed onto the development of performance indicators for ATSIC's health program. There is a need for the conceptual separation of the evaluative activities which are concerns of the State, such as the indicators of the distribution of health care and health care services; indicators relating to the performance of the ATSIC health program; and evaluative activities oriented at assessing the operation of an individual AHS.

Aboriginal community organisations are more than mere sites of the interface between service resources and Aboriginal people. In a complex way they have become integral to the production and sustenance of the social relations which are often glossed under the rubric of 'communities'. This is especially true in urban communities where the only public space which can be construed as 'Aboriginal' is indeed that of the Aboriginal organisation. This was recently highlighted at a public meeting in Melbourne, where one woman, addressing the problem of organisational instability stated simply, 'take away our organisations and we have nothing'. It is around this form of relationship with community that the service functions of AHS are built. As a result of this complex relationship between function and context, and because many of the necessary elements of successful operation of AHS remain opaque to quantification it is inconceivable that AHS be thought of as a simple production process - which characterised the development of performance indicators under the program budgeting regime (Department of Finance 1985).

Further, the social relations which underlie the development of AHS would not support an evaluative framework which gave the funding agency the ability to manipulate organisational function (in the absence of a particular crisis in operation). AHS operate within a policy framework of self-determination. They are unlikely ever to cede this to a higher level bureaucratic agency. This does not mean an absence of evaluative activity. Rather the development of internal and peer review evaluation mechanisms should play a vital role in any health service.

In the previous section we discussed the difficulties in data collection at the local level. Now we discuss in broad terms the issues around developing valid measures of performance, which can be consistently applied in AHS across Australia. To develop successfully the performance criteria envisaged by the Department of Finance it would be necessary for the indicators to fulfil the following conditions:

Consistency:	Are the variables of equal validity in different contexts. Is it possible to identify common program activities.
Feasibility:	Can the data be feasibly collected in even the most undeveloped context lacking resources.
Validity:	Is the variable measure of performance which reflects solely on the activities being measured.

A key difficulty in defining performance indicators for Aboriginal health is consistency. Rate measures which involve defining population denominators, are the only true measures of performance as they define actual activity or outcome relative to a potential total. Nevertheless, while it may be possible to define rates in contexts where there is an unequivocal service population (as in some remote and discrete communities), in an urban context any rate measure, as a measure of performance, is highly problematic. There are both high population movements (particularly to and from regional rural centres), and multiple sites of service (both Aboriginal and mainstream). Further, even though there are similarities in the activities of AHS across Australia there are also significant variations which reflect the mix of funding; the local context (which is particularly relevant to promotion of public health programs) and the stage of service development. What this suggests is that program evaluation will be more meaningful if adapted to the local or regional context, longitudinally, rather than attempting to evaluate on a national cross-sectional sample.

There is a substantial medical literature which has attempted to define those health outcomes which are amenable to improvement by medical intervention alone. These include: tuberculosis mortality; malignant neoplasm of the cervix; Hodgkin's disease; chronic rheumatic heart disease; hypertensive disease; cerebrovascular disease; appendicitis; gallstone disease; maternal deaths (Rutstein et al. 1976; Charlton and Velez 1986; Australian Institute of Health and Welfare 1994). There is considerable dispute about what can be included on this list, and the discussions refer only to amenable causes of mortality, not morbidity. The significance of these causes of amenable mortality is that they serve as warning signs, and can be used to measure the quality of medical care, as Westerling notes:

> avoidable mortality such as perinatal and maternal mortality [are] negative indices of health ... these causes of death [are] a warning signal, a sentinel health event, indicating that the quality of care may need to be improved (1992: 489).

But as noted earlier, it is not feasible to collect mortality data from AHS. Measures of morbidity generated at point of contact with health services do not provide a picture of actual community morbidity. They actually provide data on the relation between people with illness and the health service. Apart from the collection of notifiable disease data, actual morbidity prevalence or incidence can be measured only through techniques which require random sampling. Finally, the time frame for producing health transitions in many of the key aspects of Aboriginal morbidity (for example the chronic degenerative diseases) is outside the scope of the funding cycles. For some of these conditions it is far more appropriate to take a generational view, rather than a medium term cycle such as a decade.

It may be possible to view risk reduction as an outcome which is measurable (pap smear rates, screening/treatments rates for hypertension, and percentage of people smoking). It could be argued that these measures would relate to effort and not outcomes. However, the difference between a process (activity) indicator and an outcome indicator can at times be arguable. For example, measurement of blood pressure is, from a micro perspective, a measure of work or process. From a macro perspective, an effective system of blood pressure screening is an integral component of the effective management of hypertensive disease, and therefore directly an integral component of the prevention of cardiovascular disease. It should be noted that most of these measures require estimates of denominators which is difficult to arrive at in most service contexts. Finally, some measures of risk reduction can only be read longitudinally. For example, cervical dysplasia may increase rather than decrease in the early stages of program implementation and represent a health improvement, rather than a decline.

ATSIC-funded health programs are not the only provider of services to Aboriginal people. State-funded programs and mainstream programs can play a significant role. It is, therefore, extremely difficult to argue that any health outcome reflects the 'performance' of ATSIC's health program.

We do not wish to suggest that health services have no impact on morbidity and mortality. We know that they do and that health services should not be dismissed as a bottomless pit into which money is dropped from which there is no measurable benefit. The point is, as Kunitz states, that such services can and do make a difference (Kunitz 1994: 182). Under certain circumstances, accessible care has had a noticeable impact on health - infant, child and maternal mortality, and in the severity of infectious diseases - while having less impact on the severity of non-infectious chronic diseases.

What we are suggesting is that, with the exception of a very few morbidity risk reduction measures, it is not possible to define health outcomes which are feasibly measured by AHS. Even those which may be suitably used are rendered problematic by the difficulties in defining population denominators, in assessing the possible impact of other health agencies, and the fact that most measures could only feasibly be generated through service usage and therefore provide a very partial insight into community morbidity or risk. Health outcome measures, on the whole, must be separated from funding processes. They are a measure of the overall performance of the State and appropriately need to be tied to macro resource allocation processes such as the overall allocation of resources into Aboriginal health, not as measures of performance of the Aboriginal health dollar. Consequently, they must more appropriately be tied to measures of political commitment and resource allocation as suggested by WHO.

Throughput or process measures as performance indicators are problematic. Measures such as number of consultations per year do indicate effort, and a funding agency may wish to establish that such effort is occurring. However, such indicators do not measure performance or quality of service. As crude figures these data are actually meaningless. If a service sees a given number of people a year, does this mean that they are being effective? What happens if the number of consultations increases? This could mean that the AHS has made its programs more accessible. Alternatively, it could mean that their public health program is failing and community morbidity has increased.

In the original Department of Finance documentation the hegemonic role of numbers was apparent. Yet it may be the lowest ranked indicators, the narrative or qualitative indicators, that are the most useful in the context of AHS. It is entirely appropriate that a health service demonstrate the range of program activities which have been developed, and include locally developed measures of performance, or evaluation comments. Further, it is appropriate that the service demonstrate that certain forms of activity, integral to sustaining viable operations are occurring. These may include:

i evidence of planning and internal evaluation;
ii evidence of community participation, mechanisms used to guarantee community accountability;
iii evidence of training and skills development.

Given the small number of services (under 100), it is still possible to produce narrative assessments of program activity and have these reports assessed by a central office staff. Assuming an effectively functioning regional office, ATSIC or the Commonwealth DHSH, (the responsible agency is still under discussion at the time of writing), should be able to identify potential problems in program activities in particular sites, or even on a regional or national basis. It does not replace locally based evaluation which can more appropriately be contextualised against local circumstance and developments. In-house evaluations can include, for example, assessments of the quality of care by undertaking an audit of patients' medical records, as these reflect the quality of patient examinations and the relationship between health staff and patients; particularly in situations where there is high staff turnover good records are crucial for the continuity of care. There is now a considerable literature on health care evaluation, program effectiveness, and health status indicators which can be drawn upon (Public Health Association of Australia 1989; McClelland et al. 1992; Nganampa Health Council 1993; South Australian Community Health Research Unit 1994).

Given the pressures from central agencies in the Commonwealth public sector it is unrealistic to expect that ATSIC, or any department that may in future be responsible for monitoring AHS, could dispense entirely with quantitative indicators, even though their interpretation is problematic and their validity open to debate. That being the case, the most appropriate indicators would be process indicators, with possibly some outcome measures related to risk reduction. In the main, however, health outcome measures should be separated from funding cycles.

Concluding points and policy recommendations

The development of performance indicators for AHS requires reassessment and consensus from all the key stakeholders. It is, therefore, necessary for the Commonwealth to commit itself to the formulation of a national Aboriginal health policy apparatus which involves all the key stakeholders.

A major part of this policy process, vital to the development of performance evaluation, is the development and endorsement of realistic national goals and targets.

With some exceptions, health outcome measures are inappropriate performance indicators for AHS. They are, in effect, measures of the performance of the State. Such national performance indicators should, as argued by WHO, include measures of national political commitment using analyses of resource allocation and ease of access to health care. Information on State and national assessments and indicators need to be fed back to AHS as the provision of data has often been a one-way process (from the local organisation up to the central office). There are at present no avenues whereby this might happen but suitable mechanisms of feedback need to be discussed.

The development of appropriate performance indicators must take into account the feasibility of data collection. The capacity of AHS in terms of their physical infrastructure and human resources needs to be developed as a priority. To date, the development of information management systems within AHS has been extremely patchy. However, there are examples of routinely-collected administrative data having a role in prevention and in evaluation. For example, in Moree, New South Wales, a committee of representatives of community-based and State health services and the Aboriginal population, are setting up a system to collect and disseminate information about the health status of the Aboriginal population. This will be run by Aboriginal health workers and the adult Aboriginal population is the primary target for feedback of results (South Australian Community Health Research Unit 1994: 62). Some AHS have been involved in the development of their own computerised health management system, such as Health Planner which makes possible a preventive health program which allows routine health checks (Speare and Kelly 1991: 110). Other agencies, such as the Victorian Aboriginal Health Service, which has a client base of approximately 5,700 patients spread across metropolitan Melbourne and the state of Victoria, has attempted similar development, but has lacked the necessary resources to complete this process.

If a funding body is genuinely supportive of self-determination, the performance indicators provided by an AHS to the funding body should reflect the needs of the client population or community. An AHS should be properly resourced to determine the priorities and needs of that particular community, and to develop appropriate indicators as to whether these are being addressed. An AHS should also be properly resourced to negotiate with the funding body on equal terms, so that appropriate indicators can be included in the contract, service agreement or grant conditions. Small services will probably need to employ outside personnel to assist them in these processes and adequate resources should be available for them to employ such personnel. In this way, it would be possible to avoid a situation in which a State or Territory health department has divested itself of the responsibility for delivery of health services to a community-controlled AHS, but simultaneously exerts a strong influence by having its departmental officers draw up elaborate service agreements including performance indicators. It is difficult for community organisations (particularly in remote regions) to be able to negotiate these agreements properly, because they do not have the expertise. The result is often an under-resourced health service with staff spending time collecting statistics to satisfy departmental goals and targets, rather than those of the health service.

Performance indicators, if developed as quantitative variables, need to be valid and consistent measures of performance. There is a role for consistent and accepted narrative indicators which monitor the scope of AHS activities. The AHS should be called upon collectively to suggest appropriate indicators and the resources necessary to develop the capacity to collect them. There is also a need for support and professional advice to be made available to AHS so that in-house evaluations are possible.

Performance indicators alone are no substitute for the development of local mechanisms of evaluation which measure performance against the context of a particular region and the stage of development of AHS. In order to maintain a policy of self-determination in the development of evaluation strategies, such mechanisms should include internal evaluation and peer evaluation mechanisms. Accountability spreads in two directions: up to the fund providers and down to the clients.

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