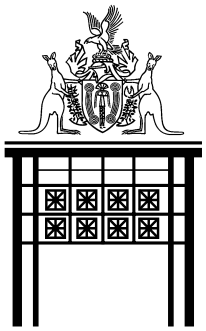


LEGISLATIVE ASSEMBLY OF THE NORTHERN TERRITORY

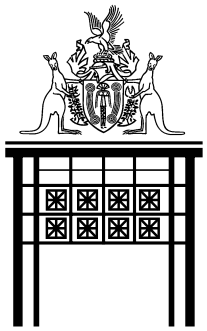
# PUBLIC ACCOUNTS COMMITTEE

# REPORT ON THE PROVISION OF HEALTH SERVICES TO ABORIGINAL COMMUNITIES IN THE NORTHERN TERRITORY

## REPORT NUMBER 28

NOVEMBER 1996

**Presented and Ordered to be printed by the Legislative Assembly of the Northern Territory on 28 November 1996**



**LEGISLATIVE ASSEMBLY OF THE NORTHERN TERRITORY**

## PUBLIC ACCOUNTS COMMITTEE

# REPORT ON THE PROVISION OF HEALTH SERVICES TO ABORIGINAL COMMUNITIES IN THE NORTHERN TERRITORY

## REPORT NUMBER 28

**NOVEMBER 1996**

**MEMBERS**
(in attendance during inquiry)

Mr Rick Setter, MLA
(Chairman)

Mr John Bailey, MLA

Mrs Loraine Braham, MLA

Mr Denis Burke, MLA

Mr Brian Ede, MLA

Mr Phil Mitchell, MLA

Mr Peter Toyne, MLA

**Legislative Assembly of the Northern Territory**

**PUBLIC ACCOUNTS COMMITTEE**

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## ABBREVIATIONS

| | |
|---|---|
| ABS | Australian Bureau of Statistics |
| ACAP | Aboriginal Cultural Awareness Program |
| ACT | Australian Capital Territory |
| AHWs | Aboriginal Health Workers |
| AIDS | Acquired Immunity Deficiency Syndrome |
| AMSANT | Aboriginal Medical Services Alliance NT |
| ARDS | Aboriginal Resource and Development Services Inc. |
| ATSIC | Aboriginal and Torres Strait Islander Commission |
| CAH | Council for Aboriginal Health |
| CAPD | Continuous Ambulatory Peritoneal Dialysis |
| CDEP | Community Development Employment Programs |
| COAG | Council of Australian Government |
| Committee | Public Accounts Committee |
| Congress | Central Australian Aboriginal Congress Inc. |
| CPI | Consumer Price Index |
| CRESAP | (not abbreviation) Towers Perrin Consultancy |
| CRS | Commonwealth Rehabilitation Services |
| DARE | Drug Abuse Resistance Education |
| FAGs | Financial Assistance Grants |
| GP | General Practitioner |
| HACC | Home and Community Care Program |
| HACS | Department of Health & Community Services (now Territory Health Services) |
| HFGs | Hospital Funding Grants |
| HIB | Haemophilias Influenza Type B |
| HIPP | Health Infrastructure Priority Projects |
| HYEs | Health Year Equivalents |
| JDAB | Joint Disability Advisory Board |
| LCA | Loan Council Allocation |
| MBS | Medical Benefit Scheme |
| Menzies | Menzies School of Health Research |
| MLA | Member of the Legislative Assembly |
| MPS | Multi Purpose Service |
| MSB | Medical Services Branch (Health and Welfare, Canada) |
| NAHS | National Aboriginal Health Strategy |
| NHMRC | National Health Medical Research Council |
| NPY | Ngaanyatjarra Pitjantjatjara Yankunytjatjara |
| NSW | New South Wales |
| NT | Northern Territory |
| NTDHCS | Northern Territory Department of Health and Community Services (now Territory Health Services) |
| DHCS | Department of Health and Community Services (now Territory Health Services) |
| OATSIHS | Office of Aboriginal and Torres Strait Health Service |
| PATS | Patient Assisted Travel Scheme |
| PAWA | Power & Water Authority |
| PBS | Pharmaceutical Benefit Scheme |
| PC | Personal Computer |
| PHC | Primary Health Care Services |
| PHC | Public Health Commission (New Zealand) |
| PIPS | Personal Information Payroll System |

| | |
|---|---|
| QALYs | Quality Adjusted Life Years |
| Qld | Queensland |
| RFDS | Royal Flying Doctor Service |
| RHA | Regional Health Authority (New Zealand) |
| RN | Registered Nurse |
| SA | South Australia |
| SAAP | Supported Accommodation Assistance Program |
| SMR | Standardised Mortality Ratio |
| SPP | Special purpose payment |
| SRA | Special Revenue Assistance |
| STD | Sexually Transmitted Disease |
| TAS | Tasmania |
| TB | Tuberculosis |
| THS | Territory Health Services |
| TPF | Northern Territory Tripartite Forum (Aboriginal Health) |
| UK | United Kingdom |
| US | United States |
| Vic | Victoria |
| WA | Western Australia |
| WNSW | Western New South Wales |

## NORTHERN TERRITORY PUBLIC ACCOUNTS COMMITTEE

## STATUS OF THE COMMITTEE

The Northern Territory Public Accounts Committee was established by temporary Standing Order 21A of the Legislative Assembly on 16 August 1986.

The Committee's status was altered, by way of a motion of the Chief Minister on 23 August 1988, from a Sessional Committee on a trial basis to a Standing Committee of the Parliament.

As a Committee of the Legislative Assembly, its authority is derived from the *Northern Territory (Self Government) Act* (of the Commonwealth) and the *Legislative Assembly (Powers and Privileges) Act* (of the Northern Territory).

The committee is comprised of five (5) members, presently three (3) Government and two (2) Opposition members.

## DUTIES OF THE COMMITTEE

The duties of the Committee under Standing Orders 21A (2) are:

(a) to examine the accounts of the receipts and expenditure of the Northern Territory and each statement and report transmitted to the Legislative Assembly by the Auditor-General, pursuant to the *Financial Management Act*;

(b) to report to the Legislative Assembly with such comments as it thinks fit, any item or matters in or arising in connection with the receipt or disbursement of the moneys to which they relate, to which the Committee is of the opinion that the attention of Parliament should be drawn;

(c) to report to the Legislative Assembly any alteration which the Committee thinks desirable in the form of the public accounts or in the method of keeping them or in the method of receipt, control, issue or payment of public moneys;

(d) to inquire into and report to the Legislative Assembly on any question in connection with the public accounts of the Territory -

  (i) which is referred to it by a resolution of the Assembly; or

  (ii) which is referred to it by the Administrator or a Minister; and

(e) to examine the reports of the Auditor-General laid before the Legislative Assembly with the accounts of a Public Authority of the Northern Territory (including any documents annexed or appended to those reports).

## COMMITTEE MEMBERS in attendance during Inquiry

The Members of the Public Accounts Committee are:

**Mr Rick Setter, MLA - Chairman**

Appointed 17 May 1988
Appointed Chairman 25 August 1994
Country Liberal Party
Member for Jingili. First elected 1984.
Chairman of Committees.
*Other Committees*: Publications (Chairman); Subordinate Legislation and Tabled Papers (Chairman); Standing Orders.

**Mr John Bailey, MLA**

Appointed 4 December 1990
Australian Labor Party
Member for Wanguri. First elected 1989.
Shadow Minister for Treasury; Education & Training; Youth and Young Families; and TIO
*Other Committees*: Constitutional Development; Environment

**Mrs Loraine Braham, MLA**

Appointed 27 June 1994
Country Liberal Party
Member for Braitling. First elected 1994
Deputy Chairman of Committees
*Other Committees:* Use and Abuse of Alcohol by the Community; Euthanasia.

**Hon. Denis Burke, MLA**

Appointed 23 August 1994
Discharged 15 August 1995
Country Liberal Party
Member for Brennan. First elected 1994
Appointed Minister for Power and Water, Work Health and Territory Insurance effective 26 June 1995

**Mr Brian Ede, MLA**

Reappointed 27 June 1994
Resigned 23 August 1996
Australian Labor Party
Member for Stuart. First elected 1983.
*Other Committees:* Constitutional Development; Standing Orders

**Mr Philip Mitchell, MLA**

Appointed 15 August 1995
Country Liberal Party
Member for Millner. First elected 1994
*Other Committees:* Publications; Constitutional Development; Environment

**Mr Peter Toyne, MLA**

Appointed 9 October 1996
Australian Labor Party
Member for Stuart. First elected 1996.
*Other Committees:* Constitutional Development

## TERMS OF REFERENCE

Pursuant to paragraph 2(d)(ii) of Standing Order 21A, the Minister for Health and Community Services referred the following matter to the Standing Committee of Public Accounts for inquiry and report:

The provision of health services to Aboriginal communities in the Northern Territory which is, at present, characterised by multiple sources of funds, multiple modes of controlling and delivering the services and multiple objectives on the part of the principal participants, with particular reference to determine:

(a) if common goals have or can be established as the basis for an efficient management framework;

(b) the impact of services currently provided and any gaps and/or duplication of services;

(c) the effectiveness of services being provided and whether present service delivery mechanisms are relevant;

(d) the cost efficiency of service delivery mechanisms and whether more cost-efficient solutions are available;

(e) the adequacy of funding arrangements between the Commonwealth and the Northern Territory involved in the delivery of those services; and

(f) strategies for achieving co-operation from the principal participants.

1 December 1994

## CONDUCT OF INQUIRY

On 1 December 1994, the Minister for Health and Community Services, the Hon. Mike Reed, MLA, requested the Public Accounts Committee to conduct an inquiry into the Provision of Health Services to Aboriginal Communities in the Northern Territory.

In mid-December 1994, the Committee corresponded with Northern Territory Government Agencies, local government councils, incorporated Aboriginal associations, remote schools, Commonwealth departments, land councils, and Aboriginal organisations. At the same time a Call for Expressions of Interest was advertised in the major regional press. Closing date for receipt of expressions of interest was Friday, 3 February 1995.

Some 31 initial responses, declaring intentions to lodge submissions were received.

In mid-February, further advertisements in the press in each major centre in the Northern Territory sought written submissions to be received by Friday, 21 April 1995. The Committee also wrote to each of the 31 respondees who expressed an interest in participating in this inquiry and to all local government councils and remote health clinics. Twenty-six (26) written submissions were received and considered by the Committee (Appendix A).

Hearings were held in Darwin and Alice Springs (Appendix B) and in 10 remote Aboriginal communities (Appendix C) during the period February 1995 to May 1996.

## CHAIRMAN'S FOREWORD

This Report is in response to a reference received from the Minister for Health and Community Services, the Hon. Mike Reed, MLA, to conduct an inquiry into the Provision of Health Services to Aboriginal Communities in the Northern Territory. This matter was referred to the Public Accounts Committee on 1 December 1994.

Hearings were scheduled in Darwin, Alice Springs, Batchelor and in ten remote Aboriginal communities where various Northern Territory, Commonwealth Government and Aboriginal agencies provided evidence. At the ten remote Aboriginal communities visited, health staff and local government bodies addressed the Committee.

The Public Accounts Committee became aware of the impact on health of other matters such as housing and education and the need for cooperation between government agencies and all health providers.

The gap in health between Aboriginal and non-Aboriginal people has widened in the last ten years. The underlying problems are related to social and environmental factors and the difficulties involved with the provision of health services to people in remote communities.

There will never be enough resources to meet the health needs of all Australians. The health dollar in the Northern territory is competitively sought for alternative health needs. Difficult decisions have to be made to determine how the health dollar is to be spent. Priorities have to be agreed and action taken to slow down the increasing percentage of Aboriginal people admitted to hospital. This action refers in particular to primary health care including preventative measures and changes in lifestyle.

I extend my thanks to Committee members for their efforts in this Inquiry and their desire to contribute towards an improvement in the health status of Aboriginal people.

On behalf of the Committee I extend my thanks to the Committee Secretariat: Jenny Mollah, Ted Rayment and Judy Herring for their assistance in the conduct of the Inquiry and preparation of this report.

RICK SETTER, MLA
CHAIRMAN

## PREAMBLE

During this Inquiry, the Public Accounts Committee received evidence that the health (taking into account health profiles) of Aboriginal people, compared to non-Aboriginal people, in the Northern Territory and compared to indigenous people in other countries, is very poor. The Committee found that, excluding medical benefits and pharmaceutical benefits, the expenditure on health for Aboriginal people in the Northern Territory is 4.75 times as much per capita as non-Aboriginal people. However the greater proportion of funds are spent at the acute end and not enough is allocated to primary health/prevention. The Committee noted that a large proportion of expenditure is absorbed by administration and costs in delivery of services.

Evidence provided to the Committee identified the large shortfall (estimated $38m) per year of medical benefits and pharmaceutical benefits that is not being received by the Northern Territory from the Commonwealth because of the lack of doctors and pharmaceutical agencies in Aboriginal communities and the consequent lack of access to the Medicare and pharmaceutical benefits. This shortfall is a major financial disadvantage when compared to other States/Territories.

The Committee is convinced that a cooperative effort to achieve change at the community level will lead to a healthier lifestyle and a reduction in hospital admissions. This requires community health information and an acceptance of responsibility by Aboriginal people.

Community control and responsibility for the provision of community based health care services is the preferred management model.

The Committee is also convinced that health decision-makers must introduce a budgetary discipline which includes an awareness of ways to maximise population health outcomes from each dollar spent.

Inter-agency collaboration to deal with health issues such as overcrowding, infrastructure, employment and education is integral to improved health outcomes. The Committee strongly supports ongoing co-operation and sharing of information by government agencies and Aboriginal organisations/communities.

The Committee is aware that there needs to be an equitable distribution of funds between Aboriginal communities. The Committee agrees that the health goal is to lift the health status of Aboriginal people to the level of non-Aboriginal people. The extent to which resources may be transferred from urban to rural areas must be managed carefully to ensure that the basic health services in the main centres still attract people to the Northern Territory who will add to the population base and the development of the Northern Territory.

Based on the evidence the Public Accounts Committee decided to approach recommendations with the following philosophical beliefs in mind.

### Philosophical Beliefs

The health of Aboriginal people is of major concern and requires proactive ‘grass roots’ intervention and the supply of health information to Aboriginal communities. This is integral to community responsibility and accountability.

Education generally and specific health education and community change programs are inadequate and under-resourced and are not, in the main, leading to any long term improvements in health outcomes.

The Commonwealth funding arrangements must adequately provide the allocation of medical benefits and pharmaceutical schemes to the Northern Territory.

The Commonwealth policy of horizontal fiscal equalisation must ensure that funding takes into account the difficulties in the provision of health to remote communities. The additional health services required for Aboriginal people who encounter ill-health and have a life expectancy 18 years less than non-Aboriginal people must also be taken into account.

Health improvement requires cooperation between government agencies and providers so that education, employment, housing, essential services and community and individual attitudes are integrated.

Health decision-makers need to assess the likely health outcomes from health expenditure and ensure the ongoing evaluation and assessment of health programs. This is necessary to provide the best health outcomes from the funds provided.

## EXECUTIVE SUMMARY

After evidence had been collected the Public Accounts Committee agreed that recommendations would be underpinned by a set of guiding philosophical beliefs. These are set out in the Preamble to this Report.

### Chapter 1

Chapter 1 addressed Terms of Reference (a) 'if common goals have or can be established as the basis for an efficient management framework'.

All providers indicated that the National Aboriginal Health Strategy (1994) provided a frame work for improving Aboriginal health. The National Aboriginal Health Strategy report included recommendations for Aboriginal community control and participation in health services as a means of promoting community responsibility and understanding and ensuring that the provision of primary health care was socially and culturally appropriate.

There needs to be an open exchange of goals and plans by the different health providers in order to improve health outcomes. The history of changes to organisational arrangements and processes and the voluminous reports into Aboriginal health issues are out of proportion to any improvement in health outcomes. Caution is required before entering into new structures or programs. The Committee recommends that new structures and arrangements should be described on the basis of their added value to health services and the process for evaluation must be defined before those structures are implemented.

One area of confusion relates to the funding by the Commonwealth to the Northern Territory for Aboriginal health. The Committee recommends that Territory Health Services give presentations to Aboriginal groups on Aboriginal health income and expenditure.

A common theme through the submissions and the research from overseas points to the development of culturally relevant goals taking into account an understanding of what Aboriginal people define as health and well-being. Education and training by Aboriginal Health Workers to help Aboriginal people realise the link between disease and hygiene is a key strategy to the development of an appropriate framework.

### Chapter 2

Chapter 2 addresses Terms of Reference (b) 'the impact of services currently provided and any gaps and/or duplication of services'.

The impact of health services is retarded by environmental factors such as overcrowding, poor hygiene, poor nutrition, smoking and alcohol abuse.

Overlapping and lack of coordination of services between the Commonwealth and Territory governments and between providers within the Territory make the task of utilising each health dollar for maximum health gain difficult.

The thrust of the recommendations in this section of the Report support measures to assist communities to improve their own health and the removal of duplication:

- Joint planning to expand Aboriginal community accommodation, appropriate to the needs of the community.
- Much higher priority be given to primary health care, targeting prevention strategies.
- Additional incentives to ensure doctors are recruited to Aboriginal communities.
- The extent of any assistance/resourcing should be linked to the degree of readiness and level of skill available to the community in question.
- Territory Health Services ensure that staff turnover statistics are analysed to monitor the effect of recruitment and cross-cultural training strategies.
- Bilateral agreements between the Commonwealth and the Northern Territory for the provision of health services in the Northern Territory be endorsed as a high priority.
- Future services must avoid duplication.

The Committee's visits to Aboriginal communities and the submissions received identified various gaps in services and a plea for additional resources at the 'grass roots' of health care.

## Chapter 3

Terms of Reference (c) 'the effectiveness of services being provided and whether present service delivery mechanisms are relevant', is addressed in Chapter 3.

The effectiveness of services is illustrated by the gaps in health outcomes between Aboriginal and non-Aboriginal people which has widened over the last ten years.

Although Aboriginal infant and still-birth mortality have improved, both remain nearly four times higher than the all-Australian rates.

There is a general paucity of Aboriginal health information between States and therefore interstate/Territory comparisons are difficult.

One example of a successful health program is the Strong Women, Strong Babies, Strong Culture Program which commenced in 1993 and an evaluation of three communities where the program was trialed, has shown a 47% reduction in the number of low birth rate infants, a 55% reduction in the number of premature births and a 141g increase in the mean birth weight.

The Committee noted the research that links poor infant health with adult health and recommends a high priority be given to food and nutrition. Public information about the dangers to family health from smoking, alcohol and other drugs should be given. This public information must stress the need for families to give good food a higher priority than smoking, alcohol and other drugs.

The Committee found that there is a need for closer collaboration between government departments to ensure improved health outcomes.

Evidence received by the Committee emphasises the importance of accurate data for reporting health status and the funding implications of discrepancies in data entry.

## Chapter 4

Chapter 4 addresses Terms of Reference (d) 'the cost efficiency of service delivery mechanisms and whether more cost-efficient solutions are available'.

The cost efficiency in health services goes beyond technical efficiency which is concerned with minimising the cost of producing a given level of output of health services.

This section of the report considers allocative efficiency which acknowledges that resources are limited and the need to transfer resources between services to maximise the benefit to the population.

The Committee believes that there are advantages in strengthening the link between Territory Health Services and research organisations.

Evidence shows significant differences in expenditure per capita between communities probably as a result of historical funding. The Committee found that there needs to be a more equitable distribution of funds between communities taking into account health profiles.

The Committee believes that service delivery should be examined to ensure that a higher percentage of resources get to the communities.

Evidence received from Dr Wendy Hoy from Menzies School of Health presented a sad story about an Aboriginal community:

- crowded living conditions
- higher unemployment
- 80% smoked cigarettes
- 86% of men were drinking beer to excess
- 29% of women were beer drinkers
- 40% had skin sores and scabies
- only 17% had two normal intact ear drums
- only 30% had at least one intact ear drum
- 20% of men and 50% of women had signs of heart damage
- 30% overweight
- 26% high blood pressure
- 20% had diabetes and prediabetes
- 25% of newborn babies weight less than 2.4 kg., a serious risk for early death and childhood illness and predisposing by inadequate development of critical organs, to diabetes, cardiovascular disease and kidney disease in adults
- 42% of children were seriously under-nourished by world standards and most children were hungry most of the time.

A review of transactions at the store, club and takeaway restaurant showed that over 50% of money was spent on beer and cigarettes.

The Committee have recommended courses on the management of money for Aboriginal people in communities.

The Committee considers that the growing incidence of renal disease which costs $50,000-$100,000 a year per patient needs to be assessed in Territory Health Services future planning.

The Committee also found that Aboriginal communities that are grant funded in accordance with health agreements should be assisted by ensuring that these agreements are worded and negotiated so that communities understand and own the conditions of the agreement.

## Chapter 5

Terms of Reference (e) 'the adequacy of funding arrangements between the Commonwealth and the Northern Territory involved in the delivery of those services' is addressed in Chapter 5.

The cost of delivering health services to remote communities when added to the unmet health needs of remote areas, requires expenditure which exceeds the current allocation.

This chapter refers to a number of studies and presentations to the Committee.

One study of 1994/95 expenditures showed that expenditure per capita was 4.75 times higher for Aboriginal people than non-Aboriginal people.

The 1995 Maningrida health study identified that the Commonwealth Grants Commission assessment for funding community health services in remote areas such as Maningrida is inadequate.

The cost of developing health services in Maningrida excluding infrastructure is more than 6 times the expenditure assessed by the Commonwealth Grants Commission and more than 4 times the NT per capita calculation.

Other estimates indicate that when unmet needs are taken into consideration the per capita expenditure in rural communities should be up to 8 times more than urban.

The Commonwealth Grants Commission is guided by the principle of fiscal equalisation where each State/Territory should be given the capacity to provide the average standard of State-type public services, assuming it does so at an average level of operational efficiency and makes an average effort to raise revenue from its own sources.

The Commonwealth Grants Commission gives consideration for services to remote communities through its 'disability' factors. A disability is an influence that requires it to spend more or less than governments on average to achieve the same objective.

The Committee found inequity with the disability factors for Aboriginal people including:

- The age factor does not adequately compensate the Northern territory for providing services to Aboriginal people who have a life expectancy 18 years shorter than non-Aboriginal people and require access to health services (normally associated with old people) much earlier than non-Aboriginal people.
- The dispersion factor only takes into account straight line distances without consideration of road lengths and road quality.

The lack of general practitioner access and private pharmaceutical services to rural communities is estimated at a $38 million per year loss to the Northern Territory.

This access to funding is available in urban locations and is a non-State service funded directly by the Commonwealth through the Medical Benefits Scheme and Pharmaceutical Benefits Scheme.

Contributions of $2.70 per week are built into the pension so that pensioners contribute up to $2.70 per week toward their pharmaceuticals. Apart from one Aboriginal community the Committee found that pensioners in rural communities do not contribute towards the pharmaceuticals that are provided by the Northern Territory Government.

Public hospital expenditure in the Northern Territory increased from $56.6 million in 1989/90 to $63.7 million in 1993/94 for non-Aboriginal people and from $46.4 million to $63.4 million for Aboriginal people.

The increasing costs of Aboriginal people (26.1% of the population) being treated in public hospitals is rising at more than twice the rate for non-Aboriginal people.

There is an urgent need to target the causes of acute illness.

## Chapter 6

Terms of Reference (f) "strategies for achieving cooperation from the principal participants", is addressed in Chapter 6.

The number of visits to a community indicate that an average community of less than 500 people will receive five visits a year from thirty-two different agencies which pre-occupies the community leadership with consultation for 60% of the year. There is wisdom in coordinating these visits.

There are some good examples of strategies which will improve cooperation among the health providers in some areas.

The Health Infrastructure Priority Projects coordinates key government departments so that services to communities, such as water supply, sewerage, priority housing, power supply and internal roads, drainage and dust controls, are delivered in a whole of government approach.

The Coordinated Care Trial for the Northern Territory pools Commonwealth and Territory health funds for health services on the Tiwi Islands and in the Katherine District.

The Committee believes that there is a general lack of cooperation among the providers. Strong leadership skills and a relationship of trust and cooperation is required from health executives to ensure that the population of the Northern Territory receive better value from the health dollar.

The Committee supports the transfer of successful primary health care programs and initiatives between communities with Aboriginal Health Workers as the key change agents. The critical role of Aboriginal Health Workers requires ongoing support, training and development of relationships with other workers and communities.

The Committee is concerned that evidence indicates that there are unregistered Aboriginal Health Workers practising in the field.

Overseas models of health services to indigenous people stress the importance of supplying health information to Aboriginal people in a form that achieves comprehension. This is a prerequisite to acceptance of responsibility.

The Committee found the link between health and education is inextricable. Improvement in the standard of education for Aboriginal people will contribute to the improvement in the general health of Aboriginal people. The education of mothers and grandmothers is vital to infant health.

The confusion and overlapping services between the Northern Territory and Commonwealth health departments lead the Committee to recommend that the Commonwealth recognise health service delivery as the responsibility of the Northern Territory. The Commonwealth would then be responsible for national policy, performance targets and evaluation.

The Committee believes that the health focus should be on the populations needs rather than the needs of the providers. To this end the Committee found that Regional Health Boards should be established.

The Committee believes that Health Boards should have representation from consumers, Aboriginal groups, Territory and Commonwealth health services, General Practitioners, private providers with the Menzies School of Health providing advice and feedback about the effectiveness of services to the funders of the service.

Finally this chapter recommends that the Office of Aboriginal Development be resourced to finalise the Aboriginal communities database and that agencies input their information about Aboriginal communities into the database on an ongoing basis so that all agencies will benefit from the consolidated information.

## COMMITTEE'S RECOMMENDATIONS

| No. | RECOMMENDATION | Page No. |
|---|---|---|
| **1** | That closer cooperation between the providers be established and draft plans must be exchanged for reciprocal comment to ensure that common goals are agreed. | **9** |
| **2** | That new organisational structures and arrangements be described on the basis of their added value to health services and the process for evaluation must be defined before those structures are implemented. | **19** |
| **3** | That Territory Health Services give a presentation on Aboriginal Health income and expenditure to the ATSIC State Advisory Council and other Aboriginal groups as appropriate. | **21** |
| **4** | Aboriginal communities be resourced to plan their goals, priorities and evaluation process. | **23** |
| **5** | That a select Task Force be established, with secretarial support, to report to the NT Health Minister, to seek out those models of health service and community action that are producing positive results for Aboriginal people and plan ways to apply those models. | **25** |
| **6** | Arising from Recommendation 5. a small implementation team under the Assistant Secretary, Aboriginal Health, be resourced to action the recommended initiatives in consultation with communities. | **25** |
| **7** | That the tools of health economics and option appraisal covered in terms of reference (d) 'the cost efficiency of service delivery mechanisms and whether more cost-efficient solutions are available' be used by all providers to assist the priority setting process. | **26** |

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| **8** | 1. That the Commonwealth and Territory produce a joint plan to expand the Aboriginal community accommodation;<br><br>2. that the accommodation be appropriate to the needs of the community;<br><br>3. that such provision of accommodation be accompanied by effective maintenance arrangements;<br><br>4. that education as to the benefits of appropriate housing maintenance and cleanliness be provided; and<br><br>5. that funds from all sources be allocated according to overall housing priorities. This includes National Aboriginal Health Strategy funds and requires coordination between Commonwealth, Territory and ATSIC with Aboriginal community consultation. | **33** |
| **9** | That a much higher priority be given to primary health care targeting prevention strategies. | **34** |
| **10** | It is recommended that the success of training programs be measured in terms of improvement to health rather than numbers of staff who attended training courses. | **41** |
| **11** | The Committee recommends that the Commonwealth should introduce additional incentives to ensure that doctors are recruited to Aboriginal communities. | **43** |
| **12** | That further research into the health models of delivery preferred by Aboriginal people be undertaken by an appropriate research unit such as the North Australian Research Unit. (The Committee prefers that this research is conducted under the auspices of the Task Force - see Recommendations 5 & 6.) | **48** |
| **13** | That the extent of any assistance/resourcing should be linked to the degree of readiness and level of skill available to the community in question. An evaluation of the skills (skill profile) in a community and the opportunity to access further skills to be a pre-requisite to the consideration of community control. | **54** |
| **14** | That the Territory Health Services ensure that staff turnover statistics are analysed to monitor the effect of recruitment and cross cultural training strategies. | **55** |

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| **15** | That a service delivery model be trialed which embraces the following elements:<br><br>• co-operation of all stakeholders<br>• an objective analysis of health needs in the community<br>• appropriate financial/administrative support<br>• plans facilitated by people who are accepted and have an understanding of both world views<br>• use of option appraisal (community assessment of resources in relation to health needs) to prioritise resources<br>• adequate physical infrastructure necessary for environmental health requirements<br>• identification of staffing needs to ensure primary health care is implemented<br>• use of change agents to assist the community in achieving its goals<br>• the necessary information base to ensure reporting of changing health status<br>• appropriate evaluation process. | **57** |
| **16** | That bilateral agreements between the Commonwealth and the NT for the provision of health services in the NT be endorsed as a high priority. | **59** |
| **17** | That the NT Minister for Health liaise with the Commonwealth Minister for Health to ensure that future services avoid duplication such as those that have occurred in Katherine. | **60** |
| **18** | That providers and community members be invited to submit suggestions for improvement to the current models of delivery and new proposals for health promotion to the Task Force/Assistant Secretary of Aboriginal Health for Territory Health Services consideration (as per Recommendations 5 & 6). | **63** |
| **19** | 1 . That programs targeting infant health be implemented as a high priority and community information delivered in a culturally appropriate manner emphasising the relationship between infant and adult health; and<br><br>2. that emphasis is placed on food and nutrition by Territory Health Services. Public information about the dangers of smoking and alcohol should include the implications for family health when smoking, alcohol and other drugs are placed before good food in the family expenditure priorities. | **78** |
| **20** | That the corporate plan and annual report for Territory Health Services highlight the health indicators showing changes since the last report and reasons for the change and also include comparisons (where available) on a regional and interstate basis. | **79** |
| **21** | That community health profiles be compiled incorporating the perception of community members of their own health needs and their prioritisation of those needs. | **79** |

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| **22** | 1. That primary health care services to Aboriginal communities embracing the concept of a holistic health care model ensure programs within and between Departments are congruent; and<br><br>2. That accountable officers be required to take into consideration issues that cut across programs between Departments to ensure congruency and sharing of data. | **82** |
| **23** | 1. That the integrity of the data in the Hospital Information System be checked to ensure the reliability and integrity of health indicators and funding; and<br><br>2. that recuperation facilities be provided to prevent return of hospital patients to an inappropriate environment. | **86** |
| **24** | That the Health Infrastructure Priority Projects' initiatives be strongly supported by Government and extended to other communities until infrastructure requirements are met. | **87** |
| **25** | That an appropriate integrated Health Information System be resourced to ensure that health information can be made available to each community. | **89** |
| **26** | That the Territory Health Services liaise with the NT Local Government Association to coordinate with the management skills project to avoid duplication of resources. | **91** |
| **27** | That Territory Health Services provide research opportunities to Menzies School of Health, Northern Territory University and Aboriginal Research Unit that will assist decisions with the provision of health services. | **95** |
| **28** | That Territory Health Services in conjunction with Commonwealth Department of Health and Family Services examine various options of service delivery to ensure that a much higher percentage of resources gets to communities. (The Committee prefers that this research is conducted under the auspices of the Task Force - see Recommendations 5 & 6.) | **96** |
| **29** | That the Commonwealth Department of Health and Family Services change the Rural Incentive Scheme so that it is based on health needs rather than being service provider based and is available for all communities regardless of who funds the communities. | **97** |
| **30** | That the PATS scheme and expenditure patterns be examined to ensure that opportunities for improving efficiency and effectiveness are promulgated. | **98** |
| **31** | That Territory Health Services continue the analysis of expenditure between communities to achieve a more equitable distribution of funds taking into consideration health profiles. | **98** |

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| **32** | That the Aboriginal Development Unit of the Education Department actively promote and deliver money management courses to communities and the use of such courses be evaluated. | **101** |
| **33** | That future options for dealing with the worsening renal disease be documented and submitted by Territory Health Services to Cabinet. | **101** |
| **34** | 1. That decisions which commit the expenditure of health dollars be related to an objective process for improving health outcomes.<br><br>2. That the following checklist be applied when priorities are being set:<br><br>a. Does the approach incorporate some assessment of the cost of interventions?<br><br>b. Does the approach incorporate some assessment of the benefits of interventions?<br><br>c. Is the approach operating on the margin so that the ratio of marginal costs to marginal benefits is the same across all programs? | **109** |
| **35** | That Health Agreements must be worded and negotiated with communities so that they are both owned and understood by those communities. | **111** |
| **36** | That Commonwealth and Territory Governments put in place procedures to recover the prescription charge from people living in remote communities who receive free pharmaceuticals. | **129** |
| **37** | 1. That Territory Health Services continue to undertake analysis of resource allocation to communities to ensure that inequities in funding between communities are redressed in a time frame that allows reasonable adjustment to the service levels; and<br><br>2. that Territory Health Services works towards a Resource Allocation Formula that is transparent. | **133** |
| **38** | 1. That Territory Health Services prepare a submission to the Commonwealth Grants Commission to change the Age factor to recognise the physical (mortality/morbidity) rather than chronological age of Aboriginal people; and<br><br>2. that the 'dispersion' factor be adjusted to take into account degrees of remoteness. | **134** |
| **39** | That the Commonwealth compensate for the estimated $38 million dollar loss to the Northern Territory in Medical Benefits Scheme and Pharmaceutical Benefits Scheme. | **136** |

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| **40** | That the NT Minister for Territory Health Services and the Commonwealth Minister for Health and Family Services ensure the allocation of resources reflect overall health priorities. | **137** |
| **41** | That Government agencies and the Northern Territory and Commonwealth take a whole of government approach to health promotion/environmental health using the Health Infrastructure Priority Projects as a model. | **138** |
| **42** | That the Northern Territory Government resources and empowers the Office of Aboriginal Development to coordinate the provision of human resources by Government departments to remote Aboriginal communities. | **143** |
| **43** | That initiatives such as the Multi Purpose Service Program be closely supported and monitored by the Commonwealth/Territory Health Departments to ensure that the performance indicators are evaluated in accordance with the agreement and the terms of the agreement do not hinder implementation. | **148** |
| **44** | That Commonwealth and Northern Territory agencies and private providers coordinate their activities aimed at introducing communication networks into Aboriginal communities. | **149** |
| **45** | That ongoing coordinated telemedicine trials continue and be linked with the communication network (Rec. 44.). | **149** |
| **46** | 1. That the Attorney-General's Department examine the implications of unregistered Aboriginal Health Workers practicing in the field; and<br><br>2. that Territory Health Services arrange for the registration fee to be deducted, by agreement, from the Aboriginal Health Worker's salary. | **154** |
| **47** | That Territory Health Services facilitate transfer of Aboriginal Health Workers to other communities where successful primary health care programs and initiatives may benefit those other communities and where the recipient community supports the arrangement. | **156** |
| **48** | That Territory Health Services ensure that the efficiency and effectiveness of the aerial medical services be reviewed. | **158** |
| **49** | That information for Aboriginal people be prepared in a user friendly format to ensure comprehension of the message. | **160** |

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| **50** | 1. That Territory Health Services work with the Education Department, including the schools, to develop a comprehensive range of education programs in infant care; and<br><br>2. that infant care education be:<br><br>- part of the compulsory curriculum<br>- part of training offered in the Women Centres<br>- related to the dangers of drug and alcohol use. | **161** |
| **51** | That the Commonwealth provide funding to the Northern Territory for delivery of health services with the Commonwealth responsible for national policy, performance targets and evaluation. | **162** |
| **52** | That Regional health boards be established with representation from consumers, Aboriginal groups, Territory Health Services, Commonwealth Department of Health and Family Services, General Practitioners/private providers and that the Menzies School of Health provide advice and feedback about the effectiveness of services to the funders of the service. | **162** |
| **53** | That Territory Health Services encourage grant funded organisations to purchase services where the market lends itself to a choice between alternative providers. | **162** |
| **54** | That the Office of Aboriginal Development be resourced to finalise the Aboriginal Communities Database and that Agencies input their information about Aboriginal communities into the database on an ongoing basis so that all agencies will benefit from the consolidated information. | **163** |

# *CHAPTER 1*

# 1. TERMS OF REFERENCE (a)

***if common goals have or can be established as the basis for an efficient management framework***

## 1.1 Introduction

There are many common goals which are shared by the providers, eg. closing the gap between Aboriginal and non-Aboriginal people and improvements to housing and promotion of community responsibility. The National Aboriginal Health Strategy (NAHS) provided a framework for improving Aboriginal health and this framework has been accepted by the providers.

The differences between the providers is illustrated by a lack of common beliefs shared by the submissions to the Public Accounts Committee (the Committee).

All providers agree that health services must be delivered to improve health outcomes. This section of the report overviews the goals of the providers and takes into account comments from staff of the Menzies School of Health.

The need for greater attention to grass roots programs are covered by the recommendations.

## 1.2 Existing Goals for Providers and Funding Agencies

### 1.2.1 National Health Policy - 30 September 1994

The National Health Policy has been agreed by Commonwealth, State and Territory Health Ministers as a shared policy framework for the Australian health system. The aim is to establish a framework that focuses on improving health, meeting the health care needs of the community, reducing inequalities in health and making effective use of the resources allocated to health.

The National Health Policy, a joint initiative of the Commonwealth, State and Territory Health Ministers (1994a, p.2) refers to $34.3 billion spent on health services in 1992/93 and states the following:

> Despite this expenditure, there are differences in health status between affluent and poorer people, and most particularly a significant gap between the health of Aborigines and Torres Strait Islanders and other Australians. To 'raise the health status of Australians to equal the best in the world' will require that the needs of Aborigines and Torres Strait Islander people, people of non-English speaking backgrounds and other disadvantaged Australians be given significantly more attention.

With reference to equity & access and customer focus, page 13 of the document reads:

> Particular attention has to be paid to improving the health of Aboriginal and Torres Strait Islander people. Health services need to be delivered flexibly, especially for remote communities. The provision of health services needs to be closely linked with environmental health measures such as the provision of adequate and appropriate housing and water supplies. All levels of Government have to work together and be prepared to adopt pragmatic and effective approaches to assist in improving the health of Aboriginal and Torres Strait Islander people. In particular there needs to be partnerships between Governments, Aboriginal and Torres Strait Islander Commission, Aboriginal controlled health organisations and local communities.

Gardiner-Garden (1994, p.3) makes the following observations:

> Not all the news with respect to Aboriginal health status is bad and the front on which the Commonwealth Government is addressing Aboriginal health issues has broadened in recent years. However, if Aboriginal health outcomes are to improve as best as they could, **the cycle of inaction, commitment and frustration, structure and restructure needs to be broken and more attention needs to be paid to monitoring the implementation of recommendations, co-ordinating the endeavours of different bodies, and acting on the many practical suggestions made over the years**.

The enormous amount of research exceeds by far action to improve Aboriginal health.

**The Committee supports the observations made by Gardiner-Garden concerning the cycle of inaction, structure and restructure and endorse the need for follow-up action rather than statements of intent.**

The Committee notes one example of structure and restructure in the Territory Health Services[1] (THS). In 1992 outside consultants (CRESAP) and the Estimates Review Committee recommended changes to the Territory Health Services structure which removed a level of senior management executive officers from the management structure. The Committee notes that the level has returned and the number of executive positions has increased. This reversal is perceived as a waste of health resources.

Gardiner-Garden (1994, p.16) also refers to a paper prepared by an independent working group for consideration by the Prime Minister's Science and Engineering Council (Nov. 93). Two observations are noted:

> No single agency is finally responsible for improving the quality of Aboriginal and Torres Strait Islander health care.
>
> Culturally appropriate community-based health services should complement, but cannot replace, the responsible mainstream health service providers. However, mainstream services must become more responsible to the communities they serve, and the balance of power must shift to Aboriginal and Torres Strait Islander peoples, with an explicit shift from consultation to negotiation .

[1] Territory Health Services (THS) was formerly named the Department of Health and Community Services until 1 July 1996.

Gardiner-Garden (1994, p.16) concludes by reflecting on a quarter of a century of Committee after Committee and report after report covering similar ground.

### 1.2.2 Aboriginal Health Framework

The National Aboriginal Health Strategy and the Royal Commission into Aboriginal Deaths in Custody have provided an agreed framework for existing goals. However the implementation of the NAHS recommendations has been frustrated by various meetings and further papers regarding the process.

The submissions from the Central Australian Aboriginal Congress (Congress) and Danila Dilba (1995) refer to the National Aboriginal Health Strategy and the Royal Commission into Aboriginal Deaths in Custody as the fundamental framework for existing goals. The Program Director for Community Health, Territory Health Services, also considered that the National Aboriginal Health Strategy is the framework in which the goals and priorities have been determined.

A brief history of NAHS (1994):

- December 1987 - working party established by Commonwealth and State/Territory Ministers for Health and Aboriginal Affairs produced a 234 page document excluding appendices.

  The report included recommendations for Aboriginal community control and participation in health services as a means of promoting community responsibility and understanding and ensuring that the provision of primary health care was socially and culturally appropriate. The report covered three broad areas:

  a) improving health services:
  b) improving essential services and community infrastructure; and
  c) improving education, training and employment in Aboriginal health.

  The Commonwealth and State/Territory Ministers for Health and Aboriginal Affairs established an Aboriginal Health Development Group to assess the NAHS report and to advise on its implementation.

- 10 June 1990 - all 21 of the Development Group's recommendations were accepted.

- 13 December 1990 - Commonwealth Ministers for Health and Aboriginal Affairs submitted the matter to Cabinet for a formal Commonwealth response to the NAHS.

  Cabinet noted that the Commonwealth Ministers for Health and Aboriginal Affairs had endorsed the objective of 'gaining equity and access to health services and facilities for Aboriginal and Torres Strait Islander peoples by the year 2001'.

- May 1991 - Recommendation 271 of the Royal Committee into Aboriginal Deaths in Custody report stated:

  > that the implementation of the National Aboriginal Health Strategy, as endorsed by the Joint Ministerial Forum, be regarded as a crucial element in addressing the underlying issues the Commission was directed to take into account, and that funds be urgently made available to allow the strategy to be implemented (p. 20).

- 10 December 1991 - Commonwealth committed $232m over five years. Federal Cabinet agreed to an interim set of National Aboriginal and Torres Strait Islander goals and targets for negotiation with State, Territory and Local Governments, Aboriginal community controlled health services and through the Council of Aboriginal Health for final consultation by the Australian Aboriginal Affairs Council/Health Ministers conference.

  However, the 46 Aboriginal and Torres Strait Islander health goals and the 100's of targets from the Aboriginal Health Development Group were not actioned because the process of consultation found the goals and targets to be too extensive for practical implementation.

In June 1995, the Territory Health Services wrote to the Commonwealth Office of Aboriginal and Torres Strait Islander health services indicating that the Northern Territory (NT) will add four additional priorities which particularly affect Aboriginal health. These additional priorities were:

- nutrition
- infectious disease
- diabetes mellitus
- respiratory disease

and they will supplement the National Health Goals and Targets for cardio vascular disease, cancers, injury and mental health.

## 1.3 Territory Health Services Corporate Plan 1993/95

### 1.3.1 Goals

NT Department of Health and Community Services (1993, p.4) had the following goals in relation to health:

- to provide health and community services for the improvement of individual health and well being
- to work with the community in the planning, development, delivery and evaluation of services
- to change attitudes and behaviour which are harmful to health and well being
- to promote independence and self sufficiency

- to enable families, children and individuals to obtain support services which improve their quality of life

- to work with Aboriginal people to achieve an improvement in their health status and well being

These goals fit under the umbrella of the mission statement, '**to promote individual and community well being'**. One of the strategic directions is improvement in Aboriginal health and well being. The specific priority areas stated on page 7 of the Corporate Plan were:

- development of primary health care services with increasing community control and responsibility

- further reduction in maternal and infant morbidity and mortality

- control of communicable diseases, particularly diarrhoea and respiratory infections

- early detection, co-ordinated management and control of renal disease, type 2 diabetes and cardio-vascular disease

- cross-cultural training for departmental staff

- improved recruitment, retention, support and training of Aboriginal Health Workers

- improved co-ordination with other Government and non-Government agencies to achieve the provision and maintenance of appropriate infrastructure.

### 1.3.2 Territory Health Programs

- With regard to **substance abuse**, the program will seek reduction in alcohol related morbidity and mortality and alcohol related crimes, in the prevalence and uptake of regular smoking to equate with the national average and in the prevalence of petrol sniffing with particular emphasis on young people. Also a reduction in the consumption of kava and the prevention of the spread of hepatitis HIV/AIDS and other infectious diseases associated with unsafe injecting of illicit drugs and unsafe sex associated with intoxication.

- Community participation and partnership with non-government service providers. This enables people to increase control over their lives. Community participation in health policy development and in planning and evaluating health services would increase community control and commitment.

- **Environmental Health Program** is aimed at providing or funding information, advice and services in a culturally appropriate manner and establishing and maintaining effective liaison with Aboriginal community infrastructure providers. The establishment and evaluation of pilot environmental health projects on 10

Aboriginal communities were planned for 1993/95. **(As at 15 June 1996, evaluation was scheduled for 1996/97.)**

- **Aboriginal Health Promotion Program** is aimed at promoting the health of individuals and communities by processes that enable people to exercise control over and improve the quality of their own health. This requires information, resources and education for community action and self-help groups. Specific objectives included increasing Aboriginal involvement and representation in health decision making and strengthening the Aboriginal communities health promotion and illness prevention activities. A network of twelve trained Aboriginal Health Promotion Officers was planned for the three year period with training of all Community Health Centre staff and Aboriginal Health Workers in health promotion strategies.

- **Dental Health Program** focuses on the improvement of children's dental service in rural and remote areas and maintaining standards in urban schools.

- **Community Health Program** covers comprehensive primary health care service which includes clinical care and preventative measures. The Primary Health Care Rural Program provides a broad range of multi-disciplinary services particularly designed for Aboriginal people living in remote communities as well as residents of rural towns and pastoral properties where the private health sector involvement is minimal. Specific target areas cover:

  - community participation in the transition to community controlled rural health services;

  - implementation of regular cross-cultural training for all staff by December 1994;

  - establishment of an Aboriginal Health Worker in-service training program complementary to the Batchelor College Associate Diploma Program by December 1994;

  - establishment of the inter-department Aboriginal Hearing Program combining health and education strategies by December 1993; and

  - co-operation with community-controlled Aboriginal health services to establish a rural community health database by December 1994.

  Health environments would be created by:

  - working with rural community food outlets to achieve an affordable food supply which reflects the Australian Dietary Guidelines in the majority of communities by December 1995;

  - advocacy for better housing design and maintenance plans to facilitate healthier family environments (includes community infrastructure - sewerage, dust control, water, etc.); and

– liaison with community leaders and staff to improve design and utilisation of rural health facilities for works planned to December 1995.

Communities would be assisted to create healthy lifestyles with support for community initiated health programs to share information and provide health assessment for the major types of illness. In-service programs were to be developed to improve health professionals knowledge and skills on key health issues by December 1994.

Mortality and morbidity programs would be for maternal and infant infection and nutrition, type 2 Diabetes, cardio-vascular disease, ear disease and hearing loss and renal disease. The hospital program had a specific target to expand cross-cultural programs to ensure at least 75% of health professionals had participated in training by December 1994.

The disease control program served to prevent, monitor and control communicable diseases in the NT. Measurable targets were:

An achievement of 95% coverage rates for childhood vaccines and provision of risk appropriate vaccinations for adults by December 1995; reduction in the incidents of tuberculosis to that of the national average by December 1995; reduction by 30% in the incidents of sexually transmissible diseases by December 1995 and maintaining the incidents of active leprosy at its current low level.

- Alcohol and Other Drugs Program had a broad objective to minimise harm associated with the use and abuse of alcohol and other drugs.
- Mental Health Program specifically mentioned the development of a cross-cultural mental health training program with and for Aboriginal people and to increase the level of community participation in self-care and community mental health.

## 1.4 Territory Health Services - Background Information

Comments provided by Territory Health Services to the Public Accounts Committee dated 19 April 1995 state:

> ... the difference between the health status of Aboriginal and non-Aboriginal Territorians is of great concern (eg. NT mortality rates for Aboriginal people are 3-4 times those of non-Aboriginal people).
>
> This is nowhere more apparent than in the Northern Territory where cross-cultural factors and remoteness make the solutions more complex. While there have been improvements in some areas, in other areas the gap is increasing.

Territory Health Services claim that any enhancement of treatment services must require a strategy to tackle living conditions incorporating the following key elements:

- enhancement of Aboriginal control and responsibility and reversal of dependency;
- relevant education including health information and a basic understanding of the dominant society;

- reinforcement of the value of Aboriginal culture and identity; and
- opportunities for meaningful occupation/employment.

The Strong Women, Strong Babies, Strong Culture Program, Healthy Kids Program (nose blowing) and the community-based mental health worker project have been named as successful programs incorporating the above elements.

The Departmental strategic directions in Aboriginal health include:

- co-ordination and co-operation between NT departments, the Commonwealth Government, the Aboriginal and Torres Strait Islander Commission (ATSIC) regional councils and NT Aboriginal organisations;
- empowerment/local Aboriginal control;
- primary health care;
- culturally appropriate services;
- Aboriginal cultural awareness program for all employees; and
- Aboriginal employment.

Uncoordinated planning and funding allocation creates competition and conflict among key health care providers and communities. The Department encourages partnership and co-operation to achieve a co-ordinated approach to make the best use of the resources available. Examples of uncoordinated planning and funding allocation between the providers is explained under Term of Reference (f): *strategies for achieving co-operation from the principal participants* (page 140). Approximately 9% of the Department consists of Aboriginal employees. The majority of these are Aboriginal health workers in remote areas.

The provision of culturally appropriate services to Aboriginals has been a priority for Territory Health Services for a long time.

In a submission to the Public Accounts Committee, Dr Spillane, Director of Medical Services in Territory Health Services, emphasised the need to establish a culturally relevant goal prior to planning a delivery model. Spillane (1995) does not believe that common goals have been established and he claims that the actions of Territory Health Services do not support equality of health status across the NT. One of the goals of the 1993/95 Corporate Plan for Territory Health Services is ‘to work with Aboriginal people to achieve an improvement in their health status and well-being.’ Spillane submits that Territory Health Services has not worked with Aboriginal people to adequately define what they regard as health and well-being.

The Aboriginal Cultural Awareness Program (ACAP) is a part-funded Commonwealth best practice program aimed at achieving improved health service delivery and better understanding and knowledge of health issues by clients through a pre-employment package for applicants and a compulsory recruitment orientation course.

Territory Health Services claimed that an appropriate boost to primary health care, although likely to increase hospital costs further in the short term, would in the medium to long term reduce the projected hospital costs of Aboriginal ill health. Co-operation and co-ordination with the Commonwealth, ATSIC and Aboriginal communities will be essential to achieve this.

In the 1995/96 budget speech, Hon. Mike Reed MLA, Treasurer, announced a new health outcome strategy stating, 'we will not turn the tide in Aboriginal health until we begin to tackle the underlying causes of the problem more effectively'.

Alcohol, nutrition, infant and maternal health and smoking were targeted. Aboriginal responsibility and control, environmental health, Aboriginal employment and training, health clinics and renal disease were specifically mentioned.

A senior officer from the Alice Springs Rural District, Territory Health Services, advised that consistency of goals and direction is through dialogue rather than an exchange of documentation with the Community Health Directorate.

Milingimbi and Ramingining Health Centres Nurses and Aboriginal Health Workers (1995) stated that common goals cannot be established because of a lack of understanding by management of the roles, duties, responsibilities and moral and ethical issues faced by nurses and Aboriginal Health Workers in rural communities. They propose a strategy to employ managers who have an understanding and interest in Aboriginal health issues.

Perusal of three ATSIC Regional plans shows that goals and strategies are covered to varying degrees. Consultation between the providers about their respective plans is necessary to achieve a coordinated approach.

In a submission to the Public Accounts Committee, Mr J. Hemmerling, Clinical Nurse Consultant, Living with Alcohol Program claimed that goals should be clearly documented and published to avoid different responses from different people in the organisation.

Evidence showed that there is a lack of agreed common goals among the providers.

In the Committee's opinion there needs to be a consistent approach to health and that outcomes will only be improved if all providers/agencies work towards common goals. These goals must be linked to the expressed needs of Aboriginal communities.

**RECOMMENDATION 1.**

**That closer cooperation between the providers be established and draft plans must be exchanged for reciprocal comment to ensure that common goals are agreed.**

### 1.5 Common Goals - Lack of Co-ordination

There is a lack of consultation about capital infrastructure between the NT and the Commonwealth. Anecdotal evidence to the Committee suggests that two years ago Harts Range received Commonwealth funded infrastructure. ATSIC allocated funding for a clinic at Harts Range without any discussion with Territory Health Services and the Department first become aware of it when the foundations appeared. Over the last two years, Alice Springs Rural District staff have travelled to communities and encouraged those communities to work out their own priorities. This was the first year that the communities contacted the District to request relief staff so that they could work through their plans.

A senior officer from the Alice Springs Rural District, Territory Health Services, advised that each community sends their priorities to the Alice Springs Rural District and an expanded management team looks at the community's priorities and sets district goals. This is a "grass roots" approach to planning which needs to be coordinated with top down direction.

A senior officer from the Darwin Rural District, Territory Health Services, confirmed that the direction is in accordance with the National Aboriginal Health Strategy and therefore complements the community health program. With respect to grant funded organisations there is a close link through the service agreements. Co-ordination with ATSIC on goals and priorities is weak. Very few communities in Darwin Rural have plans, however the service agreements will help. The direction is for every community to have a service agreement that will ensure the District plan makes sense.

Goals and targets for the District in 1994 were arranged through a workshop that did not have many Aboriginal representatives. In 1995 an Aboriginal Health Forum had been established to give advice in the District.

A senior officer from the Barkly District, Territory Health Services, was not aware of a formal link with the community health program. There is no evidence of a formal link regarding goals and priorities with ATSIC organisations. Grant funded organisations have their outcomes defined through their service agreements. Barkly District have arranged planning workshops with representatives from communities and are working towards a health service which is based on coordination between the hospital and community.

Katherine Rural District advised that even under the previous structure there was very limited linking with the Aboriginal Health Program and this has not changed. With regard to linking with ATSIC, Wurli Wurlinjang invited Territory Health Services representatives to attend the ATSIC conference. Each regional council has a plan.

Advice indicates that Wurli Wurlinjang uses accrual accounting to avoid the need to seek additional funding when assets require replacement, eg. vehicles. Two examples where communities have been assisted to achieve their own goals were the Beswick Clinic and the ablution block at Dagaragu. In the Beswick example the community was allowed to arrange the building of the clinic within the specification and in Dagaragu the suggestion was received by the community and the result was a conversion of an existing building which resulted in a larger ablution block at a lower cost.

East Arnhem District indicated that a recent workshop was held where key priority areas were set for the District with representatives from most of the communities.

Northern Territory Health Services are working towards greater Aboriginal participation in the setting of goals and priorities. The comments from the Districts indicate that there is a need for closer links with the policy program coordination area and other providers.

In a submission to the Public Accounts Committee Sister L. Benjamin, Clinical Nurse Consultant in Territory Health Services, believes that there is no common goal and that goals set by senior administration do not have sufficient input from community based staff. A management framework can only be achieved by a basic needs assessment at the point of service delivery. This will show the different and common aspects for all communities. She

believes that a relationship based on trust is required in order to achieve co-operation that will lead to acceptance of responsibility by the community, health education and a realisation of disease processes and environmental hygiene.

The Committee believes the lack of commonality and agreement in establishing goals is not beneficial for health outcomes.

## 1.6 ATSIC Health Services pre–July 1995

A meeting with a senior officer from the ATSIC, NT State Office, Darwin, indicates that priorities were application driven within the annual allocation which generally keeps pace with inflation.

Regions have earmarked and non-earmarked funding and the Regional Councils have autonomy to decide on expenditure of funds in the non-earmarked category.

The ATSIC Operational Plan 1994/95 (p. 66) had a number of objectives and strategies covering health policy, substance abuse policy and key strategies under a social and cultural division (see Appendix J). This included, inter alia:

- improve the delivery of primary health care services of Aboriginal and Torres Strait Islander peoples;

- improve the Commission's delivery of housing and infrastructure programs to better target environmental health priorities, including through a program of major projects.

Funding was transferred for health and substance abuse from ATSIC to the Department of Health and Family Services[2] on the 1 July 1995 and a memorandum of understanding was prepared to determine the new arrangements.

An executive officer with ATSIC advised that submissions for health needs have to compete with other submissions for legal services, housing, etc. He believed that one of the reasons for the transfer of health from ATSIC to the Commonwealth health department was to ensure that health submissions compete against other health submissions rather than non-health submissions. The submission-based system is underpinned by the *Aboriginal and Torres Strait Islander Commission Act.* Submissions for the 1995/96 year were received in December of 1994 and Project Officers carry out a process of examination of those submissions in preparation for review consideration by Regional Councils.

Issues of multi-regional or national significance are dealt with by the State Advisory Committee which then refers matters to Canberra for endorsement. Approved national submissions are referred back through the program areas for implementation.

The Commonwealth Health Service process for determining priorities probably varies dramatically depending on the community involved and the provision of health advice

[2] Commonwealth Department of Health and Family Services was formerly named the Department of Human Services and Health until March 1996.

available to that community. The ATSIC project officers do not make decisions about the project but about funds and outcomes. Generally the outcomes are very broad and health economics is not used to assist in determining priorities of spending. The general approach has been that decisions are best made by the communities themselves in accordance with self-determination.

An executive officer to the ATSIC Katherine Regional Council who was previously the executive officer for the Tennant Creek Regional Council advised that goals and targets and priorities are mainly historical and application driven. The Anyinginyi Congress serve the urban town camp area (approximately 7-8 town camps). They also provide a service for people within a radius of 100 km from Tennant Creek who have outstations of less than 50 people who are not receiving services from the Territory Health Department. In the wet season people from the rural areas come into Tennant Creek and it is possible that people could be accessing both the hospital and other health services from Anyinginyi Congress.

**The Committee notes that funding based on submissions is often considered on the quality of the submission rather than the health priorities and needs of the community.**

### 1.7 Transfer of Health from ATSIC to Department of Health and Family Services (Commonwealth)

With the transfer of responsibilities for health from ATSIC to Health and Family Services, the previous Minister for Health stated that she would honour all the 1995/96 commitments made by ATSIC. Decisions on spending for the year 1995/96 were made in March 1995. There would be some additional money for 1995/96 and feasibility studies would be considered by a Joint Health Planning Committee.

Vipan Maharjan, State Manager (NT), Department of Health and Family Services provided details to the Public Accounts Committee on 23 October 1996 of the additional monies.

- $2,450,000 is to be provided to Territory Health Services to construct and fit out a health service building in Maningrida to service Maningrida and its outstation communities.

  Maningrida will establish a Health Board which will pool monies from the Commonwealth and Territory Health. Training will be provided for the Health Board.

- $300,000 is to be provided to Territory Health Services to construct a health service building in Woodycupildiya to service Woodycupildiya and its outstation communities. In addition $50,000 is to be allocated to the Yantjarrwa Outstation Resource Centre Aboriginal Corporation to purchase additional medical equipment.

- $1,200,000 is to be provided to Territory Health Services to construct and fit out a self-care haemodialysis unit to be located at Nguiu (Tiwi). This also includes funding to train staff to operate the unit. $300,000 is to be provided through a separate contract to the Nguiu Community Government Council for recurrent funding for the Nguiu Clinic. This funding is to meet additional health service needs which will arise as a result of the

haemodialysis being located in Nguiu. It also includes funding for the Nguiu Clinic to provide appropriate services to the Warunkuwu community.

In Tiwi there is a broad agreement to establish an independent health board funded by the Commonwealth and the NT to oversight the Coordinated Care Trial and the renal service.

There would be a 1995/96 planning and needs assessment study with each of the services. Funding would be available on a three (3) yearly basis instead of the previous annual basis. ATSIC and the Commonwealth Department of Health and Family Services prepared a Memorandum of Understanding covering the principles for interaction to feed into the Commonwealth planning process and complement the housing program.

A Memorandum of Understanding was signed on 30 November 1995 and the new Liberal Commonwealth Government confirmed three year funding for Commonwealth funded Aboriginal health services instead of one year funding.

**The Committee supports the move to three year funding.**

## 1.8 Health Providers

### 1.8.1 Catholic Health Care, Darwin

The three previous Catholic Health Care organisations in the Darwin Rural District, ie. Nguiu (Bathurst Island), Nauiyu Nambiyu (Daly River) and Wadeye (Port Keats) have been transferred to the Community Councils and are grant funded by the Territory Health Services.

### 1.8.2 Santa Teresa - Alice Springs

(A Service Agreement was signed by the community and Territory Health Services in October 1996 which means that Santa Teresa has become a grant funded community.)

#### *1.8.2.1 Catholic Health Care (Northern Territory)*

*Vision Statement*
The vision of the Diocesan Health Care Committee is that health services are made accessible to all and that, as representatives of the Catholic Community inspired by the healing of Christ, the members of the Committee are so committed.

*Mission Statement*
- provide a focus, and to be a support to all health care staff and to Catholics employed in health care services in the Northern Territory, and to be a resource for other persons seeking advice

- identify unmet health care needs of individuals and groups

- provide health care services which are culturally sensitive and appropriate, which are enabling and empowering, seeking to make the client self-sufficient, and which allow traditional medicine as an alternative

- advocate, co-ordinate and support health care services, articulate policy, and provide an information resource including data on new developments

- recognise that our definition of health encompasses:

  . welfare services;
  . spiritual aspects;
  . prevention and education programs;
  . services to people with disabilities, to the physically and mentally ill; and
  . alcohol and drug services and rehabilitation;
  . for individuals, families and communities

- ensure that appropriate services are provided after consultation with the client, having due regard for the sacredness of life, personal dignity, individual rights, and with regard to privacy and culturally sensitive practices

- advocate for good basic health care services for all.

Father Tim Brennan, Vicar General, Catholic Health Care, advised the Public Accounts Committee on 24 July 1995 that he was not aware of any policy change or operational plan although there could be plans at community level.

## 1.9 Process used to determine Goals and Priorities

### 1.9.1 Territory Health Services

Goals are identified in the three year corporate planning process which takes into account the national framework including the National Aboriginal Health Strategy. Yearly operational plans involve a consultative process with each district and region of Territory Health Services.

The planning process for community-controlled organisations funded by Territory Health Services through grants is influenced by the capacity of the communities to manage the financial matters and to properly define the performance indicators integral to the agreements.

There is concern that the communities are not resourced to accept these tasks. The fundamental principle is that the service agreement has to be owned by the community who accept responsibility and control. Service agreements in the Darwin Rural District will include what the Department will do to support the community.

NT Department of Health and Community Services in the departmental newsletter dated 31 May 1995, conveyed the Minister's reference to Aboriginal Health as the key priority for the Department. In the 28 July 1995 newsletter, the Secretary announced the

establishment of an Aboriginal Health Strategy Unit from Monday, 24 July 1995. Its function is to spearhead implementation of the five year Aboriginal Health Strategy commitment made by the Treasurer in his Budget Speech. The manager of the unit will report to the Secretary and be a member of the Executive. The unit will co-operate with all the divisions of the Department.

Fejo (1995) gave an example of a process that has achieved success. The Strong Women, Strong Babies, Strong Culture Program began in early 1993 as a result of Aboriginal women's concern about babies being born too small, not growing well and being anaemic. It was developed by Aboriginal women incorporating traditional practices to provide women with comprehensive antenatal education.

### 1.9.2 Aboriginal Health Policy

Territory Health Services (1996a, p.7) prepared an Aboriginal Health Policy which provides a framework to address the unsatisfactory state of Aboriginal health. The document includes the following principles seen as being at the core of issues and resulting strategies to improve the health status of the NT Aboriginal population:

- **Improvement** of Aboriginal health status is a key priority of Territory Health Services.
- **Improving access** is creating the means for Aboriginal people to use a range of health services which includes local community health centres as well as special care services.
- **Equity** is the sharing of resources to ensure that an appropriate level of health service is provided for Aboriginal people. Health services must be available to Territorians at the rate it is needed to improve health outcomes.
- **Culturally appropriate and effective health services** are essential for Aboriginal people as a significant client group with special needs. All non-Aboriginal health staff must undergo Aboriginal cultural awareness training.
- **Participation** of Aboriginal people in decision making and operational processes of the health system is essential. This must be based on mutual respect between Territory Health Services and stakeholders and their shared knowledge and experiences.
- **Community control and responsibility** for the provision of community based health care services is the preferred management model.
- **Holistic view of health,** as accepted by Aboriginal people, should underlie health service delivery.
- **Information** underpins the effective delivery of health services and Aboriginal people's understanding of this process and their participation in decision making.
- **Intersectoral action** between all levels of government, Aboriginal organisations and Aboriginal communities is necessary to establish agreed priority needs, maximise use of resources, reduce duplication and assist coordinated action by different sectors.

The implementation of these principles is strongly endorsed by this Committee.

The Committee also endorses the following elements of the policy:

- the need for better needs analysis to improve resource allocation and the need to target prevention strategies;
- utilising the local health knowledge, traditions, attitudes, beliefs and strategies of Aboriginal people;

- Aboriginal input into the design, implementation and evaluation of health services;
- cooperative arrangements across agencies;
- joint health and education initiatives;
- improvements to the quantity and quality of food;
- reduction of alcohol and tobacco use; and
- improvement in health information.

### 1.9.3 Commonwealth Funded Services

Prior to July 1995 ATSIC was responsible for 12 health services and two jointly funded services (Wurliwurlingang and Bagot) where priorities for funding were application driven through the ATSIC Regions. Objectives and strategies are detailed in the ATSIC operational plan. Regional Councils had autonomy to decide on expenditure of funds in the non-earmarked category.

The future process to determine goals and priorities was not clear and was subject to finalisation of a Memorandum of Understanding between ATSIC and the Commonwealth Department of Human Services and Health (1995b, p. 2) signed on 30 November 1995. This Memorandum described the process for the development of community health plans as:

> i. ... Regional Councils will be asked to provide advice on existing and proposed future environmental health activities, to identify areas of highest need and priorities for health service delivery as well as details of their current regional plans;
>
> ii. the Department will then consult with other relevant organisations, including the community controlled services and State authorities, and then provide a draft plan, based on the outcome of all consultations, to Regional Councils for comment; and
>
> iii. the final agreed community health plan would be presented to Regional Councils for endorsement and for inclusion with their Regional plan.

The National Aboriginal Health Strategy and the Aboriginal Deaths in Custody Report provides a general framework for the goals and targets process.

In a submission to the Public Accounts Committee, Congress outlined the functions of their organisation. Congress is an example of an Aboriginal-controlled organisation funded by the Commonwealth. Its annual general meeting (which all Central Australian Aboriginal people are encouraged to attend) attracts people from town camps, town houses and bush communities who elect a 13 person cabinet which meets at least monthly and provides policy direction to the organisation. It is these people who determine what the priorities are, and what policy position Congress adopts.

The Public Accounts Committee met with staff at Mutitjulu, a Commonwealth funded community, on 9 May 1996, and noted that primary health care was identified as their highest priority. In terms of nutrition the Council are subsidising good food by a levy on bad food. $5,000 a year is allocated by the Council to the school for food.

In close proximity to Mutitjulu is the Yulara Medical Centre which is run by the Royal Flying Doctor Service which is funded by the Commonwealth 45% and NT 45% with 10% raised privately. The Yulara Service receives tourists and those people working in Yulara. The contrast between Yulara and Mutitjulu in terms of the health services questions the need for a more efficient management framework where the two services may be coordinated. Territory Health Services have advised that Mutitjulu and Yulara Health Services are organised in tune with the clients they serve.

### 1.9.4 Commonality of goals and inconsistencies in goals

There is a high degree of commonality between the providers, with regards to their goals, which is illustrated by their corporate, operational and other documents. There are also some differences of opinion with regard to the preferred funding arrangements between the Commonwealth and the NT.

There is, however, a need for closer co-operation among the providers to share goals.

All providers have identified the need to close the gap between the health of Aboriginal and Torres Strait Islanders and other Australians. The Commonwealth, State and Territory Health Ministers (1994, p. 13) refers to the National Health Policy:

> Particular attention has to be paid to improving the health of Aboriginal and Torres Strait Islander people. Health services need to be delivered flexibly, especially for remote communities. The provision of health services needs to be closely linked to environmental health measures such as the provision of adequate and appropriate housing and water supplies ... In particular there needs to be partnerships between Governments, Aboriginal and Torres Strait Islander Commission, Aboriginal controlled health organisations and local communities ... To provide the best possible health care, the community needs to be involved at all levels in the planning, organisation and evaluation of health services.

The ATSIC Operational Plan 1994/95 (1995, p. 66) identified the need to:

- improve the delivery of primary health care services of Aboriginal and Torres Strait Islander peoples;
- improve the Commission's delivery of housing and infrastructure programs to better target environmental health priorities, including through a program of major projects;

It also promotes equity in access to health services and acceptance by Aboriginal people of appropriate mainstream and community services. (Establishing community-controlled health services, where appropriate, which emphasise Aboriginal responsibility and involvement in the improvement of their own health.) The plan has a substance abuse policy section with the objective 'to minimise the harmful consequences of inappropriate alcohol and other drug use in Aboriginal communities'.

NT Department of Health and Community Services Corporate Plan 1993/95 prioritised the development of primary health care services with increasing community control and responsibility and improved co-operation with other government and non-government agencies to achieve the provision and maintenance of appropriate infrastructure. A

reduction in substance abuse is included and the prevention of the spread of hepatitis and HIV/AIDS.

Comments provided by Territory Health Services to the Public Accounts Committee on 19 April 1995 noted that any enhancement of treatment services must be supported by a strategy to tackle living conditions. This would incorporate Aboriginal control and responsibility and reversal of dependency. Relevant education, including health information and a basic understanding of the dominant society, is required along with reinforcement of the value of Aboriginal culture and identity and opportunities for meaningful occupation/employment.

### 1.10 Catholic Health Care - Santa Teresa - Alice Springs.

Common goals are included in the policy manual for Catholic health care in the Northern Territory dated 1992.

The mission statement reads:

> ... provide health care services which are culturally sensitive and appropriate, which are enabling and empowering, seeking to make the client self-sufficient, and which allow traditional medicine as an alternative (p. 1).

Apart from the specific reference to traditional medicine, this statement accords with the Commonwealth and Territory higher level documented plans.

### 1.11 National Aboriginal Health Strategy - Evaluation

Commonwealth Ministers for Health and Family Services and Aboriginal and Torres Strait Islander Affairs established the National Evaluation Committee chaired by Commissioner Stephen Gordon of ATSIC with 13 members including Mr Graham Symons from the Northern Territory. It had terms of reference agreed between Hon. Carmen Lawrence, former Minister for Human Services and Health; the Hon. Robert Tickner, former Minister for Aboriginal and Torres Strait Islander Affairs; and Miss Lois O'Donoghue, Chairperson of ATSIC. The emphasis of the Evaluation Report, December 1994, was 'assessing the Commonwealth's response to the NAHS and making recommendations about future implementation'.

Two of the major findings of the review were that the NAHS was never effectively implemented and if the Commonwealth wants to achieve environmental equity by the year 2001 there will need to be substantial increases in funding for housing and essential services in remote and rural regions in Australia, including the Torres Strait, over the remainder of the decade.

The lack of progress results in disillusionment from the Aboriginal people.

The Committee notes that there is a danger in producing documents which set targets or make promises which cannot be realised. False promises are not constructive and may cause a lack of faith by Aboriginal people in future working relationships with non-Aboriginal people.

There is a danger that future reports which result in inaction will result in further disillusionment among the Aboriginal people.

The history of organisation and process structures and reports into Aboriginal health issues are out of proportion to any improvement in health outcomes. Caution is required before entering into new structures or programs. Proposed structures should detail the process of evaluation to assess the added value that the structure will bring.

**RECOMMENDATION 2.**

**That new organisational structures and arrangements be described on the basis of their added value to health services and the process for evaluation must be defined before those structures are implemented.**

National Evaluation Committee (1994) referred to the key concept underlying the NAHS report as Aboriginal people's holistic view of health involving not just individual physical well being but the social, emotional, and cultural well being of the whole community. Aboriginal community control and participation in health services was strongly advocated as a means of promoting community responsibility and understanding, and ensuring the provision of primary health care was socially and culturally appropriate.

The health providers have accepted these principles in their documented goals and targets. Visits to the rural communities indicate that the degree of participation and involvement of Aboriginal people in primary health outside of the clinic is generally minimal.

The National Evaluation Committee found that the structures established to oversee the NAHS implementation - the Council for Aboriginal Health and State Tripartite Forums - were lacking in political support and hence became ineffective. Furthermore, many of the detailed recommendations in the Working Party Report were lost by the time they were brought to Cabinet.

### 1.11.1 NT Tripartite Forum

The Northern Territory Tripartite Forum (Aboriginal Health) (TPF) was established in June 1991. The TPF consisted of representatives from Aboriginal communities, NT and Commonwealth Governments.

The role of the TPF was to advise both governments on the implementation of the NAHS and the Royal Commission into Aboriginal Deaths in Custody; and advise ATSIC Regional Councils on issues relating to Aboriginal health. The initial membership of 46 was an impediment and in late 1992 the membership was reduced to 16. The concept of a bilateral agreement between the NT and the Commonwealth was discussed and put to Federal and NT Ministers in January 1994 and supported. A number of people associated with the TPF consider that confusion with its role and function have hampered its effectiveness. The meetings focussed on funding issues rather than advice to governments.

In a submission to the Public Accounts Committee, Ms B. Flick, Indigenous Health Adviser to the Australian Medical Association, criticises the Territory Health Services and the TPF for not establishing a comprehensive health strategy.

The terms of reference for the TPF required it to advise the national Council for Aboriginal Health (CAH) which was established by a joint ministerial forum in 1990 to provide an effective means to influence Aboriginal health and to formalise a 'partnership' in Aboriginal health policy and implementation.

In recognition of the need for participation at the regional and local level a Northern Yolngu Health Council with 30 members and a Central Australian Aboriginal Health Council with 14 members were established. These two councils have only met once or twice.

The Committee notes that this is another example of where a structure has been established and has achieved very little.

### 1.12 Commonality of goals

It is clear that all providers have stated that they wish to improve Aboriginal health. They all indicate support for Aboriginal control and participation in health services with encouragement for communities to accept responsibility for their own primary health care services. The need to improve environmental health with attention to living conditions, eg. housing and water supply and changes in attitudes and behaviour which are harmful to health and well being is also acknowledged.

The effectiveness and the extent of cooperation are considered under Terms of Reference (c) and (f) of this report (pages 62 and 140 respectively).

### 1.13 Comparison of goals

The goals of the providers are generally consistent. There is a need to raise public awareness of priorities and ways to maximise health outcomes for a population with the resources available. This raises the health economic concept of opportunity cost and marginal analysis which will be explained under Term of Reference (d) (page 92). Opportunity costs and marginal analysis assist decision makers to maximise health outcomes from the resources available.

### 1.14 Two Major Differences

There are some differences in goals relating to funding arrangements in that Aboriginal controlled health organisations prefer direct funding from the Commonwealth and there are concerns that money received from the Commonwealth is not being allocated to Aboriginal health.

In its submission to the Public Accounts Committee, Ms S. Bell of Congress provided a copy of its 1992 submission to the Commonwealth Grants Commission. Bell (1995, p. 3) favours a combination of the following two options:

1) that Grants to the Northern Territory Government are tied to providing funds to Aboriginal organisations, and that the Northern Territory Government is made fully accountable for the disbursement of these funds; and

2) that the Grants Commission provides funds directly to Aboriginal organisations.

Flick (1995, p. 6) referring to funding arrangements submitted her personal view:

> I do not support Bilateral Agreements but believe that the Federal government should enter into contracts with the independent Aboriginal health services to deliver specific services.

Danila Dilba (1995, pp. 4-5), in its submission, said:

> It is difficult to comment about the proper dispersal of Commonwealth funds which the NT government receives for Aboriginal health. We are not aware of any mechanisms which properly show how Commonwealth funds are disbursed.
>
> The Aboriginal Medical Services Alliance (NT) of which Danila Dilba is a member has been lobbying for direct funding from the Commonwealth to our organisations. Among other things, we are hoping this will make it clearer as to where and how scarce health dollars are spent and how effective that spending is and thus making all stakeholders more accountable.

Mr H.A.S. McClelland, Acting Deputy Under Treasurer, NT Treasury, in his briefing to the Public Accounts Committee dated 9 August 1995, referred to Specific Purpose Payments (SPP)(tied grants):

> The States would argue that the use of tied grants tends to be inefficient and costly to deliver, inefficient in the sense that they prefer the State Government to be determining what their priorities are rather than the Federal government (p. 5).

The funding arrangements do not have agreement and funding is considered under Term of Reference (e) and reference to efficiency under (d) in this report (pages 112 and 92 respectively).

Aboriginal groups have raised concerns that money received by the NT from the Commonwealth for Aboriginal health is not being allocated to Aboriginal health.

The NT ATSIC State Advisory Council have confirmed the need for a presentation to Aboriginal groups to advise on the allocation of health monies from the Commonwealth to the Territory.

The Advisory Council require information to help them understand the allocation.

**RECOMMENDATION 3.**

**That Territory Health Services give a presentation on Aboriginal Health income and expenditure to the ATSIC State Advisory Council and other Aboriginal groups as appropriate.**

## 1.15 Input from the Menzies School of Health Research (Menzies)

The following information has been gleaned from documentation and a series of interviews with various staff from Menzies in Darwin and Alice Springs.

Menzies School of Health Research (1995, pp. 10-13) 1993-1994 Annual Report referred to Aboriginal Health:

> Education, health infrastructure and health services will not meet real needs unless Aboriginal people themselves control planning and management so that services are culturally appropriate.
>
> ... Education, housing, food supplies and health services (including health promotion services) must be provided in accordance with the best professional standards based on real need.
>
> ... On a per capita basis, the immediate costs of providing necessary health education, health infrastructure and health services for Aboriginal people will be much greater than current costs for other Australians.
>
> ... For efficiency and effectiveness, there needs to be greater cooperation between the education, employment, housing and health sectors. Within the health sector, there needs to be greater cooperation between the research, service and education sectors.

Mathews (n.d., p.2) advocates:

- enhanced funding and fiscal equalisation;
- development of policy options, by a task force of health professionals, for consideration by governments and by Aboriginal representatives;
- consumer health education for Aboriginal people;
- analysis of cultural factors affecting uptake and compliance with services;
- professional and cross-cultural education for health professionals in Aboriginal health services;
- needs based planning for service delivery;
- development of and adherence to appropriate professional standards and protocols; and
- health development project funding to test the efficacy of innovative service strategies (p. 2).

In an interview with Professor Mathews, Director of Menzies School of Health Research, Darwin, Professor Mathews considered that the work done by Dr Paul Torzillo at Nganampa in South Australia was a good benchmark for improving Aboriginal Health. Professor Mathews considered that the key goal is to match the resources to the needs, people need to understand the needs, and that there should be specialist training for health workers with competencies to be credited - STD, maternal and child health, diabetics, etc. He advised that Dr Wendy Hoy, Head of the Renal Unit at Menzies, is researching renal problems on Tiwi Island where 30% of the Tiwi people need long term treatment to stop or slow down renal failure. In Professor Mathews' opinion, nobody has solved the funding incentives to make it work better.

In an interview with Dr Bart Currie, Clinical Associate Professor at Menzies, Dr Currie stated that the nurses have to put aside the preventative programs because the immediate needs of

acute treatment take priority. A key goal is to try and persuade people outside the Territory to allocate more resources to community clinics where the resources are needed.

In an interview with Dr David Scrimegour of the Menzies Central Australian Unit, Dr Scrimegour believed that Aboriginal people in Australia have acquired a learned helplessness.

In relation to goals for health, Dr Scrimegour believes that communities need to be resourced to help themselves decide their own goals. He quoted the American Indians where governments provide resources for two years to assist the Indians to determine their own priorities and what they can do. He believes that model could be applied here. This would create a number of consultants working with bush communities and therefore strict guidelines would be required to maintain quality and reasonable charge rates. A resource allocation formula is required and he is in favour of the funder provider split model. [Further details Term of Reference (d), page 92.]

In an interview with Dr Bagshaw of the Menzies Central Australian Unit, Dr Bagshaw said she has personal experience in African countries. In Aboriginal communities in Australia there needs to be ownership with checks and balances where people can start small and build, for example, Strong Women, Strong Babies, Strong Culture, which has been a successful program.

### 1.16 Community Involvement is vital for Change

The pressing need to react to immediate illness at the community level (dealing with the bush fire) has not allowed sufficient attention for the preventative strategies (building fire breaks).

Barnett and Abbatt (1994, p. 34) produced a manual to assist in deciding how to develop programs within existing constraints. It quotes overseas experience with primary health care:

> ... if you do not investigate your problem properly, you can come up with solutions which are totally impractical, because they do not take into account the resources you have available to you.

Communities need to be resourced to help themselves decide their own health goals, and assistance to determine their own priorities. Strict guidelines would be required to maintain quality. One source of funding could be from the Commonwealth Territory Medical Benefits and Pharmaceutical Benefits shortfall which is analysed in Term of Reference (e), page 112. The overseas research into indigenous populations clearly shows that health improvements are linked to communities understanding health information; wanting to change their circumstances; being motivated to change those behaviours that are detrimental to health; and taking responsibility for their own health and receiving feedback of their progress.

**RECOMMENDATION 4.**

**Aboriginal communities be resourced to plan their goals, priorities and evaluation process.**

The Committee expressed its concern that the excessive number of reports and research into Aboriginal health, working parties and general dialogue is well out of proportion to the level of achievement. Health outcomes for Aboriginal people are lamentable. Research needs to lead to action. Successful Aboriginal health initiatives must be promulgated and built upon. Those community initiatives that are working may have portability between communities and there are opportunities for Aboriginal people in partnership with non-Aboriginal people to introduce those successful programs into other communities. There is no guarantee that successful programs will be portable due to other community dynamics such as leadership, skin groups and different priorities.

## 1.17 Goal Setting at the Community Level

A common theme through the submissions and the research from overseas points to the development of culturally relevant goals taking into account an understanding of what Aboriginal people define as health and well-being. Education and training by Aboriginal Health Workers to help Aboriginal people realise the link between disease and hygiene is a key strategy to the development of an appropriate framework.

A Menzies Project Team is reviewing remote health services in Central Australia and a report of their first meeting with community representatives in March 1996, indicates that the project team would be visiting communities over the next 8 or 9 months to talk about what ideas people have for improving their own health services.

The Project Team will consider different ways of running the health services.

## 1.18 Goal Setting - Task Force

The Committee believes that a task force should be established to head a coordinated approach to Aboriginal health and to seek out innovation.

### 1.18.1 Terms of Reference

- To consult with Aboriginal representatives, and with health professionals who have expertise relevant to the health problems of Aboriginal people.

- To review information that is relevant to the health of Aboriginal people.

- To report the health needs of Aboriginal people that are not being met by current services.

- To seek out those models of health service and community action that are producing positive results and to seek support from Aboriginal communities to consider the application of those models within their own communities.

- To make recommendations, designed to improve the health of Aboriginal people, that relate to:
    - income, housing and health infrastructure;

- funding models;
- education and training of health professionals;
- health information for Aboriginal people; and
- other factors affecting the effectiveness and efficiency of services.

### 1.18.2 Membership

The task force be limited to four persons:

- a person with understanding of the biological, social and medical factors affecting Aboriginal people;
- a social scientist with experience of working with Aboriginal people;
- two persons with extensive experience/knowledge in Aboriginal service delivery including an Aboriginal person.

### 1.18.3 Guidelines

- The Task Force consult with senior representatives of ATSIC, Aboriginal Medical Services Alliance NT (AMSANT), Commonwealth and Territory Health Services, National Health Medical Research Council (NHMRC), Menzies School of Health and the professional bodies.

- The Task Force would recommend to the Minister of NT Health, opportunities for working parties with delegated tasks to work with a task force member/s.

### 1.18.4 Time Frame and Evaluation

The Task Force would report to the Minister within six months. The future of the Task Force will be determined by an independent evaluation of its effectiveness and efficiency after twelve months.

**RECOMMENDATION 5.**

**That a select Task Force be established, with secretarial support, to report to the NT Health Minister, to seek out those models of health service and community action that are producing positive results for Aboriginal people and plan ways to apply those models.**

**RECOMMENDATION 6.**

**Arising from Recommendation 5. a small implementation team under the Assistant Secretary, Aboriginal Health, be resourced to action the recommended initiatives in consultation with communities.**

## 1.19 Priority Setting

The ongoing process to determine priorities is dependent upon adequate data, monitoring and evaluation of performance and outcomes to measure the effectiveness of the effort. Priority setting requires an understanding of the real health needs and what health benefit additional resources will bring to a population if those resources are targeted to specific needs. Once the priority setting process has been completed it is then appropriate to consider the goals.

The concept of opportunity cost and marginal analysis is discussed under Term of Reference (d) (page 92). Direct funding by the Commonwealth, for State services without a needs assessment may impede the capacity to prioritise for health. It is important to examine all sources of funding and to ensure that the process of prioritisation provides the best health outcome for each health dollar.

**RECOMMENDATION 7.**

**That the tools of health economics and option appraisal covered in terms of reference (d) 'the cost efficiency of service delivery mechanisms and whether more cost-efficient solutions are available' be used by all providers to assist the priority setting process.**

# *CHAPTER 2*

# 2. TERMS OF REFERENCE (b)

***the impact of services currently provided and any gaps and/or duplication of services***

## 2.1 Introduction

The range of health services provided for Aboriginal communities are covered in this section of the report. The impact of environmental factors such as overcrowding, poor hygiene, poor nutrition, smoking and alcohol abuse on the health of Aboriginal people is so destructive that many of the health services are having little impact on improving health. The lack of improvement and strain on resources in health is reflected by the submissions which have an element of despair.

Overlapping and lack of co-ordination of services between the Commonwealth and Territory Governments and between providers within the Territory make the task of utilising each health dollar for maximum health gain difficult.

Overseas research and local knowledge emphasise the importance of community responsibility and control with good information about the health of each community.

The thrust of the recommendations in this section of the report support measures to assist communities to improve their own health and to remove duplication.

## 2.2 Health Services For Aboriginal Communities

The map of the Northern Territory communities and the list of Aboriginal communities (*Appendix G*) provide a general guide of location, population and funding responsibility for each of the communities.

## 2.3 Range of Services provided

Information describing the range of health services for Aboriginal communities is covered in *Appendix I.*

The demand for renal services are covered later in this report. The service is functioning at maximum capacity.

In a submission to the Public Accounts Committee, Ms C. Farley, Acting Assistant Director of Nursing with Darwin Community Health, Territory Health Services, referred to the high proportion of Aboriginal clients on renal dialysis at Nightcliff. The Nightcliff Renal Unit operates six days a week from 7 a.m. until 9.30 p.m. to accommodate two dialysis groups a day and an after hours emergency service is available. Approximately 95% of clients using the service are Aboriginal and most have had to permanently relocate to Darwin with their

families in order to be able to access this service. The Nightcliff unit is functioning at maximum capacity.

## 2.4 NT and Commonwealth grant funded health care service providers

Services provided in remote communities by other health care service providers are predominantly delivered by community controlled health services that are funded by either ATSIC (Commonwealth Department of Health & Family Services from 1 July, 1995) or Territory Health Services, or dual funded by both agencies.

- 9 Aboriginal medical services in the NT currently receive the majority of their funding from ATSIC;

- 18 Aboriginal health services are currently managed by community councils which receive the majority of their funding from the NT Government;

- A large proportion of these 27 communities receive some funding from both ATSIC and the NT Government.

Service Agreements with the NT Government provide options for communities to move direct to full responsibility for services or staged responsibility for aspects of services, as they choose, until they ultimately reach full responsibility.

The health services are basically similar to those provided by Departmental remote health centres, and where they do not have particular programs or health professionals (eg. physiotherapist, health promotions, STD/AIDS workers etc), the Department provides access to them. Emergency retrievals and access to on-call doctors, and the PATS program is also available to these health services.

## 2.5 Services provided by grant funded health care providers

Services provided by these grant funded health care providers include:

a) *Primary Health Care (PHC)*

Similar to Territory Health Services PHC services, but staffing usually consists of a resident doctor and Aboriginal Health Workers. They provide clinical services; diagnosis, treatment, monitoring and management of those medical conditions which are manageable locally; clients self present or are seen on home visits; and the more complex problems are referred to larger urban health facilities.

The Territory Health Services grant funded health services mostly do not have resident doctors but are serviced by Departmental district medical officers, who make routine community visits. These health services usually employ resident nurses as well as Aboriginal Health Workers.

Other health staff usually include a community health educator, administrative staff and sometimes Aboriginal environmental health workers.

b) *Environmental Health*

Employment of community based Aboriginal Environmental Health Workers are seen as the most appropriate option for addressing environmental health issues which impact on the health of remote communities. Aboriginal Environmental Health Workers' influence and are involved in services such as sewerage, rubbish disposal and power and water supply and how they are provided and maintained by the local community council. They also run specific programs such as the Dog Program, in collaboration with the community health centre. The Dog Program addresses sterilisation/contraception and treatment of dogs with anti-parasitic agents.

c) *Specific programs*

Maternal and child health; lifestyle diseases; communicable diseases; women's health; infectious control and clinical care are all delivered similarly to departmental health clinics.

Community controlled health services tend to utilise, more frequently and effectively, traditional health practitioners. These services, especially in Central Australia, recognise and give status to Ngangkari, Aboriginal medicine men, and involve them in the care of clients. Many of these clinics use bush herbs and foods for a variety of illnesses, bush plants for treating skin conditions and utilising medicine men in treating mental health problems.

## 2.6 Commonwealth Department of Health & Family Services

The Commonwealth Department of Health & Family Services provides two programs to Aboriginal communities. The Commonwealth Rehabilitation Services (CRS) provides their New Start Program and Program Provision in remote areas and currently have Aboriginal clients in the northern and southern areas as well as the cross-border area. CRS coordinate and consult regularly with the Aged and Disability Services and rural district staff. The Commonwealth Hearing Service provides a service to Aboriginal communities.

## 2.7 The existing framework/models that each provider is working to in the provision of health services to Aboriginal communities.

It is useful to put the existing framework/models of health services in context.

An attachment to the documentation dated 19 April 1995 from Territory Health Services (*Table 1, p. 31*) sets out the underlying and first level factors of ill health in Aboriginal communities and indicates the complexity of the Aboriginal health issues. The table illustrates that Territory Health Services will continue to have limited success in tackling the poor health of Aboriginal people without a whole of government approach. It is clear to the Committee that overcrowding impacts on hygiene and education. Children who are unable to obtain adequate rest due to overcrowding will not be attentive in school. In school many of them would not be able to learn because of hearing loss. Without reasonable numeracy and literacy skills, Aboriginal people will have difficulty accessing employment. This leads to low self-esteem and alcohol abuse which adds to the disruption in the crowded homes.

# FACTORS CONTRIBUTING TO ABORIGINAL ILL HEALTH

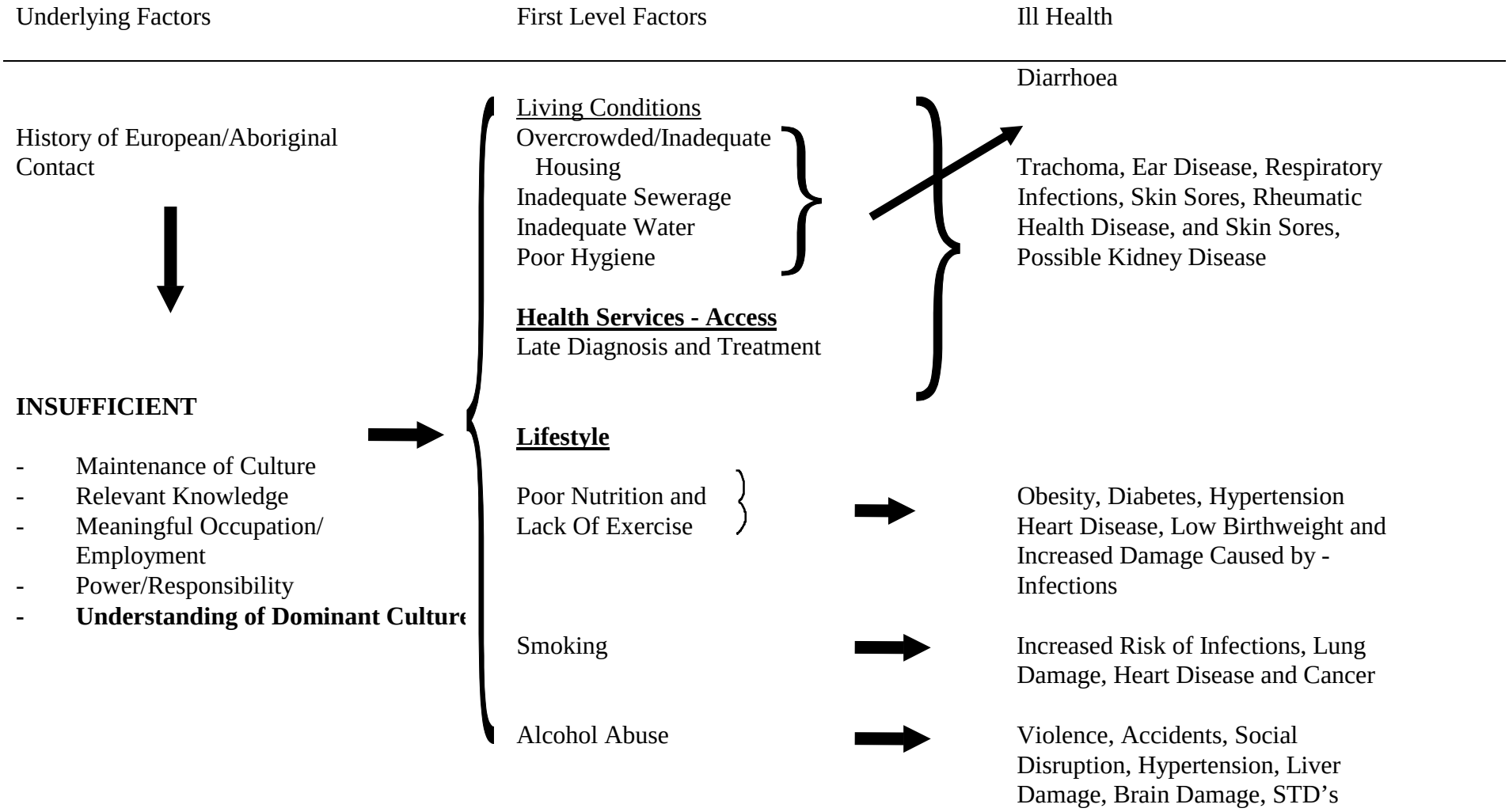


*Table 1: Factors Contributing to Aboriginal Ill Health.*
*Source: Territory Health Services. 19 April 1995.*

The shortage of housing in rural communities has been acknowledged by both Commonwealth and Territory governments. Overcrowding is a major contributor to the poor health of Aboriginal people. The additional costs required to address the shortfall of housing should take into account the estimated savings in the consequential reduction in health costs due to less overcrowding.

The factors in *Table 1* are reinforced by the work of Pholeros, Rainow & Torzillo (1993) who developed nine healthy living practices:

- washing people;
- washing clothes/bedding;
- removing waste;
- improving nutrition;
- reducing crowding;
- separating dogs and children;
- controlling dust;
- temperature control; and
- reducing trauma.

Three major areas of work were identified on the Anangu Pitjantjatjara Freehold Lands of South Australia: housing and health hardware infrastructure, hardware sustainability in communities and maintenance systems. The project demonstrated a direct link between improved living conditions and improved health. Medical evacuations were reduced by two-thirds from 1984 to 1992.

Recent advice (October 1996) from the Northern Territory Department of Housing and Local Government indicated that the pool established under the Bilateral Housing Agreement included $15m from ATSIC/Community Housing and Infrastructure Program (CHIP) funds, $4m from the NT and $19.5 from the Aboriginal Rental Housing Program.

The Indigenous Housing Authority of the NT will administer these funds.

A further $130m-140m over the next three years has been allocated by the Commonwealth as part of the National Aboriginal Health Strategy. A submission by the NT to manage this program was unsuccessful. The program will be managed by a consultant reporting to ATSIC.

Current rate of expenditure for housing and related infrastructure is $98m a year for the next three years. This is comprised of:

| | |
|---|---|
| Bilateral pool | $38m |
| CHIP infrastructure | $15m |
| NAHS | $40m |
| Strategic Board Fund | $ 5m |
| | $98m |

If the annual funding was maintained for the next 10-15 years, it is estimated that this would be about right to redress the outstanding housing requirements.

A joint plan would help coordinate the housing effort.

The challenge for the Commonwealth and the NT is to maintain the effort beyond the three years.

This includes the provision of effective arrangements for the ongoing maintenance of housing and facilities.

**RECOMMENDATION 8.**

1. **That the Commonwealth and Territory produce a joint plan to expand the Aboriginal community accommodation;**

2. **that the accommodation be appropriate to the needs of the community;**

3. **that such provision of accommodation be accompanied by effective maintenance arrangements;**

4. **that education as to the benefits of appropriate housing maintenance and cleanliness be provided; and**

5. **that funds from all sources be allocated according to overall housing priorities. This includes National Aboriginal Health Strategy funds and requires coordination between Commonwealth, Territory and ATSIC with Aboriginal community consultation.**

## 2.8 Health Framework

The National Aboriginal Health Strategy Working Party (1989, p. x) referred to health and self-determination as:

> Not just the physical well-being of the individual but the social, emotional, and cultural well-being of the whole community. This is a whole-of-life view and it also includes the cyclical concept of life-death-life.

The Working Party went on to include in its working definition of primary health care that a corollary of self-determination is responsibility.

Devanesan (1995, p.1) in a paper presented to the Aboriginal Health (Social and Cultural Transitions) Conference in Darwin, 30 September, referred to intersectoral action for Aboriginal Primary Health Care. His abstract paper made reference to an international conference on primary health care which reinforces international acceptance of the importance of primary health care:

> Intersectoral cooperation for achieving health goals has been accepted as one of the guiding principles of the health strategy that was adopted at the International Conference on Primary Health Care (Alma-Ata 1978). This strategy re-ordered the priorities in the

health sector, made primary health care its main focus, and moved from a perspective of health that was predominantly disease oriented and curative to one that emphasised the prevention of ill-health, the removal of health risks and the promotion of health.

In order to work towards improvements in Aboriginal health it is essential that there is collaboration between government departments providing services to Aboriginal people in areas such as education, housing and essential services. Each of these government departments acknowledge that there is a wide gap between Aboriginal and non-Aboriginal achievements in their sector in spite of rapidly increasing funding and support for services in Aboriginal communities.

### 2.8.1 Primary Health Care

Fry & Hasler (1986, pp. ix-x) report that the World Health Conference in 1978 at Alma-Ata recommended in its Declaration that primary health care should be the method by which the health of the people should be improved. Primary health care included the following in its broad definition:

- addresses the main problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;
- includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of water and basic sanitation; maternal and child health care, including family planning; immunisation against major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;
- involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors;
- requires and promotes maximum community and individual self-reliance and participation in the planning, organisation, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate;
- should be sustained by integrated, functional and mutually supportive referral systems, leading to the progressive importance of comprehensive health care for all, and giving priority to those most in need;
- relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitable trained and socially and technically to work as a health team and to respond to the expressed health needs of the community.

Evidence and research shows that primary health care is the key to improving health.

The Committee strongly supports the targeting of prevention strategies to arrest the high incidence of acute and chronic illness.

**RECOMMENDATION 9.**

**That a much higher priority be given to primary health care targeting prevention strategies.**

### 2.8.2 Impact of Health Initiatives

In a submission to the Public Accounts Committee, Ms S. Bell, Acting Director, Central Australian Aboriginal Congress claimed that comprehensive primary health care services have not been well resourced. The health status of Aboriginal people compared to non-Aboriginal people showed a gap in health outcomes.

Aboriginal health program initiatives were prepared for a Fact File by Territory Health Services and this information is valuable to assist the understanding of the developing framework/model of health services to Aboriginal communities.

- *Strong Women, Strong Babies, Strong Culture*

This program has the objective of improving the health of pregnant Aboriginal women and their babies in order to reduce the high incidence of low birth weight infants. The program was developed by Aboriginal women and there is community ownership of the program.

**Outcomes** indicate that low birth weight infants have reduced from 25-30% to 10%. Women are attending antenatal care much earlier. Weight gain during pregnancy has increased. Infection during pregnancy has significantly reduced. Post natal sacred ceremonies for mothers and babies have been re-established.

- *NT Food Project*

This 12 month project was to formulate an intersectoral Food and Nutrition Policy for the Territory with an emphasis on the impact on Aboriginal health.

**Outcomes** - A series of Food Project reports and updates have been produced during the project. A draft Policy document has been released for community consultation and comment. Background and issues papers are being edited for publication. An implementation plan is being prepared to build on successful community driven projects in remote areas and the action identified through Aboriginal consultations.

- *Multi Purpose Service (MPS) Belyuen - The First Aboriginal Multi Purpose Service in Australia*

MPS involves the pooling of both Northern Territory and Commonwealth funds that are cashed out and provided directly to a rural community under a single service agreement. This allows a community to reconfigure its services to better meet its health needs and use staff more flexibly across a range of health services.

**Outcomes -** A hostel for frail, aged and disabled people on the community. A community-based Coordinator for all the different health programs has been appointed to bring these services under a single administration. A community health plan that meets current and future needs of the community is being developed. A

greater community awareness and focus on health development. A single service agreement with Commonwealth and Territory Health Services is being developed.

The Public Accounts Committee visited Belyuen on 7 March, 1996. At that meeting the Belyuen Community Government Council President indicated that he was not satisfied with the agreement.

- *Aboriginal Living With Alcohol Program*

Minimising alcohol related harm socially and economically throughout the Territory to at least the same level as other Australian States by the year 2000.

**Outcomes** - Following the invitation from the community of Borroloola in May 1994, implementation of the Aboriginal Living With Alcohol Program began in that community. Stage one is now completed in Borroloola and Oenpelli. Negotiations are continuing regarding stage two. Other communities currently in stage one are Elliott and Lajamanu. Communities throughout the Territory have been visited to create an awareness of the program.

In a submission to the Public Accounts Committee, Mr P. Malavisi, Clinical Nurse Consultant, Watiyawanu Mt. Liebig, claimed that although the service has improved he is seeing a deterioration of people's health on the community. Grog problems are on the rise and there is an increasing problem with children who are not thriving.

Hemmerling (1995) claimed a gap in services in the Alice Springs region following the closure of the Central Australian Aboriginal Alcohol Prevention Unit which provided an alcohol treatment program. The submission claims that long term alcohol abusers have to shop around for assistance and that there are many overlaps with young people's services between the Commonwealth and Territory Departments.

In a submission to the Public Accounts Committee, Mrs C. Frost, President of the Drug and Alcohol Association, Alice Springs, provided information about the Sobering-Up Shelter and the Remote Area Aboriginal Alcohol Strategy.

- <u>Sobering-Up Shelter</u>

  This service provides an alternative to the police cells for people intoxicated in a public place.

  Admissions to the shelter increased from 4,577 in 1992/93 to 6,115 in 1993/94 of which 98% are Aboriginal clients. Tangentyere Night Patrol referred over 900 clients in this period which is an increase of 400% in one year.

  30% of admissions are women.

People in the Shelter are provided with a shower, a meal, clean clothes and a health check. Many of the clients have usual addresses in communities outside Alice Springs.

– Remote Area Aboriginal Alcohol Strategy

This program provides funds to initiate and support projects or proposals in remote communities of the Alice Springs and Barkly Districts. Over the past three years about twenty community projects have been funded to help communities to solve their problems.

The submission claims that the Remote Area Aboriginal Alcohol Strategy model might go some way towards indicating a way ahead. Night Patrols and other community action is supported.

Mr John Spink, Manager, Drug and Alcohol Services Association Alice Springs Inc., gave a breakdown to the Public Accounts Committee on 13 September 1996 of "Apprehensions without Arrest" to the Alice Springs Sobering-up Shelter and the Alice Springs police cells for the period 1995/96.

The Sobering-up Shelter admissions are broken down as follows:

| | | |
|---|---|---|
| **Total Admissions** | **5943** | |
| Male Aboriginal | 3608 | 60.71% |
| Female Aboriginal | 2282 | 38.40% |
| Male European | 52 | 0.87% |
| Female European | 1 | 0.02% |

The report identifies where people come from and shows most communities that are recording high alcohol problems.

Mr B. Marsh, Acting Deputy Secretary, Territory Health Services, in his letter dated 23 October 1996 advised the following outcomes from the Living with Alcohol Program:

- a 6.7% reduction in the amount of alcohol sold*
- a 17% reduction in per capita consumption of pure alcohol+
- an increase in light beer sales from less than one percent of the beer market to 28%
- a 28% reduction in the number of alcohol-related road fatalities and a 28% reduction in the number of alcohol-relation road accidents overall.
- a 35% decrease in the number of persons arrested for being in excess of the legal alcohol limit for driving

* Alcohol = all alcoholic drinks

+ Pure alcohol = alcohol content in drinks

- reductions in the number of males drinking at harmful and hazardous levels and in the contribution of alcohol to deaths examined by the coroner
- changing community attitudes, as evidenced by developments such as the restrictions adopted in Tennant Creek, the emergence of the People's Alcohol Action Group in Alice Springs and increasing local action in Aboriginal Communities (eg rationing at Umbakumba, Youth Council at Elliot [sic]).
- Provision of courses for the responsible serving of alcohol and introduction of a Code of Practice for licensed premises.
- Establishment of drink driver education.
- Licensing of security staff and strengthening of the Liquor Act.

Expenditure Figures are listed below:-

- 93/94 $9.785M
- 94/95 $10.990M
- 95/96 $12.397M (includes wine-cask levy payments and the establishing of the Tobacco Action Project).

The Committee notes that alcohol abuse is still a major cause for concern in most of the Aboriginal communities that were visited as well as the NT population**.**

- *Aboriginal Health Worker Program*

Based on the objective of maximising community participation in the development and integrated delivery of primary health care in a culturally appropriate manner.

**Outcomes** - Aboriginal Health Workers are now an integral part of the delivery of primary health care in the NT. The program has been commended as an ideal model in several reports including the Royal Commission into Aboriginal Deaths in Custody Report, the National Aboriginal Health Strategy, and has been translated interstate. The Australian Health Minister's Advisory Committee recommended that other States follow the example of the NT.

Attraction, training and retention of Aboriginal Health Workers is still a major issue.

- *Aboriginal Cultural Awareness Program*

The program is aimed at ensuring all NT health staff receive Aboriginal cultural awareness training. The objective of the training is to assist in better understanding of the cultural issues impacting on health service delivery. Ultimately, the aim is to provide more culturally sensitive services, resulting in better health outcomes for Aboriginal clients, reduced inter-cultural stress and improved staff retention.

**Outcomes** - A pilot program has commenced in Central Australia. One-day orientation programs have run on a monthly basis for several months. Anecdotal evidence suggests that this program has proved successful and will be made more widely available.

- *Darwin Rural Aboriginal Mental Health Program*

The program is based on the objective of maximising community participation in the development and delivery of mental health and mental illness in a culturally appropriate manner.

**Outcomes -** Whilst this is an area that is still being developed, reductions in both alcohol consumption and medical emergency evacuations resulting from violence, improved community and family relations resulting in decreased family fighting and improved community facilities (eg. school programs, sport and recreation, positive health promotion) have been demonstrated. Most significantly, Aboriginal Mental Health Workers have made a significant contribution to the development of support and caring systems that existed previously in Aboriginal communities. These elements are provided in culturally and responsive ways to facilitate the capacity of Aboriginal people in remote communities to manage episodes of psychiatric illness and disability.

- *Aboriginal and Torres Strait Islander Employment*

The objectives of the strategy are to increase the number of Aboriginal and Torres Strait Islander people employed in all occupational streams and at all levels in Territory Health Services to improve the retention rate of Aboriginal and Torres Strait Islander employees and to facilitate an increased and effective involvement and participation of Aboriginal and Torres Strait Islander staff in the delivery of health services.

**Outcomes -** An Aboriginal and Torres Strait Islander Employment Strategy discussion paper prepared for dissemination throughout Territory Health Services to inform all employees of issues in Aboriginal employment and to seek comment and solutions to the issues.

- *Disease Control Immunisation*

To control the spread of disease and to implement an effective immunisation program.

**Outcomes** - Rates for new cases of TB in Aboriginal people have fallen from 114 per 100,000 in 1989 to 33 per 100,000 in 1994. There was a dramatic drop in the incidence of invasive HIB disease in children aged less than five years of age in the NT in 1993. Studies have shown that remote-area communities have excellent compliance rates in their under two population for receiving the recommended childhood vaccinations.

This is a good example of a program resulting in a successful health outcome.

- *Aboriginal Environmental Health Worker Program*

The program embraces the concepts of primary health care and promotes the active involvement of all community members in the planning and development of an appropriate community infrastructure and the recognition and solution of

environmental issues which impact on the health of individuals and families. With the full participation and direction of the Community Government Council, the Aboriginal Environmental Health Worker assists the community to recognise, achieve and maintain desired environmental health standards and services for that community and nearby outstations.

**Outcomes -** Other communities have recognised the need to address environmental health issues by the appointment of community-based Environmental Health Workers.

In a submission to the Public Accounts Committee, Mr M. Owen, Executive Officer, Miwatj Health Aboriginal Corporation Inc., Nhulunbuy, submitted that gaps in services could be linked to the claim that education is the single greatest issue in the ability of Aboriginal clients to become pro-active in their own health.

- *5 Year Replacement Program for Remote Area Health Clinics*

To build new health clinics in some communities and upgrade facilities in others. To bring all remote area health clinics up to an acceptable standard. To make community health clinics more culturally appropriate.

**Outcomes -** Health clinics were constructed on seven remote communities in 1993/94. A further five clinics were added to the capital works program in 1994/95 and six new clinics were programmed to be built in 1995/96.

- *Aboriginal Controlled Health Services*

To increase the participation of Aboriginal people in decision-making and operation of the health care system. To support Aboriginal input and Aboriginal responsibility for the design and delivery of health services by providing appropriate funding to those Aboriginal communities which are keen to take control of their health services. To provide opportunity for Aboriginal people to develop culturally appropriate services targeting community needs. To promote a primary health care model, which emphasises the importance of preventative health services and health promotion as well as providing services for local health needs and linking to secondary and tertiary health services through referral.

**Outcomes** - Fifteen communities are funded by the NT Government to run their own health services. Six communities are funded to manage aspects of services as negotiated and requested by them, and, there are ten Aboriginal health services that receive the majority of their funding from ATSIC but receive some grant funding for specific programs from the NT Government. An additional $1.4m has been allocated in the 1995/96 budget to enhance primary health care services on the NT Government funded health services. Funds will be used to increase the salaries of employees in line with existing government staff and to upgrade equipment and facilities. Two community councils (Wugalarr and Nyrripi) received full funding grants to control all aspects of their clinic construction. Local Aboriginal Health Councils have been formed at Ntaria and Wugalarr. Community representatives and local Aboriginal

Health Workers are on all interview panels for Territory Health Services staff residing on communities.

- *Primary Health Care - Rural*

  To provide appropriate and comprehensive primary health care services to remote Aboriginal communities which include clinical and preventative care and referral to secondary and tertiary care.

  **Outcomes** - 62 Territory Health Services health clinics on communities outside the 5 main urban towns. 142 AHW positions, 87 registered nurses, 8 Aboriginal environmental health workers, 2 Aboriginal nutrition workers and 1 community welfare worker are based in remote areas.

- *Aboriginal Health Promotion*

Promote the health of individuals and communities by processes that enable people to exercise control over and improve the quality of their own health.

**Outcomes** - An accredited training program called 'Health Promotion Principles and Practice' for primary health care providers developed and established. Health Promotion training workshop for Aboriginal Health Workers developed and established. Over 300 primary health care workers have participated in health promotion training programs and many of these have gone on to develop and implement new strategies to promote health within the community. Strong health promotion programs continue to be developed to address alcohol, nutrition, smoking, maternal and child health and communicable disease. Numerous community-based strategies have been established to address nutrition, alcohol and environmental issues. An emphasis has been placed on the development of culturally and community appropriate strategies to ensure local needs are not glossed over in an attempt to reach the bulk of the population. A specific training program has been developed for Aboriginal people working in health promotion which has potential application throughout Australia.

The Committee notes that there is a lack of evidence at the community level to demonstrate change due to health promotion training.

**RECOMMENDATION 10.**

**It is recommended that the success of training programs be measured in terms of improvement to health rather than numbers of staff who attended training courses.**

## 2.9 Commonwealth Department of Health and Family Services

The 1995/96 budget facts sheet for Aboriginal and Torres Strait Islander Health reported on the transfer of responsibility for primary health care of indigenous people to the Department of Health and Family Services portfolio from 1 July 1995.

This move will enable Aboriginal and Torres Strait Islander health care to strengthen its position within the wider health system. It will build on the achievements of community-run Aboriginal and Torres Strait Islander health services, and they will continue to be the main model for Commonwealth funded primary health care services.

Aboriginal and Torres Strait Islander Commission (1995, App. G) Operational Plan 1994/95 sets the framework for provision of services to Aboriginal communities, the objective under the Health Policy Section.

The Territory Health Services correspondence to the Public Accounts Committee of 19 April 1995 reads:

> The Commonwealth Department of Human Services and Health currently provide two programs to Aboriginal communities. The Commonwealth Rehabilitation Services (CRS) provides their New Start Program and Program Provision in remote areas and currently have Aboriginal clients in the northern and southern areas as well as the cross-border area. CRS coordinates and consults regularly with the Department's Aged and Disability Services and rural staff. The Commonwealth Hearing Service has recently begun providing a service to Aboriginal communities (Health and Family Services).

Department of Human Services and Health (1995) referred to Aboriginal and Torres Strait Islander program. Under the National Indigenous Hearing Program - Primary Health Model, the Office of Aboriginal and Torres Strait Health Services proposes a national approach in consultation with all stakeholders. Increased effort in prevention and early intervention in the treatment of otitis media for infant Aboriginal children was recognised as a priority. The paper proposes a national strategy incorporating an agreed framework of defined roles and responsibilities for each level of government following consultation with the responsible service-providers, government authorities, Australian Hearing Services and Aboriginal community-controlled organisations.

The Commonwealth paper also refers to mental health initiatives for Aboriginal and Torres Strait Islander community-controlled health services. The paper recognised the need to consult with community-controlled Aboriginal organisations and main stream providers.

Bilateral Agreements were foreshadowed and responsibility for treatment and rehabilitation services for Aboriginal people with mental illness was recognised as belonging to State and Territory governments. Office of Aboriginal and Torres Strait Islander Health Service (OATSIHS) is to administer and promote the development of primary health care services in Aboriginal and Torres Strait Islander communities. The need for cultural awareness is acknowledged in the Department of Human Services and Health (1995, p. 20) report on page 20:

> Community-controlled health services and substance abuse prevention projects have identified the need for culturally informed approaches to promoting mental health in indigenous communities. Strategies aimed at preventing the development of mental health problems in communities are also needed.

The new funds allocated to OATSIHS for mental health initiatives will be targeted to improve and support the capacity of community-controlled service organisations to provide effective and culturally appropriate health education and early intervention services within their local communities.

### 2.9.1 Rural Incentives Program

There are particular problems for the Territory in attracting General Practitioners to the bush and the purpose of this program is to provide incentives to encourage General Practitioners to remote communities.

The Rural Incentives program provides Commonwealth funding to assist General Practitioners to relocate to grant funded rural communities. The grants include relocation grants of $20,000 or $30,000 for couples where both intend to practice. The grant is not taxable and covers the one-off costs associated with relocation, such as moving expenses and new equipment. Training grants of up to $78,000 are available, both for General Practitioners wishing to relocate and those already practising in rural and remote areas. Grants of $50,000 per year are available to support doctors practising in identified remote communities.

The Rural Incentives Program, Centre for General Practice in Darwin, advised on 12 September 1995 that seventeen grants (Commonwealth funded) were made available for the Territory. Five of the nine grants for the Top End have been taken up and the remainder have been identified for allocation. Three grants in Central Australia have been allocated to Commonwealth funded communities. Two other communities in Central Australia have been identified as possibilities for the Rural Incentive Program. This program encourages and supports the employment of General Practitioners in remote communities.

There is some concern that the restriction in Medicare provider numbers announced in the 1996 Federal Budget could adversely affect recruitment of doctors to communities because of the reduced number of new graduates and overseas recruits. It is estimated that 400 medical graduates will not be able to practice medicine. The allocation of provider numbers could be tied to location to attract services where they are most needed.

**RECOMMENDATION 11.**

**The Committee recommends that the Commonwealth should introduce additional incentives to ensure that doctors are recruited to Aboriginal communities.**

### 2.9.2 Primary Health Care & Aboriginal Community Controlled Organisations

There are 15 communities funded by the NT Government to run their own health services and 10 Aboriginal Health Services that receive the majority of their funding from the Commonwealth. A submission from Congress in 1995 reflects the emphasis on primary health care.

Congress provides services which include a Community health program: a clinic and twenty-four hour medical emergency service; programs in Aboriginal Health Worker education; health promotion; HIV/AIDS education and nutrition; dental; family support and community transport services; the Alukura women's health centre; and housing information and referral service.

In a submission to the Public Accounts Committee, Congress emphasised the importance of primary health care. Congress argued that a holistic definition of health similar to that adopted by the National Aboriginal Health Strategy and the World Health Organisation is essential if the health problems suffered by their people are to be effectively tackled.

In line with the National Aboriginal Health Strategy, the World Health Organisation, and the Royal Commission into Aboriginal Deaths in Custody, Congress is committed to the view that primary health care is the most appropriate and effective way of delivering health services to their people.

It is through primary health care informed by a definition of health that includes their people's right to self-determination that any major advances in improving health is to be made.

Community controlled health organisations receive funding directly from the Commonwealth government and they provide culturally aligned health services controlled by Aboriginal people with an emphasis on primary health care.

## 2.10 An Alternative Aboriginal Health Care framework/model

A new model for delivering health and community services to remote Aboriginal communities in the Darwin Rural District was the challenge project of the Executive Management Program, undertaken by Mr Vic Feldman in 1993. Feldman is a former senior manager with Territory Health Services and at the time of the project was employed as District Manager Darwin Rural. Feldman (1993, p.1-3) reported that:

> An examination of the organisation structure of each of the five rural districts indicates that staff, and the provision of services are, in the main, provided by clearly defined professional streams. This structure, in its various forms, has been around for a long time and is similar to most bureaucracies seen throughout the Territory. It has, however, resulted in Territory Health Services delivering services and programs to remote Aboriginal communities on mainly professional lines and with minimal input from the communities involved.
>
> ... Approximately 50% of HACS total budget goes towards the provision of services to Aboriginal people. Yet even with such expenditure, the standard of Aboriginal health has not significantly improved over the last ten years and is below that of the wider population.

Devanesen (1993, p.5) states:

> HACS has led the way in training and employing Aboriginal Health Workers to deliver, sometimes in partnership with doctors and nurses, health services on Aboriginal communities. However, the participation of Aboriginal people in determining priorities, methods of service

delivery, types of programs to be delivered etc has been minimal. We have continued to provide health and community services based on the assumption that 'western services can be delivered cross-culturally with similar outcomes as in the dominant non-Aboriginal culture'.

Feldman (1993, p.7) proposed a new model of delivering health services that would:

- increase the level of Aboriginal participation and involvement;
- incorporate a multi-disciplinary approach to the delivery of services;
- highlight primary health care; and
- emphasise health promotion and prevention.

On 28 May 1993 following workshops with representation from all remote Aboriginal communities throughout the Darwin Rural District a new definition for Aboriginal Health Care was endorsed:

> **Aboriginal Community Health Care** is the negotiated development of a culturally acceptable health care system which empowers a community to have control of their own health services. In particular, the community must have major responsibility for:
>
> - planning (deciding on the types of programs, funding and priorities)
> - implementing (delivering the program)
> - monitoring (ensuring the programs are being carried out in accordance with the priorities)
> - evaluating (ensuring the programs are meeting the needs of the community).
>
> It must:
>
> - be negotiated in a way that meets the needs of the Aboriginal people.
> - acknowledge the broad social factors that impact on health.
> - be easily accessible (p. 11).

The key features of the service delivery model are :

- The services to be provided by and to a community are determined by the community in consultation with district staff. This culminates in the signing by the Community Council Chairman and the District Manager of a *Service Agreement*.

- The development of the Service Agreement is the most significant part of the model. It is through this process that real Aboriginal participation is achieved, health teams are identified in order to evaluate success.

- Aboriginal Community Health Committees/Councils are established on each community to be responsible for monitoring and implementing the Service Agreement and determining community health needs.

- Departmental Community Health Teams, consisting of District staff, are established to provide coordinated services to communities in accordance with the approved Service Agreement.

Program Managers are identified and made responsible for the co-ordination and monitoring of program achievement, and the provision of advice to service deliverers.

Feldman (1995) advised the following which begs the real meaning of community control:

> Negotiation with Aboriginal people must be on their terms and at their pace. It is easy to make decisions on their behalf (as we have previously done in the past), but unlikely to achieve any long term benefits. On the other hand it is both frustrating and difficult to allow them to make the decisions, but likely to be far more effective and lasting.

The model submitted by Feldman (1995, pp. 22-23) proposed that the establishment of Departmental community health teams will facilitate the handing over of responsibility to the communities. These teams would provide or co-ordinate services to a particular community. Their major responsibilities would be to:

- provide information to allow communities to make informed decisions;
- encourage and assist with the development of Aboriginal Community Councils;
- assist Aboriginal Community Councils with the development of Service Agreements;
- provide training and development opportunities for community and district based staff;
- monitor the achievement of Service Agreement outcomes and provide advice and assistance as appropriate; and
- provide district services and resources needed to deliver both essential (medical, aeromedical, etc) and preventative/support (health promotion, nutrition, etc) programs.

The Darwin Rural Aboriginal Health Board would meet twice a year to provide advice and input into the budget process and to review performance and evaluate the effectiveness of current policies, procedures etc. Financial support would be provided by the District for this purpose. The Board would make recommendations direct to the District Manager.

In conclusion, Feldman (1995, pp. 27-28) noted the expected long term benefits that are likely to accrue if the model is successfully implemented:

> <u>Aboriginal Communities/People</u>
>
> - Continued provision of essential health care.
> - Increased emphasis on health promotion and prevention.
> - Increased Aboriginal community participation and involvement.
> - Services delivered in accordance with community priorities.
> - Services delivered in a culturally appropriate manner.
> - Improved equity in the distribution of resources.
> - Community empowered to ultimately take care of many of their own problems.
> - Overall reduction in the morbidity rate of Aboriginal people.
>
> <u>Department</u>
>
> - Reduction in the cost of providing acute care.
> - Incorporation of an interdisciplinary approach to the delivery of services.

- Development of a model of delivering services that can be utilised across the Department.
- Improvement in Aboriginal health and well-being.
- Better balance of acute and preventative care.
- Improved client focus.
- Increased community participation and partnership.

Verbal advice from Feldman indicated that the above model would be progressively adopted in the Darwin Rural District.

## 2.11 Community Control

The Committee consider that the extent to which services will be determined by the community strikes at the crux of the term 'community control'.

Woenne-Green (1995) was a project funded and supported by the Aged and Community Care Division of the Commonwealth Department of Health and Family Services to identify and address aged care for Aboriginal people.

The Women's Council resolved to conduct its own research to enable its members to know exactly what were the circumstances of senior men and women living in their member communities and homelands: what were their needs, what were the needs of their carers, what services were available in their communities; and how could appropriate support services be defined, developed and maintained within their communities so as to support the rights of *tjilpi pampa tjuta* (old men, old women) to be cared for and die where and how they choose.

Fieldwork for this project involved speaking with approximately 400 Anangu from 15 communities in situations which ranged from small discussions and 'focus group meetings' to larger community meetings and more formally constructed interviews.

The record of interviews mirrored the deeply spiritual desire to spend their final days on their own community.

Woenne-Green (1995, p. 87) makes the following recommendation:

> That as a matter of priority senior residents from NPY Women's Council member communities in the cross-border region, currently residing in hostels and nursing homes in Alice Springs, Port Augusta and Kalgoorlie, should be repatriated to the Lands at the earliest possibility.

Other recommendations in the report refer to the services and facilities required. The need to adapt services to more appropriately integrate with the values and lives of the Aboriginal people is clear. There may be examples where Aboriginal people may wish to exercise choice which non-Aboriginal health providers may not support. Further research into the appropriateness of current health models for Aboriginal people is recommended. Questions regarding the extent to which communities may exercise control over their own health services where the communities cultural values conflict with the expectations of the providers must be debated openly. Further research should be undertaken by those who do not have a stake in the current medical model. The North Australian Research Unit, Darwin, could be requested to undertake this research.

**RECOMMENDATION 12.**

**That further research into the health models of delivery preferred by Aboriginal people be undertaken by an appropriate research unit such as the North Australian Research Unit. (The Committee prefers that this research is conducted under the auspices of the Task Force - see Recommendations 5 & 6.)**

## 2.12 Involvement in Health Services for Indigenous Peoples of Canada and New Zealand - Introduction

Canada and New Zealand have implemented health models which have achieved some positive results for the health of their indigenous people.

The key points are:

- community control
- assistance for communities to take on health responsibility
- phased transfer of health responsibility from central health services to community organisations
- evaluation and audit of health programs
- purchaser/provider model (New Zealand)

The points are explained in further detail using the research paper of Dr Scrimgeour.

Scrimgeour (1995) in his paper on community involvement in health services for indigenous people researched information which is relevant to Australian Aboriginal people.

### 2.12.1 Canada

Scrimgeour (1995, pp. 7-10) referred to the Canadian Indian Health Program Transfer Policy.

> In 1986 Health and Welfare Canada's Medical Services Branch (MSB) announced a new policy initiative, called the Indian Health Program Transfer Policy. The stated objectives of the policy are:
>
> – to enable Indian Communities to design health programs, establish services and allocate funds according to community health priorities;
> – to strengthen and enhance the accountability of Chiefs and Councils to community members;
> – to ensure public health and safety is maintained through adherence to mandatory programs[4].
>
> The policy is designed to enable First Nation communities to assume control of some or all of certain services which had previously been provided by MSB. This includes Community health services (nursing, CHR's, health education, nutrition, mental health); environmental health services; prevention and counselling programs related to alcohol and drug abuse; and the services of some medical professionals. Non-insured Health

Benefits are not available for transfer. Medical and hospital services, covered by the universal insurance system, continue to be provided by the province.

Indian Bands which wish to take advantage of this policy and gain more control of their health service, must follow a clearly defined process, outlined in the Health Program Transfer Handbook published by the MSB.

[4] Medical Services Branch, Health Program Transfer Handbook, Health and Welfare Canada, Ottawa, 1989

The transfer process has three stages: a pre-transfer planning phase of up to two years, a negotiation phase of up to six months, and an implementation phase.

In the pre-Transfer planning phase a Health Board is established (with training if necessary), a health needs assessment can be performed, and a community health plan is developed. The MSB provides financial resources for these activities to be carried out; independent consultants can be employed by the community to assist with this process if required.

The community health plan must include certain mandatory programs, but can also include other programs to be initiated and developed by the community. The mandatory programs are:

1. communicable disease control (immunisation, notification and other control measures).
2. environmental/occupational health and safety.
3. treatment services.
4. emergency response plan.

During the negotiation phase the community health board negotiates with MSB for resources to implement the community health plan. Once this negotiation is complete, a transfer agreement for up to five years is signed. The agreement must include a requirement for an annual financial and performance audit. As well as this, the communities are expected to be involved in a short-term and a long-term evaluation of the transfer policy process, and to conduct an effectiveness evaluation of community health programs every five years.

... The MSB guidelines for the Health Transfer Policy state that the transfer will not involve any enrichment of services i.e that only those services currently being supplied are available for negotiation in the transfer process. As many health services are inadequately resourced, this means that the Bands may not get an opportunity to correct the service deficits or to deal with some issues identified in the community health plan. This results in the perception that MSB is only providing Bands with the opportunity to "administer their own misery"[8].

Despite the guidelines, some Bands have been able to negotiate with MSB to obtain resources well beyond previous levels ... This raises the possibility that some better organised or politically powerful Bands may be able to put sufficient pressure on MSB to obtain more funding, whereas other less organised Bands may follow the guidelines and continue to operate with inadequate resources.

[8] Assembly of First Nations, Special Report: The National Indian Health Transfer Conference, Ottawa, March 1988

### 2.12.2 New Zealand

Scrimgeour (1995, pp. 33-45) also referred to the New Zealand indigenous people.

> Until recently, New Zealand has had a tradition of Government spending on health care in an attempt to ensure universal access for all citizens, on the understanding that access to health care should be based on need rather than ability to pay[33]. Free hospital care was introduced in 1938, followed by the introduction of universal subsidies for general practice and other medical services.
>
> However by the early 1980s there was pressure for changes in health policy. Health spending had increased, but access to primary care had been restricted by the use of part-user charges for general practitioner services. This in turn put increased pressure on the public hospitals, which were also burdened by cumbersome management practices and increasing waiting lists.
>
> The Labor Government introduced the Area Health Boards Act in 1983, which decentralised health care decision-making to fourteen elected Area Health Boards, with resources allocated according to a population-based funding formula. However, problems with the health service continued through the 1980s, with long waiting lists, inefficient management, and poor morale amongst health care workers.
>
> Sweeping health reforms were announced by the Minister of Health of the new National Government in July 1991, which were considered to be consistent with the general movement in New Zealand public policy since 1984 towards free-market economics and a reduced role for the State[34]. The main thrust of the reforms was to separate the roles of the purchaser of health services from the providers of the services. Four regional purchasing bodies (the Regional Health Authorities) were established, with the responsibility for purchasing personal health services (including primary and secondary care) from a mixture of private and public interests (the providers). Health protection, health promotion and disease control were to be the responsibility of the Public Health Commission (PHC), established as a separate purchasing authority to ensure that public health funding would not be encroached upon by treatment services. A Core Services Committee was charged with determining the range of services which should be Government-funded, at least in part.
>
> ... In 1993 the New Zealand Government released Whaia te ora mo te iwi, containing Maori policy objectives. This document outlined the need:
>
> - to recognise Maori aspirations and structure such as those based around whanau (extended family), hapu (sub-tribe) and iwi (tribe), and the desire of Maori to take responsibility for their own health care;
> - to purchase health services and to encourage initiatives which promote positive health for Maori;

[33] Blank R., New Zealand Health Policy: A comparative study Oxford University Press, Auckland, 1994

[34] Ashton T. 'Reform of the health services: Weighing up the costs and benefits' in J. Boston and P. Dalziel (eds), The Decent Society? Essays in response to the National's economic and social policies, Oxford University Press, Auckland, 1992.

– to encourage the greater participation of Maori in order to develop health solutions which are effective, affordable, accessible and culturally appropriate.

The 1994/95 Policy Guidelines to Regional Health Authorities emphasises that Maori health status is a Government priority. The guidelines state that RHAs should actively seek to:

> contract with appropriate Maori providers, as well as using Maori organisations to deliver health services to Maori, this will involve initiatives to assist the development of Maori service providers, and ensuring Maori organisations are able, and have the opportunity, to contract to provide services.

Some of the concerns expressed by Maori included the recognition that their health status was linked to housing, employment, education and income which were not addressed by the reforms.

> ... in some areas partnerships are being formed between Maori organisations and health authorities, creating joint ventures in which both parties work towards common goals.

> ... The rationale for the separation of the purchaser and provider roles in New Zealand was presumably to establish a competitive, quasi-market approach to health service delivery. The fact that the RHA 'purchases' services and outcomes from the providers, on behalf of the community, allows the RHA to ensure that certain services are being provided and that Government objectives are being met. There is a philosophical difficulty with this concept when the provider is a community-controlled organisation: the RHA, as the purchaser, determines what services are to be provided. A community-controlled organisation could well argue that it is better equipped than the RHA to determine what services are required. The RHAs in New Zealand appear to have addressed this difficulty to some extent by the development of joint ventures and co-purchasing arrangements with Maori organisations, which gives the organisation an opportunity to determine the extent and type of services which are needed.

### 2.12.3 Conclusion

The Canadian experience is of relevance to the NT particularly in regard to the need for assistance for communities to undertake their own health services.

The New Zealand purchaser/provider model gives communities an opportunity, in conjunction with Regional Health Boards, to decide the extent and type of services required within the resources available.

## 2.13 Council of Australian Government (COAG) - The Three Streams

The meeting of COAG in April 1995, launched reforms to Australia's health and community services.

The purpose of the reform is to provide services which meet people's needs better and which contain in-built incentives for the most effective use of funds.

Marcus (1995, p.1) sets out:

> Australia's health and community services have significant strengths, including Medicare, which is the linchpin of the health system.
>
> However, there are a number of impediments which have affected the capacity of services to keep pace with changes in people's expectations and in the care environment:
>
> - Policy has focussed on service providers and institutions rather than on meeting people's needs.
> - People are not necessarily able to choose the services best suited to their needs due to lack of information on or access to alternative services.
> - There are many highly developed services which are poorly integrated and not linked well to one another. (There are over 60 discrete government programs, each with its own boundaries.)
>
> These impediments have produced a system which is often unfriendly and complex for the people who use it and inefficient for the governments which fund it. There is a need for systematic reform to the way health and community services are organised and funded to ensure both improved health gain and cost effectiveness for all governments.

The Committee notes that in the light of the above statement which refers to an unfriendly and complex system for Australians in general, it follows that this system must be even more unwieldy for people from different cultures.

Marcus (1995, p. 4) outlined the objectives of the reform (COAG, 1995):

> Meet people's needs better, by:
>
> - promoting more choice in the range of services and how they are delivered;
> - providing better information to assist people access and identify appropriate services;
> - promoting continuity of care, including better coordination and packaging of services; and
> - delivers services efficiently and contains costs, by:
>
>  – Promoting planning by governments focussed on outcomes and investment in prevention and early intervention.
>  – Planning and managing services as close as possible to the service delivery level.
>  – Providing incentives for best practice and substitution of more appropriate services which minimise gaps and get best value for money.

Marcus also made reference to the need for coordination of health and community services in the Appendix of his report. Reform should concentrate in the first instance on effective coordination at the interface between health and community services, which is often the most problematic for people under current arrangements.

- Services at this interface include: Medical (including hospital and post-acute care); allied health; pharmaceuticals; residential care for older people and people with disability; community support; and mental health.

- Other services would be examined progressively with a view to ensuring there are appropriate linkages with related services.

The framework which will be trialed is:

1) **General Care**
For care needs which are best managed by people themselves. It could also include health promotion and preventive care.

2) **Acute Care**
For care needs which are identified by a 'professional' and met by an 'episode' of treatment, often in a hospital setting and often involving three phases: preparation, delivery of a procedure and recovery.

3) **Coordinated Care:**
For care needs which are best met by a mix of services over an extended period and are difficult to meet through self-management.

The Health and Community Services Ministers Council would oversee the work on the Action Plan and provide a progress report to Heads of Government by September 1995, with a full report to be available for consideration at the first COAG meeting in 1996.

The proposed new framework for health services is aimed at introducing flexibility across programs and services. There is concern that the three stream model does not sufficiently recognise the importance of preventative strategies and health promotion.

There are no specific discussions of Aboriginal health in the COAG items. The NT has two coordinated care trial proposals very close to approval to proceed to the development stage with Tiwi Island and Katherine Rural Area.

Both trials will be involved in cashing out of MBS/PBS at approximately Australian per capita average expenditure and these funds will be pooled with current NT funds. Aboriginal Health Boards have been established in each area. These will be fund holders and will purchase health services from Territory Health Services and other providers, including Aboriginal Health Services. The trials involve the development of best practice treatment protocols and the recruitment and training of 'care coordinators'.

The Committee notes with interest this new initiative where Health Boards purchase health services from various providers.

## 2.14 Comparisons of Existing Models and Related Services within the Northern Territory

As advised above, the existing models of service delivery follow primary health care. Within Territory Health Services the extent of community involvement varies. A community that is managed by a community council does not automatically mean that primary health care is supported in practice even though it has been included in planning documents and workshops.

The written submissions to the Public Accounts Committee under this term of reference indicate that half identify gaps in the service due to a lack of resources. Three specifically are concerned with a claimed lack of services to outstations. The general message is that the

communities are hard pressed to follow the model of primary health care when they are pre-occupied with the day-to-day illnesses.

A visit by the Public Accounts Committee to Wadeye (Port Keats, 1995) contrasted the readiness of that community to enter a service agreement with the model of service delivery, proposed for the Darwin Rural District by Mr Vic Feldman, former District Manager, from Territory Health Services.

The Feldman model referred to a participative workshop, with representation from all remote Aboriginal communities throughout the Darwin Rural District which endorsed a new definition for Aboriginal Health Care. The key elements of the definition were *culturally acceptable; control of their own health services; major responsibility for planning, monitoring, evaluating and agreements negotiated in a way that meets the needs of Aboriginal people acknowledging broad social factors.*

The visits to Wadeye and other Aboriginal communities indicate that at the service delivery end there is a gap when compared to the proposed model. The response from the community council to one of the health questions was that a valid and satisfactory service agreement does not exist at this point in time. For one to be successfully negotiated will require the Council having access to independent, professional advice and extensive consultation with Territory Health Services.

This comment could be linked with the Canadian experience where independent consultants were provided to assist the process of transfer. As previously advised in Term of Reference (a) (p. 1), Scrimegour (1995), with the benefit of his overseas research, considered that communities need to be resourced to help themselves decide their own goals. Communities that accept community control require access to planning and management skills in order to meet the terms of the service agreements.

**RECOMMENDATION 13.**

**That the extent of any assistance/resourcing should be linked to the degree of readiness and level of skill available to the community in question. An evaluation of the skills (skill profile) in a community and the opportunity to access further skills to be a pre-requisite to the consideration of community control.**

Feldman (1994, p. 12) also made the following observation in his proposed model:

> trust is extremely important, yet this takes a long time to earn; and we need the capacity to approach issues from an Aboriginal perspective that recognises their traditions and culture.

Trust and a knowledge of Aboriginal culture is problematic during high turnover of ‘bush’ staff. Furthermore, staff need to be supported by appropriate cultural awareness programs to assist health service delivery. Advice indicates that the turnover level of nursing staff has been reduced in Alice Springs and improvements in recruitment practices and a one day cross-cultural program for all new staff has contributed to this reduction. However, the rate is still high and is estimated at 70%. A comprehensive Aboriginal Cultural Awareness Program was

provided in early 1996. This program will be managed by the new position of Project Manager supported by an assistant. Aboriginal people will be controlling the process which reflects the overall philosophy of the Aboriginal Cultural Awareness Program. It is clear that Territory Health Services recognises the value of cultural awareness to support primary health care.

Despite the availability of the computerised personnel information payroll system (PIPS) access to data about turnover of health professionals in rural communities has not been available. Such data is essential to monitor the extent of the success of initiatives to retain Aboriginal Health Workers and nursing staff.

**RECOMMENDATION 14.**

**That the Territory Health Services ensure that staff turnover statistics are analysed to monitor the effect of recruitment and cross cultural training strategies.**

According to advice from a senior health official the Commonwealth Department of Health and Family Services is seeking alternative models of health service delivery to achieve lasting primary health care.

Western Australia is operating the purchaser/provider split model for health services which was discussed under the New Zealand section of this report. Advice from a WA health officer referred to Waloona community. Previously most funds went to the hospitals and the desert communities did not have hospitals. The community-controlled services have received a fair amount of latitude to address their own health services. The Manager, Central Desert Health Services in WA consults with the communities to assist them with their contractual arrangements. He advised that Waloona community has 1000 people of which 900 are Aboriginals. Waloona previously was a nursing post with one or two nurses. He advised that the community now has an elected committee that understand and are committed to health. They have a doctor who has augmented the success and they acquired a second doctor. Both doctors have been recruited through the Commonwealth Rural Incentive Program.

Of particular note is the recruitment of a Project Officer, funded by the W.A. Health Department and controlled by the community. The project officer has previous experience in business in a cross-cultural setting with ***empathy and understanding*** for the people he assists. The WA Health Department has also contracted a firm of chartered accountants for 6 months to help the community establish and maintain the necessary financial records and checks and balances. Financial administration will be managed by the provider - Mercy Community Health. The infrastructure has been improved and the community is enthusiastic and vocal about their health.

Verbal advice from Feldman in his reference to a Darwin Aboriginal workshop stressed the ability of the facilitators who had the skills and knowledge to ***communicate effectively*** with the Aboriginal representatives. This comment is reinforced by the Case Study on AIDS Education by the Aboriginal Resource and Development Services Inc. in 1995. The study deals with the development and delivery of education about HIV and AIDS. Aboriginal Resource and Development Services Inc. advocate the necessity to ***understand the***

***contemporary world*** that can be conveyed using the right 'cultural keys', which open up the minds of the people.

Aboriginal Resource and Development Services Inc. (1995, pp. 2-5) give the following insight into Aboriginal Health Workers and communication difficulties:

> There are a number of reasons why basic health education is not working in traditional communities. One of the major reasons is because language is not used in the delivery of health education. To overcome this of course, policy makers have pushed the idea of Aboriginal health workers. This policy solves the problem to a degree but it fails to address the difficulties that these health workers now face in the communities they live in. Traditional people are very clan-centric in their thinking and in their social interaction, and so to educate or treat someone from another clan can be quite difficult. The other problem faced by many Aboriginal health workers is that they find it very difficult to go to members of the community they live in and talk about sensitive subjects. These are the words of one of these male health workers, 'when I go to treat someone who has syphilis, they just tell me to get out of the house, not to bring that stinkin' injection in here. They don't want to talk about it or anything, they just tell me to get out. They won't listen to anything. These are the same people who keep spreading syphilis to others all the time. What these people need is for someone to come from outside the community who can speak to the people in language, and who they will listen to'.
>
> ... The other thing that people say to the health worker is, 'if this is a real problem then why don't the Balanda doctors come and tell us about it'.

The above comments could be influenced by the lack of prestige and status in the current health model which has been given to Aboriginal Health Workers. According to submissions and other information received by the Committee, the non-clinical/environmental health role of the Aboriginal Health Worker is constrained by time spent in the clinic.

At the conclusion of the Aboriginal Health Conference in Darwin on 30 September 1995, Dr. Nugget Coombs advocated that change in health could be driven by the women of the community. Women's business includes food, exercise and learning. He proposed additional CDEP funds for Aboriginal people to resume family responsibility for Aboriginal health - women's business. Women should get the money for their responsibility.

Dr Coombs's suggestion is another possibility for health service delivery and would only succeed if it was embraced by the community.

## 2.15 Community Driven Services

The above information would indicate that the existing models of service delivery have a long way to go before there is community driven primary health care in remote communities within the Northern Territory.

The Public Accounts Committee meeting with Congress on 7 May 1996 indicated that Congress saw 26,000 clients last year (1995) and a third of those clients were from remote areas. There are 13 Aboriginal Health Workers in Congress and they are the first point of contact. It was emphasised that primary health care should be delivered by the Aboriginal Health Services and tertiary health left for Territory Health Services. This was proposed to avoid duplication of services and to ensure culturally appropriate primary health care services.

Congress claims that there are still major problems because when patients are discharged from hospital the records are not available for Congress.

Congress advocates a community development model with community control over their health service. Physical resources would be identified in each community for use by a health team.

The Public Accounts Committee's visit to Wallace Rockhole on 8 May 1996 was in contrast to other communities that were visited. There was a noticeable absence of litter and an apparent full community involvement in education and health. Wallace Rockhole has a population of 150 and is situated 110 kms west of Alice Springs. It is a dry community. The key to success in this community is *strong leadership and respect for their elders.* The community supports everyone and expects everyone to abide by their community rules. The community reported that there have only been two occasions in the last 13-14 years where the police have been called to the community. With one body in control it is easier to pursue self-determination and to have everything done within the community without outside workers. The health clinic is run by an Aboriginal Health Worker with good support from the council and twice weekly visits from a nurse. A doctor calls for one day each month and the health of the community is good. The school encourages good health. The school council is also the health council. Problems are with a few binge drinkers and there are difficulties with transport in getting patients home from hospital.

The positive signs are that the providers are becoming more proactive in seeking new ways to achieve effective health services.

Taking into account the different health models of delivery in rural communities and the overseas examples there are some common elements that are important for health delivery in Aboriginal communities.

**RECOMMENDATION 15.**

**That a service delivery model be trialed which embraces the following elements:**

- **co-operation of all stakeholders**
- **an objective analysis of health needs in the community**
- **appropriate financial/administrative support**
- **plans facilitated by people who are accepted and have an understanding of both world views**
- **use of option appraisal (community assessment of resources in relation to health needs) to prioritise resources**
- **adequate physical infrastructure necessary for environmental health requirements**
- **identification of staffing needs to ensure primary health care is implemented**
- **use of change agents to assist the community in achieving its goals**
- **the necessary information base to ensure reporting of changing health status**
- **appropriate evaluation process.**

## 2.16 Duplication of Services/Resources

A 1993 document titled: 'Joint Commonwealth/NT Funded Programs in Health and Community Services' by Department of Health and Community Services illustrated the problematic arrangements of cooperation for health services. The roles and responsibilities of the Commonwealth and State/Territory governments are confusing. Comments relate to problems arising from overlap and duplication of health and community services.

In relation to **Aged Care**, page 12 of the report reads:

> the current arrangements are characterised by duplication and overlap of responsibility, confused lines of accountability, potential for cost shifting, lack of continuity of care, structural rigidity's and poor co-ordination of services.

Examples included difficulty for clients in understanding where responsibility resides, overlapping of services and duplication of administrative arrangements.

**Home and Community Care (HACC) Program** has administrative arrangements which prescribe powers to be exercised by the Commonwealth and State or Territory jointly which brings with it, time consuming and costly duplication of administrative services.

**Child Care Program** was subject to joint funding arrangements but did not reduce duplication or assign clear roles to either level of government.

**Supported Accommodation Assistance Program (SAAP)** provides transitional support and crisis accommodation for people who are homeless or escaping domestic violence through the non-government sector.

**Aboriginal Health** has Commonwealth funds channelled to ATSIC Regional Councils without consultation with the NT as the primary funder and provider of health services. The need for bilateral agreements between the Commonwealth and the Territory were approved for discussion by the Chief Minister in July 1992.

## 2.17 Goal Setting Commonwealth/Northern Territory

There needs to be closer liaison between Commonwealth and NT health departments.

An NT Manager of the Department of Health and Family Services verbally advised on 7 September 1995, that there will be a systematic planning review by mid October to be completed by February 1996. This review was not completed in October 1996. This would be focussed on need. He advised that in the absence of joint funding arrangements it is very difficult to identify any duplicated funding.

The Council of Australian Government (COAG) met in Adelaide on 12 April, 1996 to discuss a range of issues including a redefinition of the roles of government within the Australian Federation. Cooperation and reduction of duplication was also discussed. The delegates of COAG, the Premiers and Chief Ministers of Australia, signed a Communique which reported that the Leaders agreed:

> ... duplication to be removed as a matter of urgency in service delivery ... that problems in the system caused by the current allocation of responsibility can ultimately only be resolved if one level of government has the capacity to coordinate services across the whole health and community services system (p. 2).

The leaders also agreed to seek agreement from the Commonwealth to fund all health special purpose payments as one payment or to have them included in the Financial Assistance Grants and to consider the pooling of funds.

Duplication will continue unless there is a bilateral agreement between the Commonwealth and the NT that ensures accountability for service delivery and removes the possibility of duplication.

**RECOMMENDATION 16.**

**That bilateral agreements between the Commonwealth and the NT for the provision of health services in the NT be endorsed as a high priority.**

In his submission to the Public Accounts Committee, Dr Paul Spillane, Director, Medical Services, East Arnhem District, referred to a political drive for Aboriginal control over their health services.

His submission claims that Territory Health Services and non-government services have functioned alongside one another with little co-operation and at times blatant competition for client bases. An example of overlap of services is where one community frequently had two District Medical Officers present at the same health clinic on the same day. The worsening health indicators and falling life expectancy of adults was quoted as a reflection of the impact of services. An example of a gap in health services is the failure to provide an adequate health service to Aboriginal communities around Nhulunbuy (eg. Ski Beach, East Woody Beach and Town Beach) and to the increasing number of Aboriginal people who choose to return and live in their traditional homelands.

The Committee considers that there needs to be a population focus rather than a provider focus with the provision of health services. However the current system encourages cost shifting between the Commonwealth and States/Territories and protection by the various health professionals of their domain. An example of an apparent loss of efficiency is in the Katherine Region.

The new Wurli-Wurlinjang health centre in Katherine cost $1.4m to build. The Northern Territory contributes to the funding with five Aboriginal Health Workers and one half of a medical officers salary. It serves 521 people from the five town camps. It employs three senior administrators paid at or above the level of the Territory Health Services Hospital/District Manager. The town also has a private medical service. Another service is provided by Binjari which is 15 kms from Katherine. Binjari provides services for 130-200 clients and has a part time nurse, an Aboriginal Health Worker and a visiting general practitioner who bulk bills patients. Binjari is funded through a service agreement with Territory Health Services. Advice

from a senior Territory Health Services manager indicates that duplication of services between the providers is a problem which in turn increases the administrative costs thereby reducing the resources for patient care. There is a rift between the ATSIC Regional Council and the Wurli-Wurlinjang health service and between Wurli-Wurlinjang and Binjari. This lack of cooperation among the Aboriginal organisations runs counter to a coordinated service and increases the overall costs.

Advice from Territory Health Services indicates that the Aboriginal Health Services in the regional centres provides an alternative service to General Practitioners rather than to Territory Health Services. Both Territory Health Services and Aboriginal Health Services provide some infant and maternal health services (eg. immunisations) and operate some STD services but there would be very little, if any, duplication.

Territory Health Services is working to improve communication between health service providers by improving information systems. Improvements in communication between hospitals and community services is being implemented, initially through automatic notification to a patient's general practitioner of admission to and discharge from hospital, and improved timeliness and completeness of discharge summaries to general practitioners and other community services.

The Committee notes the need for services to be coordinated to ensure the best use of the health dollar. Katherine is an example of a region where there is an opportunity to streamline services.

**RECOMMENDATION 17.**

**That the NT Minister for Health liaise with the Commonwealth Minister for Health to ensure that future services avoid duplication such as those that have occurred in Katherine.**

## 2.18 Gaps in Health Services

In a submission to the Public Accounts Committee, Mr J. Lawrence, Health Service Coordinator, Nganampa Health Council Inc., Alice Springs advised:

> Rocket Bore is some 55 km north of Amata, has a population that varies up to 80 people including many young children, and is a stones throw from the actual border between NT and SA. At present it has no health services, but receives a periodic visit from Amata Clinic staff. They have expressed the need for a resident nurse, resident Aboriginal health workers, a clinic, communication for emergencies, and a vehicle for emergencies. Within existing resource structures neither Nganampa Health or NT Health is able to help.

A submission to the Public Accounts Committee from J. Kennealy, Clinical Nurse Consultant in Peppimenarti, was approved by the President of the Peppimenarti Community Council. Peppimenarti has a population of 150 and is in the Darwin Rural area. The clinic throughput is approximately 500 per month and staffing levels consist of one full-time registered nurse, one part-time registered nurse and a trainee health worker.

Programs cover 0-5 years development, immunisation, 50 years and over monitoring, women's health, school screening with an attempt to monitor T.B., leprosy and S.T.D.'s. The gaps identified in the submission refer to outstations and equipment. The submission claims that the service providers are anticipating that they will initiate a regular outstation visit program involving ten outstations within 100 kms radius of Peppimenarti. The need for upgrading equipment was stated, namely cardiac monitor, Coucha humidifier, Ivac pump, ear examination equipment, Tympanic thermometers, audiometry equipment, weighing scales and computer. A play centre and a teaching unit for well adults are advocated to promote health and wellness.

A submission to the Public Accounts Committee from Dr Peter Thorn, Medical Practitioner, referred to Maningrida which is funded by Territory Health Services. Maningrida and associated outstations have an estimated population of 2,200.

Thorn's submission claims that chronic under-staffing has minimised the positive impact of the service. Programs for the control of sexually transmitted diseases and other programs are limited to deal with acute illness. He states that resources have not been allocated to match the appalling health statistics.

A submission from Mr David Shannon, Chairman, Ali Curung Council Association Inc., Alice Springs, referred to the living conditions on his community:

> There are approximately 350 people living in Ali Curung.
>
> There is one washing machine for the community and up to fourteen people living in the same house. There are a large number of unhealthy dogs living in the community.

The Committee became aware of gaps in health services due to a need for additional resources. These needs were advised to the Committee during its community visits. For example, one large community explained their frustration in trying to acquire basic health equipment. Finally the school donated the money. Other examples of resource needs which impact on health services were given to the Committee.

# *CHAPTER 3*

# 3. TERMS OF REFERENCE (c)

***the effectiveness of services being provided and whether present service delivery mechanisms are relevant***

## 3.1 Introduction

The effectiveness of services is illustrated by the gaps in health outcomes between Aboriginal and non-Aboriginal people which have widened.

Although Aboriginal infant and stillbirth mortality have improved, both remain nearly four times higher than the all Australian rates.

There is a general paucity of Aboriginal health information on a statewide basis and therefore interstate/Territory comparisons are problematic.

As reported in the Northern Territory Legislative Assembly by Hon. D. Burke, MLA, Minister for Health Services (Hansard, p. 25), on 8 October 1996, there are signs of improvement:

> ... programs such as 'Strong Women, Strong Babies, Strong Culture' are working. After two years, the evaluation of the three remote communities where the program was trialed has shown a 47% reduction in the number of low birth rate infants, a 55% reduction in the number of premature births and a 141g increase in the mean birth weight.

This section of the report includes recommendations concerning infant health, provision of health statistics to communities, evaluation of the corporate plan, data integrity and cooperation between government departments.

## 3.2 Feedback from Communities and Providers

In a submission to the Public Accounts Committee, Congress claimed that Aboriginal Community Controlled Health Services are the most relevant to Aboriginal people. This preferred service delivery was compared with Territory Health Services - Rural District and the Grant-In-Aid Services (Service Agreement) models.

The general feedback indicates that there is a lack of progress of results against the stated goals. The general comments from communities indicate that the work in the clinics dealing with patients leaves little time to address the education and health promotion/environmental health needs. The comment from the nurse at Numbulwar clinic that there are opportunities to improve the effectiveness of service delivery needs to be followed through. Those programs that are working such as *Strong Women, Strong Babies, Strong Culture* need to be supported by other programs at the community level and closely monitored to ensure accountability and

evaluation of results. There is merit in creating an environment where suggestions and ideas for improvements to the service is encouraged.

These ideas could be sought from community and providers through a formal mechanism.

**RECOMMENDATION 18.**

**That providers and community members be invited to submit suggestions for improvement to the current models of delivery and new proposals for health promotion to the Task Force/Assistant Secretary of Aboriginal Health for Territory Health Services consideration (as per Recommendations 5 & 6).**

## 3.3 Key Indicators to Measure the Effectiveness of Health Services Being Provided

Hogg (1991) confirmed that few comparative studies of contemporary indigenous mortality regimes have been conducted. Moodie (1973) compared the mortality patterns of NT Aboriginals in 1964 and 1965 with those of New Zealand Maoris in 1964 and American Indians from 1961 to 1963 which is one of the first investigations of this kind. Kenen (1987) compared contemporary Australian Aboriginal and American Indian mortality patterns. Kunitz (1990a) remarked on the similarities and differences between the mortality experiences of Australian Aboriginals, American and Canadian Indians and New Zealand Maoris. Gray (1990) briefly commented on similarities in Australian Aboriginal and Canadian Indian age-specific mortality levels. Hogg (1991) identified that vital data on Australian Aboriginals, Canadian Indians and New Zealand Maoris are in many cases unavailable or incomplete.

### 3.3.1 Rural/Urban Comparison

Before identifying the key health indicators it is important to understand the differences in the availability of services between urban and rural populations in Australia.

Australian Bureau of Statistics (1994a), National Aboriginal and Torres Strait Islander Survey contrasted the availability of health professionals and services. This Australia-wide survey showed that overall the availability of health professionals and services on a permanent basis within 25 km of where people lived was relatively high. However, in rural areas, availability of health professionals was lower and access to services within a rural area may be difficult for some.

In a submission to the Public Accounts Committee, Mr Gaykaynangu, President, Milingimbi Community Inc., wrote:

> the present service should have a provision to ensure that patients who are unable to visit the clinic are either transported to the clinic or visited by the health centre staff .

Ring (1995, p. 228), in an open letter to the President of the Public Health Association, referred to the lack of progress with Aboriginal health compared to other countries. He states:

> I think the most telling point lies in the international comparisons. Australia has made reasonably good progress with the health of Aboriginal infants and young children. Infant mortality is about one-fifth of what it was, say, 15 years ago, although perinatal mortality in the Aboriginal and Torres Strait Islander population is still about two to three times that of the total population. So there is still a long way to go. However, the level of indicators of the health of Aboriginal and Torres Strait Islander children is by no means exceptional and is on a par with some of the countries in South America and the former Eastern bloc.

Of particular note is the observation concerning the high adult mortality rate in middle age. Ring (1995, p. 228) reported that he had been unable to find any other population in the world that has rates as high:

> ... with estimates ranging from 6 to 12 times that of the total population in various parts of Australia for those in their forties and late thirties. Not only are the adult rates high, but there has been no real progress in reducing adult mortality in the last 20 years. This, of course, means that, because adult mortality for the total population is falling rapidly, the gap between the *Aboriginal and Torres Strait Islander population and the total population is increasing*. This is where the international comparisons come in. The expectations of life for Indian populations in Canada and the United States, and for Maoris in New Zealand are at least 10 years more than for Australian Aborigines, an enormous difference. Maori adult death rates are falling at a *faster* rate than the rate for whites in New Zealand, and the gap in the expectation of life between ... Aboriginal communities and the total population in most states is the best part of 20 years.

Ring (1995, p. 229) referred further to the level of expenditure on Aboriginal health (Australia) as lower than the rest of the population despite the higher levels of illness and need for services. He made the following comment regarding the services:

> Unpalatable as it may seem, and acknowledging that efforts are being made to address the situation, Australia has in effect been running a two-tier system in which the white population receives one level of service and the Aboriginal population, despite a greater need, receives a lower level of service. One test of this is to go to some of the remote areas of Australia, close your eyes and imagine that suddenly the Aboriginal population had become white, and ask yourself whether the level of service would be acceptable.

Leeder (1995, p. 230) is the President of the Public Health Association and made a number of comments to Dr Ring:

> ... although millions have been spent on Aboriginal Health, we probably need to spend billions to achieve high health status, at least on amenities such as clean water and infrastructure that other Australians take for granted.

Bhatia & Anderson (1995) report that the age-standardised death rate for Aboriginal men of all ages in New South Wales across the years 1985 to 1992 as 809 per 100,000 (little different from all Australian men)[3] compared with 2249 in the Northern Territory and just under 2000 in Western Australia. The New South Wales deaths for Aboriginal

[3] The Australian Bureau of Statistics (1993) have advised that only figures for the Northern Territory, Western Australia and South Australia are of publishable quality (quality better than 90%).

people are understated according to the ABS demographic working paper No. 93/2 and therefore the comparison between the Northern Territory and New South Wales should be treated with caution.

Bhatia & Anderson (1995) noted that Aboriginal populations are now an anomaly in the Fourth World where they continue to suffer tragic health inequalities. Although indigenous populations of other westernised nations have made large strides in the improvement of their health where their infant, maternal and adult mortality have declined, Aboriginal health has lagged. The infant and maternal mortality decline is slowing down and the increase in young-middle adult mortality has led to a stagnancy in health trends.

Kunitz (1994, p.24) compared the life expectancy of Australian Aboriginal people with overseas indigenous people 30 years ago:

> Aboriginal life expectancy does not differ markedly across the entire continent; it is lower than the life expectancy of any other indigenous population; and Aboriginal males are particularly anomalous, having life expectancies at birth similar to those found among other indigenous peoples 30 or more years previously.

Plant, Condon & Durling (1995, pp. x-xi) reported the Northern Territory health outcomes from 1979-1991 and studied the differences and changes in Aboriginal and non-Aboriginal health. The summary states:

> Aboriginal mortality for males has improved, although the gap between Aboriginal male mortality and the all-Australian rates has widened because the mortality rates of all-Australian males have improved at a faster rate than the Aboriginal male mortality rate.
>
> For Aboriginal females the mortality rates have increased, thereby increasing the gap between Aboriginal female death rates and the all-Australian female rates ...
>
> Both Aboriginal infant and stillbirth mortality have improved over the reporting period. However both remain nearly four times higher than the all-Australia rates.
>
> ... Looking at the total picture of mortality and morbidity it is clear that respiratory illnesses, injuries, circulatory diseases and infectious diseases are the major categories ... that are having the most impact on communities and hospitals. The underlying problems are largely related to social, environmental and economic factors. The single most important preventable cause of ill-health is smoking, but the roles of alcohol, nutrition and issues related to overcrowding and inadequate sewage disposal are also vitally important.
>
> It is of note that for Aboriginal males the mortality rates for respiratory illnesses, injuries, circulatory diseases and infectious diseases have all decreased in recent years however for Aboriginal females the rates for all except infectious diseases have increased.

Runciman & Ring (1994) from the Epidemiology and Health Information Branch, Queensland Health Department, produced a publication about indigenous Queenslanders and also referred to indigenous people in Australia and indigenous people from overseas. Selected sections of the report are as follows:

Gray, A. (1990)

> In Australia there have been significant improvements with respect to the mortality of Aboriginal children over the last 15 years. In contrast, there has been no improvement in the health of Aboriginal adults.
>
> ... Data on the causes of death and rates of death in the population living in discrete communities show that expectation of life at birth is considerably shorter for indigenous people living in those communities than for other Queenslanders. The expectation of life is 19 years shorter for discrete community dwellers.

Thomson and Briscoe (1991)

> The estimate for males living in discrete communities of 54.8 years is similar to estimates for indigenous people living in other parts of Australia, but the estimate for females of 60.3 years is shorter than the estimate for indigenous women in other States of 63.9 years

## 3.4 Trends in Health Outcomes

### 3.4.1 Pregnancies

National Health & Medical Research Council (1993) reported on the high incidence of maternal death for Aboriginal mothers:

> In 1988-90, Aboriginal mothers accounted for almost 30% of all maternal deaths but less than 3% of all confinements.

Plant, Condon & Durling (1995, p.156) recorded Aboriginal mothers accounting for 92% of all maternal deaths.

### 3.4.2 Births and Birthweight

Bhatia & Anderson (1995, p.11) reported:

> Babies born to Aboriginal mothers had an average birthweight of 3,140g which was 209g less than the average for all births. Low birthweight (less than 2,500g) is significantly more common in Aboriginal babies; in 1991, 13% of Aboriginal babies were low birthweight, more than twice the rate for non-Aboriginal babies.

Runciman & Ring (1994, p.27) also referred to the low birthweight of Aboriginal babies whereby in 1988 the low birthweight (less than 2,500g) recorded for Queensland indigenous people was 11.7 per 1,000 live births and in the United States between 1986-88, the indigenous rate was 6.1 and the New Zealand indigenous rate in 1987 was 9.2 .

Bhatia & Anderson (1995, p.11) referred to Lancaster et al (1994):

> The proportion of still births and neonatal deaths was much higher in Aboriginal babies born in Western Australia than in Aboriginal babies born in other States and Territories.

Plant, Condon & Durling (1995, p. 202) referred to the birth rate:

> ... The Aboriginal crude birth rate has increased from 27/1,000 to 31.1/1,000 over that time while the non-Aboriginal rate has decreased from 20.1 to 17.3/1,000. This is still higher than the all-Australia rate of 14.9/1,000 ...

### 3.4.3 Mortality-Life Expectancy

Bhatia & Anderson (1995, p. 12) reported on the shorter life span for Aboriginal people:

- The expectation of life at birth is much lower for Aboriginals than for other Australians. Life expectancy for Aboriginal males was estimated to be 16-18 years shorter than for non-Aboriginal males during 1990-92; the gap was slightly wider for Aboriginal females ...

- ... Improvements in Aboriginal life expectancy over the past two decades have been achieved mainly through reductions in infant mortality; high death rates in older age brackets continue to keep Aboriginal life expectancies substantially lower than those for non-Aboriginals.

Plant, Condon & Durling (1995, p.203 & 205) referred to infant mortality:

> Infant mortality accounted for 452 Aboriginal deaths and 222 non-Aboriginal deaths over the thirteen year period. Aboriginal infant mortality rates fell from 45/1,000 live births in 1979 to 27/1,000 in 1991.

The non-Aboriginal rates have moved from below the all-Australian rates to above the all-Australian rates in the reporting period.

The report suggests that this change may reflect the trend to treat children in the NT rather than in the south due to the expertise that is now available in the NT. The Aboriginal neonatal death rate is twice that of the non-Aboriginal rate.

Plant, Condon & Durling (1995, p. 25) referred to the cause of death. For all the deaths in this period 46% were non-Aboriginals and 54% were Aboriginals. The most common cause of death for Aboriginals of both sexes is diseases of the circulatory system. The second most common cause of death for Aboriginal males is external causes of injury and poisoning followed by diseases of the respiratory system and neoplasms. For Aboriginal females the second cause is diseases of the respiratory system followed by neoplasms and external causes of injury and poisoning. For non-Aboriginal males the most common cause of death is external causes of injury and poisoning followed by diseases of the circulatory system, neoplasms and diseases of the respiratory system. For non-Aboriginal females neoplasms are the most common cause of death followed by diseases of the circulatory system, external causes of injury and poisoning and diseases of the respiratory system.

Hogg (1991, p. 8) in his review of indigenous mortality studies demonstrates that heart disease is a major cause of death for Australian Aboriginals, Canadian Indians and New Zealand Maoris.

Hogg (1991) compared circulatory and respiratory diseases between Australian Aboriginals, Canadian Indians and New Zealand Maoris and noted:

> The prevalence of circulatory and respiratory system diseases is noticeably higher among Australian Aborigines than Canadian Indians or New Zealand Maoris; and death from external causes are higher among Australian Aborigines and Canadian Indians than among New Zealand Maoris (see *Table 2).*

| Cause of death | Australian Aborigines NT | WA | WNSW | Canadian Indians | New Zealand Maoris |
|---|---|---|---|---|---|
| All causes | 28.4 | 21.0 | 23.3 | 11.2 | 12.3 |
| Infectious and parasitic | 1.1 | 0.3 | 0.2 | 0.2 | 0.2 |
| Malignant neoplasms | 2.2 | 1.9 | 3.0 | 1.2 | 3.2 |
| Endocrine, nutritional | 0.7 | 0.3 | 0.2 | 0.2 | 0.6 |
| Blood and blood-forming organs | 0.1 | 0.0 | 0.0 | 0.0 | 0.0 |
| Mental disorders | 0.3 | 0.6 | 0.3 | 0.1 | 0. 1 |
| Nervous system | 0.5 | 1.2 | 0.2 | 0.1 | 0.1 |
| Circulatory system | 8.9 | 6.7 | 12.6 | 3.6 | 5.1 |
| Respiratory system | 6.2 | 3.7 | 1.3 | 1.0 | 1.5 |
| Digestive system | 0.8 | 1.0 | 1.7 | 0.5 | 0.3 |
| Genito-urinary system | 1.0 | 1.4 | 0.5 | 0.2 | 0.2 |
| Skin and subcutaneous tissue | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Musculoskeletal system | 0. 1 | 0.3 | 0.0 | 0.0 | 0.0 |
| Congenital anomalies | 0. 1 | 0.0 | 0.2 | 0. 1 | 0. 1 |
| Perinatal causes | 0.0 | 0.0 | 0.2 | 0.2 | 0. 1 |
| Signs, symptoms and ill-defined conditions | 2.1 | 0.4 | 1.0 | 0.4 | 0. 1 |
| Accidents, poisonings and violence | 4.3 | 3.3 | 2.0 | 3.3 | 0.9 |

*Table 2: Male cause-specific mortality rates[a] for Aborigines from the Northern Territory (NT) 1979-1983, Western Australia (WA) 1983, and western New South Wales (WNSW) 1984-1987, Canadian Indians[b] , 1980-1986, and New Zealand Maoris[c] , 1980-1986.*

[a] Rates are deaths per 1,000 population per year. Cause-specific rates were directly standardised to the 1986 Australian age structure. Rates may not add up because of rounding.
[b] Unpublished data from Health and Welfare Canada.
[c] Unpublished data from National Health Statistics Centre.

Source: Hogg (1991, p.65)

### 3.4.4 Injury and Poisoning

Plant, Condon & Durling (1995, p.184-186) comments on injuries and poisoning said:

> Aborigines accounted for 41% of deaths and 34% of hospital separations.
>
> The rate ratio of mortality for Territorians compared with the all-Australia rates has remained at approximately 1.5 for non-Aborigines ... For Aborigines it has fluctuated between 3 and 4.5 times the risk of mortality.
>
> Regional differences in the length of stay ... indicate that Katherine and Darwin Regions generally have a longer length of stay than the East Arnhem or Alice Springs/Barkly Regions for all population groups.

### 3.4.5 Homicide and Injury Purposely Inflicted by other Persons

Plant, Condon & Durling (1995, p.195) conclude:

> Aboriginals have a much higher rate of death from Homicide and Injury Purposely Inflicted by Other Persons, than non-Aborigines, with Aboriginal males having the highest risk of all. Aboriginal males and females have a much higher rate of hospitalisation from Homicide and Injury Purposely Inflicted by Other Persons than non-Aborigines, with Aboriginal males having about six times risk and Aboriginal females up to 50 times the risk of their same-sex non-Aboriginal counterparts. Aborigines count for 69% of deaths and 72% of hospital separations.

### 3.4.6 Mortality-Infant Mortality

Kunitz (1994) reports infant mortality rates per 1,000 live births of four indigenous populations. In the 1970s and 1980s the rates were as follows:

| *Decade* | *Canada Indians* | *Australia Aborigines* | *New Zealand Maoris* | *United States Indians* |
|---|---|---|---|---|
| **1970s** | 34.9 | 55(NT), 79(Qld) | 21 | 18.7 |
| **1980s** | 21.8 | 34(NT), 20(Qld) 24.7(WA) | 18 | 9.8 |

*Table 3: Infant Mortality in the 1970s & 1980s - Comparison between Canadian, Indians, Australian Aborigines, New Zealand Maoris & United States Indians. (Australian Institute of Welfare 1994)*

Source: Kunitz (1994)

Bhatia & Anderson (1995, p. 12) refer to Aboriginal infant mortality:

> Despite significant declines over the past two to three decades, Aboriginal infant mortality rates remain typically two to three times those for non-Aboriginal infants.

The Australian Bureau of Statistics (1994c) reported:

> In 1993, Aboriginal babies accounted for 73% of all infant deaths, but only 38% of all births, in the Northern Territory. A similarly high differential was noted in South Australia, where for 3% of all births in the State, the Aboriginal proportion of infant deaths was 9%.

### 3.4.7 Mortality-Age Specific Mortality

In 1990-92, the standardised mortality ratio (SMR) for Aboriginal males was 2.8; the ratio for Aboriginal females was slightly higher at 3.3. In the Northern Territory, the respective SMRs were 3.3 and 4.2 (Australian Institute of Health and Welfare, 1994). The Australian average SMR is 1[4].

Plant, Condon & Durling (1995, p.46) reported that within the Northern Territory the 'Aboriginal mortality for both males and females was highest for East Arnhem, followed by Darwin Rural and Katherine'. There is less variation between Districts for non-Aborigines.

### 3.4.8 Infectious & Parasitic Diseases

Plant, Condon & Durling (1995, pp. 52-53) report:

> The rate ratios for non-Aborigines indicate that they are 1.5-3 times more likely to die than their all-Australian counterparts although these ratios reflect a small number of deaths in the NT. The risk of mortality for Aborigines is exceptionally high with Aborigines being 15-40 times more likely to die from infectious and Parasitic Diseases than are the all-Australian population ...
>
> Length of stay [in hospitals] for Infectious and Parasitic Diseases has fallen substantially for both Aboriginal males and Aboriginal females from 14-15 days per admission to less than 10 days per admission over the reporting period. The length of stay for non-Aboriginals has remained stable at 6 days or less over the same time period.

### 3.4.9 AIDS/STDs (Sexually Transmitted Diseases)

Bowden (1995, pp. 22-23) provides an understanding of the incidence of STDs for Aboriginal and non-Aboriginal people:

> **Gonorrhoea** is endemic in Aboriginal communities but also occurs at up to five times the national average in the non-Aboriginal population of the NT. The relative risk of acquiring gonorrhoea for an Aboriginal in the NT versus a non-Aboriginal in the NT is 28. There is a disturbing number of cases occurring in young children and these are always considered to represent sexual transmission until proved otherwise .

[4] *An SMR of 1.0 indicates no difference between the death rates of the two populations whereas a ratio of 2.0 means that Aboriginal people are dying at twice the rate current in the total population.*

> **Syphilis** is also endemic in many Aboriginal communities but there are marked regional variations. The relative risk of acquiring syphilis for an Aboriginal in the NT versus a non-Aboriginal in the NT is 195.

Reference to the Territory Health Services, 1995 Report of the Northern Territory's Sexually Transmitted Diseases Program indicates that there has been a 28% decrease in the notification of Chlamydia, 30% decrease in gonorrhoea and a 27% decrease in syphilis. Comparisons with other States and Australia are shown in *Table 4*, p. 71. The decrease in STD's are mainly in Aboriginal communities and reflect active education, contact tracing and increased clinical activity. *Table 4* reflects the higher incidence of STDs for Aboriginal people who represent 26.1% of the NT population.

**National Notifiable STDs, Annual Rate per 100,000 Population, 1994**[1]

| Disease | ACT | NSW | NT (1994) | NT (1995) | QLD | SA | TAS | VIC | WA | Australia |
|---|---|---|---|---|---|---|---|---|---|---|
| Syphilis | 5.3 | 16.8 | 263.5 | 193 | 17.2 | 2.9 | 0.4 | 3.2 | 6.1 | 13.0 |
| Gonorrhoea | 2.7 | 5.9 | 430.1 | 301 | 22.2 | 30.6 | 1.7 | 3.4 | 49.5 | 16.7 |
| Chlamydia | 30.9 | NN | 421.9 | 302 | 79.0 | 49.8 | 62.5 | 29.2 | 49.8 | 55.3 |
| Donovanosis | 0 | NN | 36.7 | 24 | 1.0 | NN | 0 | 0 | 1.1 | 1.1 |
| HIV[2] | 55.2 | 201.8 | 47.9 | 48.2 | 48.7 | 38.8 | 15.5 | 75.4 | 44.0 | 105.3 |

*Table 4: National Notifiable STDs, Annual Rate per 100,000 Population (1994). Report of the NT's Sexually Transmitted Diseases Program 1995. Territory Health Services.*

[1] Data for rest of Australia for 1995 not available for comparison at time of printing.

[2] HIV data refers to cumulative incidence rates calculated from data collected by the National Centre for HIV Epidemiology and Clinical Research 1 Jan 1981 to 31 December 1995 rather than annual incidence as for the other notifiable STDs.

Source: Report of the Northern Territory's Sexually Transmitted Diseases Program 1995, Territory Health Services (unpub.)

Despite the encouraging downward trend in 1995, the STD figures for the NT remain alarming. Although significant under-reporting occurs in other States and Territories, the rates in the NT are up to 18 times higher than the national average.

Advice from the AIDS/STD Unit indicated that there were no Aboriginal HIV cases in the rural communities and there was one Aboriginal urban case. There were no non-Aboriginal HIV cases in 1995 but as at 22 April 1996, there were 4 non-Aboriginal HIV cases.

### 3.4.10 Non-communicable diseases

McGrath et al (1991):

> Non-communicable diseases, particularly acute myocardial infarction, diabetes, obesity and hypertension, are known to have a high prevalence among Aboriginal people.

One possible explanation for the high prevalence of diabetes in Aboriginal people is the relative short transition to the adoption of western diet and habits.

Kunitz (1990a) refers to diabetes as a cause of disability and death including renal failure. He makes the following observations in relation to diabetic caused diseases between Aboriginal and non-Aboriginal:

> A genetic mechanism, the so called "thrifty-gene hypothesis," has been suggested as an explanation of the high prevalence of diabetes in this (Polynesians) and American Indian and Australian Aboriginal populations (Neel 1962, 1982). In essence the explanation is that among hunter-gatherers for whom a constant supply of food is problematic, natural selection favoured those who were efficient in storing fat during times of plenty. But in the present era, with food supplies more assured, the ability to deposit fat efficiently ( coupled with diminished physical activity) is maladaptive and leads to obesity, insulin resistance, hyperinsulinemia, exhaustion of the pancreatic cells that produce insulin, and diabetes (Zimmet et al. 1989). Though an attractive hypothesis, it has not yet been confirmed or rejected, one of the difficulties being the question of whether food supplies did fluctuate as widely for hunter-gatherers as the hypothesis assumes. Thus while much about diabetes remains unexplained, there is quite convincing evidence (1) that it is a new disease among indigenous peoples; (2) that some groups are genetically more susceptible than others; (3) that among the susceptible populations increased obesity and diminished physical activity associated with a shift in way of life are the most important risk factors; and (4) that there may be increasing homogeneity within populations as diet and exercise patterns become more nearly similar.

As a direct cause of death, diabetes is more significant among Aboriginal than non-Aboriginal people with its standardised mortality ratios approaching 7 and 10 in Aboriginal males and Aboriginal females respectively.

Plant, Condon & Durling (1995, pp. 82-83) reported on mortality due to diabetes mellitus:

> ... The mortality risk for Aboriginal males is about five times that of non-Aborigines and for females 10-15 times ... Risks for non-Aborigines have not changed substantially.

Their report (pp. 112-137) records some disturbing trends for Aboriginal people regarding diseases of the circulatory system. They acknowledge there is a widening gap in mortality rates between Aboriginals and non-Aboriginals and while the 'hospital separation[5]' rates have declined for non-Aboriginals, the rate for Aboriginals have increased by about 50%.

<u>Rheumatic Heart Disease:</u>

Of the 121 deaths due to Chronic Rheumatic Heart Disease recorded in Plant, Condon & Durling (1995, p. 112), 107 were Aboriginal.

> The risk of death for Aboriginal females has generally been 20 to 45 times higher than for non-Aboriginal females. Rates for Aboriginal males have been a little lower than Aboriginal females, but are still very high compared to non-Aboriginal males.

[5] Patients discharged from hospital whether discharged home, absconded, transferred to another hospital or nursing home or died in hospital

In relation to morbidity, 259 of the 293 hospital separations for Chronic Rheumatic Heart Disease were Aboriginal.

Hypertensive Disease:

> ... 90 deaths due to Hypertensive Disease. Of these 71 were Aboriginal ... [the male Aboriginal rates] have remained stable during the last four or five ... the mortality rate for Aboriginal females ... increased throughout the reporting period (p. 114).

The hospital separation rates for non-Aboriginals have decreased, while the rates for Aboriginal have decreased slightly and the rate for Aboriginal females have increased. Overall the morbidity rates for Aborigines were twice as high as non-Aborigines.

Ischaemic Heart Disease:

The morbidity and mortality rates from Ischaemic Heart Disease for non-Aborigines have remained comparatively stable over the reporting period, while the morbidity and mortality for Aborigines have increased between 50 and 350%.

Cerebrovascular Disease:

> ... the [mortality] rates do not appear to have changed substantially over the Health Outcomes reporting period (1979-1991). The Aboriginal rates are 2-4 times as high as the non-Aboriginal rates ... The hospital separation rates [morbidity] have generally increased ... for Aboriginal males ... from 100 to around 300/100,000 ... and for Aboriginal females from 70 to 180/100,000.

Respiratory System:

> The rate ratios for mortality ... indicate that for [NT] non-Aboriginal males the risk is 1.5 -2 times as high as their all-Australia counterparts and for non-Aboriginal females the risk is slightly higher than their all-Australia counterparts. For Aboriginal males and Aboriginal females the mortality risk from Diseases of the Respiratory System is 6-20 times that of their all-Australian counterparts (p. 125).

The hospital separation rates for non-Aborigines indicates a decline over the study period.

> For Aboriginal males the rates have increased after a low of 2,900/100,000 in 1983 to 4,200/100,000 in 1988, compared with about 1,700/100,000 for non-Aboriginal males. For females, the rates have increased from a low of 2,500/100,000 to 3,700/100,000 in the same years, whereas for non-Aboriginal females the rates have fallen from 1,600 to 1,400/100,000 (p. 125).

Aboriginal deaths and hospitalisation from Pneumonia and Influenza were 82% and 77% respectively of the total and for Chronic Obstructive Pulmonary Disease and Allied Conditions (excluding Asthma) Aborigines accounted for 67% of deaths and 48% of hospital separations. The NT district by district comparison show that the mortality rates for Diseases of the Respiratory System are highest for Darwin Rural and East Arnhem for Aborigines and hospital separation rates are highest for the Alice Springs Urban, Rural and Barkly districts.

Plant, Condon & Durling (1995, p. 166) referred to infection of skin and subcutaneous tissues:

> The rates for hospital separations are much higher for Aborigines than non-Aborigines, and have increased over the reporting period. The rates for Aborigines are generally 2-5 times higher than the rates for non-Aborigines. Aborigines accounted for 71% of the seven deaths and 52% of hospital separations.

Kunitz (1990b, p.35) compared Aboriginal men and reported that the rate for Aboriginal men in Australia was eight times higher than for Navajo men and at least two times higher than several Indian tribes in New Mexico. He observed that in 1979-83 the median age at death of Aboriginal men in the Northern Territory was between 45 and 50, and among women, between 55 and 60. Among Navajo Indians the median age of death in the 1970s was between 60 and 64 for men and between 70 and 74 for women. Among Maoris, the median age at death for men was somewhere in the late 50s or early 60s, and for women, above 65. These figures suggest that Aboriginal men and women die of ischaemic heart disease 10 or 15 years earlier than do men and women in other indigenous populations.

### 3.4.11 Renal disease

Grime et al (1988) reported that chronic renal failure in Aboriginal Australians is a major cause of concern. Excess mortality from end stage renal disease in South Australia has been estimated at 12 times higher in Aboriginal men and 25 times higher in Aboriginal women than in non-Aboriginals.

Plant, Condon & Durling (1995, pp. 148-151) reported 94 deaths due to acute, chronic, and unspecified renal failure of which 78 were Aboriginal. Nephritis, nephrotic syndrome and nephrosis (excluding acute, chronic and unspecified renal failure) recorded 24 deaths of which 21 were Aboriginal. Aboriginals had higher hospital separation rates than non-Aboriginals which increased over the reporting period. Aboriginals accounted for 88% of deaths and 64% of hospital separations.

Hoy, Mathews & Pugsley (1995) described the incidence of end stage renal disease affecting Aboriginal people in a Top End community in the Northern Territory from 1978-1993. In the Top End average annual incidence of end stage renal disease from 1988 to 1993 was 17.4 times that of non-Aboriginals. Tiwis have a 60 fold increase, and some other groups, like Elcho Islanders, are following a similar trend. Aboriginals were 20-30 years younger than non-Aboriginals at the start of the treatment. In 1957 Dr Hargreave examined 713 people out of 800-900 and found one with hypertension and one obese. In 1992 Dr Hoy found 30% overweight, 25% with early renal disease and 25% with advanced renal disease among adults.

In a submission to the Public Accounts Committee, Ms C. Farley, Acting Director of Nursing, Community Health, Territory Health Services, referred to Continuous Abdominal Peritoneal Dialysis (CAPD) as a cost effective and culturally appropriate therapy as it allowed clients to maintain a degree of independence. CAPD is an alternative to haemodialysis, so rather than blood being cleaned by a machine, fluid is

inserted into the abdomen and the body's waste products and excess water are drawn off. Budget constraints have not allowed for training of clients to use CAPD.

In Darwin and Alice Springs, the Continuous Abdominal Peritoneal Dialysis can be delivered outside of the urban centres provided that the patients fulfil the selection criteria:

- patient's ability to comply with the program;
- conducive home surrounding; and
- patient's medical suitability.

Prior to commencement of CAPD at home, training of the patients is required to establish the patient's ability to manage CAPD independently and reliably. The training occurs gradually: first in hospital, then in the outpatient department of the hospital, community based health centre, at home under supervision, and finally at home independently.

The current number of patients on CAPD are:

10 in the Operations North Region and 10 in the Operations Central Region.

The location of the patients as at 30 September 1996 are:

Tennant Creek, Elliott, Nyrripi, Mount Liebig, Lake Nash Darwin, Tiwi, Borroloola, Daly River, Port Keats, Groote Eylandt, Lajamanu, Ngukurr.

### 3.4.12 Alcohol Misuse

Swensen & Unwin (1994) reported that hospitalisation attributable to alcohol misuse is common among Aboriginals. In the Kimberley Health Region of Western Australia, it has been estimated that Aboriginals are three to four times more likely than non-Aboriginals to be admitted as inpatients for injuries attributable to alcohol.

In a submission to the Public Accounts Committee, Mr R. Bullock, Acting Commander, Corporate Development, NT Police, referred to alcohol abuse and stated that the return for money spent was depressingly low. Studies by Anne Mosey (Remote Area Night Patrols 1994) referred to the Yuendumu community which submitted the view that the Night Patrol initiative may have contributed to the success of the 'failure to thrive' program by making available more money for food. The Northern Territory Police has delivered the DARE (Drug Abuse Resistance Education) program to school children in conjunction with the Education Department. The funding for this program is via the National Drug Strategy Committee Cost Shared Program with criteria for funding controlled and directed by the Alcohol and Other Drugs Unit in Territory Health Services.

Plant, Condon & Durling (1995) reported that mortality due to Alcohol Dependence Syndrome in the NT over the 13 year period of the NT Health Outcome report was 48 Aboriginal (38 male, 10 female) and 31 non-Aboriginal (26 male and 5 female).

### 3.4.13 Tobacco related ill-health

The Standard Mortality Ratio for Aboriginal males and Aboriginal females were 3.0 and 4.8 respectively for deaths resulting from chronic obstructive lung disease during 1985-92.

Cigarette smoking plays a large role in respiratory problems which are the foremost cause of Aboriginal hospitalisation. In the year 1991-92 Aboriginal hospitalisation for these problems was more than 2.4 times the rate in non-Aboriginals.

The incidence of smoking by Aboriginal people, and in particular women, is increasing and is of concern.

### 3.4.14 Other Substance Abuse

Verbal advice to the Public Accounts Committee from Gloria Markey, Acting Deputy Director, Alcohol and Other Drugs Program, Territory Health Services, on 11 November 1996, referred to other substance abuse.

- **Petrol Sniffing** - records indicate eight deaths in the last five years due to petrol sniffing compared to five deaths in the preceding ten years.

  People admitted to hospital are not identified as petrol sniffers as the primary reason for admission and therefore morbidity is not recorded.

- **Kava** - In 1993 increased sales were recorded. Total sales are difficult to track due to the illegal sales. There is an absence of confirmatory research linking kava to mortality or morbidity.

- **Marijuana** - There are no records of hospital admissions as a result of marijuana use.

### 3.4.15 Neoplasms (Cancers)

Plant, Condon & Durling (1995) reported that the rate ratios indicate all NT groups had a lower risk of death from neoplasms than did the all-Australian population at the beginning of the reporting period. Since 1981 Aboriginal males had an increased risk and Aboriginal females up to twice the risk of death from neoplasms than the all-Australian population. NT non-Aboriginals continue to have the same or lower rates than their all- Australian counterparts.

The mortality rates for neoplasms reflect small numbers but indicate that East Arnhem had the highest rates for both male and female Aboriginals.

### 3.4.16 Nutritional Deficiencies

In recognition of the importance in this area the NT have produced a Food and Nutrition Policy and Strategic Plan 1995-2000.

Ruben & Walker (1995) used World Health Organisation criteria and found that from an average population of no more than 480 children under two years, 34% were admitted to hospital at least once with diarrhoeal disease in the 12 months; 59% were malnourished.

In the study period an estimated minimum of 20% of all Aboriginal children in the Top End were malnourished.

The conclusion was that the 20% prevalence of malnutrition was many times higher than would be expected statistically, and higher than in many under-developed countries. International relief agencies regard a prevalence of wasting in children of more than 8% as a nutritional emergency.

Plant, Condon & Durling (1995) reported that during the period covered by the NT Health outcomes review there were 34 Aboriginal and 5 non-Aboriginal deaths due to nutritional deficiencies. The hospital separation rates for nutritional deficiencies show that the rates for Aboriginal males and Aboriginal females are 10-50 times higher than the rates for non-Aboriginal females.

Dr. Alan Ruben, a community paediatrician who works for Royal Darwin Hospital and Menzies, advised on 22 November 1995, that he recently concluded a child health survey at a community which has health problems which are much better than comparable sized communities in the Northern Territory. The survey was based on the National Health and Medical Research Council guidelines for screening and on what the Health Workers in the community wanted to know about the children. Overall, 320 children were seen.

Results belong to the community. They will remain confidential and will only be available from the community, with its permission for use and/or distribution.

The results of the survey by Ruben (1995) pointed to health issues of serious concern.

The numbers of children with poor nutrition were high. The poor nutrition of primary school age children is of particular concern. Growth is an indicator of overall health. On World Health Organisation standards 25% of the children were underweight, 15% stunted and 11% wasted[6]. One third of the children were anaemic. Almost half the children have skin infections, and half the children have tooth decay requiring dental treatment. 59% of children over 2 years of age have teeth and/or gum disease which is preventable with public health measures. Only 1 in 10 of surveyed children have healthy ears, capable of normal function. 20 children over 5 years old had heart murmurs which required review.

In a submission to the Public Accounts Committee, Dr W. Hoy, Menzies School of Health, Darwin, report that 90% of children aged 1-5 years in one community had abnormal hearing and 10% had heart murmurs.

[6] wasted refers to less than 80% standard weight for height.

The Medical Research Council (1992, p.17) Environmental Epidemiology Unit at the University of Southampton, U.K. reported on the relationship between the poor health of the foetus and infant and corresponding poor health in later life. The Council reported on the work of Lumey, H. (1988). Comments are as follows:

> The work strongly argues the value of a healthy environment during pregnancy and in early childhood as an investment likely to pay dividends in terms of preventing later disease. The work is also a reminder of the amount at stake in the care of the foetus and infant. It is a matter of straightforward arithmetic that there are more QALYs (quality adjusted life years) to be gained by improving health in infancy than at any subsequent time. Furthermore, ***the effects of under-nutrition of the foetus and infant may be seen not only in the later life of the individuals affected, but even in their children and grandchildren***, as studies of children born after the Dutch famine winter of 1944-5 suggest.

This study is of relevance to under-nutrition of the foetus and infant in Aboriginal communities. Mothers who smoke and drink alcohol to excess have a high risk of low birthweight babies (refer p. 100).

The Committee considers that the study by Dr Wendy Hoy clearly illustrates the link between life style and health problems.

### 3.5 Assessment of Health by Indigenous Australians

Useful information on community needs can be obtained from examining the rates of *health risk behaviours* such as alcohol use. This will enable information to indicate where intervention programs could be implemented. The collection of the perceptions of individual community members about their needs would be important in the process of improving health. It is important that community members are allowed to express their needs without undue influence from others. The survey instrument must take into account the lower reading ability of many Aboriginal people - the use of graphics could be helpful. The community members should be given the opportunity to prioritise their health needs. This will assist program planners to gain deeper insights into the community's perception of need.

The results will help planners to appreciate the extent to which further education in health is required. It could also identify the level of resolve in the community to change their own behaviours, eg. alcohol abuse and child neglect.

**RECOMMENDATION 19.**

**1 . That programs targeting infant health be implemented as a high priority and community information delivered in a culturally appropriate manner emphasising the relationship between infant and adult health; and**

**2. that emphasis is placed on food and nutrition by Territory Health Services. Public information about the dangers of smoking and alcohol should include the implications for family health when smoking, alcohol and other drugs are placed before good food in the family expenditure priorities.**

The corporate plans and annual reports of Territory Health Services are generally lacking in the monitoring of health outcomes from one year to the next.

**RECOMMENDATION 20.**

**That the corporate plan and annual report for Territory Health Services highlight the health indicators showing changes since the last report and reasons for the change and also include comparisons (where available) on a regional and interstate basis.**

The Committee's visits to Aboriginal communities show that there is a need to identify the health needs from a community perspective.

Research shows that community health information is integral for a community to effectively accept ownership and control of primary health care.

**RECOMMENDATION 21.**

**That community health profiles be compiled incorporating the perception of community members of their own health needs and their prioritisation of those needs.**

### 3.6 Evaluation Processes

An evaluation process generally examines the **appropriateness** of what is being done - whether the objectives match Government priorities and community needs. The **efficiency** of what is being done - the extent to which the inputs that are used match the program outputs. This should encourage the ongoing challenge to minimise the inputs to achieve the desired outputs. The **effectiveness** of what is being done examines whether the program outcomes match the stated outcomes.

- Inputs are the resources, both human and other, used to produce program outputs.
- Processes are the means used to produce the outputs designed to bring about outcomes.
- Outputs are the products or services which are produced and delivered by a program in order to achieve the program's outcomes.
- Outcomes are all of the consequences of the program beyond its outputs which the program has on clients and the wider community; they are beyond the direct control of the program, are often delayed or occurring over the long term, and may be intended or unintended, positive or negative.

Evaluation findings may demonstrate the needs of a community and help to prioritise options for addressing the need; demonstrate the success or failure of program strategies and enable decisions to extend or withdraw strategies. Evaluation also helps Government to prioritise funds between new policy proposals.

The NT Treasury requires NT Government Agencies to evaluate their programs every three years and they have provided a suggested model for conducting program evaluation and review which describes efficiency, effectiveness and appropriateness.

Advice from a senior Territory health official indicated that all programs now being developed by Territory Health Services will be required to have an evaluation component. It is recognised that a baseline is required in order to observe change.

Service Agreements with communities, in future, will have review arrangements to observe whether those Agreements are working.

The submission from Dr P. Spillane, Director of Medical Services, Territory Health Services, maintained that the services are not effective and the test of their relevance is to ask the Aboriginal people who are receiving the service.

It is noted that Territory Health Services established a management review unit to evaluate programs.

The formal attention accorded to evaluation by Territory Health Services should ensure that all programs and projects have an in-built review process. The evaluation model at 30 November, 1995 was in draft form.

The Commonwealth Department of Health and Family Services has been involved with evaluation since 1987, each Department annually prepares an evaluation plan to the Commonwealth Department of Finance.

A publication by the Commonwealth Department of Finance, titled *Doing Evaluations - A Practical Guide* (1994) is of value to those involved in evaluation. Decisions on whether appropriateness, effectiveness or efficiency should be the main focus of an evaluation depends on the purpose of the evaluation and the stage in the life of the program. Most major evaluations will consider both effectiveness and efficiency. Some will consider aspects of all three issues. Most evaluations should also address: access and equity issues; the identification and measurement of unanticipated outcomes; and the identification and measurement of factors affecting achievement of outcomes.

The Department of Finance (1994) describes *effectiveness* as follows:

> The extent to which a program's outcomes achieve its stated objectives. Evaluating effectiveness is also concerned with: measuring factors affecting achievement of outcomes; establishing cause-effect interpretations as to whether outcomes were caused by the program, or caused by external factors; identifying unanticipated outcomes contributing to the achievement of objectives or impacting negatively on clients.

The reasoning for the evaluation of effectiveness is to assist program staff, Portfolio Ministers and Cabinet in decision-making on the future of the program, program improvement, and fulfilment of accountability requirements.

The timing of an evaluation is influenced by when it is reasonable to expect that outcomes should be being achieved; regularly throughout the life of a program; depending on the nature of program, after program delivery has ceased.

When deciding what data needs to be collected either for program monitoring (performance indicators) or for an evaluation design, it is important to ensure the measures chosen, enable judgements and/or cause-effect interpretations to be made.

Judgements are made about how the program is performing compared with standards or targets, program objectives, competitors and past years. Evaluations measuring effectiveness will use judgemental data.

Interpretations are made about cause-effect relationships, in particular: the extent to which reported outcomes can actually be attributed to the program; whether the real causes of identified need have been detected; whether program strategies are appropriate and likely to be effective. Cause-effect information is the most difficult to collect and needs to be planned for well in advance of the evaluation.

The Commonwealth Department of Health and Family Services (1995a, pp. iii & 1)) stated:

> I [S.J. Duckett, Secretary] also noted that the 1995-97 Portfolio Evaluation Plan was 'just ... a list' rather than 'a true plan'... Firstly the multiplicity of lower level evaluations undertaken piecemeal in the past has been replaced with evaluations of whole Sub-programs or even whole programs ... it requires us to look at the forest rather than spending our effort examining the trees. Secondly, the plan introduces 'thematic evaluations across Programs where there are common elements, functions, objectives or indeed target populations across a number of Programs.
>
> This PEP [Portfolio Evaluation Plan] demonstrates strategies for improving the management of evaluations by:
>
> - first, identifying *key strategic evaluations* which assess appropriateness and effectiveness at the Sub-program or Program level or focus on themes of cross-program or Portfolio-wide relevance;
> - second, reducing the plethora of smaller evaluations; ...
> - third, placing greater emphasis on the development of, and reporting against, *performance indicators* ... and strengthening ... ongoing performance monitoring;
> - fourth, fostering synergies between evaluation, performance monitoring and audit by ensuring that the scheduling of evaluations and audits are complementary and that the findings of each activity inform the others; and
> - fifth, ensuring that the 'value added' of the portfolio's evaluation effort is enhanced through strategic direction and advice from the Portfolio Evaluation Committee and by regular assessment of its usefulness.

The above research indicates that Territory Health Services has recently placed a high priority on evaluation. The Commonwealth Department of Health and Family Services is moving from evaluation of lower level programs on a piecemeal basis to evaluation of whole sub-programs or whole programs.

### 3.6.1 Building in Access and Equity

Commonwealth Department of Health and Family Services (1995a, p.3) also referred to equity:

> All assessments of 'value' must measure and reflect the Portfolio's commitment to quality, and to equity and social justice: the commitment to ensuring that priority community needs are addressed flexibly, in a manner which is accessible to targeted clients (taking into consideration such issues as geographical location and cultural background) and which clients perceive as providing a quality service.

In a submission to the Public Accounts Committee, Prof. G. Mooney, Professor of Health Economics, University of Sydney, suggested that the definition of equity in the context of health services should be ***equal access for equal need***. The view of need that Prof. Mooney prefers is, in most circumstances, capacity to benefit.

Mooney commented that efficiency and equity may sometimes conflict and this is when judgement is required.

Mooney (1994, p.17) cautioned against considering efficiency and equity together:

> Perhaps the best way to handle equity in priority setting is for it to be 'added on' at the end of the efficiency exercise. If the two - efficiency and equity - are considered together - then there is a risk that waters get muddied.

In his 1994 paper and at the 1995 Public Accounts Committee hearing, Prof. Mooney encouraged a very explicit definition of equity by government.

Evaluation of Territory Health Service Agreements has been difficult. Verbal advice on 26 August, 1995 from Darwin Rural, Territory Health Services, indicated that there are outstanding audit acquittals from the 1989/90 financial year. Allocation of time to monitor the performance indicators and difficulties in the collection of data were given as reasons.

Discussions were held with staff from the Strategic and Audit Services Unit of the Department of the Chief Minister, to understand the role of the Unit in relation to co-ordination of evaluation across programs and advice to Departments.

Strategic and Audit Services is providing internal audit work. There appears to be no arrangement for ensuring complementary goal congruency between programs.

Cooperation between Government departments is necessary to ensure that resources are coordinated and duplication avoided with programs that impact on Aboriginal health.

**RECOMMENDATION 22.**

**1. That primary health care services to Aboriginal communities embracing the concept of a holistic health care model ensure programs within and between Departments are congruent; and**

**2. That accountable officers be required to take into consideration issues that cut across programs between Departments to ensure congruency and sharing of data.**

### 3.7 Adequacy and Availability of Statistics and Information

The Commonwealth Department of Finance (1994) refers to data collection and analysis providing a framework for choosing data collection and analysis.

The criteria which makes up this framework is the same as for designing an evaluation:

- usefulness, relevance and credibility;
- feasibility and cost-effectiveness;
- social justice and ethics; and
- technical validity.

Methods of data collection and analysis should be:

- credible to those who will use the information coming from them;
- capable of producing information in a form that can be understood and assimilated by the audiences of the evaluation;
- capable of being summarised simply; and
- capable of producing results in time for any relevant decisions.

Care should be taken to choose methods of analysis which honour any undertakings in relation to confidentiality. Analyses which report only on averages can conceal the fact that program clients who fall into the various social justice target groups (ethnicity, gender, aboriginality, disability) may be the ones who are gaining least from the program.

Deciding the types of information and the comparisons needed sets the parameters for selecting methods of data collection and analysis.

Statistical techniques for analysing quantitative data are of two main types:

- **descriptive statistics,** which describe numbers and the relationship between them (frequencies, percentages, proportions, averages, and measures of dispersion such as range, variance and standard deviation); and **inferential statistics,** which generalise from measures of a sample to a wider population (of people, events, etc), or look at, and make inferences about, the relationships between variables.

- Much of the data held in **management information systems** will be about resources (such as staff resources, administrative costs and program expenditure), throughput data (such as applications received and processed) and output data (such as clients seen, payments made).

This type of data which includes casemix information provides useful background for measuring whether the program is being implemented in the manner intended. The information is needed to judge the program and as a basis for interpreting outcomes.

When reading impressive graphs and other statistical presentations the reader should not overlook the possibility that the source of collection may be suspect and therefore interpretation of data for decision-making must first assess the reliability of the data.

In a submission to the Public Accounts Committee, Ms P. Anderson, Director, Danila Dilba, Darwin, raised concern with the funding arrangements regarding increases or reductions in positions and the submission states that communities do not have experience in accounting and economics and are therefore disadvantaged when negotiating with Government.

### 3.7.1 Aboriginal Deaths in Custody

Recommendation 270 of the Royal Commission into Aboriginal Deaths in Custody (1993/94) report reinforces the need to collect information and statistics:

> That:
>
> a. Aboriginal people be involved in each stage of the development of Aboriginal health statistics; and
> b. Appropriate Aboriginal health advisory bodies (such as the proposed Council of Aboriginal Health) consider developing an expanded role in this area, perhaps in an advisory capacity to the Australian Institute of Health, and that the aim of this involvement should be to ensure that priority is given to the collection, analysis, dissemination and use of those Aboriginal health statistics most relevant to Aboriginal health development.

### 3.7.2 Territory Health Services Information/Statistics

Verbal advice from two senior officers from Territory Health Services on 25 January, 1996 was helpful in understanding the availability and reliability of health information:

- The information/statistics available in January, 1996 was mainly activity data and predominantly hospital related.

- A quarterly Health Department management report as at September, 1995, included hospital activity which comprised approximately three quarters of the report. As additional data sources become available, future reports will be expanded to cover other programs. The report also included details of activities for dental services, key disease categories, child health, communicable diseases, women's health and self care centres. Although the report does not differentiate Aboriginal from non-Aboriginal statistics in all the programs, advice indicates that future reports will show the differences.

- Aboriginal communities have not been provided with their own health information to help them become aware of health trends impacting on their own community. Advice indicates that the chronic disease register has been used as the basis for a Community

Care Information System. There is a project in its early stage to produce an Integrated Community Health System and another intersectoral project to identify Health Information Priority Projects (HIPP).

- Benchmarking is predominantly for national hospital quality indicators eg. casemix and hospital weighting lists.

- In December, 1995 an additional $15 million dollars was approved over three years for the communications infrastructure, to upgrade the network, PC upgrade and CC mail facilities; Hospital Information System upgrade including clinical modules, patient costing system in all hospitals including -a nurse rostering system and a Community Care System.

- Information from program managers is mainly financial, staffing and activity data.

- More work is required on alcohol statistics to show what is working and what is not working.

Territory Health Services have funded their hospitals based on **inputs** - number of beds, staff numbers and consumables used. The relative efficiency with which these inputs are applied to the treatment of patients is difficult to measure. Within Australia historic funding left a legacy of widely varying costs between hospitals.

The development of diagnostic related groups, for characterising the work of hospitals in terms of clinically meaningful and resource homogeneous groups of patient types, has fundamentally shifted the measurement from **inputs** to **outputs (casemix)**.

Territory Health Services (1996b, p.1) included this message from the Secretary of Territory Health Services:

> Casemix is simply output-based funding. It is a system of funding hospitals on the basis of services provided (outputs) and is being introduced progressively across Australia. Under Casemix, comparisons are possible between hospitals within the Territory and between States and Territories. How does our performance compare with others? If our costs are high, is this because we are less efficient, or is it because the morbidity of our patients is high? Information gained through casemix allows us to look at these questions. If we are less efficient this information will prompt us to improve efficiencies and allow us to reallocate resources to provide better care for more people. If on the other hand our costs relate to morbidity, we will have the basis to argue our case with those responsible for funding public health.

With reference to the Territory Health Services Casemix Clinical and Resource Management Project, Territory Health Services (1996b, p.2) states:

> This project will also investigate ways to ensure THS receives fare share of revenue, through Commonwealth Government funding on the basis of the services provided. Revenue must also be recovered from other States when their residents are treated in the NT. Appropriate hospital charges must be levied for privately insured patients treated in public hospitals.

Territory Health Services moved to Casemix funding from 1 July, 1996 and patient costing (utilisation of services at the patient level in hospital) from the same date.

Dr A. Ruben, Royal Darwin Hospital, in his letter dated 23 October 1996 revealed that he had performed quality control on over 1000 computerised records of the Royal Darwin Hospital Information System. He found misclassification occurred for up to 5% records on Aboriginal ethnicity and gender. He also found up to a 20% discrepancy on length of stay, possibly due to inconsistencies in when patients were admitted or discharged, particularly in relationship to the self-care unit at Royal Darwin Hospital.

Ruben had also identified serious failures in the Casemix system to address the funding requirement for Aboriginal children; there is no reason to assume these concerns do not equally apply to adults. In essence he showed, using the recognised criteria on which Casemix is based, that the disease patterns in Aboriginal children are different to non-Aboriginal children both here and elsewhere in Australia. If these differences are not adequately accounted for there may be serious funding implications for Territory hospitals. A number of Territory Health Services personnel have endeavoured to ensure that these differences are recognised by the Commonwealth and are allowed for in the future applications of Casemix.

The Committee recognises the importance of accurate data for reporting health status and the garbage in garbage out adage. The Committee also anticipates the need to examine options for less expensive recuperation facilities than an acute hospital which will become of greater importance with the introduction of Casemix.

**RECOMMENDATION 23.**

1. **That the integrity of the data in the Hospital Information System be checked to ensure the reliability and integrity of health indicators and funding; and**

2. **that recuperation facilities be provided to prevent return of hospital patients to an inappropriate environment.**

### 3.7.3 Health Infrastructure Priority Projects (HIPP)

In the 1994-95 Federal Budget, the Commonwealth Government provided additional funding for environmental health initiatives for indigenous Australians and extended the National Aboriginal Health Strategy for another five year period.

The Health Infrastructure Priority Projects (HIPP) was established by the ATSIC Board of Commissioners at the June 1994 meeting under the Community Housing Infrastructure Program. HIPP was allocated $130-140 million over a three year period with funds managed by private contract managers appointed by ATSIC. There was consultation with communities and ATSIC Regions to determine priorities.

Anecdotal evidence from Territory Health Services in October 1996 indicates that funds allow provision for training and resourcing of Aboriginal people to manage the new infrastructure in the community.

HIPP intends to achieve a targeted approach to communities most in need of large-scale environmental health infrastructure. Projects should focus on the physical development and environmental health infrastructure, although HIPP funding will be available for associated planning, design and project management costs. Projects should target environmental health infrastructure needs in a holistic way.

Ove Arup & Partners (1995, pp. 2-3) agreed to support for the Health Infrastructure Priority Projects in response to the ATSIC initiative.

> Northern Territory agencies regard the Health Infrastructure Priority Projects (HIPP) program as an opportunity to achieve needed service and program coordination within communities and strongly supports ATSIC's initiative in pursuing inter-agency collaboration to achieve better health outcomes. **The Departments of Housing and Local Government; Education; the Northern Territory Employment and Training Authority; the Office of Aboriginal Development; the Power and Water Authority and Territory Health Services** have combined to help ensure that HIPP projects create the conditions necessary for sustained better health ...
>
> Northern Territory Government Agencies recognise that access to timely accurate data is essential for monitoring the status of health infrastructure and the effects on health status. Each Agency has progressed in development of information systems that provide such information, although gaps in the information remain.

HIPP focuses on a number of elements contained in this report.

**RECOMMENDATION 24.**

**That the Health Infrastructure Priority Projects' initiatives be strongly supported by Government and extended to other communities until infrastructure requirements are met.**

Ove Arup & Partners (1995, p. 6) referred to one of the four strategies in the Northern Territory's Aboriginal Housing Strategy (1992):

> *Develop a computerised database of community housing and infrastructure and indicators for the development of strategies.*

The NT holds data on 620 communities, outstations and town camps and data on individual dwellings for seventy larger communities.

Ove Arup & Partners (1995, pp. 41-44) also referred to monitoring and evaluation:

... A data model and information system is required which will provide baseline information on communities selected to receive HIPP funds. The information will also permit monitoring of changes in health infrastructure, environmental conditions and health status and be used to evaluate the impact of infrastructure on improvements on health status ...

Attention is focussed immediately on identifying baseline information, and information for monitoring and evaluating the impact of the HIPP program on environmental conditions, health indicators and other beneficial outcomes for the selected communities ...

However, it is expected that this information system will be expanded to other communities in the Territory and integrate with the planned Territory Health Services' Aboriginal Communities Database ...

The THS Aboriginal Communities Data Base will provide a centralised source of health information which includes demographic information, rates of communicable diseases, chronic diseases, food and nutritional status, immunisations, etc. Information on health infrastructure and environmental conditions will make an important contribution to the Aboriginal Communities Database on aspects critical to prevention of poor health in communities.

It is expected that the THS Aboriginal Communities Database will integrate with similar databases of other agencies such as Housing and Local Government, PAWA, Transport and Works, Education and the Office of Aboriginal Development ...

... Identifying and measuring causal linkages between changes in infrastructure and health status in the complex social, political and physical environments often found on communities will be a demanding process.

The final model should contain a minimum set of key data elements common to all communities, but also have the flexibility to be able to evaluate the impact of different kinds of infrastructure provision, eg. waste water disposal versus additional housing or sealing of internal roads ...

The model should be developed so that it is useful and successful at the community level, but can be integrated into other information systems for wider data retrieval purposes. For the information system to be functionally transparent, (ie. there are clear and accepted reasons for collecting different types of information), stake holders at the community level need to be involved in planning at an early stage.

### 3.7.4 Community Care Information Systems Project

The Territory Health Services has identified that there is a deficiency of timely accurate information on the needs of the community and services being provided, which is having a dramatic effect on the ability of the Territory Health Services and health workers to respond to the increasing demands on health care services. In most community care areas of the Department, there is minimal investment in information and information technology. The consequence is that even basic activity information is not available, resulting in critical decisions being made on anecdotal information or one-off data collection exercises.

There is an immediate demand for a system which will allow the recording of client demographics with associate disease data, eg. diabetes, renal, TB, STD, etc., as well as support client tracking, appointment scheduling and maintenance of basic client treatment details.

The Community Care Systems Project focuses on the trial of a system to address the above requirements.

The project for the Integrated Health System for Community Care was scheduled to complete its planning stage at the end of April 1996.

Advice received from Territory Health Services on 23 October 1996 is that the Remote Community Health Information System is shortly to be trialed at Barunga. If the trials are successful and the necessary funding can be identified, it is intended to implement it throughout the NT in remote community health centres.

Personal computers will be located in each community and 15 personal computers will be trialed in Alice Springs communities. Training and support will be a major challenge particularly in the context of high turnover of staff in communities.

Advice from senior staff in Territory Health Services indicates that there is no involvement of Aboriginal Controlled Health Services and Aboriginal organisations in the planning process. Advice also indicates there is some involvement of Menzies School of Health and General Practitioners.

At the time of this report there was no indication of any funding for the Aboriginal Community Care data base beyond the trial.

Unless reliable health information is made available to Aboriginal communities, the progress towards an enlightened community taking action to address its own health needs will be retarded and the outcome will be more acute services.

**RECOMMENDATION 25.**

**That an appropriate integrated Health Information System be resourced to ensure that health information can be made available to each community.**

### 3.7.5 Commonwealth Health

The Department of Health and Family Services does not have in place information systems that give true effectiveness measures of Aboriginal health services. Portfolio evaluation plans and programs give a measure of program effectiveness at a broad level. There are difficulties with joint programs.

Information is varied and patchy - there is a move towards outcome based indicators from the previous input based services.

The Aboriginal Community Controlled Health Service organisations will enter into service agreements to monitor inputs and outputs in addition to the acquittal process of how funds were spent.

Prior to the transfer of health from ATSIC to the Department of Human Services and Health, a minority of Aboriginal Controlled Health Service organisations had service agreements.

An example of information needs is illustrated in a Commonwealth Department of Human Services & Health (1995c, pp. 55-56) report into the efficiency and effectiveness of the Home and Community Care Program (HACC). This report refers to outcome indicators:

> The implementation of outcome indicators for the HACC Program is being carried out in stages. A number of the proposed indicators can already be measured through the use of existing data collection mechanisms. Others would rely on the completion of a number of initiatives currently under way, such as the development of a consistent approach to assessment, collection of unit costs data and the implementation of service provision measures.
>
> The purpose of the indicators is to assess the performance of the Program as a whole, rather than that of individual projects. The task of bringing together data and other information will therefore fall mainly to the State, Territory and Commonwealth departments responsible for the HACC Program. The main impact on service providers will be seen in variations to data collection forms and possible changes to the service review process to assist in the measurement of the more qualitative indicators.

The HACC Program funds community services to provide basic maintenance and support to assist frail aged and younger people with disabilities to remain in their own homes and avoid premature or inappropriate admission to institutional care such as hospitals, hostels and nursing homes. The cost is 68.71% Commonwealth and 31.29% NT.

The NT obtains information about the HACC program through the collection of data in May and November each year. A community care data system is required to support an equitable distribution of funds.

McLean L. (1995) referred to the lack of data:

> The lack of more recent data than the 1991 Aboriginal Torres Strait Islander census has meant that there is little monitoring of trends of the Government's more recent programs. The Chair of the Aboriginal and Torres Strait Islander Commission, Ms Lois O'Donoghue, said that constant monitoring and measuring of outcomes was essential if things were going to get better.

The statistics and information for the measurement of the effectiveness of service provision in Aboriginal communities is inadequate. However the proposed Aboriginal Community Health database if funded beyond the trial and the Health Infrastructure Priority Projects will, in future, provide up-to-date information and statistics to allow

the measurement of effectiveness. Communities will then have access to reliable information about their own health status.

An inquiry into other States information on Aboriginal health shows that there is a national dearth of information.

The training strategy for community health staff, needs to take into account the capacity of the community to input data and to ensure that the users see the benefits of allocating their time to this task. The high turnover of staff in the communities will require more frequent training.

The Northern Territory Department of Lands, Housing, Environment and Local Government and the Local Government Association have a joint project with the Commonwealth Government to develop management skills for Aboriginal communities. This project will also include the use of technology in communities.

**RECOMMENDATION 26.**

**That the Territory Health Services liaise with the NT Local Government Association to coordinate with the management skills project to avoid duplication of resources.**

# *CHAPTER 4*

# 4. TERMS OF REFERENCE (d)

***the cost efficiency of service delivery mechanisms and whether more cost-efficient solutions are available***

## 4.1 Introduction

Technical efficiency in health is concerned with minimising the cost of producing a given level of output of health services. Allocative efficiency acknowledges that resources are limited and transfers resources between services to maximise the benefit to the population.

This section of the report considers efficiency and equity. Equity of resource allocation between Aboriginal communities is doubtful because allocation has been based on historical funding rather than allocation of resources according to population health requirements.

Health decision-making includes consideration of how much money to invest on prevention (fire breaks) and how much to spend on acute health (fire fighting); how much to allocate for community health and how much for urban health.

The objective is to raise the health of Aboriginal people to that of non-Aboriginal people and to make the best use of the limited health dollars.

## 4.2 Submissions

In a submission to the Public Accounts Committee, Congress referred to a lack of access of Aboriginal people to primary health care services which it claimed as the direct reason for high hospital use. A properly resourced and appropriately managed health service on Aboriginal communities is proposed as a way to reduce costs of health care for Aboriginal people.

Anderson (1995) supported the need for increased services with more cost effective services by way of provision and access to local primary health care.

Kennealy (1995) considered that it would be more cost effective to equip a main centre and fund outstation visits adequately, thereby avoiding the need to supply new clinics. Greater emphasis on primary health would, according to the submission, avoid up to 50% of visits and reduce medical costs. Teaching preventative measures and making available healthy foods along with improvements to general living conditions are considered necessary to reduce the high cost of acute illness.

A submission to the Public Accounts Committee from registered nurses and Aboriginal Health Workers at Milingimbi and Ramingining Health Centres considers that improvements to health require Aboriginal people to accept responsibility for their own health and future with the development of partnerships between Aboriginal communities and Territory Health

Services. The submission also proposed a re-evaluation of jobs in major centres and decentralisation of human resources as a strategy for increasing efficiency. Work practices such as free taxi services from health staff, patient reminder system for every person requiring follow up and maintaining the birth register are identified as not improving health.

Owen (1995, p.2) referred to cost efficiency:

> Sustainable financial management is virtually non-existent to a point at which it is impossible to differentiate fraud from rank incompetence. Qualified and sane accounting and managerial staff are difficult to recruit, almost impossible to retain, extremely expensive and prevented from functioning by the constant humbug, often from their employers, to provide money to individuals for unfunded purposes.

Regional Health Resource Centres are proposed to provide administrative and locum support to independent health centres. As with other submissions primary health care is supported through early diagnosis and screening to avoid emergency evacuation and tertiary care. General practitioners are proposed to supervise treatment in the clinics.

Spillane (1995) submitted that neglecting the primary services to a population with such a high level of morbidity is ultimately going to be more expensive if the cost is shifted to aeromedical evacuation and tertiary health services. The streamlining of the administrative services and trimming administrative fat is advocated to avoid cuts to programs.

Malavisi (1995) proposed the Commonwealth funded rural incentive scheme as a cost effective proposal. The rural incentive package provides $120,000 whereas a District Medical Officer is paid $65,000 excluding overtime. District Medical Officers are employed by Territory Health Services.

The Public Accounts Committee notes that the Commonwealth Department of Health and Family Services (1994) flier titled ‘Rural Australia Needs More Good Doctors’, specifies the assistance for General Practitioners to relocate to Aboriginal communities in rural areas - relocation grants of $20,000 for a GP, training grants of up to $78,000 and remote area grants of $50,000 per year.

Benjamin (1995, p.13) said:

> Discouraging to witness enthusiasm and co-operation of local Aboriginal people in working together to provide services and education programs, but inadequate and/or inappropriate dispersal of funds to achieve same (eg. Environmental Health issues).

## 4.3 Efficiency

The **efficiency** of what is being done examines the extent to which the inputs that are used match the program outputs. Does the program/s make efficient use of the resources allocated? This gives rise to considerations such as the way the programs are undertaken, the growth in resources, how the program is funded and alternative funding, operational problems and future growth.

Palmer & Short (1994, p. 39) defined **technical efficiency** in the health area as minimising the cost of producing a given level of output of health services. However, technical efficiency should not be considered in isolation from **allocative efficiency**.

Mooney (1995, p.4) described allocative efficiency:

> The resources available for health services everywhere are limited. Demands are infinite and choice is necessary - which objectives to try to pursue and to what extent and which objectives not to pursue. The goal of objective allocative efficiency is, in essence, to maximise the benefit to the population being served with the resources available.

The efficiency within hospitals is assisted by **casemix** which is an Australian-wide measurement tool and analyses diagnostically related groups. It has shifted the measurement from inputs to outputs. Territory Health Services moved to Casemix funding from 1 July 1996 and this should assist decision-makers to ensure a more efficient allocation of resources.

Efficiency in health care lends itself to measurement of health gains in relation to dollars allocated and it is quite clear that greater health gains could be delivered to more people through prevention and health promotion rather than allocating resources at the acute side of the health equation to the detriment of primary health. Striking the right balance requires the exercise of preferences. Mooney (1995, p.12) said:

> There's a sense in which only the people themselves, whether they're Aboriginals or non-Aboriginals, can really express preferences for the weights to be attached to, for example, health gains for the elderly versus health gains for children. But I certainly agree with you that the chances are that, in terms of **efficiency**, the greatest gains are to be had through health education and primary health care.

Gains in efficiency can be achieved through culturally appropriate primary health care models such as Strong Women, Strong Babies, Strong Culture, which incorporates Aboriginal control and responsibility and reversal of dependency, relevant education and reinforcement of the value of Aboriginal culture and identity. Menzies School of Health are also aware of community initiatives that have been successful. However the health indicators, covered under Term of Reference (c) 'the effectiveness of services and whether present service delivery mechanisms are relevant', show that while there has been improvement in some areas, in other areas the health gap between Aboriginal and non-Aboriginal people is increasing.

The link between the health providers and research organisations could be strengthened so that research may have practical application.

The need to learn from and trial community programs that are successful was covered in Recommendation 5. p. 25. The following recommendation reinforces Recommendation 5.

**RECOMMENDATION 27.**

**That Territory Health Services provide research opportunities to Menzies School of Health, Northern Territory University and Aboriginal Research Unit that will assist decisions with the provision of health services.**

Another contributor to a lack of efficiency is the duplication and overlapping of health programs between the Commonwealth and Territory. This is covered in section (f) strategies for achieving cooperation from the principal participants. The written information provided by Territory Health Services to the Public Accounts Committee on 19 April 1995 said:

> Uncoordinated planning and funding allocation creates competition and conflict among health care providers and communities, the Department encourages partnership and co-operation to achieve a coordinated approach to make the best use of the resource available.

The Committee strongly supports coordination among health providers.

### 4.4 Ilan Warchivker's (1995) Expenditure Study of Rural Communities.

In 1994, the Commonwealth funded an NT initiated project to explore the development of a resource allocation methodology for allocating resources in remote and rural areas of Australia. An expenditure study was undertaken by Ilan Warchivker from the Menzies School of Health as part of the project. An attempt was made to review all regions in the NT, but due to time and data constraints, information covered Darwin Rural, Alice Springs Rural and Katherine Districts. The study showed significant differences in expenditure between communities and regions.

The reasons for this variation are probably due to historical funding, different levels of need, different service delivery models and inadequate resources to meet demand.

The study used financial data from the 1993/4 records of the Government Accounting System and Auditors' reports. In 1993/94, NT Budget Papers No. 2 reported that Community Health budgeted expenditure was $57.65m.

Clinical financial data, grants data and supporting services data were collected. Other expenditure on administration of the region, Corporate Services and expenditure of the ATSIC branch that dealt with grants to communities was not analysed.

Clinical expenditure comprised actual services provided to residents of Aboriginal communities at the clinic.

Communities were divided into small, medium and large. Results for Alice Springs showed that in the small, medium and large communities the average clinical expenditure per capita was estimated at $585, $653 and $654 respectively. Average health care expenditure for mobile clinics was $310 per capita and the Community Controlled Health Services was $880 per capita.

Results for the Darwin Rural District in terms of average clinical expenditure ranged from $1,031 per capita for small communities, $674 for medium communities and $554 for large

communities. This represented a variation of between $455 and $1,256 per capita between the Darwin Rural District communities.

| Average Per Capita Clinical Expenditure (Actual Services at the Clinic) | | | |
|---|---|---|---|
| | **Small** | **Medium** | **Large** |
| Alice Springs Rural District | 585 | 653 | 654 |
| Alice Springs Mobile Clinics | | 310 | |
| Alice Springs Community Controlled Health Services | | 880 | |
| Darwin Rural District | 1 031 | 674 | 554 |
| Katherine Rural District | 748 | 584 | 655 |

Source: Warchivker, I. (1995a, b, c)

Results for the Katherine Rural District for average per capita clinical expenditure were $748, $584 and $655 for the small, medium and large communities respectively. The analysis of variation in clinical expenditure per capita identified a range of between $291 and $1,031 per capita amongst the Katherine Rural Districts.

Warchivker, I. (1995b) advised that for Alice Springs the variation in clinical expenditure per capita in the small communities varied between $253 and $1320 per capita; medium communities between $337 and $931 per capita and the large communities between $580 and $750 per capita.

The $770 per capita in supporting services comprised $220 per capita for the Royal Flying Doctor Service (RFDS), $128 per capita Child Health Unit, $137 other medical supporting services, $151 administration, $69 departmental travel $28 Capital, $26 PATS and $11 aerial medical administration. **Overall 30% of total supporting services reached communities in the form of direct services**.

**RECOMMENDATION 28.**

**That Territory Health Services in conjunction with Commonwealth Department of Health and Family Services examine various options of service delivery to ensure that a much higher percentage of resources gets to communities. (The Committee prefers that this research is conducted under the auspices of the Task Force - see Recommendations 5 & 6.)**

The study raises questions of horizontal equity and allocative efficiency. Warchivker's paper concluded that in some cases improvement on the current distribution is necessary and could be done with little effort from the supplier of services. Importantly, reassessment of the financing of services is needed to reduce the developing disparities between the better funded and poorly funded health services.

Warchivker advised that administration as a percentage of community expenditure per capita varied between 5% and 27%.

The supporting services provided to Alice Springs Rural District amounted to $130 per capita. However, a closer analysis in Mt Allen with a population of 133 people, there is 7% in administration costs as a percentage of community expenditure.

Administrative costs were taken from the Government Accounting System and only include the administrative staff salaries and operational costs in that program.

If corporate management is also taken into account an approximate additional 8% would need to be added on.

The Warchivker study made a number of recommendations arising from the study. These recommendations included the role of the Commonwealth rural incentive scheme for doctors which impinges on the ability of non community-controlled health services to access the system.

The scheme provides Commonwealth funding for general practitioners to work in bush communities with the proviso that the scheme is available to Commonwealth funded communities and not Territory Health Services funded communities.

This is an example of where the allocation of health dollars is based on who provides the service rather than the health needs of the population. The scheme for rural doctors should be changed to recognise health needs rather than who is funding the service.

**RECOMMENDATION 29.**

**That the Commonwealth Department of Health and Family Services change the Rural Incentive Scheme so that it is based on health needs rather than being service provider based and is available for all communities regardless of who funds the communities.**

Warchivker (1995a, b, c) also analysed expenditures on the Patient and Travel Scheme (PATS). It is noted that advice from a senior health manager in Katherine in April 1996 indicates that expenditure on PATS in Katherine is estimated at $450,000 over budget by approximately 25% with over-expenditure predicted in other Districts. It is recognised that PATS is difficult to estimate, however it is recommended that the budget for PATS should either be adjusted to represent the pattern of expenditure or the PATS guidelines be changed to reduce expenditure. Advice from Katherine suggests that some patients could be transferred by road rather than air to Darwin without a risk to their health.

| PATIENT AND TRAVEL SCHEME (PATS) | | |
|---|---|---|
| | **1994/95 $m** | **1995/96 $m** |
| **Total Expenditure on PATS** (PATS excludes interhospital transfers) | 3.878 | 3.798 |
| **Interhospital transfers within Northern Territory** | 1.054 | 1.271 |
| **Interhospital Transfers Interstate** | 0.977 | 0.719 |

Source: CASEMIX Budget Officers, Territory Health Services

Verbal advice from a senior manager in Territory Health Services indicates that specialists are visiting remote communities. For example, visits by an obstetrician results in 35 patients being seen at their community which is more cost effective than PATS. Visits by specialists are discovering an unmet need which initially will increase costs but will avoid acute admissions later.

**RECOMMENDATION 30.**

**That the PATS scheme and expenditure patterns be examined to ensure that opportunities for improving efficiency and effectiveness are promulgated.**

The results of Warchivker's study show that the variations between communities do not reflect population or health profiles on a funding equitable basis.

**RECOMMENDATION 31.**

**That Territory Health Services continue the analysis of expenditure between communities to achieve a more equitable distribution of funds taking into consideration health profiles.**

In a public briefing to the Public Accounts Committee on 25 October 1995, Ms C. Beaver, Health Economist, Territory Health Services, also commented on health services in the context of primary health care and referred to the allocation of medical benefits:

> That concept of primary health care is not just about prevention and community development which unfortunately some people seem to focus on. It is also said, very strongly, that all the population should have equitable access to the same level of basic services. And we are all signatories to it. One could argue that Australia has agreed to provide the same level of access and the same quality of service that the people in Melbourne have. I have looked at the community level. It is something like $169 per capita in the Northern Territory, and it is roughly $280 in Darwin. So most of it is spent in Darwin- that's pretty easy to see. Then you go to Tennant Creek and it is something like $75 per capita. You go to Haasts Bluff, I think it is, and it is something like $4 per capita. You go to the Tanami Desert and the 23 communities we

> looked at from Alice Springs and it is nothing. In Melbourne Ports, it is $440. I don't know that Melbourne Ports has a particularly sick population. International evidence suggests that the healthier you are, the more informed you are, the better educated you are, the more dollars you spend. It seems to have got all upside down.

These comments reinforce the need to access the shortfall in Commonwealth funded medical benefits to the Northern Territory which could increase recurrent revenue by up to $38 million when the shortfall in the pharmaceutical benefits is also taken into account. Such an increase would make a major difference to the rural communities if that money could be accessed from the Commonwealth and applied to primary health (refer Recommendation No. 39., p. 136, that the Commonwealth compensate for the estimated $38 million dollar loss to the Northern Territory in Medical Benefits Scheme and Pharmaceutical Benefits Scheme).

It is important to note that in 1994/95 the budget for the Community Health Services Program, Territory Health Services, was $37m. Therefore access to the MBS and PBS has the potential to double the budget for Aboriginal people and make inroads into redressing primary health care. This increase in expenditure would be an investment in reducing additional costs at the acute end of the health equation. It would assist in tackling the health problem by building more 'fire breaks' rather than fighting 'fires'. The example is well illustrated by Hoy (1996, p.1):

> In that study we found that crowded living conditions were very common and unemployment was pervasive. 80% of people smoked cigarettes, 86% of the men and 29% of the women were beer drinkers, the men nearly all to great excess. 40% had skin sores and scabies. Only 17% had two normal intact ear drums and only 30% had at least one intact, normal ear drum, the minimal requirement for preserved hearing. One fifth of men and one half of women had signs of heart damage, the long term complication of throat and skin infections. 30% were overweight, 26% had high blood pressure, 20% had diabetes and prediabetes correlated directly with overweight, chest infections were strongly associated with smoking, and liver disease with drinking. Kidney disease was associated with overweight, high blood pressure, diabetes and skin sores.

Hoy (1996) referred to a more recent review of children's health (unpublished) as equally appalling:

> ... One quarter of newborn babies weigh less than 2.5 kg, a serious risk for early death and childhood illness, and predisposing, by inadequate development of critical organs, to diabetes, cardiovascular disease and kidney disease in adults. 42% of children are seriously undernourished by world standards and most children are hungry much of the time.

(See contrast of newborn babies overleaf - Annie Bonson, Dr Sue Sayers and Dr Alan Walker.)

A review of transactions in April 1992 at the store, club and takeaway restaurant, shows 29% of all money spent on beer and 22% on cigarettes. Together with the large amount of money changing hands in card games, this leaves little for food towards the end of each social security pay period (p. 2). Only about 20% is spent on food.

# Baby

The expenditure pattern as shown in the pie chart (overleaf) does not include food provided through the school tuck shop, private orders from town or hunting and therefore should be considered as a general guide.

The Aboriginal Development Unit in the Education Department has arranged money management courses using a board game *Family Fun*. This course has been run three times over the last five years by community councils who have become aware of its success in other communities.

**RECOMMENDATION 32.**

**That the Aboriginal Development Unit of the Education Department actively promote and deliver money management courses to communities and the use of such courses be evaluated.**

Kidney failure in the Top End has increased to 17.4 times that of non-Aboriginals with a 60 fold increase for one community. The report also indicates that the average time for the annual number of new cases to double is about three and one half years. In January 1996, 110 of the 116 dialysis patients were Aboriginal. The overall costs for each dialysis patient was $50,000 per year in 1992 excluding housing in Darwin, transportation, medicines, hospitalisations, etc.

Cost efficiency will not be achieved in isolation from addressing the reasons for the illnesses (see *Table 1: Factors Contributing to Aboriginal Ill Health*, p. 31).

**RECOMMENDATION 33.**

**That future options for dealing with the worsening renal disease be documented and submitted by Territory Health Services to Cabinet.**

### 4.5 Efficiency in Health

Efficiency needs to be considered along with equity which is covered in Term of Reference (e) that refers to the adequacy of the funding arrangements.

Efficiency in health means obtaining the greatest health gain from the available health dollars. The basis of economic appraisal (or economic evaluation or the cost benefit approach) is the comparison of costs and outcomes. The aim is to help decision-makers ensure that the allocation of scarce resources is such that health outcomes are maximised within the limits of the available resources. Cost efficiency in health requires an overview of health economics which is integral to this term of reference. Monash Distance Education (1994, pp. 20-26) refers to economic evaluation:

# Store, restaurant and club receipts

**Cost minimisation analysis**

In some cases the outcomes of two interventions may be the same and the only difference is the cost. When there is good reason to accept that the outcomes of the two alternatives are the same, we need only consider a cost minimisation analysis (p. 20).

**... Cost effectiveness analysis**

More often than not the outcome will vary between alternative programs. Sometimes the outcome can be measured in a comparable unit. In this case, the choice may be made on the relative cost for a given outcome (eg. cost per life year gained, or cost per days free of pain or some other clinical outcome). This is called *cost effectiveness analysis*. It is the most common economic appraisal tool used in the health sector at present. It can answer the question: which of two alternative programs is the best means of achieving a particular end? The end can be defined as maximising the number of life years in the community. It can also be a more immediate outcome, such as the cost per smoker who quits in alternative anti smoking campaigns, or the cost per women screened in a cervical screening program. Examples in Australia include the cost per year of life gained from alternative drugs, home versus hospital dialysis, breast cancer screening, cervical cancer screening and heart disease reduction programs. Cost effectiveness analysis is very useful for many research questions but is limited in two ways:

> It only captures one dimension of outcome. For example, if it is measuring life year saved it takes no account of the quality of that life.
>
> It cannot tell you if either of the options should be chosen, only which is a more efficient way of achieving a particular health outcome (p. 21).

**... Cost utility analysis**

A cost utility analysis allows comparisons of programs where both costs and outcomes differ. Cost utility analysis measures outcomes of a program as the health related utility of the participants. It thus goes a step further than cost effectiveness analysis by measuring not just clinical outcomes (lives saved, for example) but the quality of life of those who experience those outcomes. For example, in an evaluation of a strategy to reduce falls among the elderly, the outcome may be more than the number of hip fractures reduced. It may also be an improvement in the quality of life of the elderly. A cost utility analysis thus considers, not just the extension of life as an outcome of a program, but also the quality of that life. This is done by adjusting the life years gained from a program by the quality of each life year. In other words, the outcome is the health status or health related utility of the population involved in the program measured as quality life adjusted life years (QALYs) or healthy year equivalents (HYEs). It therefore covers a broad ranger of health benefits than cost effectiveness analysis, but does not include a measure of any changes in the overall welfare of individuals, groups or the community as a whole (ie. health is just one aspect of overall welfare) (p. 22).

**... Cost benefit analysis**

Cost benefit analysis considers how to maximise all benefits from available resources. It is, as Mooney points out, concerned with allocative efficiency.

> In order to consider a maximum of net benefits, cost benefit analysis must value all costs and benefits in a single unit of measurement. The most obvious unit of account is money. Cost benefit analysis requires a money valuation on all marketed and non marketed resources including, if necessary, human life. While it is rarely done in health care evaluation, there have been a number of attempts to use wage based and survey based values of life in accident prevention evaluations, eg. swimming pool fencing, seat belts and some Swedish research into the willingness to pay for anti-hypertensive therapy (p. 23).

Which economic evaluation technique to use depends on the breadth of the question being asked, and often the availability of appropriate data. For example, a choice between using drugs for a particular condition:

1. If we know that the outcomes are the same, then the question is 'Which is cheaper?' A *cost minimisation analysis* is the appropriate technique.

2. If the outcomes are not the same (one has more protective effect), then the question is 'Which produces greatest outcome per $?' A *cost effectiveness analysis* is the appropriate technique.

3. If outcomes differ not just in one respect (one has more protective effect, but worse side effects), then the question is 'What is the relative quality of adjusted life year saved?' A *cost utility analysis* is the appropriate technique.

4. If the question is 'Should we use either drug (should we treat this group at all)?' then we need to know what the benefits of the treatment are. A *cost benefit analysis* of costs and benefits in money is the appropriate technique.

Basically decisions have to be made about funding priorities and that means deciding on withdrawing funds from some health services to others when there will be a better health outcome for the people of the Northern Territory.

Any health should be measured in terms of opportunity costs. For example, should the Territory Health Services allocate public health dollars to an administrative position or for another health worker in a remote community? What is the added value of the administrative position?

The extent to which the above techniques will be used in decision making within Territory Health Services will be influenced through the Health Economics Resource Allocation Policy Unit which is introducing these concepts through optional appraisal, marginal analysis and program budgeting workshops.

All existing and current programs should be examined to ascertain the extent to which the shifting of resources from one program to the next may result in a better health outcome.

### 4.6 Use of the Health Economics Tools

Mooney (1994, p. 11) said the following about priority setting:

> In writing this material for the NT Health Department, I am aware of the frustrations I feel that economics seems not to have been accepted more than it has been in the field of priority setting

> in other locations. The position is changing for the good however and program budgeting and marginal analysis are being used more and more in the UK, are being recommended by the Ministry of Health in New Zealand in their latest guidelines to the Regional Health Authorities there and the NSW Health Department has funded demonstrations studies of program budgeting and marginal analysis (and in which studies I am directly involved).
>
> One difficulty I have is that it seems 'so obvious' to me what the merits are of the economic approach to priority setting. To use economic analysis in an ideal fashion can be difficult, given in particular the demands on measuring techniques especially of the benefits of health care, which are still at best developing. There are also in health care systems data deficiencies in the sense that on both the costs and the benefits side the information is just not there in the form, detail and precision that ideally we would want.
>
> Yet a lot of these measurement problems and data problems are there **whatever** methods are used to address priorities or if they are not then I would be clear that the methods are deficient. We cannot rationally set priorities in health care without knowing about the costs and benefits of different patterns of interventions. That is simply impossible. So it is not that the approaches of economics to priority setting create these problems. They are there. Insofar as other approaches sidestep these problems then they cannot be methods of priority setting that are genuinely useful in getting us further down the road to more efficient and equitable health services.

It is accepted in all health research that it will never be possible to provide everyone's total health needs. **Program budgeting** will provide information about how current resources are being used. The question to be addressed is how best any changes in resources can be made by reduction, transfer or increase - this is the process of **marginal analysis**. It involves shifting resources from one program to another or one project to another to increase total benefits from the resources available. In essence the approach seeks to locate the distribution of resources where the ratios of marginal costs to marginal benefits are the same across all programs.

The economic approach is a combination of program budgeting and marginal analysis with the key concepts being opportunity cost and the margin and this is explained by Mooney (1994, p.13).

> Program budgeting is a simple mechanism for providing an information framework to assist the process of allowing resource use and outputs generated to be set alongside health service objectives and for helping to identify and begin the examination of relevant margins through marginal analysis. Program budgeting is not evaluative in itself but rather creates a framework in which evaluation is facilitated and encouraged.

Mooney (1994, pp. 14-15) refers to programs and sub-programs with estimated expenditures and outputs as an 'information framework' to begin to consider marginal shifts in resources.

> ... However it is my experience in working with this elsewhere that the health service managers involved have not initially a clear idea as to what is contained in particular programs nor any real idea of the size of different parts of total expenditures within programs. The position in NT may be different but from conversations in Darwin during my visit I do not think that is the case ...
>
> Marginal analysis ... addresses the following three issues:

> First, if there are no more resources available can, say, $1 million be moved from program X to program Y and the overall total benefit be increased?
>
> Second, if more resources are made available, on which program or sub-program are these additional resources best spent in the sense of creating most extra benefit?
>
> And third, if expenditures are to be cut, where should the cost occur so that the impact in terms of loss of benefit is minimised?
>
> ... the optimal allocation of the budget occurs when the ratio of marginal benefit to marginal cost is the same across all programs / sub-programs.

For example, should the finite health dollars be allocated for services to improve the health of the young or to prolong the life of an elderly patient who chooses to avoid the treatment? These decisions have moral and societal implications and should be sanitised at the highest level of government on behalf of the community as a whole. Mooney (1994, p.15) discussed the challenge for decision-makers:

> Ought $100,000 to be taken from the ante-natal program and spent as extra on the post natal program? Should more resources go to screening older women in pregnancy even if younger women then get fewer resources spent on them during their pregnancies?

Decision makers may try to establish a Quality Adjusted Life Year (QALY) league table or some health gain or benefit gain league table. There is no way of removing totally the subjectivity involved in such choices.

There will be a need to undertake lots of costing studies to perform marginal analysis. The economic approach deals with allocative efficiency.

Equity needs to be considered in priority setting and Mooney (1994, pp. 17-18) recommends that the best way to handle equity in priority setting is for it to be 'added on' at the end of the efficiency exercise. He believes that if efficiency and equity are considered together there is a risk that the waters get muddied and there is a loss of clarity with respect to why particular options seem good or bad.

Mooney (1994, pp. 17-18) suggests the following process for the NT:

> First the NT Health Department as a whole might make a clear statement about what their operational goal for equity is with respect to for example health, access or use. Thereafter, they might try (but it is difficult) to give guidance as to the relative weight to be attached to equity and in what dimensions - gender, social class and geographical location are the three obvious ones and in the NT I would have thought Aboriginality as well. These equity guidelines would then be presented to the program management groups to assist them in their deliberations with the idea being that they concentrate on efficiency concerns but then indicate what the equity impact would be of their various possible strategies.
>
> When the choices overall come back from the program management groups to the main health service authority, it would be then that the final trade-offs between equity and efficiency would be made. Given the inevitably political nature of these choices, it would seem appropriate that these choices with respect to equity are made at this 'high' level.

Mooney offers caution with the needs assessment approach (1994, pp. 20-22) and suggests emphasis be given to the capacity to benefit. An understanding of the health needs of communities is required to understand where there is capacity to benefit.

The most common approach to priority setting would appear to be what is normally referred to as **needs assessment.** This is an attempt to assess the total needs for health care for a population as a whole or for a particular disease group or a particular client or age group.

> The total needs assessment approach where the total burden of disease is estimated seems so inappropriate. It entails inter alia setting priorities on the basis of the size of the problem whether there is any possibility of dealing with the problem or not ...
>
> The second approach to needs assessment is preferable. Here there is acceptance of the fact that not all illnesses can be cured and indeed that illnesses are curable or treatable to varying extents. It is here that the concept of capacity to benefit comes in. The technological constraints are accepted. This clearly is a move forward.

Mooney (1994, pp. 21-22) then considers how the information that measures total need should be used.

> One possibility is to argue that resources should be allocated pro rata with needs. The logic here would be that since this form of need reflects capacity to benefit, then allocating resources in this way would maximise the amount of need met. But resource use has to reflect the costs of treatments. What about the costs of meeting the needs? It would only be if the cost per unit of need met (perhaps health gain) were constant across all diseases and conditions and that for all of these diseases and conditions average and marginal cost were equal, that this use of the estimates of needs assessed would be valid. That is most unlikely to hold good.
>
> To put this another way, it would mean that all diseases could be treated in an equally operationally efficient way, ie. that all diseases were equally cost effective in their treatment. It would require further that technological developments in medicine and in the delivery of health care were such that they did not affect the cost effectiveness of such treatments at all. It would additionally mean that there were no economies of scale for any disease or condition.
>
> A second possibility would be to argue more basically that the needs assessments should be used simply as an ordinal ranking ie that the disease with the greatest needs should get more resources than that with the next greatest need and so on. In some ways this is more appealing. However if the cost-effectiveness of interventions varies then again there is no reason to think that the greatest need should be given priority. Further if we adopted this ordinally ranking how would it be used? At what point would we say: 'that is enough spending on the top need, now let us move to the next'. In other words the lack of cardinality leaves us able to use the margin in resource allocation decision making.
>
> A third possibility is to use the needs assessment information in some form of weighting process which might reflect priorities. Thus if it were felt that those diseases or conditions that created the most need in society should be given priority over and above any considerations of some simple cost effectiveness criteria of allocating resources in such a way as to maximise health gains, then presumably the ranking of needs assessment could be used to arrive at weights. Thus if say cardiovascular disease were the disease for which there was the greatest need, then the health gains from any interventions which had an impact on reducing the needs there, might be weighted more highly than those for interventions on other diseases which came further down the needs league table.

> ... If we do not allow for costs in priority setting then this would mean that if some new technology allowed heart transplants to be carried out at one tenth of their current cost then such a change would have no effect on priorities in health care. Again if the costs of hip replacements rose six fold would this not have an effect - should this not have an effect - on the level of supply of hip replacements?

Eccleston, R. (1996) referred to Oregon in the US where the public were asked to rank the procedures they wanted their taxes spent on, given that not everything could be done. They specifically ruled out some organ transplants as too expensive, and said the money saved could go to prenatal care. Generally people support intensive treatment at the beginning of life, preventative treatment throughout life, and were not so interested in expensive life saving treatment at the end. In practice more is spent in health care in the final year of our lives than in the rest of it put together.

Mooney (1994, pp. 22-24) also argues the futility of assessment of needs as a totality where expectations of meeting total needs are raised but cannot be met.

> Needs assessment then leaves this observer wondering what there is to gain from any assessment of needs as a totality. It is possible that a case can be made for assessing total need in the context of equity. There is no case for total needs assessment exercises for promoting allocative efficiency. They are at best irrelevant to the issue to hand; at worst they may create the illusion that total needs are capable of being met. More subtly and perhaps more dangerous still such exercises may result in allocations of scarce resources pro rata with assessments of total needs for resources for different diseases. This may get closer to where we want to be but still ignores questions of the relative effectiveness and cost of interventions on the margin. It is here on the margin and here with its lack of concern for costs that needs assessment fails as a helpful device for rational priority setting.
>
> Needs assessment is based on faulty logic ... of the imperative of the 'size of the problem'. That faulty logic needs to be exposed - and exposed again. It is so pervasive in health care. The fact that it is pervasive however is no reason for believing that it is any sense 'right'. I would be confident that those of you who are working in the health care sector or who have had contact with it will recognise this needs assessment approach - unfortunately!
>
> Before leaving needs assessment it is perhaps worth considering another phenomenon of needs assessment which may help to explain at least in part its popularity. Certainly in the UK at present and I think in many other countries there are various planning and purchasing exercises which start with needs assessment. An example in Australia is the 'Goals and Targets' documents. One of the potentially great advantages for needs assessors is that while they are engaged in such exercises, they do not have to face up to the difficult and demanding choices involved in priority setting of services - which services to expand and more difficult which services to cut? Which patients to refuse? Which patients to deny life to?
>
> **...** Explicit choices even if they are tragic ones need to be made in health care if priority setting is to get us to efficient solutions in resource allocation. If needs assessment is part of the process of keeping our distance from difficult choices then there is a need to provide better training and create appropriate incentives to get decision makers to face the choices explicitly. The dividends from such explicit choices are great and in my view more than enough to justify the extra investment in training and organisational changes that might be required to overcome

> the lack of moral fibre that may hinder better decision making in health care and lends support to the 'needs assessors'.

Mooney (1994, p. 26) emphasised the importance in applying the marginal cost, marginal benefit principle.

> ... the targets that are most frequently used in health care do not embrace the marginal cost versus marginal benefit principle so they fail to promote allocative efficiency ... Indeed that is the challenge.

Mooney (1994, p. 28) suggests the following questions when dealing with priority setting:

1. Does the approach incorporate some assessment of the cost of interventions?
2. Does the approach incorporate some assessment of the benefits of interventions?
3. Is the approach operating on the margin?

> If the answer to just one of these questions is no then the approach is suspect if efficiency is the goal of priority setting.

**RECOMMENDATION 34.**

**1. That decisions which commit the expenditure of health dollars be related to an objective process for improving health outcomes.**

**2. That the following checklist be applied when priorities are being set:**

**a. Does the approach incorporate some assessment of the cost of interventions?**

**b. Does the approach incorporate some assessment of the benefits of interventions?**

**c. Is the approach operating on the margin so that the ratio of marginal costs to marginal benefits is the same across all programs?**

Mooney (1994, p. 28) advocates the use of Quality Adjusted Life Year (QALY) league tables in priority setting because they embrace many of the principles that he would like to see in priority setting:

> They are based on the idea of weighing up costs and benefits on the margin and to that extent are to be encouraged and recommended for priority setting. However certain reservations need to be expressed about the way in which they are built and the limitations in their use. First, they tend to be based on studies and study results drawn from an illegitimately wide geographical location. Since they are about what to do with extra resources on the margin then they ought to be specific to that issue in whatever location priority setting is to be helped by these study results.

> Second, since they incorporate the concept of costs per QALY as the basis of priority setting, they can only handle priority setting in these terms. This means they do not allow other possible goals than health maximisation to come into the picture and they do not allow consideration of the use of other resources than those earmarked for health, which means that they are restricted on the cost side to health service resources. They cannot legitimately bring in resource use outside the health service - say by patients and their families or by other social services.

The Territory Health Services staff from the Health Economics and Resourcing Branch are currently applying the techniques of optional appraisal. An awareness of marginal costs compared to average costs is being introduced to operational staff.

Other concepts of economic evaluation are relatively new to the process of prioritisation of funds. It is clear that there will be mounting pressure on the decision-makers to be more explicit in justifying their choice of allocating resources to one program rather than alternative programs.

### 4.7 NT Auditor-General's Report to the Legislative Assembly August, 1995.

The section on Territory Health Services refers to service agreements with non-government organisations. It was noted that the monitoring and evaluation of service agreements were significantly behind schedule. Territory Health Services have advised that realistic targets are being set, along with a concerted effort to establish service standards and performance indicators. A program of monitoring and evaluating performance criteria against service agreements and program objectives is also being established.

Arising from the Committee's visits to communities and other discussions regarding service agreements it has become clear that there is concern that the wording of the agreements may not be understood by the community.

Community Councils require access to independent, professional advice and extensive consultation with the Territory Health Services.

The Public Accounts Committee, in its visits to communities and in receiving submissions, has been advised of weaknesses in administrative arrangements where health dollars are missing their target. Examples were:

- time sheets completed for work that was not performed
- inappropriate use of health vehicles
- service agreements with performance targets that have not been evaluated

A general lack of skills in management and administration is a major contributor to difficulties with service agreements and financial management. This may be linked to the education results for Aboriginal people in remote communities which are mostly mid-primary.

Northern Territory Auditor-General (1995, pp. 14-15) referred to the 1995 Queensland Auditor-General's report on audits of Aboriginal and Islander Councils in the context that shortcomings in financial management in some remote communities are not unique to the Northern Territory:

- a few councils have consistently performed to an acceptable standard, but mostly it has been patchy with little regard paid to basic accountability requirements;

- the ability to attract and retain competent staff at some of the more remote locations is a constant problem;

- problems stem from inadequate supervision and financial management brought about by a lack of necessary expertise and continuity of experienced staff.

The Department of Housing and Local Government have developed strategies to address these issues including training in financial management skills for council officers and Department's field staff. The Department of Housing and the Local Government Association of the NT have received Commonwealth and NT funds to implement a three year project which will develop skills for Councils of remote Aboriginal Communities.

It is clear to the Committee that self-determination will not be achieved without the communities having access to the basic skills to understand their agreements, financial and other administrative arrangements.

In support of Recommendation 13. p. 54 which refers to the need for an evaluation of skills within communities the following recommendation specifically refers to health agreements.

**RECOMMENDATION 35.**

**That Health Agreements must be worded and negotiated with communities so that they are both owned and understood by those communities.**

# *CHAPTER 5*

## 5. TERMS OF REFERENCE (e)

***the adequacy of funding arrangements between the Commonwealth and the Northern Territory involved in the delivery of those services***

### 5.1 Introduction

The cost of delivering services to remote areas when added to the health needs of remote areas requires expenditure which exceeds the current allocation.

In a submission to the Public Accounts Committee, Pearse tabled a study of 1994/95 expenditures which showed that expenditures per capita for Aboriginal people was 4.75 times higher than non-Aboriginal people. Furthermore, there are indications that the per capita expenditure in rural communities should be up to 8 times more than urban when unmet health needs are taken into account.

This section of the report shows that the factors used by the Commonwealth Grants Commission for allocating funds to the Northern Territory do not adequately compensate the NT for providing health services to Aboriginal people. For example, the age factor does not take into account that Aboriginal people have a life expectancy 18 years shorter than non-Aboriginal people and require access to health services (normally associated with old people) much earlier than non-Aboriginal people.

The estimated $38m shortfall in medical benefits and pharmaceutical benefits would be the responsibility of the Commonwealth if people in remote communities had access to general practitioners and pharmacists. The NT is providing for these services in the absence of the Commonwealth funded general practitioners and pharmacists. The NT Government is trying to access this shortfall through the Coordinated Care Trial in Katherine and the Tiwi Islands.

### 5.2 Submissions

Northern Territory Treasury (1995b, pp. 17-18) referred to health expenditure and funding for 1994/95 (see *Table 5, p. 113*).

Of total expenditure on Health in 1994/95, $86 million, or 32 per cent, was funded by Commonwealth specific purpose grants. The higher proportion of Commonwealth specific purpose grants in the Health functional area compared with Education and other areas of State expenditure reflects the funding arrangements for hospital services, which are negotiated under the Medicare Agreement, and categorised as specific purpose payments from the Commonwealth.

$157 million was funded from the Territory Consolidated Revenue Account.

| Health Expenditure and Funding 1995/96 | |
|---|---|
| *Expenditure by Activity* | *$m* |
| Corporate Management | 22.9 |
| Hospital Services | 138.6 |
| Community Health | 61.4 |
| Public and Allied Health Services | 39.2 |
| **Total Expenditure** | **262.1** |
| *Sources of Funds* | *$m* |
| Taxes Fees and Fines | 0.4 |
| Charges | 8.7 |
| Miscellaneous Receipts | 10.3 |
| Other Commonwealth Grants | 85.6 |
| Consolidated Revenue Account | 156.5 |
| HACS Departmental Operating Account | 0.5 |
| **Total Receipts** | **262.1** |

*Table 5: Northern Territory Health Expenditure and Funding* [(a)]

*(a) Details of receipts are provided in the Budget Papers for the Department of Health and Community Services as a whole. In order to derive funding estimates for health expenditure, it has been assumed that Community Services expenditure has been funded by Commonwealth specific purpose payments and funds from the Consolidated Revenue Account.*

(Source: Northern Territory Budget Paper No. 2, 1995/96, The Budget, pp. 139, 298, and Budget Paper No. 3, 1995/96, Sources of Funds, p. 17-18.)

Figure 3.4 from Northern Territory Budget Paper No. 3, 1995/96 shows that most of the specific purpose grant was related to the hospital funding grant of $77.4m for 1994/95 (see *Table 6, p. 114*). The Treasury submission states that there is no way of separately identifying Commonwealth General Revenue Grants and Northern Territory's own resource revenue flows from the consolidated revenue account. However, the paper estimates that $114m was funded by Commonwealth General Revenue Grants and the remainder $42m from Territory source revenue.

In a submission to the Public Accounts Committee, Congress advocate that funds from the Commonwealth should be a combination of tied grants and funds direct to Aboriginal organisations. This method of funding is proposed to reduce the administrative and other costs which Congress claims are rumoured to be up to or in excess of 40%.

Anderson (1995) also supports direct funding from the Commonwealth.

**Figure 3.4**

**Hospital Funding Grants for the Northern Territory**

| | 1994/95 Estimate | 1995/96 Budget |
|---|---|---|
| | $000 | $000 |
| **Total Hospital Funding Grants** | **77 391** | **80 319** |
| **Medicare Base Grant** | **24 133** | **24 817** |
| **Other Medicare SPPs** | **53 258** | **55 502** |
| **1. Bonus Payments [(a)]** | **51 811** | **54 004** |
| Base Provision (Bonus Pool A) | 49 573 | 54 064 |
| Annual Adjustment (Bonus Pool B) | -577 | -430 |
| Medical Benefits Supplement | 2 815 | 370 |
| **2. Incentives Package** | **341** | **163** |
| Area Health Management | 34 | - |
| Hospital Access Program | 1 | - |
| Devolution of Clinical Budgets | 32 | - |
| Capital Planning | 274 | 163 |
| **3. National Mental Health Strategy** | **516** | **790** |
| **4. Other Health Services (Annual Appropriations)** | **590** | **545** |
| Post Acute and Palliative Care | 218 | 231 |
| Day Surgery | 87 | 92 |
| AIDS | 285 | 222 |

[(a)] Commonwealth Health Department advice adjusted to reconcile with NT Treasury estimates

*Table 6: Hospital Funding Grants for the Northern Territory.*

Source: Budget Paper No. 3, 1995/96.

Flick (1995) stated that there is a lack of transparency in determining whether disbursal of Commonwealth funds to the NT is properly spent. Bilateral Agreements are not supported, Federal contract arrangements with the independent Aboriginal health services to deliver specific services are supported.

Gaykaynangu (1995, p. 1) said ‘the funding may be adequate however the outcomes are failing to achieve acceptable standards’.

Spillane (1995) noted that in the East Arnhem District there has been a disproportionate amount of monies available to the local Aboriginal Medical Service via ATSIC relative to Departmental funds. A streamlined provision of funding is recommended with strict

evaluation systems. Furthermore communities should not be disadvantaged financially for choosing to take control of their service.

Benjamin (1995) said:

> ... experience in Numbulwar over the past 7 years, has highlighted some inadequacies in appropriate funding to meet needs, however, in a number of cases, obtaining funding is not the issue ... appropriate use of funding is the problem.

Hemmerling (1995) advocated for the various funding bodies to get together and agree criteria for evaluation. He criticised the timing of the funding arrangements, 'they either get funding up to four times a year in small quantities, or have to put forward submissions a couple of times a year to continue to receive such funding'.

The time required to make a decision on sometimes very small amounts of money is also criticised.

## 5.3 Overview of NT Funds - Commonwealth Grants Commission

### 5.3.1 Grants from the Commonwealth

Northern Territory Treasury (1995b) Budget Paper No. 3 refers to grants from the Commonwealth that account for an estimated 75 per cent of total Northern Territory Public Sector Revenue and Grants in 1995/96.

Grants from the Commonwealth to the Northern Territory were estimated to total $1195 million in 1995/96, an increase of $36 million on 1994/95 (a nominal increase of 3.1 per cent or a real reduction of 0.3 per cent). Actual grants were $1,228m and grants for 1995/96 are estimated at $1,241m.

The nominal increase is almost entirely in the form of untied funding, with total specific purpose grants and grants direct from the Commonwealth to other agencies in the Territory estimated to remain virtually unchanged.

From the Territory's viewpoint, the key outcomes of the April 1995 Premiers' Conference and Loan Council meetings were:

- real per capita indexation of the Financial Assistance Grants (FAGs) pool, responsible for about $38 million of the increase in the Territory's Financial Assistance Grants;

- adoption of the updated per capita relativities recommended by the Commonwealth Grants Commission, with the higher relativity for the Territory resulting in an $8 million increase in grant share; and

- Special Revenue Assistance of $10 million, a decrease of $19 million on last year.

The Commonwealth has also agreed to provide an annual $5 million grant for community infrastructure needs for three years from 1995/96, in addition to not less

than $10 million of Special Revenue Assistance in 1996/97, thus giving some recognition to the severe impact on the Territory of the sudden abolition of $44 million in general purpose capital grants from 1994/95.

### 5.3.2 Total Commonwealth Grants

Commonwealth grants included in the Territory's Budget in 1995/96 at $1,195 are made up of $900 million in general purpose grants, an increase of $35 million and $296 million in specific purpose grants and grants paid direct to Agencies, an increase of $1 million.

### 5.3.3 April 1995 Premier's Conference

- Special Revenue Assistance (SRA) to the Northern Territory and the Australian Capital Territory of $10 million and $15 million, respectively, funded from the FAGs pool; and estimated $412 million in SRA to New South Wales and Victoria, arising from Medicare Guarantees to those States, reducing grants to the Territory as all but $59 million of this SRA will also be funded from the FAGs pool; and

- a Loan Council Allocation (LCA) to the Territory of $78 million (further information on LCA arrangements is provided in Chapter 2 Northern Territory Treasury (1995b) Budget Paper No. 5.

A meeting of the Council of Australian Governments also took place on 11 April 1995, at which it was decided in connection with the national competition policy to:

- maintain the real per capita guarantee of the FAGs pool on a rolling three year basis

### 5.3.4 General Current-Purpose Grants

#### *5.3.4.1 Financial Assistance Grants*

The Financial Assistance Grants are the main form of Commonwealth grants to the States and Territories and are provided as untied funds to be used at the discretion of each jurisdiction. The total 1995/96 FAGs to be distributed amongst all States and Territories is estimated at $14,858 million. This amount has been calculated by:

- adding to the total of the estimated FAGs to be distributed in 1994/95, the estimated $303 million in Special Revenue Assistance funded from the pool in that year (New South Wales $75 million, Victoria $149 million, Queensland $30 million, Western Australia $10 million, ACT $20 million and Northern Territory $20 million);

- indexing this total by the estimated Consumer Price Index increase of 3.5 per cent for the four quarters ended March 1995;

- further indexing the total by 1.02 per cent, representing the estimated growth in the total Australian population during the year ended December 1994; and

- deducting an estimated $375 million Special Revenue Assistance to be funded from the pool in 1995/96 (New South Wales $146 million, Victoria $204 million, ACT $15 million, and NT $10 million).

The Territory's share of the resulting 1995/96 Financial Assistance Grants pool (excluding Special Revenue Assistance taken out of the pool as set out above) is calculated by applying the per capita relativities for each State and Territory arising from the Commonwealth Grants Commission (1995) weighted by estimates of each State's population as at 31 December 1995.

This results in an estimated Territory share of the combined pool of FAGs and Hospital Funding Grants of 4.84 per cent in 1995/96 (compared with 4.79 per cent in 1994/95). The Territory is to receive an estimated $870.9 million in FAGs in 1995/96, an increase of $43.3 million compared with 1994/95.

#### *5.3.4.2 Specific Purpose Grants*

Grants made in this form generally relate to agreements between the Commonwealth and Territory Governments under which the Commonwealth provides funds on condition that the Territory applies the grant moneys to specific purposes. Examples are the *Commonwealth-State Housing Agreement*, agreements under the *States Grants (Primary and Secondary Education Assistance) Act* and the *Medicare Agreement.*

The small increase in 1995/96 compared with 1994/95, of around $3 million or one per cent, is largely due to an increased share of Hospital Funding Grants and indexation adjustments to a number of programs.

The present *Medicare Agreements* came into effect on 1 July 1993 and are intended to remain in place until 30 June 1998. The Medicare Agreements with the States and Territories are, in part, designed to promote increased public hospital provision. Figure 3.4 (*Table 6, p.114*) shows the various components of Commonwealth Hospital Funding Grants (HFGs) paid to the Territory under the *Medicare Agreement.*

In 1995/96 the Territory will receive an estimated total of $80 million from the Commonwealth under the *Medicare Agreement*.

Under the terms of the Agreement, the Base HFGs pool in 1993/94 was reduced by $400 million. This pool, indexed for movements in CPI, award wages, and population, is distributed on an age and sex weighted population basis. The Territory's Medicare Base Grant is estimated at $24.8 million in 1995/96.

The $400 million removed from the Base HFGs pool was placed in a new Bonus Payments pool, and augmented by $200 million from the Commonwealth. The

Bonus Payments pool is indexed annually on the same basis as the Base HFGs pool.

Funds from the Bonus Payments pool are distributed to States and Territories in the form of the following bonus grants:

- a Base Provision (Bonus Pool A) grant, related to the numbers of public and private patients treated in public hospitals before the commencement of the Agreement;

- an Annual Adjustment pool (Bonus Pool B) grant, which may be positive or negative, related to the level of public provision in the relevant grant year compared to the level of public provision before the commencement of the Agreement; and

- a Medical Benefits Supplement which can be a positive or negative adjustment, based on differences between Commonwealth per capita medical benefits expenditure in each State or Territory and average per capita medical benefits expenditure.

The Commonwealth provides incentive packages to the States and Territories to improve public hospital services under the programs shown in Figure 3.*4 (Table 6, p. 114*). Other grants are provided in support of projects to encourage innovation and accelerate mental health reform. Annual grants instituted prior to the current *Medicare Agreement* have continued for Post Acute and Palliative Care, Day Surgery and AIDS.

Commonwealth Grants Commission (1995, p. xi) resulted in the Northern Territory's per capita relativity being increased from 4.9863 to 5.0333. This increase was due mainly to revised estimates of the Aboriginal population and the updating of the review period to include 1993/94 while dropping 1988/89. This increase corresponded to a notional $8m higher Grant for the Territory in Northern Territory Treasury (1995b, Budget Paper No. 5, p. 67).

Details of health funding and expenditure from 1992/93-1995/96- refer *Appendix H*.

Commonwealth Grants Commission (1995, p. xiii) showed that the Northern Territory received $7m extra as a result of the revised population data[7]. This was

[7] Accurate figures for Aboriginal population in isolated communities has been difficult to achieve. The Australian Bureau of Statistics 6 August 1991 census was more concerned with the imperatives of collection rather than the population (advice from Tony Barnes, Head of Aboriginal Statistics Unit ABS on 4 July 1995). For the purpose of surveys, information was collected for 'collection districts' for 200 or more householders. Up until 1996 there has been no attempt to design the structure of collection Districts on the basis of remote Aboriginal structures which includes outstations.

Continued on next page

reduced by $3.3m for correction, increased by $0.1m for other data changes, with a sub total of positive $3.8m. The substitution of 1993/94 for 1988/89 brought in $26.9m for change in revenue and expenditure patterns. A reduction of $5.5m for a change in specific purpose payments and a reduction of $17m for changes in disabilities resulted in a grand total of $8.2m for the Northern Territory.

The dynamics of the distribution of monies to the States and Territories by the Commonwealth Grants Commission was illustrated in the 1996 Update where NSW had been classifying some outpatient data as community health in their returns to the Commonwealth Grants Commission. The effect of this change reduced the NT income from the Commonwealth Grants Commission by $6.3m for 1994/95 (advice from a senior Health Economics Officer, Territory Health Services).

## 5.4 Territory Health Services

In the 1995/96 budget speech the Treasurer, Hon. Mike Reed, MLA, announced a new health outcome strategy stating 'we will not turn the tide in Aboriginal health until we begin to tackle the underlying causes of the problem more effectively'.

The 1994/95 Territory Health Services Budget of $302.9m was increased by $14.06m to $317.023m in 1995/96. $8.8m of the increase was allocated to Aboriginal Health, including funding for a major new health outcomes strategy.

Alcohol, nutrition, infant and maternal health and smoking were targeted and Aboriginal responsibility and control, environmental health, Aboriginal employment and training, health clinics and renal disease were specifically mentioned.

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The Commonwealth Grants Commission Report 1995 Update on page 353 states that in its assessment the Commission allows for the effects on the costs of providing state services of three major groups of people. They are:

1. Aboriginal and Torres Strait Islanders
2. People with low fluency in English
3. People with low socio-economic status

For this update, numbers of Aboriginals and Torres Strait Islanders were measured using the experimental estimates of that population as at June 1991 published by the ABS in early November 1994. The methods used to derive the estimates are described in the ABS publication (Experimental Estimates of the Aboriginal and Torres Strait Islander Population, Catalogue No. 3230.0).

In summary, the new estimates:

correct the 1991 census count for under enumeration and age mis-statement and

include an estimate of the Aboriginal proportion of those people who did not answer the census question on Aboriginality.

Table xiii-v on page 354 of the 1995 Update Report estimates the Aboriginal population increasing from 40,009, 25.12% of the population to 43,273, 26.15% of the population.

On 25 July 1995, then Territory Health Services Minister, the Hon. Fred Finch, MLA, announced almost $1.4m additional health funds to NT Aboriginal communities. 53% of the Territory's Health Budget is allocated to Aboriginal Health.

The correspondence to the Public Accounts Committee dated 4 April 1995 and 19 April 1995 from Territory Health Services provided the same funding model (Table 7, *p. 122*) which estimated Aboriginal funding in the NT for 1994/95. The notes accompanying the model indicated that mental health, dental health, alcohol and other drug services and family youth and children's services and aged and disability services are not included.

The model identifies all Aboriginal people in the urban and rural area.

Officers responsible for analysing hospital data advise that although the address of Aboriginal people is collected when they attend hospital there is no guarantee that the address is their normal place of residence but could be where they are living in town on a transient basis. This makes it difficult to identify costs of health for each community. The model indicates that Aboriginal bed occupancy in the NT is estimated at 57%. Item 7 of the explanatory notes indicate that expenditure on pharmaceutical benefits and medical benefits in the NT is approximately $27m and less than $1.5m goes to the Aboriginal population.

The explanatory notes estimate that the age/sex/Aboriginality factor when combined for hospital services is assessed as 1.0463. If the Aboriginality factors are removed, the assessment drops to 0.6992. The resulting global factor of 1.0139 would drop the Commonwealth Grants Commission standardised assessment by $27.8m for hospital services. The example goes on to conclude that the Commonwealth Grants Commission assessed need for hospital services for the NT Aboriginal population is $47.5m. This figure contrasts with the estimated $58.1m hospital expenditure on Aboriginal clients in the same year 1992/93. In the example of community health, the age/sex/Aboriginality/socio-economic factor for 1992/93 was 2.2278. If the weighting for Aboriginality is removed the combined factor becomes 1.1513 and the standardised expenditure for 1992/93 would be $26.8m. The effect of Aboriginality weighting on standardised expenditure is $24.3m.

The conclusion reached is that the Commonwealth Grants Commission assessment of the standardised expenditure attributable to the NT Aboriginal population is $31.2m and the assessed actual expenditure $79.2m. After deducting ATSIC expenditure on Aboriginal health services and drug and alcohol services in the NT of $11.3m for 1992/93 the resultant NT government expenditure is $67.9m. The NT estimates that $42.5m of the $67.9m is spent providing services to Aboriginal clients. The $42.5m excludes ATSIC expenditure.

Correspondence from Territory Health Services dated 19 April 1995 refers to the Medicare Agreement and the effect of that Agreement on funding and services to Aboriginal communities. The document states that:

> ... preliminary investigations show residents of the Darwin urban area receive close to the Australian average of medical benefits receipts and persons in remote and rural areas of the NT average $10 per person. A more in-depth study is under way.

The Medicare Agreement and the Commonwealth Grants Commission assessments do not address the issue of inequitable access to and distribution of resources for persons from remote and rural areas under the Medical Benefits Scheme (MBS) and Pharmaceutical Benefit Scheme (PBS) schedules in the NT particularly affecting Aboriginal people. See Recommendation No. 39., p. 136 which refers to the MBS/PBS shortfall.

*Table 7: Aboriginal Health Funding in the NT - 1994/95*

Insert
Aboriginal health funding

The correspondence from Territory Health Services dated 19 April 1995 advises:

> The NT is compensated by a Grant of $841,000 per year but this does not in any way adequately compensate the NT for the level of expenditure required to provide a substitute general practitioner or pharmaceutical service.

## 5.5 Aboriginal and Non-Aboriginal Health Expenditure

Mr J. Pearse, a former employee of Territory Health Services, at a public meeting of the Public Accounts Committee on 25 October 1995 tabled the attached *Table 8,* p. 124. This table provided the expenditure per capita between Aboriginal and non-Aboriginal people. The total of Aboriginal expenditure over non-Aboriginal expenditure is around three times. For mental health it is 58.6% and for community health Aboriginal expenditure is 425%. The Aboriginal expenditure increases to approximately five times non-Aboriginal expenditure when direct funding from the Commonwealth to the Aboriginal Health organisations was taken into account. Table 9, p. 125 shows the 1994/95 expenditure for Aboriginal people compared to non-Aboriginal people and it should be noted that the Aboriginal population is 26.1% of the total for the NT.

At a Public Accounts Committee briefing by the Territory Health Services on 3 May 1995, Mr Graham Symons (then Assistant Secretary, Program Development and Planning advised that up to 8 times per capita could be what is required to deliver a similar type of service, or produce a similar health outcome on a remote Aboriginal community compared to Darwin.

Burns (1995) identified that the Commonwealth Grants commission agreement for funding community health services in remote areas such as Maningrida is inadequate. The Commonwealth Grants Commission assessed that in 1993/94 such expenditure in the NT should be only $295 per capita much less than the actual per capita expenditure of $451 by the NT Government.

Furthermore the Commonwealth Grants Commission formula does not recognise low levels of medical and pharmaceutical benefits in places such as Maningrida. Burns (1995) calculates $1,915 per capita cost, excluding infrastructure to develop the health services in Maningrida.

$1,915 is more than 6 times the expenditure assessed by the Commonwealth Grants Commission and 4 times the NT per capita calculation.

Two tables tabled by Pearse (1995), *Table 10, p. 126* and *Table 11, p. 127,* show the medical benefits and pharmaceutical benefits for the NT compared to the rest of Australia. It can be seen that the NT receives only 55.5% of the national rate per capita for medical benefits and 31% for pharmaceutical benefits. This shortfall from the Commonwealth is outside of the Commonwealth Grants Commission assessment because it is a non-State service. However the NT has to substitute the service because of the lack of private General Practitioners and Pharmacists in rural areas.

| 1994-95 EXPENDITURES: PER CAPITA | | | | |
|---|---|---|---|---|
| | *Total Expenditure $ per capita* | *Non-ATSI Expenditure $ per capita* | *ATSI Expenditure $ per capita* | *ATSI as % of Non ATSI* |
| Population (From CGC 1995 Update: Based on 30 June 1991) | 165,789 | 122,516 | 43,273 | |
| Hospital Services | 834 | 553 | 1,630 | 294.6% |
| Mental Health | 52 | 58 | 34 | 58.6% |
| CGC Community Health Category: | | | | |
| Community Health | 352 | 190 | 809 | 425.1% |
| Dental Health Services | 31 | 34 | 22 | 66.3% |
| Alcohol & Other Drug Services | 29 | 19 | 59 | 316.4% |
| Disease Control | 32 | 16 | 76 | 458.3% |
| Environmental Health | 16 | 15 | 21 | 147.1% |
| Health Promotion | 8 | 3 | 21 | 675.1% |
| Total Community Health | 468 | 277 | 1,009 | 364.2% |
| Family Youth & Children's Services | 97 | 78 | 152 | 194.7% |
| Aged and Disability Services | 50 | 49 | 52 | 107.4% |
| Corporate Management | 136 | 96 | 250 | 261.4% |
| Total | 2,105 | 1,388 | 4,136 | 298.0% |
| **CGC Community Health Category Adjusted for ATSIC Expenditures** | | | | |
| | *$m* | *$m* | *$m* | *$m* |
| Total NT Expenditures: | 77.6 | 34.0 | 43.7 | 128.6% |
| Estimated ATSIC Expenditures: | 13.0 | | 13.0 | |
| Total | 90.6 | 34.0 | 56.7 | 166.9% |
| | *$ per capita* | *$ per capita* | *$ per capita* | |
| Total NT Expenditures: | 468.2 | 277.1 | 1,009.2 | 364.2% |
| Estimated ATSIC Expenditures: | 78.4 | - | 300.4 | - |
| Total | 546.6 | 277.1 | 1,309.6 | 472.6% |

*Table 8: 1994-95 Expenditures: Per Capita.*

Source: Pearse (1995)

The Northern Territory Government is funding pharmaceuticals that would be funded by the Commonwealth Government if people in remote communities had access to private pharmacists.

Furthermore pensioners are required to pay $2.70 per week towards their prescriptions. In remote communities, there is no charge for pensioners. Subsequently there is a loss in revenue to the NT.

| ABORIGINAL HEALTH FUNDING IN THE NT - 1994/95 | |
|---|---|
| 1994/95 TOTAL EXPENDITURE FOR TERRITORY HEALTH SERVICES* | $293.062 m |
| less WELFARE PROGRAMS | $38.207 m |
| less MENTAL, DENTAL & ALCOHOL & OTHER DRUGS PROGRAMS | $ 18.603 m |
| EXPENDITURE | $236.252 m |
| FUNDING MODEL CALCULATES $119 m FOR ABORIGINAL HEALTH FUNDING IN 1994/95 WHICH REPRESENTS 50.3% OF EXPENDITURE FOR ABORIGINAL HEALTH | |
| *** Source: Budget Service Branch - Territory Health Services** | |

*Table 9: Aboriginal Health Funding in the NT - 1994/95.*

Source: Territory Health Services, 19 April 1995.

### 5.5.1 Pharmaceutical Benefits

With regard to pharmaceutical benefits, visits to communities have revealed that there are occasions where additional funds are sought when the allocation for pharmaceuticals has run out. It should be noted that those on pensions have a component of $2.70 per week in their pension to compensate for the charge of $2.70 per prescription per individual or family up to a maximum of $140.40. Further prescriptions are free.

In remote communities there are no private pharmacists and all prescriptions are free. It is interesting to note that in the Binjari community, 15 kms from the town of Katherine, money is deducted from pensions and collected in a fund for pharmaceuticals. A member of the Binjari community advised that every family contributes $6.00 from their pension. A private doctor from Katherine completes an order form for a pharmacist who bills the community at the end of each month. This arrangement has been in place for six years. Surplus monies are used for other health needs such as the dog health program.

The administrative costs in trying to recover $2.70 from people in remote communities would probably negate changing the current practice. However there may be merit in looking at other options through agreement with the Commonwealth and Territory Governments and community councils.

## Medical Benefits

### *Per Capita Benefits Paid ($)*

| | *NSW* | *Vic* | *Qld* | *WA* | *SA* | *TAS* | *NT* | *ACT* | *Aust* |
|---|---|---|---|---|---|---|---|---|---|
| 1984-85 | 169.3 | 134.2 | 132.6 | 122.5 | 141.4 | 121.2 | 55.1 | 124.4 | 144.4 |
| 1985-86 | 193.1 | 150.8 | 148.1 | 133.9 | 158.6 | 135.9 | 84.8 | 138.0 | 162.8 |
| 1986-87 | 208.8 | 162.9 | 164.7 | 147.5 | 172.8 | 149.4 | 91.6 | 147.9 | 177.1 |
| 1987-88 | 216.3 | 172.5 | 177.8 | 157.5 | 185.3 | 161.9 | 96.6 | 155.7 | 186.9 |
| 1988-89 | 229.7 | 187.2 | 196.6 | 170.9 | 202.1 | 178.2 | 109.1 | 169.5 | 201.8 |
| 1989-90 | 253.4 | 208.1 | 220.5 | 185.6 | 219.3 | 193.5 | 123.6 | 186.9 | 223 0 |
| 1990-91 | 276.8 | 230.6 | 241.0 | 206.9 | 243.0 | 211.9 | 139.5 | 207.2 | 245.2 |
| 1991-92 | 294.6 | 251.1 | 253.0 | 220.8 | 261.8 | 226.4 | 150.3 | 217.2 | 262.1 |
| 1992-93 | 317.6 | 279.0 | 268.8 | 243.0 | 280.7 | 246.5 | 154.5 | 233.9 | 284.2 |
| 1993-94 | 334.1 | 299.1 | 284.9 | 256.5 | 298.3 | 260.1 | 167.4 | 249.3 | 301.1 |
| 1994-95 | 337.5 | 307.1 | 291.9 | 266.9 | 301.8 | 265.8 | 170.5 | 279.1 | 307.5 |

Source: Review of Medicare Agreement Funding Pursuant to the Decline in Health Insurance Coverage (Attachment 5.7)
(1994-95 is from data supplied by the Commonwealth Department of Human Services and Health)

### *Per Capita Benefits as a percentage of the national rate*

| | *NSW* | *Vic* | *Qld* | *WA* | *SA* | *TAS* | *NT* | *ACT* | *Aust* |
|---|---|---|---|---|---|---|---|---|---|
| 85 | 117.2% | 92.9% | 91.8% | 84.8% | 97.9% | 83.9% | 38.2% | 86.1% | 100.0% |
| 86 | 118.6% | 92.6% | 91.0% | 82.3% | 97.4% | 83.4% | 52.1% | 84.8% | 100.0% |
| 87 | 117.8% | 91.9% | 93.0% | 83.3% | 97.5% | 84.3% | 51.7% | 83.5% | 100.0% |
| 88 | 115.7% | 92.3% | 95.1% | 84.3% | 99.1% | 86.6% | 51.7% | 83.3% | 100.0% |
| 89 | 113.8$ | 92.8% | 97.4% | 84.7% | 100.1% | 88.3% | 54.0% | 84.0% | 100.0% |
| 90 | 113.7% | 93.3% | 98.9% | 83.2% | 98.4% | 86.8% | 55.4% | 83.8% | 100.0% |
| 91 | 112.9% | 94.1% | 98.3% | 84.4% | 99.1% | 86.4% | 56.9% | 84.5% | 100.0% |
| 92 | 112.4% | 95.8% | 96.5% | 84.2% | 99.9% | 86.4% | 57.3% | 82.9% | 100.0% |
| 93 | 111.7% | 98.2% | 94.6% | 85.5% | 98.8% | 86.7% | 54.4% | 82.3% | 100.0% |
| 94 | 110.9% | 99.3% | 94.6% | 85.2% | 99.1% | 86.4% | 55.6% | 82.8% | 100.0% |
| 95 | 109.8% | 99.9% | 94.9% | 86.8% | 98.2% | 86.4% | 55.5% | 90.8% | 100.0% |

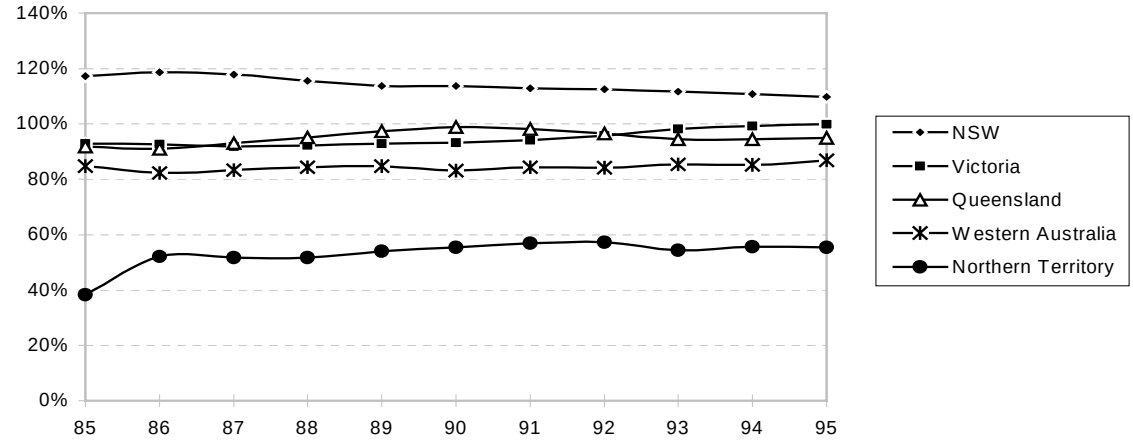


*Table 10: Medical Benefits - Inter-State Comparisons.*

Source: Pearse (1995)

## Pharmaceutical Benefits

***Benefits Paid ($)***

| | *NSW* | *Vic* | *Qld* | *WA* | *SA* | *TAS* | *NT* | *ACT* | *Aust* |
|---|---|---|---|---|---|---|---|---|---|
| | *$m* | *$m* | *$m* | *$m* | *$m* | *$m* | *$m* | *$m* | *$m* |
| 1988-89 | 391.8 | 243.3 | 160.2 | 72.9 | 83.4 | 26.2 | 2.2 | 9.1 | 989.2 |
| 1989-90 | 447.1 | 269.6 | 187.9 | 85.4 | 94.5 | 30.1 | 3.0 | 10.5 | 1,128.2 |
| 1990-91 | 433.0 | 266.5 | 187.6 | 83.7 | 91.9 | 29.9 | 3.1 | 11.0 | 1,106.7 |
| 1991-92 | 451.9 | 278.5 | 189.6 | 86.8 | 94.6 | 31.0 | 3.2 | 11.5 | 1,147.2 |
| 1992-93 | 559.8 | 347.6 | 239.1 | 109.2 | 119.5 | 38.7 | 4.3 | 15.5 | 1,433.8 |
| 1993-94 | 654.1 | 410.6 | 283.7 | 129.1 | 138.8 | 45.4 | 5.1 | 19.0 | 1,685.8 |
| 1994-95 | 722.9 | 453.8 | 313.6 | 142.7 | 153.4 | 50.2 | 5.6 | 21.0 | 1,863.3 |

Source: Review of Medicare Agreement Funding Pursuant to the Decline in Health Insurance Coverage (Attachment 5.7)
(1994-95 is from data supplied by the Commonwealth Department of Human Services and Health)

***Per Capita Benefits ($)***

| | *NSW* | *Vic* | *Qld* | *WA* | *SA* | *TAS* | *NT* | *ACT* | *Aust* |
|---|---|---|---|---|---|---|---|---|---|
| 89 | 68.24 | 56.70 | 57.56 | 46.85 | 59.10 | 57.72 | 13.96 | 33.07 | 59.33 |
| 90 | 77.01 | 61.99 | 65.61 | 53.54 | 66.32 | 65.70 | 18.25 | 37.70 | 66.60 |
| 91 | 73.81 | 60.59 | 64.04 | 51.52 | 63.85 | 64.32 | 18.91 | 38.35 | 64.44 |
| 92 | 76.22 | 62.81 | 63.29 | 52.74 | 65.20 | 66.10 | 19.36 | 39.50 | 65.99 |
| 93 | 93.56 | 78.02 | 77.84 | 65.52 | 81.93 | 82.19 | 25.58 | 52.12 | 81.59 |
| 94 | 108.39 | 91.86 | 90.02 | 76.45 | 94.73 | 95.94 | 29.79 | 63.16 | 94.95 |
| 95 | 118.77 | 101.05 | 97.26 | 83.38 | 104.19 | 105.29 | 32.35 | 68.63 | 103.85 |

***Per Capita Benefits as Percentage of National Rate***

| | *NSW* | *Vic* | *Qld* | *WA* | *SA* | *TAS* | *NT* | *ACT* | *Aust* |
|---|---|---|---|---|---|---|---|---|---|
| 89 | 115% | 96% | 97% | 79% | 100% | 97% | 24% | 56% | 100% |
| 90 | 116% | 93% | 99% | 80% | 100% | 99% | 27% | 57% | 100% |
| 91 | I15% | 94% | 99% | 80% | 99% | 100% | 29% | 60% | 100% |
| 92 | 115% | 95% | 96% | 80% | 99% | 100% | 29% | 60% | 100% |
| 93 | 115% | 96% | 95% | 80% | 100% | 101% | 31% | 64% | 100% |
| 94 | 114% | 97% | 95% | 80% | 100% | 101% | 31% | 67% | 100% |
| 95 | 114% | 97% | 94% | 80% | 100% | 101% | 31% | 66% | 100% |

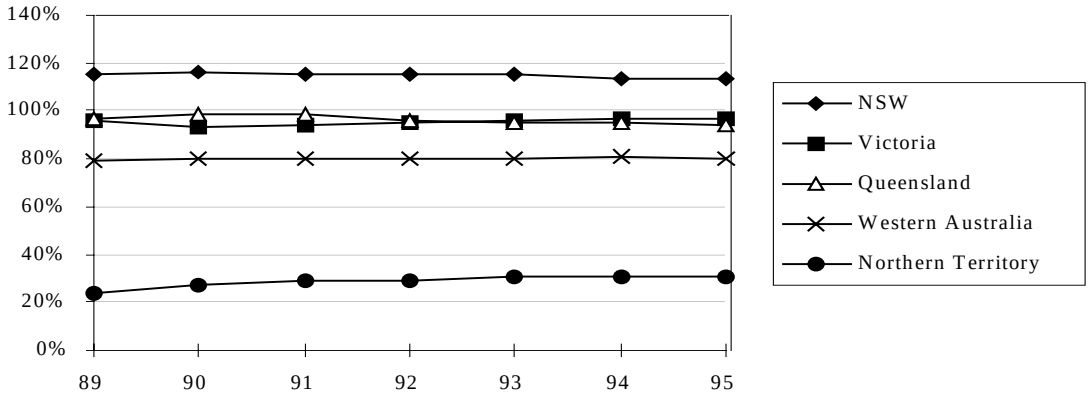


*Table 11: Pharmaceutical Benefits - Inter-State Comparisons.*

Source: Pearse (1995)

Other options are as follows:

1) Commonwealth Government to pay the pharmaceutical proportion of pensions directly to a health trust account managed by the community council.

   The Trust account would be for pharmaceuticals with the proviso that any unspent balance could be used for other health needs determined by the community.

   Advantages

   - Avoids manual collection of money for each prescription issued.
   - Does not require communities to deduct money from each pension.
   - Allows savings in costs incurred by the Territory Health Services to be reallocated to higher health priorities.

   Disadvantages

   - The rights of pensioners to receive their pension including the pharmaceutical component is a principle which is difficult to change.

2) The community council to collect the pensions and deduct the pharmaceutical proportion with the unspent balance for use by the community for its primary health.

   This is the preferred option.

   Advantages

   - Is working in Binjari and avoids individual collection of pharmaceutical payments by deduction of a percentage from the total pension for the community.
   - Allows savings in costs incurred by Territory Health Services to be allocated to high priorities in Aboriginal health.

   Disadvantages

   - Those communities that will not participate will still spend the pharmaceutical part of their pension on other goods and therefore be financially ‘better off’ than those who do participate.

3) Status quo

Advantages

Nil

Disadvantages

- Money allocated in the pension for pharmaceuticals is not being used for its intended purpose.

**RECOMMENDATION 36.**

**That Commonwealth and Territory Governments put in place procedures to recover the prescription charge from people living in remote communities who receive free pharmaceuticals.**

Northern Territory Treasury (1991, pp. 1-2) in the submission for the Commonwealth Grants Commission 1991 provide some information which is pertinent to this term of reference.

> Commonwealth policies within Medicare and the Pharmaceutical Benefits Scheme have meant that the NT has been unable to recoup appropriate levels of funds for the services it has rendered to these populations.
>
> Economies of scale have also lead to only a limited presence of a private hospital sector within the NT ... As a consequence the NT has been handicapped in its ability to raise revenue from private beds.

Pages 40-41 of this submission refer to nursing home services. This section argues that Aboriginals reach an aged physical health status where nursing home care is required at an earlier chronological age than do non-Aboriginal people.

> Thompson and Briscoe (1991) reported that the estimated expectancy of life at birth in 1985 for Aboriginal males in the NT was 53.2 years, about 19 years less than that of non-Aborigines in the NT (72.3 years). For Aboriginal females the estimated life expectancy at birth was 61.6 years compared to 77.4 years for non-Aboriginal females, almost 16 years less.
>
> In October 1989 the Aged Care Advisory Committee, comprising of Commonwealth, Territory and private sector members, was advised that the Federal Minister for Community Services and Health had agreed that for planning purposes the definition of 'frail aged' should include population figures for Aboriginals aged 50+ years and others aged 70+.
>
> An adjustment [along these lines] will have the effect of increasing the adjusted weighted age/sex composition of the NT population by some 10 percent.

Northern Territory Treasury (1991, p. 68) refers to unproductive travelling time:

> A preliminary examination of unproductive travelling time for rural health staff based in Darwin and providing services to communities in the rural areas of Darwin region, revealed that approximately 15 per cent of the staff time was devoted to travelling to and from communities. For more disbursed regions, it is expected that unproductive travelling time would account for a large proportion of staff time. If applied to all expenditures on salaries within Rural Health Services, the cost of unproductive travel time could be up to $1 million. This is possibly an overestimate as salaries expenditure also relates to staff based in Community Health Centres. The NT Department of Health and Community Services intends to conduct an internal survey of these costs.

Northern Territory Treasury (1991, p. 73) provides the following comparison between rural and urban expenditure: 'The per capita expenditure in rural areas exceeds that of urban areas by a factor of 8.3'.

Northern Territory Treasury (1991, p. 78) refers to alcohol:

> An analysis of expenditures under the NT's Alcohol and Other Drugs Program revealed that 68 per cent of expenditures related to Aboriginal people. There are certain services funded under this program that deal almost exclusively with Aboriginal clients, such as the Sobering Up Shelters, for which Aborigines make up over 96 per cent of the clientele.

Northern Territory Treasury (1991, pp. 80 & 104) identified the difficulty is assessing health needs:

> The NT submits that there is no "objective" methodology that adequately captures the extent to which Aborigines have additional needs for community health services.
>
> ... Our recent experience shows that a small increase in expenditure in community health can result in revealing previously unmet needs which in turn result in the requirement for greater expenditure. This occurred in Katherine recently when additional community health resources uncovered a significant number of Aboriginal people who required acute intervention and hospitalisation. This increased utilisation will continue until the health deficit is reduced.

Northern Territory Treasury (1992, p. 3) provides additional information which is relevant to the question as to the adequacy of funding arrangements with respect to Aboriginal health.

> ... It is also estimated that, because of casemix, acuity and co-morbidity, Aboriginal patients tend to require 15% more resources in terms of diagnostic tests and pharmaceuticals.

Northern Territory Treasury (1992, p. 12) refers to the NT and provided estimates that border patients in NT hospitals require additional expenditures of $865,000 each year.

> ... 85% of border patients are Aboriginal parents from remote areas.
>
> ... The 1992 ATSIC Housing and Community Infrastructure Study also revealed that 8,207 Aboriginal people in the NT do not have access to water available for human

consumption that complies with the National Health Medical Research Council Guidelines.

## 5.6 Urban and Rural Health Expenditure

Pearse (1992, p.12) analysis was in relation to 1990/1991 expenditure for Territory Health and the logic has relevance today:

> A complaint that is often intimated by the southern States and certain groups in the NT, is that the NT government spends most of its health funds in the urban areas. Figure 4 [*Table 12, p. 131*] presents data on expenditures related to Community Health Services for the urban (Darwin, Alice Springs, Tennant Creek, Katherine and Nhulunbuy) and non-urban areas of the NT, which basically refutes this claim for these services. Margins between urban and non-urban areas for other programs can also be observed, although because of the organisation of these services, it is somewhat more difficult to disaggreggate the data. The margin between the urban and remote areas of the NT reflects all the factors I have outlined above: greater health needs, higher costs, economies of service delivery scale and an absence of the private sector. Another feature of our expenditures is that patient transport and travel accounts for 7% of our budget.

**Table 4** **Northern Territory Department of Health and Community Services Community Health Program, Expenditures 1990/91**
*(Excludes patient travel and transport)*

| Expenditure Programs: | Program Expenditure 1990-91 | Pro-rata allocation of NT Wide Programs | $ per Capita |
|---|---|---|---|
| NT Wide Programs: | | | |
| Heating Services | 451,004 | | |
| Poisons Control | 147,351 | | |
| Grants eg Blood Transfusion Service | 1,060,659 | | |
| Renal Dialysis | 1,060,514 | | |
| Darwin Urban | 5,065,255 | 6,464,534 | 74 |
| Other Urban | 2,054,530 | 2,687,991 | 63 |
| Rural | 21,622,135 | 22,308,923 | 503 |
| | **31,461,448** | **31,461,448** | **180** |

*Population data are based on place of enumeration counts for the 1991 Census (Australian Bureau of Statistics, 1992). Other Urban includes Nhulunbuy, Katherine, Tennant Creek and Alice Springs.*

*Table 12: Northern Territory Department of Health & Community Services. Community Health Program, Expenditures 1990/91.*

Source: Pearse (1995)

## 5.7 Equity

Commonwealth of Australia (1993, p. 10) refers to equity in service provision in the Medicare Agreement:

> To the maximum practicable extent, a State will ensure the provision of public hospital services equitably to all eligible persons regardless of their geographical location. In rural and remote areas, a State should ensure provision of reasonable public access to basic range of hospital services which are in accord with clinical practices.

Pearse (1992, p.3) made the following observation:

> However it is worth noting that for the more dispersed populations, the Commission (Commonwealth Grants Commission) appears to have implicitly recognised that services are not going to be provided at precisely the same standard as for urban populations. This is sensible as there are physical constraints and cost factors that will impede achieving absolutely equal standards. There must be trade-offs between equity and efficiency. But the question this leaves open is: What standards should our remote and rural populations expect?

In trying to assess Aboriginal health expenditure in the Northern Territory it is clear that this difficult task is shared by other States. Mooney (1995, p.2) said:

> ... in looking at utilisation of services and trying to cost utilisation of services by Aboriginals across the country, to date we have found that Northern Territory data are not good, but they're a lot better than anywhere else.

Mooney (1995) described different definitions of equity and indicated that he favours the definition of equal access for equal need. He then described two definitions of need - one being the greater rates of morbidity and mortality in a community, the greater is the need. The second, and his preferred definition, is capacity to benefit. Under the second definition Professor Mooney considers that the limited resources are more likely to hit the target. He also explained that Aboriginal health is not horizontal equity - equal treatment for equals but vertical equity - unequal but equitable treatment of unequals. He then defined access as opportunity to use.

He encouraged a very explicit definition of equity by government.

The shifting of resources between urban and rural must be managed carefully. If, for example, urban services and hospital services in Darwin were reduced there would be a point where people would not wish to live in Darwin. Industry and commerce would be adversely affected and this would be detrimental for all Northern Territorians. The challenge is to strike the right balance taking into account economies of scale. Furthermore, such a shift of resources would deny rural Territorians from secondary health services.

Beaver (1995, p.8) made the following comments in her evidence to the Public Accounts Committee on 25 October 1995:

> ... we spend some 3 times more per capita on Aboriginal persons than non-Aboriginals. Of course that is not broken down into how much we spend on Aboriginal people in rural areas and non-Aboriginals in urban areas. We are all saying that we do not believe that we are spending enough, or the services aren't appropriate to meet the need, and that is shown by the level of ill-health. What we must be careful about, in shifting resources from urban to rural and from hospital to community and so on, is that we do not disadvantage one area when we are trying to advantage another ... we can't lead ourselves into a situation where we're sharing it all out and nothing happens. I don't have access to the same specialist services that I would have if I lived

> in Sydney or Brisbane. We have to try to get the most equitable distribution, but we must be very careful how we do it. We have to take into account economies of scale.

Equity across the different communities should be addressed.

Mooney (1995, p. 10) in his evidence to the Public Accounts Committee public meeting of 25 October 1995 referred to three different levels of equity:

- equity across the different communities
- urban and rural split within the NT
- NT compared to the rest of Australia (p. 10).

Warchivker, I. (1995a,b,c) refers to a study examining issues of equity and developing a needs based formula for health care delivery in the NT. The study was a cross-sectional analysis of per capita expenditure on health services in the Alice Springs Rural District. Expenditures on supporting services from corporate office were not analysed. An analysis of variation in clinical expenditure per capita identified a range of between $253 and $1320 per capita amongst the small communities. The variations in the medium communities ranged between $337 and $931 per capita, and in the large communities between $580 and $750 per capita. The expenditure on supporting services was $770 per capita. This partly reflected high transport costs.

The variations in expenditure are affected by staffing shortages and the result of historical increases in funding for specific communities. The health needs should be taken into account and the fluctuating community populations. Redistribution of funds would be problematic because the health needs are in excess of the current funding. However the extent of the variation suggests that a needs based formula is required and over time, horizontal equity between the communities should be an objective.

**RECOMMENDATION 37.**

1. **That Territory Health Services continue to undertake analysis of resource allocation to communities to ensure that inequities in funding between communities are redressed in a time frame that allows reasonable adjustment to the service levels; and**

2. **that Territory Health Services works towards a Resource Allocation Formula that is transparent.**

## 5.8 Disability Factors - Commonwealth Grants Commission

Rye (1995, p.6) defined a disability as an influence beyond a government's control that requires it to spend more or less than governments on average to achieve the same objective; or reduces or increases its relative capacity to raise revenue from the same effort.

Mooney (1995, p.18) responded to a question about the disability factors which are used by the Commonwealth Grants Commission to give weight to the health needs of Aboriginal people in remote areas:

> ... under any reasonable definition of adequacy, the disability factors do not adequately recognise the health needs of Aboriginal people in remote areas.

Some important disability factors: administrative scale; age/sex and socio-economic composition; dispersion; input costs and service delivery scale were discussed with Mr Rye, Chairman of the Commonwealth Grants Commission, and the adequacy of some of the factors for application to remote Aboriginal people was questioned.

### 5.8.1 Dispersion

Rye (1995, p. 20) advised that dispersion only takes into account straight line distances. Commonwealth Grants Commission will be undertaking a research project to look at road lengths and road quality. If accepted, this will help the Northern Territory which is disadvantaged with its services to Aboriginal communities.

Griffith (1996) has developed a model to quantify access to services in rural and remote communities. The Committee consider that this type of model could have application for giving 'dispersion' better recognition by the Grants Commission.

### 5.8.2 Age

Various publications have referred to the lower life expectancy for Aboriginal people compared to other Australians. Plant, Condon & Durling (1995) referred to Aboriginal males with 16-18 years shorter life span with a slightly larger gap for Aboriginal females. The age disability factor does not recognise this fact.

Mooney (1995, p. 14) suggested that the Committee could think about the age factor based on years to death rather than age.

**RECOMMENDATION 38.**

**1. That Territory Health Services prepare a submission to the Commonwealth Grants Commission to change the Age factor to recognise the physical (mortality/morbidity) rather than chronological age of Aboriginal people; and**

**2. that the 'dispersion' factor be adjusted to take into account degrees of remoteness.**

## 5.9 Medical Benefits Scheme and Pharmaceutical Benefits Scheme Shortfall

Commonwealth Grants Commission (1996, p. 241) indicates that for community health the NT expenditure is calculated at $264 per capita. In practice the expenditure was $544. The major reason why the assessments for community health for the NT show overspending is

because the NT provides a substitute service for medical and pharmaceutical services - a Commonwealth responsibility.

Beaver (1995, p.4) made the following comments:

> I feel very strongly that Territory Health Services are providing a pretty high level of substitute services in our rural health clinics in relation to GP services ...

This comment refers to a Territory loss of approximately $38 million (advice from Territory Health Services on 9/4/96) in MBS and PBS because these non-State services are not available to most of the Aboriginal communities. Therefore the Territory provides a Commonwealth service without recompense.

This inadequacy in the funding arrangements between the Commonwealth and the Northern Territory was put to Mr Richard Rye, Chairman of the Commonwealth Grants Commission (1995, p. 27) who referred to page 27 of the 1993 Commonwealth Grants Commission review of general revenue grant relativities:

> We had in our own calculations - the ones that were not modified by the Medicare agreements - a thing called an environmental factor, which took account of the differences between states in those areas where private health services would not be economically viable. The Northern Territory would obviously benefit considerably by the use of such a factor, but we were instructed not to include that factor ...

Territory Health Services (n.d.) referred to medical benefits for the 1993/94 year. The paper cites the average per capita use of medical benefits in the predominantly Aboriginal communities of Port Keats and Galiwinku as $4.48 and $44.50 respectively compared to $413.45 in suburban Melbourne and $430 in Sydney. Warchivker (1995b) showed that of 11 communities in Alice Springs rural district none were able to access the Medical Benefits Services. As described previously the Territory is substituting for Commonwealth services for rural communities.

The report of the National Health Ministers' Benchmarking Working Group (1996) to the Australian Health Ministers' Conference (1996) shows PBS expenditure for 1993/94 as $30 per capita for the NT and $95 for the Australian average. In remote communities the NT provides pharmaceuticals from its own budget and therefore claims to the Commonwealth would be negligible.

The Committee proposes the following options to redress the MBS and PBS disadvantage to the NT:

### 5.9.1 Option 1: Seek a special grant from the Commonwealth

Territory Health Services are trying to access additional monies in lieu of MBS and PBS through the Coordinated Care Trials with the Commonwealth.

Providers have become more aware of the NT disadvantage with MBS and PBS.

Advantages:

- Additional funds could be sought in lieu of MBS and PBS for specific health projects to improve the health of Aboriginal people in remote areas and such a proposal may have a better chance of support from the Commonwealth.

Disadvantages:

- Other funding arrangements for the NT may be reduced as a consequence.

**5.9.2 Option 2: Commonwealth Grants Commission to seek Commonwealth approval of a new disability factor 'environmental factor' to compensate for lack of access to General Practitioner services.**

Advantages:

- Ongoing recognition and update of the disability through the Commonwealth Grants Commission process.

Disadvantages:

- As a non-State service it is unlikely that the Commonwealth will instruct the Commonwealth Grants Commission to incorporate MBS and PBS into their process.

The Coordinated Care Trial in Katherine and the Tiwi Islands pools together money from the NT and the Commonwealth and this could pave the way for similar trials across the NT with access to MSB and PBS.

**5.9.3 Option 3: That Medicare benefits access for standard consultation be made available to other community health professionals**

Advantages:

- Nurses and Aboriginal Health Workers with the appropriate competencies could be funded from MBS for standard consultations freeing more NT funds for health needs.

Disadvantages:

- Unlikely to be transferred from medical practitioners.

**RECOMMENDATION 39.**

**That the Commonwealth compensate for the estimated $38 million dollar loss to the Northern Territory in Medical Benefits Scheme and Pharmaceutical Benefits Scheme.**

The funding arrangements between the Commonwealth and the Northern Territory for health services is often misunderstood. For example the money that is paid by the

Commonwealth by way of grants to the Aboriginal Medical Services is reduced from the Northern Territory untied grant total.

This makes it very difficult for the Northern Territory to prioritise health funds to the community health program when there are other health funds from the Commonwealth.

**RECOMMENDATION 40.**

**That the NT Minister for Territory Health Services and the Commonwealth Minister for Health and Family Services ensure the allocation of resources reflect overall health priorities.**

## 5.10 Relationship between Acute Care and Community Health Programs

The NT Aboriginal health expenditure has increased yearly from 1989/90 to 1993/94 by 48.1% to 53.6% (see *Table 13, p. 139*)**.**

The increasing hospital utilisation by Aboriginal people is in response to the identification of health needs in rural communities. In the longer term, a reduction in the number of Aboriginal people in Territory hospitals will be dependent upon the success of primary health care in the communities.

Advice from Territory Health Services received on 23 October 1996 indicates that since 1993/94, the proportion of expenditure on Aboriginal health would have continued to rise. Aboriginal hospital utilisation has continued to increase and there have been particular initiatives in Aboriginal health over those two years, eg. expansion of *Strong Women, Strong Babies, Strong Culture* program etc.

The Committee cannot identify a plateau in the increasing proportion of Aboriginal patients in hospitals.

It is clear from the research that the health needs are affected by other environmental conditions such as overcrowding due to a shortage of houses on communities which often include 6 people per room and sometimes more.

The upward trend in expenditure on Aboriginal health will not be arrested until the environmental factors are addressed and this requires a whole of government cooperative effort.

Attention to health funding must therefore incorporate collaboration across departments and governments.

**RECOMMENDATION 41.**

**That Government agencies and the Northern Territory and Commonwealth take a whole of government approach to health promotion/environmental health using the Health Infrastructure Priority Projects as a model.**

**NT Aboriginal Health Expenditure**
**By Program (Estimated)**
**$M**

| | 89/90 | | 90/91 | | 91/92 | | 92/93 | | 93/94 | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Program** | **Abor** | **Non Abor** | **Abor** | **Non Abor** | **Abor** | **Non Abor** | **Abor** | **Non Abor** | **Abor** | **Non Abor** |
| **Hospitals** | 46.4 | 56.6 | 51.5 | 59.2 | 53.0 | 60.8 | 58.1 | 61.8 | 63.4 | 63.7 |
| **Community Health** | 23.4 | 13.1 | 25.9 | 14.6 | 28.9 | 15.5 | 34.7 | 16.5 | 37.4 | 18.3 |
| **Disease Control** | 1.8 | 1.4 | 2.0 | 1.7 | 2.0 | 1.6 | 2.2 | 1.8 | 2.5 | 2.1 |
| **Health Promotion** | .1 | .3 | .3 | .5 | .3 | .4 | .6 | .3 | .9 | .3 |
| **Environ-mental Health** | .3 | 1.3 | .3 | 1.3 | .2 | 1.3 | .8 | 1.4 | 1.2 | 1.4 |
| **Alcohol and Other Drugs** | 1.5 | 1.5 | 1.6 | 1.6 | 2.2 | 2.2 | 4.2 | 3.3 | 5.5 | 4.3 |
| **Dental Services** | 1.0 | 2.5 | 1.0 | 2.6 | 1.2 | 2.8 | 1.3 | 2.9 | 1.5 | 3.0 |
| **Mental Health Services** | 1.1 | 4.8 | 1.3 | 5.4 | 1.4 | 5.7 | 1.6 | 5.9 | 1.7 | 6.0 |
| **Total Health Services** | 75.6 | 81.5 | 83.9 | 86.9 | 89.2 | 90.3 | 103.5 | 93.9 | 114.2 | 99.0 |
| **Corporate Services** | 8.5 | 9.2 | 9.5 | 9.8 | 10.6 | 10.7 | 10.5 | 9.6 | 10.0 | 8.7 |
| **Total $M** | 84.1 | 90.7 | 93.4 | 96.7 | 99.8 | 101.0 | 114.0 | 103.5 | 124.2 | 107.7 |
| | 174.8 | | 190.1 | | 200.8 | | 217.5 | | 231.9 | |
| **%** | 48.1 | 51.9 | 49.1 | 50.9 | 49.7 | 50.3 | 52.4 | 47.6 | 53.6 | 46.4 |

*Table 13: NT Aboriginal Health Expenditure by Program (Estimated) 1989/90 - 1993/94.*

Source: Territory Health Services

# *CHAPTER 6*

# 6. TERMS OF REFERENCE (f)

***strategies for achieving co-operation from the principal participants***

## 6.1 Introduction

There are some good examples of strategies which will improve co-operation among the providers in some areas.

The Health Infrastructure Priority Projects co-ordinates key government departments so that services to communities, such as water supply, sewerage, priority housing, power supply and internal roads, drainage and dust controls, are delivered in a whole of government approach.

The Co-ordinated Care Trial for the NT pools Commonwealth and Territory health funds for health services for Aboriginal communities. The trial is on the Tiwi Islands and in the Katherine District. Its purpose is to deliver improved health by combining health services.

However, lack of co-operation among the providers is identified throughout this section. Strong leadership skills and a relationship of trust and co-operation is required from health executives to ensure that the population of the NT receive better value for their health dollars.

The pressures on Aboriginal Health Workers and difficulties in attracting and retaining their services is covered in this section.

Overseas models for achieving co-operation have been cited. Information, skills transfer and support for indigenous people to take ownership of their own health must be planned and resourced as a prerequisite for improved health.

## 6.2 Communities and Government Agencies

Bullock (1995) recommended inter-agency cooperation and on going support for community based initiatives as a broad strategy.

The extent of cooperation between Aboriginal communities and health providers needs to be seen in relation to the large number of external agencies that interact with communities.

Phillpot (1990, p.52) says:

> The communities consult with an average of thirty-two agencies [*Table 14, p. 142*]. Even allowing for five visits per year by each agency, this indicates that the community's leadership is preoccupied with this consultation for sixty per cent of the year.

There may be merit in arranging for officers from one agency to represent the interests of another agency when there is a need for them to travel to a community.

*Table 14: Organisational Factors Affecting Communities (1990).*

Source: Phillpot (1990).

There are opportunities for the Commonwealth and the NT to co-ordinate their services to Aboriginal communities to minimise visits and streamline structures.

**RECOMMENDATION 42.**

**That the Northern Territory Government resources and empowers the Office of Aboriginal Development to coordinate the provision of human resources by Government departments to remote Aboriginal communities.**

### 6.3 Co-operation between the NT Agencies and ATSIC (Health Issues)

ATSIC established the Health Infrastructure Priority Projects in June, 1994 as a component of the National Aboriginal Health Strategy. The HIPP will operate within the Community Housing Infrastructure Program under the National Aboriginal Health Strategy. The emphasis is on the physical development of infrastructure which has an impact on promoting health such as: water supply, sewerage, priority housing, power supply and internal roads, drainage and dust control.

The Northern Territory Departments of Housing and Local Government, Education, Employment and Training Authority, Office of Aboriginal Development, Power and Water Authority and Territory Health Services agree that services to communities are best delivered in a coordinated 'whole of government' approach.

Each agency has indicated support for HIPP in selected communities and will work with communities to address knowledge and behavioural issues necessary to fully realise the benefits of the HIPP program.

On 30 June 1995 the Northern Territory and Commonwealth Governments and ATSIC signed a ground breaking agreement for the provision of housing to Aboriginal people. The agreement brings together the planning and decision-making for three separate funding programs into one process. This agreement is an excellent example of cooperation in one of the most important areas of service concerning Aboriginal people.

The HIPP Report dated 20 December 1995 is also a positive step forward toward improved cooperation among government agencies.

Resourcing at the community level is important to ensure community ownership of the HIPP initiatives.

The Committee supports the HIPP program (see Recommendation 24. p. 87).

### 6.4 Co-operation between ATSIC and the Commonwealth Department of Health and Family Services

The transfer of responsibility for Aboriginal health from ATSIC to the Commonwealth Department of Health & Family Services from 1 July, 1995 created concern from staff in both

Departments and in State and Territory Government as to how the new arrangements would work.

A Memorandum of Understanding between the chairperson of ATSIC and the Commonwealth Minister of State for Health & Family Services was signed on 13 November 1995 and will operate, unless otherwise agreed between the parties in writing, until 30 June 2000.

This Memorandum of Understanding sets out a framework for cooperation and the roles and responsibilities of ATSIC, Commonwealth Minister for Health and the Department.

The following principles underpin the goal of equal access of Aboriginal people to those health services enjoyed by non-indigenous Australians:

- acceptance of Aboriginal and Torres Strait Islander people's holistic view of health;
- recognition of the importance of local indigenous community control and participation; and
- intersectoral collaboration.

The parties agree that their goal will be to work together to improve outcomes for Aboriginal and Torres Strait Islander peoples. This will be achieved by improving access to culturally appropriate needs based and cost effective health care, community services and environmental services and facilities.

The framework for cooperation requires a collaborative planning exercise with all community controlled services, and the communities they serve, to develop an analysis of local area needs and community health plans.

The Department and ATSIC will cooperate to ensure an effective exchange of information relating to the planning and operation of health and environmental health programs by establishing mechanisms to foster a close working relationship between staff of both agencies at all levels, particularly in regional areas.

The Department, in conjunction with the Commission, will undertake initial negotiations with State Health Authorities on the provision of health services to Aboriginal and Torres Strait Islander peoples and mechanisms to ensure their access to mainstream health programs.

Chan (1995) referred to the Memorandum of Understanding. Ms O'Donoghue was reported to have said that the agreement would enshrine an acceptance of the indigenous view of a holistic approach to health, recognise the importance of local indigenous control and ensure collaboration between different sectors that provide health services.

The Committee reinforces these principles.

The wording of this agreement covers the same intention documented in many other governmental and policy documents. The test will be how closely the agreement relates to action.

## 6.5 Co-operation between Territory Health Services and Commonwealth Department of Health and Family Services

The Terms of Reference for this Aboriginal health inquiry have examined if common goals could be established. Gardiner-Garden (1994) referred to a Commonwealth Parliamentary Research Service which pointed to the major obstacle affecting cooperation: 'With divided responsibility, the planning and management of health care for Aboriginal and Torres Strait Islander people will remain inadequate'.

The written information provided to the Public Accounts Committee by Territory Health Services on 19 April 1995 said:

> Uncoordinated planning and funding allocation creates competition and conflict among health care providers and communities, the Department encourages partnership and co-operation to achieve a coordinated approach to make the best use of the resource available.

Page 2 of the information also indicated coordination and consultation with the Commonwealth:

> The Commonwealth Department of Human Services and Health currently provide two programs to Aboriginal communities. The Commonwealth Rehabilitation Services (CRS) provides their New Start Program and Program Provision in remote areas and currently have Aboriginal clients in the northern and southern areas as well as the cross border area. CRS coordinates and consults regularly with the Department's Aged and Disability Services and rural staff. The Commonwealth Hearing Service has recently begun providing a service to Aboriginal communities.

Commonwealth Department of Health and Family Services (1995b) describes each of the Commonwealth Programs:

- Aboriginal Health;
- Aged Care;
- Children's Services;
- Disability Programs;
- Health Advancement;
- Health Care Access;
- Home & Community Care; and
- the Commonwealth Rehabilitation Service.

The Department operates at three levels:

(a) Central Office in Canberra advises Ministers on policy and develops national guidelines for program administration;
(b) State and Territory offices plan, develop and monitor funded services in consultation with relevant Territory Government agencies, Local Government and community groups in the development of programs and services and
(c) Regional rehabilitation units and hearing centres.

Other services include:

> Remote Area Services - develop our working relationships with existing key agencies; maintain networks with NT Government agencies to keep up with developments on the adequacy of the NT remote and rural medical work force.
>
> Disability Services - the Commonwealth, States and Territories have agreed to provide more integrated services to remove overlap, duplication and gaps in services for people with a disability. The States and Territories will be responsible for development and administration of accommodation, independent living training, recreation and information services, while the Commonwealth will be responsible for employment services and joint responsibility for advocacy services.
>
> Verbal advice from Vipan Maharjan, NT Manager, Department of Health and Family Services, on 1 March 1996 clarified the existing mechanisms to encourage cooperation between the Commonwealth and Territory health departments in relation to these Disability Services. A Commonwealth/State Agreement in 1992 acknowledged that the Commonwealth and State had a role, with the Commonwealth accepting responsibility for all labour programs and the State/Territory responsible for residential care and essential services. Research, development and advocacy is a joint responsibility and the Joint Disability Advisory Board (JDAB) provides advice to Ministers and others.

The NT is the secretariat of this committee and the Commonwealth and NT ministers approve the members of Joint Disability Advisory Board.

Children's Services has joint responsibility for infants aged 0-5 years. The Territory has responsibility for pre-school and maternal child health and contributes to capital for child care facilities. The Children's Services Planning Committee has members endorsed by the Commonwealth and the Territory and make recommendations about needs planning. The recommendations to Ministers refer to where services could be developed and the high needs. Commonwealth advice is that Territory cooperation has been exemplary and COAG is looking at rationalising the cooperative arrangements. The local Memorandum of Understanding does not exist elsewhere. Cooperation with the Education Department for services on remote communities resulted in the Yuendumu child care service.

Aged Care has a formal Advisory Committee and a Home and Community Care Advisory Committee. In the Northern Territory both committees have been combined for a holistic aged care service. National benchmarks have been set and the NT were successful in lowering the age benchmark for Aboriginal people over 50 years of age. The Committee have recommended (Recommendation No. 38., p. 134) that the Commonwealth Grants Commission give a higher weighting for age to recognise the physical rather than chronological age of Aboriginal people. The Home and Community Care Joint Officers Group is required to develop a strategic plan and recommend priorities and funding to the Ministers. The Commonwealth has been perceived as an overbearing influence rather than as an evaluator. 80% of resources for residential and community care are allocated to recurrent projects with the remainder for new projects. The NT has decided to distribute funds to northern NT, 67% and southern NT, 33% based on population numbers. This raises questions about priorities which may not be served by a 67/33 distribution of resources.

The Commonwealth announced in the 1994 Budget, funding for improved delivery of aged care services for Aboriginal and Torres Strait Islander communities by development of more appropriate and flexible services. Correspondence dated 6 March 1996 from Vipan Mahajan, Manager of the NT Commonwealth Department of Health & Family Services to Mr Graham Symons, Deputy Secretary, Territory Health Services, illustrates a cooperative approach:

> ... the Northern Territory Office will be developing flexible Aged Care services on a number of Aboriginal communities including: Maningrida, Angurugu, Yuendumu, Ngnaringman and Ti Tree. The service at Docker River is already up and running. Development of these services on Aboriginal communities will result in significant infrastructure expenditure (up to $1.0m for one-off capital and approximately up to $200,000 for recurrent). We are keen to develop these services in partnership with Territory Health Services and where possible for these services to have closer linkages with your Health services/clinics etc.

Successful cooperation is dependent on the will and attitude of the participants not just the legislation and agreements. Some projects would not have happened without the commitment of the key staff. Belyuen is an example of cooperation and pooling of resources to achieve an outcome for aged people. The Memorandum of Understanding between the Commonwealth Department of Health and Family Services and Territory Health Services and Education Departments for child care in Aboriginal Communities is another example.

Belyuen Community Government Council 1995, a Multi Purpose Service Agreement between the Belyuen Council and the Commonwealth and Territory health Departments is a first for a remote Aboriginal community. The Multi Purpose Service Program has three main objectives:

- provision of an appropriate mix of services to meet individual client needs;
- improve quality of care for clients; and
- provision of an appropriate level and mix of service delivery in a cost effective and coordinated manner.

The agreement is a community service that combines funding provided by the Aged Care Program of Territory Health Services and other community and health funding from the Territory Health Services which is presently allocated to Belyuen. Belyuen is then responsible for the distribution of funding to best meet the health and aged care needs of their community.

The Belyuen Agreement is an encouraging example of effort by the Commonwealth and Territory to avoid duplication of activity and to utilise all the health resources. Instead of having seven (7) different grants to divide into aged care, children's services, rehabilitation, disability and health care needs, the Belyuen Community can now determine through this Service Agreement how it wants to allocate the funding.

The Belyuen Community Council advised the Public Accounts Committee that they were not satisfied with the Agreement. There is a lot of paperwork and a requirement for returns to Territory Health Services for each account.

Benjamin (1995) recommended strategies of support to health personnel living in remote communities, cultural awareness programs and listening and learning from Aboriginal people and accepting that change will not happen quickly.

**RECOMMENDATION 43.**

**That initiatives such as the Multi Purpose Service Program be closely supported and monitored by the Commonwealth/Territory Health Departments to ensure that the performance indicators are evaluated in accordance with the agreement and the terms of the agreement do not hinder implementation.**

Input from General Practitioners is being encouraged through the Top End General Practice Forum. The purpose of the forum is to develop and enhance a close working relationship between General Practitioners in the NT and Territory Health Services The terms of reference (1996) supplied to the Committee by Lyndon Sayers, the then Regional Director from Territory Health Services are to:

1) Provide an open forum within which General Practitioners and Territory Health Services can discuss policy and planning issues related to the development and delivery of health services in the NT;

2) Develop policy frameworks within which the relationship between rural/remote General Practitioners and Territory Health Services managed services can be defined and monitored;

3) coordinate the conduct of projects directed at the resolution of joint issues of concern to General Practice and Territory Health Services and

4) Foster the development of effective communication mechanics between General Practice and Territory Health Services.

It was proposed to hold meetings no less than four times a year and this new arrangement augers well for cooperation in the future. However, advice from a General Practitioner in October 1996 indicates that there has only been one meeting.

Verbal advice from Sam Herd, Regional Director, Australian College of General Practitioners, NT, on 26 July 1995 indicated that improvements in technology in remote communities are important to cooperation and service delivery. Knowledge can be updated and GPs will be less isolated. However the introduction of technology must go with the will and capacity to make it work at the operational level. In general terms, Sam Herd considered that cooperation would be improved by government employees being open to the involvement of non-government people so they may add to the overall effort to improve health services.

The community visits and evidence received by the Committee have confirmed the need to provide additional administrative and financial skills for Aboriginal communities. The use of technology and the training to use that technology for remote communities will further the development of self-determination and accountability.

It is clear that cooperation between NT Government agencies, Commonwealth and private providers could provide an opportunity to share the costs for communication networks into Aboriginal communities. Management Technology Consulting (1996, p. 24) recommended:

That the NT Government adopt an infrastructure approach to its corporate communications. With such an approach, cost justification would take into account the longer term social and economic benefits to the community, rather than individual Agency business case justification and short term cost recovery.

**RECOMMENDATION 44.**

**That Commonwealth and Northern Territory agencies and private providers coordinate their activities aimed at introducing communication networks into Aboriginal communities.**

## 6.6 Telemedicine

A submission to the Commonwealth Government dated May 1996 titled 'Aboriginal Telemedicine Network' prepared through a joint venture comprising Tanami Network Pty Ltd, the Queen Elizabeth Hospital, Territory Health Services and South Australian Health Commission offers technology solutions to the tyranny of distance with the provision of health services to remote communities.

The telemedicine network will immediately provide facilities for inservicing for health professionals, for community health education, and for remote administration. In the longer term, the telemedicine network will provide a wide range of value added services that will cumulatively ensure an improvement in Aboriginal health, such as direct remote Aboriginal participation in national and international health forums, remote access to health databases, and conferences between urban and remote health groups to support programs and alleviate social problems such as the effects of alcohol abuse.

Tanami Network and Territory Health Services have completed 150 hours of trial use of video conferencing as an aid to the delivery of health programs. Activities have included a rural nursing course, training modules for Aboriginal Health Workers, public health seminars and job interviews. Further trials are being conducted between The Queen Elizabeth Hospital, the Pintubi Health Service (Kintore) and Tanami Network. These will look at clinical applications of telemedicine.

**RECOMMENDATION 45.**

**That ongoing coordinated telemedicine trials continue and be linked with the communication network (Rec. 44.).**

Ministers for Aboriginal Affairs and Health, Commonwealth, State and Territory (1989, pp. xx & 36-37) commented on factors affecting cooperation among the providers:

> ... Generally the Working Party is critical of existing arrangements and expressed concern that formal Commonwealth/State co-ordination mechanisms in Aboriginal Affairs do not exist in most States and Territories, although the fact that the New South Wales and Victorian State

> Aboriginal consultative and advisory bodies do include some Commonwealth representation was noted .
>
> Achieving the optimum level of co-ordination and integration between the organisations involved in health care, needs: Commitment by all parties, Commonwealth, State, Territory and community controlled organisations to the principles of intersectoral collaboration; clear delineation of each Government's functions and responsibilities in the major areas of Aboriginal health; a forum for continuing coordination and dialogue between the Commonwealth, State, Territories and the communities.

The Working Party went on to recommend the setting up of a tripartite forum in each State to examine, promote and resolve issues relating to intersectoral collaboration.

The Northern Territory Tripartite Forum (TPF) was established in June 1991 and consists of representatives from Aboriginal communities, NT and the Commonwealth.

The TPF has only met twice and the submission from Bell (1995) of Congress enclosed a November 1992 document titled Forms of Aboriginal Organisation which commented on the TPF:

> In the Northern Territory the Tripartite Forum has been hampered due to lack of secretariat resources, poor understanding of its role and relationships with other structures, and difficulties in reaching agreement about the distribution of NAHS funds (p. 11).

Advice from various people associated with the Tripartite Forum confirms that the TPF has not achieved its purpose and it is likely to be replaced by a different process. The TPF has been discontinued.

### 6.7 Three Streams of Health Care

Marcus (1995, pp. 2-3) focussed on the proposed three streams of care: general care, acute care and coordinated care. In the speech notes, Marcus said:

> For many years the Commonwealth and States/Territories have argued over responsibility for health care - this has been a futile exercise. In April 1995 the Council of Australian Governments (COAG) agreed that the health and community services system needed reform.

At the Council of Australian Governments Meeting on 11 April 1995 in Canberra, an indicative milestone for late 1996 was that Governments enter into interim bilateral funding agreements, based on agreed allocation of roles and responsibilities.

Problems with achieving cooperation within the current health system was highlighted by Paterson (1996, p. 14):

> Number one is that it (health care system) is dedicated to providers rather than to patients. It is built as a series of 60 money streams directed to individual provider groups, and it does not address patients or even address or even recognise patients, systematically. Taken individually, all of them do good but taken as a system they don't work together. ... we have to decide whether ultimately we are building systems to serve the interests of political turf-holders and providers, or to serve patients.

One example of reducing the number of money streams is the Co-ordinated Care Trial.

In 1996 Territory Health Services and the Commonwealth Department of Health and Family Services entered into negotiations to progress a Coordinated Care Trial for the NT. Draft details of that trial were supplied to the Public Accounts Committee by Territory Health Services on 20 February 1996.

The primary purpose of the trial is to test service delivery and funding arrangements that may deliver outcomes for clients by a combination of services targeted to the needs of the individual. The NT Trial will be a trial of health resource delivery for Aboriginal communities with a pooling of Commonwealth and Territory health funds. A community development model will be utilised on the Tiwi Islands and a regional model in the Katherine District. The trial will test new funding models that facilitate Aboriginal involvement in management and improved inter-sectorial collaboration.

The Regional Director Operations South, Territory Health Services, advised that Alice Springs has entered into negotiations for a melting pot of Commonwealth and Territory funding. A joint planning exercise involving the Commonwealth health, Territory health, ATSIC and Aboriginal controlled organisations is a positive development in Central Australia. He advised that funds should be allocated on economic principles rather than the squeaky wheel and believes it is impossible to manage health services to communities as we do now - we need to take a more flexible approach.

Hemmerling (1995) advocates clear service delivery goals, philosophies and service agreements between the stakeholders as a strategy to achieve co-operation.

The Committee notes that delivery of health is impeded by a mosaic of services where the number of different programs and providers is unco-ordinated and confusing for the customer.

The needs of the providers must be geared to the needs of the customer to ensure that health services becomes streamlined and customer focused.

The Committee concluded that cooperation will be improved by a strong population/patient focus rather than a system which is driven by professional groups and confused health responsibility between governments.

## 6.8 Cooperation between Territory Health Services and Aboriginal communities

Royal Commission into Aboriginal Deaths in Custody (1991, p. 192) refer to the need for Aboriginal delivery of health services:

> That in the implementation of any policy or program which will particularly affect Aboriginal people, the delivery of the program should, as a matter of preference, be made by such Aboriginal organisations as are appropriate to deliver services pursuant to the policy or program on a contractual basis. Where no appropriate Aboriginal organisation is available to provide such service, then any agency of government delivering the service should, in consultation with appropriate Aboriginal organisations and communities, ensure that the processes to be adopted by the agency in the delivery of services are appropriate to the needs of the Aboriginal people and communities receiving such services. Particular emphasis should be

> given to the employment of Aboriginal people by the agency in the delivery of such services and in the design and management of the process adopted by the agency.

Territory Health Services (1996a) refers to the Aboriginal Health policy to encourage Aboriginal communities to take responsibility for their own health services and to encourage more Aboriginal people to be employed in health services complements the above Royal Commission into Aboriginal Deaths in Custody recommendation.

Correspondence to the Public Accounts Committee from Territory Health Services dated 19 April 1995 advised that eighteen Aboriginal health services are currently managed by community councils which receive the majority of their funding from Territory Health Services through negotiated service agreements or grant agreements. As covered earlier in this report, evaluation of service agreements has been difficult. Allocation of time and skills to this process appears to be lacking. Advice from a senior commonwealth officer is that service agreements between the Commonwealth and Aboriginal controlled health service organisations have not been evaluated and there are concerns about the adequacy of the service agreements. Advice from staff involved with service agreements in the Territory Health Services indicates that defining the service and results has been difficult. Initial discussion with communities 'lifted the lid' on concerns about resources and skills.

Comments from communities indicate that the skills required for identification and measurement of services are of concern to Aboriginal communities and Rural Nursing staff.

The Wadeye Community Council (Port Keats) on 13 October 1995 verbally advised the Committee that a valid and satisfactory service agreement does not exist for Port Keats. The Council considered that for one to be successfully negotiated will require the Council having access to independent, professional advice and extensive consultation with Territory Health Services. The Health Service has no dedicated financial or administrative resource and the Council is severely limited in the resources it can offer.

Bell (1995, p. 3) of Congress referred to concerns with the service agreement model relating to low funding levels and the inequity of the service agreement/contract process:

> NT Health officials negotiate with the Community Council, but mostly the Community Council have no previous experience in running a health service.
>
> Congress and the Menzies School of Health Research in Alice Springs have suggested that the Department should resource the Council to contract an independent negotiator with experience in health service development to give greater equity to this process. This has not been taken up by the Department.

Bell (1995, p. 3) also referred to service agreements with concern about lack of assistance to the Community Council stating that communities are not resourced beyond the limited administrative tasks:

> ... it seems that some of these services are being set up to fail, giving Aboriginal people the responsibility but not the resources to tackle the serious health problems on their communities.

See Recommendation 31. p. 98 of this report.

Burns (1995, pp. 4-5) in the Maningrida health study supported the direction of the Commonwealth and Territory health departments concerning Aboriginal health:

> A Health Service to successfully redress the ill health of Aboriginal people in the Maningrida region, will need the commitment and collaboration of not only the Aboriginal community but also the Commonwealth and Territory Governments.
>
> It should be emphasised that the spirit of these recommendations is to transfer as much of the required resources and decision making for the Health Service to Aboriginal people in the Maningrida region.

Verbal advice from the Assistant Secretary, Aboriginal Health, Territory Health Services, gave examples of consultative mechanisms to achieve cooperation. These include attendance at Aboriginal Medical Service Alliance NT which is the local version of the National Aboriginal Community Controlled Health Organisation and attendance at the twice yearly forum of ATSIC chairpersons with other NT Agencies and Regional Council meetings. The Office of Aboriginal Development coordinates a Standing Working Group on Aboriginal Matters. The annual meetings organised by the Office of Aboriginal Development to provide a forum for Aboriginal people and representatives of organisations to comment on the implementation of the Deaths-In-Custody recommendations is another example of cooperation. Every policy advisory committee impacting Aboriginal health requires Aboriginal representation.

## 6.9 Aboriginal Health Workers

The attraction and retention of Aboriginal Health Workers in communities was found by the Committee to be an ongoing challenge. Trained Aboriginal Health Workers were in the communities and not employed in the health area.

A priority area (p.7) in the Territory Health Services Corporate Plan of 1993/95 was:

> ... improved recruitment, retention, support and training of Aboriginal health workers.

The Health Promotion objectives (p. 17) in the 1993/95 Corporate Plan was:

> ... to increase Aboriginal involvement and representation in health decision-making.

The Program Director of Community Health, Territory Health Services, advised that the 1987 *Health Practitioners and Allied Professionals Registration Act* requires Aboriginal Health Workers to be registered following their training. Training required for registration may be the one year Basic Skills Course. Registration allows Aboriginal Health Workers to practice a range of patient services including the prescribing of medicine which a nurse is normally not permitted to do.

The Aboriginal Health Worker Registration Board established under the Act requires a skills certificate and a character reference.

Advice from a staff member of the Health Departments Professional Registration Boards identified difficulty in collecting the legally required $10 annual registration fee from

Aboriginal Health Workers despite repeated reminders. There is concern that unregistered Aboriginal Health Workers may be working in the field. This raises the need to consider new ways of collecting the registration fee. There are 300 Aboriginal Health Workers currently registered.

A list of Aboriginal Health Workers erased from the register by year shows the following:

| 1988 | 1989 | 1990 | 1991 | 1992 | 1993 | 1994 | 1995 |
|---|---|---|---|---|---|---|---|
| 9 | 6 | 11 | 8 | 21 | 22 | 11 | 21 |

*Table 15: List of numbers of Aboriginal Health Workers erased from the Register 1988-1995.*

Source: Territory Health Services

Recent advice from the Professional Registration Boards is that Aboriginal Health Workers who have not practised for three years are required to undergo a St. Johns Ambulance Course and after five years it is recommended that an Aboriginal Health Worker undergo a refresher course.

As at 25 March, 1996, 100 Aboriginal Health Workers had not paid their registration and it is suspected that the majority of the 100 are working without being registered.

**RECOMMENDATION 46.**

**1. That the Attorney-General's Department examine the implications of unregistered Aboriginal Health Workers practicing in the field; and**

**2. that Territory Health Services arrange for the registration fee to be deducted, by agreement, from the Aboriginal Health Worker's salary.**

A review of health and community services by external consultants, CRESAP, in 1991 found that only 70% of funded Aboriginal Health Worker positions were filled. CRESAP also recommended that a high priority should be given to filling the existing vacancies and increasing the participation rates of currently unemployed registered Aboriginal Health Workers.

Josif & Elderton (1992, p. 8) addressed their terms of reference which included recruitment and retention of Aboriginal Health Workers. Their research analysed the responses from Aboriginal Health Workers, to broad questions of why they stay or leave the job and what makes it either a good or bad job:

> The maintenance of a DHCS (Department of Health and Community Services) policy and management environment that continues to support the traditional medical hierarchy, which emphasises the clinical role of health service delivery and not AHWs in a primary health context, was repeatedly cited by AHWs during the course of this project as a negative part of the job. Serious deficiencies with DHCS communication processes are also cited as creating problems for AHWs at the community level.

The 1992/3 Territory Health Services Corporate Plan included objectives to provide adequate support to Aboriginal Health Workers and provide refresher courses for Aboriginal Health Workers who want to rejoin the service.

Josif & Elderton (1992, pp. 20-23) submitted a number of reasons why Aboriginal Health Workers leave the job:

> ... For most AHWs, quitting the job is the only way that a respite from the demands and pressures of the job is possible. Leaving the job and returning to it much later is often a way of coping with the need to be involved in other activities.
>
> ... it is a hard job because you're trying to educate people in health matters and people aren't interested. People think that it is the health workers job to make them well, not their own responsibility.
>
> ... Repeated references were made by AHWs about the need for additional resources in order to be able to work more effectively 'outside the clinic'. The question of how AHWs could fit their work in with cultural responsibilities was raised on a number of occasions. Some AHWs said that they were worried about treating people because of the payback system. Bad health is a big problem ... also it is dangerous for us because we might have to go against Aboriginal law. Sometimes we feel a lot of pressure because of conflicts in the job ... we have to sit down with the family first and explain why ... it can be a problem if someone dies, we have to go through two laws then.
>
> ... In some places blaming is seen as the main cause of AHW resignations. In most places the council plays a role in talking to grieving families and ameliorating the blame that is focussed onto AHWs. However, in some communities blaming is not seen as a major problem, as long as the health workers were able to fully explain the situation to the family.

Josif & Elderton (1992, pp. 22-47) provided further understanding of the health workers:

> If people die sometimes people blame us and swear at us and blame the treatment ... but we explain it is the grog or bad food or disease ... we are explaining this all the time ... that is why preventative health is so important.

The need to provide cultural training to doctors and nurses was apparent:

> ... they have got to understand the skin situation so they don't try to force us to treat the wrong skin.

Aboriginal Health Workers use the adjectives 'bossy', 'fussy' and 'cheeky' were frequently used to describe nursing staff.

Josif & Elderton (1992, p. 33) referred to perceptions of Aboriginal Health Workers at Ramingining:

> She (AHW) can be quite good when she wants to work ... she hasn't got a very good attendance record ... well I don't think they're ... (AHWs) ... very well qualified at all. They're not really good at literacy and numeracy, and I'm not happy with their qualifications at all ... I'm not very happy leaving them there (at the clinic) by themselves.

Josif & Elderton (1992, pp. 45-47) referred to education, role models, cultural and administrative services:

> ... A council President talked about the difficulty in finding young people for the job ... not much interest in doing the health worker job from the community ... maybe because they haven't got enough school ... you have to have education before you can do anything else ... kids have poor role model in many adults, like drinking.
>
> ... People from three clinics talked about wanting to work in other communities. A number of currently employed AHWs have moved between workplaces. There was a suggestion that cultural and administrative barriers would prevent the inter-community exchange of AHWs from being successful, this was not the view coming from AHWs themselves.

Nurses in one community that was visited by the Public Accounts Committee commented that Aboriginal Health Workers were not coming to work but were still being paid full time.

Tregenza & Abbott (1995) also referred to the role of health workers and the hierarchical structure which puts them on the bottom of the pile.

The Committee believe that the effectiveness of the Aboriginal Health Workers could be assisted by community acknowledgment of their role in the health system. The actions and attitudes of other professionals will be assisted by cultural awareness training and recognition of their value. There could be advantages for those communities who support exchange of Aboriginal Health Workers to receive Aboriginal Health Workers from other communities where there are successful programs in place and where the recipient community supports the introduction of that program into their own community to improve the health of their people.

The Committee considers that there should be ongoing professional training for Aboriginal Health Workers so that they may extend their competencies.

Aboriginal Health Workers are key agents of change for the implementation of the primary health care model and ongoing support and encouragement is essential.

**The critical role of Aboriginal Health Workers requires ongoing support, training and development of relationships with other workers and communities. The policies and structures should be geared accordingly.**

**RECOMMENDATION 47.**

**That Territory Health Services facilitate transfer of Aboriginal Health Workers to other communities where successful primary health care programs and initiatives may benefit those other communities and where the recipient community supports the arrangement.**

In a submission to the Public Accounts Committee, Ms C. Jobson, Joint Manager, Milingimbi Health Centre, said:

> An obvious strategy would be the employment of people with appropriate knowledge of and ability to administer, at all levels of management, delivery of this specialised area of health.

> Another immediate strategy would be the setting up of a Department of Aboriginal Health funded by the Commonwealth Department and administered by the Northern Territory Government. This would ensure accountability for spending of funding and attract people interested in Aboriginal health.

Spillane (1995) submitted that the Territory Health Services has a public relations problem with the broad Aboriginal community. His proposal to the Committee advocated an Assistant Secretary for Aboriginal Health. (Territory Health Services have subsequently created an Assistant Secretary, Aboriginal Health.)

These two submissions reinforce the need for the health bureaucracy to be in touch with the health services required for Aboriginal people.

## 6.10 Cooperation with Royal Flying Doctor Service (RFDS)

Verbal advice from the Manager NT Operations, RFDS in Alice Springs on 10 May 1996, produced the following information:

- The RFDS is funded 45% from Commonwealth, 45% NT and 10% internal fund raising.

- The RFDS *59th Annual Report 1994-1995* (p. 4) statement of cash flows for year ended 30 June 1995 for the Central Section of RFDS which covers South Australia (SA) and the NT, illustrate the funding: Government grants from SA were $4.347m (includes $1.98m capital grant), NT $1.794m and $3.689m from Federal Government (includes $1.46m capital grant). Cash flows from fundraising were $1.709m.

- The Yulara Health Service (Ayers Rock Medical Centre) is included in the NT RFDS cash flows.

- The service agreement with the NT is up for renewal in June 1997.

- RFDS in Alice Springs estimate an additional 375 hours over the budgeted amount for this year and are seeking additional funds from the NT and Commonwealth.

- The NT government does not contribute any funding for capital. Planes are replaced every 15 years and there are 43 planes nationally with 3 allocated to the NT. The NT have received two new Pilatus PC12 planes which are 70% of the operating cost of the King Air.

- 90% of the NT clients are Aboriginal.

- Half the capital costs for the NT are raised through fundraising.

- The RFDS in Alice Springs employ 30 staff including 6 nurses, 1 District Medical Officer, 6 Pilots and 3 Engineers. The medical staff are part of the Territory Health Services' Alice Springs rural team and support is provided to clinics by the nursing staff.

Royal Flying Doctor Service (1994-1995, p. 2) refers to the funding arrangements with the Commonwealth who have offered an untied capital grant and changes to the funding of operational grants. All Governments are intending to use Service Provider Contracts as the basis of future funding. The President acknowledges that:

> The dilemma facing all parties now is determining which of our services are a Commonwealth responsibility, which are a State responsibility and to what extent will the RFDS have to fund these services from its own resources.

The above information draws attention to the need to be vigilant with the monitoring of these financial developments and to ensure that the interests of the NT are advocated.

In the Top End, the Territory Health Services have an Aero Medical contract with Sky West Aviation for the aero medical services, excluding doctors and nurses who are employed by the Territory Health Services. In 1994/95 Sky West flew 593,000 nautical miles and Territory Health Services paid $3.647m for the service.

There is no formal agreement with Air North who provide a service for Tennant Creek. Advice from Tennant Creek indicates that the operator for Air North requires $25,500 per month rather than the 1996 expenditure of $18,500 per month in order for the service to continue.

Taking into account all sources of funds for the three separate services there may be benefits in assessing options to streamline the overall aero medical services to the NT.

**RECOMMENDATION 48.**

**That Territory Health Services ensure that the efficiency and effectiveness of the aerial medical services be reviewed.**

### 6.11 Overseas Models for Achieving Cooperation amongst the Principal Participants

As reported under Term of Reference (a) (p. 1) referring to whether common goals have or can be established, Dr Scrimgeour and Dr Bagshaw of Menzies School of Health in Alice Springs commented on their overseas experience in New Zealand, Canada and Africa.

Dr Bagshaw's experience in African countries indicated the value in assisting communities to build on their success rather than trying to rush into a change before the community is ready. Dr Scrimgeour's understanding of the American Indians identified government assistance over a two-year period to ensure that the Indians were resourced to be able to decide their own health goals.

Cooperation will be improved if the participants can observe real improvements in health status where health is perceived as an issue.

The African example shows that in a poorly resourced health service ownership can be encouraged through small incremental steps. Scrimgeour (1995) in the American Indian

example showed that cooperation was improved through a genuine commitment by government, followed through with resources, to empower the Indian people to take control of their own health services.

Scrimgeour (1995, pp. 7 & 9) referred to the Canadian Indian Health Program Transfer Policy which was announced by Canada's Health and Welfare Branch in 1986 and included the objectives:

> to enable Indian communities to design health programs, establish services and allocate funds according to community health priorities; to strengthen and enhance the accountability of Chiefs and Councils to community members.

Some of the communities were suspicious of Government and concerned that the primary intention was for Government to rid itself of its fiduciary obligations and implement cost-cutting measures. Others decided to accept the opportunity to gain more control over their services notwithstanding their concerns which were illustrated by the Swampy Cree Tribal Council:

> ... we entered the transfer process - but with our eyes wide open. We saw transfer as a way to achieve some of our objectives and we felt we could look after ourselves in dealing with the Government. We still feel that way.

Scrimgeour (1995, p. 35 & 37) referred to the New Zealand Maori health service and cooperative arrangements whereby in 1993 the New Zealand Government released *Whaia te ora mo te twi* which contained Maori policy objectives which included: **to encourage the greater participation of Maori in order to develop health solutions which are effective, affordable, accessible and culturally appropriate** .

> ... In some areas partnerships are being formed between Maori organisations and health authorities, creating joint ventures in which both parties work towards common goals. In such joint ventures, a Maori organisation signs a contract with a purchasing authority, agreeing to be involved in activities which may include:
>
> - undertaking needs assessments;
> - co-operating in making purchasing arrangements;
> - selection of appropriate providers;
> - evaluation and monitoring; and
> - assessing cultural appropriateness.

Scrimgeour (1995) also refers to the similarities of Australia, Canada and New Zealand with regard to colonial history and government policies towards the indigenous peoples. With reference to the Maori, he describes the separation of the roles of purchaser and providers of health care as having a beneficial effect on the involvement of Maori organisations in comprehensive primary health care.

Cunningham & Harris (1995, pp. 317-319) referred to six attributes of health care which are central to improving Maori consumer satisfaction:

- access;

- communication and information;
- informed choices;
- trust and respect;
- participation by Maori;
- seamless service provision.

> For many Maori it is important that health is addressed as one component of broad Maori development in which social, political, cultural and economic factors are also addressed. The premise is that the consumer will benefit from this more holistic approach to well-being and so services need to be more integrated both within the health sector and without. Maori value the employment and development of Maori staff at all levels in the service.

Cunningham & Harris (1995, p. 308) also referred to the purchaser/provider split:

> The health sector has undergone reform in New Zealand with a funder/purchaser/provider split and increased accountability and flexibility designed into the system. This enables an opportunity for innovative and responsive solutions for achieving Maori health gains to be implemented. One consistent difficulty has been the paucity of information on effective health services for Maori.

The paper identified the need to present information in a user friendly format which encouraged self-evaluation and improvement. The documentation for Aboriginal Australians should be presented in a similar way to achieve the same objective. Draft documentation could be tested for its comprehension with a sample of the intended audience before being released.

Aboriginal people should be invited to have input into how information should be presented and services evaluated so that the documentation may be understood.

**RECOMMENDATION 49.**

**That information for Aboriginal people be prepared in a user friendly format to ensure comprehension of the message.**

Hoy (1996, p. 4) referred to the better health profile of American Indians:

> The better health profile of American Indians reflects their different backgrounds; eg millennia of settled sophisticated community living for the original tribes of the Southwest and a long agrarian tradition, with more stability of food supply. In addition, Indians have had a long exposure to 'Westernisation', reflected in vastly better educated and empowered people, with higher rates of employment at this point in time. The Indian health service has played a critical role; this is a federal agency with a unified philosophy, clear objectives, accountability to the legislature, ongoing evaluations that drive future policy, and internal education opportunities and career paths, with a strong emphasis on 'hire (a qualified) Indian' at every level. Health education and primary care are the broad base of the program, while highly specialised services are usually contracted out.

Caldwell & Caldwell (1995, p.2) referred to overseas studies which link health status of infants with the education of the mother. Caldwells' paper included research in Nigeria 20

years ago which showed that even in areas where there was access to modern medicine, infant mortality was lower among the children of educated mothers who provided better care for their infants. The great majority of research showed that in contemporary developing societies child mortality falls with increased education among both parents but that the mother's education had the greatest influence. There is firm evidence that the more educated the mothers quickly seek medical attention and are more likely to adhere to the prescribed treatment and to report back if the treatment does not seem to be working. Less educated women seem to smoke at higher levels during pregnancy resulting in underweight births.

Malavisi (1995, p. 1) referred to lack of education by the community in addressing their health requirements. 33% of the adult population have diabetes and a recent decision of the local store to sell only diet drinks was overturned by the Council because people were complaining. A community scabies eradication program also seemed to have failed due to lack of compliance and support. Poor levels of education has been submitted as one explanation for non-compliance.

Gaykaynangu (1995, p. 1) suggested that a strategy to achieve co-operation requires closer attention to extensive education for the patients (the main participants) so that they accept health as a personal value.

The link between education and health is inextricable and therefore improvement in the standard of education for Aboriginal people will contribute to the improvement in the general health of Aboriginal people. The education of the mother and grandmother is vital to infant health.

**RECOMMENDATION 50.**

**1. That Territory Health Services work with the Education Department, including the schools, to develop a comprehensive range of education programs in infant care; and**

**2. that infant care education be:**

- **part of the compulsory curriculum**
- **part of training offered in the Women Centres**
- **related to the dangers of drug and alcohol use.**

## 6.12 Strategies for achieving cooperation among the providers

### 6.12.1 Strategy 1 - Pooling of funds

This strategy could either have the Northern Territory Government as the funder of the service or the Commonwealth as the funder.

There are advantages in having the Northern Territory Government, which has the local knowledge and infrastructure, being the conduit for all health funds from the Commonwealth, except funds covered by the Medicare agreement, with the

Commonwealth responsible for national policies, performance targets and evaluation and the Territory responsible for service delivery. It is important that national policies allow a high local input to ensure that those policies are compatible with the local needs. The overlaps in programs and duplication of services would be removed freeing up extra funds for the delivery of services with a reduction in patient confusion as to where to access those services.

The Committee considers that the Commonwealth should not be involved in actual service delivery.

**RECOMMENDATION 51.**

**That the Commonwealth provide funding to the Northern Territory for delivery of health services with the Commonwealth responsible for national policy, performance targets and evaluation.**

### 6.12.2 Strategy 2 - Regional Health Boards

In order to shift the health focus away from the providers to the client population there needs to be a framework which will concentrate on health outcomes with a population focus.

The Hospital Board in Alice Springs has an Aboriginal person with community service experience as a member. The role of the hospital boards is still inwardly forward. There is merit in moving to a regional focus so that the hospital is managed as part of a total health service rather than an institutional centre. Regional health boards would assist this change.

**RECOMMENDATION 52.**

**That Regional health boards be established with representation from consumers, Aboriginal groups, Territory Health Services, Commonwealth Department of Health and Family Services, General Practitioners/private providers and that the Menzies School of Health provide advice and feedback about the effectiveness of services to the funders of the service.**

### 6.12.3 Strategy 3 - Purchaser/Provider Split Model of Delivery

The Canadian research into indigenous people and the Western Australian progress with the Waloona community indicate advantages with the purchaser/provider split model.

**RECOMMENDATION 53.**

**That Territory Health Services encourage grant funded organisations to purchase services where the market lends itself to a choice between alternative providers.**

### 6.12.4 Strategy 4 - Whole of Government Cooperation

The Committee have noted that the Office of Aboriginal Development are developing a database of Aboriginal communities. There is evidence of agencies and governments duplicating effort with community profiles. Both the Commonwealth and Territory Health Services presented community profiles to the Committee unaware of each others duplicated efforts. Other examples of duplicated effort were also apparent. There is merit in the Department of Aboriginal Development facilitating a whole of government approach in relation to services for Aboriginal communities. This would include the sharing of a common database for community profiles to avoid the current unsatisfactory practice where government departments are duplicating information and effort.

**RECOMMENDATION 54.**

**That the Office of Aboriginal Development be resourced to finalise the Aboriginal Communities Database and that Agencies input their information about Aboriginal communities into the database on an ongoing basis so that all agencies will benefit from the consolidated information.**

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# APPENDICES

***APPENDIX A***

# *List of Written Submissions to the Public Accounts Committee*

| NO. | ORGANISATION | DATE RECEIVED |
|---|---|---|
| **H1** | Ms Penny Dennis<br>Executive Director<br>National Heart Foundation<br>GPO Box 4363<br>DARWIN NT 0801 | 6.2.95 |
| **H2** | Ms Stephanie Bell<br>Acting Director<br>Central Australian Aboriginal Congress Inc<br>P O Box 1604<br>ALICE SPRINGS NT 0871 | 1.3.95 |
| **H3** | Mr John Lawrence<br>Health Service Co-ordinator<br>Nganampa Health Council Inc.<br>PO Box 2232<br>ALICE SPRINGS NT 0871 | 13.3.95 |
| **H4** | Mr Tony Bridgman<br>Centralian Cuisine<br>PO Box 2803<br>ALICE SPRINGS 0871 | 13.3.95 |
| **H5** | J. Kennealy<br>Clinical Nurse Consultant<br>Peppimenarti Health Clinic<br>PMB 56<br>WINNELLIE NT 0821 | 28.3.95 |
| **H6** | Town Clerk<br>Alice Springs Town Council<br>P O Box 1071<br>ALICE SPRINGS NT 0871 | 31.3.95 |

| NO. | ORGANISATION | DATE RECEIVED |
|---|---|---|
| **H7** | Ms Carol Jobson<br>Joint Manager<br>Milingimbi Health Centre<br>MILINGIMBI NT 0822 | 4.4.95 |
| **H8** | Mr Michael Owen<br>Executive Officer<br>Miwatj Health Aboriginal Corporation Inc<br>PO Box 519<br>NHULUNBUY NT 0881 | 10.4.95 |
| **H9** | Beryl Djakala Mayanini<br>Senior Aboriginal Health Worker<br>Health Centre<br>MILINGIMBI NT 0822 | 11.4.95 |
| **H10** | Ms Barbara Flick<br>Indigenous Health Adviser<br>Australian Medical Association Limited<br>PO Box E115<br>Queen Victoria Terrace,<br>PARKES ACT 2600 | 24.4.95 |
| **H11** | Mr J. Gaykaynangu<br>President<br>Milingimbi Community Inc<br>MILINGIMBI VIA DARWIN NT 0822. | 24.4.95 |
| **H12** | Dr Peter Thorn<br>18/73 Progress Drive<br>NIGHTCLIFF NT 0810 | 24.4.95 |
| **H13** | Mr R. Bullock<br>Acting Commander<br>Corporate Development<br>Northern Territory Police<br>PO Box 39764<br>WINNELLIE NT 0821 | 2.5.95 |

| NO. | ORGANISATION | DATE RECEIVED |
|---|---|---|
| **H14** | Dr Paul Spillane<br>Director, Medical Services<br>East Arnhem District<br>c/- Gove District Hospital<br>PO Box 421<br>NHULUNBUY NT 0881 | 24.4.95 |
| **H15** | N.T. Medic Domiciliary & Associated Services<br>GPO Box 2893<br>DARWIN NT 0801 | 24.4.95 |
| **H16** | N.T. Medic<br>GPO Box 2893<br>DARWIN NT 0801 | 24.4.95 |
| **H17** | Mr Peter Lionel Malavisi R.N, R.M., B.Nsg, M.C.H.<br>Clinical Nurse Consultant<br>Armunturrngu Health<br>Watiyawanu (Mt Liebig)<br>VIA ALICE SPRINGS NT 0872 | 26.4.95 |
| **H18** | Ms Cecilia Farley<br>A/ADON Darwin Community Health<br>PO Box 40596<br>CASUARINA NT 0811 | 26.4.95 |
| **H19** | Sr Lorna Benjamin<br>c/- Numbulwar Health Centre<br>CMB 17<br>via KATHERINE NT 0852 | 3.5.95 |
| **H20** | Ms P. Anderson<br>Director<br>Danila Dilba<br>Biluru Butji Binnilutlum Medical Service<br>GPO Box 2125<br>DARWIN NT 0801 | 18.5.95 |

| NO. | ORGANISATION | DATE RECEIVED |
|---|---|---|
| **H21** | Mr Jurgen Hemmerling<br>Living with Alcohol<br>Department of Health & Community Services<br>ALICE SPRINGS NT 0871 | 12.1.95 |
| **H22** | Mrs Carol Frost<br>President<br>Drug & Alcohol Services Association Alice Springs Inc<br>PO Box 3009<br>ALICE SPRINGS NT 0871 | 17.1.95 |
| **H23** | Mr David Shannon<br>Chairman<br>Ali-Curung Council Association Inc<br>PMB Ali-Curung<br>via Alice Springs NT 0872 | 23.1.95 |
| **H24** | A/Under Treasurer<br>NT Treasury<br>GPO Box 1974<br>DARWIN NT 0801 | 13.6.95 |
| **H25** | Ms Dorothy Fox<br>President<br>Deafness Association of the NT Inc<br>Shop 14, Casuarina Plaza<br>258 Trower Road<br>CASUARINA NT 0811 | 7.7.95 |
| **H26** | Ms Janet Schmitzer<br>Associate Dean - Health Sciences<br>Northern Territory University<br>DARWIN NT 0909 | 31.10.95 |

## *APPENDIX B*

# *Public Accounts Committee Hearings in Darwin and Alice Springs*

| Date | Organisation/Agency | Witnesses |
|---|---|---|
| **DARWIN** | | |
| 8.2.95<br>Private | Office of the Auditor-General for the Northern Territory | Mr Iain Summers, Auditor-General |
| 3.3.95<br>Private | Office of the Auditor-General for the Northern Territory | Mr Iain Summers, Auditor-General |
| 3.5.95<br>Private | Northern Territory Department of Health & Community Services | Ms Kathryn Henderson, Chief Executive Officer<br>Mr Graham Symons, Assistant Secretary, Community Care |
| 9.8.95<br>Private | Northern Territory Treasury | Mr Tim McClelland, Acting Deputy Under Treasurer<br>Mr John Ayre, Director, Public Finance Branch |
| 25.10.95<br>Public | NSW Health Department | Mr Jim Pearse, Manager Structural and Funding, Strategies Unit |
| 25.10.95<br>Public | University of Sydney | Professor Gavin Mooney, Professor o Health Economics |
| 25.10.95<br>Public | Territory Health Services[*] , Darwin | Ms Carol Beaver, Director, Health Economics and Resourcing |
| 25.10.9<br>Public | Commonwealth Grants Commission | Mr Richard Rye, Chairman |
| 8.3.96<br>Private | Territory Health Services, Darwin | Mr Graham Symons, Deputy Secretary, Program Development & Planning<br>Ms Carol Beaver, Director, Health Economics |
| 28.3.96<br>Public | Menzies School of Health Research, Darwin | Dr Wendy Hoy, NHMRG Senior Research Fellow and Head of the Renal Unit |

[*] formerly Department of Health & Community Services

| Date | Organisation/Agency | Witnesses |
|---|---|---|
| **BATCHELOR** | | |
| 1.5.96<br>Public | Batchelor College | Mr John Ingram, Director<br>Dr David McClay, Deputy Director (Operations)<br>Dr John Henry, Assistant Director, Academic Development<br>Ms Alison Worrell, Head of the School of Health Studies<br>Mr Ron Watt, Head of the School of Educational Studies<br>Mr Ron Stanton, Senior Lecturer, Centre for Education, Research and Development<br>Mr Bill Baird, Senior Executive Officer, Council, Communities and Students<br>Ms Holly Margerrison, Registrar |
| **ALICE SPRINGS** | | |
| 7.5.96<br>Public | Territory Health Services, Alice Springs | Mr Ross Brandon, Regional Director, Operations Central |
| 7.5.96<br>Public | Central Land Council | Mr Leigh (Tracker) Tilmouth, Director,<br>Ms Olga Havnen, Senior Policy Officer |
| 7.5.96<br>Public | Central Australian Aboriginal Congress Inc. | Mr Kenny Laughton, Director<br>Dr John Boffa, Medical Officer, Public Health Unit<br>Ms Heather Brown, Branch Manager, Education and Training Unit |
| 7.5.96<br>Public | Alice Springs Town Council | Ms Carole Frost, Alderman<br>Mr Rod Oliver, Alderman<br>Mr Terry McCumiskey, Alderman<br>Ms June Noble, Alderman |
| 7.5.96<br>Public | Tanami Network | Mr Peter Toyne, Consultant |

## *APPENDIX C*

# *Public Accounts Committee Hearings at Remote Aboriginal Communities*

| Date | Organisation/Agency | Witnesses |
|---|---|---|
| 13.10.95<br>Private | Kardu Numida Health Services, Wadeye | Mr Terry Bolimore, Council Clerk<br>Mr David Sutcliffe, doctor's husband<br>Dr Ann Patton<br>Ms Mim Vastbinder, Nurse<br>Ms Leonie Conn, Nurse<br>Annunciata Dartinga, Senior Health Worker<br>Ms Jacinta Alliung, Registered Health Worker<br>Ms Stephanie Berida, Senior Health Worker<br>Mr Adrian Tunmuck, Trainee Health Worker<br>Matthias Nemarluk, Senior Health Worker |
| 13.10.95<br>Private | Kardu Numida Incorporated, Wadeye | Mr Leon Melpi, President<br>Mr Claude Narjic, Member<br>Mr Terry Bollemor, Council Clerk<br>Mr David Sutcliffe |
| 7.3.96<br>Private | Belyuen Community Government Council, Belyuen | Mr Harry Singh, Chairman<br>Mr Claude Holtze, Deputy President<br>Mr Tony Singh, Councillor<br>Ms Sandra Yarrowin, Councillor<br>Ms Lorna Tennant , Bookkeeper |
| 7.3.96<br>Private | Belyuen Community Health Clinic, Belyuen | Mr Harry Singh, Aboriginal Health Worker<br>Ms Christine Wigger, Registered Nurse |
| 19.3.96<br>Public | Maningrida Council Inc | Mr Gordon Machbirrbirr, Councillor and Assistant Council Clerk<br>Mr Charlie Yirrwalla, Councillor<br>Mr Roly Madjerr, Councillor<br>Mr Alan Clough, Council Clerk |
| 19.3.96<br>Public | Maningrida Community Health Clinic, Maningrida | Dr Tony McMullin, District Medical Officer<br>Ms Liz Stephenson, Registered Nurse<br>Ms Karen Williams, Registered Nurse<br>Ms Sue Kruske, Registered Nurse |
| 20.3.96<br>Public | Yirrkala Health Centre | Mr Stephen Murdoch, Clinical Nurse Consultant<br>Ms Burungay Maymuru, Senior Aboriginal Health Worker |

| Date | Organisation/Agency | Witnesses |
|---|---|---|
| 20.3.96<br>Public | Yirrkala Dhanbul Community Association | Mr Wunyabi Marika, President<br>Ms Bakamumu Marika, Vice Chairman<br>Ms Raymattja Marika Mununggiritj, Council Member<br>Ms Banbapuy Maymuru, Council Member<br>Mr Djuwalpi Marika, Council Clerk<br>Ms Banduk Marika, Council Member<br>Mr Howard Amory, Community Educator, North East Arnhem Region<br>Stephen Murdock, Nurse Consultant<br>Ms Torogay Burunaagay, Senior Health Worker |
| 21.3.96<br>Public | Naiuyu Nambiyu Community Health Clinic, Daly River | Mr Mark Mullins, Registered Nurse<br>Ms Helen Macarthur, RN |
| 21.3.96<br>Public | Naiuyu Nambiyu Community Government Council, Daly River | Mr Mark Mullins, President<br>Mr Jim Parry, Councillor<br>Ms Bridgette Kikitin, Councillor<br>Ms Miriam Rose Baumann, Councillor<br>Mr Robert Lindsay, Councillor<br>Mr Jimmy Numbatu, Councillor |
| 26.3.96<br>Public | Yugul Mangi Community Government Council, Ngukurr | Mr David Daniels, President<br>Mr Phillip Bush, Councillor |
| 26.3.96<br>Public | Ngukurr Health Centre, Ngukurr | Mr Alexander Thompson, Senior Aboriginal Health Worker<br>Mr David Daniels, President, Yugul Mangi Community Government Council<br>Mr Phillip Bush, Councillor |
| 27.3.96<br>Public | Elliott Health Centre, Elliott | Senior Sister Wendy Dow<br>Sister Margaret McLean |
| 27.3.96<br>Public | Elliott District Community Government Council, Elliott | Ms Bonnie Absalom, Vice President<br>Mr Ron Squires, Councillor<br>Ms Kirsteen Squires, Councillor<br>Ms Florene Bathern, Councillor<br>Ms Dawn Jackson, Council Clerk |
| 27.3.96<br>Public | Gurungu Corporation, Elliott | Mr Kevin Neade, President<br>Ms Rosemary Neade, Councillor<br>Mr Harold Ulamari, Coordinator<br>Mr Dick Rogers, Councillor<br>Mr Gordon Jackson, Councillor<br>Ms Heather Dixon, Secretary<br>Mr Oscar Wilson, Councillor<br>Ms Alice Bell, Councillor<br>Mr Raymond Winsley, Councillor<br>Teresa, Councillor |

| Date | Organisation/Agency | Witnesses |
|---|---|---|
| 8.5.96<br>Public | Wallace Rockhole Community Government Council, at Wallace Rockhole | Mr Ken Porter, Council Clerk<br>Ms Gladys Porter, Council Member<br>Mr Peter Abbott, Council Member<br>Ms Rachel Abbott, Council Member<br>Mr Max Baliva, Council Member<br>Ms Kathy Abbott, Council Member<br>Mr Bernard Abbott, Council Member<br>Mr Edmond Rubuntja, Council Member<br>Mr Peter Moketarinja, Council Member<br>Mr John Abbott, Community Member<br>Mr Ralph Abbott, Community Member |
| 9.5.96<br>Public | Yulara Health Services (Royal Flying Doctor Service) | Mr John Lynch, Executive Officer, Adelaide<br>Dr Ross Peterkin, Medical Officer<br>Ms Sally Young, Clinical Nurse Consultant<br>Mr Tim Spokes, Clinical Nurse Consultant |
| 9.5.96<br>Public | Mutitjulu Community Inc. at Mutitjulu | Mr John Willis, Community Liaison Officer<br>Mr David Scholz, Health Administrator |

## *APPENDIX D*

# *List of Transcripts of Public Accounts Committee Hearings*

| Date | Status | Organisation/Agency | Witnesses |
|---|---|---|---|
| 8.2.95 | Private | Office of the Auditor-General for the Northern Territory | Mr Iain Summers, Auditor-General |
| 3.3.95 | Private | Office of the Auditor-General for the Northern Territory | Mr Iain Summers, Auditor-General |
| 3.5.95 | Private | Northern Territory Department of Health & Community Services | Ms Kathryn Henderson, Chief Executive Officer<br>Mr Graham Symons, Assistant Secretary, Community Care |
| 9.8.95 | Private | Northern Territory Treasury | Mr Tim McClelland, Acting Deputy Under Treasurer<br>Mr John Ayre, Director, Public Finance Branch |
| 25.10.95 | Public | NSW Health Department | Mr Jim Pearse, Manager Structural and Funding, Strategies Unit |
| 25.10.95 | Public | University of Sydney | Professor Gavin Mooney, Professor of Health Economics |
| 25.10.95 | Public | Territory Health Services*, Darwin | Ms Carol Beaver, Director, Health Economics and Resourcing |
| 25.10.95 | Public | Commonwealth Grants Commission | Mr Richard Rye, Chairman |
| 7.3.96 | Private | Belyuen Community Government Council, Belyuen | Mr Harry Singh, Chairman<br>Mr Claude Holtze, Deputy President<br>Mr Tony Singh, Councillor<br>Ms Sandra Yarrowin, Councillor<br>Ms Lorna Tennant , Bookkeeper |
| 8.3.96 | Private | Territory Health Services, Darwin | Mr Graham Symons, Deputy Secretary, Program Development & Planning<br>Ms Carol Beaver, Director, Health Economics |
| 19.3.96 | Public | Maningrida Council Inc, Maningrida | Mr Gordon Machbirrbirr, Councillor and Assistant Council Clerk<br>Mr Charlie Yirrwalla, Councillor<br>Mr Roly Madjerr, Councillor<br>Mr Alan Clough, Council Clerk |

* formerly Department of Health & Community Services

| Date | Status | Organisation/Agency | Witnesses |
|---|---|---|---|
| 19.3.96 | Public | Maningrida Community Health Clinic, Maningrida | Dr Tony McMullin, District Medical Officer<br>Ms Liz Stephenson, Registered Nurse<br>Ms Karen Williams, Registered Nurse<br>Ms Sue Kruske, Registered Nurse |
| 20.3.96 | Public | Yirrkala Dhanbul Community Association, Yirrkala | Mr Wunyabi Marika, President<br>Ms Bakamumu Marika, Vice Chairman<br>Ms Raymattja Marika Mununggiritj, Council Member<br>Ms Banbapuy Maymuru, Council Member<br>Mr Djuwalpi Marika, Council Clerk<br>Ms Banduk Marika, Council Member<br>Mr Howard Amory, Community Educator, North East Arnhem Region<br>Stephen Murdock, Nurse Consultant<br>Ms Torogay Burunaagay, Senior Health Worker |
| | Public | Naiuyu Nambiyu Community Health Clinic, Daly River | Mr Mark Mullins, Registered Nurse<br>Ms Helen Macarthur, RN |
| 21.3.96 | Public | Naiuyu Nambiyu Community Government Council, Daly River | Mr Mark Mullins, President<br>Mr Jim Parry, Councillor<br>Ms Bridgette Kikitin, Councillor<br>Ms Miriam Rose Baumann, Councillor<br>Mr Robert Lindsay, Councillor<br>Mr Jimmy Numbatu, Councillor |
| 26.3.96 | Public | Yugul Mangi Community Government Council, Ngukurr | Mr David Daniels, President<br>Mr Phillip Bush, Councillor |
| 26.3.96 | Public | Ngukurr Health Centre, Ngukurr | Mr Alexander Thompson, Senior Aboriginal Health Worker<br>Mr David Daniels, President, Yugul Mangi Community Government Council<br>Mr Phillip Bush, Councillor |
| 27.3.96 | Public | Elliott District Community Government Council, Elliott | Ms Bonnie Absalom, Vice President<br>Mr Ron Squires, Councillor<br>Ms Kirsteen Squires, Councillor<br>Ms Florene Bathern, Councillor<br>Ms Dawn Jackson, Council Clerk |
| 27.3.96 | Public | Gurungu Corporation, Elliott | Mr Kevin Neade, President<br>Ms Rosemary Neade, Councillor<br>Mr Harold Ulamari, Coordinator<br>Mr Dick Rogers, Councillor<br>Mr Gordon Jackson, Councillor<br>Ms Heather Dixon, Secretary<br>Mr Oscar Wilson, Councillor<br>Ms Alice Bell, Councillor<br>Mr Raymond Winsley, Councillor<br>Teresa, Councillor |

| Date | Status | Organisation/Agency | Witnesses |
|---|---|---|---|
| 27.3.96 | Public | Elliott Health Centre, Elliott | Senior Sister Wendy Dow<br>Sister Margaret McLean |
| 28.3.96 | Public | Menzies School of Health Research, Darwin | Dr Wendy Hoy, NHMRG Senior Research Fellow and Head of the Renal Unit |
| 1.5.96 | Public | Batchelor College, Batchelor | Mr John Ingram, Director<br>Dr David McClay, Deputy Director (Operations)<br>Dr John Henry, Assistant Director, Academic Development<br>Ms Alison Worrell, Head of the School of Health Studies<br>Mr Ron Watt, Head of the School of Educational Studies<br>Mr Ron Stanton, Senior Lecturer, Centre for Education, Research and Development<br>Mr Bill Baird, Senior Executive Officer, Council, Communities and Students<br>Ms Holly Margerrison, Registrar |
| 7.5.96 | Public | Territory Health Services, Alice Springs | Mr Ross Brandon, Regional Director, Operations Central |
| 7.5.96 | Public | Central Land Council, Alice Springs | Mr Leigh (Tracker) Tilmouth, Director,<br>Ms Olga Havnen, Senior Policy Officer |
| 7.5.96 | Public | Central Australian Aboriginal Congress Inc., Alice Springs | Mr Kenny Laughton, Director<br>Dr John Boffa, Medical Officer, Public Health Unit<br>Ms Heather Brown, Branch Manager, Education and Training Unit |
| 7.5.96 | Public | Alice Springs Town Council | Ms Carole Frost, Alderman<br>Mr Rod Oliver, Alderman<br>Mr Terry McCumiskey, Alderman<br>Ms June Noble, Alderman |
| 7.5.96 | Public | Tanami Network, Alice Springs | Mr Peter Toyne, Consultant |
| 8.5.96 | Public | Wallace Rockhole Community Government Council | Mr Ken Porter, Council Clerk<br>Ms Gladys Porter, Council Member<br>Mr Peter Abbott, Council Member<br>Ms Rachel Abbott, Council Member<br>Mr Max Baliva, Council Member<br>Ms Kathy Abbott, Council Member<br>Mr Bernard Abbott, Council Member<br>Mr Edmond Rubuntja, Council Member<br>Mr Peter Moketarinja, Council Member<br>Mr John Abbott, Community Member<br>Mr Ralph Abbott, Community Member |
| 9.5.96 | Public | Yulara Health Services (Royal Flying Doctor Service) | Mr John Lynch, Executive Officer, Adelaide<br>Dr Ross Peterkin, Medical Officer<br>Ms Sally Young, Clinical Nurse Consultant<br>Mr Tim Spokes, Clinical Nurse Consultant |

| Date | Status | Organisation/Agency | Witnesses |
|---|---|---|---|
| 9.5.96 | Public | Mutitjulu Community Inc. | Mr John Willis, Community Liaison Officer<br>Mr David Scholz, Health Administrator |

***APPENDIX E***

# *List of Informal Contacts*

Amber, S. Project Officer, G.P. Rural Incentive Program, Central Australia
Amies, M. Director of the Evaluation Unit, Commonwealth Department of Human Services & Health
Angus, T. Acting Assistant Secretary, Aboriginal Health Strategy Unit
Ashbridge, D. Acting District Manager, Darwin Rural District.
ATSIC State Advisory Council
Ayre, J. NT Treasury
Bagshawe, A. Dr, Menzies School of Health Research, Alice Springs
Barnes, T. Head of Aboriginal Statistics Unit, Australian Bureau of Statistics
Beaver, C. Health Economist, Territory Health Services
Bowden, F. Dr, Disease Control Centre, Darwin
Bowden, J. General Manager, Alice Springs Hospital.
Brandon, R. Dr, Regional Director Operations Central, Territory Health Services
Brennan, T. Father, Catholic Health Care.
Burns, C. Dr, Menzies School of Health Research
Byrnes, S. Manager NT Operations, Royal Flying Doctor Service, Alice Springs
Coles, D. Office of Aboriginal Development, Department of Lands & Housing
Condon, J. Dr, Director of Epidemiology & Statistics, Territory Health Services
Cracknell, L. Policy Adviser, Information Management, NT Treasury
Currie, B. Dr, Menzies School of Health Research, Darwin
Dembski, L. Director, Aboriginal Development Unit, Education Department
Devanesen, D. Dr, Program Director Community Health Territory Health Services
Doubleday, M. Evaluation & Review Branch, Territory Health Services
Edmonds, E. Manager Personnel Operations, Territory Health Services
Elsegood, P. Darwin
Erlich, J. Dr, Senior Consultant Paediatrician, Alice Springs Hospital
Feldman, V. Territory Health Services, District Manager, Darwin Rural District
Fletcher, M. Territory Health Services, Acting District Manager, East Arnhem District
Gelding, S. Territory Health Services, District Manager, Katherine Rural District
Gray, B. Commonwealth Department of Human Services & Health
Harbridge, R. Northern Territory Library, Parliament House, Darwin
Hayes, N. ATSIC Commissioner, South
Henderson, K. Secretary, Territory Health Services
Herd, S. Dr, Regional Director, Australian College of General Practitioners
Hoffman, G. Territory Health Services, District Manager, Katherine Rural District
Hogan, J. Evaluation & Review Branch, Territory Health Services
Hoy, W. Dr, Menzies School of Health Research, Darwin
Jackson, P. Senior Economic Analyst, Territory Health Services
Kemmis, L. Territory Health Services, Acting District Manager, Barkly District
Krause, V. Dr, Director Community Disease Centre
Lea, T. Executive Officer, Territory Health Services
Lindsay, P. Director, Health Promotion, Territory Health Services
Low, C. Policy & Research Officer, Tripartite Forum, Territory Health Services

Mahajan, V. NT Manager, Commonwealth Department of Human Services & Health
Mathews, J. Professor, Menzies School of Health Research
Mayston, D.J. Professor of Public Sector Economics, Finance & Accountancy, University of York, UK
McDermott, S. Business Analyst, Territory Health Services
McClelland, H.A.S. NT Treasury
McMillan, S. Aboriginal Resource & Development Services Inc.
Meadows, D. General Practitioner, Darwin.
Mills, J. Alice Springs Urban, Territory Health Services
Moo, S. Director Business Information Management, Territory Health Services
Mooney, G. Professor, NSW
Morton, H. Health Economics, Territory Health Services
Nelson, R. Policy Analyst, Territory Health Services
O'Keith, S. Manager Central Desert Health Service, WA Health Department
Papadopolous, C. Dr, GP Rural Incentive Scheme, Darwin
Patterson, J. ATSIC Commissioner, North
Pearse, J. NSW Department of Health
Preece, R. Executive Officer, ATSIC, Alice Springs Region
Ramsey, I. Manager of Budgets Branch Finance & Services, Territory Health Services
Read, D. Aboriginal Health Unit, Tasmania Department of Health & Community Services
Rolf, D. Strategic & Audit Services, Chief Ministers Department
Rolland, D. Director, Local Government Services, Department of Lands Housing & Local Government
Ruben, A. Dr, Community Paediatrician, Territory Health Services
Ryder, P. Senior Project Manager Health Consultant, Territory Health Services
Sayers, L. Regional Director, Operations North, Territory Health Services
Schilling, J. Director Finance, Territory Health Services
Scott, L. Director Strategic Services Branch, NT Treasury
Scrimgeour, D. Dr, Menzies School of Health Research, Alice Springs
Sharp, B. Non-Government Liaison Officer, Darwin Rural District, Territory Health Services
Sporn, S. Director Accounting Services, Territory Health Services
Steel, D. Aboriginal & Torres Strait Islander Health Unit, Queensland Health Department
Steele, J. Registrar Professional Boards, Territory Health Services
Stow, K. Territory Health Services, District Manager, Barkly District
Strand, C. Executive Officer, ATSIC, Katherine Region
Summers, I. Auditor General for the Northern Territory
Symons, G. Deputy Secretary, Territory Health Services
Thomas, G. Manager Northern Territory, Aboriginal & Torres Strait Islander Commission ATSIC
Thompson, M. Director Environmental Health, Territory Health Services.
Vivien, P. Strategic & Audit Services, Chief Ministers Department
Wakerman, J. Territory Health Services, Alice Springs Rural Director
Walsh, M. Dr, North Australian Research Unit, Darwin.
Warchivker, I. Menzies School of Health Research, Territory Health Services
Williams, K. Koori Health Unit, Victoria Department of Health & Community Services
Winsley, C. Council Clerk, Binjari Community Government Council
Wright, J. Dr, Senior District Medical Officer, Darwin Rural District

## *APPENDIX F*

# *List of Relevant Tabled Papers*

| DATE | DOCUMENT DESCRIPTION | NO. |
|---|---|---|
| 1.12.94<br>Private | Letter dated 1 December 1994 from the Minister for Health and Community Services referring to the Committee for inquiry and report the provision of health services to Aboriginal communities in the Northern Territory | 1/123 |
| 8.2.95<br>Private | National Aboriginal Health Strategy | 9/125 |
| 3.3.95<br>Private | Letter of Advice from Auditor-General on how to progress inquiries into the Provision of School Education Services and Health Services to Aboriginal Communities in the Northern Territory, dated 28 February 1995 | 1/126 |
| 3.5.95<br>Private | Department of Health & Community Services - Letter from Department dated 4 April 1995 regarding a number of administrative matters. | 8/130 |
| 3.5.95<br>Private | Department of Health & Community Services - Letter from Department dated 19 April 1995 providing background information re specific Aboriginal health issues | 9/130 |
| 3.5.95<br>Private | Department of Health & Community Services - Reply dated 27 April 1995 received from the Minister for Health and Community Services offering reassurance and Agency support for employees to participate in Health Inquiry. | 17/130 |
| 9.8.95<br>Private | Northern Territory Treasury - funding from the Commonwealth Grants Commission - Brief dated 9 June 1995 from Mr K. Clarke covering:<br>• NT Government total revenue;<br>• proportion of Commonwealth grants;<br>• a breakdown of Commonwealth grants;<br>• an explanation of basis of distribution of the different grants by the Commonwealth;<br>• an explanation of how the Commonwealth grants are treated in the NT budget process; and<br>• details of the NT Government expenditure on Education and Health by activity and source of funding. | 9/135 |
| 9.8.95<br>Private | Northern Territory Treasury - funding from the Commonwealth Grants Commission - Letter dated 21 June 1995 from Mr J. Ayre attaching documents relating to the Commonwealth Grants Commission (CGC) including correspondence setting out CGC's current work program and timetable; and extracts from CGC's 1993 Update report relating to funding for Aboriginals and Torres Strait Islanders | 10/135 |
| 9.8.95<br>Private | Northern Territory Treasury - funding from the Commonwealth Grants Commission - Letter dated 23 June 1995 from Mr J. Ayre enclosing copies of Background Notes and transcripts of the Commonwealth Grants Commission's 1992 Conference with Aboriginal Organisations | 11/135 |
| 9.8.95<br>Private | Northern Territory Treasury - funding from the Commonwealth Grants Commission - Letter dated 29 June 1995 from Ms J. Large giving an analysis of the 54% applied to oncosts and relevant current extracts on administrative operations of the Grants Commission | 12/135 |
| 9.8.95<br>Private | Letter dated 20 June 1995 from the Auditor-General General re review on the management, monitoring and control of funds allocated to Aboriginal Health Services | 14/135 |
| 9.8.95 | Letter from Graham Symons enclosing corrections to transcript of briefing of 3 May 1995 and attaching copy of materials referred to therein. This transcript has been amended by Hansard incorporating Mr Symons' corrections. | 15/135 |

| DATE | DOCUMENT DESCRIPTION | NO. |
|---|---|---|
| 22.9.95 Private | Aboriginal Health Issues, a paper by John Mathews, Menzies School of Health Research, Darwin | 4/136 |
| 22.9.95 Private | Dogs and human health in Aboriginal communities, an article by Bart Currie, Menzies School of Health Research and Royal Darwin Hospital published in the Aboriginal and Torres Strait Islander Health Information Bulletin 20, April 1995 | 5/136 |
| 13.10.95 Private | Kardu Numida Health Service Wadeye, NT | 1/138 |
| 13.10.95 Private | Service Agreement between the Kardu Numida Community and the Darwin Rural District NT HACS for the Provision of Health Services to the People of Wadeye. | |
| 24.10.95 Private | *The Rope - History and Future*, paper supplied by Mr Rayment as per Committees' request arising out of the Cross Cultural presentation | 5/141 |
| 24.10.95 Private | *Local Recruit Policy - Interns, Resident Medical Officers and Hospital Medical Officers*, paper supplied by Dr Vino of Royal Darwin Hospital | 6/141 |
| 24.10.95 Private | *Department of Human Services & Health - Consultations on Aboriginal and Torres Strait Islander Health - August/September 1995* | 7/141 |
| 24.10.95 Private | Aboriginal Health Social and Cultural Transition Conference on 29-30 September 1995 - Summary | 11/141 |
| 25.10.95 Public | Curriculum Vitae of Mr Jim Pearse, Manager Structural and Funding, NSW Health Department | 1/142 |
| 25.10.95 Public | Curriculum Vitae of Prof. Gavin Mooney, Professor of Health Economics, University of Sydney | 3/142 |
| 25.10.95 Public | Context of Grants Commission Assessment | 7/142 |
| 25.10.95 Public | Approach of the CGC | 8/142 |
| 25.10.95 Public | Issues Raised in Context on CGC's Review and Medicare Negotiations | 9/142 |
| 25.10.95 Public | Hospital Services - PD-461.XLSSheet2 | 10/142 |
| 25.10.95 Public | Occupied Bed Day Rates - - PD-461.XLSSheet1 | 11/142 |
| 25.10.95 Public | Bonus Pool Share - - PD460.XLS,Bonus | 12/142 |
| 25.10.95 Public | Community Health - - PD-461.XLSSheet4 | 13/142 |
| 25.10.95 Public | Assessed Factors - - PD-460.XLS, CGC Factors | 14/142 |
| 25.10.95 Public | Socio-Economic Weights - - PD-460.XLS,SES | 15/142 |
| 25.10.95 Public | Table 4 - Northern Territory Department of Health and Community Services Community Health Program, Expenditure 1990/91 | 16/142 |

| DATE | DOCUMENT DESCRIPTION | NO. |
|---|---|---|
| 25.10.95 Public | Analysis of 1994-95 Expenditure - - PD-460.XLS, NT Expenditure | 17/142 |
| 25.10.95 Public | 1994-95 Expenditure: Per Capita - - PD-460.XLS,NT Expenditure | 18/142 |
| 25.10.95 Public | Summary | 19/142 |
| 25.10.95 Public | Medical Benefits - - PD383.XLS,2%Review | 20/142 |
| 25.10.95 Public | General Practice - - PD383.XLS,Sheet4 | 21/142 |
| 25.10.95 Public | Interstate Comparisons Based on a Social Health Atlas of Australia | 22/142 |
| 25.10.95 Public | Commonwealth Expenditure on Aboriginal Health - PD441.XLS | 23/142 |
| 25.10.95 Public | Pharmaceutical Benefits - - PD383.XLS,PBS | 24/142 |
| 25.10.95 Public | Composition of Public Sector Revenue and Own-Purpose Outlays in 1993-94 | 25/142 |
| 25.10.95 Public | Fiscal Transfers 1994-95 | 26/142 |
| 25.10.95 Public | SPPs as a Proportion of Commonwealth Grants | 27/142 |
| 25.10.95 Public | Relative Cost of Service Provision Ratios, 1993-94 / Relative Revenue Raising Capacity Ratios, 1993-94 | 28/142 |
| 25.10.95 Public | The Principle of Fiscal Equalisation | 29/142 |
| 25.10.95 Public | Disabilities | 30/142 |
| 25.10.95 Public | Some Important Disability Factors | 31/142 |
| 25.10.95 Public | Horizontal Fiscal Redistribution 1995-96 | 32/142 |
| 25.10.95 Public | The Grants Commission and the Territory | 33/142 |
| 25.10.95 Public | Some Research Projects | 34/142 |
| 25.10.95 Public | The Steps in the Equalisation Process | 35/142 |
| 25.10.95 Public | NT Expenditure: Standardised vs. Actual (Per Capita) | 36/142 |
| 16.11.95 Private | Paper by Dr David Scrimgeour, *Community Involvement in Health Services for Indigenous People of Canada, Norway and New Zealand*, Menzies School for Health Research, Issue No. 2/95 | 8/143 |

| DATE | DOCUMENT DESCRIPTION | NO. |
|---|---|---|
| 16.11.95 Private | Commonwealth Grants Commission's Terms of Reference for the 1999 Review | 13/143 |
| 29.2.96 Private | Community Background Briefing - Mutitjulu (Uluru/Ayers Rock) | 3/147 |
| 29.2.96 Private | Newspaper Article by Erwin Chlanda, Centralian Advocate, February 1996 - *Thugs Rule Rock* | 4/147 |
| 7.3.96 Public | Community Profile - Belyuen - January 1996. Belyuen School, Profile, February 1996 | 2/148 |
| 8.3.96 Private | Territory Health Services - Briefing Paper from Agency | 7/149 |
| 8.3.96 Private | "Proposal for Coordinated Care Trial for the NT", Paper forwarded from Territory Health Services | 9/149 |
| 19.3.96 Public | Community Profile - Maningrida | 2/150 |
| 19.3.96 Public | Maningrida JHPC Report - Health Service issues | 8/150 |
| 19.3.96 Public | *Feasibility Study and Service Plan of Health Services at Maningrida*, Final Report, December 1995 | 9/150 |
| 19.3.96 Public | *Manayingkarirra (Maningrida) Housing and Community Development Strategy Study 1993I*, Prepared on behalf of the Maningrida Council Incorporated | 10/150 |
| 20.3.96 Public | Community Background Briefing - Yirrkala | 2/151 |
| 20.3.96 Public | Yirrkala Community Health Profile | 8/151 |
| 21.3.96 Public | Community Profile - Nauiyu Nambiyu (Daly River), May 1994 | 2/152 |
| 26.3.96 Public | Community Profile - Rittarangu (AKA Urapunga), dated 16 Feb 1996 | 2/154 |
| 26.3.96 Public | Community Profile - Ngukurr, Updated: January 1995 | 2/153 |
| 26.3.96 Public | Letter from Andrew Bell, Senior District Medical Officer, re health services provided from Ngukurr to Urapunga | 6/153 |
| 27.3.96 Public | Community Background Briefing - Elliott District Community Government Council | 2/155 |
| 27.3.96 Public | Profile - Funded Non-Government Organisations - "Old People's Program" - Elliott District Community Government Council | 5/155 |

| DATE | DOCUMENT DESCRIPTION | NO. |
|---|---|---|
| 27.3.96 Public | Profile - Funded Non-Government Organisations - "Aboriginal Environmental Health Worker" - Gurungu Council | 8/155 |
| 27.3.96 Public | Health Profile - Elliott Health Service staff | 9/155 |
| 28.3.96 Public | Menzies School of Health Research - Briefing Paper from Agency | 1/156 |
| 28.3.96 Public | Menzies School of Health Research - Summary of Submission to the Public Accounts Committee, Dr Wendy Hoy, Menzies School of Health Research, March 28, 1996 | 7/156 |
| 28.3.96 Public | Menzies School of Health Research - *Treatment of Australian Aboriginals with end-stage renal disease in the toe end of the Northern Territory: 1978-93* | 8/156 |
| 28.3.96 Public | Menzies School of Health Research - *Preventable Risk Factors for Kidney Disease* | 9/156 |
| 28.3.96 Private | Territory Health Services - Aboriginal Health Policy 1996 - Draft Only | 15/156 |
| 7.5.96 Public | Alice Springs - Tanami Network - *National Indigenous Communications Network* | 4/160 |
| 7.5.96 Public | Alice Springs - Tanami Network - *Network Communications* | 5/160 |
| 8.5.96 Public | Wallace Rockhole Community Profile | 2/161 |
| 9.5.96 Public | Yulara Medical Services, RFDS - Paper entitled *RFDS Yulara Clinic 1995-96: Provider/Patient Contact Statistics* | 5/162 |
| 9.5.96 Public | Mutitjulu Health Service - Mutitjulu Health Service Staff | 8/163 |
| 5.6.96 Private | *Northern Territory Food and Nutrition Policy & Strategic Plan 1995-2000,* Northern Territory Government Territory Health Services | 3/168 |
| 5.6.96 Private | *Review of NT Government Remote Health Services in Central Australia,* Report of the first meeting with community representatives 14 & 15 March 1996, Menzies School of Health Research | 4/168 |

## *APPENDIX G*

# *Northern Territory Community Health Clinics in Remote Areas*

## ALICE SPRINGS RURAL DISTRICT

### *NTDHCS HEALTH SERVICES*

| Community | Location of Community | Area Serviced | No. of Aboriginal people serviced |
|---|---|---|---|
| **HEALTH CLINICS** | | | |
| Engawala (Alcoota) | 143 kms NE Alice Springs | None | Population 120 |
| Bonya (Baikal) | 360 kms NE of Alice Springs | Atula | Population 40 |
| Titjikala (Maryvale) | 120 km SW of Alice Springs<br><br>Titjikala is an excision from Maryvale Station | N/A | **208**<br>Pop. 150 |
| Yuelumu (Mount Allan) | 270 km NW of Alice Springs<br>60 km E of Yuendumu<br>Located on Mount Allen Cattle station | Outstation: Petardi (once a month) now handed over to Napperby | **253**<br>180<br><br>Pop. 300? |
| Tara (Neutral Junction) | 30 km N of Barrow Creek<br>120 N of Ti Tree | N/A | 143 |
| Wilora (Stirling) | 250 km N of Alice Springs<br>50 km N Ti Tree Town | N/A | 161 |
| Pnmara Jututa (6 Mile Camp) | 10 km south of Ti Tree | N/A | Pop. 247 |
| Nturiya (Ti-Tree Station) | 200 km N of Alice Springs<br>19 km from Ti Tree Town | N/A | Population 317 |
| Wallace Rockhole | 110 km West of Alice Springs | 3.5 $km^2$ | **150**<br>150 |
| Utju (Areyonga) | 98 km WSW of Hermannsburg | N/A | **196**<br>Population 150-200 |
| Ukaka | | | |
| Ulpanyali | | | |
| Wanmarra | | | |
| **COMMUNITY HEALTH CENTRES** | | | |
| Ikuntji (Haasts Bluff) | 230 kms W of Alice Springs | Land trust is 39,610 sq. kms | **99**<br>Population 80 |
| Kaltukatjara (Docker River) | 720 km SW Uluru<br>10 kms from WA border | Petermann Land Trust of 44, 970 kms<br><br>16 outstations | **311**<br>265 (census) varying from 230 to 300 throughout year |

Population figures unbold = Population census Australian Bureau of Statistics
Population figures in **bold** = Estimates from NT Department of Lands Housing and Local Government

| Community | Location of Community | Area Serviced | No. of Aboriginal people serviced |
|---|---|---|---|
| Nyirripi (Waite Creek ) | 450 km WNW of Alice Springs<br>150 km WSW of Yuendumu | | **297**<br>252 |
| Amunturrngu (Mount Liebig) | 325 km WNW of Alice Springs<br>Located on Haast's Bluff Aboriginal Reserve | 78 $km^2$<br>Mt Liebig and Outstations:<br>Warren Creek, Brown's Bore, New Bore, Inyalingi | 300 and growing (?) |
| Ntaria (Hermannsburg) | 130 kms W of Alice Springs | 18 outstations on the eastern and western side of Ntaria, Areyonga, Wallace Rock Hole | **540**<br>Population 850 (1100?), half of whom live on the surrounding outstations |
| Papunya | 250 km WNW of Alice Springs<br>Located on Haast's Bluff Aboriginal Reserve | Papunya and Outstations:<br>Town Bore, Mbunghera, Browns Bore, Tarenera, Waparakau, Punou Punu, Inyalingi<br>New Bore **271**<br>Back up service to Haast's Bluff | **310**<br>400 approx |
| Atitjere (Harts Range) | 215 kms NE of Alice Springs | Covers Sandover region<br>Alcoota, Irrelere, Mt. Eaglebeak | Population 100 + 3 outstations |
| Ti-Tree | 195 km from Alice springs | 30 000 $km^2$<br>Outstations:<br>Tara, Wilora, Athangarangate, Ankweleyelengekwe, Illurawarra, Yaninj, Wood's Camp, Carter's Camp, Nturiya/Ti Tree Stn, Werle/Woolla Downs, Pmere Jutunta, Anungumbe, Alyune, Laramba, Wirliatjarrayi/, Willowra (Relief Only), **Stations:**, Neutral Junction, Stirling, Barrow Creek, Aningie, Pine Hill, Aileron, Mt Skinner, Napperby (Relief Only | Ti Tree 55<br><br>Area: 1,224 |
| Willowra | 250 km NW of Alice Springs<br>153 km from Ti Tree | Outstation: Mt Barkley | **435**<br>380 |

Population figures unbold = Population census Australian Bureau of Statistics
Population figures in **bold** = Estimates from NT Department of Lands Housing and Local Government

| Community | Location of Community | Area Serviced | No. of Aboriginal people serviced |
|---|---|---|---|
| Yuendumu | 290 km NW of Alice springs<br>Located on Yuendumu Aboriginal Reserve | 22,142 km$^2$<br>Outstations:<br>Mt Theo, Bean Tree, Jeudrel Bore, Jila Wells, Malar Bore, Warkulpa-Sampson, Yumilpo, Walilimpa, Nyrripi, Mt Allen, Pulardi, Wayililinypa | **1 095**<br>800 - 1200 |
| Laramba (Napperby) | 205 km NW of Alice Springs<br>70 km S of Ti Tree | Laramba, Palardi, Garden bore, Napperby Station | 389 |
| Alpurrurulam (Lake Nash) | 645 km NE Alice Springs<br>8 km west Lake Nash Station<br>148 km from Camooweal | Lake Nash Station<br>Irrmane | **463**<br>Population 450<br><br>Health records for 420 |
| Petermann Mobile (Finke/ Maryvale/Kings Canyon) Kings Canyon Mobiles Area | From Ukaka, 90 km west from South Stuart Highway, along road to Kings Canyon | | Ukaka 80<br>Ulpanyali 63<br>Frontier Lodge 40+<br>Kings Creek 12<br>Wanmarra 20<br>Lilla 30<br>Stockyard 10<br>Rangers Stations 18 |
| **ALICE SPRINGS URBAN** | | | |
| Alice Springs Community Health Centre | | | |
| Alice Springs Hospital | | | |

## *NTDHCS GRANT FUNDED HEALTH SERVICES*

| | | | |
|---|---|---|---|
| Santa Teresa (Ltyentye Purte) | 85 km SE of Alice Springs | 1 242 km$^2$ | **478**<br>483 |
| Finke Mission (Aputula) | 420 km SE Alice Springs | N/A | **311**<br>Population 250 |
| Yulara | | 104 km$^2$ | **1 304** |

## *ATSIC FUNDED HEALTH SERVICES*

| | | | |
|---|---|---|---|
| Central Australian Aboriginal Congress | | | |
| Urapuntja (Utopia) | | | **628** |
| Mutijulu | | | |

Population figures unbold = Population census Australian Bureau of Statistics
Population figures in **bold** = Estimates from NT Department of Lands Housing and Local Government

| Community | Location of Community | Area Serviced | No. of Aboriginal people serviced |
|---|---|---|---|
| Aherrenge (Amplitawatj) | 325 km NE of Alice Springs | Outstations: Atnungurrpa, Engawanyere and Irrultja, all within a 70 km radius | **399**<br>Pop. 250 approx |
| Imanpa | 260 kms south of Alice Springs | 4 sq mile excision on Mt Ebenezer Station Illamurta | **158**<br>143 |
| Pintubi Homelands (Kintore)-Walungurru | | | **271** |
| Nganampa Health Council | | | |
| Nganyatjarra | | | |

Population figures unbold = Population census Australian Bureau of Statistics
Population figures in **bold** = Estimates from NT Department of Lands Housing and Local Government

# BARKLY

## *NTDHCS HEALTH SERVICES*

| Community | Location of Community | Area Serviced | No. of Aboriginal people serviced |
|---|---|---|---|
| **COMMUNITY HEALTH CENTRES** | | | |
| Ali Curung (Warrabri) | 170 km E Tennant Creek | Canteen Creek<br>Epenarra<br>Murray Downs | **467**<br>Pop. 700 |
| Elliott | 250 km north of Tennant Creek | 3.1 $km^2$<br>North Camp<br>South Camp<br>Newcastle Waters | **506**<br>400-500 in town (600-700 in district) |
| **HEALTH CLINICS** | | | |
| Epenarra | 206 km from Tennant Creek | | 100-110 |
| Canteen Creek | 275 km from Tennant Creek | | 200 |
| Barkly Mobile:<br>Brunette Downs<br>Murul Murula | <br>346 km from Tennant Creek<br>300 km NE of Tennant Creek | | <br>35-50<br><br>25 |
| **Tennant Creek Urban** | | | |
| Tennant Creek Community Health Centre | | | |
| Tennant Creek Hospital | | | |

## *ATSIC FUNDED HEALTH SERVICE*

| | | | |
|---|---|---|---|
| Anyinginyi Congress | | | |

Population figures unbold = Population census Australian Bureau of Statistics
Population figures in **bold** = Estimates from NT Department of Lands Housing and Local Government

## KATHERINE DISTRICT

### *NTDHCS HEALTH SERVICES*

| Community | Location of Community | Area Serviced | No. of Aboriginal people serviced |
|---|---|---|---|
| **HEALTH CLINICS** | | | |
| Amanbidji | | | |
| Bulla Camp | | | |
| Bullman | | | |
| Dagaragu | 470 km SW of Katherine<br>7 km from Kalkaringi | | **590**<br>250 |
| Djilkminggan | 130 km SE of Katherine | | **170**<br>180 |
| Pigeon Hole | 40 km south of Yarralin | | Pop 75 |
| Robinson River | | | |
| Urapunga | | | |
| **COMMUNITY HEALTH CENTRES** | | | |
| Barunga | 87 km ESE of Katherine | 3 783 km$^2$<br>Manyallaluk (107) | **450**<br>358 |
| Wugularr (Beswick) | 118 SE of Katherine | 3 185 km$^2$ | **535**<br>550 |
| Borroloola | 670 km SE of Katherine | 11.3 km$^2$<br>Outstations:<br>Bujana, Bone Lagoon, Campbell Springs, Devil Springs, Limmen Bight, Police Lagoon, Ryan's Bend, South West Island, Wada Wadala, West Island | **796**<br>730 |
| Minyerri (Hodgson Downs) | 200 kms SE of Katherine,<br>128 kms SW from Ngukurr | | Pop. Approx. 200 |
| Kalkaringi (services Dagaragu) | 460 kms SW of Katherine | 43.2 km$^2$<br>Dagaragu, 8 km north of Kalkaringi | 253 |
| Lajamanu | 555 km SW of Katherine | 7 313 km$^2$ | **806**<br>720 |
| Mataranka | 102 km SE Katherine | 233.04 km$^2$ | **301**<br>Pop. 227 (fluctuates with the season, essentially a European town with an Aboriginal Town Camp |

Population figures unbold = Population census Australian Bureau of Statistics
Population figures in **bold** = Estimates from NT Department of Lands Housing and Local Government

| Community | Location of Community | Area Serviced | No. of Aboriginal people serviced |
|---|---|---|---|
| Ngukurr | 320 kms SE of Katherine | 12 269 $km^2$<br>Outstations:<br>Badawarra, Bringung, Costello, Hodgson River, Minyeri, Nallawan, Numerloori, Nutwood Downs, Turkey Lagoon, Wanmarie<br>10 - 120 kms from Ngukurr | 1074 which includes approx. 400 who move between Ngukurr and the 11 outstations |
| Pine Creek | 90 km north of Katherine | 400 $km^2$<br>Kybrook farm | **744**<br>770, approx 588 town area and approx 142 Aboriginal at Kybrook Farm and approx. 40 people living in the council area outside town |
| Timber Creek | 284 km W of Katherine | 16 $km^2$<br>Council area includes two wards of Timber Creek and Ngaringman. Two town camps of Myatt and Murriyung | **244**<br>Pop. 187 residents, 50% aboriginal |
| Victoria River Downs (services Yarralin) | | | |
| Yarralin | 160 km south of Timber Creek, 500 km SW of Katherine | Community Government Status to cover Yarralin, Lingara, Pigeon Hole and Yinguwinarri in the near future (Jan 1995) | 160 |
| **Katherine Urban** | | | |
| Katherine Urban Health Centre | | | |
| Katherine Hospital | | | |

## *NTDHCS FUNDED HEALTH SERVICE*

| | | | |
|---|---|---|---|
| Binjari | 18 km W of Katherine | | **182**<br>130 - 200 |

Population figures unbold = Population census Australian Bureau of Statistics
Population figures in **bold** = Estimates from NT Department of Lands Housing and Local Government

| Community | Location of Community | Area Serviced | No. of Aboriginal people serviced |
|---|---|---|---|
| ***ATSIC and NTDHCS FUNDED HEALTH SERVICES*** | | | |
| Wurli Wurlinjang (Kalano) | Katherine North Bank | Aboriginals with both the Katherine Town Area and Town camps, Mialli Brumby (Kalano) 203, Rockhole 150, Gorge Camp 12, Walpiri/Transient Camp 60 | 203 |

Population figures unbold = Population census Australian Bureau of Statistics
Population figures in **bold** = Estimates from NT Department of Lands Housing and Local Government

# EAST ARNHEM DISTRICT

## *NTDHCS HEALTH SERVICES*

| Community | Location of Community | Area Serviced | No. of Aboriginal people serviced |
|---|---|---|---|
| **COMMUNITY HEALTH CENTRES** | | | |
| Alyangula | Groote Eylandt, 50 km from the eastern coast of Arnhem Land | Angurugu **(926)** Umbakumba and other homeland centres on the island | Pop. 700 |
| Angurugu | Groote Eylandt, 50 km from the eastern coast of Arnhem Land | 2 $km^2$ | 900 plus 150 at outstations |
| Milingimbi | | | **798** |
| Nhulunbuy | | 2.6 $km^2$ | |
| Numbulwar[8] | 500 W of Gove<br>990 SE of Darwin<br>120 NE of Ngukurr | 450 $km^2$ | **825**<br>800-900 |
| Ramingining[9] | 400 km by air from Darwin<br>200 km by air from Gove | | **743**<br>800 in community<br>200 at outstations |
| Umbakumba | 44km E of Angurugu | | **388**<br>350 |
| Yirrkala | 18 kms from Nhulunbuy | | **837**<br>700 |

## *NTDHCS GRANT FUNDED HEALTH SERVICE*

| | | | |
|---|---|---|---|
| Galiwinku (Elcho Island ) | | | **1 452** |
| Bickerton Island | 13 km W of Groote Eylandt<br>8km E of mainland Australia | | 200 |

## *ATSIC and NTDHCS FUNDED HEALTH SERVICE*

| | | | |
|---|---|---|---|
| Laynhapuy Homelands | | | |
| Lake Evella (Gapuwiyak) | | | **670** |

## *ATSIC FUNDED HEALTH SERVICE*

| | | | |
|---|---|---|---|
| Miwatj | | | |

[8] AHW positions grant funded to community council
[9] some ATSIC funding for homelands service

Population figures unbold = Population census Australian Bureau of Statistics
Population figures in **bold** = Estimates from NT Department of Lands Housing and Local Government

# DARWIN RURAL DISTRICT

## *NTDHCS HEALTH SERVICES*

| Community | Location of Community | Area Serviced | No. of Aboriginal people serviced |
|---|---|---|---|
| **COMMUNITY HEALTH CENTRES** | | | |
| Adelaide River | | | |
| Batchelor | | 1 500 $km^2$ | |
| Jabiru | | | |
| Maningrida | | | **1 291** |
| Milikapiti (Snake Bay) | 120 kms north of Darwin, on Melville Island | 27 $km^2$ | **482**<br>450 |
| Pirlangimpi (Garden Pt) | | 17 $km^2$ | **349** |
| Minjilang (Croker Island) | 230 kms from Darwin, on the north-eastern coast of Coburg Peninsular | Island covers 325 $km^2$<br>Several non-permanent outstations. | **197**<br>196 |
| Nguiu (Bathurst Island) | | 2 071 $km^2$ | **1 233** |
| Palumpa Station | | | **3080** |
| Nauiyu Nambiyu (Daly River) | 220 kms from Darwin | 42.62$^2$<br>Scattered farms and Aboriginal outstations | **416**<br>Pop. 350 at Daly River<br>150 at the farms and outstations |
| Peppimenarti | | | **200** |
| Wadeye (Port Keats) | 500 km SW of Darwin | Approx. 10 outstations in varying stages of development. Some outstation people of Peppimenarti and Daly River sometimes visit for medical care | Approx. 1400 |
| Warruwi (Goulbourn Island) | | | **361** |
| Belyuen (Delissaville) | 130 km from Darwin, 25 km by air | 4 $km^2$<br>Outstation: Balgul, located near Channel Pt | **225**<br>250 |
| Gunbalanya (Oenpelli) | | | **904** |
| Gagadju Association | | | |
| **DARWIN URBAN** | | | |
| **Hospitals** | | | |
| Royal Darwin Hospital | | | |
| Darwin Private Hospital | | | |

## *ATSIC and NTDHCS FUNDED HEALTH SERVICE*

| | | | |
|---|---|---|---|
| Danila Dilba | | | |

Population figures unbold = Population census Australian Bureau of Statistics
Population figures in **bold** = Estimates from NT Department of Lands Housing and Local Government

## *APPENDIX H*

# *Northern Territory Health Expenditure and Funding[(a)]*

| | 1992/93 | 1993/94 | 1994/95 | 1995/96 |
|---|---|---|---|---|
| *Expenditure by Activity* | ***$M*** | ***$M*** | ***$M*** | ***$M*** |
| Corporate Management | 23.23 | 24.38 | 22.93 | 25.40 |
| Hospital Services | 118.26 | 130.50 | 138.57 | 140.44 |
| Community Health | 52.31 | 57.65 | 61.45 | 67.08 |
| Public and Allied Health Services | 29.34 | 34.38 | 39.17 | 41.50 |
| **Total Expenditure** | **223.13** | **246.91** | **262.12** | **274.42** |
| *Sources of Funds* | | | | |
| Taxes Fees and Fines | | | 0.45 | 0.53 |
| Charges | 13.90 | 7.75 | 8.74 | 8.79 |
| Miscellaneous Receipts | | 9.20 | 10.33 | 11.03 |
| Sale of Other Assets | 0.20 | 0.15 | 0.04 | 0.04 |
| Other Commonwealth Grants | 29.13 | 88.50 | 86.25 | 89.46 |
| Intrasector Receipts | 1.50 | | | |
| Consolidated Revenue Account | 179.38 | 141.31 | 155.86 | 163.90 |
| General Government Trust Fund | -0.97 | | | |
| HAS Departmental Operating Account | | | 0.46 | 0.66 |
| **Total Receipts** | **223.13** | **246.91** | **262.12** | **274.42** |

Source: Northern Territory Budget Papers No. 2. *The Budget:* 1993/94, pp. 121, 256; 1994/95,. pp. 137, 272; 1995/96, pp. 139, 298. Budget Paper No. 3, *Sources of Funds:* 1993/94, pp. 15-17; 1994/95, pp. 17-19; 1995/96, pp. 17-18.

## *APPENDIX I*

# *Territory Health Service*

Remote health services in the larger populated communities consist of:

- health clinics/centres which provide primary health care and emergency care services;
- resident Nurses (1 to 4 depending on population size and community need);
- resident Aboriginal Health Workers (1 to 7 depending on population size and community need); and
- routine District Medical Officer visits (frequency of visits range from weekly to monthly according to population size and health need.

Remote health services in the smaller populated communities consist of:

- smaller health clinics (usually a demountable building) which provide primary health care and emergency care services;
- resident Aboriginal Health Workers (1 to 2);
- routine mobile nurse visit, from either the nearby larger health centre team or a specific mobile nurse like the Petermanns Mobile nurse in Central Australia, (frequency of visits range from weekly to monthly); and
- routine District Medical Officer visits (range from fortnightly to monthly). Clients can also attend doctor visit days at nearby larger communities.

Additional health services provided to remote communities through the health centres and clinics include:

- Community Welfare Workers;
- Environmental Health Workers;
- Dental services;
- Mental Health Workers;
- Nutritionist;
- Occupational Therapist;
- Alcohol and Other Substance Abuse Workers;
- Women's Health Workers;
- Aboriginal Health Worker Educators;
- Quality Assurance Officer;
- Communicable Diseases Workers;

- Health Promotion Officers;
- Physiotherapist;
- Paediatric Specialist; and
- Pharmacist.

Frequency and regularity of these services vary according to individual client need, integrated program activities and special initiative projects conducted in communities. For example, a National Better Health Program Project was conducted in a smaller community in Central Australia, and this required more frequent visits by several services (Health Promotions, Environmental Health, AHW Educators) than would normally occur there. The Department's Rural Districts cover large geographic areas where travel can be difficult due to poor road conditions and diverse weather patterns. As such, some health staff, like the Allied Health Professions, and there is usually only one of each profession, can only visit remote communities once or twice a year.

The rural district medical officers also provide a 24 hour consultation (by phone or radio) and emergency retrieval service for all remote communities. Medical evacuations are carried out in conjunction with the Royal Flying Doctor Service in Central Australia and Air Medical Service charters in the Top End, evacuations may include a combination of road and air transport and the retrieval team usually consists of a doctor and nurse.

The Patient Assisted Travel Scheme (PATS) assists those in remote areas to access specialists in the small and large hospitals of the NT, as well as interstate. PATS also assists clients to access outpatient clinics and diagnostic procedures.

In the remote health centres or clinics, clients can present themselves to the clinic for treatment or consultation during the normal clinic hours or be seen on a home visit by the health staff. The health staff also provide an after hour call-out service, meant for urgent and emergency care only. Clinic hours are generally between 0800 and 1700, but can vary according to local need and priorities. An example is that one community clinic opens at 0800, closes at midday for a few hours (because the community has an afternoon rest period) and reopens for the late afternoon.

The health care services provided by nurses and AHWs in the clinics include:

1. *Maternal and Child Health Programs*

   Childhood immunisations; screening and monitoring the under-fives; screening of school aged children; growth monitoring; antenatal clinics for all pregnant women and health education on maternal and child health matters.

2. *Communicable Diseases Programs (Disease Control)*

   Screening and treatment of STDs and TB and health education on STD/AIDS;

3. *Lifestyle Diseases Programs*

   Screening and case management of lifestyle diseases like diabetes, hypertension, cardio-vascular disease and health education on diet, smoking and exercise.

4. *Infectious control*

   Screening, treatment and management of infections (like skin, chest and respiratory, diarrhoeal etc) and health education on environmental health.

5. *Clinical and minor surgical care*

   Performing suturing and minor uncomplicated surgical procedures (like removal of foreign bodies from ears and eyes).

6. *Women's Health*

   Pap smear screening; breast examinations and screening, treatment and management of reproductive health problems.

7. *Referral point*

   Clinic staff assess, diagnose and treat, or diagnose and refer to secondary care. this may be to the doctor, mental health services, alcohol program, community welfare services, dental etc.

8. *Other services*

   Clinic staff are frequently called upon to assist in many tasks, and include assessing and referring clients to appropriate services, these include a diverse range of issues like domestic/family violence; social security advice; employment assistance; assistance in filling out forms; schooling and education issues.

**Health Services and staff.**

The health services available and personnel providing the service is similar across all Departmental districts. The following is a brief description of the health services available:

a) *Primary health care services (PHC) in remote communities*

   Provided by AHWs and nurses.

b) *Community Welfare Workers*

   The Family, Youth and Children's Services District staff work closely with other health professionals and the local health teams to provide a prevention and crisis intervention

program to communities. Preventive Family Care and Support includes a range of services designed to assist communities in preventing family breakdown and in the need for crisis intervention. The services available to communities are family support and counselling; nutrition and home maker services; women's information and referrals; 24 hour phone counselling; respite care and availability of Aboriginal community welfare workers (eg Yuendumu community has a resident community worker). Services available from the Crisis Intervention, Substitute Care and Support to communities are assistance in the protection and support of children, youth, women and men who are homeless or victims of abuse and neglect; domestic violence or sexual assault; provision of crisis accommodation; counselling; child and family protective services; substitute care and guardianship of children; and adoption services. There are other services also available through the Children's Services unit of the Department.

*c) Environmental Health Workers*

The Department has service agreements with 10 Aboriginal communities for the employment of 11 Departmentally funded Aboriginal Environmental Health Workers (AEHW). District Environmental Health Officers provide a range of services to remote communities and include assistance with the training of AEHWs and the development of specific environmental health programs for each community; undertake special projects like the environmental health promotion project for the upgrading of housing sanitation at Ntaria and Titjikala, and the development of a broad based scabies and home hygiene program in Darwin Rural District in conjunction with the Disease Control Program; routine surveillance of premises and community activities which have potential to adversely impact on health; and respond as required to community requests for assistance on the enhancement of environmental health standards and the resolution of environmental health complaints on remote communities. Departmental funding is also allocated to communities for community environmental health initiatives (eg to Maningrida, Lajamanu and Kintore for the establishment and operation of a sustainable dog health program), and whilst it is not a remote community, Wurli Wurlinjang Aboriginal health service in Katherine received funding for their dog health program.

*d) Dental Services*

Trained dentists and dental therapists provide scheduled mobile visits to remote communities in fully outfitted dental vans. Dental caries and dental hygiene are big problems in Aboriginal children and adults and the existing service has not been able to effectively address these issues to date. Access to dental health by remote communities is a problem, in conjunction with an increase in dental service provision needs to go comprehensive health education, including diet and oral hygiene.

*e) Mental Health Workers*

Trained mental health nurses provide a range of services including community based assessment, case management and treatment, in conjunction with a multi disciplinary

team. Aboriginal Community Mental Health Workers are employed in Darwin Rural and East Arnhem Districts.

*f) Nutritionist*

Rural nutritionists work closely with other District health professionals, local health teams and communities to provide advice and increase awareness of nutritional issues. Nutritionist visits to remote communities involve the promotion of a healthy diet through community stores, schools and health clinics; the surveillance of food supply and pricing; and assistance in conducting specific nutrition campaigns on communities (eg diabetes program in Ntaria)

*g) Occupational Therapist and Physiotherapist*

These rural practitioners provide a range of services that include individual client care for complicated cases; training and advice to local health staff and family members on how to perform simple follow-up care (eg massage and use of aids); arranging the provision and delivery of special equipment (eg wheelchairs, frames etc); involved in the design, delivery and advice in using mobility equipment specifically designed for use in remote communities (eg adult and paediatric manual transporter, motorised 4 wheel drive buggy and artist table); assisting communities in assessing the needs of their old and disabled people (eg the 'Good Life for Old and Disabled People in Remote Aboriginal Communities' project in Willowra and the multi-purpose centre project in Belyuen); and coordinating other aged and disability services programs delivered to remote communities (eg Home and Community Care projects, Commonwealth Rehabilitation Services projects).

*h) Alcohol and Other Substance Abuse Workers*

Aboriginal Living With Alcohol Community Development Facilitators have been recruited to the Aboriginal Living With Alcohol Program to work with remote communities in implementing alcohol education programs community wide. Where other substances are a problem, for example petrol sniffing and kava, specialist workers work with the community and local health centre to come up with strategies to deal with the issue. These programs are not prescriptive across the Territory but in place where needed and identified by communities.

*i) Women's Health Workers*

District Women's Health Nurse and Aboriginal Health Workers (AHWs) work with local health teams and community women's groups in planning, developing, implementing and overseeing educational and clinical programs in all aspects of women's health. This includes assistance in conducting Pap smear screening; establishing Pap smear registers, data base and recall systems; provide support and information to women's groups; and conducting 'Well Women's Clinics'.

*j) Aboriginal Health Worker Educators*

These workers coordinate in-service training for AHWs; visit and support AHWs in remote communities and assess their training needs; and assess AHWs eligibility for registration. This role does not have direct client care but works directly with remote area staff.

*k) Quality Assurance Officer*

Visit each remote health centre to provide advice and support to local health team in order to ensure that the quality of client care is appropriate and acceptable. The role covers all health professionals visiting remote communities, including medical officers. This role does not have direct client care but works directly with remote area staff.

*l) Communicable Diseases Workers (Disease Control Program)*

Communicable diseases workers coordinate their program activities through and with other district health professionals and local health teams. This includes the surveillance and control of selected communicable diseases, developing and monitoring of immunisation programs, sharing information and educating other health professionals and community groups, and providing screening and clinical services for tuberculosis, AIDS, STDs and leprosy.

*m) Health Promotions Officers*

Health Promotion Officers are involved in implementing key training programs for senior Haws to enhance their role of health workers in health promotion. Health promotion officers also work with communities as requested and are needed to assist with special health promotion campaigns (eg. Titjikala nutrition and environmental program); plan, implement and evaluate health programs (eg. Gapuwiyak scabies program); assistance in identifying specific health issues and developing resources to address the issue (eg. Belyuen alcohol video).

*n) Paediatric specialist*

The Rural District Paediatric Specialists in the Centre and Top End visit and conduct clinics in the larger communities. They also assist in the coordination of services for children; improve liaison between communities and hospitals; monitor child growth; ensure follow-up of special cases in remote areas; and work closely with local health teams and district medical staff in addressing general child health issues in remote areas.

*o) Pharmacist*

The District Pharmacist visits the larger health centres yearly to assist local health staff in the storage, usage and ordering of drugs and other pharmaceutical supplies. This role does not have direct client care contact but with the remote area health staff.

Source: Territory Health Services
Tabled Paper 9
Public Accounts Committee Meeting: 3 May 1995

## *APPENDIX J*

# *Extracts from ATSIC Operational Plan 1994/95*

> To promote the improvement of the health and well-being of Aboriginal and Torres Strait Islander peoples consistent with their expressed social and cultural aspirations. Health is defined as: '... not just the physical well-being of the individual but the social, emotional and cultural well-being of the whole community. This is a whole- of- life view and it also includes the cyclical concept of life-death-life (The National Aboriginal Health Strategy Working Party Report 1989)' p. 70.

The strategies were documented as follows:

- promoting equity in access to health services and facilities for Aboriginals and Torres Strait Islanders of, appropriate mainstream and community services;

- establishing community controlled health services, where appropriate, which emphasise Aboriginal and Torres Strait Islander responsibility for, and involvement in, the improvement of their health;

- promoting the establishment of satisfactory environmental conditions, especially safe and adequate water supplies and waste disposal, in Aboriginal and Torres Strait Islander communities;

- liaison and co-ordination with other agencies in order to resolve access and equity issues at the Commonwealth level;

- developing and providing policy advice and guidelines which ensure that the needs of specific groups are recognised by the Regional Councils in planning and decision making processes;

- promoting, in line with ATSIC's Access and Equity Plan, programs that seek Aboriginal and Torres Strait Islander women's participation in the design and delivery of health programs and strategies for the removal of institutional forms of discriminatory practices in the workplace; and

- promoting, in line with the objectives of ATSIC's Corporate Plan, increased Aboriginal and Torres Strait Islander employment, training and education, both in health departments and in community organisations and promoting, in line with ATSIC's EEO Plan, strategies for the removal of institutional forms of discriminatory practices in the workplace (pp. 70-71).

Under the section 'Part 7 - Social and Cultural Division of the ATSIC Operational Plan 1994-95' the following key strategic issues assist the explanation of the framework for health services to Aboriginal communities:

- implement the delivery of primary health care to Aboriginal and Torres Strait Islander peoples in co-operation with the Department of Human Services and Health and Aboriginal health organisations;

- recognising in particular the need to address the underlying causes of Aboriginal and Torres Strait Islander ill health and the rights of indigenous people to the provision of equality services:

  - improve linkages with State and Local Government in the provision of essential services and provide better access to mainstream services in health, housing and infrastructure;

  - undertake an evaluation of the National Aboriginal Health Strategy;

- as part of the review of the Community Housing and Infrastructure Program (CHIP) introduce a range of initiatives to enhance project management and the operation of the program; and

- using the Housing and Community Infrastructure Needs Survey results, develop a national strategic framework for the allocation of CHIP funds which includes a negotiation process with State and Territory Governments on the provision of infrastructure services (pp. 65-66).