Evidence-based policy making in Aboriginal and Torres Strait Islander health

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AIATSIS

Abstract: *Evidence-based policy making in health is of great importance when addressing issues of Aboriginal and Torres Strait Islander health inequalities. I explore the role of evidence in influencing the decisions of policy makers, and question the relevance and accuracy of current evidence to the life experiences, social and cultural environments, and aspirations of Aboriginal and Torres Strait Islander persons. I examine the concept of evidence and Lin's (2003) competing rationalities within the context of Aboriginal and Torres Strait Islander health. Lin describes three competing rationalities: cultural, political and technical. A social rationality can also be included, one that relates to how we see and know the world. Social rationalities may differ according to gender, class, age, ethnicity and place. White middle-class persons and politically marginalised Aboriginal and Torres Strait Islander peoples do not think and interpret realities in the same way because of divergent structural positions, histories and cultures. Cultural rationality informs and shapes social, political and technical rationalities because the latter are grounded in and developed by the former.*

Evidence-based medicine is the conscientious and explicit use of current research findings in clinical practice. It involves integrating the best available clinical evidence derived from systematic research with clinical expertise (Sackett et al. 1996; Straus & Sackett 1998). Evidence-based practice is central to health-care interventions and treatment in Australia, as it is in many developed countries of the world. The idea of using evidence as a basis for policy making in health is a more recent phenomenon that has arisen from the older and more established area of evidence-based medicine, and the development over the past 20 years of greater accountability in public sector management.

The philosophical origins of evidence-based medicine extend back to the nineteenth century and earlier (Sackett et al. 1996). Seminal books such as *Effectiveness and efficiency: random reflections on health services* (Cochrane 1972) and *Evidence-based medicine* (Sackett et al. 1997), and international organisations such as the Cochrane Collaboration (Anon. 2006a), have stimulated and supported the concept and practice of evidence-based medicine worldwide. Evidence-based approaches now extend beyond medicine to include population health (Brownson et al. 2002; Heller & Page 2002; Rychetnik et al. 2002), health promotion (Rychetnik & Wise 2004), health policy making (Lin & Gibson 2003), Aboriginal primary health care (Anderson 2003a; Couzos & Murray 2003), and humanitarian work (Banatvala & Zwi 2000; Robertson et al. 2002).

In recent years, evidence-based practice has become more central to public policy making. The Campbell Collaboration (Anon. 2006b), an international organisation, inspired by the Cochrane Collaboration, provides systematic reviews of the effectiveness of social and behavioural interventions in education, crime and justice, and social welfare (Davies & Boruch 2001). There has also been discussion about evidence-based policy making for Aboriginal and Torres Strait Islander peoples (Webster 2002).

The practice of evidence-based policy making in health is much less developed than evidence-based

medicine. As Lin and Gibson (2003) have pointed out, the practice of evidence-based policy making in health in Australia involves a problem-based approach. This approach should have positioned Aboriginal and Torres Strait Islander health at the centre of health-care interventions and treatment in Australia. The health of many Aboriginal and Torres Strait Islander persons is much poorer than that of other Australians, with life expectancies of up to 17 years less for both males and females, as shown in Table 1 (ABS & AIHW 2005:148; AIHW 2006:221–32).

Table 1 Life expectancy at birth in Australia (years)

	Indigenous Australians	All Australians
Females	64.8	82.0
Males	59.4	76.6

During the 1980s, life expectancies of Aboriginal and Torres Strait Islander Australians were significantly less (6–14 years) than those of Indigenous peoples of comparable countries such as New Zealand, Canada, and the United States, as shown in Table 2 (Kunitz 1994:25).[1]

Table 2 Years of lower life expectancy at birth experienced by Aboriginal and Torres Strait Islander males and females in the 1980s compared with Indigenous peoples in comparable countries

	Males	Females
Canada	10 years	11 years
New Zealand	10 years	6 years
USA	13 years	14 years

The Australian government's official health statistics agencies—the Australian Bureau of Statistics and the Australian Institute of Health and Welfare—have, since 1997, recorded the health of Indigenous Australians through five editions of their joint biennial series of reports entitled *The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples* (ABS & AIHW 1997, 1999, 2001, 2003, 2005). The fifth report is fairly gloomy reading, although some positive initiatives are apparent.

Evidence-based policy making in health

It is well known that politics are driven more by values than facts, and that public policy is a product that expresses a government's intention, and is thus political and reflects the interests of political parties. Policy making is an interactive process, involving participants from inside and outside government, which leads to policy, resource allocation, and courses of action. Evidence-based policy making in health may be viewed as a complex mix of evidence-based health care and public policy analysis (Lin & Gibson 2003). Much has been written about the connection between research, dissemination, uptake and policy (Lomas 1997a, 1997b, 2000; Lomas et al. 1993).

Black (2001) recommends caution when considering evidence-based policy making. He states that research currently has little direct influence on health services policy or governance policies, and argues that the implicit assumption of a linear relation between evidence and policy needs to be replaced with a more interactive model. He concludes that researchers need a better understanding of the policy-making process, that funding bodies must change their conception of how research influences policy, and that policy makers need to become more involved in the conceptualisation and conduct of research.

Marmot (2004) considers that a simple prescription for evidence-based policy making would be to review the scientific evidence of what would make a difference, formulate policies, and implement them. However, he goes on to say that the relation between science and policy is more complicated than this, and that science engages with busy minds that have strong views about how things are and ought to be.

The Office for Aboriginal and Torres Strait Islander Health (OATSIH), located within the Commonwealth Department of Health and Ageing, is the federal agency responsible for supporting sustained action coordinated across all governments to achieve improvements in Aboriginal health. OATSIH's (2006a) long-term strategy is to improve Aboriginal and Torres Strait Islander peoples' access to comprehensive primary health services, and aims to provide coordinated clinical care, population health and health promotion activities to facilitate illness prevention, early intervention and effective disease management.

The National Aboriginal and Torres Strait Islander Health Council recently prepared a two-volume report, *National strategic framework for Aboriginal and Torres Strait Islander health*, which recognises the importance of an evidence base to support approaches in Aboriginal and Torres Strait Islander health, but which points out the difficulties involved (AHMC 2004a:ii), whereby:

> The academic literature has been heavily biased towards largely non-Aboriginal and Torres Strait Islander academics, working within well-resourced institutions

that have a capacity to publicise their activities. Health services and programs have historically had limited funding and have developed in a climate of such need that service delivery has been given priority over monitoring and evaluation. In the community sector, past experiences with research and researchers has frequently resulted in a legacy of ambivalence and mistrust associated with data collection activities. It is also widely acknowledged that there are large gaps in information and data, that quality of information and data varies significantly from state to state and that the current data collections are hampered by under-reporting and non-identification of Aboriginal and Torres Strait Islander status. In the light of this, this document recognises and promotes local programs where less formal evidence of health gain exists.

It also identified 'Key Result Area Seven: Data, Research and Evidence' for action by governments (AHMC 2004b:25). This key result area aims to support appropriate and practical research and data collection that:

- involves collaboration in the design, management, evaluation and dissemination phases of the research / data collection
- results in changes in policy, service delivery and people's behaviour
- includes a focus on communicating research / data collection findings in cross-cultural and non-academic contexts
- strengthens Aboriginal and Torres Strait Islander data collection and research capacity
- encourages multi-disciplinary and cross-cultural skills and perspectives
- tries to look at problems by evaluating health interventions and practices, instead of repeating the nature and scale of those problems.

Despite the report, the overall health policy-making process in Australia remains complex (Figure 1).
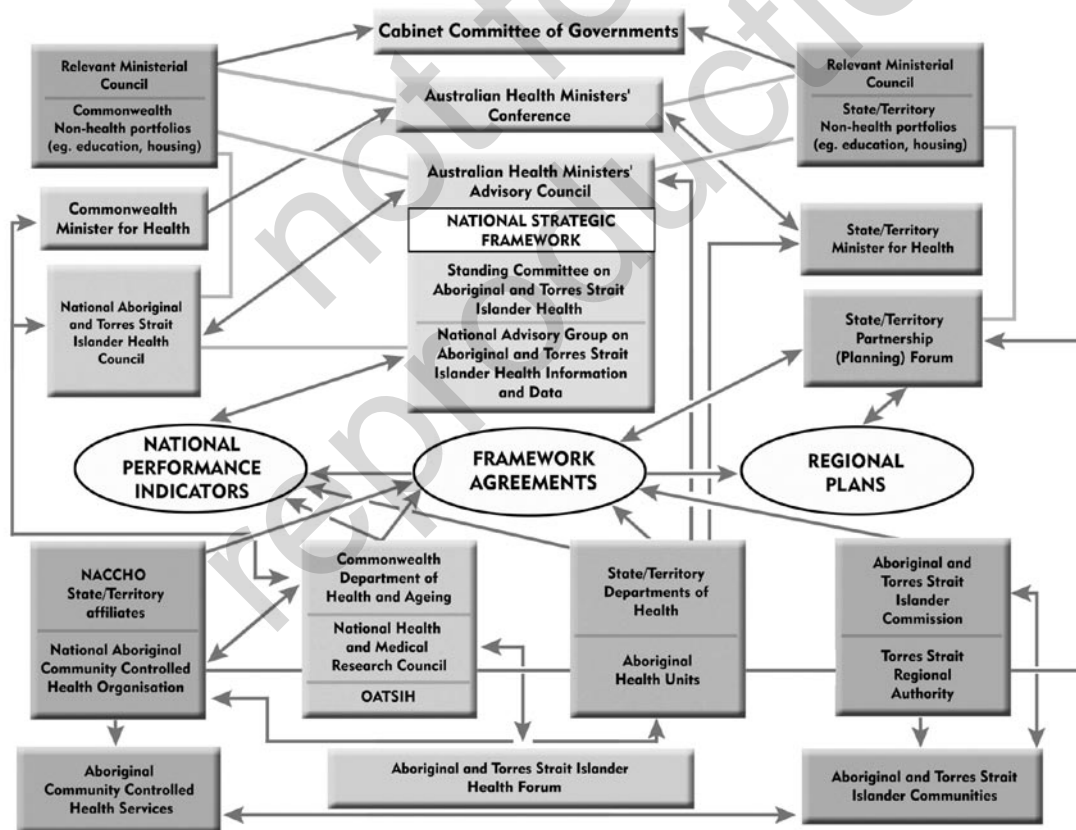

Figure 1
The complex context of Aboriginal and Torres Strait Islander health policy making in Australia (Source: OATSIH 2006b. This policy framework has recently changed as the Standing Committee on Aboriginal and Torres Strait Islander Health has been disbanded and its policy advisory role to the Australian Health Ministers' Advisory Council taken over by the National Aboriginal and Torres Strait Islander Health Council.)

The Aboriginal and Torres Strait Islander health framework in place in Australia recognises the importance of evidence in the policy-making process, and this framework must operate in a complex environment of health information governance arrangements.

Evidence and how it is used in Indigenous health policy making

I now explore, in the context of Aboriginal and Torres Strait Islander health, the concept of evidence and how it is used in health policy making. Anderson (2003b) has previously discussed this issue. Lin (2003:14) describes health policy as a set of three competing rationalities: cultural, political, and technical (Figure 2).

Political rationality, according to Lin, is concerned with the distribution and management of power, and the creation of legitimacy, including accountability and transparency of process. This rationality deals with the influence and participation of interest groups, media, experts and lobbyists within the policy-making process. *Technical rationality* refers to research evidence and could, according to Lin, make explicit knowledge, values and intentions which underlie the use of information. *Cultural rationality* is about values, ethics and societal opinions, which may vary between gender, class, age, place and ethnicity categories. Cultural rationality encompasses the values concerning health and quality of life held by individuals, groups and societies.
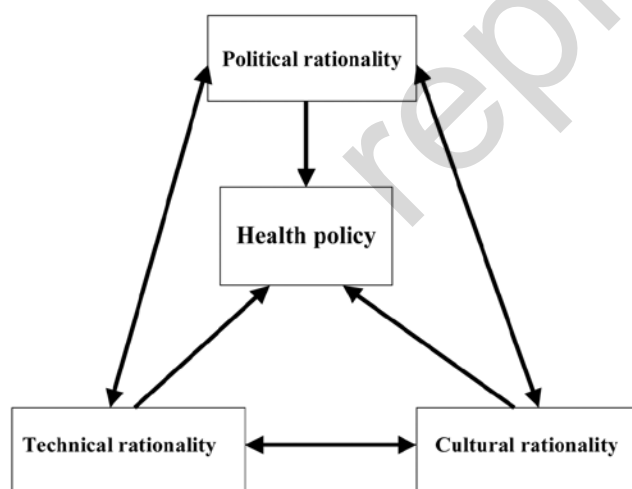

Figure 2
Health policy as a set of competing rationalities

I examine this model of competing rationalities from a different perspective. Lin's model shows how health policy can be viewed as a set of coinciding rationalities. The model contains boundaries that may blur and also at times converge. Dominant tendencies exist for all players as there are different forms of logic and discourse and different ways of understanding and explaining reality. Lin contends that health policy is dominated by political rationality which occasionally reflects cultural rationality. Lin sees the need for a greater focus on technical rationality which would provide evidence for the right audience, the right issues, and use of the right methods. Lin's answer for a successful health policy lies in establishing the right balance between all rationalities.

I consider that the above rationalities do not compete with each other, but coexist in different ways depending on the situation. Moreover, I contend that there are four rationalities, not three as described by Lin, and include a *social rationality*. My view of social rationality is similar to Lin's description of cultural rationality. It reflects values, ethics, and what (perceived) societal opinions feel is right in relation to health policy. Of particular importance are the dimensions of the significance of health: the meaning and extent of solidarity (or significance attached to universality), the value accorded to health and quality of life, and the importance of choice and opportunity for participation. The values and expectations may vary across gender, class, age, ethnicity and place. Social rationality encompasses the values concerning health and quality of life held by individuals, groups, and societies. Cognitive style, which refers to the way peoples see and know the world, contributes to social rationality. This is a construction of reality that forms our social knowledge. Stanfield (1985), in his classic paper, 'The ethnocentric basis of social science knowledge production', discusses social science knowledge as a production that is created, defined and validated according to social rationality.

I briefly develop here my idea of *cultural rationality*. Hall (1997), in *Representation: cultural representations and signifying practices*, asserts that members of the same culture share similar conceptual maps. A conceptual map, or conceptual system, is about how persons interpret the world, and refers to the way concepts are organised, arranged and classified into complex relations with one another. Not only do members of the same culture share broadly similar conceptual maps, they also share roughly the same interpretations of signs (meaningful words, sounds and images) within a language. It is the existence of

these common languages which allows us to express meanings and to communicate thoughts to others. According to Hall, this is what it means to say 'we are members of the same culture'. And it is through these interpretations that we are able to build a shared culture of meaning and construct a social world to inhabit together. Cultural rationality can be expanded to include values, beliefs and methods of interpreting the world through a conceptual system and a set of signs that is organised and classified into a language which represents those shared concepts.[2]

Sindall (2003) analyses health policy at four levels: strategic, sectoral, operational, and clinical. I have summarised his analysis in the context of Lin's competing rationalities (Figure 3).

According to Sindall (2003), the *strategic level* refers to health policy activity within the goverment. This is multi-sectoral and can include things such as taxation levels, immigration, and quarantine. The *sectoral level* deals with health financing, resource allocation, health system structure and institutional arrangements. The *operational level* deals with more specific areas such as clinical governance, screening programs, drugs subsidisation, medical research and training, professional registration and medical technology assessment procedures. Finally, the *clinical level* is where health practitioners make patient care decisions within the context set by the other levels.

The evidence gradient, as shown in Figure 3, is highest at the clinical level where evidence-based
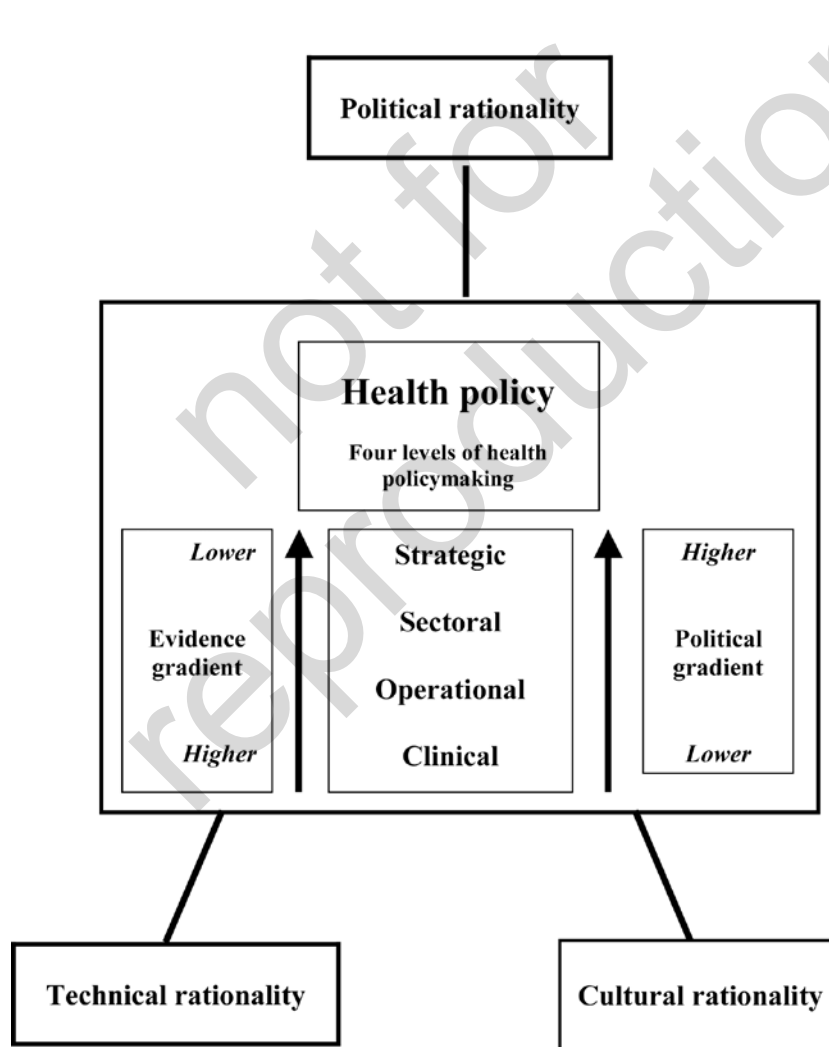

Figure 3
The four levels of health policy making

medicine and technical rationality are strong, unlike the strategic level where there is a weak evidence base. In contrast, the political gradient is highest at the strategic level, where there is strong influence from the political rationality, and lowest at the clinical level. These four different levels at which the application of evidence in health care can occur also cause the nature of evidence to change according to the context (Havighurst et al. 2001).

For Aboriginal and Torres Strait Islander health policy making, perhaps the greatest struggle has been at the strategic and sectoral levels, where politics is strongest and the evidence base weakest. With the recent advent of several key policy documents—the *National strategic framework…*(AHMC 2004a,b) and the *NHMRC road map…*NHMRC 2004), and the development of the Cooperative Research Centre for Aboriginal Health (CRCAH 2006)—progress in effective Aboriginal and Torres Strait Islander health policy making, implementation, and improved health outcomes will likely accelerate in the coming years.

I contend that, of the four interdependent rationalities—cultural, social, political and technical—that together form an intellectual framework for better understanding the Indigenous health policy-making process, cultural rationality is the key rationality within which the other rationalities are embedded (Figure 4).
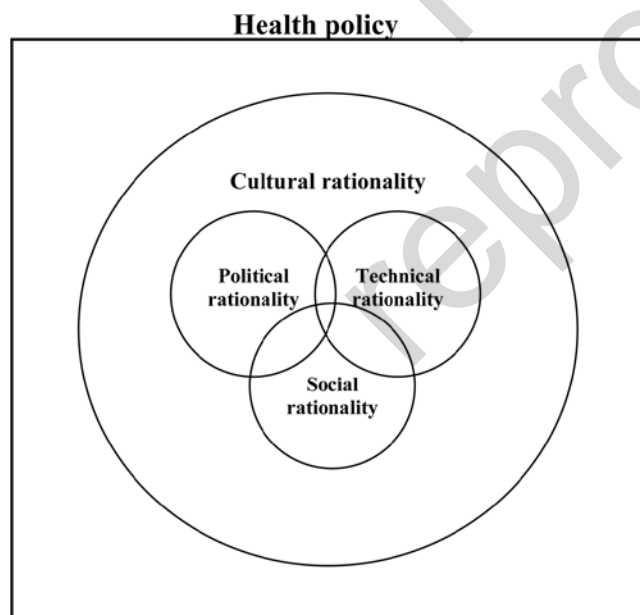

Health policy

Figure 4
A model of the determinants of Aboriginal and Torres Strait Islander health policy

Stanfield (1985) uses the term 'cognitive style' to refer to the way peoples see and know the world. This is a construction of reality that forms our social knowledge. Cognitive style differs according to class, gender, age, place and ethnicity. Members of these social categories have different experiences, priorities, and ideas about what is relevant. Dominant cultural groups such as white middle-class Australians, and subordinate ethnic groups such as politically marginalised Aboriginal and Torres Strait Islander peoples, do not think and interpret realities in the same way because of their divergent structural positions, histories and cultures. Stanfield questions a positivist approach to social-science knowledge production and asserts that social research instruments for data and collection are human constructs that require human interpretation and human decisions on how to use the data. This results in evidence which is produced within the cultural background and cognitive style of social scientists.

Epistemological racism

Scheurich and Young (1997:4) discuss 'race' as a critically significant epistemological problem, viewing racism in two forms (overt and covert) and across four levels: individual, institutional, societal, and civilisational. They contend that cultural rationality incorporates at the societal level prevailing assumptions, norms, concepts, habits and expectations. Epistemological racism emerges at the broadest societal level—the civilisational level. When considering the racial bias of research epistemologies, they stress the need to move beyond the issues involved at individual levels of racism. The civilisational level contains assumptions about the nature of reality (ontology), the ways of knowing that reality (epistemology), and morality and values (axiology), and presumptions about the real, the true and the good.

How peoples create, define and validate social knowledge and thus reality is determined largely by their cultural contexts. Researchers and policy makers engage in 'world making' or 'reality making' practices that are influenced by their cultural norms, assumptions and ideas. Throughout Western modernity, the influential in political, policy-making and research arenas have been white. 'And it is they [whites] who have constructed the world we live in—named it, discussed it, explained it (Scheurich & Young 1997:8). White racial dominance of Western civilisation since the beginning of modernity has resulted in the dominant concerns, that is, ontologies,

epistemologies and axiologies, being seen as natural rather than as social and historical constructions. These come together to form a social construction of 'the world' or 'the real', and serve to relegate other socially constructed worlds, such as those of Aboriginal and Torres Strait Islander Australians, to the margins of social life.[3]

In a US study, Muntaner, Nagoshi and Diala (2001) found that middle-class whites have a strong tendency to attribute their health to lifestyle choices and biology rather than to social factors (contributed to no doubt by the dominance of bio-medicine). There is a fundamental attribution error among this class to attribute health outcomes to 'free will' rather than to social factors. 'Even in the face of well-documented lack of opportunity among most non-whites and the growing rejection of race as a variable in the scientific community, attributions of racial inequality in health to social factors lag behind biology' (2001:665). Tesh (1988) refers to the hypothesis that blames stress, lack of exercise, use of drugs, alcohol and tobacco, and improper nutrition for most chronic diseases, as 'the lifestyle theory'. This notion underpins the United States Department of Health and Human Services' approach to health promotion and disease prevention.

The Muntaner and colleagues' study found that middle-class whites have two explanations for racial inequalities in cardiovascular health: a belief in self-determination, choice, and individual responsibility; and the perception of race as an attribution of organism (biologism) rather than social circumstance: 'More than 60% of United States white people attribute racial inequalities to psychological or biological attributes' (2001:660). Contemporary middle-class whites have a large influence on public opinion and the health-policy process, and their explanations for racial inequalities in health appear to include assumptions that justify class inequality.

While Tesh stresses that neither sedentary living nor high-fat diets are healthy, she shows scientific findings which reveal a weak relationship between diet and cancer, blood-cholesterol levels and heart disease, and between exercise, physical fitness and disease prevention. Critics of the lifestyle theory argue that the 'primary responsibility for health lies beyond the individual' and includes political and economic institutions (Tesh 1988:47). Lifestyle is derivative. It is necessary to review the social contexts which give rise to lifestyle changes (Tesh 1988). Better health calls for socioeconomic change. Adoption of evidence-based policy making in Aboriginal and Torres Strait Islander

health in Australia must include an investigation of racial economic exploitation, racial political oppression, and racial ideology.

Practice innovation

Cultural rationality informs and shapes political, social and technical rationalities because, in my view, the latter are grounded in and developed by the former. The social sciences developed as ethnocultural institutions that reflect and are microcosms of the hegemonic societal privileges of dominant cultures.

Knowledge is formalised when it has been validated in a cultural context and becomes the official way of organising and conducting life. The validation of knowledge is grounded in objectification processes which are a matter of power and privilege. In Australia, objectification of the dominant culture's experiences and their systematic diffusion reproduces hegemonic cultural domination. The everyday knowledge of the dominant society is validated, formalised and objectified as the science of experience. This justifies the promotion of the dominant society's normative conceptions and the distortion of ethnic minority experiences. Through this process, Aboriginal and Torres Strait Islander peoples' ethnoculturalisms are delegitimised.

What can be learned?

The world of evidence-based medicine is dominated by positivist science, and we must take care not to impose assumptions from one cultural practice to another (Marks 2002:13). White values continue to set the norms for public health policies and general medical practice in Australia. In order to understand the links between ethnicity and health inequalities, the distribution of power and economic resources among cultural groups needs to be analysed. Identification of cultural biases requires a different approach from traditional research programs. The context of evidence-based policy making needs to be deconstructed and biases minimised and controlled through cultural awareness.

To reduce Aboriginal and Torres Strait Islander health inequalities it is necessary to focus on structural processes such as institutional racism, distribution of power, and access to health resources (Wamala & Agren 2002). Feminist standpoint theory proposes that female researchers conduct research about and for women (Stanley & Wise, cited by Wamala & Agren 2002). This proposal can be extended to other

marginalised and disempowered groups. In order to challenge the positional and ideological superiority (Marks 2002) of non-Indigenous knowledges, Anderson (2003b) promoted the need for Aboriginal and Torres Strait Islander organisations to undertake their own research. These organisations can reduce cultural biases in research and policy making by engaging their own researchers and policy makers. Culturally sensitive evidence-based policy making can be achieved by developing technical skills within decision-making processes based on collaboration between Aboriginal peoples and health organisations.

Conclusion

The adoption of evidence-based policy making in Aboriginal and Torres Strait Islander health in Australia must take into account the cultural and social rationalities involved in the policy-making process. For many years Australian state, territory and federal governments, and others involved in policy making, have struggled with Aboriginal and Torres Strait Islander health inequalities. The evidence base within the Aboriginal and Torres Strait Islander health policy-making process needs to be interpreted not only as a source of knowledge and a basis for action but as a reflection of the underlying values and intentions of researchers. White middle-class health researchers, policy makers and politicians need to develop awareness of the cultural and social influences on their assumptions concerning the political, economic and social disadvantage of Aboriginal and Torres Strait Islander peoples.

I have emphasised the requirement that Aboriginal and Torres Strait Islanders' cultural and social rationalities define the policy-relevant research necessary to improve their health. I have examined the pathways by which dominant cultures subordinate others and stressed the importance of decolonisation of research and evidence-building. This new research is necessary to ensure that the evidence that guides policy making to improve Aboriginal and Torres Strait Islander health addresses the issues of racial economic exploitation, racial political oppression and racist ideology.

Acknowledgments

NOTES

1. Productive comparisons could also be made between sociocultural system types, for example, mobile hunter-gatherers (Aboriginal Australians, Great Basin Indians, Inuit); seasonally sedentary hunter-gatherers (Siberian Khanty, Northwest Coast Indians); semi-nomadic pastoralists (Navajo); and sedentary stratified horticulturalists (Maori, Hopi) (Sutton 2005).

2. A criticism of Hall is that his view of culture tends to be static. He fails to acknowledge that contemporary Indigenous youth in many countries occupy a cultural world and landscape profoundly different from that of their parents, and that there arguably exists a much greater divide between generations in Australia than between non-Indigenous youth and bicultural Indigenous youth (Eckersley 2005; Graham et al. 2000; Rutter & Smith 1995; Sampson 1989). This generational cultural divide is the real cross-cultural challenge in Indigenous social and emotional wellbeing issues (Reser 2004).

3. This scenario is gradually changing as Indigenous peoples undertake decolonising research and develop Indigenous research methodologies (Cunningham 1998; Mutua & Swadener 2004; Rigney 2001, 2003; Smith 1999). In the discipline of psychology, for example, non-Western psychologists have been engaged for a number of decades in decolonising psychology and in developing Indigenous psychologies (Kim & Berry 1993; Sinha 1990; Hwang & Yang 2000). Western psychological theories that emphasise individualistic values (innate ability, intrinsic interest, and self-esteem) have been unable to explain behavioural competence and personal achievement in relational cultures. Notions of social, relational and family efficacies are being developed to facilitate behavioural change in collectivist societies (Kim & Park 2005). Australian Indigenous psychologists are also engaged in this decolonising process (Westerman 2000).

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