Power, politics and the street-level bureaucrat in Indigenous Australian health

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Abstract
Street-level professional workers’ influence over Indigenous health policy implementation is an important variable in a contested policy environment distinguished by an Indigenous median age of death approximately 20 years less than for non-Indigenous citizens. Street-level workers are guided by personal political values in the ways that they prioritise their work and make decisions about the care that will be available to particular patients. The possibility that street-level workers may make decisions with reference to stereotypical or prejudiced judgements about Indigenous peoples makes their bureaucratic discretion a point of particular significance. Alternatively, their capacity to work on the assumption that they have the professional agency and a moral duty to make a substantive contribution to improving Indigenous health outcomes positions their work in the context of social justice. The street-level worker is, then, drawn into the politics of public policy and policy activism, where ideology sits alongside professional knowledge and skills as determinants of Indigenous health outcomes, and where public policy’s intellectual and practical inconsistencies simultaneously constrain opportunities for bureaucratic discretion in some respects and provide new opportunities in others, such that the street-level worker is a central participant in the politics of Indigenous health.

Keywords
Indigenous health, Indigenous policy, street-level bureaucracy

Introduction

Public policy is not best understood as made in legislatures or top-floor suites of high-ranking administrators, because in important ways it is actually made in the crowded offices and daily encounters of street-level workers. (Lipsky, 1980: xii)
Street-level workers (for example doctors, nurses, dentists and social workers) are guided by personal political values in the ways that they prioritise their work and make decisions about the care that will be available to particular patients. The possibility that street-level workers make decisions with reference to stereotypical or prejudiced judgements about Indigenous peoples makes their bureaucratic discretion a point of particular significance. Alternatively, their capacity to work on the assumption that they have the professional agency and moral duty to make a substantive contribution to improving Indigenous health outcomes positions their work in the context of social justice. As the Royal Australian and New Zealand College of Psychiatrists notes in its *Principles and Guidelines for Aboriginal and Torres Strait Islander Mental Health*:

> Health professionals and scientists have considerable influence in the creation of stereotypes and over their eventual abandonment. At times, health professionals have contributed to the development of pejorative and disempowering stereotypes of Aboriginal and Torres Strait Islander people. On the other hand, health professionals have considerable influence over the beliefs and practices of the wider community and can make great contributions to breaking down prejudice and unfair practices. Psychiatrists have an important part to play in the removal of prejudice from all mental health services and the encouragement of Indigenous community efforts to improve mental health and social and emotional well being. (Royal Australian and New Zealand College of Psychiatrists, 2009: 1)

Similarly, the Medical Board of Australia proposes that: ‘Good medical practice involves using your expertise and influence to protect and advance the health and wellbeing of individual patients, communities and populations’ (2013: 17). Yet, inconsistent and contested public policy appreciations of the nature of Indigenous citizenship and the terms of Indigenous belonging to the modern liberal democratic state means that Indigenous health policy is itself theoretically under-conceptualised and a site of practical confusion at each level of the policy process, which further draws the street-level worker into the politics of public policy and policy activism, where ideology sits alongside professional knowledge and skills as determinants of Indigenous health.

In its first section, this article sets out the policy context in which discretion and agency are exercised and provides examples of their exercise being conditioned by contested accounts of Indigenous citizenship. The second section further considers relationships between discretion and agency and political values, while the third shows how these considerations can position the street-level worker as a policy activist of some influence. The article demonstrates, then, the ways in which street-level health workers’ bureaucratic discretion and professional agency are among the political determinants of Indigenous health.

The ideologically contested nature of the Indigenous affairs policy environment means that there is considerable space for street-level work to be carried out with reference to workers’ own philosophical preferences and priorities.

State efforts to direct street-level work in the Weberian sense are compromised by conflicting policy objectives, which means that the street-level worker’s personal political values have increased opportunity to find their own intellectual space and to influence the nature and quality of the care that is available to Indigenous peoples. Constraints on agency, such as the use of military health workers during the Northern Territory
Intervention, occurred at the same time as measures conducive to cultural cognisance and Indigenous self-determination in health policy were being introduced.

**Discretion, agency and the policy environment**

Street-level workers influence the policy process through bureaucratic discretion and professional agency. Their capacity to influence occurs because policy is ‘rarely applied directly to the external world, but is mediated through other institutions and actors’ (Hudson, 1989: 42). Admitting the significance of street-level discretion and agency is preliminary to a broad understanding of the political determinants of Indigenous health, especially as the clinician, as street-level worker, influences who and what is treated and with what level of care (Lipsky, 1980). Street-level work is ideally guided by a political philosophy that privileges professional agency. However, agency is compromised when professional duties are performed in a highly contested yet theoretically under-conceptualised policy environment, where the ability to treat an Indigenous patient with neither fear nor favour is a relatively recent right and expectation (see e.g. Dodson and Wilson, 1997). Indeed, intellectual tensions and philosophical incoherence distinguish contemporary Indigenous public policy, a domain which is marked by constant change. Policy change can alter the tenor of public debate and the positioning of Indigenous peoples vis-a-vis the policy process.

The tension is expressed when, at one level, the bureaucracy is instructed to operate in ways that do not discriminate, while in practice there are certain measures and modes of operation that are inherently discriminatory and are, themselves, determinants of sustained Indigenous ill-health (NTER Review Board, 2008). In this context, bureaucratic failure may be as much the outcome of failures in democratic governance as the outcome of the inept or even discriminatory exercise of discretion.

Failures in democratic governance occur when decision-making arrangements do not admit the proposition that the citizen is ‘he who has power to take part in the deliberative or judicial administration of any state’ (cited in Ebenstein and Ebenstein, 1991: 87). For example, philosophical confusion and intellectual inconsistency on the matter of common Indigenous citizenship and the terms of their ‘belonging’ to the modern liberal democratic state shapes and constrains policy possibilities. Greater deliberative capacity would provide Indigenous peoples themselves with better opportunities to confront bureaucratic inertia, challenge street-level prejudice and establish what they might reasonably expect from the public health system.

Indigenous democratic exclusion casts the Aboriginal person as an anthropological artefact who is ‘never where an actual Aboriginal subject stands and speaks’ (Povinelli, 1999: 34). Prevailing liberal accounts of sovereignty make access to decision-making processes conditional on deliberating in ways that require acceptance of dominant cultural practices and framing political aspirations in the language of non-Indigenous political concepts because the unacknowledged “client” of aboriginal development … is the non-indigenous voter and the political class that is responsive to them’ (Sullivan, 2009: 63). In contrast, self-determination is grounded in differentiated citizenship, which presumes Indigenous deliberative engagement of the sort explicitly prevented by the Northern Territory ‘Intervention’, for example. The Intervention was a Commonwealth
policy response to widespread sexual abuse in a number of Northern Territory Indigenous communities. It was developed without the engagement of the communities, themselves, and required the suspension of the Racial Discrimination Act 1975 (Cth) to enable measures such as the sequestering of welfare payments and compulsory health checks of community children (NTER Review Board, 2008). In 2008, an independent review board found that the Intervention was explicit in its disregard for non-discriminatory and culturally cognisant policy development and implementation (NTER Review Board, 2008).

Limiting Indigenous policy participation, and therefore the overall distribution of political power, was among the Intervention’s essential bureaucratic objectives (NTER Review Board, 2008), and one of the outcomes was that, rather than providing the interface between government and citizens, the front-line workers’ role that the army assumed became one of restricting Indigenous peoples’ access to policy influence.

Procedurally, the Intervention was the antithesis of Shergold’s (2009) model for more ‘open structures’ of governance because, as the former Secretary of the Department of the Prime Minister and Cabinet noted, open governance requires:

shifts of power. Decision-making needs to be less bureaucratic and more citizen-centric. That requires far more flexible organisational structures and delivery systems and more collaborative leadership cultures. It demands that governments embrace social innovation and that public services are willing to manage the risks that inevitably accompany it. It needs to be recognised that too much ‘accountability’, too much public service process and too much ‘professional’ expertise kill creativity. (cited in Shergold, 2009: 15)

Shergold’s hope that Australia might ‘develop as a participatory society’ (2009: 1) remains an elusive goal for Indigenous citizens because as Shergold himself notes:

Trust and engagement are the twin pillars of a participation society. In their absence, the ties that bind – the networks of ‘social capital’ that underpin civility, respect for others and a collective sense of mutual responsibility – are loosened. (2009: 1)

There is a philosophical incongruence between positioning ‘mutual responsibility’ as a guiding paradigm and concurrent policy decisions that are injurious to the maintenance of trust and engagement. The Intervention confirmed Indigenous peoples’ place in a discourse of ‘disadvantage’ and qualified citizenship. While the army did bring significant resources to the Northern Territory (Lea, 2008), it also brought a command structure more easily able to constrain bureaucratic discretion, as the military health worker’s professional agency is conditioned by the obligation to observe military discipline. The outcome was to diminish opportunity for professional capture by co-opting the military to perform street-level work, with the soldier’s responsibility to military hierarchical authority meaning that tight ministerial and managerial control of the workforce was firmly in place.

Scope for street-level influence is also diminished as normative practices shift towards more managerialist, discretion-limiting, civilian administrative arrangements. While street-level workers can be well placed to assess policy efficacy, their capacity for influence can be constrained by public management theory’s resistance to ‘provider capture’, and, while individual workers may aim to make a positive difference in the lives of
others, ‘bureaucratic control systems’ impact negatively on individual motivation (Paarlberg and Lavigna, 2010: 710) as accountability is conceptualised in these terms: ‘accountability of the minister to the public, accountability of public servants to the minister, and accountability of Indigenous people to white Australia in general’ (Sullivan, 2009: 58). Yet, on the other hand, Weber’s ‘iron cage’ directs street-level workers to implement culturally respectful policies responsive to Indigenous experiences and priorities such as the National Mental Health Policy 2008 (Department of Health, 2008), the Australian Health Ministers’ Advisory Council’s Cultural Respect Framework (2004), the National Aboriginal and Torres Strait Islander Health Plan (2013). These policies’ intention was to use bureaucratic authority to impose requirements on health workers that would, ideally, give substantive recognition to relationships between culture and well-being. Street-level workers’ acceptance or rejection of such relationships shows how ideology precedes the exercise of discretion.

Policy priorities that accord respect to cultural imperatives re-frame the political context of public policy, so that it is both ‘universal and differentiated’ (Fleras, 1999: 183) and able to grant Indigenous peoples the greatest possible autonomy over their own affairs, potentially through existing bodies such as Aboriginal Community Controlled Health Organisations (ACCHOs), as a way of ‘mainstreaming indigeneity’ to reflect ‘moves towards participatory governance, but also … a commitment to indigenous models of self-determining autonomy’ (Maaka and Fleras, 2009: 1). The implication for street-level bureaucrats is that a rights-based discourse requires the distinct conceptualisation of Indigenous communities for policy purposes, and recognition that ‘culture counts’ in service delivery (Bishop and Glyn, 1999). Similarly, ACCHOs show that relationships between policy and practice are culturally contextualised and that the distinction between what is inside and outside the government is narrowing to recontextualise the role of street-level workers.

The ‘contracting out’ of street-level responsibilities changes the power relationship between governments and street-level professionals. It means that there is no immediate employment relationship to provide the state with direct control over people’s work. The lines of accountability are blurred as these workers’ salaries may be paid from public money, and their work regulated by legislation and public policy imperatives. Yet, they are formally employees of an agency with an overt commitment to self-determination. In this sense, the policy process’s ‘layers of relations … involves a succession of struggles for control over action’ (Hupe and Hill, 2007: 295).

The ideological inconsistencies that pervade Indigenous health policy reflect Lea’s (2008) description of a fragmented, intellectually disjointed state, functioning in this way because the state itself ‘does not have a conscience, misanthropic or otherwise; there is no singular architect, no authorial centre for the institutional ability to engender self-replicating practices. It is a dynamic that exceeds individual actors’ (Lea, 2008: 16). As Lea continues, the ‘point about the bureaucratic emanations’ of the state is that ‘such emanations have a magical relationship to the worlds that they simplify, distort and describe. Exact correlation between ‘rhetoric and reality’ is not required’ (2008: xv), especially in the context of street-level work being constrained by the absence of substantive data on particular community needs. For example, in 2008 policy-makers in the Northern Territory were advised that: ‘We have new information systems being put in
place but it will still take a few years for community-level data to be easily available’ (Lea, 2008: 118).

The street-level worker’s role in adding to or detracting from health inequality is, then, an illustration of Weber’s conceptualisation of inequality as an outcome of values and group memberships, just as it is an outcome of economic considerations (Marmot, 2005). As Hupe and Hill observe:

Since most of the activities of street-level bureaucrats are multi-faceted, some bits will be structured where others are not. The institutional context helps determine that structuring. The implication for practice is that there are some important political choices, not only about what to structure and how to structure it, but also, about who should be in control … (2007: 296)

Indeed, the complexities of bureaucratic power mean that even well-considered and broadly endorsed policy measures can fail, with the health system then perpetuating disadvantage (Marmot, 2005). For example, the street-level bureaucrat’s professional agency can be compromised and confused by the role’s multiple accountabilities: to the patient, the bureaucracy, the profession, the public and personal conceptions of justice. Indeed, it is the practitioner’s ideological disposition that rationalises and negotiates these multiple accountabilities that must be managed in a context where workers unavoidably present themselves as the public face of government. The reality of ‘being the state’ (Lea, 2008: 9) means that street-level workers must, individually and with the guidance of their own philosophical dispositions, mediate the logical inconsistencies that pervade the formal expressions of public policy. Therefore, the street-level bureaucracy is ‘a complex socio-cultural domain with its own passions and inanities, pains and pleasures, complicities and truths, mysticism and magic’ (Lea, 2008: 10).

**Discretion, agency and political values**

Political and moral conceptions of social justice are also relevant to the street-level worker’s sense of agency and responsibility, and there is an argument that discretion ought to be exercised in support of socially just and altruistic goals (Maynard-Moody et al., 1990). Indeed, the capacity to use the resources at their disposal to provide services beyond personal contractual obligations makes street-level influence ‘a pre-requisite for justice’ just as much as it is a potential ‘source of considerable abuse’ (Maynard-Moody et al., 1990: 833). Further, the bureaucracy’s collective capacity to effect change depends on promoting personal agency through the institutional conceptualisation of goals that are congruent with specific, culturally acceptable policy priorities, relevant to the needs and aspirations of a particular community.

However, it is still ideology that provides the motivation to support or undermine particular policies and practices. Ideology rationalises the decisions that people make about the levels and quality of professional attention that individuals will receive, and its influential capacity is enhanced when the regulations governing policy implementation do not always make sense to the street-level worker in the context of an immediate problem they are trying to resolve.
Workers in one agency admitted to deceiving STH [the South Australian Government’s Street-to-Home programme] about whether they were working with particular clients. STH were sometimes informed that a particular client was not receiving a service, if the worker thought that STH may offer the client better resources than their agency could. (Talbot et al., 2010: 45)

Yet Bacchi et al. (2006) argue the centrality of street-level contributions to the resolution of policy problems, and point to the importance of transparent policy-making in establishing street-level understandings of a policy objective:

>The testing of selected … frameworks ‘on the ground’ revealed that such frameworks are not static; rather, they are malleable and subject to continual political pressures, reflecting the changing contexts in which they operate. (Bacchi et al., 2006: 62)

Uncertainty is among the public policy environment’s distinguishing characteristics. It is an environment where change is usually incremental, but where the possibility of rapid and unexpected development also exists. In this context, personal agency is important, but there also remain significant systemic barriers to the individual worker’s capacity to effect improvements in health outcomes. The broader policy environment can be constraining and the inevitable tendency to ‘fall back on answers conceptualised in terms of their own agency’ (Lea, 2008: 15) can inhibit the individual’s critical reflection on the broad philosophical context in which policy occurs.

Political values account for the ways in which decisions are made about the rationing of public resources and the claims that Indigenous peoples make on the health system. Institutional workplace cultures also influence street-level decisions about service delivery to show, as Sullivan (2008) found, a fundamental cultural and physical distance between Indigenous communities and bureaucratic communities, such that ‘Aboriginal people become symbolic capital in patterns of action determined by the bureaucratic imagination’ (2008: 127). Sullivan’s description is one that has long distinguished Indigenous policy. Historically, governments have used the public service to position the Indigenous person beyond citizenship. For example, street-level health bureaucrats were essential agents in discriminatory policies such as the removal of Indigenous children from their families (stolen generations), of which ‘most Indigenous families have direct experience’ (Zubrick et al., 2010). The legacy of the relationship between health workers and Indigenous peoples helps to account for their present wariness of health workers as well as the system itself. Indeed, Jamieson et al.’s research in South Australia found people who:

felt that historical legacy impacted on the oral health of community members, through continued practices of being told what to do, where to live and what oral health services were available to them. Participants perceived they had little power over their oral health or oral health care decisions. (2008: 52)

Street-level bureaucrats’ perceived unfriendliness, inflexibility and intolerance also impedes Indigenous access to health services, and locates street-level workers and their professional activities into a context where racism is commonly experienced (Cutcliffe, 2006; Paradies et al., 2008), even as many health workers bear no conscious ill-will
towards Indigenous peoples, and as Lea (2008) demonstrates, are motivated by a well-developed passionately held sense of social justice. For example, one health worker in the Pilbara region of Western Australia told Walker et al. that:

We can do all the cultural awareness training in the world, but we are not Aboriginal and cannot understand everything. We need to be able to offer what is needed. (2012: 432)

Alternatively, as one health professional put it to Dwyer et al.:

A really difficult thing for me, being a white male in a foreign environment, is having any possibility of communicating with a shy woman with poor English, possibly, who comes from a totally different cultural background…. I just have to say that I really don’t … communicate very well with the women and that just is a fact of life. (2011: 10)

This perhaps explains why: ‘Generally speaking, these women don’t ask for anything, and much to their detriment at times I think’ (Dwyer, et al., 2011: 11). Nevertheless, racism does occur at levels suggesting that the generally attentive view that contemporary professional associations show towards Indigenous aspirations are contested among their memberships. Officially sanctioned professional Codes of Ethics may not actually determine workplace practice. This is because, as well as allowing flexibility and responsiveness in service delivery, discretion also allows prejudiced accounts of Indigenous citizenship and positions grounded in stereotypes to become, in effect, the public policies that are implemented at the street level (Lipsky, 1980). It is in this context that Dwyer et al. (2011) identified poor communication between hospital staff and Indigenous patients as significant to the relationship between professional practice and health outcomes:

when my sister was in hospital they didn’t want a lot of people there – because there was a lot of blackfellas coming in and out – I said, well, this is the only way that’s going to bring her back to us … if she hears her people, her mob, she’ll come home. Well, [one nurse] she didn’t want the people there. She said, ‘only you’. I said, not only me. That’s all her cousins, they’re like her sisters and brothers, you’ve got to let them in, if you don’t she’ll only get worse. Let them in, she’ll be home next week … and sure enough, she was too. (2011: 30)

On the other hand there are Indigenous perceptions that the systemic tendency to discharge patients early, for financial rather than clinical reasons, may be applied in discriminatory fashion:

they knew my baby was premature and the birth weight wasn’t up. Why they didn’t keep me in then? … They said, ‘oh, he’s still not putting on weight’, and they still end up sending me back here, you know, why they send me back … the midwife from here told me they don’t usually send babies back that way. (Dwyer et al., 2011: 30)

Yet Dwyer et al. also found instances of effective and culturally respectful practices:

The actual service in the hospital is really good. I couldn’t fault it. The staff were fantastic and did their job very well. There was the same level of care and respect shown for all families
there. Our experience has been very positive. We didn’t encounter anything negative based on being Aboriginal. You have your radar on when you go somewhere new, and there was nothing to detect…. There are posters there, things around that are culturally inclusive. You can see yourself as a patient within the system. Aboriginality is acknowledged and it looks like it is respected. These signposts make a huge difference. (2011: 8)

And:

The [Aboriginal health service GP] is really mindful of our needs. She is really busy and everything, but she makes time to talk about things and follow through. She explains things really well. With the medication she tells me why, what it does, not just taking it and not knowing. If you get the right help, you can get through…. What we need is friendly people, with friendly processes. The specialists in Adelaide are not friendly, but the [rural and remote] mental health people … were better…. There was a teleconference with the doctors in Adelaide, I chatted with her for a half an hour and discussed all sorts of things…. We are pretty shy people, not right out there, it is a huge thing for us. Speaking to us makes a huge difference. Talking in terms that we can understand is much better. (Dwyer et al., 2011: 11)

Stereotypical assumptions cannot be set aside by bureaucratic directive. They can retain pervasive influence even where institutional cultures mean that attitudes of negative consequence to Indigenous people can only be subtly expressed. Discretion is thus a paradoxical influence that ‘promotes flexibility and innovation, yet allows indifference and abuse’ (Maynard-Moody et al., 1990: 833). Therefore, service delivery decisions can constitute a ‘moral judgment and statement about [a person’s] social worth’ (Hasenfeld, 2000: 329). The capacity to subvert the position that all citizens ought to enjoy the same quality of health care reflects the ‘dilemma of discretion’ (Maynard-Moody et al., 1990: 833) that occurs when individuals neglect aspects of their work that they dislike, or find difficult or philosophically objectionable.

**Street-level work and policy activism**

In spite of the personal and systemic constraints on professional agency, street-level workers’ complex, highly skilled, and professionally autonomous policy contributions allows their agency to be used to advance alternatives to government policy priorities. Weber’s ‘ideal’ bureaucratic ‘type’, where occupational expertise is conditioned by systemic rules and regulations (Germov, 1996: 739) is therefore challenged. Indeed, professional autonomy positions Weber’s (1958) conceptualisation of the bureaucracy as an ‘iron cage’ of control in a continuously evolving tension with people whose philosophically guided professional priorities can conflict with prevailing state paradigms and their attendant ‘contradictions and resource limitations’ (Wells, 1997: 333) at the points of policy delivery. Professional agency is enhanced when street-level workers account for relationships between personal political values and policy outcomes. One of the ways in which they do this is through their professional associations, which are not, themselves, impeded by the bureaucratic obligations that may constrain their members’ individual agency. Professional associations do not have bureaucratic loyalties, but they can respond to Giles’ (2009) argument that the ideological disposition of street-level workers is,
itself, among the determinants of Indigenous health, with positive as well as negative potential. For example, in the field of social work, she explains that:

By paying greater attention to the details of the relationship between social factors and physical and mental health, these present both challenges to current social work practices and opportunities for the profession to continue to advance, in collaboration with related professions, common goals of reductions in poverty, the alleviation of oppression and enhanced social equality; that is, the development in each practitioner of a health equality imagination that inspires action. (Giles, 2009: 530)

Giles continues to propose that the explicit politicization of the social work profession to respond to ‘discrimination and injustice’ (2009: 530) is a reasonable professional responsibility that draws ideology, professionalism and political activism together to pursue substantive Indigenous rights. Her view is supported by the growing international acceptance of health care as a human right, embodied in the Constitution of the World Health Organization (1946) among other international legal instruments.1 Certainly, the Australian Association of Social Workers’ Code of Ethics (2010) emphasises ‘respect for human dignity and worth’ on the basis that ‘each person has a right to wellbeing, self-fulfilment and self-determination, consistent with the rights and culture of others’ (2010: 12). The medical practitioners’ and nurses’ codes are grounded in similar conceptions of social justice. For example, the Australian Medical Association’s (AMA) Code of Ethics (2004) precludes denying treatment ‘because of a judgement based on discrimination’, while the nursing Code of Ethics requires that care is provided with ‘just and due consideration’ for ‘ethnicity, culture, gender, spiritual values, sexuality, disability, age, economic, social or health status, or any other grounds’ and that: ‘Nurses respect and uphold the rights of Australian Indigenous peoples’ (Australian Nursing Council, 2002). These professional obligations give effect to insistence of the United Nations (2007) Declaration on the Rights of Indigenous Peoples that:

Indigenous peoples have the right to the full enjoyment, as a collective or as individuals, of all human rights and fundamental freedoms as recognized in the Charter of the United Nations, the Universal Declaration of Human Rights and international human rights law. (Article 1)

And that:

Indigenous peoples and individuals are free and equal to all other peoples and individuals and have the right to be free from any kind of discrimination, in the exercise of their rights, in particular that based on their indigenous origin or identity. (Article 2)

In subscribing to these international positions professional bodies are, in fact, challenging the way the policy process conditions Indigenous citizenship, and contributing to the mainstreaming of indigeneity as an alternative way of reducing the dissonance between policy-makers and Indigenous people (Maaka and Fleras, 2009). Professional associations can function as political lobby groups with the capacity to engage in public debates even to redefine policy problems. For example, the AMA’s annual ‘report card’ on Indigenous health combines professional expertise with ‘street-level’ experience to
make proposals and critiques that challenge the philosophical presumptions of government policy and add to the complexities that governments experience in maintaining control of the Indigenous affairs policy agenda. The bureaucracy’s ‘power to direct any individual or section is attenuated by the subordinates’ power to resist, resilience or reinterpret’ (Sullivan, 2008: 138), which can be done indirectly through professional associations. For example, in 2007, a government review of Shared Responsibility Agreements (SRAs) found that:

Most communities appear in the main to be very supportive … [of the Agreements] and the … process. There is consistent positive feedback that this new way of working is very consistent with Indigenous customs, community traditions and values regarding working together, community and family obligations, and reciprocity. (Department of Families, Community Services and Indigenous Affairs, 2007)

The AMA’s contrasting argument that the government’s position was paternalistic and lacking in ‘respect and equality’ (AMA) was based on a fundamentally different philosophical position on the meaning of Indigenous citizenship, while the Australian Indigenous Doctors’ Association’s (AIDA’s) critique of the Northern Territory Emergency Response (Intervention) argued that the Intervention ‘overlooked the centrality of human dignity to health’ (AIDA and University of New South Wales, 2010).

The street-level bureaucrat’s capacity to effect change can counter inadequacies, or even philosophical indifference, in policy design. In Canada and New Zealand, for example, policy environments more conducive to Indigenous self-determination provide greater scope for Indigenous health workers to work for the benefit of their own communities. In these jurisdictions, community-controlled health services operate in policy environments where limited self-determination is uncontested and where a culturally competent workforce is held to be – practically and substantively, as well as rhetorically – a preliminary to significant impact on health outcomes. As the associate Minister of Health and Maori party co-leader, Tariana Turia, put it to the University of Otago, Faculty of Medicine:

Training and recruiting culturally competent staff to work with Maori is also vital if we expect Maori to use health services and if we expect that Maori health and well-being will improve. The Maori Health Committee of the Medical Council has championed the vision that cultural competence must be a core competency for physicians and paediatricians and that clinical competence requires cultural competence. In other words cultural competence cannot be separated from clinical competence in achieving best Maori health outcomes. (Turia, 2013)

‘Transformational leaders’ are thus able to ‘influence followers by elevating their goals beyond their own self-interest’ to counter the bureaucratic development of health policy in the absence of ‘a compelling vision’ (Paarlberg and Lavigna, 2010: 711) of what ought to be achieved and to what end. In an overall sense, the street-level worker’s capacity to influence Indigenous health outcomes can be of negative consequence. However, where professional agency and ideological disposition suggest that street-level work requires policy activism, there is scope for professional health workers to make significant contributions to improved health outcomes at the point of policy delivery.
Conclusion

Bureaucratic discretion and professional agency are significant political determinants of Indigenous health, especially as the broader Indigenous affairs policy environment is sharply contested, yet able to provide street-level professionals with considerable scope to carry out their work with reference to their own philosophical preferences and priorities. While the state tries to direct street-level work, the philosophically inconsistent positions that distinguish Indigenous policy make this difficult and there is, consequently, intellectual space for street-level policy activism to influence the nature and quality of the care that is available to Indigenous peoples.

For many people, the street-level worker is the state. Their discretion and agency becomes government policy and the possibility that they might make decisions based on stereotypical assumptions about Indigenous peoples, grounded in deficit accounts of their relative ill-health, illustrates the significance of their role as policy actors. However, it is just as illustrative of street-level capacity to influence, to admit that a philosophical commitment to social justice positions street-level workers and their professional associations to make significant contributions to effective public policy capable of providing improved health outcomes to Indigenous peoples. In making choices about the ways in which they will use their professional skills, street-level workers are taking a position on the contested understandings of the nature of Indigenous citizenship and the terms of Indigenous belonging to the nation state. Theoretical debates on these questions have implications for what Indigenous peoples might reasonably expect from the public health system and inter alia from those who work within it.

The street-level health worker is, then, a policy activist with considerable capacity to interpret, promote, resist or contribute to alternative policy paradigms from those sanctioned by governments.

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Notes


2. Shared Responsibility Agreements were introduced by the Howard Government (1996–2007) to make Indigenous access to certain public services conditional on meeting specified ‘mutual responsibilities’ to the state.

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Author biography