

A Critical History of Indigenous Eye Health Policy-Making



Towards Effective System Reform



The terms 'Aboriginal' and 'Indigenous' refer to the many different peoples and language groups who were living in Australia at the time of European settlement, including the Aboriginal peoples of the continent and later the Torres Strait Islander people. This report uses the term Indigenous except where it is appropriate to retain the terms Aboriginal and Torres Strait Islander as used in historical documents referred to in this study.

Acknowledgements

We thank the interviewees (who will remain anonymous) in this study for generously providing their time and wisdom as a contribution towards a better understanding of the policy-making process in Indigenous eye health from the time of the National Trachoma and Eye Health Program to the present. We acknowledge the funding support of the Indigenous Eye Health Unit, Melbourne School of Population Health, The University of Melbourne, and the secretarial support provided by Judith Carrigan and Judy Pryor and Rachael Ferguson. We also thank John Thompson and Roslyn Henderson for their unquestioning support.

Cover Image

Artist: Ngarralja Tommy May, DOB 1935, Language Walmajarri

Title: Wati Kujarra (Two Men)

Story: "This was my brothers country in Wangkajungka country"

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We thank the Fred Hollows Foundations for providing the photograph of their painting.

Title Page Image

Artist: Eileen Forrest (Kurputti), DOB 1969, Jubilee Downs Station, Language Walmajarri

Title: Pulkartujarti

Story: "Spider Dreaming, this story from Jumangkarni (dreamtime). These are the hills along the road to Djugerari. This hills are fenced off now. If you go there you will get bitten by the little spiders, everyone who goes there gets bitten. There are lots of different types of spiders there. Back in the Jumangkarni the spiders were a lot bigger and they hunted and killed people".

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This project was initiated in early 2009 by Professor Hugh Taylor and Professor Ian Anderson in the Melbourne School of Population Health at The University of Melbourne. The project forms part of a larger program of research on Indigenous eye health within the Indigenous Eye Health Unit of the Melbourne School of Population Health. Other projects in this research program include: The National Indigenous Eye Health Survey (Minum Barreng); The National Indigenous Eye Health Services Survey; Funding Eye Services in Remote Australia; and Improving Indigenous Eye Health by Mapping the Research Evidence to the Needs of Indigenous People.

The poor state of Indigenous eye health in Australia is well described in the literature (e.g. Taylor 1978; RACO 1980; Belleair 1985; Thomson & Merrifield 1988, pp. 185-193; Taylor 1997; Thomson & Paterson 1998; OATSIH 2001; Burns & Thomson 2003, pp. 273-289; Taylor et al 2004; AIHInfoNet 2004; Wright 2007; Atkinson et al 2008, p.553; Couzos et al 2008; Durkin 2008; Bragge et al 2009; Taylor et al 2009; AIHInfoNet 2010; Kelaher et al 2010; Taylor & Stanford 2010); in Appendix M of this report; and in the work of prominent ophthalmologists in Indigenous public health ophthalmology (Mann 1966, pp. 444-483; Mann 1983; Fiske & Johnson 1995; Hollows & Corris 1997; Allen 1994; Taylor 2008). However, there is less published literature about the historical development of Indigenous eye health policy in Australia (e.g. Belleair 1985; Taylor 1997; Taylor et al 2004; Kaplan-Myrth 2004), and the important role Indigenous people have played in this development (e.g. Jones et al 2008; Briscoe 2010).

The literature on Australian Indigenous health policy (e.g. Osborne 1982; Toussaint, 1982; Hollows 1984; NAHSWP 1989; Saggars & Gray 1991a; Anderson 1994; Anderson & Brady 1995; Anderson 1997; Brian & Smith 1999; Anderson 2001; Anderson 2002; Murray et al 2003, pp. 1-37; Anderson 2004; Griew et al 2004; Kelaher et al 2005; Anderson 2006; Aldrich et al 2007; Anderson 2007; Kaplan-Myrth 2007¹; Couzos & Murray 2008, pp. 29-73; Dugdale & Arabena 2008, pp. 148-169; Matthews et al 2008; AIHInfoNet 2008) highlights the large amount of work done in this area, the importance and complexity of the processes involved, and the weaknesses in rollout and implementation of policies. Murray et al (2003, p. 33) concluded that:

The political will and resources required to deal with the legacy of discrimination, neglect and destructive social policy remain elusive. An understanding of the health policy process and the history of Aboriginal health policy can assist Aboriginal communities, service providers, politicians and public servants to improve efforts to address inequity.²

A good case can be made that a critical history of Indigenous eye health policy-making may provide valuable insights for future debates in both eye health and Indigenous health policy-making more broadly³. These debates may include strengthening the link between policy formulation and implementation of policy directions (Matthews et al 2008), vertical (i.e. condition focused) program development compared with other models of primary health care development, community control in Indigenous health, health care financing and systems development.

¹ This book published in 2007 had its origin in her Yale University PhD thesis (Kaplan-Myrth 2003) although her thesis is not mentioned in this book.

² It is worth remembering here the comment by British physician Geoffrey Rose (1992, p. 2) that 'Doctors often act as though their professional responsibility does not go beyond the sick and the nearly sick (those at imminent risk), and politicians, who influence health more than the doctors, are rarely troubled by thoughts for the distant future.'

³ For example, Osborne (1982, pp. 66-83) includes trachoma as one of 3 examples to illustrate the necessity of redefining Indigenous health problems and re-assessing the delivery of health services.

Preface (continued)

The *National Trachoma and Eye Health Program* (NTEHP) lead by Professor Fred Hollows, his Associate Director Gordon Briscoe and Assistant Director Hugh Taylor during the period 1976-1979 was instrumental in raising broad public and political awareness of the poor health and living conditions of Indigenous Australians at that time, and in particular, their poor eye health (RACO 1980). Various key reports, programs, guidelines and policies on Indigenous eye health followed the NTEHP (e.g. Mayers 1982; TFFNTEHP 1984; Belleair 1985; NAHSWP 1989, pp. 166-168; Taylor 1997; OATSIH 2001; Taylor et al 2004; CDHA 2004a; AHMC 2005a⁴; 2005b⁴; BHC 2006; CDHA 2006a).

Much past policy-making and implementation in Indigenous health by Australian governments appears to have been ad hoc, under-funded, often compartmentalised, uncoordinated, and not based on clear evidences⁵. The purpose of this project was to prepare a critical history of Indigenous eye health policy-making from the NTEHP to the present time. We have reviewed the relevant literature and interviewed 23 individuals who have played a significant role in Indigenous eye health policy-making during this 30-year period.

⁴ These are mainstream documents, but have identified Indigenous people as a vulnerable group.

⁵ Osborne (1982, p. 3) noted 'Responsibility for Aboriginal health has shifted between federal and state authorities, charitable organisations and private enterprise medicine, without a satisfactory improvement in Aboriginal health.' Cochrane once wrote (Cochrane & Blythe 1989, p. 201) 'The methods of ophthalmologists seemed so beautifully quantitative, and there seemed so much that might be gained by the study of the aetiology and possible prevention of cataract and glaucoma.'

Trachoma is a major cause of visual impairment in Indigenous communities in Australia. It is the leading infectious cause of preventable blindness and occurs where people live in overcrowded conditions with limited access to water and health care. Trachoma is frequently passed from child-to-child and from child-to-mother within the family (WHO 2003a). Trachoma occurs in 46 countries. However, Australia is the only developed country in which it still occurs (Lansing et al 2001).

Recent analyses of the contribution of vision loss to the overall health gap between Indigenous and non-Indigenous Australians indicates that for mainstream Australians vision loss resulted in 40,000 Disability-Adjusted Life Years (DALYs) or 2.7% of the total burden of disease (Taylor & Keeffe 2005). An informal analysis using the National Indigenous Eye Health Survey suggested vision loss in Indigenous Australians causes 2% of the total Indigenous health gap in DALYS or 7% of the non-fatal component of years lost to disability (Vos, T. 2010, pers. comm.).

It was not until 1981 that the Commonwealth Government started to put any emphasis on improved environmental living conditions for Indigenous Australians. Attaining such improved conditions remains a goal in Commonwealth Government policymaking and implementation in 2010.

Most of the Indigenous eye policy development has been Commonwealth Government funded. For this reason the review has provided a detailed Commonwealth Government policy analysis (to the exclusion of State and Territory policies) in an attempt to understand the context of Indigenous eye health policy development from 1980-2010 within the complex Commonwealth health portfolio.

The review draws attention to the peaks and troughs in Indigenous eye health policy development and implementation, the characteristics of the peaks being dedicated change leaders such as Fred Hollows and Gordon Briscoe, and in more recent times international evidence-based research propounded by medical professionals and academics such as Hugh Taylor who have delivered and continue to deliver evidence-based Indigenous eye health research. The troughs have occurred during periods of mainstream and Ministerial apathy, shared departmental responsibility for Indigenous health and its location in 3 different organisations from 1984 to 1995.

Drawing on their considerable experience in Indigenous eye health a Royal Australian and New Zealand College of Ophthalmologists (RANZCO) respondent in the study considers that future policymaking requires input from individuals with a background of working in rural areas, an interest in Indigenous eye health, and having cultural awareness. Future lobbying/advocacy requires key high profile, passionate people who can communicate, and policy implementation requires a correct mix of appropriate people, and interested persons in all levels of government, with leadership and mentoring qualities.

The National Trachoma and Eye Health Program (NTEHP) funded by the Commonwealth Department of Health (CDH) and administered by the Royal Australian College of Ophthalmologists (RACO), was initiated in 1975. From 1976-1979 under Fred Hollows' strong and charismatic leadership the NTEHP examined and treated Indigenous people and non-Indigenous people throughout rural and remote Australia. The NTEHP was the first large scale epidemiological survey and example of evidence-based public health care in Australia, and found the prevalence of blindness in Indigenous people to be 15/1000 compared with 1-4/1000 for non-Indigenous people, and that trachoma was a major contributing factor in 42% of Indigenous blindness (RACO 1980; Thomson 1984). To continue the provision of eye care after the NTEHP, State-based Trachoma and Eye Health Committees were established in 1980.

Summary (continued)

In 1975 the Visiting Optometrists Scheme (VOS) was established. This was the forerunner of Commonwealth Government programs which extended health services from large cities and towns to rural and remote areas and laid the basis for future Indigenous eye health initiatives.

Commonwealth Government initiatives during the 1970s form the basis of later policy development and implementation. For example, the first Aboriginal Community Controlled Health Service (ACCHS) in Redfern Sydney in 1971 was followed by the establishment of the Commonwealth Department of Aboriginal Affairs (CDAA) in 1973 and the National Aboriginal and Islander Health Organisation (NAIHO) in 1976. The introduction of ACCHs (now numbering in excess of 140) provided a launching pad for Indigenous control and participation in health care policy, service delivery and financial support (ANAO 1998, p. 123).

The National Aboriginal Community Controlled Health Organisation's (NACCHO) replacement of NAIHO in 1992 brought widespread recognition of the national importance of ACCHs in delivering primary health care to Indigenous people. However, the goals of the ACCHSs, NACCHO and OATSIH (currently located within the Commonwealth Department of Health and Ageing) have not always coincided, resulting in conflicts in communication and coordination of policy implementation.

Although many encouraged Indigenous community control and self determination, this has not always occurred in more recent times. Modern day bureaucrat respondents in the study involved in developing Indigenous health policies indicate that improvements have been made towards greater community consultation, negotiation and feedback. Other respondents have noted that the requirement for extended community consultation periods is an issue for governments and there needs to be a shift in power between government and Indigenous people, as evidenced during the 2007 Northern Territory Emergency Response.

The NTEHP Report (RACO 1980) had far-reaching effects in bringing the poor living conditions and poor health of Indigenous Australians to the attention of the wider Australian population and the media. However the literature review and respondents' perspectives of the 1980s and part of the 1990s record instability in Indigenous eye health policymaking, a reduction in eye health funding under the Aboriginal and Torres Strait Islander Commission (ATSIC) thereby reducing community control, and competition for funding for other problem areas. The 1989 National Aboriginal Health Strategy (NAHS) considered that Indigenous community control and participation found in ACCHSs was paramount to the physical wellbeing of the individual and the social, emotional, and cultural wellbeing of the whole community. However, the 1994 evaluation report of the implementation of the NAHS found little evidence that the strategy had been adequately implemented as it was significantly under-funded.

The literature review found that eye health service delivery to much of rural and remote Australia was limited and ad hoc in the mid 1990s, although several successful models for specialist eye service delivery to rural and remote communities had been developed.

Following the Review of Indigenous Eye Health (Taylor 1997) the remaining Trachoma and Eye Health Committees of Queensland South Australia and the Northern Territory were replaced with regional eye health services. The implementation phase of the recommendations of the 1997 Review became known as the National Aboriginal and Torres Strait Islander Eye Health Program, although we could find no Commonwealth Government policy document with this title. Respondents considered the implementation was piecemeal and recalled the difficulties encountered in obtaining commitment from the States and Territories, and a certain lack of expertise in policy implementation.

Specific implementation problems were Medicare's reluctance in making a special allowance for Indigenous people, and RACO's delay in developing a financing system for ophthalmologists who would visit remote areas, critical in delivering eye health services 'on the ground'. In addition, it was found necessary to stop the \$4 million tendering process for eye equipment, a reflection of the many internal problems within OATSIH.

The release of the 1997 Review of Indigenous Eye Health, the adoption of the WHO endorsed SAFE strategy (the components of which are surgery, antibiotic treatment, facial cleanliness and environmental changes) and the launch of Vision 2020 Australia (part of a global initiative of the WHO) in 2000 heralded another period of support for treating trachoma. Some Commonwealth Public Service respondents in the study recalled their recent involvement in implementing elements of the SAFE strategy in Western Australia, Northern Territory and South Australia and the need to complete mapping exercises in Queensland and New South Wales. They commented that Indigenous eye health gains in importance when referring to eye health data, and noted that areas such as eye health have lower priority and struggle in the overall Indigenous health agenda because of so many other competing issues.

The 2000 to 2010 period was characterised by a concerted Commonwealth Government effort in Indigenous health policymaking, building upon preceding policy work. However it was apparent from the 2004 Review of the Implementation of the National Aboriginal and Torres Strait Islander Eye Health Program (see Taylor et al 2004) that successive policy documents commissioned by the Commonwealth contained similar recommendations which do not seem to be implemented.

Indigenous disadvantage was the framework for the whole-of-government approach in 2004. Resultant Indigenous eye health policymaking further refined VOS and the Medical Specialist Outreach Assistance Program (MSOAP) to ensure Indigenous people living in rural and remote areas had better access to these outreach programs. In 2005 a 'National Framework for Action to Promote Eye Health and Prevent Avoidable Blindness and Vision Loss' was developed. In 2006 'Guidelines for the public health management of trachoma in Australia' were published, a National Trachoma Surveillance and Reporting Unit was established in Melbourne, and a feasibility report of an integrated regional eye service in Central Australia and planning for a Central Australia Integrated Eye Health Program were developed.

Following the 2007 Northern Territory Emergency Response (renamed Closing the Gap: NT), six targets were identified for Closing the Gap nationally across urban, rural and remote areas with \$4.6 billion provided for Indigenous initiatives in early childhood development, health, and housing. The National Indigenous Health Equality Council was established in 2008 and a \$1.578 billion National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes commenced in 2009-10. The CDHA improved access for Indigenous people to the Medical Benefits Scheme (MBS), Pharmaceutical Benefits Schedule (PBS) and mainstream health services. There was a relative increase in CDHA spending for Indigenous health programs over the period 1997-8 to 2008-9.

The respondents in this study indicated that they had been involved in much of the associated work of these Indigenous health initiatives. In spite of the transfer from vertical (disease focused) to horizontal (comprehensive primary health care) programs in 2004 there is ongoing debate around the vertical versus horizontal model of delivery, broad-based funding in the reform agenda, and the lack of emphasis on Indigenous eye health in Closing the Gap initiatives.

Summary (continued)

The recurrent debate about policymaking and policy implementation suggests that a consistent focus on Indigenous eye health that addresses system barriers for change in the face of many competing challenges for attention in Indigenous health must be maintained. For example, a tightly focused strategy to address diabetic retinopathy can bring about broader system change because such a strategy requires properly co-ordinated eye services working with a well established and integrated primary health care centre having a chronic disease management program, improved nutrition, and patient education. Similar arguments can be mounted for a range of interventions.

There is an urgent need for a revised policy framework that balances both the horizontal and vertical aspects of health care delivery. Much Indigenous health policy is built around big “Gap” issues. Rheumatic heart disease and trachoma for example, are no longer problems in mainstream health, but are egregious examples of diseases that are morally unacceptable in their inequity because they can be relatively easily addressed in Indigenous health.

The “best buys” economic argument in policymaking favoured by Commonwealth bureaucrats where funding is allocated in Indigenous health “buckets” of resources is a false argument. Policy choices should not be made from one priority to another in Indigenous health, but comparisons made between Indigenous and non-Indigenous health issues.

There has been considerable similarity in the Indigenous eye health policies developed over the time period of our study. What is lacking are not ideas for policy but the ability to have policies implemented. The following points summarised key lessons (not necessarily in order of importance) from our findings:

- Indigenous eye health programs should be integrated in Comprehensive Primary Health Care Services;
- Indigenous eye health requires a champion(s) for lobbying and advocacy for action;
- The divide between Commonwealth, State, and Territory governments is in the context of Indigenous health;
- The attainment of improved environmental living conditions for Indigenous Australians;
- The need to reduce conflicts between ACCHSs, NACCHO and OATSIH;
- Widespread lack of expertise in policy implementation;
- More serious involvement of Indigenous communities and their organisations from the outset in health policymaking, programs and implementation;
- Suitably qualified Indigenous staff should occupy key decision making positions at the highest level in OATSIH and the CDHA;
- ACCHSs play a key role in Indigenous health policymaking, programs and implementation;
- The need to elevate the relative importance of Indigenous eye health;
- The recommendations of many reviews, reports and studies have not been implemented;
- Recognise what works and what doesn't work, and change programs accordingly;
- Proper funding for eye health programs is essential;
- There have been significant policy implementation failures for various reasons including: a very slow bureaucracy often made worse by developments having to work together; workforce issues (failures in human capital); issues in Commonwealth and State/Territory relations; capturing resources 'on the ground'; and
- Indigenous eye health policymaking and implementations should be an exemplar for Indigenous health policymaking, programs and implementation.

The following recommendations are framed around the necessity for change in organisational culture of the policymaking and implementation organisations in adopting a true commitment to diversity in Indigenous policymaking environments. This requires strong, ongoing and visible leadership in support of that change:

- Maintain a consistent focus on Indigenous eye health that addresses the system barriers for change in the face of many competing challenges for attention in Indigenous health.
- Instigate a more sophisticated policy framework in Indigenous health that simultaneously maintains a focus on system issues and develops targeted strategies for problems such as eye health.
- Treat Indigenous eye care as urgent and a priority in government(s) policymaking and so reduce occurrences of repeating neglected recommendations in successive reports.
- Develop comprehensive primary care that integrates visiting specialist services including ophthalmologists and optometrists and which have strong links to regional hospital services.
- Train Remote Area Nurses, Aboriginal Health Workers, and Rural General Practitioners working in areas where trachoma is endemic in the diagnosis and treatment of trachoma.
- Provide adequate funding and training for proper co-ordination of visiting services and the patient pathway of care.
- Develop an Information Network – a central point for an information/evidence base to be used to influence policymaking and implementation in Indigenous eye health.
- Place Aboriginal and Torres Strait Islander public servants in sufficiently high level positions in CDHA to provide leadership in organisational cultural change in Indigenous eye health policy making and implementation.
- Revitalise the National Aboriginal Health Strategy focusing on community control and the significant participation of ACCHSs addressing the physical wellbeing of the individual and the social, emotional and cultural wellbeing of communities.
- Introduce governance capacity building in communities and ACCHSs to better coordinate the delivery of Government programs.
- Train Aboriginal and Torres Strait Islander people in ophthalmology, optometry and general eye health care.

List of Abbreviations

AAAC	Australian Aboriginal Affairs Council
ABS	Australian Bureau of Statistics
ATSIC	Aboriginal and Torres Strait Islander Commission
ATSIHF	Aboriginal and Torres Strait Islander Healing Foundation
ATSIHPF	Aboriginal and Torres Strait Islander Health Performance Framework
ACCHS	Aboriginal and Torres Strait Islander Community Controlled Health Service
ADCA	Aboriginal Development Commission Act
ADC	Aboriginal Development Commission
AHDG	Aboriginal Health Development Group
AIH	Australian Institute of Health
AIHW	Australian Institute of Health and Welfare
AHW	Aboriginal Health Worker
AMS	Aboriginal Medical Service
ASSA	Academy of the Social Sciences in Australia
ACAC	Anyinginyi Congress Aboriginal Corporation
ANZSOG	Australia and New Zealand School of Government
ACT	Australian Capital Territory
AGDHA	Australian Government Department of Health and Ageing
AGPS	Australian Government Publishing Service
AHPIB	Aboriginal Health Project Information Bulletin
AHMAC	Australian Health Ministers Advisory Council
AHMC	Australian Health Ministers Conference
AHRC	Australian Human Rights Commission
AIDA	Australian Indigenous Doctors' Association
APY	Anangu Pitjantjatjara Yankunytjatjara
ASGC-RA	Australian Standard Geographical Classification-Remoteness Areas
BHC	Banscott Health Consulting
CAAC	Central Australian Aboriginal Congress
CAIEHP	Central Australia Integrated Eye Health Program
CAEPR	Centre for Aboriginal Economic Policy Research
CERA	Centre for Eye Research Australia
CHETRE	Centre for Health Equity Training, Research and Evaluation
CTGSCIHE	Close the Gap Steering Committee for Indigenous Health Equality
CDA	Commonwealth Department of Aboriginal Affairs
CDCSH	Commonwealth Department of Community Services and Health
CDEET	Commonwealth Department of Employment, Education and Training
CDFaHCSIA	Commonwealth Department of Families Housing Community Services and Indigenous Affairs
CDH	Commonwealth Department of Health
CDHA	Commonwealth Department of Health and Ageing
CDHAC	Commonwealth Department of Health and Aged Care
CDHFS	Commonwealth Department of Health and Family Services
CDHHCS	Commonwealth Department of Health, Housing and Community Services
CDHHLGCS	Commonwealth Department of Health, Housing, Local Government, and Community Services
CDHSH	Commonwealth Department of Human Services and Health
CDTC	Commonwealth Department of Transport and Construction
CDNA	Communicable Disease Network Australia
CAG	Community Advisory Group
CHIP	Community Housing Infrastructure Program
CRAH	Cooperative Research Centre for Aboriginal Health
CRCATSIH	Cooperative Research Centre for Aboriginal and Torres Strait Islander Health
CGRIS	Coordinator-General for Remote Indigenous Services
COAGRC	Council of Australian Governments Reform Council
DALY	Disability-Adjusted Life Years
EF	Eye Foundation
FACS	Family and Children's Services
FHF	Fred Hollows Foundation

List of Abbreviations (continued)

HAHU	Heads of Aboriginal and Torres Strait Islander Health Units
HealthPACT	Health Policy Advisory Committee of Technology
HRSCAA	House of Representatives Standing Committee on Aboriginal Affairs
HREOC	Human Rights and Equal Opportunity Commission
ICC	Indigenous Coordination Centre
IPAA	Institute of Public Administration Australia
ICEE	International Centre for Eye Care Education
IAPB	International Agency for the Prevention of Blindness
LI	Lowitja Institute
MBS	Medical Benefits Scheme
MSAC	Medical Services Advisory Committee
MSOAP	Medical Specialist Outreach Assistance Program
MCFFR	Ministerial Council for Federal Financial Relations
NACCHO	National Aboriginal Community Controlled Health Organisation
NAC	National Aboriginal Conference
NAIHO	National Aboriginal and Islander Health Organisation
NAHS	National Aboriginal Health Strategy
NAHS-EHP	National Aboriginal Health Strategy – Environmental Health Program
NAHSEC	National Aboriginal Health Strategy Evaluation Committee
NAHSWP	National Aboriginal Health Strategy Working Party
NATSIHA	National Aboriginal and Torres Strait Islander Health Authority
NATSIHC	National Aboriginal and Torres Strait Islander Health Council
NATSIHCP	National Aboriginal and Torres Strait Islander Eye Health Program
NACMH	National Advisory Council on Mental Health
NCEPH	National Centre for Epidemiology and Population Health
NEHDGP	National Eye Health Demonstration Grants Program
NHHRC	National Health and Hospitals Reform Commission
NHMRC	National Health and Medical Research Council
NIHEC	National Indigenous Health Equality Council
NIRA	National Indigenous Reform Agreement (Closing the Gap)
NPA	National Partnership Agreement
NSFATSIH	National Strategic Framework for Aboriginal and Torres Strait Islander Health
NTDHF	Northern Territory Department of Health and Families
NTEHC	National Trachoma and Eye Health Conference
NTEHP	National Trachoma and Eye Health Program
NTRC	National Trachoma Review Committee
NTSRU	National Trachoma Surveillance and Reporting Unit
NSW	New South Wales
NGO	Non Government Organisation
NT	Northern Territory
NTDHCS	Northern Territory Department of Health and Community Services
NTER	Northern Territory Emergency Response
n.d.	Not Dated
OATSIH	Office for Aboriginal and Torres Strait Islander Health
OATSIHS	Office for Aboriginal and Torres Strait Islander Health Services
ORH	Office of Rural Health
OAA	Optometrists Association of Australia
OA	Oxfam Australia
PAPL	Parliament of Australia Parliamentary Library
PBS	Pharmaceutical Benefits Schedule
PHAA	Public Health Association of Australia
QLD	Queensland
QTEHP	Queensland Trachoma and Eye Health Program
QTEHPC	Queensland Trachoma and Eye Health Program Committee

List of Abbreviations (continued)

RACO	Royal Australian College of Ophthalmologists
RANZCO	Royal Australian and New Zealand College of Ophthalmologists
RCIADIC	Royal Commission into Aboriginal Deaths in Custody
SES	Senior Executive Service
SRA	Shared Responsibility Agreement
SA	South Australia
SCRGSP	Steering Committee for the Review of Government Service Provision
SAFE	Surgery, Antibiotic, Face, Environment
TFFNTEHP	Task Force on the Future of the National Trachoma and Eye Health Program
TAS	Tasmania
TCC	The Cochrane Collaboration
TSHS	Torres Strait Health Strategy
TSI&NPAHC	Torres Strait Islander & Northern Peninsula Area Health Council
VIC	Victoria
VAHS	Victorian Aboriginal Health Service
VOS	Visiting Optometrist Scheme
V2020A	Vision 2020 Australia
WA	Western Australia
WHA	World Health Assembly
WHO	World Health Organisation

Timeline of Important Events

Timeline of important events/ policy making in the periods referred to by respondents in the study

1967-1968	Prime Minister John McEwen
1967	Referendum.
1968-1971	Prime Minister John Grey Gorton
1968	Commonwealth Office of Aboriginal Affairs established.
1971-1972	Prime Minister William McMahon
1971	First Community Controlled Aboriginal Medical Service at Redfern.
1972-1975	Prime Minister Edward Gough Whitlam
1973	Commonwealth Department of Aboriginal Affairs established.
1975-1983	Prime Minister John Malcolm Fraser
1975	Visiting Optometrist Scheme commenced.
1976	National Aboriginal and Islander Health Organisation established.
1976-1979	Commonwealth funded National Trachoma and Eye Health Program, administered by the Royal College of Ophthalmologists.
1980	National Trachoma and Eye Health Program had far reaching effects beyond eye health and other services it provided to rural and remote Australians. It brought attention to the poor health and living conditions of Indigenous people.
1981	Commonwealth invested in improving environmental living conditions for Indigenous communities.
1983-1991	Prime Minister Robert James Lee Hawke
1983-1985	Instability in Indigenous health policy making. Responsibility transferred from the Commonwealth Department of Health to the Commonwealth Department of Aboriginal Affairs; Australian Institute of Health and Welfare was established and focused on health including Indigenous health data, critical for evidence-based policy making.
1984	Commonwealth Health portfolio lost responsibility for Indigenous health to Commonwealth Department of Aboriginal Affairs.
1986	The National Aboriginal and Islander Health Organisation lost Commonwealth funding; the World Health Organisation progressed the diagnosis of trachoma worldwide; the Commonwealth Department of Aboriginal Affairs funded Trachoma and Eye Health Committees in Queensland, South Australia and the Northern Territory.
1988	The Royal Commission into Aboriginal Deaths in Custody formed and had an impact on later policy making initiatives in Indigenous health and Indigenous affairs.
1989	The Commonwealth National Aboriginal Health Strategy responsible for whole of government comprehensive primary health care policymaking advances including the National Strategic Framework for Aboriginal and Torres Strait Islander Health.
1990	Commonwealth Department of Aboriginal Affairs and Aboriginal Development Commission abolished. Replaced by Aboriginal and Torres Strait Islander Commission.
1991-1996	Prime Minister Paul John Keating
1991	Final Royal Commission into Aboriginal Deaths in Custody Report containing many health related recommendations.
1992	The National Aboriginal Community Controlled Health Organisation replaced the National Aboriginal and Islander Health Organisation with wide recognition of the national importance of Aboriginal Community Controlled Health Services.
1993	Torres Strait Health Strategy released.
1994	Evaluation of the National Aboriginal Health Strategy (implementation of Strategy underfunded and inadequate).
1995	Commonwealth Department of Health and Family Services took responsibility for Indigenous Health from the Aboriginal and Torres Strait Islander Commission. Eye health services in rural and remote Australia were limited and ad hoc.

Timeline of Important Events (continued)

1996- 2007	Prime Minister John Winston Howard
1996	Implementation report on the 1993 Torres Strait Health Strategy.
1996	National Aboriginal and Torres Strait Islander Health Council established.
1997	National Review of Indigenous Eye Health followed by the National Aboriginal and Torres Strait Islander Eye Health Program.
1997	Surgery, Antibiotic, Face, Environment (FACE) Strategy for Trachoma control endorsed by the World Health Organisation. Professor Taylor recommended this Strategy be adopted in Australia.
1997	Australian Health Ministers' Conference endorsed set of national performance indicators and targets.
1997-1998	Increase in Commonwealth Department of Health and Ageing spending for Indigenous health programs.
1998	Framework Agreements for implementation of the 1997 National Review of Eye Health concluded.
1999	Review of National Aboriginal Health Strategy by National Aboriginal and Torres Strait Islander Health Council.
2000	Vision 2020 Australia launched.
2004	Shift to whole of government approach. The Council of Australian Governments addressed Indigenous disadvantage as the framework for whole of government approach. Indigenous eye health policy making followed this approach. The visiting Optometrist Scheme and the Medical Specialist Outreach Assistance Program refined for improved rural and remote access and Commonwealth Outreach Programs.
2004	Review of National Aboriginal and Torres Strait Islander Eye Health Program released and Commonwealth response to the Review. A number of initiatives on trachoma followed.
2004	The National Strategic Framework for Aboriginal and Torres Strait Islander Health published by the Australian Health Ministers Conference. Commonwealth implementation plans and Health Performance Framework reports released. Whole of government approach made mainstream agencies responsible for delivery of Indigenous specific services.
2005	Aboriginal and Torres Strait Islander Commission/Aboriginal and Torres Strait Islander Services abolished.
2005	Development of National Framework for Action to promote Indigenous health and prevent avoidable blindness and visions loss (5 key action areas).
2006	Guidelines for public health management of trachoma published. National Trachoma Surveillance and Report Unit established in Melbourne.
2006	Feasibility report on an integrated regional eye service in Central Australia and planning for this program.
2007-2010	Prime Minister Kevin Michael Rudd
2007	Northern Territory Emergency Response with considerable reporting. Renamed Closing the Gap: NT.
2008	Progress report on Implementation of the Framework.
2008	Council of Australian Governments agreed to six targets for Closing the Gap including health.
2008	National Indigenous Health Equality Council established.
2008-2009	Increase in Commonwealth Department of Health and Ageing spending for Indigenous Health Programs.
2009-2010	\$1.578 billion National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes.
2010	Prime Minister Julia Eileen Gillard.

1.0 INTRODUCTION

Dugdale (2008) reminds us that the health policy scene in Australia is large, complex⁶, vigorous, and populated by nine federal, state and territory governments, and numerous professional associations, charities and lobby groups - all with their own agendas. To comprehend this scene we need to understand the interests of the many players (Sax 1984). Tatz (1964, pp. 264-265) considered that there is no dividing line between policy (word formulation by politicians) and administration (execution of the will of the policy-framers) 'provided that ultimate aims are broken down into sub-aims that are mutually consistent at a given point and are progressive over successive time'. Sax (1984, p. 236) observed that:

A health care administration's goal could be summarised in the following words: to provide reasonable access to effective care, supplied in a humane way, and to do so at a cost that society will accept. The fact is that no one can be confident that we know what to do and, even if we could agree on what to do, in many instances we would not know how to do it (Mechanic 1979:ix). Inevitably in such cases, issues are resolved in "a political, ad hoc, learn-as-we-go fashion" (Stoelwinder 1983).

Whilst health outcomes and health system performance are generally good for most Australians (AIHW 2010a), the situation for Indigenous Australians is less optimistic (ABS & AIHW 2010), and successful major reform is slow in coming for Indigenous health policy-making (e.g. Anderson 2007; Dugdale & Arabena 2008). Aldrich et al (2007) have suggested that, at the federal level at least, politicians' negative discourses about Indigenous Australians has permeated and shaped health policies such that the potential for health gain is limited by the very scope of the policies⁷.

Kaplan-Myrth (2004) completed a case-study in Victoria of the history of Indigenous eye health programs and policy processes from the time of the NTEHP to the present day in the context of exploring community and government relations in Indigenous health more broadly (Kaplan-Myrth 2007). Amongst other things, she felt that Indigenous eye health policy and politics had made significant gains in the past 5 years, however (Kaplan-Myrth 2004, p. 34):

Despite government commitments to engage with Aboriginal communities and organisations as collaborators in health policy, eye health programs are developed through top-down processes. The outcomes of eye health programs in Aboriginal and Torres Strait Islander communities are influenced by imbalances in decision-making power, professional interests, unsustainable infrastructure and resources, and lack of attention to regional differences in the needs and capacities of those communities.

⁶ For example, Appendix A shows the advisory groups to the Australian Health Ministers Advisory Council (AHMAC), Australian Health Ministers Council (AHMC) and Council of Australian Governments (COAG) (OATSIH 2010, pers. comm., May).

⁷ In this regard, there has never been an Indigenous First Assistant Secretary of the Office of Aboriginal and Torres Strait Islander Health since its establishment within the Commonwealth Department of Human Services and Health in 1995, despite the availability of capable and qualified Indigenous professionals (personal communication, Respondent 17).

Our history of Indigenous eye health policy-making in Australia over the past 30 years takes a different approach to that of Kaplan-Myrth (2004), but builds upon the findings from her work. We hope that our report will be helpful for future eye health policy-making, and that it may also provide useful insights towards effective system reform for Indigenous health policy-making and implementation more generally.

The history of Indigenous eye health in Australia is characterised by a unique combination of exceptional individuals (both Indigenous and non-Indigenous)⁸ at the community, government, health service, non-government, and research sector levels, together with a well documented record of Indigenous eye health policy initiatives and challenges (refer to 6.0 Findings of this report).

2.0 BROAD AIM OF PROJECT

To document a critical history of Indigenous eye health policy-making in Australia from the time of the *National Trachoma and Eye Health Program* (RACO 1980) to the present time to assist effective system reform in Indigenous eye health in the context of the Close the Gap policy environment of the Commonwealth Government and the Council of Australian Governments (CDHA 2007d; COAG 2008d; COAG 2009c; NATSIHC 2004a,b).

2.1 Specific Aims

To:

1. Describe the development of Indigenous eye health programs and policy from the NTEHP forward;
2. Identify the key barriers and facilitators to effective policy and program development; and
3. Identify strategies for future systems reform in this field.

3.0 KEY QUESTIONS

These were:

- What are the key Indigenous eye health reports and policies and their timelines from the NTEHP to the current time?
- What was the wider context of health in Australia during this period?
- Who were the key decision makers and organisations influencing Indigenous eye health policies and programs during this period?
- What factors and circumstances influenced the actions of these key decision makers? and
- How can an understanding of the 4 questions above inform recommendations for effective system reform?

⁸ For example, Ida Mann, Frank Flynn, Fred Hollows, Hugh Taylor, Gordon Briscoe, Naomi Mayers, Sol Belleair, Jilpia Nappaljari Jones, Trevor Buzzacott.

4.0 OBJECTIVES

These were:

- To critically review key Indigenous eye health reports and other documents from the NTEHP to the current time;
- To review the wider context of health in Australia during this period;
- To identify a purposive sample of key decision makers in Indigenous eye health during this period;
- To design a face-to-face interview questionnaire that would provide useful information when used to interview the purposive sample of key decision makers;
- To obtain ethical approval for this research;
- To undertake the interviews;
- To collate and analyse the information from the interviews;
- To integrate the main findings into a coherent form that covers the key questions of the study; and
- To prepare a report of the overall findings.

5.0 METHODS

The research design was a qualitative study based on a review of the literature and face-to-face interviews with a purposive sample of individuals involved in significant Indigenous eye health policy-making over the past 31 years (i.e. 1980-2010).

5.1 Literature review

The literature review focussed on a number of key Commonwealth Government reports and other documents related to Indigenous eye health policy-making and policies produced during the study period. Interviewees drew our attention to a number of these documents. We have tried to place these specific documents in a broader context of health policy in Australia where appropriate. Whilst State and Territory government are responsible for the delivery of a significant proportion of mainstream eye health services a significant proportion of Indigenous specific services has been Commonwealth funded and most of the policy development has occurred through initiatives at this level.

A bibliography of Indigenous eye health was prepared, and is shown in Appendix M. The published literature for the bibliography was accessed through the databases Australian Indigenous Health*InfoNet*⁹⁺, ISI Web of Knowledge⁺⁺ and Informit⁺⁺⁺⁹. Search terms included Aboriginal eye health OR Torres Strait Islander eye health OR Aboriginal eye health OR Indigenous eye health AND Australia* AND eye health policy* AND access OR utilization. Other search terms included ocular, cataract, diabetic retinopathy, trachoma, ophthalmia, eye blight, water and environment*. A 'snowballing' technique was used with related articles being located from reference lists of accessed articles.

⁹⁺ The Australian Indigenous Health*InfoNet* is a website that provides free access to information on Australian Indigenous health. Available at <http://www.healthinfonet.ecu.edu.au/> Viewed 30 May 2010.

⁺⁺ ISI Web of Knowledge is an online academic database provided by Thomson Scientific's Institute for Scientific Information, which gives comprehensive access to databases including Current Contents Connect, Medline and Web of Science.

⁺⁺⁺ Informit includes around 90 databases including several full text collections and many index/abstract databases. Most Informit databases are produced in Australia and contain mainly Australian content. Included are AIATSIS - Indigenous Studies Bibliography, ATSIhealth - Aboriginal and Torres Strait Islander Health Bibliography and RURAL - Rural and Remote Health Database.

5.2 Interviews

5.2.1 Research ethics

The study followed ethical guidelines for human research in Australia (NHMRC 2003, 2007), and was approved by The University of Melbourne Human Research Ethics Committee in December 2009. We prepared an Informed-consent form, an Information sheet about the project, and ensured the privacy and confidentiality of the respondents using no names on the questionnaire sheets, conducting interviews privately, and storing the completed documents in a secure location accessible only by the researchers. The Informed-consent form is shown in Appendix B, and the Information sheet is shown in Appendix C.

5.2.2 Questionnaire

We designed a face-to-face questionnaire with 24 questions. The questionnaire had two parts (Part A: General questions - 5; Part B: Specific questions - 19). The 19 questions in Part B were grouped into 5 main themes: *Your role in policy development*; *Policy processes in Indigenous health*; *Evidence and resources*; *Implementation issues*; and *Other possible issues*. The questionnaire is shown in Appendix D.

5.2.3 Sample

We used purposive sampling (Schofield & Jamieson 1999). The selected respondents were well known to the researchers, and were all senior professionals in various sectors related to Indigenous eye health policymaking and policies at various stages of their careers. The sectors covered were: government (federal, state and territory) – (7 interviews); university – (5 interviews); ACCHs – (2 interviews); politicians (federal) – (2 interviews); medical practitioners – (2 interviews); non-government organisations – (4 interviews); and a private organisation – (1 interview). The basic characteristics of the 23 respondents were: 6 females and 17 males; age range 34-71 years (mean and median 55 years); and 5 were Indigenous Australians.

5.2.4 Interviews

Twenty-one (21) of the interviews were face-to-face, one was by telephone, and one by written response to the questionnaire. The face-to-face interviews took about 1.5 hours to complete on average. A number of respondents preferred a less rigid format than the questionnaire shown in Appendix D, and we accommodated this ensuring that the 5 main themes were covered in the interview.

5.2.5 Analysis

The completed questionnaires were analysed using a matrix of the 5 themes, and reported in the findings according to the research aims.

5.3 Writing of report

The authors wrote the report according to the *Style Manual for Authors, Editors and Printers*, Fifth edition (AGPS 1994), and Sixth edition (Snooks & Co 2002), using the Harvard system (author-date) of referencing.

6.0 FINDINGS – LITERATURE REVIEW

6.1 A history of Indigenous eye health policies within the context of broader key health policies in Indigenous and non-Indigenous Australia, 1980-2010

6.1.1 Introduction

This history has been informed by the Australian Indigenous Health/InfoNet 'Indigenous health policy timelines' (AIH/InfoNet 2008), a history of the Commonwealth's role in Indigenous health (Gardiner-Garden 1994; Anderson & Sanders 1996; ANAO 1998, p. 26, Appendix 2 pp. 122-134), and other documents where cited.

The Commonwealth has played an important role in Indigenous health for much of the period of our review, particularly from 1995 onwards. Reflecting the complexity of the Commonwealth health portfolio during the period 1980-2010 (up to August), there have been 3 changes in the political party in power at the Commonwealth level, 11 different Commonwealth Ministers of Health (6 Liberal and 5 Labour), 9 different Heads of the Commonwealth Department of Health, and 7 Department name changes from the original name 'Commonwealth Department of Health' (established in 1921) (CDHA 2007)¹⁰. The Gillard Government in Canberra called a federal election on 21 August 2010, and subsequently formed a minority government.

Since 1988, there have been 12 biennial health reports entitled 'Australia's Health' (AIHW 2010b), and since 1997, 7 biennial reports entitled 'The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples' (ABS 2010) that have provided a reliable evidence base for Indigenous health policymakers.

Before we start our history of Indigenous eye health policymaking, and Indigenous health policymaking more broadly, it is worth looking at briefly the contribution of vision loss to the overall health gap between Indigenous and non-Indigenous Australians. The Commonwealth Department of Health and Aged Care (CDHAC) funded the University of Queensland in 2003 to develop for the first time burden of disease and injury estimates of fatal and non-fatal health outcomes for Indigenous Australians (Vos et al 2007, p.11). The 'Indigenous health gap' was calculated as 'the difference between the burden of disease estimates for Indigenous Australians in 2003 and what these estimates would have been if Indigenous Australians had experienced mortality and disability at the level of the total Australian population' (Vos et al 2007, p. 1). The report from this study provided estimates of the comparative importance of over 170 diseases and injuries using Disability-Adjusted Life Years (DALYs)¹¹. The study found that cardiovascular disease, diabetes, lung disease and chronic respiratory disease accounted for half of the Indigenous health gap (Vos et al 2007, pp. 1-9).

¹⁰ The name, abbreviation, and year of change were: Commonwealth Department of Health (CDH) from 1921; Commonwealth Department of Community Services and Health (CDCSH) 1987; Commonwealth Department of Health, Housing and Community Services (CDHHCS) 1991; Commonwealth Department of Health, Housing, Local Government and Community Services (CDHHLGCS) 1993; Commonwealth Department of Human Services and Health (CDHSH) 1994; Commonwealth Department of Health and Family Services (CDHFS) 1996; Commonwealth Department of Health and Aged care (CDHAC) 1998; and Commonwealth Department of Health and Ageing (CDHA) 2001 (CDHA 2007a).

¹¹ The DALY is a health gap measure that compares the current health status of a population against an 'ideal' in which everyone lives into old age free from disease. $DALY = YLL + YLD$ where YLL is the sum of years of life lost due to premature death, and YLD is the years lived with a disability (Vos et al 2007, pp. 14-15).

Vos et al (2007, pp. 49-50) noted that the burden from vision disorders was attributed to multiple underlying causes in the primary listing of diseases and injuries and thus not discussed explicitly in their report. The burden from total vision loss was divided among diabetic retinopathy, glaucoma, cataract, refraction errors, age-related macular degeneration, trachoma, and other causes of vision loss. Indigenous vision loss resulted mainly in non-fatal burden (73% non-fatal and 27% fatal), and Indigenous females experienced the majority of vision loss burden (61% compared to 39% for males). The burden from total vision loss in 2003 was estimated to be 859 DALYs (0.9% of total Indigenous DALYs), or 1.8 DALYs per 1000 Indigenous persons. The total vision loss DALY rate ratio between Indigenous and all Australians was 1.3 (Vos et al 2007, pp. 49-50)¹². The inclusion in the burden of disease estimates of health conditions such as vision loss that do not have a significant mortality impact helps to ensure that these conditions are properly considered in the context of health policies and programs developed to close the large Indigenous health gap. Detailed analyses by the Centre for Eye Research Australia/Access Economics (CERA 2005 Taylor HR, Keeffe J. *Investing in Sight: Strategic Interventions to Prevent Vision Loss in Australia*, Eye Research Australia, 2005. ISBN 0-9757128-8-8) estimated for mainstream that vision loss resulted in 40,000 DALY or 2.7% of the total burden of disease. An informal analysis using the National Indigenous Eye Health Survey (NIEHS) suggested vision loss in Indigenous Australians caused 2% of the total Indigenous health gap in DALYS or 7% of the non-fatal component of years lost to disability (Vos 2010, personal communication).

The NIEHS conducted in 2008 found Indigenous children had much better vision than mainstream and had five times less poor vision but by the time Indigenous adults reached the age of 40 and above, they had six times as much blindness. Some 94% of vision loss (less than 6/12) was unnecessary being either preventable or treatable, although a third had reported never having had an eye exam. This was the first nationally representative data on Indigenous eye health since the National Trachoma and Eye health program Report was published in 1980. Then they reported blindness was 10 times higher in Aboriginal people, but the majority of the blindness was due to corneal scarring and trachoma.

Prior to the publication of the findings of the *National Trachoma and Eye Health Program* (RACO 1980), the starting point of our history, a number of important initiatives relevant to our story took place.

6.1.2 The period pre-1980

The Commonwealth Government established a new Office of Aboriginal Affairs in 1968¹³, and made specific purpose grants to State Indigenous Health Units that became established in the early 1970s (ANAO 1998, p. 123; Franklin & White 1991, pp. 26-27; Siggers & Grey 1991b, 126). The first Aboriginal Community Controlled Health Service (ACCHS) commenced in Redfern in Sydney in mid 1971 (Briscoe 1974; Foley 1982; Waterford 1982; Foley 1991), and one of us (JNJ) was the second nurse to work there (after Sally Goold) starting in late 1971 (Jones 2005)¹⁴. Fred Hollows actively participated in its establishment. The Central Australian Aboriginal Congress (CAAC) was founded on 9 June 1973 (Nathan & Leichleitner Japanangka 1983), and the Victorian Aboriginal Health Service (VAHS) was established in Fitzroy in 1974 (Nathan 1980). There are now more than 140 ACCHSs around Australia delivering health care to Indigenous Australians (NACCHO 2008a)¹⁵.

¹² The DALY rate per 1000 persons for the total Australian population was age standardised to the total Indigenous Australian population, 2003 (Vos et al 2007, p. 50).

¹³ The year following the successful referendum giving the Commonwealth power to legislate for Indigenous Australians.

¹⁴ The location of the original clinic was 147 Regent Street, Redfern (Refer to Appendix E).

¹⁵ NACCHO has 8 affiliates (except in ACT and Tasmania) with: 135 members and 30 associate members (NACCHO 2008c).

A peak body for ACCHSs was proposed at a meeting in Albury in 1974, and in 1976 the National Aboriginal and Islander Health Organisation (NAIHO) was established (NACCHO 2008b). The establishment of the early ACCHSs provided a launching pad for Indigenous control and participation in health care policy, service delivery, and financial support (ANAO 1998, p. 123). The Commonwealth Department of Aboriginal Affairs (CDA) was established in 1973 after a change of Commonwealth Government (ANAO 1998, p. 123; Franklin & White 1991, p. 27).

The Commonwealth Government assumed responsibility from the States¹⁶ for Indigenous policy, planning and coordination in 1973. This responsibility was shared between the CDA and the Commonwealth Department of Health (CDH) (Osborne 1982; Thomson 1985, pp. 36-37; ANAO 1998, p. 124). The role of the Aboriginal Health Branch established in the CDH Public Health Division in 1973 was 'to provide a central advisory function and to develop a system for the collection, analysis and dissemination of information on all aspects of Aboriginal health.' (Thomson 1985, p. 36). A ten year National Plan for Aboriginal Health was approved by the Commonwealth Minister for Health in 1973 (Thomson 1985, pp.40-41; ANAO 1998, p. 124), although this was little more than a statement of intent to develop a plan (Thomson 1985, p. 33)¹⁷. However, apart from a period in the late 1970s until 1984 - including the time of the NTEHP (RACO 1980) and two other key reports on Indigenous eye health (Mayers 1982¹⁸; TFFNTEHP 1984) - the CDH did not take a direct role in Indigenous health again until 1995 (Anderson & Sanders 1996; ANAO 1998, p. 125; Anderson 2007, p. 242)¹⁹.

The *National Trachoma and Eye Health Program*, funded by the CDH and administered by the Royal Australian College of Ophthalmologists (RACO)²⁰, was initiated in 1975, and over the period 1976-1979 examined (and treated where necessary) 62,116 Indigenous people and 38,616 non-Indigenous people throughout rural and remote Australia. The program found the prevalence of blindness in Indigenous people to be 15/1000 compared with 1-4/1000 for non-Indigenous people, and trachoma was a major contributing factor in 42% of Indigenous blindness. The prevalence of trachoma in the survey population was 38% in Indigenous people and 1.7% in non-Indigenous people (RACO 1980; Thomson 1984). The NTEHP was the first large scale epidemiological survey and example of evidence-based public health care in Australia²¹.

The Commonwealth universal health insurance scheme Medibank operated from 1975 to 1978, and its replacement scheme Medicare was established in 1984 (PAPL 2005). The implementation of these important health policies provided the opportunity to improve the accessibility of health services to all Australians, including Indigenous Australians. The 'Section 129A Scheme' (named after the relevant part of the *Health Insurance Act 1973*), usually called the "Visiting Optometrists Scheme", became available in 1975, and provided payments to optometrists for providing optometric care to all Australians, including Indigenous people, living in remote areas (OAA 2000b, p. 3)²². Remote was defined as >50 km from the nearest permanent optometric practice.

¹⁶ Except in Queensland (Osborne 1982).

¹⁷ The 1973 National Plan for Aboriginal Health took up a single A4 sheet of paper.

¹⁸ This report was to the RACO, but CDH officers (R. Packer, M. Wilson and G. Briscoe) were consulted.

¹⁹ The Commonwealth Government in 1984 consolidated Indigenous health programs in the CDA, and the Aboriginal Health Branch in the CDH disappeared (ANAO 1998, p. 125).

²⁰ RACO became the Royal Australian and New Zealand College of Ophthalmologists (RANZCO) in November 2000 (RANZCO 2010).

²¹ Archibald Cochrane, a distinguished British epidemiologist, was an epidemiological mentor for Fred Hollows, and the international organisation *The Cochrane Collaboration* is named in his honour (TCC 2010). Cochrane visited Australia during the NTEHP (see Appendix F).

²² This scheme paid for the full cost of travel and half other costs incurred by optometrists visiting remote areas (OAA 2000b, p. 3). This scheme later became known as the Visiting Optometrists Scheme (VOS), and continues to the present time (see Appendix K of this report).

The House of Representatives Standing Committee on Aboriginal Affairs (HRSCAA) report *Aboriginal Health* was tabled in parliament in 1979 (HRSCAA 1979). This report provided a broad but limited picture of the health of Indigenous people at this time, and made 15 recommendations and 24 suggestions to improve Indigenous health. The recommendations related to the physical environment, culture, health care programs, self-determination, community development, Aboriginal involvement and employment of non-Indigenous people in the health sector. None of the recommendations or suggestions focused on improving the low socio-economic circumstances of Indigenous people, and the recommendations had only partly been acted upon a decade later (NAHSWP 1989).

6.1.3 The period 1980-1989

6.1.3.1 Indigenous eye health

The National Trachoma and Eye Health Program - Report of the Royal Australian College of Ophthalmologists was tabled in the Australian Senate on the 1st April 1980 (Senate Journal No. 164-01 April 1980). The 5 aims of the public health program were challenging (RACO 1980, p. 185)²³, and not all were achieved; however profound and far reaching effects on the communities visited, Aboriginal health, especially the work of Aboriginal Health Workers, the emergence of Aboriginal Medical Services and the people, Aboriginal and others, who worked on the project' (Taylor 1997, p. 12)²⁴. The epidemiological findings of poor Indigenous health (e.g. of ocular, ear, skin and nasal conditions and their association to environmental factors such as climate, housing, water access, sewerage systems, nutritional status) were detailed and comprehensive (RACO 1980). The recommendations were wide ranging from improving living conditions to the provision of health services, including continuation of the NTEHP (RACO 1980, p. 183). The Commonwealth Government did commit to ensure improvements achieved by the NTEHP were maintained, and consultations on the need for development of adequate on-going eye health care services took place between major State and Territory health authorities and RACO (CDH 1981, p. 37). There were delays in developing a viable follow-up activity to the NTEHP; support was provided for continuation of on-going activities in Western Australia (WA), and renewed activities in New South Wales (NSW), Northern Territory (NT), South Australia (SA), Queensland (QLD) and Victoria (VIC) were planned. These activities were to be conducted on a State/Territory basis controlled by relevant committees containing a majority of Aboriginal representation (CDH 1982, p. 33). The Commonwealth budget allocation for the NTEHP in 1981-1982 was \$480,000 (NTEHP 1982, p. 4).

Ms Naomi Mayers²⁵ was commissioned in November 1981 to prepare a report for the Trachoma & Eye Health Committee of RACO on an appropriate structure for an on-going NTEHP based on her consultations in all mainland states, NT and Canberra (Mayers 1982)²⁶.

²³ These were:

1. The elimination of trachomatous blindness in Australia;
2. Presentation of the ocular health status of persons in rural Australia to interested agencies;
3. Provision of immediate eye care to persons in rural Australia;
4. Establishment of ongoing eye care programs for rural Australia; and
5. Training of medical, paramedical and interested lay persons in the skills necessary to provide eye care in rural Australia.

²⁴ Brian & Smith (1999, p. 230) considered that: 'Although NTEHP did not fulfill all its medical aims, it accomplished much on the wider agenda of Indigenous health, and led to the establishment of many community controlled health services in remote areas. It was a project for its time, in contrast for instance to a recent project in which the army provided ophthalmic surgery in tents pitched in the grounds of a public hospital, basically relieving the health authorities of the need to provide a sustained accessible service. There is a consensus now that there is no longer a place for one-off medical specialist and hospital extravaganzas, and that services must be provided on a continuing or regularly repeated basis, in or close to communities'.

²⁵ Administrator of the Redfern Aboriginal Medical Service in 1982, and currently remains in that position.

²⁶ Ms Mayers had only a short time frame to complete this work, from 11th November 1981 to 22 January 1982 (Mayers 1982, p. 2).

Mayers made 8 recommendations in her report, including: that Trachoma and Eye Health Programs (Committees) be re-established in each state and territory, and where appropriate, more than one in any jurisdiction; that a National Trachoma and Eye Health Committee be established; that Aboriginal community control be applied to all the committees; that Professor Hollows be appointed to the position of consultant to the NTEHP; and that an Aboriginal National Co-ordinator be appointed for the NTEHP directly responsible to RACO. In the conclusion to her report, Ms Mayers wrote (Mayers 1982, p. 10):

...I would personally like to remind members of this committee that Aboriginal people throughout Australia have high expectations of the programme beginning again soon, under meaningful Aboriginal guidance. I sincerely hope that members of this Committee and the College do not ignore those expectations, or this resume of Aboriginal advice. To do so would constitute a grave misjudgement on the part of the RACO and would lead to widespread disappointment in Black Australia.

RACO accepted the importance placed on meaningful Indigenous participation in the Mayers Report recommendations, and in 1982 established State and Territory Trachoma and Eye Health Committees and Secretariats, with decentralised treatment programs. CDH funding was channeled to the State/Territory Committees through RACO (CDH, 1983, p. 32). The committees had a majority of Indigenous members thus enabling their direct involvement in policy-making as well as in the work place. RACO however did not appoint a national coordinator. Other members of these committees included State or Territory Health Department representatives and RACO branch ophthalmologists (NTEHP 1982, p. 4; Taylor 1997, pp. 12). This decentralised phase of the NTEHP did not seem to go well²⁷. RACO withdrew its involvement as an agent for the Commonwealth Government in funding and co-ordinating the State/Territory Trachoma and Eye Health Committees from December 1983 (CDH 1984, p. 38-39). Commonwealth funding was cut off to a number of Trachoma Committees (Belleair 1985, p. 4.3), and another report on the NTEHP was initiated by the CDH in late 1983 (TFFNTEHP 1984).

The Commonwealth Minister for Health, Dr N. Blewett, appointed a Task Force in late 1983 with wide terms of reference, namely 'the formulation within a period of two months of a detailed proposal for the future of the National Trachoma and Eye Health Program' (TFFNTEHP 1984, p. 1). The Task Force included representatives from the CDH and NAIHO, and was chaired by the CDH. The NAIHO representatives withdrew from the Task Force soon afterwards January 1984)²⁸, and the report was completed by CDH staff²⁹ in March 1984³⁰. The report outlined the current NTEHP program, the requirements for a re-vitalised program, a range of options for achieving the requirements, and a recommended option. The recommended option was a national secretariat to oversee the development of a revitalised NTEHP with a national field program, national data collection and an epidemiological surveillance unit (TFFNTEHP 1984). However, Commonwealth Indigenous health programs (including the NTEHP) were transferred from the CDH to the CDAA in January 1985, and the Indigenous Health Branch within CDH disappeared (CDH 1985, p. 47; ANAO 1998, p. 125).

²⁷ One of us (JNJ) was asked in 1983 to be a member of the North Queensland Trachoma and Eye Health Program (QTEHP) Committee, and continued in this role, together with Mary Butler as the Secretariat, from 1983-1995. This involved travel all around the Cape and the Torres Strait. We were not aware of the broader level difficulties with the national program at that time, nor the serious concerns about the QTEHP expressed by Brian (1997, pp. 19-21). One example of a Northern Queensland field report is shown in Appendix A of the Trachoma and Eye Health Report (Belleair 1985, pp. A.1-A.5).

²⁸ A later report stated that NAIHO withdrew because 'it was not satisfied that its policy of community-control was being correctly interpreted by other members of the Task Force' (Belleair 1985, p. 4.2).

²⁹ These CDH staff were Mr G. Briscoe, Dr L. Smith, and Dr D. Stansbury, personal communication from respondent 20.

³⁰ In Appendix IX of the report, there were two submissions from Professor Hollows - one a letter direct to Dr Blewett dated November 1983, and another dated December 1983.

A third review of the NTEHP in as many years was requested in February 1985 by the Commonwealth Minister for Aboriginal Affairs, Mr Clyde Holding³¹ (CDAA 1986, p. 46), and a 128 page report was subsequently submitted to the Minister in October 1985 by the chairperson of the Review Committee, Mr Sol Bellear (Bellar 1985).

The three terms of reference of the Review Committee were to: 1. Report on the current ocular health status of Indigenous Australians; 2. Assess the effectiveness of existing Indigenous Trachoma and Eye Health Programs; and 3. Provide plans to effectively deal with trachoma and poor eye health among Indigenous Australians according to the findings from terms of reference 1 & 2, recommendations from the RACO report (RACO 1980, pp. 180-183) and Commonwealth Government policy on Indigenous self-determination (Bellar 1985, p. 1.1). The review visited 20 communities in WA (5), NT (8) and SA (7), 17 of which had been previously screened during the 1976-1979 NTEHP (RACO 1980). A total of 2228 individuals were screened, of which 2008 were Indigenous. The review found the prevalence of both follicular trachoma and trachomatous conjunctival scarring in Indigenous people aged ≤ 19 years varied widely among the communities, but overall in the 17 communities previously screened there was a decrease in the prevalence of follicular trachoma (especially severe follicular trachoma) and trachomatous conjunctival scarring compared with the screening in 1976-1979 (Bellar 1985, p. 2.2). The main recommendations of the review were that: there be an on-going NAIHO eye health, blindness prevention, and trachoma eradication program; that Commonwealth funding of the existing State/Territory trachoma committees be wound down; that Indigenous community-controlled health services and facilities be provided with more resources and their numbers be expanded; that NAIHO establish a National Eye Health, Blindness Prevention, and Trachoma Eradication Program Committee; that a Program Secretariat be established, initially in Sydney; and that the Program Committee be provided with resources for development of a public and family health strategy with particular emphasis on Homelands needs, and be represented on the Commonwealth Government's Aboriginal Public Health Improvement Program's Central and Regional Committees (Bellar 1985, p. 2.1). The report was distributed to Trachoma Committees, Indigenous Health Services, State and Territory Ministers for Aboriginal Affairs and Health, CDH, and other interested bodies, and all invited to comment (CDAA 1986, p. 46). Whilst the recommendations were strongly in support of Indigenous representation and central control, Taylor (1997 p. 13-14) observed that 'There was little support for the recommendations. Concerns were expressed that the national secretariat would direct funds away from service delivery. Some Aboriginal Medical Services (AMSs) also considered that they were better placed to deliver co-ordinated eye health programs'. The Minister met with Professor Hollows, NAIHO, and State and Territory Trachoma Committees on 8th May 1986, and this meeting agreed that (CDAA 1986, p. 47):

- Surveillance, monitoring, and treatment of trachoma should be continued in order to eliminate trachomatous blindness in Australia and to improve generally the state of eye health in Aboriginal communities
- The involvement of Aboriginals and Aboriginal Health Services should be emphasised in the delivery of anti-trachoma programs
- Existing State and Territory Trachoma Committees should continue to function and
- The Minister agreed to new arrangements under which all relevant groups would meet twice yearly to exchange information and advise the Minister on trachoma and eye health priorities and needs.

³¹ A NAIHO committee was appointed in December 1984 to oversee and manage the NTEHP. This committee, after discussions with the Minister of Aboriginal Affairs, formed the basis of a National Trachoma Review Committee (NTRC) which included representatives from CDAA, CDH, and Professor F C Hollows or his nominee (Bellar 1985, p. 4.6). Members of the NTRC were: Mr S Bellear – Chairperson (NAIHO), Ms N Mayers (NAIHO), Mr S Houston (NAIHO), Dr W Roberts (NAIHO), Professor FC Hollows or nominee, Dr D Stanbury (CDH), and Mr K Wisdom (CDAA) (Bellar 1985, p. B1).

The CDAA Annual Report 1985-96 (CDAA 1986, p. 5) recorded under the Trachoma and eye health section that:

Following receipt in October 1985 of the report of the joint review of trachoma and eye health programs the Minister agreed to the continuation of existing programs.

Taylor (1997, p. 14) referred to these new arrangements as the 'National Trachoma and Eye Health Conference'³², and observed that:

The National Conference endorsed goals and objectives of progressive improvement in Aboriginal health status, the provision of adequate eye health services, the maintenance of trachoma education programs and improvements in environmental health services.

A number of significant events impacted upon Indigenous eye health policymaking and implementation during the period 1985 to 1990³³. NAIHO lost its CDAA funding from 31st December 1986³⁴ (CDAA 1987, pp. 60-61). A simple grading system for trachoma based on the presence or absence of 5 selected key signs was developed in 1987 (Taylor et al 1987; Thylefors et al 1987), and a version of this was used in 3 workshops arranged by the National Trachoma and Eye Health Conference (NTEHC) to train Aboriginal Health Workers to identify trachoma (CDAA 1987, pp. 62)³⁵. A sub-committee of the NTEHC developed a pilot survey to gauge the extent of diabetic retinopathy in Indigenous communities in Queensland and South Australia, and interim results indicated that suitably trained AHWs could use a portable camera as a useful diagnostic tool to detect blinding retinopathy in remote areas (CDAA 1990, pp. 37). The CDAA continued to fund Trachoma and Eye Health Committees in QLD, SA, and the NT (CDAA 1989, pp. 87-88).

A meeting in December 1987 between the Minister for Aboriginal Affairs and other Commonwealth, State and Northern Territory Ministers responsible for Aboriginal Affairs and Health agreed to a co-ordinated strategy to improve Indigenous health, and established a working party to develop a National Aboriginal Health Strategy (NAHS)³⁶.

³² This term was used in the CDAA Annual Report for 1987-88 (CDAA 1988, p. 49).

³³ At a high level impacting on Indigenous health policymaking more generally, there were 3 changes of Commonwealth Minister of Aboriginal Affairs (C. Holding 1983-1987; G. Hand 1987-1990; R. Tickner 1990-1991), 2 changes of Secretary of the CDAA (Charles Perkins resigned in 1988 and was succeeded by W Gray), and the CDAA was replaced on 6th March 1990 by the Aboriginal and Torres Strait Islander Commission (ATSIC).

³⁴ The Minister ceased funding NAIHO following an unsatisfactory audit, and instructed that 'from 1 January 1987, Aboriginal Health Services could elect to pay a voluntary annual affiliation fee of up to \$3,000 each to NAIHO, so that an administratively restructured NAIHO could undertake national Aboriginal health projects on a contract basis as required' (CDAA 1987, pp. 60-61). In 1992, NAIHO changed its name to NACCHO (NACCHO 2008b).

³⁵ Workshops were held in Kununurra and Wiluna in WA in April 1987, Thursday Island in June 1988, and Bourke in NSW in 1989 funded by CDAA. The students were mainly Aboriginal Health Workers, and as much detail was provided as would be to undergraduate medical classes, and for the majority of participants, this level was appropriate. Similar courses were run by Aboriginal Medical Services in Perth, Yalata, and Santa Teresa (Brian et al 1990).

³⁶ The working party had 19 members chaired by Ms Naomi Mayers, and had 6 terms of reference (CDAA 1988, p. 46).

The findings of the working party were published in March 1989 (NAHSWP 1989)³⁷, and another meeting of Ministers held in March 1989 agreed that the NAHS report be assessed for implementation by a development group (CDAA 1989, p. 35)³⁸. The NAHS Report included 3 goals and 7 strategies for Indigenous eye health (NAHSWP 1989, pp. 166-167). The goals focused on trachoma and diabetic retinopathy and were:

- To reduce the incidence of trachoma amongst Indigenous communities;
- To introduce public health measures aimed at preventing trachoma amongst Indigenous people; and
- To reduce the incidence of diabetes amongst Indigenous people.

The specific eye health strategies were:

- Eye health screening and treatment programs should be introduced into those States not currently served by State Trachoma and Eye Health Committees (e.g. NSW, VIC, WA);
- Eye health programs should be introduced at the primary level of care, through Indigenous health services;
- Transfer of skills to Indigenous health workers is essential;
- Intra-ocular lens implant surgery (i.e. new cataract surgery) should be made available free to Indigenous people requiring this treatment;
- Public health measures to improve living conditions, e.g. water supply, must be introduced as a matter of urgency;
- Health awareness and education programs which focus on nutrition, hygiene and eye care should be developed and introduced to all at-risk people; and
- There is a need to integrate primary health care services with specialist trachoma and ocular programs.

6.1.3.2 Broader significant policy events

A number of other key Indigenous health policy events that could impact on Indigenous eye health occurred during this period. They included: The establishment in 1980 of the *Aboriginal Development Commission* (ADC), a Commonwealth Statutory Authority with functions to advance social and economic development of Indigenous people (ADCA 1980).

A *Program Effectiveness Review* Report was prepared in 1980 within the Commonwealth Department of Prime Minister and Cabinet, and considered Indigenous involvement in Indigenous health policy development, the introduction of specific health initiatives, and the existing arrangements for funding and administration of Indigenous health. This review recommended, among other things, consolidation of Commonwealth health functions in the Commonwealth Department of Health (PER 1980; Thomson 1985, p. 36-37; Anderson & Sanders 1996; Anderson 1997, p. 120; AIHInfoNet 2008, Endnotes ii & iii).

³⁷ A number of authors briefly explained the NAHS at the time, targeting several 'audiences' (e.g. Houston 1989; McMichael 1989). An in-depth analysis of the NAHS came later (Anderson 1997, pp. 119-135).

³⁸ The development group comprised Ms Naomi Mayers and one representative from CDAA, CDH, and each State and Territory government. The development group met in May, July, October and November 1989, and subsequently recommended action in 7 broad areas (CDAA 1990, p. 35). The meeting of Ministers also resolved to take urgent action in:

- Environmental health matters
- Education and training programs for Aboriginal and Torres Strait Islander health workers
- Development of a uniform system of Aboriginal and Torres Strait Islander statistics

An *Aboriginal Public Health Improvement Program* was started in 1981 by the Commonwealth Government in response to recommendations from the HRSCAA report on Aboriginal Health (HRSCAA 1979). This program focused on environmental living conditions (water supply, sewage disposal systems, and power supplies), and was administered by CDAA (Thomson 1985, pp. 22-23).

Responsibility for all Commonwealth Indigenous health programs was consolidated within the CDAA in 1984³⁹ (ANAO 1998, p. 26)⁴⁰. This was despite earlier recommendations from Gray (1976, p. 38)⁴¹ and the *Program Effectiveness Review Report* (CDPMC 1980) to the opposite. Thomson (1985, p. 37) observed that given the Commonwealth's failure to co-ordinate its own efforts it was not surprising that it had little success in co-ordinating non-Commonwealth efforts in Indigenous health.

The Australian Institute of Health (AIH) was established within the CDH in September 1984,⁴² and was responsible for the development of Indigenous health statistics. The AIH became an Australian Government statutory authority in 1987, and published its first biennial report in 1988 (AIH 1988)⁴³.

The National Aboriginal Conference (NAC) was terminated as from 30 June 1985 by the Minister for Aboriginal Affairs, Mr C. Holding (AHR 1985, p. 1266). This was done on advice that the NAC was not adequately representative of Indigenous opinions and aspirations⁴⁴.

A National Aboriginal Health Strategy Working Party (NAHSWP) was established in 1987, and its final report prepared in March 1989 (NAHSWP 1989). An Aboriginal Health Development Group (AHDG) and a Community Advisory Group (CAG) were established in 1989 to advise on implementation of the NAHSWP report (Gardiner-Garden 1994; Anderson 1997, p. 125).

The Royal Commission into Aboriginal Deaths in Custody (RCIADIC) was formed in 1988, and the final report with 339 recommendations was signed on 15 April 1991 (NAA 2008).

³⁹ The 1984-85 Commonwealth appropriation for specifically Aboriginal health programs was \$43.231m, with \$37.793m administered through the CDAA, and \$5.438m administered through the CDH (Thomson 1985, p. 17).

⁴⁰ Osborne (1982, p. 114) had earlier been of the opinion that 'The Commonwealth Department of Aboriginal Affairs must be the central planning authority for an effective national Aboriginal health care policy'.

⁴¹ Gray (1976, p. 38) wrote that 'long term direction of the AMSs, if they continue to receive Commonwealth financial support, be evaluated, including alternatives: 1. that they be fully financed by the Department of Health with functions similar to community health centres but financed by direct grant under a separate appropriation. or 2. that they remain separate, predominantly clinical, bulk billing under Medibank wherever possible.

⁴² The first Director of the AIH was Dr John Deeble (CDH 1985, p. 43).

⁴³ The AIH was renamed the Australian Institute of Health and Welfare (AIHW) in 1991 to reflect its wider role involving the collection of data about disabilities and children's services.

⁴⁴ This advice was from a report prepared by Coombs (1984).

6.1.3.3 Summary

The period prior to 1980 saw a number of important developments take place in Australia at the Commonwealth level that have had an important impact on Indigenous health policymaking to the current time. The Commonwealth set up a new Office of Aboriginal Affairs in 1968, following the 1967 referendum. The first community-controlled AMS started in 1971 at Redfern in Sydney, and the CDAA was established in 1973. NAIHO was established in 1976, and helped mobilise the Indigenous community-controlled health sector. Initially, the CDAA and the CDH shared responsibility for Indigenous health. Medibank operated from 1975-1978, and the Commonwealth funded NTEHP ran from 1976-1979, and was administered by RACO. The Visiting Optometrists Scheme (VOS) started in 1975, and was a forerunner of government programs aimed at extending health services out from the large cities and towns into rural and remote areas where many Indigenous people lived.

From 1980 onwards, the NTEHP had far-reaching effects beyond the eye health and other services it provided to rural and remote Australians. The poor living conditions and poor health of Indigenous people at that time was effectively brought to the attention of the wider Australian population and media by the NTEHP. However, the NTEHP was followed by a period of Indigenous eye health policymaking instability, with three reviews in nearly as many years. The Commonwealth transferred responsibility for Indigenous health between the CDH and CDAA at this time which contributed to policymaking instability. The Commonwealth started to invest more seriously in improved environmental living conditions for Indigenous communities in 1981.

NAIHO lost its Commonwealth funding in 1986, a temporary setback for the growing number of advocates for community control in Indigenous health. The World Health Organisation (WHO) progressed the diagnosis of trachoma worldwide through its five key signs, and the CDAA funded the Trachoma and Eye Health Committees in QLD, SA, and NT.

The AIH, later renamed the Australian Institute of Health and Welfare (AIHW), was established in 1984 as the second Commonwealth agency responsible for data consolidation and analysis, but focused on health data, including Indigenous health – critical for evidence-based policymaking. A dialogue continued during this period about whether Commonwealth Indigenous health programs should be consolidated within the CDAA or the CDH.

A Commonwealth funded working party developed the first NAHS in 1989, and, although biomedical in nature, the NAHS was later a guide for a number of significant whole-of-government comprehensive primary health care policymaking advances, including the National Strategic Framework for Aboriginal and Torres Strait Islander Health. The RCIADIC formed in 1988, and its subsequent findings had an important impact on later policymaking initiatives in Indigenous health and more broadly in Indigenous affairs.

6.1.4 The period 1990-1999

6.1.4.1 Indigenous eye health

The Aboriginal and Torres Strait Islander Commission Act was proclaimed on 7th February 1990, and ATSIC commenced on the 5th March 1990, replacing the CDAA and the ADC (ATSIC 1991, p. xiii). ATSIC inherited the former CDAA role of funding and administration of all Commonwealth programs relating to Indigenous health, including eye health. ATSIC responsibility for Indigenous health continued until the Commonwealth Department of Health and Family Services (CDHFS) assumed responsibility from the 1st

July 1995 (ATSIC 1995, p. 115)⁴⁵. Throughout the period ATSIC was responsible for Indigenous health (i.e. 5th March 1990 to 30th June 1995), the Indigenous controlled Trachoma and Eye Health Committees in QLD, SA, and NT continued to be funded, and community screening for trachoma made up a large component of their workload (ATSIC 1990; ATSIC 1991; ATSIC 1992; ATSIC 1993a,b; ATSIC 1994)⁴⁶. However, few specialist eye care services existed in these jurisdictions outside the work of the committees (Taylor 1997, p. 28). Specialist eye health services in the other jurisdictions of WA, Tasmania (TAS), NSW, and VIC operated on an ad hoc basis with no nationally-based and little state-based co-ordination or assessment of need against service delivery, and a mix of public and private services (Taylor 1997, pp. 15, 28). The Australian army undertook exercises to reduce a backlog of eye surgery cases in Alice Springs in 1994, Katherine in 1995, and Tiwi Islands and Maningrida in 1996. However, these exercises could not provide on-going or routine care (Taylor 1997, p. 36-37).

The Fred Hollows Foundation (FHF) was officially launched on 3 September 1992 (Lynskey 2002, p. xi)⁴⁷. For the first ten years, the FHF did core work on eye health and blindness in less developed countries (FHF 2002), while in Australia, it took a broader approach, developing a model of specialist eye service delivery to rural and remote communities of Far North Queensland (FHF 1996, p. 13; Brian 1997⁴⁸), advocacy for improving Indigenous eye health, and an increasing focus on prevention and development – with nutrition, literacy and financial management programs in Jawoyn communities near Katherine in the NT (Barunga, Manyallaluk and Wugularr) (Fyfe 2002; O’Loughlin 2002; Leggatt 2002). This approach was somewhat controversial at the time, as Fyfe (2002, pp. 9-10) describes:

Aboriginal blindness was Fred Hollows’s original *cause célèbre* – before Eritrea, Nepal and Vietnam – but it is not the Foundation’s core work in its own back yard. Despite what the public and its supporters might think, the Foundation has not run eye-specific health programs in Indigenous Australia for many years. At first glance this seems cruel indifference: especially when you consider that 25 years after Fred first raised hell about trachoma – an eye disease of the third world – it still exists at hyper-endemic levels in some Aboriginal communities. Australia, as leading ophthalmologist and Foundation director Professor Hugh Taylor often points out, is the only first world nation harbouring trachoma – the scarring of the cornea as the eyelashes turn in – and its levels are worse here than in the ‘worst parts of Africa’. Yes, it does seem odd, at first glance. But the Foundation’s decision to move away from running eye health programs is in line with what Fred realised before he died. Gone were the days of rushing out to the bush, white coats flapping, to ‘save the blacks’ and fix their eyes. Aboriginal people themselves had to take control and governments had to take responsibility for providing adequate services, he believed. And this is also the Foundation’s opinion.

⁴⁵ The Commonwealth reviewed funding in the 1995-96 Budget and determined that the administration of Indigenous health and substance abuse programs should be transferred from ATSIC to the CDHSH from 1 July 1995. A memorandum of understanding was developed between ATSIC and CDHSH that clarified the ongoing roles and responsibilities of the two agencies (ATSIC 1995, p. 115).

⁴⁶ The total funding allocated for these committees was \$710,000 for 1991-92 (\$310,000 for Qld, \$150,000 for SA, and \$250,000 for NT) (ATSIC 1992, p. 56) and \$753,000 for 1992-93 (\$330,000 for Qld, \$158,000 for SA and \$265,000 for NT) (ATSIC 1993b, p. 93). The amounts were not recorded in the ATSIC annual reports for the other years, although Taylor (1997, pp. 28, 31, 32) records \$968,471 for 1995/96 (\$447,835 for Qld, \$205,365 for SA, and \$315,271 for NT) and \$980,391 for 1996/97 (\$471,844 for Qld, \$204,765 for SA, and \$303,783 for NT). ATSIC provided \$1m to Aboriginal and Torres Strait Islander communities for the provision of eye care in 1993-94. 16 organisations were funded to operate projects relating to trachoma and diabetic retinopathy and to support training in eye care for Indigenous Health Workers (ATSIC 1994, p. 100). During 1989-90, \$18,000 was provide to continue a study of diabetic retinopathy (ATSIC 1991, p. 41), but this project was not referred to again in all subsequent ATSIC annual reports nor Commonwealth Department of Health and Family Services/Commonwealth Department of Health and Aged Care Annual Reports up to 1999-2000. A number of scientific papers were later published on the prevalence of diabetic retinopathy in Indigenous populations in NT and SA where support was acknowledged from, among other organisations, the Commonwealth Department of Health and the NT Aboriginal Eye Health Committee (Jaross, Ryan & Newland 2003,2005), and the SA Eye Health Program (Durkin, Casson & Newland 2006).

⁴⁷ Professor Fred Hollows died on 10 February 1993.

⁴⁸ A full copy of this paper is shown in Appendix G.

The FHF started working in far north Queensland, Cape York and the Torres Strait in 1994, and in 1995-1997, worked with the ophthalmologist Dr Garry Brian⁴⁹ to develop and conduct a demonstration model for specialist eye service delivery to rural and remote communities in far north Queensland (Brian 1997; FHF 1995, p. 10; FHF 1996, p. 13; FHF 1997, pp. 14-15; FHF 1998, p. 12; Fyfe 2002, p. 17)⁵⁰. The context, history, and details (e.g. implementation, service provision, challenges, impediments) of the model are shown in Appendix F, and a summary in Taylor (1997, pp. 37-41). The demonstration model included people living in the Torres Strait, Cape York, and Indigenous communities served by Wuchopperen Health Service (<http://www.wuchopperen.com/>) in Cairns, and was in line with FHF policy of not providing long-term health services that are clearly the responsibility of government. The innovative approach of the FHF model was not in the medical treatments or their application, but in the organisation and financing of the service, with potential for widespread application around Australia (Brian 1997, pp. 14-21). The FHF hands-on involvement in the service ceased in January 1997, but the hope was that the eye health service would continue with its unique mix of public and private partnerships, and that a national review into Indigenous eye health at that time would build upon the lessons learned in this demonstration project (Brian 1997, p. 22)⁵¹.

The FHF and Dr Brian recorded a number of critical observations about the Queensland Trachoma and Eye Health Program (QTEHP) at the time (Brian 1977, pp. 16-21)⁵² that influenced Recommendation 3 of the national review (Taylor 1997, p. 3) and the subsequent Commonwealth Government decision to cease funding of the State and NT based eye health services (CDHFS 1998, p. 118).

When the CDHFS assumed responsibility for Aboriginal and Torres Strait Islander specific health and substance abuse programs on 1st July 1995, it set up an Office for Aboriginal and Torres Strait Islander Health Services (OATSIHS) to manage these programs (CDHFS 1996, p. 5). This administrative shift was aimed at developing a greater focus on Aboriginal and Torres Strait Islander needs in mainstream programs.

The OATSIHS works (CDHFS 1998, p. 117):

across all areas of the Department to ensure a coordinated approach to the development of policies and programs. This is essential because the Office cannot be responsible for all Aboriginal health matters. Mainstream programs in the Department also have a responsibility to ensure that they meet the needs of Aboriginal and Torres Strait Islander peoples.

⁴⁹ Dr Brian had been providing an ophthalmic service in the Torres Strait since 1986 (Brian 1997, p. 8).

⁵⁰ The original FHF project with Apunipima Health Council changed considerably from a broader lifestyle diseases approach to a narrower project of specialist eye service delivery to rural and remote communities (Brian 1997, p. 5). See Appendix G for more details.

⁵¹ The FHF and Dr Brian were central to the then Commonwealth Minister for Health and Family Services, Dr Michael Wooldridge, commissioning the national review by Professor Hugh Taylor (Fyfe 2002, p. 17).

⁵² These included: 'QTEHP, despite years of community visits, with sufficient funding and manpower, was unable to admit to The Foundation that any meaningful information concerning ocular morbidity had been collected.' (Brian 1997, p. 19); 'QTEHP produces and retains its own notes. Sometimes a copy finds its way into a patient's community clinical file. This makes integration of the eye service with existing primary and local medical officer care difficult.' (Brian 1997, p. 20); 'QTEHP has difficulty securing services for its patients.' (Brian 1997, p. 20); 'QTEHP offers free spectacles. Indeed, the distribution of these seems to be the program's raison d'être' (Brian 1997, p. 20); 'In order to satisfy the need to generate suitable attendance statistics, it is not unknown, when adult attendance is down, for QTEHP to visit a community school and flip eye lids as a screen for trachoma. This practice is at odds with a commitment to good quality comprehensive service.' (Brian 1997, p. 21).

OATSIHS primarily concentrated on direct funding support to ACCHSs (CDHFS 1996, p. 78). Over the five year period 1995/96 to 1999/2000, a median of 75.6% of total OATSIHS outlays were for ACCHSs⁵³. The Trachoma and Eye Health Committees in QLD, SA and NT were funded by CDHFS in 1995/96 and 1996/97, but funding ceased in 1997/98 (Taylor 1997, pp. 28, 31, 32; CDHFS 1998, p. 118).

The Commonwealth Minister for Health and Family Services commissioned a major review of eye health in Indigenous communities in 1996 (CDHFS 1997, p. 121). The review was undertaken by Professor Hugh Taylor, and his report was presented to the Minister on 13 June 1997 (Taylor 1997; CDHFS 1997, p. 121). OATSIHS commissioned 5 separate consultancies for this review at a total cost of \$132,120 (CDHFS 1997, p. 291). The reviewer was instructed to report on (Taylor 1997, p. 1):

- the status of eye health amongst Aboriginal and Torres Strait Islander peoples;
- the effectiveness of eye health programs and their capacity to meet eye health needs; and
- how quality eye health services could be delivered in the future.

The process of this review was criticised as echoing past colonial practices, and being top-down in nature (Kaplan-Myrth 2004, pp. 8-11). The review was completed quickly, within 6 months, and had no formal ethics review; however, the criticism is somewhat harsh for a number of reasons. Firstly, the review had a 7 member steering committee, including a representative from NACCHO and another from the Indigenous controlled commonwealth-funded Trachoma and Eye Health Committees (Taylor 1997, p. 139). Kaplan-Myrth (2004, p. 9) considered these organisations were at the bottom of the hierarchy of people responsible for eye health policy in the review, but that was not the case; moreover, the steering committee was missing from the diagram showing the policy hierarchy (Kaplan-Myrth 2004, p. 10). Secondly, the criticism does not adequately take account of the origin of the review; this went back to 1994 and the formation of Apunipima Cape York Health Council and the work of the FHF and Dr Garry Brian responding to their request for help to set up a credible eye health service program in far north Queensland. As described earlier, this work lead to the meeting in Canberra with the Minister of Health and Family Services (FHF 1996, p.13). Thirdly, the review consulted widely in various ways (Taylor 1997, pp. 121-141): there were 51 written submissions; the following organisations were contacted - 149 Aboriginal and Torres Strait Islander Community-Controlled Health Services, health authorities of the 8 State/Territory jurisdictions, 40 ophthalmologists and researchers from around Australia, and 6 regional organisations with an interest in public health and eye health; meetings were held in 70 different locations around Australia; and 3 stakeholder workshops jointly chaired by Mr Sol Bellear who had direct experience in Aboriginal and Torres Strait Islander eye health following the NTEHP (Bellear 1985), and was an inaugural ATSIC Commissioner in 1990 and 1991 (ATSIC 1991, 1992).

⁵³ The total OATSIHS outlays were: \$120,681 in 1995/96 (CDHFS 1996, p. 94); \$121,802 in 1996/97 (CDHFS 1997, p. 126); \$139,861 in 1997/98 (CDHFS 1998, pp. 128-129); \$165,659 in 1998/99 (CDHAC 1999, p. 192-193); and \$182,274 in 1999/2000 (CDHAC 2000, p. 291).

The review produced 17 recommendations (Taylor 1997, pp. 1-9; Appendix H). These related to: Primary eye care services (1,2); Specialist eye services (3,4,5); Specific eye conditions (refractive error [6,7,8], Cataract [9], Diabetic retinopathy [10,11,12], Trachoma [13,14]); The environment (15); and A National Information Network (16,17). OATSIHS responded positively to the report (OATSIHS 1997; CDHFS 1998, p. 118)⁵⁴:

An implementation plan in response to the Taylor report on 'Eye Health in Aboriginal and Torres Strait Islander Communities' has been developed and approved by the Minister. Following recommendations in the report, funding for State based eye health services has ceased and major advances have been made in developing regional implementation plans in several states. The one treatment drug for trachoma, Azithromycin, has been added to the Pharmaceutical Benefits Scheme (PBS) and is being trialed as a free drug for remote area Aboriginal Health Services.

OATSIHS commissioned a consultancy of \$34,814 to advise on the implementation of regional eye health services for Indigenous communities (CDHAC 1999, p. 333). Consultations for the consultancy took place between March 1998 and April 1999, and 6 documents were produced with recommendations for implementation of the service delivery aspects of the Taylor Report (Taylor 1997) for SA, NT, QLD, NSW, VIC, and TAS (Brian 1998a,b,c,d,e; Brian 1999). WA did not participate in the consultations (Brian, G. 2010, pers. comm., 8 April). Appendix I shows a 'Regional Model of Public-Private Eye Service' Delivery (Brian 1998c, pp. 7-12).

The Indigenous Framework Agreements between the Commonwealth, State and Territory Governments, ATSIC, and the community controlled health sector were signed by all participants by 1998/99, and these agreements committed the signatories to increased resources, joint planning, access to mainstream and Indigenous – specific services, and improved data collection and evaluation (CDHAC 1999, p. 174; Anderson 2004a, pp. 254-72). The Framework Agreements were necessary for implementation of the recommendations of the Taylor Report (Taylor 1997).

We could not find a policy document called the 'National Aboriginal and Torres Strait Islander Eye Health Program' (NATSIEHP)⁵⁵, although the Program is referred to widely (e.g. CDHA 2004a; Taylor et al 2004; CDHA 2005a; Murray et al 2005, pp. 521, 523⁵⁶), and is briefly described in various documents (e.g. CDHA 2004a, pp. 1-2; Taylor et al 2004, pp. xiii, xv). Taylor et al (2004, p. xv) write that:

The NATSIEHP arose from recommendations Professor Taylor made in his review of eye health in Aboriginal and Torres Strait Islander communities. His report recommended, among other things, a model of service delivery that is based on a regional co-ordination of services using a mixture of public and private sector funding and resources. This was to replace the remaining elements of the National Trachoma and Eye Health Program (NTEHP). In response, the Commonwealth implemented a NATSIEHP with three strands: regional eye health services coordination; access to specialised equipment; and training assistance.

⁵⁴ The CDHFS implemented a National Aboriginal and Torres Strait Islander Eye Health Program (NATSIEHP) with three strands: regional eye health services coordination; access to specialised equipment; and training assistance (Taylor et al 2004, p. xv).

⁵⁵ The Eye and Ear Health Section of the Office for Aboriginal and Torres Strait Islander Health (OATSIH) was unable to find a policy document entitled the 'National Aboriginal and Torres Strait Islander Eye Health Program' when we requested this (De Ruyter, G. Assistant Director, 2010, pers. comm., 15 July). We also could not find such a policy document using the CDHA 'Wayback Machine' internet archive, viewed 14 July 2010, http://web.archive.org/web/*/http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-oatsih-eyehealth-index.htm

⁵⁶ This Medical Journal of Australia article gives a web link to the NATSIEHP (reference 7), but this link did not work when we tried it a number of times in July 2010. We referred this problem to OATSIH but they were unable to help.

According to the CDHA (2004, p. 1), the aim of the Program was to improve the eye health of the Indigenous population, mainly through 'the provision of a skilled workforce and appropriate infrastructure, thereby increasing the regional access of Aboriginal and Torres Strait Islander peoples to quality eye health services', particularly in rural and remote areas.

Implementation of the NATSIEHP commenced in 1998, and was administered by OATSIHS (CDHA 2004a, p. 1)⁵⁷. The major components of the Program emphasised improving primary eye health care through a regional model, including the following (CDHA 2004a, p. 1-2)⁵⁸:

- the establishment of 29 eye health co-ordinator regions with 34 positions nationally to facilitate access to optometry and ophthalmology services in the Aboriginal and Torres Strait Islander primary health care setting⁵⁹;
- the provision of ophthalmic and optometric equipment in identified ACCHSs across the country, to reduce barriers in service delivery for specialists visiting regional areas;
- the provision of eye health training for regional eye health co-ordinators and Aboriginal Health Workers;

In 1998/99, OATSIHS reported a number of advances in national eye health programs.

These were:

Development of infrastructure for the regional implementation of eye health services, including access to equipment and coordination of specialist eye services; the completion of regional eye health plans in most States and Territories, and associated funds provided to employ regional co-ordinators, provide equipment, and improve access to specialist services at the regional level (CDHAC 1999, p. 174, 178).

However, OATSIHS noted that implementation of new payment arrangements for ophthalmologists in rural and remote areas under the Eye Health Program were slower than expected due to the complexity of existing arrangements and variations in the arrangements within and between the States and Territories (CDHAC 1999, p. 179).

OATSIHS established a National Aboriginal and Torres Strait Islander Eye Health Advisory Group which met for the first time in March 2000, providing OATSIH with strategic advice on how to progress key eye-health initiatives⁶⁰. This group was made up of key stakeholders including NACCHO, specialists (RACO and Optometrists Association of Australia [OAA]) and Heads of Aboriginal and Torres Strait Islander Health Units (HAHU) (CDHAC 2000, p. 275). OATSIH also worked with the OAA to encourage more practitioners to visit rural and remote communities (OAA 2000a,b,c), and funded the development and publication of Specialist Eye Health Guidelines for use in Aboriginal and Torres Strait Islander Populations (OATSIH 2001).

⁵⁷ Taylor et al (2004, p. 45) wrote that 'OATSIH developed a generic national plan for the rollout of the NATSIEHP which was then directed to their state offices for modifications based on the state office's priorities and other state differences.'

⁵⁸ Other actions under the umbrella of the NATSIEHP included the development of Specialist Eye Health Guidelines (OATSIH 2001) and the listing of azithromycin (a semi-synthetic macrolide antibiotic) on the PBS for treatment of trachoma (CDHA 2004a, p. 2).

⁵⁹ Taylor et al (2004, pp. 153-154) list 34 eye health regions and co-ordinators: 7 in NSW; 8 in SA; 7 in QLD; 2 in VIC; 5 in the NT; and 5 in WA.

⁶⁰ This Group was not referred to again in subsequent documents we examined in this research.

The WHO endorsed the SAFE strategy for trachoma control in 1997 (WHO 1997, p. 18)⁶¹:

A manual ("green") has been developed by WHO and The Edna McConnell Clark Foundation for district and community workers to explain how to work with communities and achieve community support for trachoma control.

The manual promotes the SAFE strategy:

- S – surgery for trichiasis, TT (in the community)
- A – antibiotics to treat inflammatory disease, TF and TI
- F – face washing, to encourage clean faces in children
- E – environmental activities, to improve water supply and household sanitation

It was emphasised that the SAFE strategy requires an ongoing dialogue, partnership and full participation of the communities with the eye care workers.

The SAFE strategy has been favourably reviewed internationally (e.g. Bailey & Lietman 2001; Kuper et al 2003; West 2003; Emerson et al 2006), and whilst there are many questions without answers (Emerson et al 2006, p. 613), West (2003 p. 18) concluded that the 'SAFE strategy is a safe bet to accomplish the elimination of blinding trachoma'. The WHO remains supportive of the SAFE strategy (WHO 2010a), and there is a large international literature on trachoma and SAFE (ICEH 2010)⁶².

Taylor (1997, pp. 89-90) recommended that the SAFE strategy should be implemented in Australia⁶³. The NT Government prepared guidelines for the management of trachoma incorporating the SAFE strategy in 1998, and these were updated by a second edition in 2008 (Coffey 2008; NTDHF 2008)⁶⁴.

Ewald and colleagues (Ewald et al 1999; Ewald & Hall 2001; Ewald et al 2003) undertook a two and a half year evaluation of health outcomes in Yuendumu in Central Australia, beginning field work in June 1998, and finishing in late 2000, twelve months after the completion of National Aboriginal Health Strategy – Environmental Health Program (NAHS-EHP)⁶⁵ interventions.

⁶¹ One of us, H.R. Taylor, participated in the WHO meeting in Geneva on 17-20 June 1996 when the SAFE strategy was discussed. The abbreviations used in the 1997 WHO quotation for key signs of trachoma are: TT – Trachomatous Trichiasis; TF – Trachomatous inflammation, Follicular; and TI – Trachomatous inflammation, Intense. Others not referred to in the quotation are: CO – Corneal Opacity; and TS – Trachomatous Scarring (Taylor 1997, p. 89).

⁶² There were four Cochrane Reviews (at the time of writing this report) of randomised or quasi-randomised controlled trials of interventions in individual arms of the SAFE strategy for trachoma control. The reviews investigated were surgery for trichiasis (S) (Yorston et al 2006), antibiotics (A) (Mabey et al 2005), face washing (F) (Ejere et al 2004), and environmental sanitary interventions (E) (Rabiu et al 2007). There were no reviews of combined arms of the SAFE strategy. The conclusions of the four reviews showed there was some or little evidence each intervention alone reduced or controlled trachoma. The Cochrane Review by Ejere et al (2004) included a randomised controlled trial of the effects of eye drops and eye washing on follicular trachoma among Aboriginal children (Peach et al 1987).

⁶³ We discuss later in our report the adoption nationally in 2006 of the *Guidelines for the public health management of trachoma in Australia* based on the WHO SAFE strategy (CDHA 2006).

⁶⁴ The 1997 report of WHO 'Future Approaches to Trachoma Control' noted that 'Further field research is needed to identify optimal ways of achieving community support and sustainability for the various components of the SAFE strategy, including the important hygiene/behavioural aspects of trachoma prevention' (WHO 1997, p. 19). Trachoma management in the NT is currently based on the WHO SAFE strategy (NTDHF 2008, p. 11).

⁶⁵ The Community Housing Infrastructure Program (CHIP) of ATSIC focused on community infrastructure issues, and NAHS-EHP was initiated in 1990 to facilitate major infrastructure development beyond the scope of CHIP and thought to have a direct impact on health such as water supply, sewerage, housing, power supply, internal roads and dust control (ATSIC 1997).

The interventions in Yuendumu included 24 new or renovated houses, a reticulated sewerage system and upgraded treatment works, sealing some community roads, and landscaping the sports oval (Ewald & Hall 2001, p. 13). Ewald and colleagues incorporated disease control programs for trachoma and using a before-and-after cross-sectional design. The control program for trachoma was in three rounds each consisting of community census, screening of children < 13 years of age, health promotion activities, and antibiotic treatment with oral azithromycin (Ewald & Hall 2001; Ewald et al 2003). This was essentially a short-term evaluation of the 'A', 'F', and 'E' components of the SAFE strategy in Australia.

The prevalence of trachoma among Yuendumu children aged < 13 years was 40% (95% CI 32-46%) in November 1998 - before the trachoma control intervention started, 33% (96% CI 26-40%) in June 1999 seven months after the trachoma control intervention started, and 37% (95% CI 29-46%) in August 2000 twenty-one months after the trachoma control intervention started and twelve months after completion of the NAHS-EHP interventions. The differences in prevalence of trachoma were not statistically significant (Ewald & Hall 2001, p. 123; Ewald et al 2003). However, Ewald and colleagues pointed out the change in age specific prevalence between November 1998 and June 1999 among pre-school age children (45%-26%) and < two year olds (30%-4%) was of borderline statistical significance, and may have been of clinical significance (Ewald & Hall 2001, p. 123). This observation may reinforce the important message that 'Trachoma is the disease of the crèche' (Taylor 1997, p. 89).

Ewald and Hall (2001, p. 176) concluded from their study that the level of trachoma remained endemic⁶⁶ one year after the NAHS-EHP capital works were completed, despite an intensive public health treatment and education program during this period, and the envisaged theoretical benefit of combined disease treatment and environmental interventions. The reasons offered for this lack of improvement in trachoma prevalence in children aged < 13 years were (Ewald & Hall 2001, p. 176):

- Inadequate level of environmental improvement;
- High level of mobility between and within communities;
- Insufficient level of taking the azithromycin medication; and
- Inadequate face washing.

Wright (2007, p. 3) found that the A and F components of SAFE can be effective interventions for trachoma, but that there are barriers impeding its widespread implementation in the NT.

Vision 2020 Australia (V2020A)⁶⁷, a peak body for the eye health and vision care sector in Australia, was formed in September 1999, and launched in Sydney in October 2000 by the Director General of the WHO and the Commonwealth Minister for Health and Aged Care. The eye health needs of Indigenous people were a major area of concern at that time (Taylor 2002), and remain a concern today (V2020A 2010).

⁶⁶ Endemic disease is: 'The constant presence of a disease or infectious agent within a given geographic area or population group; may also refer to the usual prevalence of a given disease within such an area or group' (Porta 2008, p. 78).

⁶⁷ Vision 2020 Australia is part of Vision 2020, a global initiative for the elimination of avoidable blindness, a joint program of WHO and the International Agency for the Prevention of Blindness (IAPB) with an international membership of Non Government Organisations (NGOs), professional associations, eye care institutions and corporations (Vision 2020 2010).

During 1995 Laming et al (2000, pp. 163-166) evaluated the impact of single-dose azithromycin for trachoma in children of school age (14 years) and younger. The study found that single dose azithromycin did have advantages over prolonged courses of oral erythromycin or tetracycline drops. However it should only be considered one of four components of the SAFE Strategy. However, the Lansingh et al (2010) study of mobile communities in Central Australia found during 4 visits in 1999 and 2000, that the addition of extensive environmental improvements did not increase the impact of antibiotic treatment and the promotion of facial cleanliness needs to be adapted to the dynamics of the local setting.

6.1.4.2 Broader significant policy events

Commonwealth, State and Territory Ministers for Aboriginal Affairs and Health (called the Joint Ministerial Forum) met in Brisbane in June 1990 and agreed on processes to start implementing the recommendations of the AHDG they had tasked in March 1989 to assess how to implement the NAHS (ATSIC 1991, pp. 39-40)⁶⁸. The Commonwealth Government Cabinet decided on 13 December 1990 to support the NAHS (ATSIC 1992, p. 34), and initially allocated \$232 million over five years for its implementation (ATSIC 1992, p. 93)⁶⁹. An Office of Aboriginal Health was established within ATSIC to: implement the NAHS; provide a secretariat for a Council for Aboriginal Health⁷⁰; assess infrastructure and environmental conditions in Indigenous communities; and monitor Commonwealth sector activities in Indigenous health (ATSIC 1992, p. 38). The Commonwealth reviewed the progress of Commonwealth and State/Territory negotiations with respect to implementation of the NAHS in December 1991 and confirmed funding to 30 June 1995, with an evaluation to be conducted prior to the end of that period which would form the basis for directions over the subsequent five year period (NAHSEC 1994, p. 9).

Interim Aboriginal and Torres Strait Islander Health Goals and Targets were developed in 1991 by consultants engaged by the CDHHCs in order to evaluate the effectiveness of the NAHS (Wronski & Smallwood 1991; ATSIC 1993b, p. 59). The report developed 46 goals grouped as: major causes of illness (20); risk factors for illness (5); housing, water, sanitation, environmental and personal safety (3); employment, education, and training (6); and resource allocation, access and appropriateness, intersectoral collaboration, decision making, health development support, and research (12). Goal 11 was 'Reduce the occurrence, progression and disability from visual impairment (Wronski & Smallwood 1991, pp. 28-29)⁷¹.

⁶⁸ Anderson (1997, p. 125) describes how the ACCHSs met in June 1989 and unanimously rejected the need for the AHDG, and upon their advice, the Commonwealth Minister for Aboriginal Affairs appointed a CAG to provide advice on the implementation of NAHS. Both the AHDG and the CAG produced reports that had notable strategic differences (AHDG 1989; CAG 1990). The views of the CAG were not considered by the Joint Ministerial Forum, but the Forum endorsed all 21 recommendations of the AHDG (ATSIC 1991, pp. 39-40; Anderson 1997, p. 125). The Forum agreed to the establishment of a Council for Aboriginal Health and its terms of reference, and the establishment of Tri-Partite Forums in each State and Territory with representatives from Indigenous communities, Commonwealth, and State and Territory Governments (ATSIC 1992, p. 38).

⁶⁹ The cabinet decision also directed the Commonwealth to secure broadly matching funds from States and Territories, and this resulted in long delays in the release of Commonwealth funds (Anderson 1997, pp. 125-126).

⁷⁰ The Council for Aboriginal Health was a standing committee to the Australian Aboriginal Affairs Council (AAAC) and the Australian Health Ministers Conference (AHMC), to advise both bodies on Indigenous health. The membership of the Council comprised one Indigenous representative from each of the 17 ATSIC Zones, one representative from each State/Territory Government, an ATSIC Commissioner, and Senior Executive Service (SES) representatives from each of ATSIC, Commonwealth Department of Employment, Education and Training (CDEET) and CDHHLGCS (ATSIC 1993, p. 95). The Council for Aboriginal Health only met four times during the first five years of the NAHS, and its operation was reviewed after two meetings (Anderson 1997, p. 128).

⁷¹ More than 700 copies of the document were distributed for comment but only 27 responses were received, many of which did not support the document (NAHSEC 1994, p. 29).

NACCHO rejected the interim goals and targets, the Council for Aboriginal Health expressed concern at the lack of consultation in their development⁷², and little progress was made towards agreement on Indigenous goals and targets at this time (NAHSEC 1994, p. 29).

A national conference of ACCHSs was held in Melbourne on 12-15 March 1991 to discuss the establishment of: a National Aboriginal Community Controlled Health Organisation (NACCHO)⁷³; a Council for Aboriginal Health; and to select Indigenous representatives on the Council for Aboriginal Health (ATSIC 1992, p. 38). Anderson (1997, p. 127) describes the importance of ACCHSs during this period as key sites for delivery of Indigenous primary health care, and providing key linkages with secondary and mainstream health systems. The definition of Aboriginal community control in the NAHSWP report (NAHSWP 1989, p. xiv):

the means by which Aboriginal people have in countering the systems imposed on them by non-Aboriginal people. Such imposed systems must be modified to accommodate Aboriginal aspirations if an appropriate and effective national health strategy for Aboriginal people is to be developed.

is indicative of support by the NAHSWP for the role of ACCHSs in Indigenous health (Anderson 1997, p. 127). The RCIADIC was supportive of ACCHSs (RCIADIC 1991a).

The final report of the RCIADIC was released in 1991 (RCIADIC 1991b). This report had 339 recommendations grouped under 28 themes, many of which were health-related. For example, the themes of: Harmful use of alcohol and other drugs (63-71); Housing and infrastructure (73-76); Custodial health and safety (122-167); Towards better health (246-271); Coping with alcohol and other drugs (272-288); and Improving the living environment: housing and infrastructure (321-327). Recommendation 271 was explicitly about the NAHS (RCIADIC 1991c):

That the implementation of the National Aboriginal Health Strategy, as endorsed by the Joint Ministerial Forum, be regarded as a crucial element in addressing the underlying issues the Commission was directed to take into account, and that funds be urgently made available to allow the Strategy to be implemented.

Recommendation 246 was (RCIADIC 1991d):

That the State, Territory and Common wealth governments act to put an end to the situation where insufficient accurate and comprehensive information on inputs to and activities of Aboriginal health programs is available. Such information is needed if Aboriginal organisations, governments and the community are to be in a position to understand and monitor what is taking place in this area, to estimate the benefits derived there from and to develop appropriate policies and programs to address existing and newly emerging needs.

⁷² The document recorded no consultations, and the only acknowledgement was for the helpful comments of 12 individuals most of whom were non-Indigenous (Wronski & Smallwood 1991, p. 74). Oversight of the project was provided by a committee made up of officers of the CDHHCS, ATSIC, CDEET, and Mr Sol Belleir representing the ATSIC Commissioners (Wronski & Smallwood 1991, p. 2).

⁷³ NAIHO changed its name to NACCHO in 1992 (NACCHO 2008b).

The recommendation 246 was based on a number of observations of the Royal Commission, including about eye health (RCIADIC 1991d):

Over the years, the Commonwealth Government has allocated additional funds for a number of special purposes. For example, in response to extremely high levels of trachoma and other avoidable disorders of the eyes among Aboriginal people, the then Commonwealth Department of Health funded a special National Trachoma and Eye Health Program, which undertook during the period 1976-79 an Australia-wide screening and treatment program for eye disease, and reviewed a number of other diseases. It also undertook a detailed evaluation of the physical environmental factors that contribute to disease. After a brief interruption in 1980-81, the Program was re-established. State and Territory-based Trachoma Committees, on which Aboriginal people occupied a majority of the positions, were established. These Committees attempt to link their specifically targeted eye health work with other services, both Aboriginal community-controlled and State-run. Separate figures for 1989-90 are not available, but in 1988-89 the Department of Aboriginal Affairs allocated \$0.52m to enable the Committees to undertake their work.

Recommendation 247 of the Royal Commission focused on more and/or better quality training in a range of areas for all health professionals working with Indigenous Australians (RCIADIC 1991b), and this was based on a number of observations including (RCIADIC 1991e):

A number of conditions and diseases, such as leprosy and trachoma, although not directly implicated in any of the deaths examined by the Commission, are very uncommon among non-Aboriginal Australians. Their prevalence is far greater, however, among Aboriginal people. One result of their uncommon status in the places where medical and other health professionals are trained is that health professionals are poorly trained in their diagnosis and management.

A Torres Strait Health Strategy was developed in 1993 following a Torres Strait Health Workshop entitled 'Our Health, Our Future, Our Decision' held on Thursday Island (Waiben) from 27-29 April 1993 in response to specific health concerns in the Torres Strait (NAHSWP 1989, pp. 15-127; P&TSRHA 1993). The strategy had 35 overall recommendations about programs (10), policy issues (3), funding issues (5), development (12), and lobbying (5) (P&TSRHA 1993, pp. 34-35), and built upon the Torres Strait Islander focus in the NAHS Report (NAHSWP 1989, pp. 115-127). There were no attendees at the 1993 workshop with a specific interest in eye health, and this may have contributed towards a lack of any discussion about eye health services in the Torres Strait at the workshop (P&TSRHA 1993, p. 38-41)⁷⁴. An implementation plan for the Torres Strait Health Strategy (TSHS) was prepared by a consultant in May 1996 for the Torres Strait Islander & Northern Peninsula Area Health Council (TSI&NPAHC) (TSI&NPAHC 1996).

⁷⁴ Dr Peter Holt, Medical Superintendent of Thursday Island Hospital for many years, gave a presentation at the workshop entitled 'A local perspective', but did not speak about his support for the NTEHP in the Torres Strait (RACO 1980, p. 12), and his invitation in 1986 to Fred Hollows to visit again, which led to Garry Brian (who was working with Fred Hollows in Sydney at the time) developing an ophthalmic examination and treatment program in the Torres Strait from 1987 (Brian 1997, pp. 3).

An Evaluation Report of the first 5 years of implementation of the NAHS was published in December 1994 following a 6 month timeline for completion (NAHSEC 1994). The evaluation was overseen by an Evaluation Committee of thirteen members chaired by an ATSIC Commissioner⁷⁵. The evaluation included consultations over the period 15th August 1994 to 23rd September 1994 (i.e. 40 days) with 73 Indigenous and non-Indigenous organisations from all State and NT jurisdictions (including the SA Trachoma Program on 5 September 1994), and 23 written submissions were received from various Indigenous and non-Indigenous organisations and individuals (NAHSEC 1994, pp. C-1 to C-11). There were 5 major recommendations and 14 major findings (NAHSEC 1994, pp. 2-4). Some of the major findings were:

- The National Aboriginal Health Strategy (NAHS) was never effectively implemented.
- All governments have grossly underfunded NAHS initiatives in remote and rural areas if the objective of environmental equity by the year 2001 is to be attained.
- ATSIC has been a convenient scapegoat for inaction and the failure of governments to deliver.
- The National Council of Aboriginal Health which was established to oversee implementation of NAHS lacked political support from Commonwealth and State/Territory Ministers and ATSIC.
- Local community involvement and participation as espoused in NAHS is critical not only to improving quality of life but also to the attainment of an experience of health and length of life to be expected in a technologically advanced nation.
- Public health providers need to create meaningful coalitions with Aboriginal and Torres Strait Islanders so that communities and individuals can make informed choices regarding health.
- The Commonwealth objective of 'gaining equity in access for Aboriginal and Torres Strait Islander peoples to health services and facilities by the year 2001' – if taken to include "environmental health facilities" (for example, housing and essential services) – is unattainable at both current and projected levels of funding.

The NAHS Evaluation Report noted that a major resolution at the fourth and last meeting of the Council of Aboriginal Health in October 1993 was to recommend to the Ministers for Health and Aboriginal Affairs that NAHS funding be transferred to the Commonwealth Health portfolio for five years, to be reviewed after that time (NAHSEC 1994, p. 31). The transfer of administrative responsibility for Indigenous health programs from the Commonwealth Aboriginal Affairs portfolio to the Commonwealth Health portfolio finally took place on July 1st 1995 after considerable argument and lobbying by concerned organisations and individuals over many years (e.g. Gray 1976; PER 1980; Thomson 1985; Anderson 1994; Bartlett & Legge 1994; Gardiner-Garden 1994; NAHSEC 1994; Bartlett & Boffa 2005; Anderson 1997)⁷⁶.

⁷⁵ The Evaluation Committee comprised 2 ATSIC Commissioners (the Committee Chairperson and one for the Torres Strait), 2 NACCHO representatives, 2 ATSIC Regional Council Chairpersons, the President of the Public Health Association of Australia (PHAA), 1 senior bureaucrat from each of OATSIHS, NT Department of Health and Community Services, Commonwealth Department of Finance, and the Commonwealth Department of Housing and Regional Development, and 2 senior bureaucrats from ATSIC (NAHSEC 1994, p. 8).

⁷⁶ ATSIC was allocated \$232 million over the first 5 years for implementation of the NAHS primary health and environmental health programs, and \$171 million of this (73.7%) was directed to housing and infrastructure services (NAHSEC 1994, p. 51). During this period, the resources available for ACCHSs was only marginally increased (Anderson 1997, p.129-130).

The following briefly summarises a number of other noteworthy events that occurred during the ten-year period 1990-1999 that had an impact on Indigenous health policy-making more generally:

- The Hawke Labor Government was re-elected in March 1990, the Keating Labor Government was elected in March 1993, and the Liberal/National Party Coalition won office in March 1996 and governed under Prime Minister John Howard until December 2007⁷⁷;
- The 111th Session of the National Health and Medical Research Council (NHMRC) held in Brisbane in June 1991 endorsed the 'Guidelines on ethical matters in Aboriginal and Torres Strait Islander health research' (NACCHO 2008d)⁷⁸.
- The Australian Bureau of Statistics (ABS) published the detailed findings of the National Health Survey: Aboriginal and Torres Strait Islander Results 1995 (ABS 1999). This had a short section on health (pages 10-24), and referred very briefly to eye health problems (page 17). Subsequent health surveys and reports were more useful (ABS 2006)⁷⁹.
- From July 1 1996, the CDHAC approved: all existing ACCHSs to bulk-bill Medicare – new ACCHSs were required to submit applications for approval; and some State health department services to bulk-bill for salaried medical officers and to return the additional funds to the community for expanded services (ANAO 1998, p. 107).
- The CDHAC approved in April 1997 an implementation plan to fund PBS medicines to remote ACCHSs under Section 100 of the National Health Act, and for an ophthalmologist to operate from public hospitals in the Torres Strait and to bulk-bill (ANAO 1998, p. 107).
- In August 1997 Australian Health Ministers Council (AHMC) endorsed a set of National Performance Indicators (NPIs) and targets that governments should report against to monitor improvements in Indigenous health, subject to further refinement. AHMAC agreed to refined set of NPIs in March 1998 (ANAO 1998, pp. 45-46; CDHFS 1998, p. 124).
- Framework Agreements between all State/Territory governments, State affiliates of NACCHO, ATSIC, and the Commonwealth Minister of Health and Family Services were concluded in 1998 (CDHFS 1998, p. 117). These agreements were for improved access to health services, full Indigenous participation in decision making and priority determination, and for the collection of better data (ANAO 1998, pp. 94-99).
- OATSIHS was renamed the Office for Aboriginal and Torres Strait Islander Health (OATSIH) in 1999, and remained within the CDHAC.
- A National Aboriginal and Torres Strait Islander Health Council was established in May 1996 (CDHFS 1996, p. 79), was restructured by the Commonwealth Minister for Health and Aged Care in 1999, and commenced a review of the NAHS to take Indigenous health into the twenty-first century (CDHAC 2000, pp. 264, 269).

⁷⁷ John Howard's Government was re-elected in 1998, 2001, and 2004.

⁷⁸ The NHMRC later published two other Indigenous research ethics guidelines (NHMRC 2003; 2005) that are supposed to supersede the 1991 document, however, NACCHO did not endorse either of these more recent guidelines, and as of 2008, considered the NHMRC 2001 guidelines as still valid (NACCHO 2008d). Taylor and colleagues recently described the difficulties associated with ethics approval and community consultation processes in their multi-site studies for the National Indigenous Eye Health Survey (Taylor & Fox 2008; Studdert et al 2010).

⁷⁹ The National Aboriginal and Torres Strait Islander Health Survey 2004-05 Australia (ABS 2006) compared health conditions between 1995, 2001, and 2004-05, and showed that eye/sight problems were consistently the most reported long term health conditions during this period (28%, 29% and 30% respectively) (ABS 2006, pp. 17). More detailed comparisons between 2001 and 2004-05 disaggregated the data by: remoteness; State/Territory; Torres Strait Islander in Queensland; labour force status; Indigenous/non-Indigenous (age standardised); age; sex; and more specific condition - cataract, short sighted/myopia, long sighted/hyperopia, blindness (complete/partial), other diseases of eye and adnexa (ABS 2002, pp. 3,12-15,18; ABS 2006, pp. 24,26,28,34,36). The primary data for 1995 is shown in ABS (1999, pp. 6,18-19,21-23).

6.1.4.3 Summary

This period was characterised by major changes at the Commonwealth level in the administration of Indigenous affairs, including Indigenous health. CDAA and ADC were abolished and replaced by ATSIC in 1990. The CDHFS took over responsibility for Indigenous health from ATSIC in 1995, eleven years after the Commonwealth health portfolio lost responsibility for Indigenous health to CDAA in 1984. The delivery of eye health services to much of rural and remote Australia was limited and ad hoc during this period. The FHF developed a demonstration model for specialist eye service delivery to rural and remote communities in far North QLD. The Trachoma and Eye Health Committees of QLD, SA, and NT were funded by the Commonwealth until the findings of the 1997 national review of Indigenous eye health recommended replacing them with regional eye health services. Implementation of the comprehensive recommendations of the 1997 review of Indigenous eye health became known as the National Aboriginal and Torres Strait Islander Eye Health Program. The SAFE strategy for trachoma control was endorsed by the WHO in 1997, and Professor Taylor recommended the SAFE strategy be adopted in Australia. Vision 2020 Australia was launched in 2000.

The evaluation report of implementation of NAHS was released in 1994, and implementation was found to be seriously underfunded and inadequate. NACCHO replaced NAIHO in 1992, and there was wide recognition of the national importance of ACCHSs in the delivery of primary health care to Indigenous people. The final report of the RCIADIC was released in 1991 with 339 recommendations, many of which were health-related. Changes to Medicare and the PBS improved the access by Indigenous people to health services. The Torres Strait Health Strategy was released in 1993, and an implementation report in 1996. A National Aboriginal and Torres Strait Islander Health Council was established in 1996, and commenced a review of NAHS in 1999. The Framework Agreements were concluded in 1998, and AHMC endorsed a set of National Performance Indicators and Targets in 1997.

6.1.5 The period 2000-2010

6.1.5.1 Indigenous eye health

The NATSIEHP continued to be implemented during 2000-01, according to the CDHAC (2001, p. 173). Regional Indigenous eye health co-ordinators were appointed in 25 of 29 regional eye health service areas in Australia to establish regular ophthalmological and optometrical specialist services. Training for co-ordinators and AHWs was conducted in QLD, NSW, VIC, and SA (CDHAC 2001, pp. 173, 434). Regular optometry clinics in Indigenous communities throughout NSW resulted from collaboration between ACCHSs, OATSIH, NSW Health, and the International Centre for Eye care Education (ICEE)⁸⁰. Thirty Indigenous people received eye surgery at Weipa Hospital as a result of a partnership between the regional eye health co-ordinator, Queensland Health, ophthalmologists and OATSIH (CDHAC 2001, p. 174).

The CDHAC had a change of name to the Commonwealth Department of Health and Ageing (CDHA) during 2001-02 (CDHA 2002), and the Department published *Specialist Eye Health Guidelines for use in Aboriginal and Torres Strait Islander Populations* (OATSIH 2001).

A tender process to engage a consultant to undertake a review of implementation of the NATSIEHP was completed in 2001-02 (CDHA 2002, p. 231), and the review was conducted for OATSIH between September 2002 and July 2003 (Taylor et al 2004, p. xiii).

⁸⁰ The ICEE was formed in Australia in 1998, and is involved in eye health activities in a number of countries around the world, including Australia. The website was viewed 12 July 2010, <http://www.icee.org/who_we_are/index.asp

OATSIH received a draft Review Report in mid-2003 and a final Review Report in October 2003 (CDHA 2003, p. 206; CDHA 2004a, p. 2)⁸¹. The final Review Report was released by the CDHA in May 2004 together with an Australian Government response to the review recommendations (CDHA 2004, p. 210; CDHA 2004a).

The Review consultancy team was advised by a Review Reference Committee comprised of ten public servants (from OATSIH, NT and QLD Governments) and health professionals, and included two NACCHO representatives (Taylor et al 2004, p. 155). There appears to have been no ethical approval process for this review, although a combined Community Participant Information Sheet and Consent form was included as Attachment 8 in the final Review Report (Taylor et al 2004, pp. 157-158). The reviewers obtained information using the following methods (Taylor et al 2004, pp. 11-16):

- A review of the available literature;
- Distribution of three self-administered questionnaires:
 - Questionnaire for ophthalmologists (8 questions – Attachment 1. The questionnaire was circulated by RANZCO, and of the active ophthalmologists, 184 [27%] responded [Taylor et al 2004, p. 63]);
 - Questionnaire for ophthalmology registrars (8 questions – Attachment 2. The questionnaire was circulated by RANZCO, and responses were received from 36 of 80 registrars [45%] Taylor et al 2004, p. 66]);
 - Questionnaire for Regional Indigenous Eye Health Coordinators (10 questions – Attachment 5. The questionnaire was sent to all 34 coordinators, and completed questionnaires were received from 24 [70.6%] [Taylor et al 2004, p. 12]);
- National datasets (e.g. OATSIH Service Activity Reporting Data [Taylor et al 2004, pp. 85-96]);
- National consultation (Letters were sent to 39 national stakeholders OATSIH identified as having a key role in eye health care for Indigenous communities. A written submission was received from nine organisations. Attachment 4);
- Regional consultations (The review visited six regions: Central Australia; the Kimberley in WA; Port Augusta in SA; VIC; the south coast of NSW; and Cape York in QLD. One hundred and sixty-one individuals from QLD, NT, WA, SA, VIC and NSW were identified in a consultation list in the final Review Report – Attachment 3. Information was gathered using a semi-structured questionnaire for each specific set of key informants).
- A national workshop of Regional Indigenous Eye Health Coordinators was held in May 2003 and was attended by 26 coordinators [Taylor et al 2004, p.16].

⁸¹ The review was conducted by a team of Indigenous and non-Indigenous reviewers assembled by the Centre for Remote Health, Alice Springs (Taylor et al 2004, p. xiii), and cost OATSIH \$337,430 (\$239,715.0 [CDHA 2003, p. 464] plus \$97,715 [CDHA 2004, p. 475]. The report was rescinded by the CDHA on 4 April 2008, and is available on the internet only for historical purposes according to the CDHA, viewed 12 July 2010,

<<http://www.health.gov.au/internet/main/publishing.nsf/Content/health-oatsih-pubs-eyehealth.htm>

The Review focused on the implementation of the NATSIEHP, its relationship to broader mainstream health programs, and strengthening its integration into primary health care services for Indigenous peoples (CDHA 2004a, p. 3). The Review Report had 24 recommendations under 8 broad headings: Major eye conditions and the literature (2); The eye program and the primary health care sector (2); Specialist services (4); Equipment (5); Utilising mainstream programs (5); Program monitoring (3); Models of service delivery (1); and Future direction (2) (Taylor et al 2004, pp. xviii-xxvii). The recommendations are shown in full in Appendix J.

The Commonwealth Government response supported the majority of the Review recommendations, and centred around five key areas: Strengthening integration of eye health into primary health care services and the role of the eye health coordinator; Better utilisation of mainstream specialist services⁸²; Data and information systems; Infrastructure support; and Trachoma (CDHA 2004a, pp. 4-13). The response enunciated six guiding principles for further evolution of the Indigenous eye health program (CDHA 2004a, p. 13):

- Eye health must be addressed as a component part of comprehensive primary health care;
- Mainstream programs and services, including specialist services, have the same responsibility to address the health needs of Indigenous Australians as other Australians and at all levels of the health system;
- Regional approaches to eye health will, over time, place more emphasis on strengthening the capacity of local primary health care services in an organised approach to chronic disease detection and management;
- Trachoma control in endemic regions requires a public health response with the involvement of public health units, primary health care services, and housing and essential services;
- Existing capacity in eye health in the Aboriginal and Torres Strait Islander primary health care setting must be preserved; and
- Program development and implementation should be based on the best available evidence.

The Commonwealth Government response noted that the future direction of the NATSIEHP would be supported by the implementation of the National Strategic Framework for Aboriginal and Torres Strait Islander Health (NATSIHC 2004a,b), specifically in Key Result Areas: One (Community controlled primary health care services); Two (Health system delivery framework); Three (A competent health workforce); Five (Environmental health); and Seven (Data, research, and evidence)⁸³. Moreover, the response noted that the role of the Indigenous eye health coordinator in the NATSIEHP may develop into a broader specialist co-ordinator or it may become integrated into the chronic disease programs of the service/region (CDHA 2004a, p. 5).

Australia is the only developed country where trachoma is endemic, and persists mainly in rural and remote Indigenous communities (WHO 2003; Polack et al 2005; Taylor 2008, p. 232; Tellis et al 2007, 2008; Tellis et al 2009; Taylor et al 2009). Recommendation 2 of the NATSIEHP Review (Taylor et al 2004, p. xviii; Appendix J) was:

Trachoma control should be the responsibility of government-run and regional public health units and be organised on a regional basis where population mobility is high. Primary health care services should be involved in the detection and treatment of trachoma under the co-ordination of public health units.

⁸² The term 'specialist' refers to both ophthalmologists and optometrists as specialist eye health service providers (CDHA 2004a, p. 2).

⁸³ However, Couzos et al (2008 p. 709) point out that the NSFATSIH 'lacks policy direction for improvements in the levels of trachoma, and the health system's responsiveness to this problem'.

Consistent with the guiding principles of the Commonwealth Government response to the NATSIEHP Review (CDHA 2004a), the CDHA, through the Communicable Diseases Network Australia (CDNA)⁸⁴ established a Trachoma Steering Committee in September 2003 to provide recommendations on standards for surveillance and reporting of trachoma, and a mechanism to develop a nationally consistent approach to the public health management of trachoma (CDHA 2004, p. 210; CDHA 2006a, p. 44)⁸⁵.

Consultations with CDNA members and key stakeholders on draft national guidelines occurred over the period 19 November 2004 to 28 February 2005⁸⁶, and the guidelines were endorsed by the CDNA in September 2005 (CDHA 2005, p. 179; CDHA 2006a, p. 44). A document entitled Guidelines for the public health management of trachoma in Australia was subsequently published in March 2006 (CDHA 2006a).

The Australian Government awarded a tender to the Centre for Eye Research Australia (CERA) at the University of Melbourne in 2006 to establish (in November 2006) the National Trachoma Surveillance and Reporting Unit (NTSRU) with the responsibility of providing high quality information on trachoma prevalence based on data received from state and territory jurisdictions (Tellis et al 2007, p. 14). Annual trachoma surveillance reports have been prepared since 2006 (Tellis et al 2007, 2008; Tellis et al 2009; Adams et al 2010)⁸⁷. A Trachoma Reference Group (comprising 16 members from WA, SA, NT, CDHA, and NACCHO, plus co-opted members as required) approve the annual reports and provide advice to the NTSRU which in turn reports to OATSIH (Tellis et al 2007, p. 55).

Australian Governments responded to the 28th May 2003 Fifty-sixth World Health Assembly (WHA) resolution (WHA 56.26) on the 'Elimination of avoidable blindness' (WHO 2003) by agreeing in July 2004 at a meeting of AHMC to develop a National Eye Health Plan for Australia to promote eye health and reduce the incidence of avoidable blindness (CDHA 2005a, p. 1; CDHA 2006, p. 75)⁸⁸.

The CDHA and the Victorian Department of Human Services and Health, in consultation with all states and territories, developed a Framework document that was endorsed by AHMC in November 2005 and published by the CDHA together with an accompanying Background Paper⁸⁹ in 2005 (CDHA 2005a,b).

⁸⁴ The CDNA was established in 1989 as a joint initiative of the NHMRC and AHMAC to, among other tasks, oversee the co-ordination of national communicable disease surveillance (CDHA 2008a).

⁸⁵ The Trachoma Steering Committee had four members from the Department of Health Western Australia, Northern Territory Department of Health and Community Services, Department of Health South Australia, and the CDHA (CDHA 2006a, p. 44). A consultant from the Department of Health Western Australia was funded \$29,250.0 by OATSIH to undertake the work of the Trachoma Steering Committee (CDHA 2004, p. 477).

⁸⁶ Written submissions were received from eight individuals and organisations (CDHA 2006a, p. 44).

⁸⁷ NTSRU has published shorter versions of these annual reports in the CDHA *Journal Communicable Diseases Intelligence* (Tellis et al 2007a, 2008a; Tellis et al 2009a; Adams et al 2010).

⁸⁸ WHA 56.26 urged member states: (1) to commit themselves to supporting the Global Initiative for the Elimination of Avoidable Blindness by setting up, not later than 2005, a national Vision 2020 plan, in partnership with WHO and in collaboration with non-governmental organisations and the private sector; (2) to establish a national co-ordinating committee for Vision 2020, or a national blindness prevention committee, which may include representative(s) from consumer or patient groups, to help develop and implement the plan; (3) to commence implementation of such plans by 2007 at the latest; (4) to include in such plans effective information systems with standardized indicators and periodic monitoring and evaluation, with the aim of showing a reduction in the magnitude of avoidable blindness by 2010; and (5) to support the mobilization of resources for eliminating avoidable blindness.

⁸⁹ The Background Paper was prepared for an intended audience of health planners, policy makers, and others concerned with promoting eye health and preventing avoidable blindness in Australia (CDHA 2005b, p. 1).

The consultation process during the development of the Framework Document included: a national workshop in Canberra in March 2004 sponsored by the CDHA and convened by Vision 2020 Australia involving key eye health stakeholder groups; the preparation of two consultation papers⁹⁰; a request for written submissions from over 100 organisations and individuals nationally⁹¹; and a series of stakeholder workshops attended by 155 individuals during July-August 2005 in the ACT, VIC, TAS, QLD, NSW, NT, WA, and SA. Thirteen of the 155 attendees appeared to have an Indigenous perspective (7 represented OATSIH, 5 had a community perspective, and 1 was based at NSW Indigenous Health) (CDHA 2005b, pp. 74-80). So there was at least some Indigenous input during the consultation process, although only one ACCHS⁹² and the WA Aboriginal Community Controlled Health Organisation were represented at the regional workshops.

The Framework document was titled *National Framework for Action to Promote Eye Health and Prevent Avoidable Blindness and Vision Loss* (CDHA 2005a), and does not focus on any one specific eye condition or any particular group in Australia, although it does refer to certain population groups at particular risk of developing eye disease such as: Indigenous people; older people; people with a family history of eye disease; people with diabetes; and marginalised and disadvantaged people (CDHA 2005a, p. 4)⁹³. The Framework seeks to cover the underlying issues that are common to the prevention and treatment of eye disease and vision loss in general. There were 5 key areas for action in the Framework document: Reducing the risk of eye disease and injury; Increasing early detection; Improving access to eye health care services; Improving the systems and quality of care; and Improving the underlying evidence base (CDHA 2005b, p. 7). The Framework document is the main policy instrument currently being used by the CDHA, and OATSIH in particular, to drive Indigenous eye health programs nationally⁹⁴.

⁹⁰ These were titled 'Towards a National Eye Health Plan for Australia 2005 to 2010: Developing a National Framework for Action to Promote Eye Health and Prevent Avoidable Blindness and Vision Loss', and 'Eye Health in Australia', both dated July 2005 and labeled 'Not for Citation'. These consultation papers were informed by a Vision 2020 Australia submission to CDHA resulting from the national workshop of key eye health stakeholder groups in Canberra in March 2004 (CDHA 2005b, p. 72).

⁹¹ Submissions were made by 30 organisations and individuals (CDHA 2005b, pp. 73-74).

⁹² Danila Dilba Aboriginal Medical Service, Darwin (CDHA 2005b, p. 79).

⁹³ Interestingly, this document lists the NATSIEHP (for which there is no formal document as we have explained earlier) as a national initiative at three points in the document under Key area for action 1 (page 15), Key area for action 2 (page 19), and Key area for action 3 (page 26).

⁹⁴ Respondent 15 2010, pers. comm., 29 April.

Key area for action 1 in the Framework document - 'Reducing the risk' - has the objective 'Eye disease and vision loss are prevented, where possible, through addressing known modifiable risk factors', with action areas: 'Raising public awareness'; 'Maternal and child health'; 'People with diabetes'; 'Eye injury prevention'; and 'Research' (CDHA 2005a, pp. 9-19). Indigenous people are not referred to specifically in key area for action 1 except in passing as one of a number of groups for the production of targeted eye health communication materials (CDHA 2005a, p. 12)⁹⁵.

Key area for action 2 in the Framework document - 'Increasing early detection' - has the objective 'Treatable eye conditions are detected early, so that interventions can be applied to preserve vision and prevent any further vision loss', with action areas: 'Public awareness'; 'Primary health care'; 'People with diabetes'; and 'Childhood screening' (CDHA 2005a, pp. 16-19). Indigenous people are specifically referred to in key area for action 2 in the context of Indigenous health checks (MBS items 704, 706, 710) and increased access to eye health assessments for those with diabetes (CDHA 2005a, pp. 17-18).

Key area for action 3 in the Framework document - 'Improving access to eye health care services' - has the objective 'All Australians have equitable access to appropriate eye health care when required', with action areas: 'Workforce supply'; 'Rural and remote communities'; 'Access to cataract surgery'; 'Affordability'; 'Cultural accessibility'; 'Public awareness'; and 'Research' (CDHA 2005a, pp. 20-26). Indigenous people are specifically referred to in key area for action 3 in relation to upskilling Indigenous Health Workers in selected areas of preventive and primary care, accessibility of subsidised spectacles programs in remote locations, use of Indigenous Liaison Officers in mainstream health services, and eye health service delivery in partnership with Indigenous primary health care services (CDHA 2005a, pp. 23-25).

Key area for action 4 in the Framework document - 'Improving the systems and quality of care' - has the objective 'Eye health care is safe, affordable, well co-ordinated, consumer-focused and consistent with internationally recognised good practice', with action areas: 'Service integration'; 'Workforce development - specialist workforce'; 'Workforce development - primary health care workforce'; and 'Consumer focus' (CDHA 2005, pp. 27-31). Indigenous people are specifically referred to in key area for action 4 in relation to strengthening partnerships between the mainstream eye health sector and Indigenous primary health care services in urban, rural and remote settings, increased Indigenous medical officers in the Ophthalmology Training Program, and the development of National Competency Standards for Indigenous Health Workers, including eye health competencies for each level of training and qualification (CDHA 2005a, pp. 29-30).

Key area for action 5 in the Framework document - 'Improving the evidence base' - has the objective 'Eye health care policy, planning and programs are supported by high quality research and data collection systems', with action areas: 'Research gaps and priorities'; 'Eye research workforce development'; 'Knowledge transfer'; and 'Eye health data' (CDHA 2005a, pp. 32-34). Indigenous people, surprisingly, are not specifically referred to at all in key area for action 5, and no national initiatives that impact on improving the evidence base are listed (CDHA 2005a, p. 32-34)⁹⁶.

⁹⁵ A National Eye Health Awareness Campaign commenced in 2006 (CDHA 2006b)

⁹⁶ For example, the Co-operative Research Centre for Aboriginal Health (CRAH), which was funded from 2003-2009, and whose work continues through the Lowitja Institute (LI) which incorporates the Co-operative Research Centre for Aboriginal and Torres Strait Islander Health (CRCATSIH) funded from 2010-2014 (Lowitja Institute 2010, viewed 20 July 2010, <<http://www.lowitja.org.au/>

The Framework document overall listed twenty-seven national initiatives that impact on four of the five key areas for action, and six of these related to Indigenous people (CDHA 2005a, pp. 9-34). However, only one of these six initiatives related to Indigenous eye health, NATSIEHP, and this particular initiative has no document explaining what it is.

The Framework document proposed that the nine jurisdictions in Australia report three yearly to AHMC on progress made on implementation of the National Eye Health Framework (CDHA 2005a, p. 38). The first Progress report was prepared for AHMC in August 2008 (CDHA 2008b). This report concentrated on eye health and vision care activities undertaken by governments during 2005-2008, but points out that other agencies including non-government organisations, professional associations and philanthropic bodies, have made a substantial contribution towards meeting the objectives outlined in the Framework document (CDHA 2008b p.54)⁹⁷.

The Progress report addressed the five Key action areas for each of the nine jurisdictions (CDHA 2008b). The Commonwealth Government, through the CDHA and OATSIH, was the jurisdiction that appears to have made most progress in tackling Indigenous eye health during 2005-2008 according to the roles and responsibilities agreed to by the Commonwealth, State and Territory Governments in the Framework document (CDHA 2005a, pp. 35-36). This progress included seventeen initiatives listed below, of which thirteen had total funding of \$2,766,307. The funding contribution of the Indigenous specific eye health components of the Commonwealth funded Visiting Optometrists Scheme (VOS) and Medical Specialist Outreach Assistance Program (MSOAP) are not included in this funding total.

The seventeen initiatives were :

- \$150,000 provided by CDHA under the National Eye Health Demonstration Grants Program (NEHDGP)⁹⁸ to the International Centre for Eye care Education (ICEE) to improve awareness and accessibility to quality eye health and vision care education resources for Indigenous communities in remote areas of Australia (CDHA 2008b, p. 4);

- \$920,000 allocated over 3 years by CDHA in December 2005 for implementation of a systematic approach to target, treat, and control trachoma in Indigenous communities (CDHA 2008b, p. 5). Initiatives included:

- * CDHA through the Communicable Diseases Network Australia (CDNA) production and distribution to health professionals and key interest groups of *Guidelines for the public health management of trachoma in Australia* (Trachoma Guidelines) (CDHA 2006a);

- * CDHA support to WA, SA and NT for training health care workers in the use of the Trachoma Guidelines and the extension of current trachoma control programs into areas where screening and treatment had not previously occurred; and

- * CDHA established a National Trachoma Surveillance and Reporting Unit (NTSRU) to improve overall quality and consistency of data collection and reporting of trachoma in Australia;

- The CDHA funded Visiting Optometrists Scheme (VOS) was reviewed in 2005-2006, and new arrangements commenced in October 2007 whereby better access to optometric services in remote and very remote communities in priority locations, particularly Indigenous communities, was encouraged by financial assistance to optometrists (CDHA 2007b; CDHA 2008b, pp. 26-27)⁹⁹;

⁹⁷ During the next reporting period, 2008-2011, an evaluation strategy will be instigated to measure national performance against the Framework objectives (CDHA 2008b, p. 54).

⁹⁸ The NEHDGP is administered by the CDHA and covers eye health for all Australians (CDHA 2008c, 'Eye Health Demonstration Grants', viewed 22 July 2010,

<<http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-eyehealth-demogrants.htm>>

⁹⁹ New Guidelines for Participating Optometrists were released again in October 2009 (CDHA 2009d). Refer to Appendix K of this report for background to the VOS.

- The CDHA funded Medical Specialist Outreach Assistance Program (MSOAP)¹⁰⁰ provided \$2.19 million from 1 July 2005 to 31 December 2007 nationally to support 246 ophthalmology services, resulting in 38,000 people being consulted and treated by an ophthalmologist (CDHA 2008b, pp. 27-28). There was no specific mention of Indigenous patients in these figures, but the NT Government reported that with MSOAP support, 51 ophthalmology services (91 sessions) were provided over the period July 2007 to April 2008 in the Top End (Darwin, East Arnhem, and Katherine (CDHA 2008b, p. 31).
- The CDHA through OATSIH funded the Fred Hollows Foundation to co-ordinate 'eye surgery blitzes' at the Alice Springs Hospital over 3 weeks in May, September and November 2007, and 1 week in April 2008, to reduce waiting lists for eye surgery in central Australia. Additional support was also received from the RANZCO Eye Foundation. Two hundred and two additional surgeries, primarily cataract, were completed (CDHA 2008b p. 29);
- The CDHA through OATSIH funded the Central Australian Aboriginal Congress (CAAC) to pilot a 2 year project to employ a full time optometrist to delivery services and training in central Australia, focusing on the detection and treatment of diabetic retinopathy (CDHA 2008b p. 29);
- \$198,896 was provided by CDHA under the NEHDGP to the ICEE to develop and implement a training program to improve the skills and knowledge of Regional Indigenous Eye Health Co-ordinators in the NT and selected Aboriginal Health Workers from the Darwin region (CDHA 2008b, p. 29);
- The CDHA through OATSIH provided the Fred Hollows Foundation with \$462,519 over 3 years from 2006 to 2009 under the EHDGP to employ an Eye Health Program Manager to develop a new model to improve integration of eye health services in central Australia (CDHA 2008b, p. 39)¹⁰¹;
- The CDHA funded the Fred Hollows Foundation \$150,000 under the EHDGP to improve the co-ordination of eye health and vision care services for the Top End of the NT. The key objectives of this project were to establish a clear picture of existing services and identify gaps across the eye health and vision continuum and to trial and evaluate a co-ordinated and integrated service delivery model for eye health and vision care (CDHA 2008b, p. 39);
- The CDHA through OATSIH provided \$50,000 in 2006-07 for two Indigenous workshops in May and June 2007 to promote effective models of eye health service delivery and inform participants about recent developments in OATSIH eye health policy. The participants were 86 eye health workers from 54 ACCHSs from all States and Territories (CDHA 2008b, p. 39)¹⁰²;
- The CDHA through OATSIH provided \$150,000 in 2005-06 for a national stock-take of eye health equipment funded by OATSIH. The resulting un-published report in February 2006 was used to develop a depreciation and maintenance schedule for eye health equipment, and to inform future equipment policies for OATSIH (CDHA 2008b, p. 39);

¹⁰⁰ MSOAP Guidelines are published by the CDHA (2010, 2010a). Refer to Appendix L of this report for background to the MSOAP.

¹⁰¹ The Fred Hollows Foundation will provide \$3 million towards the capital cost of additional facilities in Alice Springs (CDHA 2008a, p. 43).

¹⁰² The workshops were evaluated by a company Evolution Research (CDHA 2008a, p. 39), viewed 21 July 2010, <<http://www.evolutionresearch.com.au/evolution/projects/projects-relating-to-indigenous-programs.html>

- The CDHA funded the Canning Division of General Practice in WA¹⁰³ \$159,970 under the EHDGP to trial and evaluate strategies to integrate eye health care for Indigenous people into mainstream general practice, and develop appropriate referral protocols (CDHA 2008b, p. 39);
- The CDHA funded the Queensland Aboriginal and Islander Health Council (QAIHC)¹⁰⁴ \$150,000 under the EHDGP for a range of activities to strengthen integration of eye care with primary health care, and to improve eye care knowledge amongst health care providers within ACCHSs in Queensland (CDHA 2008b, pp. 39-40);
- The CDHA provided \$199,990 to the Royal Australian and New Zealand College of Ophthalmologists (RANZCO) to help fund the Indigenous Eye Health Survey (CDHA 2008b, p. 47)¹⁰⁵;
- The CDHA through OATSIH provided \$25,000 to help support specialist eye health services in remote Indigenous communities in SA while the VOS was being reviewed in 2005-06 (CDHA 2008b, p. 27);
- The CDHA funded the Limestone Coast Division of General Practice¹⁰⁶ \$53,950 under the EHDGP to provide a series of workshops for general practitioners, practice nurses and Aboriginal Health Workers to enhance their eye care skills and to improve triage of eye incidents and referral protocols (CDHA 2008c);
- The CDHA funded the Western Australian Country Health Service Goldfields \$95,982 to pilot the establishment of a regional retinal screening program in partnership with local Aboriginal Community Controlled Health Organisation and eye health care providers (CDHA 2008c)¹⁰⁷.

The Fred Hollows Foundation (FHF) commissioned Banskott Health Consulting (BHC) in 2005 'To assess the feasibility of establishing a Sustainable Integrated Regional Eye Service to serve the needs of the Central Australian population' (BHC 2006, p. 3). BHC had consultations with stakeholders involved in service provision in Central Australia, prepared an Issues Paper, convened a workshop on October 6 2005 using the Issues Paper as a basis for discussion, and prepared a final report entitled *Integrated Regional Eye Service in Central Australia: Feasibility Assessment Report* (BHC 2006)¹⁰⁸. The report concluded among other things that: eye health services in Central Australia were fragmented and ad hoc; Indigenous people were the major client group of a total population of 55-60,000 people; recruitment of a program manager was pivotal to improve co-ordination and cost-effective use of available resources; funding arrangements were unreliable; cross jurisdictional responsibilities create overlap/duplication of resources, complex reporting, and promote discord between services due to lack of overall co-ordination; and role delineation between primary and secondary care was not clearly defined (BHC 2006, p. 4-5).

¹⁰³ The Canning Division of General Practice is based in the Perth suburb of Bentley (viewed 21 July 2010, < <http://www.canningdivision.com.au/index.html>

¹⁰⁴ QAIHC has offices in Brisbane, Townsville and Cairns (viewed 21 July 2010, <<http://www.qaihc.com.au/>

¹⁰⁵ The findings are available at the Indigenous Eye Health Unit, School of Population Health, The University of Melbourne (viewed 21 July 2010, <http://www.iehu.unimelb.edu.au/the_national_indigenous_eye_health_survey

¹⁰⁶ The Limestone Coast Division of General Practice is based in Millicent, SA (viewed 22 July 2010, <<http://www.limestonecoastgp.com/index.html>

¹⁰⁷ The WA Country Health Service Goldfields is based in Kalgoorlie (viewed 22 July 2010, <http://www.health.wa.gov.au/services/detail.cfm?Unit_ID=140

¹⁰⁸ The report noted that stakeholders in eye care delivery in Central Australia included those serving the Barkley Region and adjacent parts of South and West Australia (BHC 2006, p. 3), and included: Appendix A - Stakeholder list; Appendix B - Attendees of October 6 2005 Workshop; and Appendix C – Issues Paper (BHC 2006, pp. 28-47).

Following the BHC report (BHC 2006), planning commenced in 2006 for the Central Australia Integrated Eye Health Program (CAIEHP), and involved the CDHA, Northern Territory Department of Health and Community Services (NTDHCS), CAAC, Anyinginyi Congress Aboriginal Corporation¹⁰⁹ (ACAC), FHF, and the Eye Foundation¹¹⁰ (FHF 2006 p. 23; V2020A 2007, p. 7; EF 2010). The CDHA (through OATSIH) in 2006 funded the FHF \$462,519.0 over 3 years to employ a program manager for the CAIEHP, as advised by the BHC report (BHC 2006, p. 4), to develop a model to improve integration of eye health services and to reduce the eye surgery waiting lists in Central Australia (CDHA 2008b, p. 39). The CAIEHP was launched in 2007, and planning is underway to establish a centre of eye health excellence in Alice Springs (FHF 2007, p. 5). The FHF committed to a new eye clinic at the Alice Springs Hospital as part of the CAIEHP (FHF 2009, p. 12).

The Australian Government announced on the 26 February 2009 the provision of \$58.3 million over four years starting from 2009-10 for the *Improving Eye and Ear Health Services for Indigenous Australians for Better Education and Employment Outcomes* initiative. The eye health component of the initiative included trachoma surveillance and control activities, expansion of VOS, and intensive eye surgery sessions at Alice Springs Hospital to reduce the eye surgery waiting lists in Central Australia under the CAIEHP (CDHA 2010c)¹¹¹. In a joint media release with the Minister for Families, Housing, Community Services and Indigenous Affairs the former Prime Minister (Rudd 2009) announced at least 1,000 additional eye and ear surgical procedures and an increase of at least ten regional optometric teams to treat and prevent eye disease in the NT, WA, SA and other states where trachoma is identified. The Minister for Indigenous Health, Rural and Regional Health and Regional Services Delivery announced on 17 May 2010 under this \$58.3 million initiative a \$6.5 million expansion of VOS to 106 rural and remote Indigenous communities (Snowdon 2010a). More details of the expansion of VOS are shown in Appendix K. The same announcement by the Minister on 17 May 2010 also included \$1.7 million to the West Australia Country Health Service to expand trachoma prevention and control programs to more than 85 communities, including 20 communities not previously visited in WA (Snowdon 2010a). An additional \$5 million was announced for a special MSOAP for ophthalmology services in the May 2010 budget.

6.1.5.2 Broader significant policy events

The House of Representatives Standing Committee on Family and Community Affairs (HRSCFCA) published its report 'Health is Life: Report on the Inquiry into Indigenous Health' in May 2000 (HRSCFCA 2000). The report had 35 recommendations covering many Indigenous health-related issues including: Commonwealth responsibility for Primary Health Care (PHC); Reconciliation; Resources for Community Controlled PHC; Planning, delivery and monitoring of health and related services; Establishment of a National Council for Indigenous Health Affairs to report annually to the Prime Minister; Access to MBS and PBS; Minister of Aboriginal and Torres Strait Islander Affairs to report annually to Parliament on Government progress in improving the health and wellbeing of Indigenous Australians; Housing and infrastructure; Water; Food and nutrition; Substance misuse; Indigenous health services and community control; Health workforce; and Research and data collection, including the NHMRC devoting 5% of its total research budget to Indigenous health research (HRSCFCA 2000, pp. xv-xxv). The Government response to the 'Health is Life' Report was released in March 2001, and accepted most of the 35 recommendations (CDHAC 2001a).

¹⁰⁹ Anyinginyi Congress Aboriginal Corporation (ACAC), located in Tennant Creek, was the third AMS incorporated on 24 August 1984, viewed 26 July 2010 <http://www.aboriginalexperience.com.au/organisations/org_congress.html>

¹¹⁰ The Eye Foundation is the research arm of RANZCO (EF 2010).

¹¹¹ An intensive eye surgery session took place in Alice Springs Hospital from 19-23 April 2010. This was the ninth intensive eye surgery in Central Australia since 2007 as part of the CAIEHP. According to the Minister for Indigenous Health, Rural and Regional Health and Regional Services Delivery, the Commonwealth has committed more than \$600,000 to CAIEHP since it was established, and will contribute a further \$450,000 over the next three years until 2012-2013 (Snowdon 2010).

The CDHAC released the report 'Better Health Care: Studies in the successful delivery of Primary Health Care Services for Aboriginal and Torres Strait Islander Australians' in October 2001 (CDHAC 2001b). This report examined the elements of Comprehensive Primary Health Care (CPHC) in Australia using more than twenty Indigenous case studies delivered by stand-alone services or by a range of service providers around Australia. The case studies included: Nganampa Health Council, SA – Sexual Health Program, Patient Referrals to Specialist Services, Reducing Emergency Evacuations, and Antenatal Care Program; Wurli Wurlinjang, NT – Cervical Screening Program; Apunipima Cape York Health Council, QLD – Well Persons Health Check Program; Townsville Aboriginal and Islander Health Services Limited, QLD – Mums and Babies Project; Halls Creek, WA – Alcohol Restriction Program; South Coast Medical Service, NSW – General Practitioner Aboriginal Health Clinics Project; Tiwi Islands, NT – Renal Disease Program; Central Australian Aboriginal Congress, NT – Impact of collaborative planning on end-stage renal failure outcomes. The report concluded that CPHC service elements need to be: adequately planned and evaluated; integrated and coordinated at a local level; appropriate for the health conditions they are to address; implemented by a competent workforce; sustainable; and able to engage individuals and communities in action to improve their own health (CDHAC 2001b, p. 15).

The 'National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013' was published by AHMC as two complementary documents in 2004 (NATSIHC 2004a,b). The National Strategic Framework for Aboriginal and Torres Strait Islander Health (NSFATSIH) was developed over a number of years through broad consultations with stakeholders and from the findings of a number of key earlier reports, including the 'National Aboriginal and Torres Strait Islander Health Strategy: Draft for Discussion, February 2001' (NATSIHC 2001), 'A National Aboriginal Health Strategy: An Evaluation December 1994' (NAHSEC 1994), the 'National Aboriginal Health Strategy' (NAHSWP 1989), findings of the Royal Commission into Aboriginal Deaths in Custody (RCIADIC 1991a,b,c,d,e), and the 'Bringing them home' Report (HREOC 1997). The NSFATSIH has nine 'Key Result Areas' (KRA)¹¹² in three groups: Group A – Towards a more effective and responsive health system; Group B – Influencing the health impacts of the non-health sector; and Group C – Providing the infrastructure to improve health status. An Aboriginal and Torres Strait Islander Health Performance Framework (ATSIHPF) was developed to enable performance measurement and reporting of progress in Indigenous health against NSFATSIH. Two ATSIHPF reports have been published to date (AHMAC 2006, 2008). We discuss these reports later. A 'National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013: Australian Government Implementation Plan 2007-2013' was published in 2007 (CDHA 2007d)¹¹³.

The Australian Government introduced a 'whole-of-government' approach to Indigenous Affairs in 2004, and responsibility for delivery of Indigenous specific programs was transferred to mainstream agencies. ATSIC and ATSIH were abolished in 2005, and their programs transferred to 16 mainstream agencies. An Office of Indigenous Policy Co-ordination (OIPC) was established within the Commonwealth Department of Immigration, Multicultural and Indigenous Affairs (DIMIA) to coordinate Commonwealth Government policy development and service delivery through regional Indigenous Co-ordination Centres (ICC's) (HREOC 2004, pp. 67-139).

¹¹² KRA One - Community controlled primary health care services; KRA Two – Health system delivery framework; KRA Three – A competent health workforce; KRA Four – Emotional and social well-being (KRAs 1-4 in Group A); KRA Five – Environmental health; KRA Six – Wider strategies that impact on health (KRAs 5-6 in Group B); KRA Seven – Data, research and evidence; KRA Eight – Resources and finance; KRA Nine – Accountability (KRAs 7-9 in Group C) (NATSIHC 2004b, p. 1).

¹¹³ This was the second Australian Government Implementation Plan against the NSFATSIH (CDHA 2007d, p. 5).

The ICC's were required to negotiate 'Regional Participation Agreements' setting out the regional priorities of Indigenous peoples, as well as 'Shared Responsibility Agreements' (SRAs) at the community, family or clan level. These agreements were based on the principle of shared responsibility and involve mutual obligation or reciprocity for service delivery. Some SRAs had a focus on eye health and Anderson's (2006) example of the Mulan SRA highlights the problems they posed for Indigenous health planning and strategy. The commitments of COAG to addressing Indigenous disadvantage formed the framework for the 'whole-of-government' approach to the delivery of services and policy development, and required constructive co-operation between commonwealth, state, territory and local governments (HREOC 2004, pp. 79-80)¹¹⁴.

The report of the NT Board of Inquiry into the protection of Aboriginal children from sexual abuse was released publicly on 15 June 2007 (Wild & Anderson 2007). The report '*Ampe Akelyernemane Meke Mekarle: "Little Children are Sacred"*' had ninety-seven recommendations on leadership, government responses, family and children's services, health-crisis intervention, police FACS prosecutions and the victim, offender rehabilitation, bail, prevention is better than cure, health-a role in prevention, family support services, education, community education and awareness, alcohol, other substance abuse, community justice, the role of communities, employment, housing, pornography, cross-cultural practice, gambling, and implementation of the report (Wild & Anderson 2007, pp. 21-33). The Commonwealth Government was unhappy with the NT Government response to the report, and announced a national emergency response to protect Aboriginal children in the NT on 21 June 2007. This led to the introduction into the Commonwealth Parliament on 7 August 2007 the "Northern Territory National Emergency Response Bill 2007" (PADPSPL 2007). The Commonwealth Chief Medical Officers Report for 2007-2008 stated that (CDHA 2008, p. 14):

As part of the Australian Government's Northern Territory Emergency Response, 9,454 voluntary health checks were delivered to children under the age of 16 who live in the prescribed areas. Oral health issues and ear diseases were the two most prominent health issues identified through the child health checks. Other conditions associated with poor nutrition, housing and hygiene were also detected.

A progress report of the Northern Territory Emergency Response (NTER) Child Health Check Initiative was published in December 2008 (AIHW & OATSIH 2008)¹¹⁵. A review of the NTER and the joint NT and Commonwealth Government final response to this review were released on the 21 May 2009 (CDFaHCSIA 2009). Independent evaluation of the NT Child Health Check and Expanding Health Services Delivery initiatives has to date produced an Evaluation Design Report (Allen & Clarke 2009), and release of a final evaluation report is expected in early 2011 (CDHA 2010g). A final report on results from the Child Health Check and follow-up data collections was released in December 2009 (AIHW & OATSIH 2009)¹¹⁶.

¹¹⁴ The Co-ordinated Care program was a large-scale initiative of COAG aimed at strengthening primary health care. The overarching objective of the Co-ordinated Care Trials was 'To provide additional benefits to clients and communities through co-ordination and integration of care and effective use of resources for identified populations' (CDHA 2008d, p.9). Benefits of the Indigenous trials were achieved at a whole-of-population level and funding levels below mainstream norms. These trials provided lessons for implementation of the whole-of-government approach to Indigenous health (HREOC 2005).

¹¹⁵ Eye health was not mentioned in the Key Findings (p. x) or in Follow-ups (pp. xi). Table 2.4 (p. 10) included trachoma (7.3%) and visual impairment (0.7%) for 6-15 year-old children, but note (b) of Table 2.4 indicates that only 52% of children in the age range were screened for trachoma. Of the 1.3% of children who got referred to an optometrist or ophthalmologist (Table 2.5, p. 12), a relatively low number were seen by a specialist at the time of the report (Table 3.4, p. 22).

¹¹⁶ Table 2.4 from the preliminary results was repeated in the final report. At completion of the child health checks, the referral rate for optometrists and ophthalmologists was the same (1.2% of the children who had had eye examinations). In the Arnhem region, 2.8% of children aged 6-15 years had trachoma, and 0.5% had some visual impairment (p. 90). In Central Australia, 8% of children had trachoma, and 0.8% had some visual impairment (p. 88). In the Barkly/Katherine region, 12.2% of children aged 6-15 years had trachoma, and 1.0 % had visual impairment (p. 92). In Darwin rural, 5.2% had trachoma, and 0.6 had visual impairment (p. 94).

The Commonwealth Government now calls the NTER 'Closing the Gap: Northern Territory' (CDHA 2010g)¹¹⁷. A Health Impact Assessment of the NTER by the Australian Indigenous Doctor's Association (AIDA) and the Centre for Health Equity Training, Research and Evaluation (CHETRE) made a number of recommendations grouped as: measure should be stopped; measure is unlikely to be effective in the long term; and proceed with caution (AIDA & CHETRE 2010, p. x).

The Human Rights and Equal Opportunity Commission (HREOC) *Social Justice Report 2005* of the Aboriginal and Torres Strait Islander Social Justice Commissioner at that time, Tom Calma, proposed a human rights based approach to achieving Indigenous health equality within a generation (HREOC 2005)¹¹⁸. The first of five recommendations in this report stated:

That the governments of Australia commit to achieving equality of health status and life expectation between Aboriginal and Torres Strait Islander and non-Indigenous people within 25 years.

The other recommendations outlined how the first recommendation could be achieved using a targeted approach.

A Campaign for Indigenous Health Equality emerged in March 2006 from these recommendations, involving more than forty organisations and individuals guided by a Close the Gap Steering Committee for Indigenous Health Equality (CTGSCIHE) chaired by Tom Calma, and 'Close the Gap' was used as the catch phrase for the Campaign (HREOC 2008). The Steering Committee prepared a number of publications during the Campaign, including a Community Guide (AHRC 2010c), and a Position Paper (CTGSCIHE 2010a).

The Campaign was formally launched in Sydney on 4 April 2007 (AHRC 2010b; HREOC 2008, p.3). NACCHO and Oxfam Australia (OA) prepared a policy briefing paper in April 2007 entitled 'Close the Gap: Solutions to the Indigenous Health Crisis facing Australia' (NACCHO & OA 2007), and three working groups of the Steering Committee for Indigenous Health Equality developed targets (HREOC 2008). The Campaign gathered momentum.

COAG 'reaffirmed its commitment to closing the outcomes gap between Indigenous people and other Australians' on 13 April 2007 (COAG 2007, p. 7). The elected Rudd Labor Government took office in Canberra on 3 December 2007, and COAG agreed on 20 December 2007 to a partnership between all levels of government to work with Indigenous communities to 'Close the Gap' on Indigenous disadvantage (COAG 2007a, pp. 2-3, 11). The Australian Prime Minister, Kevin Rudd, gave an apology on behalf of all Australians to Australia's Indigenous peoples on 13 February 2008 in Parliament House Canberra.

The Campaign culminated in a Close the Gap National Indigenous Health Equality Targets Summit in Canberra on March 18-20, 2008 (HREOC 2008). A Statement of Intent was jointly signed at the Summit on 20 March 2008 by the Prime Minister and key Indigenous and non-Indigenous stakeholders to work together to achieve equality in health status and life expectancy between Indigenous and non-Indigenous Australians by 2030 (HREOC 2008 pp. 16-17). Five groups of Close the Gap National Indigenous Health Equality Targets were proposed at the Summit: Partnership Targets; Health Status Targets; Primary Health Care and other Health Services Targets; Infrastructure Targets; and Social Determinants Targets (HREOC 2008, pp. 19-51)¹¹⁹.

¹¹⁷The WHO Commission on Social Determinants of Health released its final report in August 2008 (CSDH 2008). The title of the report was "Closing the Gap in a Generation: Health equity through action on the social determinants of health.

¹¹⁸HREOC changed its corporate identity to the Australian Human Rights Commission (AHRC) in 2008 (AHRC 2010c).

¹¹⁹Trachoma control programs expanded through implementation of the SAFE strategy were included in the Primary Health Care and Other Health Service Targets (HREOC 2008, p. 40).

COAG meetings in 2008 (26 March, 3 July, 2 October, 29 November) reaffirmed the national importance of closing the gap between Indigenous and non-Indigenous Australians (COAG 2008, 2008a, 2008b, 2008c), agreed to six targets for closing the gap across urban, rural and remote areas¹²⁰, and agreed to initiatives for Indigenous Australians of \$4.6 billion across early childhood development, health, housing, economic development, and remote service delivery (COAG 2008c, pp. 7-9, 13)¹²¹. The Commonwealth Government announced the establishment of the National Indigenous Health Equality Council (NIHEC) in March 2008, announced its membership in July 2008, and NIHEC held its inaugural meeting on 25-26 August 2008 in Canberra (CDHA 2010e). The 2008 COAG initiative on health was a \$1.578 billion National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes (NPACGIHO) over four years beginning in 2009-10, with the Commonwealth contributing \$806 million and the States \$772 million (COAG 2008c, pp. 13, 17-18; COAG 2009c). The NPACGIHO specified outcomes, outputs, and financial arrangements from 2009-10 to 2012-2013 for the following initiatives: Tackle smoking; Healthy transition to adulthood; Making Indigenous health everyone's business; Primary health care services that can deliver; and Fixing the gaps and improving the patient journey (COAG 2009c). All COAG jurisdictions prepared a 'National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes: Implementation Plan' (MCFFR 2010).

COAG meetings in 2009 (30 April, 2 July, 7 December) and 2010 (19-20 April) considered a large number of Indigenous Close the Gap policy issues, including: the operating arrangements for the Co-ordinator-General for Remote Indigenous Services (CGRIS)¹²², the first CGRIS report on 4 December 2009 recommending - improved coordination of service delivery in 29 priority remote communities in areas of community governance, education and training, delivery of renal health services, and reporting (COAG 2009, pp. 11-12; COAG 2009a, p. 2; COAG 2009b, p. 13), and a progress status report addressing the CGRIS recommendations (COAG 2010, p. 17); a National Integrated Strategy for Closing the Gap in Indigenous Disadvantage (COAG 2009a, p. 2)¹²³; a Closing the Gap Indigenous Education Action Plan (COAG 2009a, p. 3); a Closing the Gap National Remote Indigenous Food Security Strategy (COAG 2009a, p. 3; COAG 2009b, pp. 12-13); a Closing the Gap National Urban and Regional Service Delivery Strategy (COAG 2009a, p. 4); and a Closing the Gap National Partnership Agreement on Remote Indigenous Public Internet Access (COAG 2009a, pp. 4-5).

COAG agreed to a National Indigenous Reform Agreement (Closing the Gap) (NIRA) in 2008 that provides the overarching framework for the six targets that all governments have committed to achieving through their various National Agreements and National Partnerships (COAG 2008c, p. 8; COAG 2008d)¹²⁴. NIRA has 27 Indigenous-specific performance indicators to measure progress against the Closing the Gap targets. The difference between Indigenous and non-Indigenous outcomes against each of these indicators will be used by COAG to help assess progress towards the Closing the Gap targets (COAG 2008d, pp. 9-16).

¹²⁰ The targets were: to close the gap in life expectancy within a generation; to halve the gap in mortality rates for Indigenous children under five within a decade; to ensure all Indigenous four year olds in remote communities have access to early childhood education within five years; to halve the gap in reading, writing and numeracy achievements for Indigenous children within a decade; to halve the gap for Indigenous students in year 12 attainment or equivalent attainment rates by 2020; and to halve the gap in employment outcomes between Indigenous and non-Indigenous Australians within a decade.

¹²¹ Partnership Agreements included in this Indigenous specific funding include: National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes; National Partnership Agreement on Remote Service Delivery; National Partnership Agreement on Indigenous Early Childhood Development; National Partnership Agreement on the Northern Territory; and National Partnership Agreement on the East Kimberley (NIHEC 2010, p. 3).

¹²² Who reports to the Commonwealth Minister for Families, Housing, Community Services and Indigenous Affairs (COAG 2009, pp. 11-12).

¹²³ This includes an additional \$46.4 million over four years for the ABS and AIHW to improve the evidence base and address data gaps (COAG 2009a, p. 2).

¹²⁴ The NIRA is Schedule F of the Intergovernmental Agreement on Federal Financial Relations (COAG 2010a).

The National Indigenous Health Equality Council (NIHEC), established in March 2008, has 15 members - a large majority of whom are Indigenous, was given the role of providing advice to Government on the provision of equitable and sustainable health outcomes for Indigenous Australians (CDHA 2010e). The NIHEC has broad terms of reference, the first of which is to advise the Australian Government about commitments made under the March 2008 Close the Gap Statement of Intent on achieving Indigenous health equality by 2030 (AHRC 2008). The inaugural meeting of the NIHEC was held in Canberra on 25-26 August 2008, and the NIHEC has held 8 meetings to June 2010 (CDHA 2010e).

Achievements of the NIHEC to date have included (CDHA 2010e):

- The development and joint launch in March 2010 of a National Target Setting Instrument: Evidence Based Best Practice Guide to inform target setting in Indigenous health (NIHEC 2010), and a Child Mortality Target: Analysis and Recommendations report (NIHEC 2010a);
- The preparation of an Indigenous Youth Health and Wellbeing Roundtable Outcomes Report that will form a foundation for developing an Indigenous youth policy framework;
- Recommendations to the Ministerial Council for Education, Early Child Development and Youth Affairs (MCEECDYA) to strengthen the draft Indigenous Education Action Plan 2010-2014;
- Provision of advice to the NHMRC on The NHMRC Road Map II about research priorities for Indigenous health research¹²⁵;
- Co-convened with the National Advisory Council on Mental Health (NACMH) an Indigenous Mental Health Forum;
- Hosted an Indigenous Health Workforce forum, and progressed work on the Health Workforce Target: Analysis and Recommendations Part I: Indigenous Health Workforce draft report;
- Discussions on: the Aboriginal and Torres Strait Islander Healing Foundation¹²⁶; the monitoring and evaluation framework of the Australian Government's Indigenous Chronic Disease Package¹²⁷; the National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan (NATSINSAP) and potential options for Indigenous nutrition¹²⁸; and a new national Indigenous representative body¹²⁹; and
- Maintained a watching brief on the study of renal dialysis services in Central Australia¹³⁰, and the NIHEC role in relation to the Australian Government health reform agenda¹³¹. NIHEC had discussions about the National Health and Hospitals Reform Commission (NHHRC) Final Report with the Minister for Indigenous Health¹³².

¹²⁵ Road Map II: A strategic framework for improving the health of Aboriginal and Torres Strait Islander people through research (NHMRC 2010).

¹²⁶ The Aboriginal and Torres Strait Islander Healing Foundation was incorporated on 30 October 2009 (ATSIHF 2009).

¹²⁷ *Closing the Gap: Tackling Chronic Disease. The Australian Government's Indigenous Chronic Disease Package* (CDHA 2009g).

¹²⁸ NATSINSAP October 2008 update, viewed 4 August 2010,

<http://www.healthinfor.net.ecu.edu.au/uploads/resources/13991_natsinsap_update_2008_october.pdf

¹²⁹ The National Congress of Australia's First Peoples was announced in November 2009 (AHRC 2010).

¹³⁰ Snowdon 2010b, Agreed Terms of Reference for Central Australia Renal Study.

¹³¹ COAG (2010).

¹³² A Healthier Future for all Australians: National Health and Hospitals Reform Commission – Final Report June 2009 (CDHA 2009h). The Executive Summary of this report stated: 'We want all the funding for Aboriginal and Torres Strait Islander people to be aggregated. We want a new National Aboriginal and Torres Strait Islander Health Authority (NATSIHA) to take all funding and actively purchase and commission the very best health services – services that are effective, high quality, culturally appropriate and meet the needs of Aboriginal and Torres Strait Islander people, their families and their communities (CDHA 2009h, p. 3).

The period 2000 – 2009 was characterised by considerable effort by the CDHA to improve Indigenous access to the Medical Benefits Scheme (MBS), the Pharmaceutical Benefits Scheme (PBS), and mainstream health services (UKY 2006; MA 2010). Policy initiatives included:

- Assisting comprehensive primary health care by allowing salaried doctors in approved Indigenous Health Services to access the MBS under Section 19(2) of the Health Insurance Act 1973 (CDHAC 2001, p. 168; CDHA 2003, p. 203)¹³³;
- Provision of PBS medicines free in approved remote area Indigenous Health Services under Section 100 of the National Health Act 1953 (CDHA 2010d)¹³⁴;
- Health Insurance Commission campaigns to enrol Indigenous people in Medicare (CDHA 2003, p. 203; CDHA 2004, pp. 206-207);
- Streamlined Medicare enrolment and billing arrangements, employing additional Indigenous Access Liaison Officers, and providing a 1800 Indigenous free-access telephone number (CDHA 2004, pp. 206-207);
- Workshops were held across the country for Indigenous Health Services to provide information on Medicare and major health programs of the CDHA (CDHA 2007, p. 120);
- Funding of 5 urban brokerage services to link Indigenous people with networks of mainstream health service providers (CDHA 2007, p. 120);
- New PBS listings for medicines specific to Indigenous people, such as iron and folic acid supplements, thiamine, a variety of topical anti-fungal agents,
- hookworm treatment, and a new treatment for chronic otitis media (CDHA 2007, pp. 120-121);
- A PBS amendment for all Indigenous people in very high risk categories to access lipid-lowering therapy at any cholesterol level (CDHA 2007, p. 121);
- Implementation of key findings of a national review that identified barriers in Indigenous access to Medicare funded health services and the PBS (UKY 2006; CDHA 2008, p. 131);
- MBS Primary Care initiatives over the period 1999-2009 specifically for Indigenous people to improve their access to the Australian health care system (CDHA 2009a)¹³⁵. The MBS initiatives included:
 - * 1999 – health assessment for Indigenous people aged 55 and over (MBS items 704 and 706);
 - * 2004 – health assessment for Indigenous people aged 15-55 (MBS item 710);
 - * 2006 – health assessment for Indigenous children (MBS item 708);
 - * 2008 – follow-up allied health services for Indigenous people who have had a GP health assessment (MBS items 81300-81360)¹³⁶. They may also be eligible for up to 10 follow-up services (item 10987) provided by a Practice Nurse or registered Aboriginal Health Worker.

¹³³ Access to Medicare also allows access to other mainstream funding programs such as the Practice Incentives Program and General Practice Immunisation Incentives Program (CDHA 2005, p. 176).

¹³⁴ Clients of 166 remote area Indigenous Health Services, including ACCHSs and remote services operated by States and Territories benefit from this improved PBS access (CDHA 2010d).

¹³⁵ The MBS items 704,706,708,710 have now been replaced by the single MBS item 715, and the MBS item 711 has been replaced by MBS item 10986 for a health assessment provided by a Practice Nurse or registered Aboriginal Health Worker, viewed 12 July 2010, <[http://www.health.gov.au/internet/main/Publishing.nsf/Content/A7D118B45060743ECA257743000BE3D3/\\$File/GPfactsheet.pdf](http://www.health.gov.au/internet/main/Publishing.nsf/Content/A7D118B45060743ECA257743000BE3D3/$File/GPfactsheet.pdf)

Government reporting on progress in Indigenous health occurs via a number of routes. These include:

- The annual reports on Closing the Gap presented to the Commonwealth Parliament by the Prime Minister. To date, there have been two (AG 2009; AG 2010a). The second of these annual reports described progress against the six COAG approved targets (AG 2010a, pp. 9-32).
- Reports direct to COAG. For example - the COAG Reform Council 'National Indigenous Reform Agreement: Baseline Performance Report for 2008-09' that assessed the performance of governments against their commitments to life expectancy, child mortality, access to early childhood education, literacy and numeracy, education attainment and economic participation (COAGRC 2010); the 'National Healthcare Agreement: baseline performance report for 2008-09' that considered social inclusion and Indigenous health, and the COAG agreed target to halve the gap in mortality rates for Indigenous children under five within a decade (COAGRC 2010a, pp. 193-215, 244); and the first report from the Co-ordinator-General for Remote Indigenous Services in December 2009 (COAG 2009b, p. 13);

Overcoming Indigenous Disadvantage series of reports commissioned by COAG and produced by the Steering Committee for the Review of Government Service Provision (SCRGSP) at the Australian Government Productivity Commission (AGPC)¹³⁷. The fourth report in the series entitled 'Overcoming Indigenous Disadvantage: Key Indicators 2009', has a framework that aligns with the six targets of COAG for Closing the Gap in Indigenous disadvantage (SCRGSP 2009). The framework has 'priority outcomes' at the top, and in successive layers below, 'COAG targets and headline indicators', 'strategic areas for action', and 'strategic change indicators' at the lowest level (SCRGSP 2009, pp. 2.1-2.7);

The Aboriginal and Torres Strait Islander Health Performance Framework (ATSIHPF) was developed under the auspice of AHMAC to provide the basis for measuring the impact of the National Strategic Framework for Aboriginal and Torres Strait Islander Health (NATSIHC 2004a,b; CDHA 2007d). Two ATSIHPF reports have been completed to date, and both described modest improvements in several indicators of Indigenous health (AHMAC 2006, p. 10; AHMAC 2008, p. 4). The ATSIHPF has three tiers of performance reflecting the whole of government comprehensive primary health care approach to Indigenous health (AHMAC 2008, p. 10):

- * Tier 1 – health status and health outcomes (Measures of prevalence of disease or injury, human function, life expectancy and well being. How healthy are people? Is it the same for everyone? What is the opportunity for improvement?);
- * Tier 2 – determinants of health status (Measures of the determinants of health including socio-economic status, environmental factors and health behaviours. Are the factors that determine good health changing? Is it the same for everyone? Where and for whom are these factors changing?);
- * Tier 3 – health systems performance (Measures of the health system including effectiveness, responsiveness, accessibility and sustainability, and how they are changing over time).

¹³⁶ Details viewed 12 July 2010, <http://www.health.gov.au/internet/main/publishing.nsf/Content/allied_health_ATSI_descent

¹³⁷ The SCRGSP reports are commissioned by COAG. The first edition of 'Overcoming Indigenous Disadvantage: Key Indicators' was published in November 2003, the second in July 2005, the third in June 2007, and the fourth (with 791 pages) in July 2009 (SCRGSP 2009, p. 1.1).

- The Aboriginal and Torres Strait Islander Social Justice Commissioner reports annually to federal Parliament on significant Indigenous human rights issues including health (AHRC 2010d).

The Close the Gap Steering Committee for Indigenous Health Equality (CTGSCIHE) published a 'Shadow report on the Australian Government's progress towards closing the gap in life expectancy between Indigenous and non-Indigenous Australians' in February 2010 (CTGSCIHE 2010b). This report acknowledged that the Government had made significant progress since signing the 'Statement of Intent' in March 2008, but that key commitments from the 'Statement of Intent' remained unmet (CTGSCIHE 2010b, p. 5). These commitments included:

- To developing a comprehensive, long-term plan of action, that is targeted to need, evidence-based and capable of addressing the existing inequalities in health services, in order to achieve equality of health status and life expectancy between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians by 2030;
- To ensuring the full participation of Aboriginal and Torres Strait Islander peoples and their representative bodies in all aspects of addressing their health needs; and
- To supporting and developing Aboriginal and Torres Strait Islander community controlled health services in urban, rural and remote areas in order to achieve lasting improvements in Aboriginal and Torres Strait Islander health and wellbeing.

A Policy Roundtable of senior bureaucrats held on 26 March 2010 in Adelaide by the Academy of the Social Sciences in Australia (ASSA), the Institute of Public Administration (IPAA), and the Australia and New Zealand School of Government (ANZSOG) discussed Indigenous disadvantage and ways the public service could contribute to improvements in Indigenous well-being (Edwards 2010). The public service was criticised for top-down interventionist strategies, a failure to develop the capacity of its officers to engage and build relationships with Indigenous communities, and the mismatch between stated principles by governments and the time given to implement those principles (Edwards 2010). Podger (2010) considered the public service is disproportionately the problem, finding it hard to operate through close and consistent personal and community relationships. He suggests a new Indigenous agency with a leadership attending to bottom-up relationships with a public service culture not preoccupied with ministers, cabinet and the parliament as occurs in a portfolio department¹³⁸.

There has been an increase in specific funding for Indigenous health over the twelve year period from 1997-98 to 2008-09. One indicator for this is the relative increase in 'Actual Expenditures' on Indigenous health reported in the CDHA annual reports over this period (CDHA 2010f). Figure 1 shows this relative increase in both 'Actual Expenditure' and staff levels in the Central Office of OATSIH in Canberra¹³⁹. The increase in 'Actual Expenditures' (not adjusted for inflation) by OATSIH was from \$139,861,000 in 1997-98 (CDHFS 1998, p. 128) to \$571,658,000 in 2008-09 (CDHA 2009, p. 148)¹⁴⁰.

¹³⁸ Professor Podger was Secretary of the CDHFS (1995-96 to 1997-98) and CDHAC (1998-99 to 2000-01), and Dr Michael Wooldridge) was his Minister over this six year period.

¹³⁹ This data was calculated from the Financial Summaries from each annual report over this period. We have used OATSIH staff numbers in the Central Office compared to the total CDHA staff levels for each financial year because of the completeness of the data over this period compared with OATSIH staff levels across all eight jurisdictions.

¹⁴⁰ The total 'Actual Expenditure' for the CDHFS in 1997-98 was \$21, 820,724,000 (CDHFS 1998, p. 29), and that for the CDHA in 2008-09 was \$49,893,487,000 (CDHA 2009, p. 31).

The increase in staff numbers of the OATSIH Central Office in Canberra over this period was from 72 in 1997-98 (CDHFS 1998, p. 246) to 223 in 2008-09 (CDHA 2009, p. 249)¹⁴¹. According to the AIHW Report (2010b, p. 45) the per-person spending on health and high-level residential aged care in 2006-07 was 25% higher for Aboriginal and Torres Strait Islander Australians than for other Australians. This was due to the significantly higher rates for injuries and a range of major diseases for Aboriginal and Torres Strait Islander Australians. It should be noted however that the bulk of expenditure on health care services for Aboriginal and Torres Strait Islander Australians is through various mainstream programs or funding schemes such as the MBS, hospital care and public health activities.

6.1.5.3 Summary

This period was characterised by a concerted effort by governments, lead by the Commonwealth, on Indigenous health policymaking, building upon preceding policy work. There was a shift towards a whole-of-government approach in 2004, with COAG addressing Indigenous disadvantage as the framework for the whole-of-government approach. Incorporated within this concerted Indigenous health policymaking activity, Indigenous eye health policymaking followed the whole-of-government approach. The VOS and MSOAP schemes were further refined to ensure Indigenous people living in rural and remote areas had better access to these Commonwealth funded outreach programs. A review of implementation of NATSIEHP was released in 2004 together with the Commonwealth Government response to the review. The Government supported the majority of the recommendations of the review. A number of initiatives on trachoma followed soon afterwards. Guidelines for the public health management of trachoma were published in 2006, and a National Trachoma Surveillance and Reporting Unit was established in Melbourne in 2006. The Australian response to the 56th World Health Assembly on the elimination of avoidable blindness in 2003 was the development in 2005 of a National Framework for Action to Promote Eye Health and Prevent Avoidable Blindness and Vision Loss, with five Key Areas for Action. A progress report on implementation of the Framework was released in 2008, and addressed the five Key Areas for Action. A feasibility report of an integrated regional eye service in Central Australia was completed in 2006, and planning for a Central Australia Integrated Eye Health Program commenced in 2006.

The NSFATSIH was published by AHMC in 2004, and Commonwealth Implementation plans and Health Performance Framework reports were released. The whole-of-government approach to Indigenous affairs made mainstream agencies responsible for the delivery of Indigenous specific services. ATSIC and ATSIH were abolished, and ICCs established. The NTER commenced in 2007, and there was considerable reporting around this Commonwealth program; the NTER has now been renamed Closing the Gap: NT. In 2008 COAG agreed to six targets for closing the gap across urban, rural and remote areas, with \$4.6 billion provided for Indigenous initiatives in early childhood development, health, housing, economic development, and remote service delivery.

A NIHEC was established in 2008, and a \$1.578 billion National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes commenced in 2009-10. The CDHA improved access for Indigenous people to the MBS, PBS, and mainstream health services through a number of initiatives over this period. There was a relative increase in CDHA spending for Indigenous health programs over the period 1997-8 to 2008-9.

¹⁴¹ The total staff in the Central Office of CDHFS was 2,110 in 1997-98 (CDHFS 1998, p. 246) and 3,453 in 2008-09 (CDHA 2009, p. 250).

6.2 A case-study of water and Indigenous eye health

There is strong evidence that access to an adequate supply of clean water for all uses (e.g. drinking, washing, bathing, and recreation) is essential for human health and wellbeing (WHO 2010). A study of children living in Yalata community in SA in 1967 found a high prevalence of trachoma, which was associated with limited access to water (Hardy et al 1967). Ida Mann reportedly once said the best medicine for trachoma was water (Newfong 1989, p. vii), and Fred Hollows recommended in 1978 during the NTEHP that swimming pools be built in three Aboriginal communities in WA (Interviewee 2, 2010, pers. comm., 11 March; Interviewee 10, 2010, pers. comm., 11 April)¹⁴².

The SAFE strategy for trachoma control indicates that access to water is an essential part of the components F and E (WHO 1997), and the swimming pools which have been built in a number of Indigenous communities provide more opportunity for bathing (Audera et al 2000; HPEPL 2009; Lehmann et al 2003; Silva et al 2008). The first swimming pool in an Indigenous community was built in Santa Teresa in 1972 by the Catholic Church, and by 1998, twelve swimming pools had been built in Indigenous communities around Australia (Audera et al 2000). A more recent report describes three swimming pools built in communities in the Anangu Pitjantjatjara Yankunytjatjara (APY) Lands in SA (HPEPL 2009).

The benefits to health of two swimming pools in WA and three in SA Indigenous communities have been evaluated, and two studies found reduced levels of skin infection (HPEPL 2009; Lehmann et al 2003; Silva et al 2008). One of these studies also reported reduced levels of ear infection (Lehmann et al 2003; Silva et al 2008), although the design of this study was criticised methodologically (Roe & McDermott 2009). It was not possible to demonstrate a reduction in trachoma after the opening of the three swimming pools in SA (Mathews et al 2009). Problems with studies such as these have included: small sample sizes; population mobility; reporting bias; and a high turnover of health personnel (Mathews et al 2009). Some pools were closed for extended periods for maintenance or because of the absence of a manager for the pool (Audera et al 2000; HPEPL 2009).

To date, it has been difficult to unequivocally demonstrate the benefits to eye health of swimming pool usage in Indigenous communities because of the multifactorial nature of the risk factors involved. However, there is a strong consensus amongst health professionals that regular access to safe and properly maintained swimming pools is a common good, beneficial to health and wellbeing, and that pools are a component of a broader response to health (Hall & Sibthorpe 2003; EHSC 2006; Rubin et al 2008).

6.3 Screening for diabetic retinopathy

Everybody with diabetes is at risk of developing retinopathy and essentially everybody will. Good control of diabetes reduces the risk specifically with good control of blood glucose, blood pressure and blood lipids. Because timely laser treatment can prevent 98% of the blindness from vision loss, regular screening for diabetic retinopathy is recommended in countries around the world. In most countries, the frequency of screening is recommended to be once every year and this is the frequency recommended for screening of Aboriginal and Torres Strait Islander people. One exception to this global recommendation is for mainstream Australia where the better management and control of diabetes leads to a reduced incidence of complications and exams are recommended to be performed every two years.^{143 144}

¹⁴² The communities were Jigalong, Cundalee, and Wiluna.

¹⁴³ NHMRC. 1997. Working Party on Diabetic Retinopathy. Management of Diabetic Retinopathy. Clinical Practice Guidelines. AGPS. Canberra.

¹⁴⁴ NHMRC. 2008. Australian Diabetes Society for the Department of Health and Ageing. Guidelines for the Management of Diabetic Retinopathy. Commonwealth of Australia. Canberra.

Non-mydriatic retinal photography (photographs taken of the back of the eye with cameras that do not require the use of dilating drops) is a well established and widely used method of detecting retinopathy and the use of these cameras was recommended by NHMRC in 1997 & 2008^{145 146} and also specifically for use in Aboriginal and Torres Strait Islander communities in the 1997 review of Indigenous eye health.¹⁴⁷ Similar recommendations were made in 1998 by the Office for Aboriginal and Torres Strait Islander Health Services.¹⁴⁸ However, the specific recommendation in the Taylor report for Medicare funding or some other form of sustainable funding for this activity was not implemented.

OATSIH funded the purchase of a number of retinal cameras that were placed in Aboriginal Medical Services and in many instances, Aboriginal Health Workers or Regional Eye Health Co-ordinators were trained to operate these cameras. In the absence of sustainable funding for the taking of the retinal photographs, almost all these programs stopped with one or two exceptions such as in the Kimberly.¹⁴⁹ The 2003 report by Taylor & Ewald recommended that there was an “optimal” integration of the specialist services into the primary health care to manage “diseases such as diabetes”. This diffused any further responsibility for collecting retinal photographs, although a recommendation was made for the remuneration of ophthalmologists who read fundus photographs and that this should be in the form of a Medicare Item Number. The Government’s response to this review recognised the importance of regular screening for diabetic eye disease and referred the request for Medicare funding for the reading of photographs to Health Policy Advisory Committee of Technology (HealthPACT) but no further action was taken. There was no mention of funding for the actual staff required to take the photographs.

The 2003 Horizon Scanning Report prepared for the HealthPACT, a sub committee of the Medical Services Advisory Committee (MSAC), concluded that “screening with either mydriatic or non-mydriatic retinal photography by a mobile clinic in rural areas was found to be cost-effective”.¹⁵⁰

The NIEHS also found only 20% of Indigenous people with diabetes had had an eye exam in the preceding 12 months.¹⁵¹ Applications have been made to MSAC for Medicare support for non-mydriatic screening on at least three occasions since 1997 and at the time of writing, a further application has just been lodged.

¹⁴³ NHMRC. 1997. Working Party on Diabetic Retinopathy. Management of Diabetic Retinopathy. Clinical Practice Guidelines. AGPS. Canberra.

¹⁴⁴ NHMRC. 2008. Australian Diabetes Society for the Department of Health and Ageing. Guidelines for the Management of Diabetic Retinopathy. Commonwealth of Australia. Canberra.

¹⁴⁵ Ibid.

¹⁴⁶ Ibid.

¹⁴⁷ Taylor, HR. 1997. Eye Health in Aboriginal and Torres Strait Islander Communities. Canberra, Commonwealth of Australia.

¹⁴⁸ Kimberley Aboriginal Medical Services’ Council. 1998. Recommendations for Clinical Care Guidelines on the Management of Non-Insulin-Dependent Diabetes in Aboriginal and Torres Strait Islander Populations. Canberra, Commonwealth of Australia.

¹⁴⁹ Taylor, V. Ewald, D., Liddle, H., Warchiver, I. 2004. Review of the Implementation of the National Aboriginal and Torres Strait Islander Eye Health Program. Canberra, Commonwealth of Australia.

¹⁵⁰ Australia & New Zealand Horizon Scanning Network. 2005. National Horizon Scanning Unit Horizon Scanning Report: The detection of diabetic retinopathy utilising retinal photography in rural and remote areas in Australia, October 2004, Commonwealth of Australia.

¹⁵¹ Taylor HE. 2009. National Indigenous Eye Health Survey – Minum Barreng (Tracking Eyes). Melbourne, Indigenous Eye Health Unit, Melbourne School of Population Health in collaboration with the Centre for Eye Research Australia and the Vision CRC [cited 2010 17 February]. Available from <http://www.iehu.unimelb.edu.au>.

7.0 FINDINGS – INTERVIEWS

7.1 Introduction

This section is divided into 5 parts namely:

- The aims of the research.
- Respondent details and interview themes.
- 1976-1979 National Trachoma and Eye Health Program - Respondents' perspectives about Indigenous eye health policies (7.2).
- 1990-2010 Commonwealth public servant and consultant perspectives of Indigenous eye health policies (7.3).
- 1990-2010 - Fred Hollows Foundation, Royal Australian and New Zealand College of Ophthalmologists, Alice Springs Hospital Eye Department perspectives of Indigenous eye health policies (7.4).

7.1.1 The aims of the research

The aims of the research were to:

1. Describe the development of Indigenous eye health programs and policy from the National Trachoma and Eye Health Program forward;
2. Identify the key barriers and facilitators to effective policy and program development; and
3. Identify strategies for future systems reform in this field.

7.1.2 Respondent details and interview themes

The details of the 23 respondents are described in section 5.2.3 of the Methods on page 4. The individual interviews contained four themes related to the aims of the research. They were:

- a) Respondents' role in policy development (related to Aim no 1);
- b) Policy processes in Indigenous eye health (related to Aim no 1);
- c) Evidence and resources (related to Aim no 2); and
- d) Implementation and Other Issues (related to Aim no 3)

The accounts of the respondents who were associated with the 1976-1979 National Trachoma and Eye Health Program and afterwards in the area of Indigenous health, are shown separately (see 7.2) to respondents who were involved in Indigenous eye health post NTEHP. A timeline of significant events/policy making is at page 11 as a reference point while reading the interview findings.

7.2 1976-1979 National Trachoma and Eye Health Program - Respondents' perspectives about Indigenous eye health policies

7.2.1 Respondents' role in policy development

The seven respondents (4 non-Aboriginal males, 2 Aboriginal males and 1 Aboriginal female) associated with the National Trachoma and Eye Health Program were also at various times associated with organisations such as Aboriginal and Torres Strait Islander Health Organisations, ACCHSs, Central Australian Aboriginal Congress, academic institutions and State and Commonwealth Departments. Their collective experience in Indigenous health is considerable, the longest individual period being 40 years. Their initial roles were either located within the NTEHP or they were influenced by or worked closely with members of the NTEHP.

All the respondents considered Indigenous eye health very important as a result of their involvement with the NTEHP. Other factors were that Aboriginal organisations had the potential to influence Aboriginal health, their first hand knowledge that eye health was a major problem, and the NTEHP could make a difference and be used as a guide for other problems. One respondent observed:

Eye health was very important at that time. Fred [Hollows] said people thought blindness was a natural progression. Fred said it didn't have to be like this. Many of Fred's colleagues were shocked about trachoma, only this was so (Respondent 06).

Community people also worked on the NTEHP. There were 5 to 6 AMS programs running at the same time which became an example of community control. The NTEHP also recognised the need to treat Aboriginal people in bush camps and that more complex training was required in primary health as well as eye health.

Some respondents contributed to the NTEHP Report (RACO 1980) which had far reaching effects beyond eye health, such as the other services that the NTEHP provided to rural and remote Australians. The Report brought attention to the poor health and living conditions of Indigenous people and the worth of a 'good' AMS.

Members of the NTEHP were all like-minded people who had enjoyed good leadership during the Program. Some noted there had been a need to 'stir up' the AMS movement at the time, and emphasised the importance of treating people with respect and recognising the differences between language groups and country. They stated that the NTEHP was one of the first major programs that led to many other instances of applying policies to need in all areas of health, which impacted on State and Federal programs.

The NTEHP and the subsequent Trachoma Program shaped these respondents' thinking because the NTEHP exposed the fact that poor eye sight is not normal. Consequently, Indigenous eye health gained importance for these respondents who lobbied for the surgery program to continue. Certain members of the NTEHP sought recognition that a national coordination unit was required to oversight co-ordination of communities, clinics, eye teams in the field, regional hospitals and the central areas.

However it was obvious to some respondents that their thinking about the relative priority of Indigenous eye health differed from Government agencies, and other doctors involved in Indigenous health in particular, who had their own agenda in areas such as diabetes or heart disease. One respondent stated:

They had a body part approach and a holistic approach was not considered fashionable. Responding to chronic disease was not advisable and therefore eye health was not given the priority it deserved at that time (Respondent 01).

7.2.2 Policy processes in Indigenous eye health

In recalling the time leading up to the NTEHP respondents noted that after 1967 the Federal Government directed Aboriginal affairs including health. And only after the Redfern AMS was set up in 1971 did State Governments introduce Aboriginal agencies. Fred Hollows helped initiate the Redfern AMS, guided eye health services for Aboriginal people, and brought into focus that eye health was a major problem.

In 1973 the CDAA was established followed by the VOS in 1975 and NAIHO in 1976. From 1976 to 1979 the Commonwealth funded NTEHP administered by RACO was rolled out. Respondents considered this Program resulted from Fred Hollows' drive, and his influence with certain politicians. They observed, from this experience, that key individuals need to be in the right place at the right time to influence government ministers in policy making.

The respondents who were involved in the 1978/79 enquiry into Aboriginal health initiated by Prime Minister Fraser lobbied the Prime Minister to make him aware of their opposition to separating ACCHSs and Primary Health Programs.

Extent of Indigenous people's involvement in policy development and implementation

In considering the extent of Aboriginal people's involvement in implementing policies at the time of the NTEHP one respondent said that the Aboriginal people were involved in all aspects of the Program. For example, consultations were carried out with ACCHSs and the local community people were employed as team members. There was local community control in the Program and community people communicated with the non-Indigenous professionals in State and Territory government departments about the Program. Debriefing sessions considered any problems, and they were rare. While some resentment existed at the time about 'blow-ins' from the outside, the NTEHP introduced a continuing relationship with communities.

Another respondent considered there was not sufficient Aboriginal involvement in developing policies at the time of the NTEHP, although certain processes existed through NAIHO. There was a lack of 'forward going energy' by key individuals, and community drive to address issues.

Relationship between Federal, State and Territory Indigenous policy makers

Strained relationships existed between Federal and State Governments at all levels of the bureaucracy, some respondents noting the perennial problem of the State or Territory withdrawing funds and the Commonwealth left with the responsibility for funding programs.

Barriers and enablers of policy development and implementation

The respondents considered that the barriers which affected the priority attached to Indigenous eye health development and policy implementation included the Federal and State issues of funding and responsibility, as well as 'crippled policy making processes' at Indigenous and non-Indigenous levels. In addition various government ministers had other priorities, due to the difficulty of focusing on Indigenous eye health when no constituency existed for this. The barriers the NTEHP encountered on the ground were the State Branches of the College of Ophthalmologists, the agitators in bureaucracies who refused to let in the NTEHP, and the Station Managers. Those who enabled development and implementation of policies were the Indigenous people, ACCHs, the NTEHP, and journalists who organised publicity.

7.2.3 Evidence and resources

At the time of the NTEHP evidence was a part of the whole policy making process. The NTEHP (RACO 1980) Report contained wide ranging recommendations from improving living conditions to the provision of health services and continuing the NTEHP. The CDH initiated another report in late 1983.

The recommended option was a national secretariat to oversee the development of a revitalised NTEHP with a national field program, national data collection and an epidemiological surveillance unit. Following a third review in 1985 the Minister of the day agreed to the continuation of existing programs. In addition, the 1989 NAHS contained 3 goals and 7 strategies for Indigenous eye health.

Under ATSIC (1990-2005) the Indigenous controlled Trachoma and Eye Health Committees in QLD, SA and NT continued to be funded. Community screening for trachoma made up a large component of their workload. Specialist eye health services in WA, Tasmania, NSW and VIC operated on an ad hoc basis. The Australian Army undertook exercises to reduce a backlog of eye surgery cases in Alice Springs in 1994, in Katherine in 1995 and the Tiwi Islands and Maningrida in 1996 but could not provide on-going or routine care. In 1997 the trachoma teams were abolished and replaced by a regional program model. Fred Hollows had concluded his trachoma and Indigenous eye health work in Australia in the late 1980s except for providing eye care to the people of Bourke. The FHF was officially launched on 3 September 1992 and Fred Hollows died in 1993.

In thinking about the resources which were available for the work of the State-based Trachoma and Eye Health Committees, one respondent considered that initially the number of people working on the NTEHP and the financial resources were adequate. The unforeseen setbacks encountered tended to be sorry business and floods. However, even when financial resources were reduced people still kept working. There was a lot of voluntary work, improvisation, and strong advocacy by RACO. Another respondent added that although most policies had fallen into disuse by mid-1980, a number had been integrated into ACCHSs and other health services. These committees ended in 1997.

7.2.4 Implementing the National Trachoma and Eye Health Program policies

Respondents commented that the NTEHP policies were implemented almost immediately and initially were 'overwhelmingly successful'. Aboriginal people and health experts worked together and Referral Service Centres referred clients to the ACCHSs and beyond. The NTEHP legacy is there are more than 140 ACCHSs throughout Australia. However, some associated policies were not implemented because they encountered the Federal/State responsibility divide. Other policies were not implemented due to briefings provided to politicians by bureaucrats. Attention wavered when the NTEHP concluded and the responsibility for the provision of on-going eye care passed from the Commonwealth to the States.

7.2.5. The role of the community controlled health services

When asked to comment on the role played by the Community Controlled Health Services during the NTEHP respondents considered that they as well as Fred Hollows had played a major role – people on the ground listened to Fred. The NTEHP was successful because it was community controlled and consequently self determination ensued.

7.2.6 Respondents' involvement in policy development and implementation after 1980

The respondents' subsequent work since 1980 has been in advocating for Indigenous eye health, formulating reports which contribute to shaping State and Commonwealth Government Indigenous eye and primary health policies, developing evidence-based advocacy with governments and oppositions, working with community health clinics, and organising regional co-ordination of State/private services.

In particular, their involvement in policy making has included participation in the Ministerial review into the continuation of the Trachoma Program 1983/84; the 1989 National Aboriginal Health Strategy and its review in 1999; Aboriginal Medical Service programs in 1990; the 1997 National Review of Indigenous Eye Health, and the National Strategic Framework for Aboriginal and Torres Strait Islander Health in 2004.

The respondents observed that in the 1980s and 1990s there was not a great deal of interest in Indigenous health, adding that there was a reduction in eye health funding around 1990 when ATSIC wanted to reduce community control. Although government ministers might have been supportive of NACCHO which replaced NAIHO in 1992, Indigenous eye health was not a high priority in spite of the recognition by some that Indigenous health is a moral issue. At that time regional health services were predominantly for non-Indigenous people. The general thinking was that money spent on Indigenous health was wasted money. In addition, the State/Federal divide meant there was competition for funding for other problem areas.

The 17 recommendations contained in the 1997 National Review of Indigenous Eye Health related to primary eye care services, specialist eye services, specific eye conditions, the environment and a national information network. Following the recommendations in the Report funding for State based eye health services ceased and major advances were made in developing regional implementation plans in several States. In addition the one treatment drug for trachoma, Azithromycin, was added to the PBS for trailing. In 1997 the Minister of the day abolished the remaining State-based trachoma teams on advice from his department and these were replaced by the National Aboriginal and Torres Strait Islander Eye Health Program.

Respondents also noted that there were implementation issues with OATSIH following the 1997 National Review of Indigenous Eye Health – recommendations were partially carried out, ignored, or considered on-going. The important recommendation for an annual national overview and for accountability reporting to the Australian Health Ministers' Advisory Council was not adopted.

The current approach in influencing Indigenous eye health policies is to influence government ministers of the day. Emphasis is on lobbying the policy makers (politicians and bureaucrats) at the State and Federal level as well as at the community level, and producing reports to obtain lasting import on the ground. It is important to engage government ministers with a strategic approach including international experience. One respondent observed that creating evidence-based reports containing eye care health economics is important in mainstream eye health policy making and it is important to employ the same approach in the Indigenous eye health policy process. Another respondent considered that supported research funding has helped change policies, and better links now exist with the OATSIH and NACCHO.

When asked about the role played by ACCHSs in developing and implementing Indigenous eye health policies respondents considered that:

The Aboriginal Medical Services were a barrier to change as they were too interested in their own survival, but the Royal Australian College of Ophthalmologists could be a real cause for good (Respondent 11).

Stand alone projects cannot work. Task Force projects should be integrated into the community structure to engage local champions in the work. Aboriginal Medical Services played no real pro-active role when the National Trachoma and Eye Health Program concluded. They did however integrate some eye health into their services with some access to ophthalmological services. Much of the policy work of the Aboriginal Medical Services was taken over by national provider lobby groups such as the Australian Indigenous Doctors' Association, the National Aboriginal and Islander Health Organisation and the National Aboriginal Community Controlled Health Organisation (Respondent 10).

Another respondent noted the huge variation of ACCHSs across the country adding that some need a wider view and others have issues and problems of power and control in decision making.

7.2.7 Concluding comments

In offering concluding comments respondents considered that: recommendations and guidelines contained in many existing reports (for example, Taylor 1997; OATSIH 2001; Taylor et al 2004; CDHA 2005a; CDHA 2006a) should be implemented across Australia; an Indigenous Health Department - a statutory authority independent of government funding and funded through the GST contribution should be created; and an Indigenous Unit should be included in the former Prime Minister's (Kevin Rudd) proposed health network.

7.3 1990 - 2010 Commonwealth public servant and consultant perspectives of Indigenous eye health policies 7

7.3.1 Respondents' role in policy development

ATSIC was established in 1990, and abolished in 2005. Eight respondents (3 non-Indigenous females, 3 males, and 2 Indigenous males) provided perspectives of Indigenous eye health policies from the 1990s to 2010 drawing on their experience while employed in the Commonwealth's Indigenous health portfolios. The perspectives of 3 non-Indigenous respondents (1 female, 2 males) who have been involved in Indigenous eye health policies in consultancy roles are also included.

7.3.2. Policy processes in Indigenous eye health

Following the NAHS in 1989, the respondents were involved during the 1990s, in a variety of programs such as: designing a more systematic approach to health interventions; applying for ATSIC grants for ACCHSs; sexual health, HIV/AIDS and renal health; the Trachoma Program until its conclusion in 1997; the National Review of Indigenous Eye Health in 1997, and the National Aboriginal and Torres Strait Islander Eye Health Program Review in 2003.

Indigenous health debates in the 1990s centred around eye health and its over emphasis over other illnesses with higher burden of disease, the need for a long term view of primary health care, and conflict with competing vertical programs and primary health care. One respondent commented:

A focus on the big burden of disease and less focus on body parts approach was needed and we needed the best evidence base available to do this (Respondent 07).

Respondents noted that ACCHSs also wanted to move away from body parts programs to the primary health care approach. They were against the 'fly in fly out model' and wanted adequate services, especially ophthalmologists' services. Some respondents commented on the increasing influence of politicians to import their own ideas on the policy process which generally involved input from committees and NACCHO.

By 1998 OATSIH was implementing the service delivery facet of the regional eye health model recommended in the 1997 National Review of Indigenous Eye Health. Issues of role clarification and systems infrastructure, tendering for eye equipment, a financing system for ophthalmologists visiting in remote areas, and Medicare funding for Aboriginal people were being worked through. The specific problems public servant respondents encountered in implementing the Indigenous eye health policy were

Medicare's reluctance in making a special allowance for Indigenous people, and RACO's delay in developing a financing system for ophthalmologists who would visit remote areas, critical in delivering eye health services 'on the ground'. In addition, it was found necessary to stop the \$4 million tendering process for eye equipment, a reflection of the many internal problems within OATSIH.

In commenting about the years after 2000 respondents noted that there was a transfer from vertical to horizontal programs in 2004, as well as a change from the body parts approach. Health was the first agency which tried to integrate Indigenous health into broader programs in 2004. Respondents were involved with the Alan Banscott Review of Central Australia Eye Health in 2005, the Guidelines for Primary Health Review (documents were trachoma centred) in 2006, and the Indigenous Eye Health Survey in 2008. One respondent noted that OATSIH's new broad based funding approach has meant that transparency has been somewhat lost in eye health as well as other areas. In thinking about Indigenous eye health policy making another respondent noted that:

Policy development for sustained change needs an integrated approach. Policy is decision making within structure (Respondent 20).

In recent times specific policies have included the integrated eye health service delivery model for Central Australia and the Barkly - including putting in place the senior co-ordination position in the Alice Springs Eye Health Unit, dealing with the backlog of eye surgery (i.e. improved delivery and access), improvements to VOS and MSOAP, and agreements between the CDHA, States and Territories to tackle trachoma and eye care in Indigenous communities. Respondents noted the significance nationally as well as internationally of the Surgery, Antibiotic, Face, Environment (SAFE) Strategy Guidelines. The Guidelines have gained a primary role in working with three jurisdictions (WA, NT and SA) as well as mapping exercises in QLD and NSW.

Much of the focus has changed from the National Strategic Framework to the work of COAG and Closing the Gap. Closing the Gap in Indigenous Health has also introduced new initiatives such as a 'big emphasis on big diseases' and improvements linked to a productivity agenda. Targets have been agreed to by all jurisdictions. One respondent added that the end result is to try to get good policy agreed to, and to direct health professionals into Indigenous health.

On the importance of Indigenous eye health, respondents offered the following views associated with their experience in Indigenous eye health:

- Indigenous eye health gains in importance when referring to eye health data.
- Areas such as eye health have lower priority and struggle in the overall Indigenous health agenda because of so many other competing issues.
- It is difficult to estimate whether more resources given to eye health would impact on broader issues.
- Medics come and go. It is important to encourage Indigenous people to study in the field of ophthalmology
- Policies were not seriously trying to implant cost effective interventions (e.g. cataract, surgery). Indigenous eye health workers employed with Northern Territory Health were not sure of what they were doing or the source of funds.
- Policies emphasised Indigenous involvement. There was a huge gap after Fred Hollows died.

Extent of Indigenous people's involvement in policy development and implementation

Respondents considered that Indigenous people are involved in eye health policy consultations and negotiations and feedback is given to communities from the bureaucracy in the policy making process. Thinking further about this process they added that:

- There are more Indigenous people in organisations such as AIDA and consequently the system is now more robust than before. Indigenous control is not going away; it is here to stay.
- Indigenous public servants in Commonwealth Departments are involved in the policy making process.
- Broad consultation takes place on National Partnership Agreements. The major focus is on outcomes and less direct management from the Commonwealth.
- The National Aboriginal Community Controlled Health Organisation, Aboriginal Medical Services, Australian Indigenous Doctors Association are all involved in consultation.
- The Department has responded to feedback, such as the body parts criticism which was widespread. Feedback has been received about the need for better co-ordination of chronic diseases.
- Many Departmental staff have visited communities.

Relationship between Federal, State and Territory Indigenous policy makers

Referring to earlier times one respondent stated that there were some issues concerning the State/Territory Government relationship in the Tri-State sexual health project. Co-ordination was good but the project needed a partnership approach.

While some respondents commented that they have had no direct involvement with other governmental Indigenous policy makers and had not been involved in consultations in recent times about the Trachoma Program, others thought that there were not enough educated Indigenous people 'to fight it out' with the Federal and Northern Territory government health people on policy detail. They considered that education is critical for advancement and this is the reason why health issues are not resolved.

Barriers and enablers - policy development and implementation

Enablers – Respondents' views about enablers included:

- Fred Hollows' resultant influence.
- Individuals who lobbied and had an impact; regional eye health co-ordinators; the AMA and RANZCO.
- A Minister of the day who was supportive of the Central Australia work.
- Achievements of staff despite all the barriers.

Barriers – Respondents' views about the barriers included:

- The time when ear health had higher priority than eye disease and eye health was not the key driver of policy making.
- No recognition that intergovernmental relationships are strengthened through partnerships.
- Barriers caused by NACCHO's disinterest in eye health.
- The NT Government which did not put enough resources into the Centre for Eye Health in Central Australia.
- Eye health is not heavily featured in Closing the Gap: NT.

7.3.3 Evidence and resources

Some respondents considered that in the 1990s evidence was required on the burden of disease, and whether the need was the greatest in rural, urban or remote locations. There was a bias towards remote locations in discussions. However chronic diseases were widespread in all locations and limited funding resources could not meet all needs.

Other respondent observations about the importance of evidence and resources were that:

- The Surgery, Antibiotic, Face, Environment (SAFE) strategy for trachoma has some evidence base.
- Evidence is needed to substantiate the impression that main streaming should not be enforced by the Department.
- Evidence is critical. Real data on trachoma rates was obtained in 2008/9.
- Eye health is more political than other areas. However, there is a need to fight for eye health and adequate resources. Administrators' inability to co-ordinate and communicate is a problem.
- The NTEHP put eye health on the map and continues to receive attention about the inequalities.
- A robust health system and value add programs are required to benefit Indigenous eye health programs.
- Consultancy resources have been generous.
- There have been insufficient resources to develop policy. The COAG framework may demand stronger evaluative framework.

7.3.4 Implementation issues

The respondents noted that the recommendations in the 1997 National Review of Indigenous Eye Health were implemented in a piecemeal fashion and it took a long time to implement Azithromycin. One respondent had been involved in implementing policies related to the Indigenous Eye Health Centre in Alice Springs and another in primary health care policies (including eye health).

7.3.5 Role played by community controlled health services in the development and implementation of Indigenous eye health policies

The following respondents' perspectives about the role played by Community Controlled Health Services relate to their experiences from the 1990s to the present time.

- Active participation of ACCHSs in the Northern Territory and Central Australia is critical. The regional eye health co-ordination has had a mixed role. The AMS control is good but implementation needs strengthening.
- Real improvements were made when the primary health care approach was developed. The professionals working in the ACCHSs were very influential and some tensions developed. NACCHO wanted community members to be involved in the process of implementation as well as the non-Indigenous medical staff.

- By 1999 most eye health co-ordinators were operating out of ACCHSs. Resources were limited, responsibilities were broad and there was a wide area to cover. The program depended on ophthalmologists.
- Difficulties were encountered due to the lack of co-ordination between ACCHSs and State and Federal Governments in delivering programs.
- In 2006 there was active participation of ACCHSs in the Northern Territory and Central Australia. ACCHSs have a mixed role in regional eye health co-ordination. Implementation needs strengthening. The Government's goal is that not all services be delivered through ACCHSs as there is a need for State and Territory Government services as well.

7.3.6 Concluding comments

The respondents also offered the following concluding comments:

- Ian Anderson was a conduit for much broader views of health, and primary health care including international views.
- Eye health provides a good example for understanding the health system.
- Indigenous eye health policymaking needs to be rigorous. Need evidence, reality about what is possible, accountability, and high quality work.
- Need to acknowledge the transformative power of education for Indigenous people. Teachers in bush schools do not have the training required in a cross cultural environment. Cross cultural education has to go in both directions.
- There is still debate around the vertical versus horizontal model of delivery in the reform agenda.
- Specialists will need to decide how to work with Indigenous people. The fly in fly out model is not sustainable. Need sustainable system and education. There is little cultural training in remote areas.
- Requires financing changes in the Australian health system and support for people such as the Alice Springs Hospital Eye Department.
- The bureaucracy needs a broader perspective on health. Poor staffing in the bureaucracy means that communities suffer.
- The campaign that led to the Close the Gap approach was predicated on a human rights approach.
- There needs to be a shift in power between government and Indigenous people.
- Indigenous health professionals are building capacity across the health workforce. An Indigenous Health Workforce Association is required as well as governance capacity building across the board.
- The potential exists for an international agenda on sovereignty and human rights and relationship with WHO and other international agencies.
- Cultural change is needed within the bureaucracy in current times.

7.4. 1990 - 2010 Fred Hollows Foundation, Royal Australian and New Zealand College of Ophthalmologists, Alice Springs Hospital Eye Department perspectives of Indigenous eye health policies

7.4.1 Respondents' role in policy development

Five non-Indigenous respondents (1 female and 4 male) representing the FHF, RANZCO and the Alice Springs Hospital Eye Department described their various roles in Indigenous eye health policy making.

The FHF was launched in 1992 prior to Fred Hollows' death in 1993. A FHF office was set up in Cairns and included Indigenous eye health. Referring to the 1990s respondents reported that the FHF recognised that eye health needed to be considered in the wider health context as Indigenous eye health is part of a much bigger picture. The FHF adopted the approach that it was not its role to carry out Indigenous health across the board but to help solve issues regarding eye doctors' operations in local communities.

The FHF is currently participating in the Central Australia Integrated Eye Health Strategy. The Strategy is outcome focused and most of the Strategy's actions are operational. One of its aims is to ensure Central Australia and Barkly eye health stakeholders remain active and influential on the wider eye health agenda. The Strategy Steering Committee conducts data gathering and analysis, identifies problems and solutions, and uses this evidence base to advocate for policy reform. The Strategy is funded by Federal and Northern Territory Governments and receives contributions from FHF and the Royal Australian and New Zealand College of Ophthalmologists Eye Foundation.

Eye health and general Indigenous development are the FHF two core areas of activity in Australia, and follow Fred Hollows' pioneering work of community-based action in Indigenous eye health. In addition, Professor Hugh Taylor's work in the 1990s exposed the degree and scale of eye health problems in remote Indigenous communities and was a major catalyst for FHF's involvement in eye health care in Central Australia.

In 2009 the National Indigenous Eye Health Survey demonstrated that eye health for Indigenous Australians is still far worse than for the rest of the population and in fact getting worse in some areas. For example, the incidence of type 2 diabetes amongst Indigenous people has risen 80 fold since the early 1970s, with resultant increases in diabetic eye disease.

The need for action was further highlighted in late 2005 when the Foundation commissioned the Banskott Health Consulting Report Feasibility Assessment to develop a sustainable eye service in Central Australia. The Report identified a fragmented eye health service system in Central Australia that did not sufficiently address the needs of the local Indigenous population. The FHF believes that a base for sustainable improvement exists, including the presence of an ophthalmologist in Alice Springs with a demonstrated long term commitment to Indigenous eye health.

There is some divergence of approaches amongst the Strategy partners (NT and Federal governments, Central Australian Aboriginal Congress Inc., Anyinginyi Health Aboriginal Corporation and the FHF). The FHF advocates a development approach to improving Indigenous health which is consistent with the thinking of the two ACCHSs associated with the Strategy. The NT Government is represented on the Steering Committees by the Alice Springs Hospital. Respondents commented that the NT Government approach to Indigenous health is focused on clinical outcomes with particular emphasis on surgical statistics, to the detriment of cultural procedures. Inappropriate methods of delivery occur through lack of cultural education.

7.4.2 Policy processes in Indigenous eye health

One respondent noted that there has been no overarching policy for Indigenous Eye Health in the FHF. Indigenous eye health is addressed through the mainstream health system and the Indigenous specific primary health care system. This situation has led to service gaps and poor outcomes for remote residents of the NT which has resulted in governments approaching the FHF to support the development of an integrated approach in Central Australia.

In the mainstream eye health field Vision 2020 Australia has provided a strong advocacy voice for Indigenous health. Their Aboriginal and Torres Strait Islander Committee provides input which has been integral to the Strategy project in Central Australia. The Alice Springs Hospital Eye Department co-ordination role is critical and difficult because of the need for a pragmatic application of policies. One respondent further commented that patients deserve the highest quality of care and current policies do not allow this to happen due to the lack of structural support.

Extent of Indigenous people's involvement in policy development and implementation

Respondents considered that community feedback had been taken into consideration in the 1990s providing an example of assisting an ACCHS to develop its own data bases which were utilised in place of the OATSIH system.

Regarding current Indigenous involvement in the development of policies, the Vision 2020 Australia Committee chaired by the CEO of NACCHO provides input. In addition the input of Indigenous people through the two ACCHSs has been integral to the Strategy project in Central Australia.

Respondents noted the importance of adequate consultation, discussion with and feedback to the Indigenous community. They added that the requirement for extended community consultation periods is an issue for governments. The Alice Springs Hospital Eye Department involves Indigenous people in the service and the local committees are involved in the development of policy proposals. The Department has a dynamic relationship with communities and considers the provision of continuing services in Indigenous communities are critical.

Relationship between Federal, State and Territory Indigenous policy makers

Respondents observed that while there is a shared commitment to the delivery of health services between governments and policy makers, there is sometimes not a shared understanding of how best to achieve this and there may be differences of priority. They spoke about the poor relationship between government policy makers due to responsible bureaucrats lacking knowledge and experience in eye health.

Barriers and enablers - policy development and implementation

Thinking about the 1990s one respondent commented that ACCHSs had short annual budget cycles which caused a serious problem and considered it might have been better to align Indigenous health with migrant and poor people's health funding.

The FHF observed that the Federal Government has currently committed strongly to international eye health through programs like the *Avoidable Blindness Initiative* and has engaged positively with the eye health sector through Vision 2020 Australia. However, specific attention to Indigenous eye health and achieving an appropriate priority has proved more challenging. The size of the health system is a significant barrier and there are difficulties in developing policy for the hospital sector or a small population group. Consequently despite evidence of high levels of avoidable blindness, as a result of low access to

cataract surgery there has not been any major initiative across the whole system to address these issues.

While the FHF considered that enablers are the highly committed politicians and bureaucrats who develop policies and allocate funding, RANZCO considered that enablers are visits to communities, the people with understanding and prior knowledge of provision of Indigenous health, the grass roots people who drive funding, the Minister who is interested in Indigenous health because it is a vote catcher as well, and individuals who advocate for the cause. The barriers are found in the rigid funding guidelines and the misunderstandings which occur in communication with government bureaucrats.

From the Alice Springs Hospital Eye Department perspective there is frustration associated with the policy process and policies already developed are not implemented. The observation was made that patients' views are inconvenient in the policy making process and therefore their opinions are not taken into consideration.

7.4.3 Evidence and resources

Respondents considered that the 1997 National Review of Indigenous Eye Health provided evidence which was previously lacking. Available resources in the 1990s included the Cape York Indigenous Eye Health Model which respondents considered could be applied nationally. Other resources nominated by respondents included public and private facilities for clinical services, consultations with the Federal Government, and assistance from State Governments.

The FHF observed that governments have responded to the evidence of high rates of trachoma in some locations by instituting trachoma policies and programs. While this is positive it does not address the eye health problems that are contributing to the main burden of blindness among Indigenous Australians. A national survey of Indigenous eye health issues released recently does not seem to have had a significant impact on eye health policy to date. The Alice Springs Hospital Eye Department recognises the need for evidence-based policies and collects data on surgery and clinics.

Regarding resources, the FHF has received funding from government to support a position to carry out the work of the Strategy as well as resources to fund the eye surgery work, community engagement and patient support at the Alice Springs Hospital. The FHF and RANZCO have contributed resources to ensure the success of the Strategy and allow the complete range of activity to be implemented. The FHF supports the Alice Springs Hospital Eye Department in an environment of insufficient resources due to competing interests.

7.4.4 Implementation issues

The policies recommended in the 1997 National Review of Indigenous Eye Health took a long time to implement and were not implemented totally. The Government was reluctant to set up the information network, the central point for information to influence policy making and policies. Respondents considered that this is still needed in Indigenous health and added that it has been the FHF's biggest failure not to achieve this. One respondent who became involved in the implementation of the 1997 Review for a time through OATSIH recalled the difficulties they encountered in obtaining commitment from the States and Territories, and the project officers' lack of expertise in this field of work. When the 1997 Review did not get much traction the suggestion was raised whether the FHF should re-focus on eye health rather than community development.

Around the late 1990s the FHF considered that with the 1997 National Review of Indigenous Eye Health it was time for the government to take responsibility for Indigenous eye health. The FHF did however assist the Sunrise Health Service in its health delivery in the Katherine region, including putting good food into the stores, and cooking programs. The FHF co-ordinated 'eye surgery blitzes' in Alice Springs over 5 years, and provided low cost glasses in the Top End for 3 years. At this time the FHF also decided that any action needed to come from the ground up, from community people and empowerment of Indigenous people would be critical to moving forward. Respondents noted however, that the FHF kept in touch with the politicians, wrote submissions and attended meetings.

The FHF Strategy is in the process of implementation. This is an on-going project over some years. Ophthalmologists visit and work with communities. The next stages will involve the FHF giving control of the project to the health services and government agencies responsible for eye health in the region. The FHF is hopeful that the outcomes will influence broader policy in other regions.

7.4.5 Role played by community controlled health services in the development and implementation of Indigenous eye health policies

Respondents considered that the community controlled health services play an important role in policy development. The input of the Indigenous people on the Strategy in Central Australia through the two community controlled health services, has been integral to the project. As equal partners with the Federal and Northern Territory governments in the development and implementation of the Strategy the two ACCHSs have been pivotal in ensuring that the needs, rights and wishes of Indigenous people have been the major driver of policy development.

7.4.6 Concluding comments

From a RANZCO viewpoint future policy making requires input from individuals with a background of working in rural areas, an interest in Indigenous eye health, and having cultural awareness. Future lobbying/advocacy requires key high profile, passionate people who can communicate, and policy implementation requires a correct mix of appropriate people, and interested persons in all levels of government, with leadership and mentoring qualities.

From the Alice Springs Hospital Eye Department perspective, it is important that the Department receives help with what needs to be done in providing support and resources, instead of advice about what should be done. The work is on-going and there must be improvements in efficient, cost-effective care. The North Queensland Model of Care should be given consideration.

8.0 DISCUSSION

The respondent perspectives of Indigenous Eye health policies were presented in three groups:

1. Respondents associated with the 1976-1979 NTEHP and afterwards.
2. Commonwealth Public Servants and consultants - 1990-2010.
3. Respondents associated with FHF, RANZCO and Alice Springs Hospital Eye Department – 1990-2010.

8.1 Respondents' role and policy processes in Indigenous eye health

The respondents' role in Indigenous eye health policy processes vary from hands on to policy development and delivery. Consequently each group contained members having different characteristics. They can be described as follows. The NTEHP group exhibited passion for their work and

were guided by the strong charismatic leadership of Fred Hollows. The NTEHP attracted Indigenous and non-Indigenous people who became more convinced of the importance of Indigenous eye health the more they gained first-hand knowledge of trachoma. They experienced personal connections with the communities they assisted while travelling and working on the Program. And they came to the realisation that the NTEHP could make a difference and be used as a guide for change in considering other problems. This is evidenced in the on-going work of certain members today in research and journalistic endeavours.

A contemporary example of similar dedication in providing Indigenous eye health care is found in the third group in the connection that the Alice Springs Hospital Eye Department has with Indigenous communities in delivering eye health care in Central Australia. As part of Central Australia Integrated Eye Health Program the Alice Springs Hospital Eye Department has been funded to carry out intensive eye surgery from 2010 to 2013.

Other contemporary compassionate change leaders are the medical professionals and academics that have delivered and continue to deliver, through their consultancies with the Commonwealth Government and through their evidence-based Indigenous eye health research. Their expertise contributes to policymaking and programs. However, the extent that their recommendations are taken up has depended on Government funding, the attitude of the Minister of the day, and the content of departmental Ministerial briefing notes. Recognition of the importance of consultation and negotiation with and feedback to Indigenous communities has increased in recent times. However, the methods used to introduce the Northern Territory Emergency Response in 2007 raise doubts that this philosophy is understood and followed by government policy makers and implementers.

The lack of Indigenous people employed in high level positions in the Commonwealth Public Service and the transitory nature of Public Servants have contributed to the poor eye health and cultural knowledge which can impede policy making and program delivery. Sufficient emphasis has not been given to training Public Servants in carrying out their duties in this culturally specific area.

8.2 Barriers and facilitators to effective policy and program development

The respondents' perceptions of the barriers to effective policy and program development include a lack of evidence base in Indigenous eye health, a lack of resources, report recommendations not implemented, narrow attitudes of ACCHSs, the size of the health system, poor co-ordination/structural support for programs, and lack of cultural education for workers in the field and in the Public Service. Respondents also nominated the Federal/State Government responsibility divide over funding, different priorities, and lack of knowledge and experience in eye health. Respondents considered that the facilitators are the highly committed politicians, advocates, bureaucrats, ACCHSs, RANZCO, FHF, and the AMA.

Barriers and facilitators of Indigenous eye health programs can be tracked through its peaks and troughs commencing with the NTEHP's success. Funding for the NTEHP catered for non-Indigenous as well as Indigenous people throughout rural and remote Australia. The Program had a strong champion in Fred Hollows who was able to exert influence on the Minister of the day.

Policy development suffered in the 1980s and 1990s in the absence of a champion for Indigenous eye health, mainstream apathy, shared departmental responsibility for Indigenous health, and its location in 3 organisations from 1984 to 1995. Respondents have noted that Indigenous eye health was not a high priority in the 1980s and 1990s following the NTEHP and money spent on Indigenous health was considered wasted money. There was a reduction in eye health funding around 1990 when ATSIC wanted to reduce community control. The State and Federal divide meant there was competition for funding for other problem areas.

Respondents indicated policy implementation issues existed at OATSIH in carrying out the 1997 National Review of Indigenous Eye Health recommendations which were partially carried out, ignored or considered ongoing. They reported poor linkage between OATSIH and NACCHO (which has since improved).

A period of renewed interest in Indigenous eye health occurred after Professor Hugh Taylor drew attention to the internationally recognised SAFE Strategy. Additionally, an advocacy role for Indigenous eye health was undertaken by Vision 2020 Australia (a part of the joint global initiative of the World Health Organisation and of the International Agency for the Prevention of Blindness) when it was established in Australia in 2000. The Department of Health and Ageing is a member organisation and the chair of its Indigenous Committee has been the NACCHO CEO. Respondents commented that the SAFE Strategy has provided some evidence base for trachoma and Vision 2020 Australia has provided a strong advocacy voice for Indigenous eye health. They also noted the transfer from vertical to horizontal programs in 2004 and a change from the body parts approach in policy making.

In 2004 the Council of Australian Governments addressed Indigenous disadvantage as the framework for whole of government approach. This approach has made mainstream agencies responsible for delivery of Indigenous specific services, refined the Visiting Optometrist Scheme and the Medical Specialist Outreach Assistance Program for improved rural and remote access as well as Commonwealth Outreach Programs. Some respondents in the study expressed concern about the viability of the fly-in fly-out model of treatment. However, this is often the only viable option in small communities when specialists cannot live in a community of 1000 and patients cannot travel to a capital city for service.

In 2006 Guidelines for public health management of trachoma were published and the National Trachoma Surveillance and Report Unit was established in Melbourne. Planning for an integrated regional eye service in Central Australia also commenced.

Following the Northern Territory Emergency Response in 2007, renamed Closing the Gap: NT, the Australian Government committed \$58 million over four years in 2009 for chronic eye and ear disease for Indigenous Australians. The former Prime Minister (Rudd, 2009) and the Minister for Families, Housing Community Services and Indigenous Affairs announced at least 1,000 additional eye and ear surgical procedures and an increase of at least ten regional optometric teams to treat and prevent eye disease in NT, WA, SA and other states where trachoma is identified.

Within a small interview base of 11 Public Servants and consultants, respondents indicated that they had been involved in some of the associated work of these initiatives. They noted the requirement for a shift in power between government and Aboriginal people, the ongoing debate around the vertical versus horizontal model of delivery and broad based funding in the reform agenda, and the lack of emphasis on Indigenous eye health in Closing the Gap: NT.

8.3 Strategies for future systems reform

The task of raising awareness of the existence of trachoma in communities today is not clear cut. Fred Hollows galvanised the Minister of the day in a program which included mainstream and Indigenous people suffering from trachoma. His enthusiasm was caught by Indigenous and non-Indigenous colleagues and community members whom he empowered.

Today's champions in eradicating trachoma in Australia are the authors of numerous articles, evidence-based reports and reviews on trachoma. They also lobby Ministers, State and Federal bureaucrats, private foundations and Aboriginal communities to draw attention to Australian and international evidence for action in eradicating trachoma in Indigenous communities in Australia. The importance of Indigenous leadership suggests that in 2010 empowerment for placing trachoma and Indigenous eye health at the forefront of consciousness could be found within the newly formed Indigenous organisations in 2010.

Additionally, the necessity for change within the organisational culture of the policymaking and implementation organisation must be recognised as a strategy for future reform. Theorising about organisational culture in 1993 Goldhaber concluded that 'culture is usually long term, rooted in deeply held values, and often very hard to change' (1993:69). More (1998:30) argues that 'successful organisations are those that initiate change, respond to change, plan change, and implement change as an on-going way of life'.

Adopting a true commitment to diversity in Indigenous policymaking environments requires strong leadership while influencing people to follow that direction. A more sophisticated policy framework in Aboriginal health that simultaneously maintains a focus on system issues and develops targeted strategies for problems such as Indigenous eye health is paramount.

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