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Research

Beyond the rhetoric: how can non-government organisations contribute to reducing health disparities for Aboriginal and Torres Strait Islander people?

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Abstract. The prevailing disparities in Aboriginal health in Australia are a sobering reminder of failed health reforms, compounded by inadequate attention to the social determinants shaping health and well-being. Discourse around health reform often focuses on the role of government, health professionals and health institutions. However, not-for-profit health organisations are also playing an increasing role in health policy, research and program delivery across the prevention to treatment spectrum. This paper describes the journey of the National Heart Foundation of Australia in West Australia (Heart Foundation WA hereafter) with Aboriginal employees and the Aboriginal community in taking a more proactive role in reducing Aboriginal health disparities, focusing in particular on lessons learnt that are applicable to other non-government organisations. Although the Heart Foundation WA has employed and worked with Aboriginal people and has long identified the Aboriginal community as a priority population, recent years have seen greater embedding of this within its organisational culture, governance, policies and programs. In turn, this has shaped the organisation's response to external health reforms and issues. Responses have included the development of an action plan to eliminate disparities of cardiovascular care in the hospital system, and collaboration and engagement with health professional groups involved in delivery of care to Aboriginal people. Examples of governance measures are also described in this paper. Although strategies and the lessons learnt have been in the context of cardiovascular health disparities, they are applicable to other organisations across the health sector. Moreover, the most powerful lesson learnt is universal in its relevance; individual programs, policies and reforms are more likely to succeed when they are underpinned by whole of organisation ownership and internalisation of the need to redress disparities in health.

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Introduction

As encapsulated by the Close the Gap campaign and a plethora of reports, there are enormous disparities between the health of Aboriginal Australians and the rest of the population. Recently released data from the AIHW (2011) indicate that ~80% of the mortality gap for Indigenous Australians aged 35–74 years is attributable to chronic disease, with heart disease the biggest contributor accounting for 22%, followed by diabetes (12%) and liver disease (11%). Compared with other Australians, Aboriginal people are three times more likely to have a major coronary event (Mathur *et al*. 2006). Moreover:

> *After experiencing a major coronary event, Indigenous Australians are more likely to die from it without being admitted to hospital, and to die from it if admitted to hospital compared with other Australians. There would have been almost 60% fewer in-hospital deaths for CHD* [coronary heart disease] *among Indigenous Australians had they experienced the same in-hospital fatality rates as other Australians*. (Mathur *et al*. 2006, p. 24)

Aboriginal people also have a far higher prevalence of risk factors for cardiovascular disease, including smoking, high blood pressure, and overweight and obesity (Mathur *et al*. 2006; AIHW 2011). Thus, improving cardiovascular disease prevention, treatment and outcomes for Aboriginal people has the potential to contribute significantly to reducing observed disparities in morbidity and mortality and health care between Aboriginal and non-Aboriginal Australians.

The prevailing disparities in Aboriginal health are a sobering reminder of neglect of Aboriginal health and of many failed health reforms to date, compounded by inadequate attention to the underlying social determinants shaping health and well-being. While discourse around closing the gap often places the spotlight on government or on the health system as a somewhat generic

entity, recent decades have seen peak body not-for-profit health organisations play an increasing role generally in health policy, research and program delivery across the prevention to treatment spectrum.

But what does it mean in practice for a not-for-profit, non-government organisation (NGO) to prioritise Aboriginal health?

Although the National Heart Foundation of Australia in West Australia (Heart Foundation WA hereafter) has long identified Aboriginal cardiovascular health as a priority, recent years have seen greater embedding of this within its organisational culture, governance, policies and programs. In turn, this has shaped the organisation's response to external health reforms and issues. This paper describes the journey taken by the Heart Foundation WA, together with some key leaders in the Aboriginal community, to take a more proactive role in reducing Aboriginal health disparities, focusing in particular on lessons learnt that are applicable to other NGOs and health reform more broadly.

Cultural principles and cultural security

While there is increasing recognition in the Australian public health arena of the need for more culturally appropriate responses to Aboriginal health and Aboriginal issues more broadly, many organisations (government and non-government) struggle with how to effectively do this. It can be easy to acknowledge traditional landowners when we open events but much harder to embed Aboriginality within the culture and day-to-day operations of health organisations and systems. Similarly, it is easy to articulate the need to redress Aboriginal health disparities in policy documents, but far more challenging to achieve this in practice.

The culture of the Heart Foundation itself is rarely a focus of explicit attention, but the increasing focus on Aboriginal health has in some respects forced the organisation to give greater consideration to its internal culture and to what it really means in practice to embed a commitment to Aboriginal health within the culture of a 'mainstream' organisation.

Over the past decade, terms such as 'cultural safety', 'cultural competence', 'cultural awareness' and 'cultural security' have increasingly entered the public health lexicon in relation to Aboriginal health. Cultural security can be regarded as encompassing cultural awareness (Coffin 2007), and refers to the maintenance and protection of cultural identity and has implications for both policy and practice, and for whole organisations as well as individuals working within the health system. Coffin (2007) argues that it is attainment of cultural security that can have one of the greatest impacts on the health of Aboriginal Australians, and as noted by Simpson (2009):

> *Cultural security is the next step in strengthening community leadership, for attitudinal and behavioural change in mainstream society and within the Aboriginal community.*

Similarly, cultural competence is more than awareness of cultural differences, as it focuses on the capacity of the health system to improve health and well-being by integrating culture into the delivery of health services (NHMRC 2006).

Implementation of culturally secure and competent health practices requires a multi-dimensional approach with action at systemic, organisational, professional and individual levels (NHMRC 2006), which is what the Heart Foundation WA has endeavoured to develop across the whole organisation through a range of different means. This has included proactive employment of Aboriginal people, appointment of Aboriginal people to boards, senior committees and working groups, establishment of a dedicated Aboriginal health program and team, and integration of Aboriginal health across all areas of activity. All staff members in the Heart Foundation WA office are required to participate in cultural competency annually. This includes Aboriginal history and has a strong focus on upskilling staff to be more knowledgeable about Aboriginal ways of working, and to include Aboriginal health within all program areas.

However, implementation of cultural security requires an ongoing process as staff and programs change, funding priorities shift, and new strategic directions emerge. Within the Heart Foundation WA, as in the health system more broadly, Aboriginal health is also competing with other priorities in a tight fiscal environment, hence strengthening the embedded cultural competence of an organisation to address Aboriginal health disparities is an important safeguard against vulnerability.

Governance: principles and practice

The ultimate goal of the Heart Foundation WA is to fully embed cultural principles and commitment to cultural security and competence across all areas of the organisation in an integrated and systemic way. This is articulated in *Championing hearts Aboriginal and Torres Strait Islander cardiovascular health. Our plan for 2008–2012* (National Heart Foundation of Australia 2009).

Although there is often scepticism about 'top-down approaches' to Aboriginal health, it is clear that closing the gap requires a new way of seeing and doing things at all levels of an organisation, including 'from the top'. Without endorsement and commitment at senior and governance levels, effectiveness and credibility is diminished. This was recognised in a recent articulation of the Heart Foundation's strategic plan nationally, which elevated the National Aboriginal Health Unit and noted the need to adopt governance principles that facilitate a cross-organisation approach and culture.

One of the key planks of organisational governance is the composition of an organisation's board. In Australia, Aboriginal representation on the boards of government and NGOs is generally low. Yet 'having Aboriginal representation has been shown to improve board decision making and produce positive outcomes in the way local health services are delivered and received' (Simpson 2009, p. 3). The over-representation of Aboriginal patients in the health care system further reinforces the imperative for the inclusion of Aboriginal people on boards, not only 'ethically' but also because of the positive contribution such representation can make to improving the relevance and effectiveness of programs and services for Aboriginal people.

The Heart Foundation WA first appointed an Aboriginal director to its board in 1997 (second behind the Northern Territory). There has since been a strong commitment to continuing Aboriginal representation on the board, and representation on the Cardiovascular Health Committee has also contributed to ensuring Aboriginal health remains a program

priority. However, continuous representation has not always been achieved, and the board is currently seeking to fill the current vacancy in its Aboriginal membership. One of the challenges in filling such positions is that it is often the same leaders in the Aboriginal community or Aboriginal health field, who are being over-stretched with multiple demands and roles. This highlights the need for Aboriginal capacity building not only at the coalface of service and program delivery in public health, but also to increase Aboriginal representation in board, committee and senior management roles, and to facilitate this in a genuine, not token way.

In 2009, Aboriginal health was further prioritised by the Heart Foundation of WA when the board formed a Close the Gap Subcommittee with a specific focus in this area. This not only gave impetus to greater prioritisation of Aboriginal issues within the board's own remit, but also served as an important 'symbol' of whole of organisation commitment and support to the Aboriginal health program staff internally. As Aboriginal staff within the Heart Foundation WA often note, working to improve Aboriginal health can be a long and difficult journey:

> *. . . it is thus vital that those working in the area know that they do so with the backing of strong support and sound governance structures from the board and senior management* (Aboriginal health manager).

The governance structure of the Heart Foundation nationally enables the Heart Foundation WA to take issues of importance to the national board and through other governance and committee processes. For instance, the Heart Foundation WA has sought to be an internal advocate for change nationally and has proposed national governance principles that strengthen Aboriginal health and embed Aboriginal representation, leadership, cultural competence, cross-agency integration and advancement of Aboriginal health within the organisation's strategic plan. It was thus encouraging to see that the National Aboriginal Health Unit has been renamed and formalised as a distinct business unit within the national office and there is strong momentum to elevate Aboriginal health to be one of the Heart Foundation's national priority areas in its 2013–2018 national strategic plan. However, as with health reforms for health equity and Aboriginal health more broadly, persistence will no doubt be required in continuing to keep the Aboriginal health agenda and its translation into action top of mind within the organisation at both the state and national levels.

An advocacy focus

Advocating for improved health is part of core business for non-government health agencies (Chapman 2005; Shilton 2008) and a role that the Heart Foundation WA has taken very seriously. Wherever there is a discrepancy between the evidence in favour of action on a health issue and the commitments being made by governments and other decision makers, advocacy must be a priority strategy (Shilton 2008). Discrepancies between evidence and action compound inequity in health outcomes, and nowhere is this more pronounced than in Aboriginal health.

Strong advocacy for action on Aboriginal health has thus been a key feature of the Heart Foundation WA's work and this advocacy has focussed on both internal and external change.

Internally, it is vitally important that the organisation make a contribution to closing the gap, and be seen in the community as a positive role model that is 'walking the walk as well as talking the talk'. As articulated by the Aboriginal health manager:

> *. . . it is important to embed a community development way of working into our programs and projects, but it is also important for the Aboriginal community to see me out there as a face in the crowd, and walking the walk alongside our Aboriginal people.*

Strong internal advocacy has led to Aboriginal health being firmly embedded in the Heart Foundation WA culture, programs and governance. This has developed over a number of years. Internal champions have been important in this regard, with leaders within the organisation (within and outside of the specific Aboriginal program area) playing a key role in advocating internally and persisting with the vision of elevating the status of Aboriginal health. The qualitative dimensions of advocacy – persistence, passion, interpersonal persuasion and being media savvy – are often overlooked in discourse on effective advocacy (Yach *et al*. 2005; Shilton 2008), yet are hallmarks of the integral positioning that Aboriginal health now holds within the Heart Foundation WA.

Sometimes advocacy has taken the form of supporting other broader initiatives relating to Aboriginal well-being, such as the Close the Gap campaign (Australian Indigenous Health *InfoNet* 2010). In 2008, the Heart Foundation WA board unanimously committed to the national campaign to close the gap in life expectancy between Aboriginal and non-Aboriginal people, and advocated for the national organisation to do likewise. Actions such as these serve as important signals to the organisation internally and externally of a growing commitment to act and help focus the efforts of the organisation to reduce Aboriginal heath disparities. Such signals can also be communicated to partner organisations, potential funders, government, donors and, importantly, to the Aboriginal community.

External advocacy has occurred on several other fronts, including efforts targeting the health system, politicians and health professional peak bodies. Prior to the last WA state election, for example, the Heart Foundation WA drafted a document entitled *Time for action in Western Australia* outlining six evidence-based strategies for cardiovascular health improvement and called on the major parties to respond (National Heart Foundation WA 2008). A response from the opposition spokesperson for health (now current Health Minister) made particular reference to the Heart Foundation WA's call for more attention to cardiovascular outcome for Aboriginal people in WA hospitals. This is an example of seeking political influence for health improvement, including across party lines, which is consistent with the successful strategy of the Close the Gap campaign.

Program integration and dedication

The Heart Foundation WA aims to give a voice to Aboriginal health disparities in all program planning and resource decisions and to match the internal commitment with outward demonstration of cultural principles through communications and interactions with the media, donors, funders, collaborators, external stakeholders and the broader Heart Foundation affiliation

nationally. Examples of these Heart Foundation WA applications are incorporated in the remainder of this paper.

At the program level, the Heart Foundation WA approach is two-pronged, entailing both a dedicated unit with a specific mandate for Aboriginal health program delivery, in tandem with integration of Aboriginal health into all program and service delivery areas. This twin approach has enhanced the position of the Aboriginal Health Unit while at the same time fostering whole of organisation participation in Aboriginal health.

Much of this activity has been intertwined in practice and has evolved as the Heart Foundation WA has sought to further prioritise Aboriginal health throughout its operations. But this evolutionary process has been enabled by complementary changes in organisational governance and strategic priorities initiated by the board and senior management. This leadership at the strategic and conceptual level, the connection between Heart Foundation governance, embracing of cultural principles and a strategic focus through programs is depicted in the framework shown in Fig. 1. It is pertinent to note that this framework has been devised by the Aboriginal health manager not only for internal use, but to show Aboriginal groups and people how the Heart Foundation WA has a holistic body of work that straddles many settings, as well as the individual, the family and the community.

The integrated approach has been particularly effective in the program and campaign areas relating to prevention around cardiovascular risk factors. Some examples of this are summarised in Table 1. All staff members are required, for example, to demonstrate in their operational planning how their program will target and include Aboriginal people. Initiatives

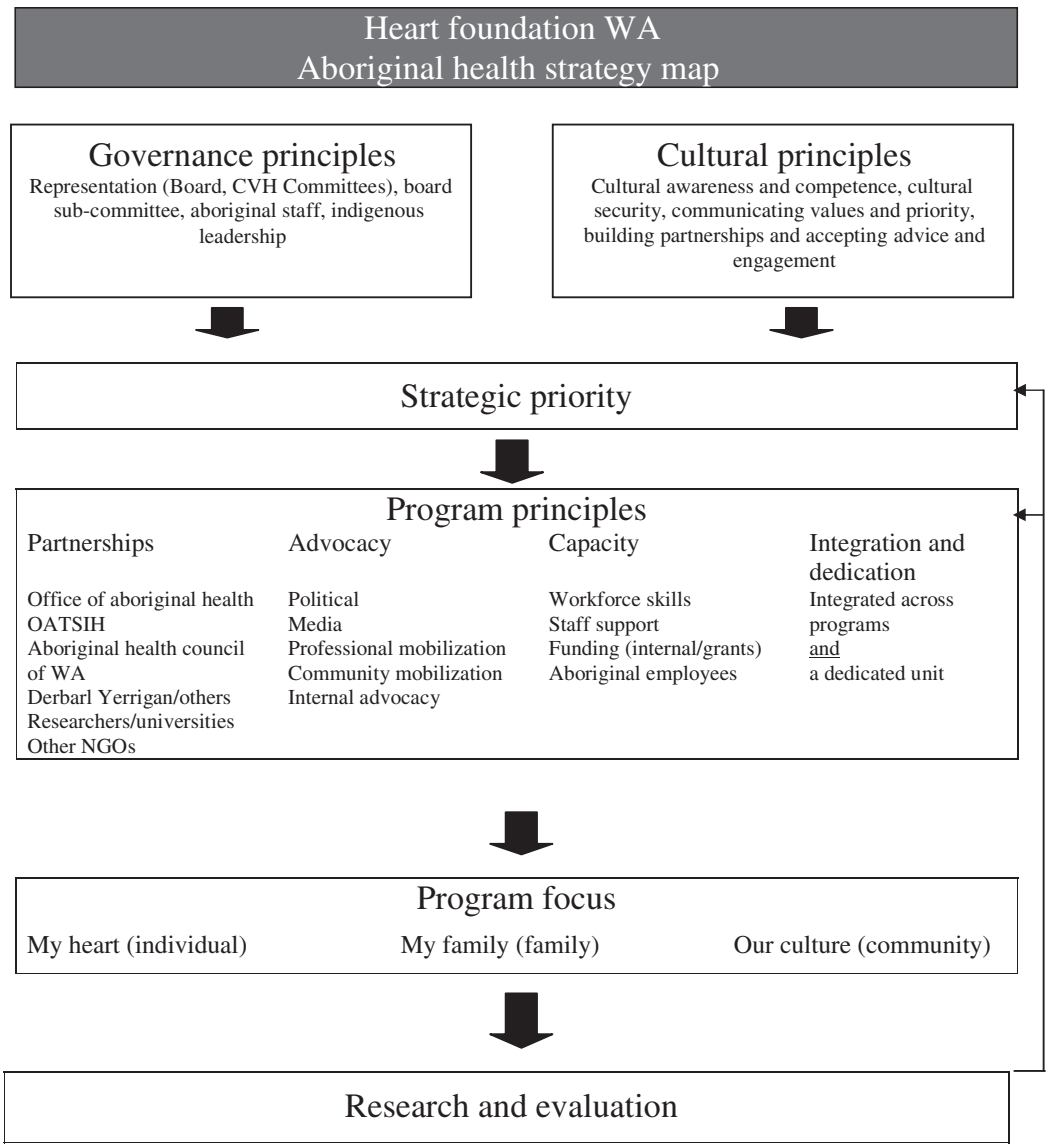

Fig. 1. Brokering of collaboration around Aboriginal Health (an example). CVH, cardiovascular health; NGO, non-government organisation; OATSIH, Office for Aboriginal and Torres Strait Islander Health.

Table 1. The Heart Foundation of Western Australia's Aboriginal health initiatives

'Integrated' initiatives in broader program areas	'Dedicated' initiatives in the Aboriginal health program area
Smarter than Smoking youth smoking prevention campaign: Aboriginal representation on youth advisory committee and the overarching committee; proactive formative research with Aboriginal young people; targeted school and sports sponsorship strategies	Targeted resources and workforce training: Aboriginal health worker training and programs such as My Heart My Family Our Culture; state-wide Aboriginal health video conference series and Aboriginal health workshops; Aboriginal Women and Warning Signs (of heart attack) project; national Aboriginal targeted resources for chronic heart failure and hypertension
Heart Foundation walking program: Aboriginal people enlisted in walking groups in metropolitan and country areas and as registered leaders to conduct walking groups in their communities	Service-based initiatives to improve Indigenous access to culturally appropriate health care: proposal to improve services at Royal Perth Hospital for Aboriginal patients with cardiovascular disease; development of position paper and recommendations – *Eliminating disparities in hospital cardiovascular care for Aboriginal people*; initiation and support of Heart Health program based at the local Aboriginal Medical Service
Find Thirty every day® physical activity campaign: focus group testing conducted with Aboriginal people as part of campaign development; media strategies depict Aboriginal people and Aboriginal ways of incorporating physical activity into daily life	Research program involvement: e.g. Monitoring Coronary Heart Disease in the Modern Era (Aboriginal) research team; State Health Research Advisory Committee evaluating WA implementation of the Strengthening Cardiac Rehabilitation and Secondary Prevention for Aboriginal and Torres Strait Islander Peoples (National Health and Medical Research Council framework); imparting research outcomes to community people involved in research and encouraging research translation into practice; ensuring cultural input and ethical requirements for Aboriginal research are being met

relating more to clinical care, training and on-the-ground community intervention often necessitate a more targeted approach, as part of the 'dedicated' Aboriginal health program. Some examples are described in Table 1.

In practice, of course, there are also programs and activities that have both integrated and dedicated elements, and the presence of a dedicated Aboriginal health unit employing people with specific cultural knowledge and skills has greatly assisted in enabling the integration of Aboriginal health across the organisation's programs. This occurs not only formally through program activity, but also more informally through opportunities for knowledge sharing and mentorship.

Building Aboriginal health workforce and capacity

Building culturally secure health organisations entails not only 'cultural security' training, policies and practices, but also increasing the number of Aboriginal employees at all levels throughout the health system (Health Reform Committee 2004). As articulated by Anderson *et al*. (2009):

> *. . . increasing the participation of Indigenous people in the health workforce is an important workforce development strategy, as well as an important goal to pursue for equity reasons* (p. 580).

The Heart Foundation WA has sought to respond to this both internally and externally, through its partnerships and roles with other organisations and professions within the broader health sector.

Internal workforce capacity

For over a decade, the Heart Foundation WA has sought to be proactive in employing Aboriginal staff. In 2000, an Aboriginal project officer was appointed. She has remained in the organisation to now become the manager of the Aboriginal health team, with a focus of capacity building to increase the number of Aboriginal staff members. A new project officer has recently been employed full-time, and other capacity building has occurred through regular involvement of undergraduate Aboriginal university students and volunteers in the activities of the team.

In many Aboriginal communities and organisations there is often a limited pool of individuals with the skills and confidence to take on leadership and management roles in health and other areas (National Public Health Partnership 2005). The Aboriginal health manager has recruited Aboriginal staff to the Heart Foundation WA with varied backgrounds (e.g. community development, accounting and nursing) with the hope that these skill sets could be integrated into the health promotion setting. However, sometimes these staff members have stayed for only 3–12 months. This has prompted the organisation to further investigate possible barriers to employment longevity in the course of performance development interviews with staff. Some of the emergent barriers include:

- The shift towards an advocacy-based role rather than grass roots delivery over recent years has often been in contrast with the Aboriginal staff's preferential way of working: at a community level rather than with policy makers and meetings.
- A preference for a 'hands on' approach rather than being in an office setting. Roles with a mix of office and community work were preferred.
- Some staff members were not familiar with 'open plan office culture'.
- Some were unfamiliar with office processes and procedures, highlighting the need for enhanced induction and training.
- Dedicated funding is required for targeted professional development in areas such as advocacy, policy, health promotion, information technology skills and office processes.

- Ongoing professional development should be an integral part of the employment package.

The feedback above has proved both insightful and challenging for the Heart Foundation WA and has implications more broadly for any organisation struggling with attraction or retention of an Aboriginal workforce. Some of the strategies being enacted to try and address some of these issues may also be transferable. For instance, as noted in the above feedback from employees, the work of the Heart Foundation WA is often predominantly upstream and about advocating for policy and system change in Aboriginal health, which is very different to service delivery or community-based work that staff may have engaged in previously. In an effort to respond to this, the organisation identified the competencies required for project officer roles. Training and mentorship have been put in place to try and upskill staff in advocacy and policy work.

Mentoring has also been recognised as playing a significant role more broadly in staff support. Most employees need to be nurtured and supported to perform at their best. From our experience this need can be even greater in Aboriginal employees, particularly when working within a traditionally mainstream organisation. The Aboriginal health manager has also been working with the Australian Health Promotion Association (WA branch) to modify and adapt scholarship criteria to meet the needs of Aboriginal people and offer more employment opportunities in the health promotion field for Aboriginal health graduates.

Given the high turnover of Aboriginal staff experienced by many organisations in the health sector (including the Heart Foundation WA), the Aboriginal health manager's own 11 years of employment is an interesting case study in its own right. When asked, she attributes this to a range of factors including:

- her own passion, commitment and dedication
- the role that the organisation has played in enabling her to be part of a wider team sharing the same values
- support received from managers and board members
- opportunity to develop personal and leadership skills within the organisation
- flexibility, trust and understanding of the importance of family from the employer – the time off to attend funerals within the Aboriginal community is one example of this.

A sense of belonging to an organisation can also be important and the current Aboriginal health manager often uses the vernacular of the 'Heart Foundation family'. She notes:

> *Opportunities within the organisation for Aboriginal and non-Aboriginal people to work side by side, converse in the tea room or share a place on the board or committees encourages reciprocated learning and empathy. Informal learning can benefit all.*

External workforce capacity

While there are dedicated Aboriginal health services and centres (e.g. Aboriginal Community Controlled Health Services, ACCHOs), much of the treatment of Aboriginal people occurs through general health services. Despite the disproportionately poor health status of Aboriginal people, they represent only ~1% of the health workforce (Pink and Allbon 2008).

Although significant increases in the number of Aboriginal people working within the health sector is the ideal, the reality is that many programs and services will continue to be delivered by non-Aboriginal people until the great deficit in Aboriginal workforce capacity is remediated (Hoy 2009). To this end, there are a growing number of guidelines and documents that seek to improve accessibility and cultural competence for Aboriginal people within various aspects of the health system. The National Health and Medical Research Council *Guide for health professionals strengthening cardiac rehabilitation and secondary prevention for Aboriginal and Torres Strait Islander Peoples* (NHMRC 2005) is an example of this. Yet a recent study found that there was limited awareness and poor implementation in WA of these recommendations (Thompson *et al*. 2009). Even if well-implemented, such guidelines also need to be complemented by other strategies to facilitate the sharing of knowledge at the interface of Western medicine and Aboriginal culture (McGrath 2007). This is reflected in some of the more 'hands on' approaches being used by the Heart Foundation WA to upskill and support professionals working in the Aboriginal health arena, including delivering workshops, regular state-wide video conferences and workplace training sessions. Aboriginal staff members at the Heart Foundation WA also play a valuable role in mentoring Aboriginal health professionals in other organisations who are new to working in health promotion or cardiovascular health.

Many of the Aboriginal health related programs developed by the Heart Foundation WA also have a strong focus on building workforce capacity more broadly, such as orientating and supporting Aboriginal health workers (AHWs) through the My Heart My Family Our Culture project. This project is a vehicle for information sharing and empowering AHWs with the knowledge to impart evidence-based material to their community. The project commenced in 2004 and was developed in response to a need for appropriate heart health resources. Since 2009, 8000 consumer resources and 1300 health professional resources have been distributed primarily in WA. Cultural training to non-Aboriginal health professionals using the resources with clients has also been delivered.

Programs, practice and partnerships

The need for partnerships and collaborative effort across the health sector is critical for health reform and improved health outcomes generally, but perhaps even more so in relation to Aboriginal health, which by its very nature is complex. For many Aboriginal people, the underlying causes of poor health are often socially determined (Carson *et al*. 2007) and intertwined with factors relating to services and access to quality care and prevention programs. Moreover, an interconnected approach is more congruent with holistic Aboriginal concepts of health and illness than artificial distinctions based on single diseases or body parts (NHMRC 2006). Additionally, co-morbidities are common, and many Aboriginal people may simultaneously need primary, secondary and tertiary prevention and health services. As noted by Aitken and colleagues:

> *Efforts to address ill health in the Aboriginal population therefore require positive and respectful interaction between Indigenous and mainstream Australia as a*

> *starting point if sustainable clinical and public health benefits are to be achieved* (Aitken *et al*. 2007, p. 9).

As a peak NGO working across the continuum of cardiovascular health, the Heart Foundation WA has been able to play a somewhat unique role in the facilitation of partnerships and more collaborative responses to Aboriginal heart health. Positive outcomes have been achieved by the Aboriginal health manager's ability to act as a 'broker'. An example of this 'brokering' role is summarised in Fig. 2. Another example is taking non-Aboriginal staff along to meetings at Aboriginal organisations. This display of trust enhances acceptance and credibility and has enabled opportunities for engagement with the Aboriginal community in many programs.

Health sector engagement has also underpinned the development of programs and resources in the Aboriginal health area. During the development of the My Heart My Family Our Culture heart health education resources, consultation occurred with key Aboriginal and non-Aboriginal stakeholders in all areas of health to ensure the resources met the needs of practitioners. Strong links with ACCHOs in rural and remote WA then enabled wide dissemination and uptake of these resources. Programs such as Heart Foundation Walking have endeavoured to engage Aboriginal community groups with Aboriginal people enlisted as registered leaders in metro and rural areas. The Heart Foundation's Heartmoves (exercise program designed for people with stable long-term health conditions), is also looking at ways to engage Aboriginal people as leaders using lessons learnt from AHWs trained as leaders in NSW.

The Heart Foundation WA has also worked closely with other state-wide agencies such as Diabetes WA and the Aboriginal Health Council of WA. There is increasing recognition of the synergies and benefits gained from such collaborations. Resources showing the strong links between heart health and diabetes have been developed through this partnership. The Heart Foundation WA has also been instrumental in setting up a culturally appropriate Heart health program that commenced in March 2009 at the Perth-based Aboriginal community-controlled health service, Derbarl Yerrigan Health Service (DYHS). This program, a collaboration between DYHS, the Heart Foundation WA, hospital and university staff, has attracted over 200 clients (average 30 per week) with positive health outcomes reported, and has successfully expanded to a chronic disease focus in DYHS with the strong support of its board.

While in mainstream health the reference to partnerships often pertains to external stakeholders and organisations, in Aboriginal health it needs to be just as much about the partnership and engagement with communities and Aboriginal people themselves. As articulated by the Aboriginal health manager:

> *For Aboriginal people, heart disease is not just an issue for the individual, hence an effective response needs to be inclusive of the family and community to which the family belongs, and provided in a holistic way. Community engagement is integral to program ownership and success.*

Given this preference for a more holistic approach to health and the underlying social determinants of Aboriginal health, partnerships should include broader engagement outside the health sector. This is an essential part of the community development approach to cardiovascular health, which underpins much of the effective work in this area. Collaborative work with the WA Department of Sport and Recreation, the prison system and schools has enabled both a top-down and bottom-up approach. Resources and programs have reached the people through Heart Foundation WA staff attending community events and meetings. While this can be hindered by capacity constraints, it is vital to remain in touch with community sentiment.

Research and evaluation

Since the creation of a dedicated Aboriginal health unit and strong Aboriginal elements to Heart Foundation WA programs,

In 2000, The Heart Foundation collaborated with the Australian Medical Association and Aboriginal groups to convene a workshop that would pave the way for its Aboriginal health and advocacy priorities in the decade that followed. In 2008, the Heart Foundation WA convened a meeting of cardiologists and cardiothoracic surgeons representing each of the teaching hospitals in WA, along with Board members, senior Aboriginal Health Department staff and senior Heart Foundation WA staff to discuss in-hospital care of Aboriginal people. This was prompted by alarming national data regarding higher in-hospital death rates, lower coronary intervention rates and higher rates of discharge against medical advice among Aboriginal people. As a result of this meeting, the specialists and hospitals represented agreed to recommendations for further cooperative efforts to improve the patient journey and treatment experience for Aboriginal patients. This included seeking funding for dedicated Aboriginal Health Workers on cardiac wards in the major teaching hospitals. The Heart Foundation WA continues to progress work in this area. In 2010–2011, the Heart Foundation's Board has forged a collaborative relationship with the Health Department (WA) Cardiovascular Health Network. Together, the Network and the Heart Foundation have identified the reduction of disparity in Aboriginal hospital mortality as a priority.

Fig. 2. Brokering of collaboration around Aboriginal Health (an example).

Aboriginal and non-Aboriginal staff members have increasingly become engaged in contribution to Aboriginal health research partnerships. The Aboriginal health manager is often consulted for cultural input and to ensure ethical requirements are met.

Direct contributions have been made by Heart Foundation WA (Aboriginal and non-Aboriginal) staff as associate investigators on several Aboriginal health research studies being conducted in WA universities, such as monitoring coronary heart disease in the modern era in Aboriginal people (MOCHAb study) (Katzenellenbogen *et al*. 2010). Staff members have also been involved with a State Health Research Advisory Committee grant evaluating the implementation in WA of the NHMRC framework, strengthening cardiac rehabilitation and secondary prevention for Aboriginal and Torres Strait Islander peoples, and the important role of the AHW in the cardiology ward setting (Thompson *et al*. 2009, DiGiacomo *et al*. 2010, Taylor *et al*. 2010, Taylor and Thompson 2011). This AHW position had been developed as a result of a Heart Foundation led collaborative proposal in 2005 to improve services for Aboriginal patients with cardiovascular disease at Royal Perth Hospital, which successfully advocated for the creation of this AHW role.

Other research collaborations have been formed to assist in the evaluation of Heart Foundation WA's cardiovascular health programs and help to inform state-wide social marketing campaigns run by the Heart Foundation WA. For example, in the formative research phase for the most recent iteration of the Find Thirty every day® physical activity campaign, focus groups and in-depth interviews were undertaken with Aboriginal people in Perth and Geraldton (regional) to ensure messages, images and program materials were acceptable to an Aboriginal audience. This research found that Aboriginal people related similarly to the underlying messages about the importance of physical activity for health and well-being, but raised additional considerations about the need for campaign images to convey cultural diversity, different body shapes, low- or no-cost options for being active, and regional lifestyles. The importance of family (both as a reason to stay healthy and as a source of social support for being active) also emerged from the research with Aboriginal people (O'Donoghue *et al*. 2008). These considerations were then incorporated into the development of campaign materials.

Similarly, the Smarter than Smoking prevention program targeting 10–15-year-olds (Wood *et al*. 2009) has conducted focus groups with Aboriginal youth to test the relevance and cultural appropriateness of the campaign media materials. While the 'mainstream' campaign measures have been found to resonate with Aboriginal young people, findings from this research and from consultation with Aboriginal stakeholders have led to the development of some more targeted initiatives, including school-based initiatives in schools with a higher proportion of Aboriginal students, collaboration with the David Wirrpanda Foundation to incorporate smoking prevention strategies into programs involving young Aboriginal people in sport, and promotion of the Smarter than Smoking message through Healthway funded sponsorship of Aboriginal events and programs in remote, regional and metropolitan areas.

Focus groups with Aboriginal people in rural and remote areas were also undertaken in the development phase of the Warning Signs for Heart Attack, and Women and Heart Disease programs. These found that most resources resonated well with an Aboriginal audience.

Through research and evaluation initiatives, the Heart Foundation WA is seeking to further the evidence base and support needed to make inroads in closing the gap. An ongoing challenge for the Heart Foundation WA is the creation of a substantially increased and sustained capacity building effort for high-quality Aboriginal cardiovascular research in Western Australia.

Discussion

This article articulates what we believe is an important journey in Aboriginal health undertaken by a state-based NGO, the Heart Foundation WA. A combination of strategies have been used including: the adoption of cultural principles; governance leadership and support; the forging of vibrant and effective partnerships; the attraction, development and retention of Aboriginal staff; and the development of dedicated Aboriginal health programs, while integrating an Aboriginal health focus across the organisation. As observed by Fielke *et al*. (2009) embedding cultural competence and training within an organisation can help to develop champions for cultural change and reinforces that Aboriginal health is 'everyone's business'. The Heart Foundation WA experience resonates strongly with this, with several champions who are passionate, committed and dedicated to Aboriginal health.

In the same way that Aboriginal people see health as an interconnected weaving of individuals, family and community culture, an interconnected organisational response is required to redress prevailing disparities in Aboriginal health. As encapsulated in the critical framework of Lewis (2005), health policy exists within a dynamic relationship that exists between institutions and health systems, governance, power and influence, professions and, finally but importantly, ideas. Ideas represent the place at which structure and action meet and play a central role in connecting the key factors. The Heart Foundation WA has clearly used ideas in a dynamic engagement of the key factors that Lewis describes as critical. For example, the central idea that Aboriginal health is everybody's business has been increasingly adopted across the Heart Foundation WA, throughout its programs and strategies and by increasing numbers of staff, in governance processes and the organisational culture itself. The same idea has been used to influence power, in the form of government and funders, as well as professions and health systems (e.g. cardiac services).

While Heart Foundation WA seeks to go beyond the rhetoric in its efforts to implement policies, there is awareness that the evidence presented here may not be the ideal case study of 'evidence-based policy'. Non-government organisation evidence from the field is often grey and too infrequently published. It is difficult to be overly scientific about the health outcomes of work in the fields of advocacy, community support and governance – effect sizes may be small and actual health benefits may occur long after the intervention. There are important questions for NGOs, such as the Heart Foundation, when seriously reflecting on evidence-based policy making in Aboriginal health. The perspective of Larkin (2006) is relevant

here, drawing on his many years as an Aboriginal man in senior positions in the health bureaucracies and academia. He adds cultural rationality to the three well established competing rationalities that form health policy, that is to the social, political and technical rationalities, but contends that cultural rationality is the important lens through which we view the others. Without the necessary cultural and social perspective, predominantly non-Aboriginal decision-makers are at risk of using a biomedical framework to analyse Aboriginal health problems, and as a consequence misunderstand what they are dealing with. Unsurprisingly, their interventions will not be fully effective. Larkin uses this framework to explain how to reduce Aboriginal health inequalities 'it is necessary to focus on structural processes such as institutional racism, distribution of power, and access to health resources' (Larkin 2006). Larkin's approach challenges NGOs and other organisations to go further in incorporating more Aboriginal people into its governance and leadership, and to combine cultural, social, political and technical rationalities in its thinking and action on Aboriginal health policy.

The literature on NGO policy in Australia demonstrates diversity and innovation in approaching the problem of improving services where health inequities exist. Helen Szoke, the chief executive officer of the Victorian Human Rights and Equal Opportunity Commission, describes the benefits of using a charter of human rights, the provision of human rights protections and the identification of standards for service delivery in a large state (Szoke 2009). Australia is among 150 countries that have adopted the 2007 United Nations (UN) declaration on the rights of Indigenous peoples (UN 2009), but to date it seems to be Indigenous people and groups themselves, along with some aid agencies (e.g. Oxfam) that are more comfortable with a rights-based approach to issues of equity. But perhaps the time is ripe for the health sector, including NGOs, such as the Heart Foundation WA, to consider this further, given the enormous disparities in Aboriginal health that still prevail. There are examples of a rights-based approach being harnessed elsewhere in the broader health sector, such as the growing movement of patient advocacy groups (e.g. International Alliance of Patients' Organizations, Consumers Health Forum of Australia) and the evidence for patient-centred care (ACSQHC 2011). Applied to Aboriginal health, this may open new opportunities for organisations such as the Heart Foundation WA to work with an even broader groundswell of people to fulfil the rights of Aboriginal people to greater equity in health.

In Australian health policy reform, and particularly in Aboriginal health, reform and progress is rarely a linear process; it is perhaps more accurately viewed as an incremental process, often the product of several actors, and a process requiring time, internal champions, and a preparedness to think and do things differently to bring about effective change. The Heart Foundation WA's journey has resulted in both important successes and progress, but also in some important lessons learnt. Figure 3

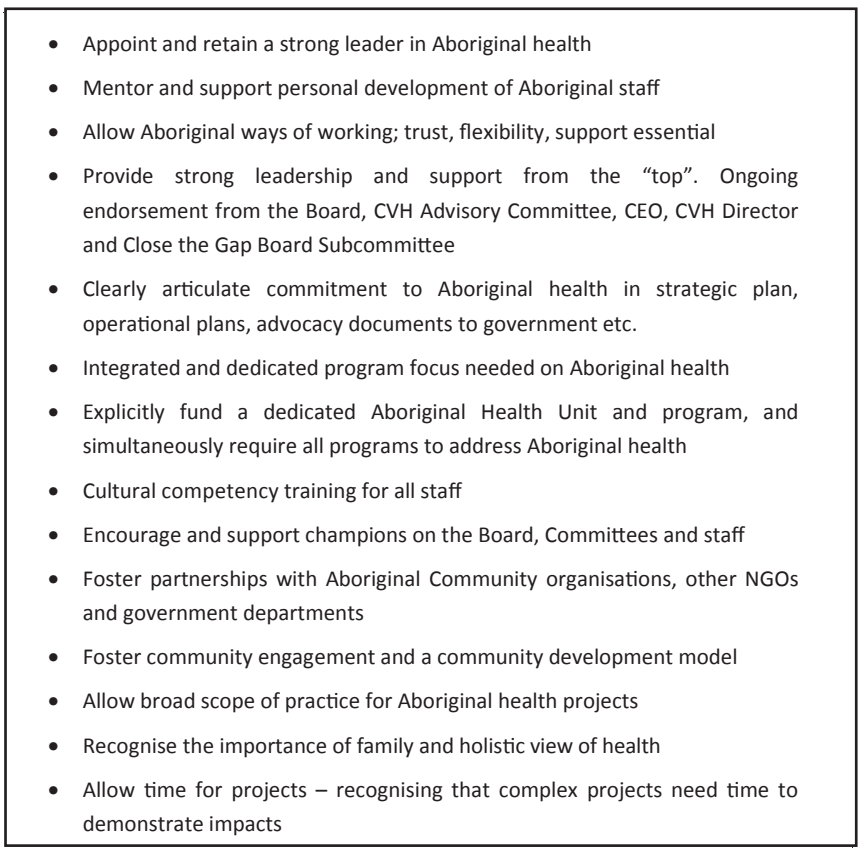

Fig. 3. Key lessons learnt in embedding Aboriginal health into a NGO. CEO, chief executive officer; CVH, cardiovascular health; NGO, non-government organisation.

highlights some key lessons learnt. However, importantly, while the strategy has been necessarily flexible, it has been implemented as a deliberate, coordinated strategy and as a priority of the board and senior management.

In sharing the Heart Foundation WA's experience as an NGO trying to go beyond rhetoric to reduce health disparities for Aboriginal people, we have also sought to share a framework and future challenges for forging long-term progress. In this regard, the experiences and approach of the Heart Foundation WA may be of assistance to other organisations working in the Aboriginal health arena.

There is, of course, still considerable work to be done. One of the most pressing short-term 'internal' goals for the Heart Foundation WA is to make Aboriginal cardiovascular health one of the top priorities for the national organisation. But as noted by Kaplan-Myrth, stories of progress and success need to be told:

> *Positive developments in the arena of Aboriginal health, including successful community-government partnerships, are unfortunately overshadowed by ongoing crises in Aboriginal health. Perhaps it is time to set the record straight by acknowledging the achievements in Aboriginal health, rather than just the flaws*. (Kaplan-Myrth 2005, p. 81)

Conflicts of interest

L. D., J. S. and T. S. are employees of the Heart Foundation WA and L. W. and T. L. are members of the board of the Heart Foundation WA. However, the views expressed in this paper are those of the authors and should not be taken to represent the views of the Heart Foundation.

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