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Does more equitable governance lead to more equitable health care? A case study based on the implementation of health reform in Aboriginal health Australia



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ABSTRACT

There is growing evidence that providing increased voice to vulnerable or disenfranchised populations is important to improving health equity. In this paper we will examine the engagement of Aboriginal community members and community controlled organisations in local governance reforms associated with the Aboriginal Health National Partnership Agreements (AHNPA) in Australia and its impact on the uptake of health assessments.

The sample included qualitative and quantitative responses from 188 people involved in regional governance in Aboriginal health. The study included data on the uptake of Aboriginal health assessments from July 2008 to December 2012. The study population was 83190 in 2008/9, 856986 in 2009/10, 88256 in 2010/11 and 90903 in 2011/12. Logistic regression was used to examine the relationships between organisations within forums and the regional uptake of Aboriginal health assessments. The independent variables included before and after the AHNPA, state, remoteness, level of representation from Aboriginal organisations and links between Aboriginal and mainstream organisations.

The introduction of the AHNPA was associated with a shift in power from central government to regional forums. This shift has enabled Aboriginal people a much greater voice in governance. The results of the analyses show that improvements in the uptake of health assessments were associated with stronger links between Aboriginal organisations and between mainstream organisations working with Aboriginal organisations. Higher levels of community representation were also associated with improved uptake of health assessments in the AHNPA. The findings suggest that the incorporation of Aboriginal community and community controlled organisations in regional planning plays an important role in improving health equity. This study makes an important contribution to understanding the processes through which the incorporation of disadvantaged groups into governance might contribute to health equity.

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"In order to address health inequities, and inequitable conditions of daily living, it is necessary to address inequities ... in the way society is organized. To achieve that requires more than strengthened government – it requires strengthened governance: legitimacy, space, and support for civil society, for an accountable private

sector, and for people across society to agree public interests and reinvest in the value of collective action. In a globalized world, the need for governance dedicated to equity applies equally from the community level to global institutions."

(Commission for the Social Determinants of Health, 2008)

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There is growing evidence that providing increased voice to vulnerable or disenfranchised populations is important to

improving health equity at a number of different levels (Beckfield and Krieger, 2009). A systematic review of the literature on the influence of political context on health equity at a national level found that the only factor consistently associated with improvements in health equity was the political incorporation of formerly subordinated groups—an association was found in 6 out of 7 studies (Beckfield and Krieger, 2009). Within countries, a meshing of top-down and bottom-up approaches to policy development has been viewed as a key mechanism to make policy and institutions more inclusive of citizens and more responsive to their needs (World Health Organisation, 1998). Research on place-based initiatives has demonstrated that the quality of local governance is associated with better outcomes even when taking variation in the projects delivered into account (Belsky et al., 2006; Kelaher, Dunt, Nolan, Feldman, & Raban, 2009a, 2009b), although this finding varies depending on the context of the program.

This embryonic literature suggests that how governing bodies involve the community in their processes can have a significant impact on their ability to improve health equity. There are a number of pathways via which greater voice to disadvantaged groups would be expected to contribute to improved health equity. Health inequities are produced by poorer access to economic and social resources, education and health care, increased exposure to environmental and social hazards as well as through stress, which may contribute to poorer health either directly or indirectly through the adoption of coping strategies (Blane, 1993; Macintyre, 1986; Townsend et al., 1990; Wilknison, 1996). Greater incorporation of disenfranchised populations in governance could improve health equity by developing social resources, improving access to

resources, reorientating services to meet community needs and improving living and working conditions (Marmot et al., 2008).

One of the ways in which greater participation in governance could increase health equity is by improving access to health care. Access to health care occurs at the interface between individuals, households, social and physical environments, health systems, health organisations and health providers (Shand and Arnberg, 1996). The five dimensions of access to health care are generally defined as 1) Approachability; 2) Acceptability; 3) Availability and accommodation; 4) Affordability, and; 5) Appropriateness (Beckfield and Krieger, 2009). Most of these parameters are directly related to the level of synergy between health services and the community. Therefore, access to health care would be expected to be influenced by greater direct community engagement in planning and governance (Liaw et al., 2011). In Fig. 1, we show the pathways via which community engagement has been hypothesised to influence access to health care (Beckfield and Krieger, 2009; Haddad and Mohindra, 2002; Peters et al., 2007; Shand and Arnberg, 1996; Shengelia et al., 2003).

1. Governance in health

Governance is defined as the process of decision-making and the process by which decisions are implemented (or not implemented) (Barten et al., 2011). Good governance in health systems promotes effective delivery of health services and population health programs. It has been argued that improved governance could almost double the effectiveness of individual interventions (Kickbusch and Gleicher, 2011).

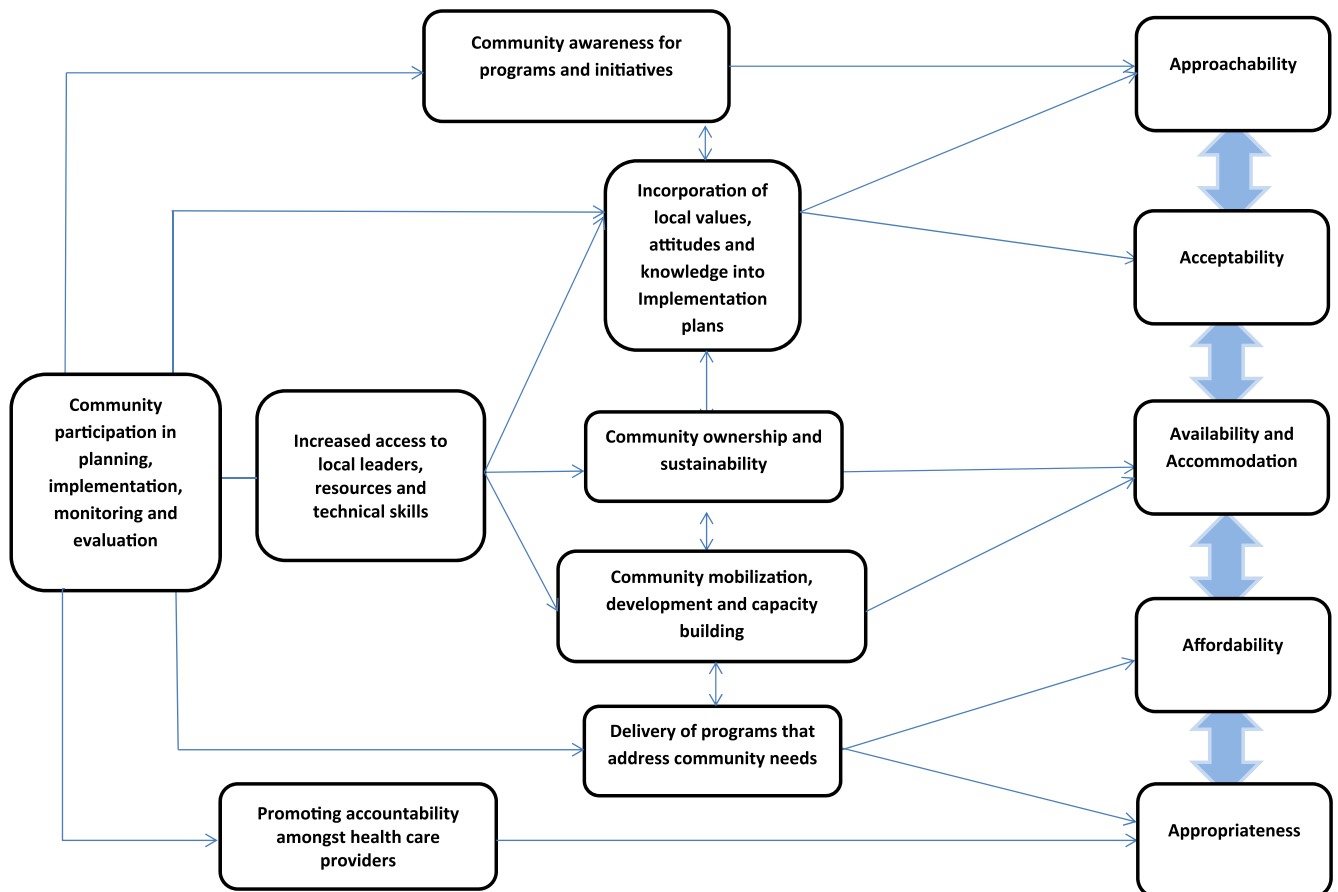


Fig. 1. Pathways between participation and improved equity in access to health care.

The development of more inclusive approaches to governance has been driven by changes in normative expectations around the level and quality of public scrutiny in governance (Keane, 2009). This naturally includes an increased focus on consultation and public reporting. However, there is also an increased expectation that non-governmental organisations, advocacy organisations and community will directly participate in governance (Kickbusch and Gleicher, 2011). For example, health democracy (*democratie sanitaire*) was recognised in France in 2002 with the passing of laws to ensure user engagement in health care management, patient protection and to ensure the provision of quality health care. The notion of involving community in decision-making is long-standing in Aboriginal health, where its links to self-determination are critical for establishing the legitimacy of decisions. Governance in health has also shifted to multi-agency and multi-actor models fuelled by the notion that closer collaboration will lead to better services by improving innovation, integration and quality (Shengelia et al., 2003). These forms of governance provide a platform for greater participation from a range of stakeholders.

The research response to this sea-change in approaches to governance has lacked coherence. The discourse on governance in health has progressed from seeing participation in governance as merely instrumental to achieving program and policy outcomes to seeing intrinsic value in transforming power relationships (Nelson and Wright, 1995). However, the study of governance in health has not kept pace. Research on governance-based interventions from a health program evaluation and epidemiological perspective has focussed on the achievement of policy/program health goals rather than the processes that led to these achievements. Governance is therefore conceptualised as a “black box” (Phillips et al., 2010).

In contrast, research from sociological and political science perspectives have tended to focus on the processes that particular governance structures engender and the benefits of these processes in and of themselves. This is exemplified in the large literature on deliberative democracy (Mutz, 2008). This literature has been useful in highlighting the complexity of developing legitimate collective decisions in situations of disagreement, a circumstance that often applies to governance in health (Thompson, 2008). It has also provided evidence that people are motivated to adopt a deliberative approach to situations where there is accountability (Ryfe, 2005), high stakes (Taber et al., 2001) and diversity (Mutz, 2002). However, there is ongoing debate about synergy between theoretical and empirical work (Thompson, 2008). It has been argued that research has been hampered by a “structural ambivalence between talk and action”, where there are very few real-world examples demonstrating deliberative forums that have the power to dictate future actions in a binding way (Ryfe, 2005). Governing bodies in health provide an opportunity to bring together these two streams of research in a meaningful way.

2. Developing equitable approaches to governance

Power is a key construct for understanding whether particular approaches to governance engage participants in a meaningful way. As shown in Fig. 1, in order for governance to improve health equity through access to health services a number of conditions need to be met and there must be a transformation in power relations toward a more equitable distribution of power. First, this requires that governance occurs in a context where governing bodies have genuine power over decisions and resources. Second, it is important that there is appropriate engagement in each planning and governance phase. This is reflected in research on participation which has shifted from static typologies describing levels of participation, to more fluid and ad hoc models that recognize the various efforts that can be employed at each step of the policy making process, from

agenda-setting through to evaluation and monitoring (Bishop and Davis, 2002; Painter, 1992; Shand and Arnberg, 1996; Thomas, 1990). Third, participants must be able to engage equally in governance processes (Ryfe, 2005). In cases where there is a strong power differential, equal participation may in fact require privileging some perspectives over others. Fourth, participants must be able to act with autonomy. Previous research has demonstrated that the ability of advocates to represent the interests of their constituency can be compromised when the interests of their constituency and their own financial interests conflict (Grogan and Gusmano, 2007). Finally, in order to influence access to health services, participation in governance must lead to some change in the way the participants work together. These changes would be expected to be reflected in changes in interorganisational networks.

In this paper, we examine the engagement of Aboriginal community members and organisations in local governance in Aboriginal health reform in Australia. Aboriginal organisations are defined as Aboriginal Community Controlled Health services (ACCHSs) and other community controlled organisations. These organisations are governed by a board of directors elected from the communities that they serve.

We use this example to develop the evidence around the incorporation of disadvantaged groups in governance has in improving health equity. The paper will address:

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

The representation of Aboriginal community/organisations in governance is a necessary but not sufficient condition for improvements in health equity. Our main hypotheses are that greater progress towards health equity will be made when: 1) Aboriginal community/organisations are incorporated in all phases of planning and governance and this results in interorganisational networks where 2) mainstream organisations work more frequently with Aboriginal organisations and, 3) these relationships are considered important.

3. Aboriginal health reform in Australia

In 2008, there was a formal apology to the Aboriginal people of Australia for the suffering caused by dispossession and forced removal of children. This followed an agreement by the Council of Australian Governments (COAG) to form a partnership between all levels of government to work with Aboriginal people and their communities to achieve the target of closing the gap on Aboriginal disadvantage (Council of Australian Governments, 2008b). The agreement included a commitment to closing the life expectancy gap between Aboriginal and other Australians within a generation; halving the mortality gap for children under five within a decade; and halving the gap in reading, writing and numeracy within a decade. The health targets were to be addressed by two Aboriginal Health National Partnership Agreements (AHNPA): “Closing the Gap in Indigenous¹ Health Outcomes” (Council of Australian Governments,

¹ The term Indigenous in an Australian context refers to Aboriginal and Torres Strait Islander Australians. Aboriginal is the preferred term in Victoria and Western Australia and is used throughout except where citing other sources.

2008c) and “Indigenous Early Childhood Development” (Council of Australian Governments, 2008a). These initiatives collectively represent over a \$2 billion dollar (AUD) investment.

The AHNPA emphasised both the importance of Aboriginal people in developing solutions in health care and the importance of increasing the responsiveness of mainstream health services to the needs of Aboriginal people. Despite these measures, there were no recommendations concerning best practice or key performance indicators to be met in either area. The absence of clear guidance was one of the key tensions associated with the otherwise welcome investment of the AHNPA. Aboriginal organisations expressed concern about competition for funding and being overwhelmed by the far more numerous mainstream service providers in regional planning. The contrasting view was that competition should be encouraged because it would increase consumer choice, thereby ensuring that consumers could obtain services that best meet their needs and promoting better health outcomes.

4. State-based implementation of the AHNPA

The federal government and the seven State and Territory Governments jointly deliver the AHNPA. In our study, we included two state case studies, Victoria and Western Australia. Victoria, the smallest of the mainland states, is 227,416 km² in area. It has no remote areas (Pink, 2011). Western Australia is the largest state in Australia (2,529,875 km²) and the second largest state/province/national region in the world. Seven per cent of Australia’s Aboriginal people live in Victoria and 13% in Western Australia. The percentage of the population that is Aboriginal is 1% and 3% respectively for Victoria and Western Australia.

Both states chose to manage their contribution to the AHNPA through regional planning forums that were responsible for the planning, implementation and governance of the AHNPA activities created in accordance with corresponding service boundaries of the regional health department branches. Forums were comprised of local ACCHSs, health departments and mainstream health providers. Some forums included representation from the Aboriginal community and other relevant Aboriginal and mainstream organisations. All Victorian forums had representation from Aboriginal community members. Western Australian forums, on the other hand, were for the most part comprised only of organisational representatives. In Victoria, forums were co-chaired by an ACCHS representative and the Director of the regional health department branch. In Western Australia, forums were usually chaired by an ACCHS. Both states had a rotating chair policy amongst the Aboriginal members.

The processes for developing and approving plans were similar in both states. Individual organisations within forums developed proposals, there was an internal cull process, a local plan was developed and then the budget approved by the state health department. However, in Victoria the forums knew their allocated budget and the role of the health department was to provide advice and ensure adherence with the guidelines. Priority setting was done at a forum level. In contrast, Western Australian forums did not know how much money would be allocated to their region and decisions about which components of the plans to fund were made by the state health department.

5. Methods

The project was approved by the human research ethics committee at the University of Melbourne (1034509) and Western Australian Aboriginal Health Information and Ethics Forum (WAAHIEC). State and Territory tripartite forums in Victoria and Western Australia endorsed the collection of study data. Tripartite forums consist of representatives from state government, federal

government and the Aboriginal Community Controlled Health sector. Each forum identified representatives to sit on the project reference group (PRG). The PRG played an active role in refining the scope, focus and design of the follow-up project. PRG members identified regional case studies for the project. There were two levels of informed consent in the project. First, consent to participate was sought from each forum before contacting members of the forum. Second, informed consent was sought from each member as to who should be approached to participate.

5.1. Governance data

After reviewing the literature on power and the literature on governance and planning, we developed a research framework outlining indicators to measure different aspects of how participants are conferred with power in the context of governance (Table 1). The framework encompasses all aspects of the process from representation to implementation. Consistent with the literature, the framework addresses *who is included*, the process of deciding *what is to be achieved* and the structure that determines *how is it to be achieved* (Barten et al., 2011).

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

1. Interviews to examine the process of planning and governing AHNPA activity
2. Social network survey data

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

Sample – In total, there are 29 forums in Victoria, representing 148 organisations, and 21 in Western Australia, representing 127

Table 1
Indicator framework for regional governance in health.

Aspects of governance	
Who is involved	
Representation	Indicators
Community representation	% Community representatives % Community organisations represented
Legitimacy of representation	Selection process Constituency (formal/informal) of representatives Recognition of legitimacy within the Forum
What is to be achieved	
Planning processes	
Strategic planning processes	Reporting/consultation Assessment of community needs and priorities Review of community health status Focus of change Review of existing resources and activities (Goverde et al., 2000)
Shared Goals	
Shared understanding of purpose	TOR Role within the planning cycle Consistency of Terms of Reference (ToR) and Acceptance/understanding of ToR and Role within forum (Clegg, 1989)
How will it be implemented	
Process decision-making	
Identification of strategies and goals	Engagement in Preference-shaping (Lukes, 1974)
Prioritisation	Engagement in Agenda-setting (Lukes, 1974) and “non-decision making” (Bachrach and Baratz, 1962)
Decision making	Patterns of influence (Goverde et al., 2000; Hay, 2002; Lewis, 2005)
Access to resources	Resource allocation
Diffusion of innovation	Formal and Informal network links (Varda et al., 2008; Lewis, 2005)

organisations (n.b.: organisations are usually represented on forums by more than one person). Aboriginal community/organisations make up 29% and 21% of the forum members in Victoria and WA respectively.

The sample for this study included all state level forums and regional case studies (9 in Victoria and 7 in WA). In the Western Australian case study, regions included the South Metropolitan area, Kimberly, Pilbara, Goldfields and Midwest. Victorian case study regions were Barwon South West, Gippsland and Loddon Mallee, Hume and the South Metropolitan and East Metropolitan regions. Organisations rather than individuals were the unit of analysis for the study. In terms of organisational representation, the response rate was 77% in Victoria and 71% in WA. Table 2 outlines the characteristics of the sample. Each person in the sample completed an interview and a survey.

Interviews – The interviews were semi-structured with questions focusing on:

- the composition of the forum, involvement in strategic planning processes;
- the extent to which goals and values were shared amongst the members;
- particularly between Aboriginal and mainstream organisations;
- the process of decision-making; successes and
- areas for improvement as well as key learnings.

Given the open-ended nature of the questions posed, interviewees also shared information about the nature of relationships within forums. Participants taking part in the various forums represented their organisation (or local community) at the regional or sub-regional level.

Interview data was taped with the consent of interviewees. This data was transcribed and interviewees were given the option of viewing the transcription. Guaranteeing complete anonymity for interviewees was difficult as it was expected that interview data would at least be linked to a region and a jurisdiction. Quotes associated with the interviews were sent to participants for approval if they so requested or if it compromised their request for anonymity.

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

- frequency of contact (Never/We only interact on other issues; Once a year or less; Every few months; Every few weeks; Every week)
- the importance attributed to the relationship (Not at all; A small amount; A fair amount; A great deal)

Organisational links were coded into four groups:

1. from Aboriginal organisation to Aboriginal organisation
2. from Aboriginal organisation to mainstream organisation
3. from mainstream organisation to Aboriginal organisation and
4. from mainstream organisation to mainstream organisation.

The survey also asked organisations about their satisfaction with the governance processes they were involved in (Not at all satisfied; Somewhat satisfied; Satisfied; Completely satisfied). This was recoded into a dichotomous variable (Not at all satisfied/Somewhat satisfied and Satisfied/Completely satisfied). Organisations were also asked about the perceived likelihood that the plans developed would be successfully implemented (Very unlikely; Unlikely; Likely; Very likely; Don't know). This was also recoded into a dichotomous variable (Very unlikely/Unlikely/Don't know and Likely/Very likely).

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

5.2. Health service data

The uptake of Aboriginal health assessments was used as an indicator for changes in access to health services. Aboriginal health assessments help ensure that Aboriginal people receive primary health care matched to their needs, by encouraging early detection, diagnosis and intervention for common and treatable conditions that cause high morbidity and early mortality. Aboriginal health assessments were selected as outcome measures for a number of reasons. There is longstanding disparity in the uptake of health assessments for Aboriginal Australians compared to the equivalent health assessments for other Australians (Kelaher et al., 2005; Kelaher et al., 2012). Moreover, because Aboriginal health assessments preceded the introduction of the AHNPA there is baseline data available to assess the impact of the intervention. Positive changes in uptake are likely to require the engagement of both the ACCHSs and mainstream health services and as such may be influenced by the relationships between these services.

Data on the uptake of Aboriginal health assessments by regions from July 2008 to December 2012 was obtained from Medicare Australia. The study population was 83190 in 2008/9, 856986 in 2009/10, 88256 in 2010/11 and 90903 in 2011/12. The AHNPA implementation period spanned the period July 2010 to December 2012. It should be noted that actual AHNPA activity commenced in May 2010, so an allowance is made for the gap between the official commencement of the program and actual service implementation.

5.3. Analysis

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

- examine the participation of Aboriginal community/organisations in planning;
- identify key relationships between participating organisations;
- identify the extent to which key values are shared;

Table 2
Breakdown of participants in terms of state remoteness and Aboriginality of organisation.

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

- understand the role of these organisations in relation to planning processes.

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

Logistic regression was used to examine the relationship between the representation of Aboriginal community/organisations on the forums and satisfaction with the process and the perceived likelihood that the planned project would be implemented.

Logistic regression was used to examine the relationships between organisations within forums using the survey data and the regional uptake of Aboriginal health assessments. The independent variables included time (before (ref) and after the AHNPA), state (Victoria (ref), Western Australia), percentage of the forum comprised of Aboriginal organisation representatives, percentage of the forum comprised from the Aboriginal community and links between Aboriginal and mainstream organisations. Two analyses were conducted to examine interorganizational networks based on frequency organisations worked together and the importance they placed on each relationship. The analyses controlled for remoteness (major cities, inner and outer regional, remote and very remote).

6. Results

The implementation of the AHNPA was greeted with a great deal of energy and enthusiasm. The AHNPA provided access to resources that were not previously available. The regional forums provided an opportunity for engagement that was not funded prior to this initiative. Almost all participants agreed that the introduction of the regional forums, while imperfect, created a platform for consolidated activity to improve Aboriginal health. The forums provided a valued opportunity for mainstream and Aboriginal organisations to work together in a way that facilitated greater collaboration and integration to achieve better health.

6.1. Engagement in each planning and governance stage

The forums were mindful of the need to engage Aboriginal community/organisations in all phases of planning and planning and governance. For many participants this was a key strength of the forums:

"[They allow participants to] ... share good stories and good lessons, and also to explore avenues for collaborative partnerships."

(ACCHS representative)

"I think the process of having to plan together and then having to implement together is actually strengthening the forums ... I think it also gives the forums a vehicle to have dialogue with both the Commonwealth and the State in a productive way rather than in a, you know, 'bang your fist on the table way' which used to be the old way of doing things."

(ACCHS representative)

"... any point at which we've made decisions about allocation of resources or identification priorities, [any] way in which we're going to work, we've always made sure that there has been good representation of Aboriginal people in that process and that therefore any concerns, issues that they may have about the approach have been incorporated."

(Mainstream service representative)

This was supported by quantitative data which suggested that the odds of being satisfied/very satisfied/completely satisfied with the

forum process increased with the percentage of Aboriginal organisations involved in the forums once jurisdiction and remoteness were controlled for (OR = 1.04, 1.01–1.08, $p = 0.017$). There was no association between the percentage of community members involved in the forums and satisfaction (OR = 0.97, 0.93–1.0, $p = 0.05$).

There was also evidence that where the processes were not inclusive this negatively affected the functioning of the forums. For example, the timelines for planning were very tight because of a rush to implementation imposed by the conditions of the AHNPA. Smaller or more isolated Aboriginal organisations often lacked the resources to engage fully in planning under such time constraints. Larger Aboriginal organisations were under similar time pressures and, as a result, were often not in a position to offer assistance. In most cases, a subset of forum members made the selection of projects to be included in the plans. There was often no formal process for determining members of the selection committee, although State health departments, mainstream health providers and ACCHSs were almost always included. Consequently, in some forums the larger and therefore more powerful Aboriginal organisations had greater access to resources associated with the AHNPA due to their involvement in selection, service capacity and ability to submit funding proposals. Some smaller Aboriginal organisations therefore felt marginalised by the process.

6.2. Equal participation

The forums privileged the views of Aboriginal organisations through their procedures such as having representatives for ACCHSs chair the meetings. Ensuring Aboriginal engagement in decision-making was a key value of regional forums process. It was considered necessary for a valid process by both Aboriginal and mainstream participants. According to the interviews this was achieved by valuing and listening to Aboriginal perspectives:

"... about being inclusive and having that procedural fairness and getting the feedback and getting people locally to develop ideas, it's all about empowering."

(Mainstream service representative)

"... we didn't want too much interference from non-Indigenous organisations. We'll work in partnership alongside them, but we didn't want ... them saying 'You've got to do this, you've got to do that.' They have to ask us what we want. They had to consult with us before following, going ahead with what they have to do."

(Community representative)

"... the bureaucrats are actively listening to us and taking on board what we're saying, that we're not just like letting them push us around. We made that clear that it's not what they wanted, it's what the community needs are important."

(Community representative)

6.3. Autonomy

There were few direct issues around autonomy within the forums. However the lure of additional funding did create competition between organisations and in some cases contributed to organisations focussing on their own needs rather than the health needs of the population. It was initially anticipated that competition would primarily be between the mainstream and Aboriginal organisations. However, competition between Aboriginal organisations was found to be a significant issue.

"I think some of the things that hinder [the process is when] sometimes ... the funding is competitive, and it forces people to be

Table 3
Frequency of working together and importance of relationship on changes in health assessments over time.

	Model 1	Model 2
	Frequency of working	Importance of the relationship
	R ² = 20.9	R ² = 21.5
	OR 95%CI ^a	OR 95%CI ^a
After IHNPA vs before	9.42, 7.23–12.27	8.41, 6.74–10.5
% Aboriginal organisations	1.68, 1.54–1.83	0.6, 0.55–0.66
% Aboriginal community reps.	3.06, 2.86–3.27	2.01, 1.86–2.17
% Aboriginal organisations by IHNPA	0.75, 0.68–0.84	0.42, 0.38–0.47
% Aboriginal representatives by IHNPA	0.77, 0.72–0.82	1.26, 1.19–1.34
Links Aboriginal and Aboriginal org.	0.2, 0.18–0.22	0.42, 0.4–0.44
Links Aboriginal and Mainstream org.	2.55, 2.41–2.69	2.18, 2.07–2.29
Links Mainstream and Aboriginal org.	0.15, 0.12–0.17	0.93, 0.77–1.12
Links Mainstream and Mainstream org.	25.99, 20.4–33.11	3.57, 2.95–4.31
Links Aboriginal and Aboriginal org. by IHNPA	1.68, 1.52–1.85	1.12, 1.06–1.17
Links Aboriginal and Mainstream org. by IHNPA	0.52, 0.48–0.55	0.88, 0.84–0.93
Links Mainstream and Aboriginal org. by IHNPA	2.71, 2.23–3.29	8.86, 7.29–10.78
Links Mainstream and Mainstream org. by IHNPA	0.32, 0.24–0.42	0.1, 0.08–0.12

^a Controlling for state and remoteness.

adversarial, competitive where personalities are ... lacking—it's not lacking respect but combative because of wanting, seeking, the sole custody and sole service rights to a group.

(Mainstream service representative)

“Competition squabbles around who ... would be best placed to deliver services, who should be delivering service, People saying they can do everything and they can't really demonstrate competencies for them doing everything. And therefore the service on the ground wouldn't be what it should be.”

(Mainstream Service representative)

The competition was not a consequence of the forums but rather a consequence of the funding model associated with the ANHPA. The forums did however provide an environment where these tensions could be played out. While this did make participants uncomfortable it enabled interorganisational tensions to be discussed and, in some cases, resolved in a transparent way.

Overall, the regional forums provided an opportunity for greater incorporation of Aboriginal community/organisations in the planning and governance of programs to improve the health of their community. However, the influence of these forums on improving access to health services is likely to contingent on how these forums influence the networks formed between organisations.

6.4. Interorganisational networks and Aboriginal health assessment uptake

The percentage of the population receiving health assessments annually was 8.4% pre-AHNPA and 10.8% after the AHNPA. However, this varied substantially with some regions having an assessment rate of 1.1% pre-AHNPA and others having a baseline rate of 12.9%. Some regions decreased slightly in the post-AHNPA period, while others showed increases up to around 8.0%.

Table 3 shows the relationship between Aboriginal representation and links between organisations and changes in the uptake of the Aboriginal health assessment before and after the AHNPA. If either the representation of Aboriginal community/organisations or the links between organisations influenced the effectiveness of the AHNPA then there would be expected to be a significant interaction between these variables and the AHNPA effect.

Model 1 (Table 3) shows the analysis for the frequency of contact network. The level of representation from Aboriginal community members and Aboriginal organisations was positively associated

with the uptake of Aboriginal health assessments overall. Neither of the representation variables interacted with the AHNPA effect. This suggests that the level of representation Aboriginal community members and Aboriginal organisations on forums did not influence the effectiveness of the AHNPA in increasing uptake of health assessments.

There was a higher uptake of Aboriginal health assessments overall in regions where Aboriginal organisations worked more frequently with mainstream organisations and where mainstream organisations worked more frequently with each other. A higher frequency of Aboriginal organisations working with each other and mainstream organisations working with Aboriginal organisations was associated with lower uptake of health assessments overall.

Changes in the uptake of health assessments before and after AHNPA significantly interacted with the frequency of organisations working together. There were greater improvements in the uptake of health assessments in regions where Aboriginal organisations worked with each other and mainstream worked with Aboriginal organisations more frequently. Changes in the uptake of health assessments in response to the AHNPA decreased as the frequency of working together on the remaining link types increased.

Model 2 (Table 3) includes the analysis for the importance of the relationships network. The representation of Aboriginal organisations was not associated with Aboriginal health assessment uptake, nor did it interact with the AHNPA effect. Representation from community members was positively associated with the uptake of health assessments overall and was also associated with increased improvements in the uptake of health assessments following the introduction of the AHNPA.

The importance Aboriginal organisations attached to working with mainstream organisations and that mainstream organisations placed on working with each other was associated with higher uptake of Aboriginal health assessments overall. Higher ratings for the importance of Aboriginal organisations working with each other and mainstream organisations working Aboriginal organisations was associated with lower uptake of health assessments overall.

Changes in the uptake of health assessments before and after the AHNPA significantly interacted with the importance links between organisations. There was an increase in uptake of health assessments in regions where the importance of Aboriginal organisations working with other Aboriginal organisations and the importance of mainstream organisations working with Aboriginal organisations was higher. Changes in the uptake of health assessments post-AHNPA decreased as scores on the remaining links increased.

7. Discussion

The implementation of the AHNPA met many of the criteria that are hypothesised to be associated with increased equity (Ryfe, 2005). The initiative was associated with both an increase in funding and increase in local control through the engagement of regional forums in planning, governance and implementation of the initiatives (Nelson and Wright, 1995). This provided a forum for the involvement of Aboriginal community members and organisations.

The implementation of the AHNPA was associated with a significant shift in power from central government to regional forums comprised of local health service providers and community groups. The results showed that the interorganisational networks formed in the context of these forums influenced improvements in access to health services as a result of the AHNPA. The links that were associated with improving uptake were those from mainstream organisations to Aboriginal organisations and those between Aboriginal organisations. The findings add further support to evidence that suggests that the incorporation of minority groups into governance is an important strategy in improving health equity.

7.1. Incorporating Aboriginal community and organisations in regional governance for the AHNPA

Most regional forums created an environment where there was appropriate engagement of Aboriginal community/organisations in each phase of planning and governance and where participants were able to engage equally in governance processes. These are critical features that support meaningful participation in governance processes (Bishop and Davis, 2002; Painter, 1992; Shand and Arnberg, 1996; Thomas, 1990).

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

The major constraint to equal participation in governance was caused by a political imperative to rush to implementation. This caused a collapsing of the timelines for the development of project proposals and the selection of these proposals for inclusion in plans. Larger organisations were more likely than smaller organisations to have the resources to prepare proposals, whereas community members were reliant on others to write proposals. The legitimacy of the process was compromised by the fact that the selection of final plans was made by a subset of seemingly more powerful forum members with no clear mandate. This violation of the conditions of equality, although not catastrophic, hampered the ability of some forums to cohesively work together.

While there were limited barriers to participant autonomy, there were some concerns that organisational interests were put before the best interests of the Aboriginal population in some cases. Participants universally saw competition between the forums as negative. These concerns tended to fall into two major categories. First, there were concerns that competition adversely affected relationships within the forums. Second, there were concerns that the best services did not always win in competitive processes. Creating an environment where health services compete to provide services to groups they formerly eschewed may have benefits in terms of equity of access to health services if they are actually delivered. On the other hand, such an environment could also be an

impediment to working together to make the best collective decisions. The relative influence of these two factors should be disentangled in future research about governance and health equity.

7.2. Interorganisational networks and Aboriginal health assessment uptake

The study provides empirical support for the idea that the participation of disadvantaged populations in governance plays an important role in improving health equity. This is an important finding given that there is little existing evidence demonstrating the effectiveness of governance in primary health care (Phillips et al., 2010).

Interorganisational networks formed in the context of regional forums were associated with improved uptake of Aboriginal health assessments. As hypothesised, the links between mainstream and Aboriginal organisations were critical to determining the impacts of the forum on the uptake of health assessments. However, an unanticipated finding from this data indicates was that the relationships between the Aboriginal organisations themselves are also important and may be an important factor in reducing competition. Both the qualitative and quantitative data suggest that forums might be most effective in reducing health disparities when they privilege the relationships with Aboriginal community and organisations, and when mainstream organisations develop partnerships with Aboriginal organisations. The analysis of the importance of networks also showed that the representation of Aboriginal community was also associated with greater improvements in uptake of health assessments.

The study also suggested that the level of representation of Aboriginal organisations and community members on forums and links from Aboriginal organisations to mainstream organisations and between mainstream organisations were associated with higher uptake of health assessments overall.

Taken together, the data suggests that regional forums reflected a genuine shift in power from State government to the Aboriginal organisations and community members who participated. For Aboriginal organisations, the welfare of Aboriginal people has always been their core business. For most mainstream organisations, however, explicitly considering how to provide better quality of care to Aboriginal people has only recently been on their agenda (Kelaher et al., 2012). The data suggests that where mainstream organisations worked frequently with Aboriginal organisations and saw these relationships as important, positive results ensued.

The analyses focusing on the frequency of working together and the importance of relationships suggested that not only are links between mainstream and Aboriginal organisations important but also those between Aboriginal organisations. The qualitative data suggested that the success of both types of relationships were pivotal in the success of the forums. In the context of the current health reform there has been much emphasis on the need for mainstream organisations to improve the way they work with Aboriginal community and organisations (Kelaher et al., 2012). Our data suggests that there would also be benefit in investing in developing better ways for Aboriginal organisations to work with each other.

7.3. Limitations

In this paper we have successfully made a prima facie case for the role of governance and associated social processes in having a role in improving health equity. In doing so, we have simplified some very complex social processes. The analysis has focused on the links themselves rather than network indices. While there is value in this generalised approach, it should be considered a

complement to, rather than an alternative for detailed network analysis of the forums (e.g., statistical models for social networks).

The study uses changes in health service uptake as an indicator of health equity. The study will be extended to examine a range of outcome related data as these become available. This study examines regional governance in the context of a national policy initiative that precluded both experimental and quasi-experimental designs. However, variation in the performance of different regional forums has been used as a way to better understand the role of governance in health equity.

8. Conclusion

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

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