PART A – Detailed Summary

1. THE DOCUMENTS

For Western Australia (WA) the Department of Health’s Senior Policy Officer in Population Health Policy Branch and the Manager of Federal Affairs Branch together recommended ten government documents that had been guiding the Department’s strategic directions between 2000 and mid-2006. Also recommended were the Healthways Strategic Plan (Health Promotion Foundation) and the Western Australian Aboriginal Health Strategy (WA Joint Planning Forum on Aboriginal Health).

The Report of the Health Reform Committee (2004) [The Reid Report] resulted from a review commissioned by the WA Department of Health in 2003 to develop a new vision for the WA health system to meet changing needs to 2020. These were identified as including an ageing population, widening gaps in health status between “the wealthy and the poor, and between the Aboriginal and non-Aboriginal population”, and increasing difficulty in funding the escalating costs of health care systems. The Review Committee made 86 recommendations for improvement (strategies and initiatives), of which 85 were endorsed by the WA government. Following an interim document entitled Strategic Directions 2005, the WA Health Strategic Intent 2005-2010 document was written to outline key intentions and commitments to “deliver Healthy WA” up to 2010 and says that it was developed as a result of the Health Reform process.
Other documents target specific health issues or health groups. *Eat Well Be Active: A Strategic Framework for Public Health Nutrition & Physical Activity 2004-2010* (2004) was written to provide a framework for action and sets out the strategic vision for “a society where a healthy lifestyle is an easy choice for all”. *Healthy Lifestyles. A Strategic Framework for the Primary Prevention of Diabetes and Cardiovascular Disease in Western Australia 2002-2007* (2002) was written to provide a vision to 2007 and “to facilitate a more coordinated and strategic approach to the development and implementation of strategies and interventions to prevent type 2 diabetes and cardiovascular disease” in WA. It says it was developed in line with other policies and plans at international, national and state levels, including the WHO non-communicable diseases strategy and the National Health Priority Areas. Other issue or group specific documents recommended for analysis were the Early Years Strategy and Children First Strategy, and the Drug & Alcohol Strategy 2005-09 and the Alcohol Plan.

Two WA documents specifically address issues relating to immigrant and refugee groups. The Language Services in Health Care Policy Guidelines (1998 update) was written to encourage all WA public health sector service providers to recognise the need for professional and appropriate language assistance when communicating on health matters with non-English speaking patients. The Policy Framework for Substantive was written by the Substantive Equality Unit (Equal Opportunity Commission) to express the principles of the WA Charter of Multiculturalism for the whole-of-government. It aims to create an “inclusive and harmonious WA” where everyone is treated equitably and fairly.

Two non-Health Department documents were also recommended: the Healthway Strategic Plan 2004-07 and the Western Australian Aboriginal Health Strategy (WAAHS). The latter is one of the oldest documents recommended, having been published in 2000. The Healthway Plan was written to set the direction for the Health Promotion Foundation for three years and to build on past success, and WAAHS was developed by a Joint Planning Forum to oversee implementation of the national Framework Agreement on Aboriginal Health. This document provides a vision for a shared agenda and long-term strategic approach to improve Aboriginal health and guide health resource decision-making and regional planning.

2. **PROCESS, DEVELOPERS, STAKEHOLDERS**

Some documents appear to have been developed solely by the Department of Health, while others are based on what is said to be “extensive consultation” with “the community”, key stakeholders, and other government and non-government organizations.

The Review of the Health System which is reported in *The Reid Report* was carried out by the Health Reform Committee over 12 months. The committee says it “consulted fully” with “the community” and key stakeholders through accepting over 500 public submissions, conducting consultations with clinical groups and other stakeholders, and engaging the Health Consumers Council to “consult with the community”. The Health Reform Implementation Taskforce (HRIT) was established to implement 85 of the Review’s 86 recommendations. Based on these, the Department of Health has coordinated its activities into six priority areas which include Healthy Communities, Healthy Resources and Healthy Leadership.

*Strategic Intent 2005-2010* was developed following the interim document Strategic Directions 2005 which built on the vision provided by the Reid Report and its initial implementation through the Health Reform Implementation Taskforce. However, Strategic Intent says its six priority areas were identified by the State Executive Team in December 2004, and the document does not make any clear reference to the Reid Report’s recommendations in relation to reducing health inequities, to the Report’s section on Equity in Health and Health Care, or to the need identified in the report to clearly target health-disadvantaged groups (apart from Aboriginal people).

*The Language Services Policy* appears to have been written as an internal Department of Health document. There is no literature evidence provided to support the rationale. *The Substantive Equality Framework* was developed by an Anti-Racism Steering Committee established by the Premier in 2001.
on an election promise. The committee comprised representatives from community groups, professional bodies and the public sector to oversee the development of an Anti-Racism Strategy, of which the Substantive Equality Framework forms a part.

**Eat Well Be Active** was written by the WA Department of Health to fit with the national *Eat Well Australia 2000-2010* agenda, the *National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan* and *Be Active Australia*. The *Diabetes and Cardiovascular Disease Framework* says it was informed by a literature review, key informant interviews, and a series of focus group discussions with stakeholders to determine current actions and visions and explore ways to move towards a best practice approach.

**The Healthway Strategic Plan** was developed following a review of achievements over the previous Plan period, an independent “Review of Healthway’s Health Priorities” by the School of Population Health at The University of WA, consultations and workshops with the Healthway team, Board and Committee members, and “extensive open consultation” with key representatives from various stakeholder groups. A Strategic Planning forum involving over 200 community representatives from metropolitan and regional areas canvassed opinions about important health issues and trends, key areas for health promotion, and the degree to which these should be prioritized. The **WA Aboriginal Health Strategy** was developed by a Joint Planning Forum comprising representation from the WA Aboriginal Community Controlled Health Organisation, the ATSI Commission, the Commonwealth Department of Health & Aged Care, and the WA Health Department. The Strategy was based on the work of six regional health planning teams plus Aboriginal community expertise and input.

### 3. VALUES, DEFINITIONS & LANGUAGE

Most of the WA documents exhibit a commitment to improve health for all as well as working for equitable and fair treatment and access to health services. However, while some documents talk of the need to address the social determinants of health, WA has only patchy acknowledgement of the need to address health inequities and improve equity of health outcomes. This is despite the Reid Report including “reduce inequities in health status” as the second point in its first of 86 recommendations. Priorities that focus on improving health for disadvantaged groups and areas are mentioned in some Department of health documents (e.g. the Eat Well Strategy), but they are most clearly evident in the non-Departmental documents - The Healthway Strategic Plan and the Aboriginal Health Strategy.

**The Reid Report** notes the substantial and widening gap in health status and health access between “the wealthy and the poor, and the Aboriginal and non-Aboriginal population”. It contains a whole section about Equity in Health & Health Care which notes that the greatest disparity and worse health outcomes are experienced by Aboriginal people, those with mental health problems, and those of lower socio-economic status. In particular it notes the “appalling” state of Aboriginal health and access to health services, and the fact that gap between Aboriginal and non-Aboriginal health has continued to widen over the past 25 years despite knowledge of its existence and “despite the fact that priority is claimed to have been given to Aboriginal health”. The second point of the first of its 86 recommendations is to “reduce inequities in health status”. It recommends that the Department of Health should have statements to describe its Vision, Values and Mission which include “emphasis on improving the health status of our indigenous, rural and remote, and disadvantaged populations”, and that its Values should include “ethical behaviour, equity and justice”. The Report also recommended that a primary health care plan be developed (recommendation 15) but this has so far not eventuated.

**Strategic Intent** focuses on key components of the health care system such as hospitals and health workforce. Within it talks of increasing the focus on the promotion of health and wellbeing through an awareness of the social determinants of health. It also includes “healthy communities” as a key component and states that a key rationale of the reform in WA’s public health system includes delivering equitable health care services. However, there is otherwise little use of health inequities language and although the key strategies are said to stem from Reid Report recommendations, the document makes no mention of health differences between groups or areas, and no explicit intention to “reduce inequities in health status” for any of the disadvantaged groups mentioned in other documents, (except for Aboriginal
people). Instead, the focus is on improving health infrastructure. Within “Healthy Hospitals” there is an intention to improve access to health and hospital services based on population needs and to develop new models of facilities which better fit the needs of individual communities. However, there is no mention in relation to this of developing population profiles to determine such needs (which nevertheless are discussed as appropriate tools in the Department of Premier & Cabinet documents Substantive Equality and Children First). Under “Healthy Partnerships” there is a commitment to establishing rural/metropolitan links which improve access to services for rural and remote communities.

**Eat Well Be Active** explicitly highlights the social determinants of health and mentions the influence on health of living and working conditions, access to food and essential services. It also mentions economic, cultural and environmental factors and sees nutrition and physical activity as additional basic determinants of good health. It contains specific objectives to improve health for Aboriginal and remote populations, to make food accessible and affordable for “vulnerable groups”, and to improve access to physical activities (including for people with a disability).

The Diabetes and Cardiovascular Disease Framework’s Vision for 2007 does not mention “health equity” but includes a vision that “programs and activities are relevant and accessible to everyone”. Of all WA Department of Health documents (except for the Reid Report) this Framework has the most clear goal which implicitly aims to reduce health inequities, which is “to reduce disparities (including differences that occur by socioeconomic status, gender, ethnicity and location) among different segments of the Western Australian population with regard to the risk factors and health outcomes identified in this framework” (although it does not specify how such a reductions would be measured). The document talks explicitly and implicitly about the social determinants of health in highlighting that risk factors are linked with the “broader socio-economic determinants of health and quality of life, particularly education and employment”. However, in discussing a need to take a risk factor approach to addressing the burden of disease, this document implies that diabetes and cardiovascular disease are equally distributed and does not mention any data to show that certain sub-groups carry a heavier burden. It does however acknowledge the need to target improvements in Aboriginal health.

**Language Services in Health Care** aims to provide improved health outcomes for non-English speaking clients of the public health care system by improving language communication with health care providers. Its rationale for such action is that “social justice requires” that this group has “access to the same high quality health services enjoyed by the rest of the population” and that cultural and linguistic differences and knowledge of available health services affect health status. **Substantive Equality** was developed “to express the principles espoused in the WA Charter of Multiculturalism” and focuses on reducing racist harassment, racial vilification and incitement to racial hatred, rather than on socio-economic equity or health equity. It defines “substantive equality” as involving “achieving equitable outcomes as well as equal opportunity”, and says it recognises that “rights, entitlements, opportunities and access are not equally distributed throughout society”. The **Drug & Alcohol Strategy** says it is consistent with the National Drug Strategy which foregrounds a focus on supply reduction, demand reduction and harm reduction. It does mention the need to focus on some “priority target groups” and in relation to prevention the need to include mechanisms to develop community inclusion, safe environments and physical environments that decrease drug problems.

The **Healthway Strategic Plan** provides the most obvious and explicit commitment to address social determinants of health, reduce health inequalities and target disadvantaged groups in WA, perhaps because the Plan’s development process included widespread consultation and an independent review of its “Health Priorities” by university academics in Population Health. From the start this document acknowledges “increasing evidence concerning the need to address health inequalities and the effects of disadvantage on the health of various population groups”. Its key principles include “continue to focus on key settings and population groups where health inequalities exist”, defined as including workplaces, educational institutions and communities, and groups such as young people, children and families, Indigenous people, and groups or communities who experience social inequality. The **Aboriginal Health Strategy** also talks about health inequities and social determinants of health, albeit mainly implicitly, when mentioning that “level of ill health among Aboriginal people in WA remains unacceptably high” and that low income, unemployment, limited education, etc are “social problems which are reflected in
health”. The document talks of “inequalities in health status” as requiring an intersectoral approach, and mentions that in funding and policy “more public resources require devotion to disadvantaged people”.

**Who is responsible for health equity?**

The Health Review Committee noted the increasing discussion at the wider level on the social determinants of health and the importance of these being seen as the responsibility of the broader system and community, not just of health departments. However, the Review allocated the Deputy Director General of Health responsibility for ensuring that “a strong policy and planning framework underpins the delivery of health services and resource allocation at all levels”. This could be construed as including responsibility for equity of allocation and health equity action bit it is not explicitly stated. The Review allocated responsibility to the Department of Health’s Population Health Division for maintenance and improvement of the population’s health, including policy, planning, resource allocation, program evaluation and quality assurance. (However, it should be noted that both of these positions/divisions which were allocated responsibility no longer exist in 2006). The WA Department of Health would acknowledge a responsibility for taking leadership in reducing health inequities if it were to enact the Health Review recommendation to emphasise in its Vision and Mission the values of “equity and justice” and an aim for health improvement for “indigenous, rural and remote, and disadvantaged populations”, and to explicitly highlight these in strategic documents and funded initiatives.

4. **HEALTH OUTCOMES AND HEALTH ACCESS**

Most WA documents aim to improve the health of the whole population, but also talk of the need to target those with poorer health (particularly the Aboriginal population). There is also a stated aim to distribute health resources more equitably. The Reid Report specifically recommends that Aboriginal health be addressed as a high priority, with an increased focus on health promotion, improved “interface” between GPs and the public health system, enhanced community-based aged care, preventative care for hospital avoidance, and the establishment of mental health and Aboriginal health services. The main strategy in the Strategic Directions/Intent documents relevant to health equity is on the “major health challenge” of improving Aboriginal health by developing culturally appropriate health service delivery. There is no other explicit mention of reducing health inequities and Strategic Intent focuses predominantly on improving the health system (“healthier” hospitals, workforce, partnerships, resources, and leadership), and on establishing rural/metropolitan links which “improve access for rural and remote communities”. Otherwise Strategic Intent has only one intention under “Healthy Communities” to improve equitable and accessible health services”, and no explicit focus on improving health outcomes for non-Aboriginal groups.

Substantive Equality includes a commitment for service delivery to consider the needs of minority groups. It states that objectives for service delivery will be “based on needs assessment and consultation”, and that action plans have been implemented. However, targets and objectives that are “specific, measurable, realistic and timetabled” and supported by resources, were yet to be defined. It aimed specifically to “develop actions for policies, practices or procedures that have been assessed as having an adverse impact on different Indigenous and ethnic groups”, and to “take steps to reach different groups who are underrepresented in services provision”.

Eat Well Be Active defines various contexts for action which include building healthy public policy, creating supportive environments, and strengthening community action. Its focus is on managing the factors that foster good health for the whole population, rather than managing illness or disease. Where there are “issues for specific populations” it will target the group but “keeping in balance with the population focus”. The aims addressing child and maternal health through improved activity and nutrition include one aim which implicitly targets lower socio-economic groups by designating “women at risk of delivering low birth weight babies” as one specific target amongst others. Two “Health Gain Areas” to improve nutrition and physical activity specifically target “Aboriginal communities and Aboriginal children” and “vulnerable groups” (which includes “older people” and “people with disabilities”). Whilst there are no targets to enable improvement to be measured, some general health indicators are mentioned
for WA or Australia against which general change might be measured (eg “Only 55% of WA adults were sufficiently active to gain health benefit in 2002”).

The Diabetes and Cardiovascular Disease Framework takes a population approach and cites evidence that small changes in the whole population produce much greater community benefits than large changes in a small number of high risk individuals. However, whilst it therefore aims to support social and physical environments so that healthier choices are easier choices for individuals, it says that this does not exclude consideration of the needs of different populations or the provision of intensive interventions for high risk groups such as ATSI people. It also recognizes that such groups may require different strategies and approaches.

The Healthway Plan aims to improve the health of all through health promotion which addresses priority issues in the prevention of ill health, addresses risk factors for poor health, addresses social and environmental determinants of health, and targets priority populations. This includes “economically, socially or educationally disadvantaged groups”, young people and children, Indigenous people, rural and remote communities and other disadvantaged groups or groups in whom inequalities exist. The Aboriginal Health Strategy says that state and Commonwealth governments and the Aboriginal Community have a partnership agreement to achieve equitable health outcomes for Aboriginal people. The Strategy aims “to secure the greatest possible improvement in the health and wellbeing of Aboriginal Western Australian” by improving the health system so that it delivers services in a manner that allows Aboriginal people to have the opportunity to attain their full health potential and engages them in informed decision-making, encourages individual responsibility for health, provides adequate and appropriate finances and resources, and reflects cultural and health needs. It notes that improving physical access is particularly important because two thirds of the WA Aboriginal population live in rural and remote areas.

5. STRATEGIES FOR ACTION: HEALTH

WA has no specific plan to explicitly address health inequities. However, The Reid Report does recommend that strategies should be developed to “reduce health inequities” and the strategies or objectives in some WA documents do target interventions to “vulnerable groups” or groups with poorer health status, either specifically or as part of general population approaches. In particular these groups are identified as including women, Aboriginal people, older people, people with disabilities, children, and people living in rural and remote areas. The second of the Report’s 86 recommendations was that a major, coordinated and long-term health promotion program should target the major chronic diseases, with a particular focus on Aboriginal communities.

Strategic Intent talks neither explicitly nor implicitly of specific plans to reduce health inequities because it is a strategic document. Whilst it does mention the Aboriginal population as a disadvantaged group, it does mention any other disadvantaged groups, such as the homeless, refugees or those on low incomes. This is despite the Substantive Equality Framework saying that service delivery should consider the needs of minority groups so that they do not “miss out” when services are designed only for the majority group. Strategic Intent does mention that a statewide Clinical Services Plan should be developed based on “population needs” but provides no detail on this.

Eat Well Be Active has broad objectives but no specific plans around health equity. The Diabetes and Cardiovascular Disease Framework names only general interventions to address the “disparities in risk status and health outcomes” that it mentions. For example, in encouraging healthier lifestyles and preventative care, it has an action to “ensure that all women have access to community-based, appropriate and effective antenatal programs”, rather than targeting women in groups with poorer maternal and infant health outcomes. Some stated priority is given to the Aboriginal population. The Drug & Alcohol Strategy says it provides a basis for the development of Drug & Alcohol Action Plans by government agencies who are members of the Drug and Alcohol Office Senior Officers’ Group. These plans are to provide a framework for activity addressing alcohol and other drug problems and will specify target populations where appropriate for each activity or program. A priority area for action is to undertake initiatives that develop the knowledge, attitudes and skills of the community to prevent, delay and reduce
alcohol and other drug-related problems, and particularly for priority groups (Aboriginal people and communities, children and young people, people from regional and remote areas, and families).

The Healthway Plan has two priorities for action: to address health determinants (social/environmental/individual) and priority populations. It specifically prioritises children, Aboriginal, rural/remote populations and “groups who are economically, socially or educationally disadvantaged” because of the overwhelming evidence linking disadvantage to poorer health outcomes and behaviours. The Plan includes key goals, strategies and indicators to “get to the right people” specifically to reduce health inequities. The Aboriginal Health Strategy was written based on the six WA Regional Aboriginal Health Plans to build a common framework for them. It therefore does not provide specific plans to address health equity but does talk of the need to increase the number of Aboriginal employees in the health system to contribute to “culturally secure” health services, to improve training and accommodation opportunities as incentives for Aboriginal people from rural and remote communities to enter the health workforce, and to improve the Patient Assisted Transport Scheme.

TARGETING CHILDREN AND REFUGEES

CHILDREN

are targeted in several WA strategies, and Strategic Intent mentions the need for a “good start to life”. The Reid Report recommended a coordinated approach to child and maternal health and WA has policies and planned actions to improve infant and maternal nutrition, and reduce overweight, especially amongst Aboriginal groups and remote populations. The Early Years Strategy is a fundamental element of the Children First Strategy launched in 2003 to invest $4 million in improving wellbeing for children under 8 years. This includes initiatives to target rural families with new babies, and an In-House Practical Support Program to improve housing management and life skills for low income families. Even where the social determinants of health are discussed, such as in relation to improving education in the Children First Strategy, this does not always target disadvantaged areas or families (except for Aboriginal students). There is however mention of a “Students at Educational Risk Strategy” which may indicate that such help is indeed being targeted, and there is intention to expand postnatal depression initiatives to Aboriginal and migrant mothers

REFUGEES

Attention to refugee health is most obvious in Substantive Equality (although this focuses mainly on reducing racism and is not directly aimed at immigrants or refugees), and in Languages in Health Care, which notes that the 16% of the WA population who do not speak English very well should have access to the same high quality health services enjoyed by the rest of the population. Substantive Equality aims to provide services in a fair manner to support a multicultural society and acknowledges that different groups have ‘differentiated needs” and require “more targeted services”. The Framework has a “substantive equality filter” to encourage public sector agencies to assess how their policies, programs and practices affect Indigenous people and ethnic minorities. The Diabetes Framework gives only passing mention to “non-English speaking” people who might require specific programs with appropriate language. Both Children First and Substantive Equality aim to produce comprehensive demographic profiles of communities to help deliver better services to ethnic families. Some WA initiatives directly target migrant groups (eg a free tuberculosis screening program for migrants) and others could be duplicated for refugee women, such as one which encourages breast screening for Aboriginal rural women. Other initiatives broadly aim to assist multicultural groups, children, youth and newly-arrived families better integrate into the community and access services. The Annual Report mentions migrants in relation to the Migrant Health Unit, which it says has improved migrant screening and treatment procedures through increased liaison with the Department of Immigration and Multicultural and Indigenous Affairs and other community and health organizations. It also mentions other “disadvantaged groups” in the Tuberculosis (TB) Control Program which it says has “continued to be highly successful in controlling he incidence of TB in WA” by providing free TB screening, prevention and treatment for recent migrants and socially disadvantaged groups considered at higher risk of the disease.
6. STRATEGIES FOR ACTION: OTHERS INVOLVED

As with most other jurisdictions, WA documents have much rhetoric about the need to work with others, take cross-sectoral approaches, and involve “the community”, in order to effectively improve health services, outcomes and access. The Reid Report recommends increased community discussion initiated by government to discuss priorities, especially in light of limited funding and unmet needs. It recommends that WA Department of Health values include commitment to engaging “the community” and in relation to the Aboriginal community recommends the development and implementation of a primary care strategy based on the informed preferences of these communities and in collaboration with the Federal office for ATSI Affairs. Some specific examples where there are strategies for action with others include in Strategic Intent which has one focus on developing strong relationships with other health care related bodies whose activities impact on health, such as Education and Environmental Health, in order to provide “innovative, cost effective and high quality health care services”. The Diabetes and Cardiovascular Disease Framework has a key objective to “address issues outside the health sector which influence healthy lifestyles” which focuses on the need for cross-sectoral collaboration, for example with Family & Children’s Services, Education, Housing, Transport, Agriculture, and Local Government. It also contains a section on “Community Action” with specified actions that include “helping communities to identify problems that impact on lifestyle and health and encourage them to identify workable solutions”, and “work with local community members to foster leadership and community empowerment”. However, there is no evidence that such collaboration is occurring or being conducted in a way which to “the community” is appropriate and effective. Other examples can be found in the Drug & Alcohol Strategy, which includes initiatives for the criminal justice and correctional services system, and in the Aboriginal Health Strategy which specifically notes that intersectoral collaboration is important to “address health inequalities” and “the underlying determinants of ill health”.

7. IMPLEMENTATION

WA shows little evidence of health plans that are resulting in concrete health improvements for disadvantaged groups. If actions are indeed occurring to improve health outcomes for disadvantaged groups and/or areas, then these could be better evidenced in key documents and reported in the Annual Report through measurable health targets and stated funding allocations. One example of a specific improvement in relation to health inequity is in the Aboriginal Health Strategy, which notes that a targeted program for Aboriginal women (“Strong Women, Strong Babies, Strong Culture”) resulted in a measurable reduction in infant low birthweight in intervention communities (20% to 11% low birthweight – closer to the national average of 6%), while there was little change in the non-intervention communities (17.4% to 16%). There is however no evidence that this initiative is being continued or expanded to other Aboriginal communities.

Many of the other documents do not report on initiatives because they are strategic documents. However, Language Services provides a language services kit and a training videotape for health staff to know how to use interpreters effectively in dealing with non-English speaking clients. Children First also reports on some existing initiatives because it builds on previous work. However no information is given to assess their impact on health. Examples include a handbook for health professionals to improve consultations with children (including refugees), a program to address alcohol and tobacco exposure during pregnancy for ATSI women, and a program for preventing postnatal stress for rural families with new babies.

The latest Annual Report (2004-05) pays little attention to highlighting health disparities for disadvantaged groups or initiatives that might be reducing these, except for the Aboriginal population (and especially on diabetes). Where health indicators are used in the Health Overview section to report on performance they are only for the whole population (eg overall decrease in lung cancer or suicide) and while such indicators are disaggregated to highlight some differences such as by sex, age and rurality, there are no indicators by health equity-related variables such as area of residence, education level or SEIFA quintile. One obvious exception is the report that Breastscreen WA “worked closely with community health nurses and indigenous health workers to facilitate block bookings for Indigenous rural women at BSWA mobile units”, although no measure is given as to how many women attended.
Otherwise, the Performance Indicators in the Annual Report focus predominantly on Service Provision rather than reporting outcomes from health improvement initiatives or reductions in health inequities.

In terms of funding to improve health equity, the Aboriginal Health Strategy says that funding has been historically submission-based and needs to change to needs-based. The Reid Report recommended that urgent attention be given to more fairly and effectively allocating the annual health budget, including the development in 2004 (and implementation in 2005-06) of a transparent and fair resource allocation formula which is population and output based, which recognises the needs of specific population groups, and which “quarantines” funds for designated services or programs such as for Aboriginal people. Strategic Intent follows this by committing to incrementally introduce a population based Resource Allocation Funding Model, and phased implementation has now commenced. The Diabetes and Cardiovascular Disease Framework highlights the need to particularly fund longer-term strategies.

8. EVALUATION

The WA Department of Health generally commits to address health disparities and improve health behaviours, outcomes and access for “vulnerable groups” in its strategic directions and objectives but there is an overall absence of health equity indicator data in departmental documents and an associated lack of reporting and evaluation of initiatives that could indicate whether this commitment is resulting in concrete change. The absence of targets may reflect the lack of data available which is disaggregated by indicators of disadvantage, or the annual report focus on service provision. Most documents note a strategy or action to improve data collection and performance evaluation, and the Reid Report specifically recommended an annual epidemiological report on health to be published by an independent “health watchdog” which was to include analysis of patient outcomes achieved by health services and particularly to highlight where health problems are avoidable or failing to improve. Such a report would hopefully include disaggregated data to inform health equity assessment, such as health indicators by education level, SEIFA quintile, country of birth, rurality, Aboriginality. This could in turn facilitate the development of health targets to allow measurement, evaluation and reporting on health outcomes and access for particular sub-groups, and on the reduction of health inequities. Indeed, the Aboriginal Health Strategy notes that one challenge is “the use of long term health indictors such as mortality rates to determine resource needs” and the need to introduce structured evaluation of programs/projects and to identify and promote successful programs. Similarly, the Children’s Strategy aims to develop a comprehensive set of indicators to monitor children’s health and wellbeing and to guide policy. The Diabetes and Cardiovascular Disease Framework also notes the need for “relevant, timely, local data” on level of exposure to risk factors and their determinants” to contribute to policy formulation, planning, advocacy and program evaluation. Data to indicate exposure would lend itself to disaggregation by the indicators of disadvantage suggested earlier. The Department of Health now has a process underway (mid-2006) to develop an extensive set of indicators to monitor health outcomes in general and also in relation to inequities, as recommended in the Reid Report. It is expected that these will be reported on in documents such as the Annual Report and Budget Statements.

Substantive Equality states that information and monitoring systems for assessing progress are to be identified, and an organizational framework is to be developed to report progress against targets. The Diabetes and Cardiovascular Disease Framework notes the need for systematic ways to provide resources to test new initiatives as well as to integrate successful interventions into existing resources. To facilitate implementation it allocates roles and timeframes for each objective and activity. It also contains a major strategy to “develop an information base for action”. Whilst this will bring together existing and new data collections, there is no mention of collecting data that will enable monitoring of changes in the current “disparities in risk factor and health outcome” between identified groups. Eat Well Be Active’s periodic review of its 6 Health Gain Areas are intended to allow assessment of the impact of strategies, and the Nutrition & Physical Activity Branch is meant to undertake research and evaluation supporting priorities and interventions. One of Healthway’s major foci is on “Finding and Using the Right Strategies” to support evidence-based health promotion, and this has some performance indicators clearly related to measuring the impact for disadvantaged groups::

Newman, Baum & Harris (2006)
- Number of projects funded and proportion of funding allocated to programs and initiatives targeting priority population groups

- Proportion of applications received which include a high priority target group

Presumably the report against such indicators will be retrospective reports as the indicators are not worded so as to measure change against even general preset benchmarks or targets.

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**PART B – Key documents used for this analysis**

Recommended via Mark Miller, Manager, Federal Affairs Branch, and Ann Blunden, Senior Policy Officer, Population Health Policy Branch, Department of Health

Department of Health Western Australia:


and related key strategies on the WA Health website which stem from recommendations in this Report, at http://www.health.wa.gov.au/about/


(2005). *Western Australian Aboriginal Alcohol & Other Drugs Plan 2005-2009*


*n.d. Western Australia’s Early Years Strategy.*

Department of Premier & Cabinet


Department of the Premier & Cabinet – Social Policy Unit. n.d. *Western Australia’s Children First Strategy*.

Healthway: WA Health Promotion Foundation


WA Joint Planning Forum on Aboriginal Health.

Western Australian Aboriginal Community Controlled Health Organisation (WAACCHO), Aboriginal and Torres Strait Islander Commission (ATSIC), Commonwealth Department of Health and Aged Care, and Health Department of Western Australia (2000). [cited 2006 July 5]. *Western Australian Aboriginal Health Strategy: A Strategic Approach to Improving the Health of Aboriginal People in Western Australia*.

Also referred to by the researchers:


Department of Health *Strategic Intent 2005-2010*. n.d.  