Central Australian
Aboriginal Congress
ABORIGINAL CORPORATION | ICN 7823

Submission to the

Northern Territory Legislative Assembly Public Accounts Committee

Inquiry into Local Decision Making

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Aboriginal health in Aboriginal hands.

Executive Summary

Congress commends the Northern Territory Government (NTG) for establishing the Local Decision Making (LDM) framework and strongly supports its mission of partnering with Aboriginal communities to progress the transition of government services and programs to Aboriginal community control.

However, based on our extensive evidence-informed policy and practical experience of community control and Aboriginal empowerment, we have a number of suggested reforms to support the LDM approach and increase its reach and effectiveness.

REFORM 1.The Northern Territory Government should establish and resource a formal, ongoing Aboriginal partnership structure with senior representation from the Aboriginal community / organisations and the Australian and Northern Territory Governments, to advise and lead the LDM process and to monitor implementation of LDM policies and programs, as per existing commitments under the *National Agreement on Closing the Gap*.

REFORM 2.Responsibility for all matters relating to supporting or transferring services to community control in the health sector should remain with the Northern Territory Aboriginal Health Forum, as per existing commitments under the *National Agreement on Closing the Gap*.

REFORM 3.The Northern Territory Government, through the partnership structure described in Reform 1, should identify a number of likely sites, services and models for the transfer to community control, and then formalise a transparent pooled funding commitment from Government *prior* to entering into the detailed process of negotiating a transfer of government services to Aboriginal community control.

REFORM 4. In line with the *National Agreement on Closing the Gap's* Sector Strengthening process, the NTG should support, with the Australian Government, the funding and establishment of peak bodies for Aboriginal sectors to allow them to engage on an equal basis with government in supporting and extending community control. The priority should be establishing peak bodies in sectors where there already are existing Aboriginal community controlled organisations, noting that no peak bodies should be established that fragment existing sectors.

REFORM 5. That the Northern Territory Government establishes partnership structures under the *National Agreement on Closing the Gap*, as already agreed (see Reform 1) as an alternative to proposals for 'Local / Regional Voices' as proposed under the Australian Government's Indigenous Voice Co-Design process.

Background

Central Australian Aboriginal Congress

1. Central Australian Aboriginal Congress (Congress) is a large Aboriginal Community Controlled Health Service (ACCHS) based in Alice Springs. We are one of the most experienced organisations in the country in Aboriginal health[1], a national leader in primary health care (PHC), and a strong advocate for the health of our people. Since the 1970s, we have developed a comprehensive model of primary health care that includes:

    - multidisciplinary clinical care,
    - health promotion and disease prevention programs, and
    - action on the social, cultural, economic and political determinants of health and wellbeing.

2. Congress has extensive experience in establishing and supporting structures for Aboriginal community control and the transition of government services across the Northern Territory.

3. As a member of the Aboriginal Medical Services Alliance Northern Territory (AMSANT) we have participated in the work of the Northern Territory Aboriginal Health Forum (NTAHF) since its establishment almost 25 years ago and have advocated for and supported the transition of numerous NTG health services to local or regional Aboriginal control during this period.

4. Congress has also become the health service provider of choice for many remote Aboriginal communities in Central Australia. Originally delivering services only in and around Alice Springs, Congress now runs PHC services in remote communities across Central Australia including Ltyentye Apurte (Santa Teresa), Ntaria (Hermannsburg), Wallace Rockhole, Utju (Areyonga), Mutitjulu and Amoonguna. Negotiations are currently being finalised for Congress to take responsibility for PHC service delivery at Imanpa, Kaltukatjara (Docker River) and Yulara. In delivering these services, Congress has established and supports local structures for community input and decision-making, under a broader structure of community control.

The Local Decision Making approach

5. The LDM approach accords with the evidence that Aboriginal community control is the most effective and responsive governance platform for service delivery in Aboriginal Australia. For example, ACCHSs have contributed significantly to reductions in communicable disease, improved detection and management of chronic disease, and better child and maternal health

[1] Congress uses the term 'Aboriginal' as the most appropriate term in the Central Australian context to refer to Australia's First Peoples.

outcomes including reductions in preterm births and increases in birth weight [1]. They have also played a leading role in the response to the COVID-19 pandemic, combining evidence-informed public health action with detailed social and cultural knowledge of local Aboriginal communities [2].

6. The key role of community control in PHC delivery was confirmed by one major study which concluded that:

   up to fifty percent more health gain or benefit can be achieved if health programs are delivered to the Aboriginal population via ACCHSs, compared to if the same programs are delivered via mainstream primary care services [3].

7. The LDM approach program also is in accordance with the rights to self-determination of Aboriginal peoples as established under international agreements to which Australia is a signatory, including the *United Nations Declaration on the Rights of Indigenous Peoples* [4].

8. Congress therefore commends the Northern Territory Government for establishing the Local Decision Making (LDM) framework and strongly supports its aim of partnering with Aboriginal communities to progress the transition of government services and programs to Aboriginal community control.

9. However, based on our extensive evidence-informed policy and practical experience of community control and Aboriginal empowerment, we have a number of suggested reforms to support the LDM approach, as outlined in the following sections responding to the terms of reference of the Inquiry.

Progress, achievements, challenges and future potential of LDM implementation across the Northern Territory

10. We support LDM program's mission of "Government and Aboriginal community partnerships in the transition of services and programs to community control". However, a program based on single, one off grants to organisations to improve governance capacity or economic development will not lead to progress on this aim. Instead, **it requires a well-resourced, collaborative and strategic partnership** such has been developed in the health sector for close to twenty five years in the Northern Territory.

11. The signing of the *Framework Agreement on Aboriginal Health* in 1997 established the Northern Territory Aboriginal Health Forum (NTAHF) which brings together senior representation from the Australian and Northern Territory Governments with the community controlled sector (AMSANT) to work collaboratively to:

    a) ensure appropriate resource allocation;

b) maximise Aboriginal community participation and control as a key element of sustainable, viable, effective and efficient health services;

c) encourage better service responsiveness to / appropriateness for Aboriginal people;

d) promote quality, evidence-based care;

e) improve access for Aboriginal people to both mainstream and Aboriginal specific health services; and

f) increase engagement of health services with Aboriginal communities and organizations.

12. The NTAHF has also helped to ensure that the social determinants of health are addressed through high level collaboration and advocacy outside the health system.

13. Progress through the NTAHF has had to overcome many systemic barriers. A study of reforms transfer control of PHC for Aboriginal and Torres Strait Islander communities in the Northern Territory and Queensland, including the NTAHF as a case study, found that particular attention needed to be given to three key areas to make progress [5]:

a) *Authorisation, auspice and control*: high-level commitments to transfer of control must be matched with secure structures and processes for sharing power and to manage the process;

b) *Resources*: investment of sufficient money, time and institutional capacity is needed; and

c) *Working in partnership across cultures*: government and community partners need to establish robust, effective and trusting relationships which takes time, resources and commitment to realise.

14. Despite the barriers, the NTAHF, guided by key documents such as the *Pathways to Community Control* [6] has persisted with the aims of improved health services for Aboriginal communities. Over time this has led to a significant extension of Aboriginal community control of health services, including amongst other places in East Arnhem (Miwatj Health); West Arnhem (Mala'la Health Service, Red Lily Health Board); and Central Australia (Congress).

15. The LDM program should examine and learn from this long and ultimately successful process for supporting and extending Aboriginal community control in the Northern Territory. In particular, it should establish a formal, ongoing Aboriginal partnership structure with senior representation from key Aboriginal organisations and leaders and the Australian and Northern Territory

Governments, to advise and lead the LDM process and to monitor of implementation of LDM policies and programs.

16. This formal partnership structure will need to be resourced and should be aligned with the *National Agreement on Closing the Gap* [7] which has been agreed by the Northern Territory Government and includes commitments to:

    a) *Shared decision-making* and *Building the community-controlled sector* which are consistent with the aims of the LDM (clause 17);

    b) establishing formal partnership arrangements to support Closing the Gap between Aboriginal and Torres Strait Islander people and governments in each state and territory (clause 81);

    c) respecting and adding to existing partnership arrangements (such as the NTAHF rather than seeking to replace them (clause 34).

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How to foster community and leadership interest in and commitment to new LDM agreements

17. One of the key learnings from our long experience with attempts to extend community-control in the health sector is that Aboriginal communities are unlikely to be interested in taking responsibility for entering a transition process without a transparent and confirmed commitment of funding from government up front. This is not a reflection of a lack of interest in community control itself, but an understandable caution about investing what is often considerable effort into gaining community agreement on community control, setting up governance structures, and negotiating transfer processes before there is any concrete commitment from government. Many attempts at extending community control in the health sector failed at this point.

18. Accordingly, relying on 'expressions of interest' from communities or relying on short-term grant-driven processes, such as in the current LDM process, is

highly unlikely to achieve the LDM's mission of transferring government services to community control.

19. Instead, the formal NT-wide partnership process described above (Reform 1) should pro-actively identify a number of likely sites, services and models for the transfer to community control – including both need and community interest – and then work on obtaining a formal commitment to the transfer of funding and services from the relevant funding bodies. This could then lead to a process of local / regional negotiation with a greater degree of community commitment to the process.

20. Note that a commitment to transfer funding to support community control will need to identify the amount of funding available for transfer, including:

    a) transparency in funding, with Australian Government and State / Territory Aboriginal-specific funding pooled to prevent cost-shifting and encourage joint responsibility and commitment for achieving outcomes;

    b) funding to be transferred to include 'back of office' functions that are located outside the community / region (e.g. HR, finance or other administrative services) *and* 'visiting' services normally provided from outside the community / region;

    c) identification of additional funding required to support effective community control, noting this governance model requires investment and support if it is to be effective.

21. Effective engagement with the Aboriginal community sector requires that sector to have the resources to engage on an equal basis with government. In the health sector, AMSANT has played this vital role since its establishment in the mid-1990s.

22. Accordingly, as per the *National Agreement on Closing the Gap's* Sector Strengthening process, the NTG should support, with the Australian Government, the funding and establishment of peak bodies for community controlled sectors, noting that:

    a) peak bodies by definition are representative bodies – they represent a sector and have a membership of organisations that make up that sector. Peak bodies – such as AMSANT – arise from the collective actions of member organisations and serve to represent their interests. The NTG should therefore commit to building strong peak bodies in sectors where there already are existing Aboriginal community controlled organisations. In particular, Congress notes and supports the Central Land Council's work in developing a proposal for community control in the housing sector in the Northern Territory; and

b) no peak bodies should be established that fragment existing sectors. For example, early childhood development (ECD) is a core part of comprehensive PHC. It is our ACCHSs which have the links to women and families, developed through antenatal care and childhood immunisation and growth monitoring, and our services which are able to then seamlessly provide ECD programs to women, integrated with post-natal and child health services, up to the age at which children start pre-school. Setting up a peak in early childhood would therefore risk dividing and fragmenting the ACCHS sector.

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The impact of technology, Treaty, Truth-Telling and Voice on LDM development

23. Congress supports the 2017 *Uluru Statement from the Heart* and its recommendations regarding the establishment of a constitutionally enshrined national 'Voice to Parliament' alongside a Makarrata Commission to supervise a process of agreement-making and truth-telling [8]. In our view, the *Uluru Statement from the Heart* has the support of the Aboriginal communities that we serve.

24. However, the Australian Government has rejected the demands of the delegates at Uluru, and has instead established an Indigenous Voice co-design process which includes a proposal for the establishment of 25-35 'Local and Regional Voices' nationally to provide a forum for dialogue between the Aboriginal and Torres Strait Islander community and governments on policy, programs and services [9].

25. Little detail is available about these proposed bodies, however Congress suggests that this model:

    a) does not accord with the *Uluru Statement from the Heart's* call for a constitutionally enshrined national Voice to Parliament, noting that consultations under the Australian Government's Co-Design process found strong support for the Uluru Statement [10]; and

    b) it duplicates and could potentially undermine the structures already committed to by all Australian Governments under the *National Agreement on Closing the Gap*.

REFORM 5. That the Northern Territory Government establishes partnership structures under the *National Agreement on Closing the Gap*, as already agreed (see Reform 1) as an alternative to proposals for 'Local / Regional Voices' as proposed under the Australian Government's Indigenous Voice Co-Design process.

References

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