Central Australian Health Planning Study
Final Report
July 1997

PlanHealth Pty Ltd

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2.

Central Australian Health Planning Study

July, 1997
PREFACE

This is the Final Report of the Central Australian Health Planning Study.

It covers:
- a summary of policy directions of Commonwealth and Territory Governments;
- an overview of the demographics of the Region;
- an analysis of current PHC service provision;
- a proposed model of PHC service delivery for Central Australia based on Health Service Zones, and the delivery of agreed core functions of Primary Health Care under a collaborative planning structure.
- An analysis of gaps in services
- Recommended priorities in PHC service development.

We have also provided a section on health service issues and, as an appendix, brief community profiles.

We include a number of specific proposals as part of a suggested implementation strategy.

We have attempted to discuss issues involved in what we have described as institutionalised conflict in primary health care services to Aboriginal people in Central Australia. We are aware that others may have different perceptions of these issues, and we do not intend that our discussion inflames tensions between current providers. However, we consider that a frank discussion of these issues is an important part of moving beyond the institutionalised conflict into a more productive and creative dynamic.

Acknowledgments:

We are grateful to those people who provided detailed information about what is actually happening out there – where people are, how out-stations are occupied, what access people have to services, and others who gave us advice and support. They are Alison Anderson, Des Carne, Frank Baarda, Mike Burrows, Elaine Quinn, Warren Kellet, Robert Hoogenraad (IAD), Marg Bowman, (IAD), staff of the CLC, in particular Lindsay Bokie, James Ensor, Gina Allen, Austin Sweeney, Barb Cox, Francine McCarthy, Del Boyd, Terry Mahoney, Gavín O’Brien, Dave McEvoy (NLC), Chris Walsh (Nurratjuta), Andrew Johnson (Titjikala), Ginger Ross and Bruce Fyfe (ATSIC), Gaynor Cleary, Elaine Bohning (Irrwanyerre), Margie Lynch, Leslie Alford, Dennis W illets (Ingkerreke), Chippy Miller (Telstra), Darren Fraser (NLC), Robert Ross and staff at Aputula Council Office, Alan Passmore (Kaltukatjara), Barry Byerely (Amoonguna), Jane Uliker, David Scrimgeour, David Legge, Jo Wynet, John Hill, Bob Durnan, Jane Lloyd, Paul Rivalland, Malcolm Blake, John Caplehorn, April Campbell Napanadi, Karen Collas, John Gill (Ampilatwatja), Bill Williams (PHHS), Graham Kelly, Brian Nolan (Urapuntja), Don Blackman (Aputula), Mollie Kennedy (Santa Teresa), Darryl Kantawara, Mike Bowden (Tangentyere Council), Marlene Bennett, Virginia Haly, John W akerman, Komla Tsey, (Menzies), John Liddle, Stephanie Bell, Lynore G eya, Chris George, John Boffa (Congress), Francie Turner (Alukura).

We are especially appreciative of Peter Bartlett’s efforts in providing us with up to date detailed information.

We are grateful to the many health service workers who spared us their valuable time in giving us information about their service.

Edward Tilton provided his computer programming wizardry without which we would not have managed the analyses of the data.

We thank IAD for their permission to reproduce their map of the Distribution of Central Australian Languages.

This study has been funded by OATSIHS, Commonwealth Department of Health and Family Services.
## GLOSSARY

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tr>
<td>AAAC</td>
<td>Australian Aboriginal Affairs Council</td>
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<tr>
<td>ABTA</td>
<td>Aboriginal Benefits Trust Account</td>
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<td>ACAP</td>
<td>Aboriginal Cultural Awareness Program</td>
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<td>ADC</td>
<td>Aboriginal Development Commission</td>
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<td>AHC</td>
<td>Australian Health Ministers Advisory Council</td>
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<tr>
<td>AHW</td>
<td>Aboriginal Health Worker</td>
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<tr>
<td>AHW</td>
<td>Aboriginal Health Worker</td>
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<tr>
<td>ALFC</td>
<td>Aboriginal Land Fund Commission</td>
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<td>ALRA</td>
<td>Aboriginal Land Rights Act</td>
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<td>ALT</td>
<td>Aboriginal Land Trust</td>
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<tr>
<td>AMSANT</td>
<td>Aboriginal Medical Services Alliance – Northern Territory</td>
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<td>ASH</td>
<td>Alice Springs Hospital</td>
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<tr>
<td>ATSC</td>
<td>Aboriginal and Torres Strait Islander Commission</td>
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<td>CAC</td>
<td>Central Australian Aboriginal Congress</td>
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<td>CARHTU</td>
<td>Central Australian Rural Health Training Unit</td>
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<td>CARPA</td>
<td>Central Australian Rural Practitioners Association</td>
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<td>CDEP</td>
<td>Community Development Employment Program</td>
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<td>CLC</td>
<td>Central Land Council</td>
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<td>CRC</td>
<td>Collaborative Research Centre</td>
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<td>DAA</td>
<td>Department of Aboriginal Affairs</td>
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<td>DMO</td>
<td>District Medical Officer</td>
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<td>DRG</td>
<td>Diagnostic Related Group</td>
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<td>HSZ</td>
<td>Health Service Zone</td>
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<td>IHANT</td>
<td>Indigenous Health Authority of the Northern Territory</td>
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<td>JHPC</td>
<td>Joint Health Planning Committee</td>
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<td>NACCHO</td>
<td>National Aboriginal Community Controlled Health Organisation</td>
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<td>NAHS</td>
<td>National Aboriginal Health Strategy</td>
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<td>NHMRC</td>
<td>National Health &amp; Medical Research Council</td>
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<td>NLC</td>
<td>Northern Land Council</td>
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<td>NT</td>
<td>Northern Territory</td>
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<tr>
<td>OAATSIHS</td>
<td>Office of Aboriginal and Torres Strait Islander Health Services.</td>
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<td>PATS</td>
<td>Patient Assisted Travel Scheme</td>
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<td>PBS</td>
<td>Pharmaceutical Benefits Scheme</td>
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<td>PHC</td>
<td>Primary Health Care</td>
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<td>PHHS</td>
<td>Pintupi Homelands Health Service</td>
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<td>RADGAC</td>
<td>Research and Development Grants Advisory Committee</td>
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<tr>
<td>RHSET</td>
<td>Rural Health Support, Education and Training.</td>
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<td>RIP</td>
<td>Rural Incentives Program</td>
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<tr>
<td>RN</td>
<td>Registered Nurse</td>
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<tr>
<td>SAC</td>
<td>State Advisory Committee</td>
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<td>TC</td>
<td>Tennant Creek</td>
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<td>TCHIP</td>
<td>Town Camp Housing Improvement Program</td>
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<td>THS</td>
<td>Territory Health Services</td>
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<td>TPF</td>
<td>Tripartite Forum</td>
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<td>UHS</td>
<td>Urapuntja Health Service</td>
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EXECUTIVE SUMMARY

Our work has involved identifying the details of the location, size and mobility of the population of Central Australia. In doing this we have looked at official population data (ABS and HINS), and have also utilised the knowledge of local informants. We have also documented the current level of primary health care services in Central Australia.

The most telling aspect of our findings is the enormous mobility of people, particularly in some areas of the Region. Small family groups are living in many out-stations or communities with no access to Primary Health Care services. While these groups are small (often numbering less than 30 people), their total number is large, numbering in the vicinity of 4,500 people. Providing health services to these populations is the key challenge for the health care system.

We have provided a summary of policy development in health, both nationally and in the Northern Territory.

We have analysed the demographics of the Central Australian Region and have presented that information in detail. This has included detailed analyses of population groups, and the development of Health Service Zones, based on language, cultural and relationship factors as well as logistic considerations. This has built on the Draft THS Review proposed areas that only cover THS serviced communities.

Analyses of current health care services have identified barriers to effective delivery and include institutionalised conflict between the different organisations involved in health care. At the same time there has been agreement about the broad policy direction needed to address Aboriginal health disadvantage, but there has been no operationalised collaborative effort.

Proposed Regional Health Services Plan

We have developed a regional health services plan that is aimed at a more integrated system, to ensure better outcomes for all people in the region, and particularly the inhabitants of out-stations who are missing out.

The elements of the PHC model, central to this plan, are:

1. **Health Service Zones** within which services will be organised with PHC staff to live in the Zone wherever possible;
2. The delivery of agreed core functions of PHC which are:
   i. **Clinical services** which all can access through a mixture (depending on population size) of:
      • Resident health care services in the community;
      • Visiting professional services;
      • Provision of medicine kits to designated holders;
      • Access to medical advice via phone or radio.
   ii. **Regional support** for PHC - staff education, management and the provision of specialist and allied health professional services.
   iii. Access to **Special Health Prevention Program funding** for preventive programs addressing the underlying non-medical causes of poor health.
3. Establishment of a Regional Indigenous Health Planning Forum to facilitate the development of collaborative planning of health services involving THS, OATSIHS, AMSANT and ATSCIC.
4. Pursue opportunities to increase **community control** (ie to increase the local communities say) of PHC services, and the further development of consumer inputs.

The matter of which clinical services people should have access to needs further definition. We have not offered a list of services which people should have access to, but consider that this issue should be pursued through a Working Group of the Planning Forum.

Our work has confirmed a continuing crisis in regard to the role of Aboriginal Health Workers. There are currently no AHW educators working in remote areas, and in-service education for AHWs has been virtually non-existent for the past few years, outside the larger community controlled services. The role of AHWs is a key aspect of the proposed model of PHC delivery.

A further key element of the model is a reorganised regional support system for PHC delivery. This includes support for management of remote health services, recruitment of staff, pharmaceutical and other supplies, policy and procedure development, and evaluation.
We have analysed the health service resource data so as to show health service staff to population ratios for AHWs, nurses and doctors across the 12 Health Service Zones in the three ATSIC Regional Council Areas of Yapa kurangu, Papunya and Alice Springs which largely correspond to the Central Australian Region of THS.

We have then ranked these to identify which Health Service Zones have greatest need. However, there is enormous difference within Zones with health service resources frequently concentrated in one or two communities. We have, therefore, analysed each Zone to identify the most needy areas. We have not attempted to say precisely which are worst off, and which are next worse off. We hope that we have presented the need in a way that will enable action to be taken to address some of the need in all of these situations.

The results of these analyses show that the following areas are in greatest need of a better service. Note they are not in any particular order. These communities should be the priority for any new resources for primary health care services that becomes available for Central Australia. They should also be a focus for negotiations about any reorganisation of health care services. They are:

**Northern Barkly**
Nicholson River.
Barkly Tablelands.

**Southern Barkly**
Canteen Creek.
W utunagurra (Epenarra).

**Eastern Arrernte-Alyawarre**
The eastern area, including Bonya and Uralme.

**Kaytetye - Warlpiri**
Tara (Neutral Junction).

**W arlpiri**
Yuelamu (Mt Allen).

**W arlpiri**
The out-stations of NTaria (Hermannsburg).

**Anmatjere**
Ti Tree area.

**L uritja - Pintupi**
I kuntji (Haasts Bluff) and its out-stations.

**P itjantjatjara/ L uritja**
A putula (Finke) and the growing out-station population in the south east.
T tjikala (M aryvale).

We have also highlighted the difficulties for the large population living on out-stations around Alice Springs, and the needs of Amoonguna.

In highlighting these needs, it is important to recognise that there is a general inadequacy of health service resources to Primary Health Care to Aboriginal people. It is unlikely that adequate resources will be available, despite new commitments from OATSIHS, in the short term. This makes the project of collaboration to ensure optimal utilisation of available resources paramount, even though such collaboration will not be able to achieve adequate health care services without further funding support.

A re-jigging of the health care system will require a collaborative relationship between major providers and funders in Central Australia. We have made some tentative proposals about how this might be done.
IMPLEMENTATION OF CENTRAL AUSTRALIAN HEALTH PLAN

Prioritising health service needs is not a simple process. Clearly the urgency is to get more primary health care practitioners into communities. But we know that without appropriate support they will not deliver. Staff turnover and the consequent constant influx of new (and inexperienced) staff is a product of inadequate support. Thus, we cannot ignore the priority of developing more strategic regional support for Primary Health Care in communities. AHWs continue to have inadequate access to educational support. Investing in regional support for PHC must be a priority.

Further, we appreciate the overall inadequacy of funds to develop the optimal system.

Collaborative Health Service Planning in Central Australia

1. We propose that a Central Australian Indigenous Health Planning Forum be established.

The Interim Forum should consist of:
- Zone Commissioner, ATSIC.
- Regional Director, THS.
- Director, OATSIHS.
- 1 AMSANT.

The first things this group needs to do is to:
- Agree on a model of PHC service to be implemented;
- Establish a management structure to ensure an effective and timely implementation of the model;
- Determine the composition of the CA Indigenous Health Planning Forum;
- Determine the operational guidelines of the Forum.

The agenda for the Forum will be focused on health service development issues in Central Australia. However, it should foster inter-sectoral relationships that are practical relationships with specified outcomes and defined timelines.

Functions of the Forum will be:
1. To oversee the reorganisation of PHC service delivery focused on populations within Health Service Zones, including out-stations, and organised around:
   i. Community based PHC service delivery;
   ii. Regional support to PHC;
   iii. Regional organisation of Specialist and Allied Health Professional service visits to remote communities.
   iv. Assessing and coordinating special health prevention programs aimed at supporting the community in addressing major health problems requiring community action, and not amenable to clinical interventions.
2. To assist in developing consumer input to PHC services both at the community and regional level.
3. To assist in strengthening community participation/ control of PHC service delivery.
4. To develop and implement strategies to ensure adequate resource allocation to PHC service delivery in Central Australia.
5. To establish Working Groups on particular areas that requires attention. These Groups should have very specific terms of reference, with a specified (and usually short) time frame. This is necessary to prevent such groups becoming institutionalised and stagnant.

Figure 1 suggests an approach that integrates relationships between various sections of the health sector according to function, and thus becomes supportive to the processes of primary health care, rather than over stretching them.
Regional Indigenous Health Planning Unit

Membership
- ATSIC
- AMSANT
- THS
- OATSIHS

Presentation of Information - Data & Analyses.

Regularly Collected Data - Epidemiological, Demographics, Hospital Separation Data, Births, Deaths.

Teaching/Research Institutions - CRC, Menzies, NH&MRC, NT & Inter State Universities

Service Development Working Groups.

Child Health

Women's Health

Men's Health

Mental Health

Substance Abuse

Nutrition (Diabetes, Heart Disease)
Urgent issues that should be addressed by the Forum, and will require the establishment of a Working Group include:
1. Determining which clinical services people should reasonably expect access to.
2. How to address the needs of Aboriginal Health Workers so that they can fulfil their obligations in the primary health care setting. This will require agreement by the Health Planning Forum and the Aboriginal Health Workers Association on what role AHWs are to play in PHC service delivery. It may also require inter-departmental negotiations involving DEETYA (Department of Education, Employment, Training and Youth Affairs) to ensure adequate funding for a strategic development of AHW education.

**Funding Issues**

2. *We propose guidelines for funding which strengthens comprehensive primary health care service delivery to Aboriginal communities, in line with the agreed core functions of primary health care.*

These guidelines are aimed at ensuring adequate levels of resourcing for the effective implementation of:
- clinical services, including preventive programs that have a clinical dimension;
- appropriate regional support to primary health care services; and
- support for communities to get financial and logistic assistance to develop programs to address the health issues that are not amenable to clinical interventions.

It also ensures a balance between clinical and non-clinical aspects of comprehensive primary health care delivery.

It is clear that in order to improve primary health care services in terms of both coverage and quality, more resources need to be found. The collaborative planning processes described above are geared to facilitate an agreement about how funds can be injected into the region. It will also facilitate the process of identifying where further resources are needed.

Figure 2 illustrates diagrammatically these guidelines for funding lines to support the development of comprehensive primary health care services in the community.

Figure 2: Funding Lines For Comprehensive Community-Based Primary Health Care.

3. *We propose that the Planning Forum facilitate investigations of the level of funding required to provide adequate PHC services to people in Central Australia, and where such funding might come from.*
Primary Health Care Services in Central Australia

Health Service Zones

4. We propose that the Central Australian Region (incorporating the 3 ATSIC Regions of Yapakurlangu, Alice Springs and Papunya and the THS Districts of the Barkly and Alice Springs) be divided into 12 Health Service Zones for the purpose of PHC service development.

Figure 3: Map of Central Australia Showing Proposed Health Service Zones.
These Zones can then assist the following elements of Primary Health Care:

- The identification of resource needs;
- The efficient utilisation of resources within those Zones;
- The delivery of regional support services to those Zones;
- The on-going involvement of consumers and community organisations in the processes of PHC service delivery.

5. **We propose that the boundaries of these regions be viewed as a flexible working arrangement, as community relationships are changeable, and different arrangements will be required from time to time.**

We advise that the proposed boundaries need to be treated with some caution. They are a compromise between language, cultural and community relationship factors and health service delivery logistic factors. The mobility of people is a hallmark of the Central Australian region. A hallmark of PHC is its ability to be responsive. In Central Australia a major issue in responsiveness of PHC is its ability to respond to population mobility.

Indeed, there are already, in the proposed Zones, some anomalies that may demand change.

6. **We propose that, wherever possible, primary health care services be developed under community control arrangements, whether under existing community councils, or through the establishment of health councils, but that they be provided with adequate regional support, as outlined, and be able to take control of selected aspects, rather than an all or nothing approach. The Planning Forum should facilitate these processes.**

The issue of implementing community control of Aboriginal PHC services has proved problematic, and has been historically divisive. However, it is widely recognised that community control/participation/involvement adds a qualitative dimension to PHC services. In the Aboriginal context, this cannot be replaced simply by external agencies becoming more culturally sensitive. We suggest that there will be greater success if moves to community control are pursued within a collaborative framework represented by the Planning Forum.

7. **We propose that in Health Service Zones where there are few opportunities for community control of PHC services at this point of time, that health councils or committees (whether in a particular community or over a wider area through the nomination of health delegates) be collaboratively pursued.**

These groups have the possibility of developing as consumer voices. However, they should again be developed under collaborative arrangements so that they are available to all players in the health care system. If they are developed by one government agency only, say, THS, then their legitimacy will be challenged. Success of such organisations is dependent on their being widely recognised. However, they must also be open to community intervention.
Regional Supports for PHC

Pharmaceuticals:

8. We propose that a regional approach be established for the purchase and distribution of pharmaceuticals.

This arrangement should include the supply of medicine kits to designated holders in out-stations, including keeping track of expiry dates. It would also take responsibility for the supply of dosette boxes to particular patients on chronic medications. Whichever mechanism for achieving this is adopted, it will require oversight from the Indigenous Health Planning Forum.

There are a number of alternative models that could achieve this function:

1. The Regional Pharmacy of the THS could expand to accommodate this function. Previous barriers to this have been the limited capacity of the Regional Pharmacy to be the central supply point for all services without some increase in space and staff. Further, the 25% handling fee charged by Regional Pharmacy have meant that some drugs are much cheaper to buy through inter-state suppliers. In this area, the larger health services like Congress have done reasonably well, whereas smaller services in remote communities have had more limited options.

2. Contract a private pharmacist to provide drugs to remote PHC services. This may open up some possibility of accessing funds through the PBS.

3. Establish a pharmaceutical purchasing and distribution authority to manage the pharmaceutical needs of PHC services in Central Australia.

9. We propose that a regional Pharmaceuticals Field Worker be appointed.

An appropriately qualified person (either a pharmacist or Registered Nurse) should be appointed to coordinate the Pharmaceuticals program, and to provide basic education and assessments of medicine kit holders. This person would also be responsible for reviewing the various grades of kits and their contents with health care staff from time to time. This might best sit with the CARPA Standard Treatment Manual Editorial Committee. This person could be employed through either a community controlled health service with capacity to carry the function, such as Congress, or through THS's regional support capacity. We do not recommend that this person be employed by the mechanism adopted for distribution of pharmaceuticals.

10. We propose that a system of support for medical kit holders be developed as a means of improving small community/outstation access to health care.

The Health Care Agents Subsidy Scheme already operates in the NT for unqualified persons on pastoral properties who are designated agents. We suggest that that system be abolished and replaced with a new system where designated medical kit holders can be supported to provide a health care role in their family group. This will apply to small out-stations/communities that cannot sustain permanent, resident health care services. Their access will be supplemented by maintenance of communications technology (telephone or radio) and visiting health care services.
**Transport**

11. *We propose that a driver's position be included in PHC services serving populations greater than 200 people.*

We are not convinced that 1 driver per Health Service Zone will be adequate in most situations, given the lack of relationship between some communities in the same Zone. This needs to be considered for each Health Service Zone and for each community, and should be an issue placed on the Planning Forum's agenda to be taken up with negotiations for each community.

12. *We propose that a short term project be conducted aimed at negotiating a transport system, utilising the travel opportunities presented by other Aboriginal organisations and government agencies, to ensure people discharged from hospital can return to their community as quickly as possible.*

There is a continuing problem of people getting transport back to their community after hospitalisation. While the employed driver, mentioned above, may be able to perform this role for some communities close to Alice Springs, it may be difficult for them to provide a reliable service to more distant communities.

We recommend that an intersectoral approach be taken to this problem. Many government agencies and Aboriginal organisations are travelling to communities from Alice Springs all the time. It ought be possible to develop a system where the hospital discharge planner, or other designated person, is able to identify who will be travelling where and on what days. It may be that the hospital discharge planner will require an assistant to assist with this. This question should be included in the project's terms of reference.

His development of a transport support system will require a short-term project officer (for, say, 2 months) to negotiate an arrangement with various organisations and Government agencies.

13. *We propose that the issue of responsibility for emergency evacuations and especially the appropriateness of medical escorts be kept under review.*

As discussed in this report the skills often required in medical escort for emergency evacuations are not those of primary care or public health, but rather of emergency medicine. We understand changes are taking place in this area, and outcomes need to be reviewed.

14. *We propose that a telephone medical advisory service be established for AHWs and medical kit holders who do not have access to other resident health professional support.*

We have proposed a three-prong approach to ensuring universal access to primary health care services. These are the development of a network of medicine kit holders, visiting health professionals, and the ability to access expert advice when needed. This could either be to the health service in the associated community, or, in some cases, access to advice in Alice Springs.
**Regional PHC Management Support Facility**

15. We propose that a regional management support facility be established to take responsibility for a number of common management functions, and the development of policy and procedures for all primary health care facilities in Central Australia, regardless of who provides such a service.

Many of the problems of management in remote communities are a product of multiple, infrequent tasks meaning that no system ever gets developed. They are problems related to economies of scale. The sort of issues that fall into this category include:

- **Recruitment of Staff.** The regional management support service should include assistance with developing job description, selection criteria and process with the PHC staff or community members, advertising the job, confirming professional registration, checking any police record, checking previous employers, short listing applicants, organising interviews with selection panel, and informing applicant of the result. Organising relocation of successful applicants, and clarifying terms of employment should also be done regionally.
- **Industrial Relations matters** – such as ensuring appropriate processes for hiring and firing of staff, payment of Award wages and other entitlements, options of salary packaging and staff grievance procedures.
- **Workers Health and Safety matters** – such as workers compensation procedures, and workplace health and safety policies.
- **Other policy development** – such as drivers/ vehicles policy, assets register and maintenance, confidentiality, complaints procedures, and medical waste disposal arrangements.
- **Insurance policies** – fire & theft, vehicle, public liability, professional indemnity.
- **Smoking and alcohol policies.**

This facility could be established as either:

1. A separate unit under a collaborative management arrangement, or
2. A unit within an existing health organisation such as Congress or THS.

We emphasise that this facility will not determine policies for primary health care service agencies, but will provide them with examples of such policies for them to adapt to their needs.

In order for this to be effective, appropriate agreements need to be reached between funding bodies and providers.

**Workforce Facility**

16. We propose that a regional health service workforce unit be established to provide relief staff, and to organise regular Specialist and Allied Health visits to communities in the region.

**Relief Staff**

All PHC service, regardless of their funding arrangements, need to access relief staff so that staff can attend educational opportunities and take annual and other leave. This applies to AHWs, nurses and doctors. This would best be organised regionally. Remote services, particularly those not serviced by THS have serious difficulty in this area, and is a significant barrier to such staff accessing in-service training.
**Specialist Visits**

The unit will take responsibility for organising specialist visits to all PHC services in Central Australia. We expect that the majority of medical specialists would be employed primarily through the Alice Springs Hospital. This Unit would negotiate with the hospital and the specialist, to ensure appropriate coverage and regularity of bush community visits.

The services that are currently of highest priority include:

1. Paediatrician.
2. General Physician.
3. Ophthalmologist or Optometrist.
5. Renal Physician.
6. Psychiatrist.

The role of these visits, apart from consulting with patients, is for the Specialists to work with PHC staff so that the quality of PHC work in the particular specialist area in the community is strengthened.

**Allied Health Professionals**

The unit will take responsibility for organising allied health visits throughout Central Australia. An Allied Health section within this unit could be responsible for the employment and management of allied health staff, as well as organising appropriate visits to bush communities.

Regular visits should include:

- Dentist.
- Physiotherapist.
- Occupational therapist.
- Mental Health Service (these should be coordinated with the psychiatrist visits)
- Speech pathologist.
- Aged Care and Dementia Workers.
- Renal Unit staff.
- Nutritionist.
- Podiatrist.
- Audiologist.
- Continence adviser.

Palliative care staff should visit communities when appropriate to assist PHC staff to manage a terminally ill resident. All of these services have a clinical focus. Generally communities should receive a visit twice a year. However, some particular clinical problems may require more frequent support, and some services may only be required from time to time.

Opportunities for developing particular skills amongst PHC staff should be incorporated into the purpose of remote community visits.

**17. We propose that the Unit is established by re-organising the existing capacity within THS, and that this be developed as a major function of THS role.**

This will necessitate bringing all allied health staff for the whole Central Australian Region into the Workforce Unit, and negotiating allocation of this resource to ensure equity of access across the Region. This will involve re-organising the responsibilities of Alice Springs Urban and Alice Springs Remote, so that the professional skills embodied in THS can be made accessible to all citizens throughout the Region.

This process will assist in identifying gaps in these services so that new resources can be found to achieve an adequate level of service. This reorganisation is likely to require extra resources to ensure the desired outcomes.
18. We propose the Central Australian Regional Indigenous Health Planning Forum facilitate a women’s health working group which has clear objectives for the strengthening of women’s PHC services.

Women’s health PHC services need strengthening. The objectives should be directed at strengthening PHC antenatal and well women’s programs and strategic approaches to overview planning, development and implementation. This includes the more effective integration of current resources aimed especially at strengthening the capacity of PHC services in remote communities to better deliver women’s health care.

19. We propose the Central Australian Regional Indigenous Health Planning Forum facilitate a men’s health working group which has clear objectives for the strengthening of men’s PHC services.

Men’s health programs also need to be developed and may require visits from a male AHW, for example, especially to communities that lack a male AHW in the community. Issues that require attention relate to developing better access to PHC services for men.

Special Preventive Health Programs

20. We propose that the Central Australian Indigenous Health Planning Forum facilitate a process whereby the non-clinical concerns of communities can be taken up appropriately by the health care system, and resources allocated to support community initiatives aimed at addressing these community concerns.

Such resources may include program development skills, veterinarian skills, sexual health skills, negotiating skills and cyclical qualitative evaluation skills. These should be mobilised as needed, and all efforts should be made to put the focus on the community’s own action rather than that of an ‘expert’ external agent.

With these type of programs, support is often best provided intermittently, so that local people can shape it in ways that best suit the perceptions of the community, rather than the intellectual constructs of the professional. Appropriate evaluation should also enable other communities to access the details (success and failure) of these initiatives.

Education and Training Support

21. We propose that the in-service educational resources of THS be made available to staff of all PHC services regardless of provider.

We understand that this applies mainly to in-service programs for nursing staff. It may be appropriate for the Central Australian Rural Health Training unit to play a coordinating role with the nursing in-service program. The Planning Forum should facilitate arrangements.

22. We propose that the Central Australian Rural Health Training Unit develop education and training support that is relevant to the re-organisation of PHC services and regional support in Central Australia, particularly in regard to AHW needs, and PHC management.

This strategic orientation will require a specific focus on AHW needs, not in regard to basic AHW education leading to registration, but to providing on-going educational support to AHWs, particularly in remote communities.

Further, educational support needs to be developed to support PHC management. At present there is virtually no in-service programs for primary health care management.

23. We propose that educational support be provided for members of Boards of health services which address both their legal rights and responsibilities as Board members, as well as issues of health service delivery and the determinant of health status.

Central Australian Health Planning Study

July, 1997
We have discussed in this report the difficulties that some health service Boards or Committees have with asserting their control of the health service. In order for members of Boards to understand their legal roles, programs should be available to them. This could be facilitated through the CARHTU.

24. We propose that the Central Australian Rural Health Training Unit maintains close liaison with rehabilitation units, and other clinical services so that it can facilitate the attachment of specific training modules to particular situations where there is a clear deficit in the knowledge and skills of existing PHC staff, so that this can be addressed when it is needed, in the community where it is needed.

The CARHTU has brokerage funds where educational resources can be bought to address particular needs. The most effective use of these resources is to provide educational support to PHC when a particular problems presents. An example is a person with paraplegia (paralysis) returning to a community where the PHC staff has no experience in managing paraplegia. It is possible that the rehabilitation unit designs a, say 3-day course, and that staff from the specialist unit accompanies the patient back to the community where they deliver the 3-day course.

25. We propose that orientation programs for new staff be integrated so that they are available to all staff, regardless of employing agency. We further propose that orientation is divided into two aspects, one focused on Aboriginal cultural matters which could be achieved through ACAP, and the other an orientation to the Central Australian health care system that needs to be developed, but could be the responsibility of the CARHTU, with the assistance of CARPA.

Orientation requires the following foci:
1.  Orientation to Aboriginal communities and culture in Central Australia;
2.  Orientation to the local community where the new staff member will be working;
3.  Orientation to the health care system in Central Australia (various agencies who offer services, mechanisms of referral, PATS)
4.  Orientation to the local community health service including its client records, patient recall systems, and schedule of out-station visits.

The first could be delivered by ACAP. The second might require some assistance to the local community to develop. The orientation to the health care system could be facilitated through the CARHTU, but should involve CARPA. The final part of orientation should be the responsibility of the employer.

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1 Aboriginal Cultural Awareness Program.
ABORIGINAL HEALTH WORKERS

26. We propose that the Basic Skills road to Registration with the NT AHW Registration Board be revamped as a major alternative to accredited courses.

27. We propose that at least one AHW educator be employed for each Health Service Zone, but that the details of how these positions will work, and what access AHWs get to these educators be negotiated through the CA Indigenous Health Planning Forum.

This report has highlighted the failure of the health care system to adequately support the educational and professional needs of AHWs. It is important that AHWs get recognised qualifications that are recognised nationally, and that they have career paths that lead into areas other than AHWs practise in the community. However, educational values and standards have been dominant since the transfer of responsibility for AHW education from T H S to Batchelor College. The needs of primary health care services in the community have become less of a driving force. In many communities it was the senior people who communities chose (when given the opportunity) to be their health workers. They have the status in the eyes of the community to play important roles in their community. For many such people their literacy is inadequate to comfortably tackle the Certificate level course. Further, their broader community responsibilities make it difficult for them to leave their community for such studies. They need on-the-job educational support in order to be effective. The Basic Skills road to Registration was effective in assisting such AHWs to get their Registration. Some have suggested that they not be called AHWs, but called liaison workers, or cultural workers. This view tends to prize the academic attainment of gaining the Certificate, above the judgements of the community, and the skills and wisdom held by these senior people.

We propose that the Basic Skills road to registration be re-established, and that the role of Zone AHW Educators, and the program of CARTHU be organised to deliver these educational opportunities.

28. We propose that a dynamic program be developed aimed at identifying and supporting people in small communities/out-stations to become AHWs or medicine kit holders.

A strategic approach is required to ensure people’s access to primary health care. Such an approach needs to recognise the role AHWs have in the model of primary health care being implemented in Central Australia. Where communities/out-stations have no AHW, there needs to be a process developed to work with the community in identifying appropriate people who can either be medicine kit holders or become AHWs. The AHW Association may be able to play a role in this process.

29. We propose that the following areas in the designated Health Service Zones be the priority areas for Primary Health Care development in Central Australia:
   a. Northern Barkly
      • Nicholson River.
      • Barkly Tablelands.
   b. Southern Barkly
      • Canteen Creek.
      • W utunagurra (Epenarra).
   c. Eastern Arrente-Alyawarre
      • Eastern area, including Bonya and Ulrampe.
   d. K anyerri - W arlpiri
      • Tara (Neutral Junction).
   e. W arlpiri
      • Yuelamu (M t Allen).
   f. W estern Arrente
      • Out-stations of N taria (Hermannsburg).
   g. Anmatjere
   h. L uritja – P intupi
      • Ikuntji (H aasts Bluff) and its out-stations.
   i. P tjantjatjarra/ L uritja
      • Aputula (Finke) and the growing out-station population in the south.
      • Titjikala (M aryvale).
   j. Alice Springs
      • Amoonguna
      • Out-stations – Iwupataka (Jay Creek), Yambah and Northern Titjikala.

New resources available for PHC services to Aboriginal communities should be directed to these areas as a priority.

Central Australian Health Planning Study
Paradise River Ltd
July, 1997
BACKGROUND TO THE STUDY

The Central Australian Health Planning Study is the consequence of a number of decisions dating back to 1994. The Commonwealth Labour Government had been under some pressure from Aboriginal community controlled health services and their national peak body, the National Aboriginal Community Controlled Health Organisation (NACCHO) to transfer the funding of Aboriginal health services from the Aboriginal & Torres Strait Islander Commission (ATSIC) to the Commonwealth Department of Human Services and Health (now the Department of Health & Family Services). Senator Richardson was the Health Minister at the time, and had proposed that the transfer take place. However, he resigned just before the budget was to be brought down, and Dr Carmen Lawrence became the Health Minister. She also supported the change, but the Cabinet rejected her proposal, and the responsibility for health service funding remained with ATSIC. Lawrence, however, went ahead and established the Office of Aboriginal & Torres Strait Islander Health Services (OATSIHS) within her Department.

The '95 – '96 budget allocated an extra $25 million to ATSIC for Aboriginal Primary Health Care, and a special committee, the Joint Health Planning Committee (JHPC) was established to make decisions on how this extra funding would be spent. ATSIC, OATSIHS and NACCHO were represented on the Committee. A number of feasibility projects were submitted to the committee for funding. In Central Australia, these included renal feasibility projects at Mutitjulu and Papunya, a more general PHC proposal for Papunya, and the establishment of a primary health care facility at Uralmpe.

In 1995, the Federal Cabinet agreed to the transfer of health service funding from ATSIC to OATSIHS. The NT State Office of ATSIC decided to delay the implementation of the JHPC projects until that transfer had taken place so that OATSIHS could decide how best to proceed. OATSIHS negotiated with the stakeholders of these projects and it was decided to roll the resources of all the projects together so that an overall planning study of Central Australia could be conducted. A Steering Committee was established by OATSIHS consisting of representatives of the three ATSIC Regional Councils (Alice Springs, Papunya and Yapakurlangu), the communities involved with the JHPC studies (Papunya, Uralmpe, and Mutitjulu), representatives of the Anmatjere Community Council, Territory Health Services (THS), OATSIHS, and the Aboriginal Medical Services Alliance NT (AMSANT).

The Terms of Reference for the study were agreed upon, and tenders were called for in late 1996. Consultants were appointed in January 1997, and the final planning document was required by the end of June 1997.

Included in the original proposal was the intent to conduct health service development work in communities which had been identified as being a priority for improved access to primary health care services simultaneously with the overall regional planning process. The announcement of these new service initiatives was to follow the signing of the Framework Agreement by the Commonwealth Minister for Health, Michael Wooldridge and the NT Minister for Health, Denis Burke. This agreement still has not been signed, and, therefore, the new health service initiatives have not been announced. This has meant that we have been unable to pursue that part of the study.

Significant other projects have been conducted at the same time as this study. Our explicit instructions from OATSIHS and the Steering Committee have been to build on previous planning processes and information, and to avoid consulting with communities unless absolutely necessary. The most significant existing documents or processes informing our planning process have been:
1. Alice Springs, Papunya and Yapakurlangu ATSIC Regional plans;
2. Aboriginal Health Profile, Northern Territory Southern, OATSIHS.
3. The Territory Health Services Review, Wakerman et al, Menzies School of Health Research, Alice Springs.
The Commonwealth Government has taken some level of responsibility for Aboriginal health since the late 1960s. This involvement followed the results of the 1967 referendum, which gave the Commonwealth the constitutional right to legislate on behalf of Aborigines and to allow them to be counted in the census. Commonwealth involvement gathered momentum in the early 1970s with the establishment of Aboriginal Medical Services, first in Redfern, NSW, and then in many other parts of the country. The Central Australian Aboriginal Congress was established in Alice Springs in 1973. The establishment of these services was through community initiatives without government funding. However, they quickly put pressure on the Commonwealth Government for resources to operate. There have been a series of investigations or inquiries since that time. The first Commonwealth Government policy document was the Ten Year Plan, which was little more than a statement of intent to improve Aboriginal health status to the level of other Australians within 10 years.

Under the Fraser Government, more Aboriginal health services were established including Urapuntja Health Service at Utopia, Lyappa Congress at Papunya and the Pitjantjatjara Homelands Health Service at Kalka. In the early years of the Hawke Government the Pintupi Homelands Health Service at Kintore was established after the collapse of Lyappa Congress. All of these services were funded through the Department of Aboriginal Affairs (DAA). Some funding was also provided through the Community Program Grants of Medibank for health professional salaries in lieu of bulk billing Medibank for patient consultations. These funds were ‘cashed out’ in the early 1980s, and DAA became the single funding source for Aboriginal health services apart from special projects.

Most inquiries and investigations into Aboriginal health at that time had some characteristics in common. Firstly, they emphasised the importance of environmental health issues. Secondly, the issue of community control of health services was a source of conflict between the State/ Territory Governments and the Commonwealth. The stance of the State/ Territory Governments tended to be that the Aboriginal community did not have the expertise. Thus, there was a persistent fragmentary approach in attempts to address Aboriginal health.

The Commonwealth Ministers for Health and Aboriginal Affairs attempted to get a national strategic approach in 1986, and suggested a Task Force be established. This was rejected by the AAAC. However, community controlled health services continued to lobby for a national strategic approach. Finally, a joint Health and Aboriginal Affairs Ministers meeting in Perth in December 1987 agreed to establish a Working Party to develop a National Aboriginal Health Strategy (NAHS).

The consequent report was presented to the Ministers in 1989. The main elements of the NAHS were:

1. Aboriginal community control of PHC services as a guiding principle,
2. the establishment of a number of structures for overseeing the strategy, including:
   • A National Council of Aboriginal Health at the national level
   • A Tripartite Forum at the State/ Territory level.
3. An intersectoral approach to housing and infrastructure developments.
4. Improved educational opportunities for Aboriginal people.
5. Strengthening of the role of Aboriginal Health Workers.

The Commonwealth established a Development Group made up of health bureaucrats for the States, Territories and Commonwealth to look at the report in detail. Their Report was presented to the Ministers meeting in Brisbane in 1990, and it was this document that was endorsed. For the first time all Australian Governments had agreed on a policy framework and strategic approach to addressing Aboriginal health. The Development Group costed some aspects of the Strategy. They estimated that to fix up housing and community infrastructure in Aboriginal communities across Australia would cost $2.5 billion.

The Commonwealth Government allocated $232 million over 5 years from 1990 - 1995 to the implementation of the NAHS. The funds allocated for the implementation of the NAHS were administered through ATSIC. It was expected that State & Territory Governments would match this funding. Cabinet determined how these funds would be allocated and this is represented in Table 1.

Figure 4: NAHS Commonwealth Funding 1990-1995.

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4 Australian Aboriginal Affairs Council.
<table>
<thead>
<tr>
<th>Program</th>
<th>'90-'91 $M</th>
<th>'91-'92 $M</th>
<th>'92-'93 $M</th>
<th>'93-'94 $M</th>
<th>'94-'95 $M</th>
<th>Total $M</th>
<th>Estimated need $M</th>
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<tr>
<td>ATSIC Environmental Health</td>
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<td>18.38</td>
<td>33.57</td>
<td>58.96</td>
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<td>10.80</td>
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<td>0.38</td>
<td>0.4</td>
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<td>1.73</td>
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<td>DCS&amp;H National Campaign Against Drug Abuse</td>
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<td>1.47</td>
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<td>1.60</td>
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<td>0.12</td>
<td>0.12</td>
<td>0.56</td>
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<tr>
<td><strong>TOTAL</strong></td>
<td><strong>10.44</strong></td>
<td><strong>29.72</strong></td>
<td><strong>45.89</strong></td>
<td><strong>71.82</strong></td>
<td><strong>74.38</strong></td>
<td><strong>232.25</strong></td>
<td><strong>2,576.7</strong></td>
</tr>
</tbody>
</table>

Source: ATSIC.

It was expected that the State & Territory Governments would match this funding. Part of the NAHS recommendations was for the establishment of structures to oversee the implementation of the strategy. These included a National Council of Aboriginal Health, and Tripartite Forums in each State and Territory. These bodies were comprised of representatives of State/ Territory Government, Commonwealth Government and the Aboriginal community.

The Council met officially only twice, and a Review of the Council was conducted. The problems with the Council related predominantly as to their relationship with the Board of Commissioners of ATSIC. The Board and the Council could not agree on the parameters of their relationships and responsibilities and the Council was virtually abandoned.

It had been believed that the Tripartite Forums (TPF) would be involved in the prioritising of projects and distribution of these funds. The TPF was established as a vehicle through which different jurisdictions could collaborate on the project of improving Aboriginal health, as well as being a vehicle for inter sectoral collaboration. Problems with the operation of the TPF in the NT were:

1. Size of the TPF. There were more than 40 members of the TPF, mostly representatives from the Aboriginal community. This was too large a number to effectively make decisions. However, despite this, there was confusion among many community representatives, about who they actually represented. An executive was established which reduced the size of the TPF, but further confused the nature of the representation.

2. There was a clash at times between people from Central Australia and those from the Top End. Should the distribution of funds be on a per capita basis, or on the basis of need? The more populous Top End tended to support a per capita arrangement, and those from the centre, a needs basis.

3. Intersectoral collaboration also failed, and became more like intersectoral conflict. People from the health services wanted resources for that, whilst others argued for more resources for water and housing.

4. Some government departments put up proposals for infrastructure/capital programs that would have taken virtually all the dollars available.

Finally, the State Advisory Committee (SAC) of ATSIC made up of Commissioners and Regional Council Chairs, made the decisions about allocation of NAHS funds without any consideration of the views of the TPF.

The dissatisfaction with the implementation of the NAHS on the part of Aboriginal health services was not confined to the NT. The National Aboriginal Community Controlled Health Organisation (NACCHO) was formed in Perth in early 1993. One of the issues that NACCHO took up was the problems of the NAHS implementation, and called for the transfer of funding of Aboriginal health services from ATSIC to Commonwealth Health.

Aboriginal health services in the NT also took this up and lobbied Commonwealth Ministers, Opposition members and health bureaucrats. His campaign included calls for the establishment of a more effective health system around the needs of Aboriginal health.

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6 Department of Community Services and Health.
In 1994, Minister of Health Richardson toured Aboriginal Australia, and announced his support for the transfer of responsibilities. He suggested that the responsibility for funding Aboriginal health services be transferred to Commonwealth Health, and that ATSIC keep their current funds for health services to boost their resources to deal with housing and community infrastructure needs. He then resigned, and Dr Carmen Lawrence became minister. Cabinet rejected her submissions on this issue. However they did allocate an extra $25 million for Aboriginal Primary Health Care, and established the Joint Health Planning Committee (JHPC) to determine how these funds would be allocated. The funds were administered through ATSIC.

Pressure on the Government continued from Aboriginal health services, and from some public health bodies, including the Australian Medical Association. In 1995 the Government announced that funding responsibility for Aboriginal health services would be transferred from ATSIC to Commonwealth Health (OATSIHS). A Memorandum of Understanding was developed between ATSIC and the Department of Health.

OATSIHS has given some emphasis to collaborative regional planning of Aboriginal health services and this approach is reflected in the make-up of the Steering Committee of this study. The Framework Agreements on Aboriginal and Torres Strait Islander Health between the States/ Territories and the Commonwealth have now been signed by most jurisdictions. The key issues in the Agreements are:

- Improving access to health care;
- Increase level of resources to reflect increased need of Aboriginal and Torres Strait Islander peoples;
- Joint planning processes allowing Aboriginal and Torres Strait Islander participation in decision making, improved cooperation and coordination of service delivery, and increased clarity in respect of roles and responsibilities of stakeholders.

Issues of intersectoral collaboration and reporting and monitoring arrangements are also covered in the agreement.

The other significant policy direction of the new Commonwealth Government is the pursuit of Public Health Partnerships with the States and territories. This will ‘broad band’ monies for public health programs such as Breast Screening, cervical cancer screening, and HIV/AIDS which will give the States and Territories much greater flexibility in how such programs are delivered within their jurisdiction. It is difficult to know what effect, if any, this will have on Aboriginal health programs. Certainly the previous arrangements with these vertical programs was problematic for Aboriginal health. These programs were developed from the standpoint of perceived problems in the mainstream, and were designed to provide added focus and impetus to some areas that were not being well addressed through existing services. For Aboriginal communities who had inadequate services to begin with, the parameters that had been developed to drive these vertical programs were quite inappropriate. We understand that Minister Wooldridge has determined that Aboriginal and Torres Strait Islander HIV/AIDS program will not be included in the Public Health Partnerships, but will be managed by OATSIHS.
Northern Territory Policies

Self-government of the Northern Territory was decreed in 1978. Prior to this time the Commonwealth Department of Health was responsible for the delivery of health services in the NT. After self-government the newly created NT Department of Health took over this responsibility. In 1988 the Department of Health was combined with Community Services to become the Department of Health and Community Services. At this time there was a regionalised structure with a Central Australian Region. After a number of public disputes about health services in Central Australia, and some public pressure exerted by CARPA (Central Australian Rural Practitioners Association), and some community controlled health services, the NT Government appointed Prof Charles Kerr in 1991 to conduct a review of Central Australian health services. This review recommended that the community controlled health services be formally recognised by THS as part of the health care system, and that collaborative health service development be pursued. In early 1992 a review of the Department, known as the CRE SAP Review, was conducted. This review abolished the regional structure, and recommended the development of vertical program lines with responsibility based in Darwin. In 1995 the name of the Department was changed to Territory Health Services (THS) and the regional structures were again put in place.

Aboriginal health has always been a main concern for the Department, and it has significant primary health care service delivery responsibilities to Aboriginal communities, through Remote Area Services (previously known as Rural Health). In 1990, the NT Minister for Health, along with other State and Commonwealth Ministers, endorsed the NAHS as presented in the Development Group's Report.

THS developed an Aboriginal Health Policy that was endorsed by the NT Government in 1996. This policy endorses the NAHS, promotes community control of health services and recognises primary health care as a key vehicle for addressing Aboriginal health problems. It also recognises education and employment status as one of the social determinants of health status. Other key strategic areas identified are health promotion and prevention, cultural appropriateness of health services, environmental health, infant and maternal health, food and nutrition, mental health, substance abuse, health information and intersectional action.

THS policy has promoted community control of health services for some years. Two communities in Central Australia have been funded by THS through a Service Agreement with the community Councils. These communities are Santa Teresa and Aputula.

Other relevant policies include the NT Cattle Stations Health Policy. A number of people live on pastoral leases in remote areas of Central Australia, and they have legitimate concerns about their continued access to health care services in any changes directed at addressing Aboriginal health problems. This policy only recognises nurses and doctors as health service providers. It outlines the responsibilities of pastoralists in regard to maintenance of airstrips, procedures to be followed for evacuations, and guidelines in regard to pastoral medical kit holders. It also outlines responsibilities of the THS in providing health care. It is contradictory with the NAHS in advising that there should be no inquiry by health care providers as to the ethnic origin of patients.

THS have commissioned the Menzies School of Health Research to conduct a review of their Remote Services. The draft report has just been released. It proposes the establishment of 9 Health Service Areas based on language groups, community relations and service delivery logistic issues. It advocates that a driver and clerical assistant be provided for each Area, and that two Areas will share 1 educator and 1 allied health professional. Further, each Area will have its own manager and doctor. In principle all of these staff will be resident in the Area they serve. The Report advocates a staff: population ratio of:

- 1 AHW to 100 people;
- 1 nurse to 250 people;
- 1 doctor to 800 people.

They have also recommended a tripartite health agreement for each area that involves THS, OATSIHS and the local client community, but excludes the peak body of Aboriginal health services.

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9 'Aboriginal Health Policy' Territory Health Services, Darwin, 1996.
10 'Northern Territory Cattle Stations Policy.' Territory Health Services, undated.
PLANNING PROCESSES

Steering Committee
A steering committee which reflected OATSIHS's approach to collaborative regional planning was established to oversee this project from the development of the terms of reference, through the selection and appointment of the consultants, to the steering of the project to the Final Report. The Steering Committee consisted of:

1. William Tilmouth, Chair, Alice Springs ATSIC Regional Council.
2. Clarrie Robinya, Chair, Papunya ATSIC Regional Council.
3. Noel Hayes, Chair, Yapakurlangu ATSIC Regional Council.
4. John Liddle, Aboriginal Medical Services Alliance, NT (AMSANT). (Stephanie Bell filled this position in the early part of the project.)
5. Alison Anderson, Papunya Community.
8. David Scholz, Mutitjulu Health Service.
9. Ross Brandon, Director, Central Australian Region, Territory Health Services.
11. Michelle Adams, OATSIHS, Alice Springs Regional Office.

APPROACH

Our approach to this study involved examining the population distribution and mobility of Central Australia, and its access to health services.

In order to measure access to health services it was necessary to develop:

- a concept of core functions of primary health care.
- staff: population ratios for AHWs, Nurses and Doctors.
- a classification of out-stations to reflect their diversity and changeability.

This project was explicitly designed, in line with directions from the Steering Committee, to avoid repeating consultations with Aboriginal communities. A number of projects have involved community consultation over the years, and a strong message from many people is that they are sick of being asked the same silly questions. Thus we have relied on previous reports, various sources of previously collected information, and on utilising knowledgeable local people to provide us with up to date information in a way that (we hope) has not hassled people in communities.

The main message from all previous consultations has been that people want services. By that we have understood it to mean services that provide care to the sick and needy. The other need that we have recognised is for support to communities to deal with the issues that they identify as problems. We have tried to address these needs in this report.
**REGIONAL PROFILE**

**Definition of Regions**

There are a number of administrative regions in Central Australia. Those most relevant to this study are:

1. **ATSIC Regions**
   - Yapakurlangu
   - Papunya
   - Alice Springs

Figure 5: Map of Australia showing the ATSIC Regions of Yapakurlangu, Alice Springs and Papunya. These Three Regions Correspond with the Central Australian Region of Territory Health Services.

The three ATSIC Regions of Central Australia and the THS Central Australian Region correspond fairly closely with the northern boundary virtually the same. However, the boundary between the Barkly District and Alice Springs District have some small differences with the ATSIC boundary between the Yapakurlangu and Papunya ATSIC Regions. Thus Tara, Wilora, A nkweleyelengkwe and A lpurrurulam are in the Alice Springs THS District, whilst being in the Yapakurlangu ATSIC Region. Also, Antarrengeny and N gkwarterlanem are serviced by the U rapuntja H ealth Service (whose communities are predominantly in the Papunya ATSIC Region) whilst being in the Yapakurlangu ATSIC Region.

2. **Territory Health Service Regions**
   - Territory Health Service Central Australian Region
   - THS Districts
     • Alice Springs Urban

25.

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The Alice Springs Urban District of THS is confined to the Alice Springs Town Area, and bears no relationship with the Alice Springs ATSIC Region.

The Territory Health Service Review has proposed 9 Health Service Areas for the purposes of THS Remote Service's health service delivery. Thus they do not cover the whole Central Australian population.

3. Central Land Council Regional Office Areas include:
   - Region 1 - Alice Springs Area South
   - Region 2 - Southern Area
   - Region 3 - North Western
   - Region 4 - Tanami Area
   - Region 5 - Western Area
   - Region 6 - Tennant Creek Area
   - Region 7 - Eastern Area North
   - Region 8 - Eastern Area South
   - Region 9 - Alice Springs Area North

The Central Land Council (CLC) has developed these 9 regions in the Central Australian area as part of their decentralising administrative process. They are based largely on language and cultural relationships. However, discussions with CLC officers have indicated that the main intent of these regions is for CLC administrative purposes.

The northern border between the different jurisdiction of the CLC and NLC cuts the Yapakurlangu ATSIC Region in two, thus communities in the northern part of this ATSIC region are in the NLC area.

The anomalies involved in the various ways of dividing up the region are important when considering a range of health service and other issues that impact people's health issues such as housing and community infrastructure where there is a different jurisdiction involved.
Population of Central Australia

Population data has been gathered from the following sources:
2. Health Infrastructure Needs Survey (HINS) which was conducted by ATSI in 1992. This gives population figures for some out-stations.
3. Tjuntjuntjara Council, Amoonguna Community Council, Ingkerreke Resource Centre, and Jukurrpa Council have also provided population figures.
4. Information from the Institute of Aboriginal Development (IAD), Central Land Council (CLC), local informants, and the THS Review has been used to identify language groups as one of the main factors determining a health service delivery framework.
5. Tjuntjuntjara Council, Amoonguna Community Council, Ingkerreke Resource Centre, and Jukurrpa Council have also provided population figures.
6. Health Services have provided their estimates of populations.
7. Out-station population estimates have come largely from knowledgeable community informants.

The Draft THS Review has used population information based on the ABS 1991 census figures, but has made adjustments to take into account obvious errors, such as not counting children. The figures are presented as one population figure for each Health Service Area.

We consider there also needs to be some way of demonstrating that people are living in small groups dispersed across these areas. This has important health service delivery implications such as the need for communications technology and vehicles if people are to have access to health care. On the other hand, the mobility of people is important to appreciate. So whatever population figures are accurate today, will be inaccurate tomorrow. Thus figures should be seen as indicative only. The most important story to tell is one about the mobility, and changeability of demographics in Central Australia.

From an examination of these sources a ‘best estimate’ of populations has been determined from which levels of community access to health service resources are analysed, and priorities developed.

We emphasise the inaccurate nature of this data, and do not claim that our ‘best estimates’ are any more accurate (or inaccurate) than other sources.

A regional structure for health service delivery should take account of the following characteristics:

1. The mobility of the population throughout the Region. Such mobility relates to a range of issues. Movement away from missions and government settlements has been pronounced in the past 25 years. There has been a plethora of out-stations developed with small family groups moving away from some of the disruptions of life in the larger settlements. People often have multiple residences – a bush community, an out-station, a town camp or town house in Alice Springs.

Reasons for this mobility can include deaths (sorry business), other cultural and ceremonial business, social security, shopping, sporting events, visiting relatives in hospital or gaol, police business, and generally accessing services such as education and medical.

The movement of people occurs without regard for administrative jurisdictions, and indeed crosses State/Territory borders, as well as smaller administrative regions, and the recognised language group areas.

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12 NT Department of Lands, Planning and Environment ‘NT Aboriginal Communities.’ Darwin, November, 1996.
2. **The changing relationships between groups of people** within and beyond communities and language group areas (‘sorry business’ and disputes). It is common that places of residence are vacated after a death. The length of time people stay away is extremely variable depending on the importance of the person, the significance of place and other factors. This accounts for the vacancy of a number of out-stations throughout Central Australia. The history of particular ‘communities’ in Central Australia has been that different language groups and families were forced together. This has played a role in determining the nature of these communities. The relationships between different groups are not always harmonious. These relationships have been complicated by non-Aboriginal influences. Indeed settlements have been established predominantly as part of non-Aboriginal agendas. The issue of governance in these communities has also been influenced by non-Aboriginal agendas, including those of service providers. Periodically these tensions have resulted in significant disputes which have led to a significant rift with one group wanting nothing to do with another. These are not unusual events, and will affect service delivery issues.

3. **The unreliability of population estimates.** There is a tendency to under-estimate populations in the census with people hiding from census collectors for fear of eviction in overcrowded houses, and the constant difficulty of people living in make-shift camps away from more formal settlements. However, service provider information often involves double counting with mobile clients being included in the data base of more than one community. Organisations in communities have been known to fudge data to gain resource allocation advantage, whilst some adjustments can be made to allow for some of these problems (eg by standardising data for age-sex distribution) inaccuracies will remain.

Any population data, especially occupation levels of out-stations/communities will always contain inaccuracies. Populations are highly mobile and will continue to be. The consequence of this for health service planning is to attempt to get the decision making power as close to those communities as possible. Young has argued that the pre-occupation of planners with collecting accurate population data is misplaced, and advocates that a behavioural assessment of population mobility needs to be included in the planning process, rather than attempting to eradicate such mobility.

One way of accommodating this mobility is to provide a flexible structure where services are attached to the client population rather than just a place. There has been a history of service providers attempting to centralise service delivery and infrastructure development in an attempt to reduce this mobility. By this we are not just talking about Alice Springs or Tennant Creek as service centres, but just as importantly we are referring to the allocation and location of resources in the bush to designated ‘central’ communities rather than more imaginative and creative modes of service delivery which enable such services to be attached to people rather than place. Rigid frameworks will fail. Flexibility and responsiveness are the hallmarks of effective PHC service delivery.

**Out-station Categories**

In consultation with the steering committee, a categorisation of out-stations has been developed as part of painting a picture of the population dispersion of the region. This classification should be used cautiously because of its changing nature, and the complexity of issues influencing the occupation of out-stations. The purpose for using these categories is to communicate the sort of population distribution across these zones that can be expected. So whilst the patterns and realities of out-station occupancy is likely to be remain the same, the details of occupancy are likely to be highly changeable.

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The Categories are:

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>An out-station occupied permanently, apart from particular crises or outings.</td>
</tr>
<tr>
<td>2</td>
<td>An out-station generally occupied permanently, but currently unoccupied due to ‘sorry business’ or other cultural matter.</td>
</tr>
<tr>
<td>3</td>
<td>An out-station occupied more than half the time in a year.</td>
</tr>
<tr>
<td>4</td>
<td>An out-station occupied less than half the time in a year mainly because of lack of service (e.g. schools).</td>
</tr>
<tr>
<td>5</td>
<td>An out-station that is occupied only on weekends or holidays.</td>
</tr>
<tr>
<td>6</td>
<td>An out-station that is not occupied at all.</td>
</tr>
<tr>
<td>7</td>
<td>An out-station that is undeveloped, and unoccupied, but is the subject of serious developments that are likely to lead to occupancy in the near future.</td>
</tr>
</tbody>
</table>

Figure 6: Out-station Categories.

The limitations of this categorisation are that the status of out-stations tends to change fairly rapidly. ‘Sorry business’ is a common reason to vacate previously viable and vibrant out-station communities. The lack of resources is also a major reason for some out-stations to be occupied only intermittently. This may relate to school age children needing access to a school, sick people requiring more ready access to health care, or old people requiring access to support.

**Language Groups**

There are many language and cultural groups in Central Australia including:

1. **Arandic**
   - Eastern Arrernte (including Ngkerripere, Akityarre, A karre and N harre)
   - Central Arrernte (Mparntwarenye)
   - W estern Arrernte (Alulipere)
   - Southern Arrernte (including Pertame and A lenyerntarrpe)
   - Anmatyerre (Annmaterr)
   - Alyawarre (Alyawarr)
   - Kaytetye (Kaytej, Kaiditj)

2. **Western Desert**
   - Ngaanyatjarra
   - Ngaatjatjarra
   - Pitjantjatjara
   - Yankunytjatjara
   - L uritja (including M atutjara)
   - Papunya L uritja
   - Pintupi
   - Kukatja

3. **Ngarrkic**
   - Warlpiri
   - Warlmanpa

4. **Other**
   - Warumungu
   - Jingili

Many people have English only as a second, third or fourth language. Aboriginal culture and traditional education is based on oral rather than written means. Whilst illiteracy rates are high (and maybe getting higher), those people with literacy have mostly developed it through English rather than their first language.

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The distribution of language groups is not necessarily geographically determined. This is due to a number of factors including people's relationship to country, marriage, the location of missions and government settlements. People's relationship to country is complex and does not simply fit into mutually exclusive borders but includes significant cross-overs with other language groups.

It also should not be assumed that because people are from the same language group that they will have harmonious relationships and be prepared to share health service or other resources. Likewise, it should not be assumed that because people are of a different language group they will not have harmonious relationships and will not be prepared to share resources.

Nevertheless, in general, there tends to be affinity between people from the same language group, and in the context of health service delivery these language groups are important because they do indicate something about people's relationships, and people's movement. This provides some opportunity for improving continuity of care by organising health service resources more closely to meet those factors.

Figure 7: IAD Map Showing Current Distribution of Central Australian Languages

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16 We have used the term 'country' instead of 'land' in this report, as the term country is in very common usage amongst Aboriginal people in Central Australia, and has some connotations about relationship that is not quite expressed by the term 'land'.

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Profiles of Region

1. Yapakurlangu ATSIC Region

The Yapakurlangu ATSIC region covers an area of 301,110 square kilometres, an area traversed north to south by the Stuart Highway. The Barkly Highway provides the major lateral transport link across the region and beyond to Mt Isa in western Queensland. The only other major road in the region, the Tablelands Highway runs north of the Barkly Highway and provides a sealed link to the town of Borroloola in the adjoining Garrak-jarru ATSIC region administrated from Katherine. Geographically it is a region of stark contrasts encompassing open expanses of the Tanami Desert in the west, the pastoral wealth of the Barkly Tableland and its black soil plains in the north, the Rankin and Georgina river systems along the Queensland border in the east, large central semi-desert areas east of Tennant Creek and an extensive pastoral belt dominated by the Murchison and Davenport Ranges and lesser systems in the south and south-west. Historically the main industries of the region have been mining, cattle grazing and related service industries. More recently however service provision to a growing Aboriginal population and an increasing number of Aboriginal communities has broadened the economic base of the region in addition to increased emphasis on tourism.

In administrative terms the Yapakurlangu region encompasses a number of regional jurisdictional boundaries affecting the servicing of Aboriginal people at both the Commonwealth and Territory level particularly in areas of health and other essential service provision such as housing, power, water and roads. It also spans the statutory boundary between the Central and Northern Land Council established under the Aboriginal Land Rights (NT) Act 1976 distinguishing areas of responsibility for representation, land acquisition, land management and cultural heritage protection. Other representation of Aboriginal interests and service requirements is provided by the Yapakurlangu ATSIC regional council and staff, Julalikari Council and Julalikari-Buramana Out-station Resource Centre all based in Tennant Creek based in Tennant Creek. Significantly for the purpose of this appraisal a number of Aboriginal communities across the southern perimeter of the region fall within the Alice Springs Remote Services District of the Territory Health Service or are serviced by the Urapuntja Health Service operating from the Angarapa ALT (formerly Utopia Pastoral Lease) in the adjoining Papunya ATSIC region.

The Yapakurlangu region is sparsely populated, the Aboriginal population comprising 3,074 people or 43% of the total population of the region\(^\text{17}\). The dominant language groups of this region are W akirra (eastern) W arlpiri in the west, W arlmanpa, M udburra and J ingli in the north, K ayteye in the south, A iyawarr(e) in the south-east and east, W urumungu in the central area of T ennant Creek and W ambaya and W aanyi in the north-east. Other language groups in lesser numbers include the W akaya, Y anyuwa, K arrwa, K urdanyi and K angkalita\(^\text{18}\). The main population and service centre is the remote town of T ennant Creek, 500 km north of Alice Springs, where the town's Aboriginal population of approximately 930 people make up 27% of the population. With the exception of the minor township of Elliot, 250 km north of T ennant Creek, all other significant populations in the region occur in Aboriginal communities on land acquired or claimed through the provisions of the Aboriginal Land Rights (NT) Act 1976 (ALRA) or otherwise by negotiation with the NT Government and pastoralists. The largest of these is A lekarenge (Ali Curung) 170 km south of T ennant Creek, a former government welfare settlement known as W arrabri. Other long-established Aboriginal communities occur within pastoral leases where resident populations of Aboriginal employees and their families survived the consequences of the equal wages decision, enduring extremely poor living conditions until limited improvements in recent times. Such communities continue to maintain a presence on Rockhampton D owns, A lroy D owns and B runette D owns in the north, E penarra and L ake N ash in the east and M urray D owns, N eutral J unction and S tirling in the south. For a variety of reasons other residential pastoral communities still in existence in some cases as late as 1983 have since dispersed, these being associated with B ank a B ank a, A lexandra D owns, A von D owns and K urund i stations. Many of the people that left these stations were those that instigated the earliest out-station developments in the region these being the N gurrullui out-station venture arising from the K urundi walk-off of 1977 and the early development at Canteen Creek by the A von D owns group.

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\(^{17}\) Alpurrurlam, W ilora, A nkwelyelenkwe and T ara whilst in this ATSIC region are in the Alice Springs Remote Services District of THS and we have included it in the Papunya ATSIC Region section. Likewise, Ngkwarlerlanem and A ntarrenyeng are serviced by U rapuntja Health Service, and will be discussed under U rapuntja in the Papunya ATSIC Region section.


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These early out-station initiatives pre-empted the outcome of land claims and land grants and were instigated and sustained on meagre resources. Their drive came from both a desire to escape unacceptable conditions on pastoral leases and the signal inherent in the ALRA that governments, and therefore the wider population, were finally giving due recognition to their system of traditional Aborigional ownership to land. The reinforcement of this view by the momentum of research associated with the earliest land claims in the area brought other out-station developments in the early 1980s at K alumpurlpa on land under claim to the west of Banka Banka and at Jarra Jarra on the Kaytej-W arlpiri Land Claim west of the Hanson River. Antarrengenary, an out-station to the south of A lekarenge was established also at this time on the first area granted in the region as a result of a land claim under the ALRA (now known as the A lyawarra A boriginal L and T rust). It is also considered that traditionally-based interpretations may have been a significant impetus for the release of accumulated tension in settlements such as A lekarenge (W arrabri) between resident traditional owners and people of other language groups forced into co-existence by government policies beyond their control. W ithout any notion of the magnitude of the legal and bureaucratic obstacles that would be placed in their way there was some growing expectation that such people should also return to live on their traditional country. One outcome of this was the movement of a large number of W arlpiri people out of A lekarenge in the early 1980s and the progressive development of out-station initiatives westerly from T ennant Creek across the closely related traditional countries of the eastern T anami desert. Dedicated support from sympathetic individuals in government service departments and later A boriginal resource agencies such as the former J urnkurakurra A boriginal Resource Centre resulted in the drilling of a series of bores reflective of these traditional interests and the acquisition of community vehicles to support occupation. Unfortunately however this movement did not flourish as originally envisaged but for some consolidation in the establishment of two out-stations at K unayungku, 50 km west of T ennant Creek, and M angalawurru to its north. O f these two out-stations only M angalawurru remains occupied K unayungku having been abandoned since the coinciding events of the 1988 T ennant Creek earthquake (with its epicentre in the immediate vicinity) and the death of a senior woman of the community. Although a complex of circumstances require analysis in reviewing the 'waxing and waning' of such initiatives these moves were always challenged by their remoteness from the limited spheres of service provision at that time, particularly in the area of health given the age of their proponents. W hat was also lacking however was committed government recognition in both policy and financial terms of the acknowledged benefits to A boriginal health and welfare in supporting such moves. Significantly in the second half of the 1980s successful activism by better resourced town camp organisations such as T angentyere Council in A lice Springs and J ualkarri Council in T ennant Creek saw a large financial commitment being made by the Commonwealth Government through its T CHIP scheme to relieve overcrowding and poor living conditions in town camps. 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Although a complex of circumstances require analysis in reviewing the 'waxing and waning' of such initiatives these moves were always challenged by their remoteness from the limited spheres of service provision at that time, particularly in the area of health given the age of their proponents. W hat was also lacking however was committed government recognition in both policy and financial terms of the acknowledged benefits to A boriginal health and welfare in supporting such moves. Significantl...
• Scheduling of portion of stock routes and reserves (so-called ‘red areas’) under 1989 amendments to the Aboriginal Land Rights (NT) Act including three areas within the vast Alexandria group of pastoral leases;
• Purchase and claim of pastoral leases made possible with funding from the Aboriginal Benefit Trust Account (ABTA) eg. Mclaren Creek and Muckaty.

Affiliated processes of negotiation, albeit protracted in nature, involving Land Councils, the NT Government, local authorities and pastoral land-holders have succeeded also in resolving other longstanding land needs. Significant land swap agreements in relation to areas recommended for grant under the ALRA have achieved mutually beneficial outcomes in cases such as the Tennant Creek town boundaries settlement agreement in the Warumungu Land Claim and more recently the South Barkly Stock Route settlement on Rockhampton Downs. Secure tenure is also now held by long-established pastoral communities referred to above and additional living areas or ‘excisions’ are slowly being achieved, largely through consent agreements with pastoralists, under provisions of the NT Pastoral Land and Act for Aboriginal people with historical and traditional ties to land within other pastoral leases in the region. Notable among these are three living areas on Phillip Creek to the near north of Tennant and others on Elkedra and Neutral Junction in the south. With the ‘sunset clause’ preventing further claims being lodged under the ALRA after 4 June 1997 activity to satisfy outstanding land needs of the region is likely to now be largely confined to such direct negotiations with land-holders and the NT Government. These will continue to occur in the context of the excisions legislation and whatever framework that is established from current legal and political processes affecting recent claims lodged under the ALRA and the status of the Native Title Act. Unmet needs on pastoral leases such as Banka Banka and Brunchilly in the north and Stirling in the south remain significant priorities for the two land councils.

The implications of the out-station growth that has occurred in the wake of these land grants for the provision of an adequate health service are profound. What faced NT Government health officials in the early 1980s in terms of remote service delivery to Aboriginal people in the region were 10 resident communities on pastoral leases, major communities at Alekarenge and Elliott and as few as 6 out-stations in their formative stages of establishment. In the 1990s eight of these pastoral leases still have sizeable Aboriginal populations and there are now more than 35 out-stations actively in use or in various stages of infrastructure development across a much greater proportion of the region. There are also at least another 20 recorded out-station proposals subject to ongoing land negotiations with pastoralists. The capacity also exists for at least five other equipped out-stations, vacated for a variety of reasons, such as transport difficulties, and prolonged grief absences, to be progressively reoccupied. In some instances delays in providing infrastructure are being experienced due to ATSC’s 1996 moratorium on the provision of funding for new out-station developments. However, the combined efforts of Tennant Creek resource agencies such as CLC, ATSC, and Julalikari/Buramana, have yielded successes in accessing other funding which has maintained the momentum of out-station initiatives in the region which are receiving some form of development assistance eg ATSC forward estimates, submissions, or preliminary field work, and a further nine proposals subject to ongoing land negotiations with pastoralists. The capacity also exists for at least five other equipped out-stations, vacated for a variety of reasons, such as transport difficulties, and prolonged grief absences, to be progressively reoccupied. In some instances delays in providing infrastructure are being experienced due to ATSC’s 1996 moratorium on the provision of funding for new out-station developments. However, the combined efforts of Tennant Creek resource agencies such as CLC, ATSC, and Julalikari/Buramana, have yielded successes in accessing other funding which has maintained the momentum of out-station initiatives in the region eg. The IHANT’s housing and infrastructure program. Levels of occupation may also range widely throughout the year in any given out-station for a variety of mobility factors inherent in the Aboriginal population of the region. Nevertheless, the capabilities of existing services operated by THS and the Tennant Creek-based Anyinginyi Congress (limited to a 100 km radius from Tennant Creek), are conspicuously well below the levels required to match the not unreasonable expectations of Aboriginal people in these remote areas, regardless of population levels, to access an adequate and reliable level of health service provision.

In the 1990s the Barkly area is one of the most poorly resourced areas. The health service is largely by the Barkly Mobile and a part time Medical Officer, outside established clinics in Elliott, Tennant Creek, and Alekarenge. A few smaller communities have a small clinic staffed by part-time AHWs. Otherwise health service delivery relies on school facilities such as telephone and fax, as well as running clinics from the back of a vehicle or on the veranda of people’s houses. The Barkly Mobile leaves basic medical sundries at the places it visits. The Barkly Mobile consists of 2 nurses (1 male and 1 female), and positions for 2 AHWs, although one of those positions was unfilled at the time of this report. Visits to Tableland communities become impossible during the wet, so most visits occur between the months of March and October.

22 Ngurrutiji, Canteen Creek, Antarrengeny, Jarra Jarra, Kunayungku and Kumpurpura.
23 Indigenous Housing Authority, Northern Territory.
2. PAPUNYA ATSIC REGION

With the exception of the small ATSIC region centred on Alice Springs the Papunya region occupies the whole of the southern third of the Northern Territory sharing its boundary with the Queensland, South Australian and Western Australian borders. It is traversed from south to north by the Stuart Highway and served by a number of major arterial roads into neighbouring states such as the Tanami Highway to the north-west, the Ernest Giles Highway to Uluru (Ayers Rock) and beyond in the south-west and the Plenty and Sandover Highways to the east and north-east respectively. In its geographical contrasts it is comparable to the Yapa kurlangu ATSIC region to the north in its mix of a substantial pastoral domain and large areas of desert and semi-desert, typified by the so-called Western Desert of the former Lake Mackay and Petermann Reserves, the central and southern areas of the Tanami Desert in the north-west and the extensive dunes of the Simpson Desert in the south-east. Significant industries in the region are cattle grazing, tourism, mineral development and service industries to remote communities.

The linguistic diversity among Aboriginal people of the region is considerable. No fewer than 10 major Aboriginal languages of varying strengths are in common usage these being Pintubi, Luritja and Western Arrernte in the west, Warlpiri in the north-west, Anmatyerr in the north, Alyawarr in the north-east, Eastern Arrernte in the Alice Springs and eastern areas, and Pitjantjatjara, Southern Luritja and Yankunytjatjara across the south. The distribution of these languages, similarities between them and the traditional affiliations to country that they accompany contribute to the establishment of regional associations among Aboriginal people and their communities. Such associations, particularly those that cross regional administrative and state borders are essential considerations in any review or assessment of regionalised service provision, health or otherwise, to the communities of the region.

The major service centre for the region is Alice Springs the only other significant townships in the region being Ti-tree in the north, the tourism-based township of Yulara in the south-west, and the Aboriginal town of Aputula (formerly the railway town of Finke). All other significant population centres are comprised within Aboriginal communities on land granted under the provisions of the Aboriginal Land Rights (NT) Act 1976 or otherwise obtained through negotiation with pastoralists and the NT Government. Among these are former mission and welfare settlements such as Santa Teresa in the east, Yuendumu in the north-west, Hermannsburg, Haasts Bluff and Papunya, in the west, Yuendumu in the north-west, and Docker River in the south-west. Established largely out of an era of profound paternalism such communities have been the origin of some of the earliest and strongest reactions to the confinement that early administrations imposed on Aboriginal people. What once served as ration depots and ‘reservations’, now provide the base for support services to the ‘out-station’ or ‘homelands’ movement that they gave rise to, along with other minor remote centres, such as Kintore, which themselves developed from out-stations. Other large self-managing communities also now exist across the extensive pastoral areas of the region where previously dependent communities were maintained by pastoralists often in the harshest of living conditions up until very recent times in some cases, as a ready source of cheap labour. Enduring such conditions and succumbing to the requirements of the pastoral industry was for many a preferable option to settlement life and the only means of maintaining ceremonial life and the physical continuity of association with their traditional lands.

These communities now include Arts Range in the north-east, Tjilkala on M argyale station in the south, Laramba on Napperby in the north, and Ampilatwatja in the Ammaroo locality in the north-east. A large community has also developed in more recent times at M uttiulju within the Uluru (Ayers Rock) - Kata tjuta National Park in the south.

The provisions of the Aboriginal Land Rights (NT) Act 1976 and the representation given generally to Aboriginal interests by the Central L and Council in negotiations with the NT Government and pastoral land-holders has established a land base for Aboriginal people comprised in the following forms:

Large areas of former Aboriginal Reserves in the western desert scheduled as Aboriginal freehold at the commencement of the ALRA in 1976 such as Yuendumu, Lake Mackay and Petermann Reserves;
Large areas of former Crown land consisting predominantly of the Lake Macleay claim and claims to areas of the Tanami and Simpson Deserts, granted as Aboriginal freehold as a result of successful land claims;
16 small portions of stock routes and stock reserves (so-called ‘red areas’) across pastoral areas of the region, granted as Aboriginal freehold under the Aboriginal Land Rights (NT) Amendment Act 1989 including 4 in the Aputula locality, 6 in the H enbury-O range Creek-M argyale locality to the south of Alice Springs and a further 6 in the east and north-east of the region;
Twelve (12) pastoral leases purchased on behalf of traditional owners since 1973 made possible with funding from the Aboriginal Land Fund Commission (ALFC) and later agencies such as ADC, ABTA and ATSIC, 8 of which have subsequently been converted to Aboriginal freehold as a result of successful land claims;

24 Aboriginal Development Commission
25 Aboriginal Benefit Trust Account
Living areas or excisions of pastoral leases held as NT freehold title granted to long standing resident communities and others that have since been successful in negotiations held under the onerous community living area provisions of the

In addition to the economic benefits of some of the more productive pastoral leases purchased others have provided the basis for many Aboriginal people to achieve the enormous social and cultural benefits of being fully reinstated to their traditional lands, particularly where appropriate health service support has been readily accessible. The notable example among these is the former Utopia Pastoral Lease now the Angarapa ALT which supports more than a dozen out-stations and provides the base for the successful Urapuntja Health Service. The operation of this service has also provided reliable health support to support out-station development on affiliated smaller areas of Aboriginal land in the Sandover region of the north-east. Other pastoral lease purchases include Ti-tree, Yuelamu (Mt Allen) and W illowra in the north, Atula and Loves Creek in the east and Tempe Downs in the south-west.

While large areas of Aboriginal land in the western desert and the Utopia example are typically considered to be the domain of the out-station movement similar regional associations of small family-based communities are continuing to develop in pastoral areas of the region. Such innovative decentralised planning initiatives developed among Aboriginal people in these areas were recorded in the early 1980s, such as at Yambah, Atityere and in the Kings Canyon area. Only those groups however who were prepared to take matters into their own hands and reoccupy their country without the formal considerations of land title succeeded at this time, notable cases being the Little Well (Aluralkwe) group on Loves Creek in the south-east and the Ukaka group on Middleton Ponds in the south-west. Heated political debate involving the Land Councils, the NT and Commonwealth Governments, and the NT Cattlemen's Association stifled any serious response to the obvious social and cultural merits of such proposals but to improve services to where people were presently living, and not where they wanted to live. Although such improvements were desperately needed in many of these places at the time, including H arts Range and Bonya, there were clear signals being given that many people felt the desperate need to physically resurrect the traditional affiliations to country that had for so long been dominated by the pastoral industry before it was too late to do so. It has not been, however, until the mid-1990s, and too late for some, that such initiatives have gained sufficient momentum in reality to warrant serious attention now being given to a serious and appropriate response being made in the provision of such basic services as health. This has largely been due to the considerable persistence of the Aboriginal people concerned and the statutory Land Councils which contributed largely to the issue being addressed finally in the form of the Memorandum of Agreement between the Commonwealth and the Northern Territory Government of the Granting of Community Living Areas in Northern Territory Pastoral Districts. Many such land needs are still to be resolved. However the granted portions of stock route and reserves (so-called 'red areas') and subsequently negotiated community living areas or excisions obtained under legislation arising from that Memorandum now exist in such numbers and proximity for service delivery to the people concerned to be justifiably considered on the basis of the regional cultural associations that bind them. Developments of this nature exist in all areas of the pastoral district including Yambah, Ti-tree, Bonya, H arts Range, A putula and Maryvale.
3. **Alice Springs ATSIC Region**

The 1993 Alice Springs ATSIC Regional Plan describes the region as follows:

“The Alice Springs ATSIC Region has an irregular cross-shape, and at its widest parts, it measures 172 kilometres from east to west, and 135 kilometres from north to south. The central geographic features are the MacDonnell Ranges, the upper Todd and Hugh River basins, the Simpsons Gap National Park and the town of Alice Springs. The boundary follows around that of the number of pastoral leases which are contained within the region, viz Owen Springs, Hamilton Downs, Yambah, Bond Springs and Undoolya.

“Towards the east, the region encompasses W illiams Creek and Corroboree Rock, but falls just short of the Ross River and N’dhala Gorge Nature Park. To the west, the region takes in Serpentine Gorge, Ellery Big H ole, Hamilton Downs Homestead and the Sixteen Mile Creek floodout (but not Fish H ole nor Glen H elen). In the south the region includes O range Creek and the W atahouse Range, the boundary stopping along Log H ole Creek and near its intersection with the H ugh River. The region extends across the Burt Plain in the north to incorporate the intersection of the Plenty and Stuart H ighways as well as Burt Creek and Yambah Homestead.

“T he land contained within the region is all A rrernte land, and predominantly that of the Central A rrernte. It contains many hundreds of A boriginal sacred sites.

“As A lice Springs is the regional centre for all of C entral A ustralia, the A boriginal residents of this town incorporate representatives from many tribal and language groups in addition to the Central A rrernte, including W arlpiri, W urmunu, K aytej, A lyawarrre, A mmayerr, P ertame, E astern A rrernte, W estern A rrernte, L uri tja, P intupi, Pi jantjatjara, Y ankunytjatjara, and N gaanyatjara. M ost of these people reside on the 19 T own C amps and in urban housing in the Alice Springs suburbs. A small proportion are River C ampers in the T ood R iver. T here is one other discrete A boriginal Community in close proximity to Alice Springs, that of A moonguna (eight kilometres to the south-east of the A lice Springs P.O.).

“M any of the A rrernte people from this A TSIC region have established out-stations, 28 at the time of writing, mostly to the north and west of A lice Springs. T heir development has been and continues to be slow due to the problems of obtaining appropriate land tenure and adequate water supplies. N evertheless the out-station movement is firmly established and with continued support it is expected that their populations will slowly increase in the future. T he out-stations thus form an important part of the Plan.

“A lice Springs contains over 70 A boriginal organizations, agencies or incorporated associations. A number of these service the Alice Springs ATSIC Region exclusively, whilst some service the other ATSIC Regions in C entral A ustralia, and even interstate. Some organizations provide services to both Alice Springs and other ATSIC Regions, especially Papunya, I mpiyara and A rltarlpilta. F or this reason, multi-regional services and associated funding sources is an important issue and forms one aspect of the Plan.

“A ccording to the 1991 Census, the A boriginal population of the region is approximately 3,950, an increase of 500 on the 1986 Census. A 1992 Census indicated that this regional population could be broken down into 1,100 T own C amps, 270 A moonguna residents, and 280 O ut-station residents, thus leaving approximately 2,200 U rban residents and 100 River campers. H owever much of the A boriginal population is residentially dynamic, there being high rates of visitation and temporary residence by people from throughout C entral A ustralia. H ence the precise figures are constantly changing, albeit within predictable limits.

A part from A boriginal people, there are over 20,000 other residents of A lice Springs. O f these, about 1,500 are A merican personnel connected to the Pine Gap facility. T he relations of the A boriginal people of the Region with the non-A boriginal people, forms one aspect of the Regional Plan.”

Some developments have occurred since this planning process was completed. Changes to the Regional Council boundaries took place in 1993, with the 3 ATSIC Regional Council areas in southern Central Australia being amalgamated into the one region, now known as the Papunya ATSIC Region.

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There is continuing mobility between Alice Springs and communities throughout the whole of Central Australia. More families have been granted title to parcels of their country, and have moved out of the Alice Springs town area as well as out of the Alice Springs ATSIC area (eg. out-stations north and west of Alice – Yambah & Iwupataka, north of Titjikala, Tempe Downs and Aputula). They maintain continuing family and service links (eg. Irrwanyere Aboriginal Corporation\textsuperscript{27}, Ngurratjuta Out-station Resource Centre, Ingkerreke and Congress) with Alice Springs. Frequently, population numbers swell from family visiting from Alice Springs.

The out-station developments around Alice Springs are vibrant and strong. We estimate that the population of out-stations in this area is around 750 people living in small groups of 30 people or less.

\textsuperscript{27} Irrwanyere Aboriginal Corporation holds a 99 year lease from the SA Government for the area of W tjira National Park. Its administrative base is Alice Springs and the majority of its members are Aputula based although others come from Oodnadatta and Port Augusta. Its residential interests span the SA/NT border and there are several proposed out-stations in the area.
CURRENT SERVICE PROVISION

A. Primary Health Care

Primary health care to the Aboriginal communities in Central Australia is delivered by THS, through THS Service Agreements with Community Councils, and through OATSIHS funded community controlled health services.

Figure 8: Percentage of Aboriginal population of Central Australia who receives PHC Services through various models of service delivery.

<table>
<thead>
<tr>
<th>THS</th>
<th>OATSIHS</th>
<th>Service Agreement</th>
<th>No Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population 5,925 (35%)</td>
<td>7,525 (45%)</td>
<td>860 (5%)</td>
<td>2,575 (15%)</td>
</tr>
</tbody>
</table>

This figure shows the populations serviced by the various types of PHC service delivery. This was calculated by adding the populations of the Aboriginal communities that had a service of one of the three types. It did not take into account the large number of people from remote communities who use other services, especially the town based services of Congress in Alice and Anyinginyi in Tennant Creek. It also does not take into account the greater choice that town-based people have (eg accessing hospital or private GP services). It assumes that everyone in a community has access to the health service in that community which is almost certainly not the case.

The 2,575 people, who were designated as having no service, are people living on out-stations that get no visiting service at all, and for whom no arrangements are made to assist them to access services. Some of these people have private transport through which they can access services; others do not. Some have phones or radios; others do not. And some are close to larger centres that have a health service, but others are not.

It should also be pointed out that some of those who have been counted as receiving a service of one of the three types do not receive an adequate service.

1. THS Delivered PHC Services.

The following communities have services with resident nursing staff and (in most) AHWs:

- Elliott;
- Alekarene (Ali Curung);
- Artetyerre (Harts Range);
- Atpurrurulam (Lake Nash);
- Ti T ree;
- W llowra;
- Nyrrippi;
- Laramba (Napperby);
- Yuendumu;
- Ntaria (Ermannsburg);
- Mt Liebig
- Papunya;
- W abarra (Kings Canyon);
- Kaltukatjara (Docker River);

Ikuntji (H aasts Bluff), Yuelamu (Mt Allen), Tjilikala (M aryvale), Barkly T ablelands, W utunagurra (Epenarra), Canteen Creek, T ara (Neutral Junction), Areyinga, P mara J utunta, W llora (Stirling Station), Engawa la (Alcoota), the W abarra (K ings Canyon) area and W allace Rockhole have visiting nurses. M any also have resident AHWs, sometimes part time or trainees. None of the PHC services delivered through THS have resident doctors, but receive medical officer visits at varying intervals.
The dominant services are clinic-based and involve treatment of sick people and the delivery of public health programs with a clinical dimension, such as immunisation, growth monitoring of children, antenatal care, communicable disease control, and some screening programs. The effectiveness of these programs varies from time to time, and from place to place. This is dependent on the experience and skill of local staff, and the strategic support that they receive regionally. There are a few situations where AHWs play a broader community care or an environmental health worker role.

Few doctors provide health care visits to out-stations.

Doctors are employed centrally, and spend significant amounts of time in the central location and travelling. Further, in the early 1990s the revamped Award for District Medical Officers (DMOs) wrote Public Health skills into their job description, and gave financial reward to those doctors who undertook training in the Faculty of Public Health Medicine. However, the primary reason doctors are needed, and indeed wanted, in communities is for their clinical skills. Any public health input can only be applied when this need has been met. The central location of doctors, and the emphasis on public health medicine, limits the clinical role of DMOs.

Nurses and AHWs have been relied upon to provide the 24 hour clinical care in Aboriginal communities. Unfortunately nurses have not been adequately trained for this role, although many have done it well. Doctors’ organisations nationally have put up resistance to better training for nurse practitioners to gain diagnostic and therapeutic skills. AHWs have not had that resistance, but resources available to them for appropriate education and training has been far from satisfactory, and the crisis in AHWs is underlined by the large number of qualified AHWs living in Aboriginal communities, but not working.

**Management:**

These services are managed from Alice Springs or Tennant Creek and there is no local administrative staff. Nursing staff perform administrative and clerical tasks ranging from clinical notes, organising appointments and evacuations, ordering of supplies, and providing various performance data to management.

**Regional Services:**

THS also provides certain specialist visiting services, dental, allied health services, and mental health services. Some of these services are available to communities other than those whose PHC is provided by THS.

The Population Health Unit was established in 1994-1995 with a stated role of supporting primary health care providers to plan, implement and evaluate population health (illness prevention) projects. They have organised their resources into the following program areas:

- Environmental health;
- Health promotion;
- Health information;
- Public health nutrition;
- Sexual health (which includes the Tristate Project)
- Communicable Diseases Control.

Whilst this unit has developed business plans, and certain strategic approaches on paper, including the development of community profiles, their influence in remote communities was not really apparent. Whilst they promote collaborative work, their appears to be little evidence of that. Indeed the development of community profiles explicitly states that they are being prepared “… initially only for THS staffed remote Aboriginal communities.” Likewise, health promotion workshops are only offered to THS staff. Thus a new unit, with an opportunity to transcend past divisive practices, has continued to perpetuate them. In fairness to the Unit, they are aware of the problems of the environment in which they work – an environment riddled with conflicts, misinformation, and reaction. There is no regional collaborative structure that provides direction or support. Thus individuals, regardless of their approach, must try and create collaborative processes that should be integral to the health care system.

One of the most critical roles of this unit is the Communicable Disease Control function. This is the one area where medical knowledge of the disease process, and appropriate interventions at population level, utilising vaccines, and therapeutic agents, can (and has) save lives. It is not clear from the information we have received that the Population Health Unit is adequately geared to ensure that any communicable disease epidemic will be contained. However, a public health physician is to be appointed shortly, and, hopefully, this will help fill the gap.

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39.
Important regional support roles of T H S have tended to be provided only to those PHC services delivered by T H S. They include assistance with recruitment, in-service training, orientation programs, and other services. Small PHC services not administered by T H S do not have access to these regional services.

Ancillary and specialist services to remote communities are more widely available. Historically, those allied health professionals employed by T H S Remote Services largely focused their service delivery to communities that had their PHC delivered by T H S. This has changed over recent years. However, the organisation of these services has been confusing. Over the past year or so, a physician has been employed by Remote Services, and his work has been divided between the hospital and visits to Aboriginal communities. This has tended to work better than where the specialist has been employed by the hospital. In the latter cases the priorities of the hospital tended to dictate how often the specialist made visits to communities. The location of the physician in Remote Services has protected the community visits role from hospital demands. However, we believe that how specialists work, or more importantly where they work, has been left too much to them. Other visiting specialists includes:
- Paediatrician whose work is predominantly with the Child Health Unit in Alice Springs.
- Eye health registrar;
- Psychiatric registrar;
- Public health medical officer.

Generally, they do not have a set schedule of visits, but visit as requested by the DMOs. Recently, the Psychiatric registrar and Eye Registrar have had a set schedule of visits which has improved services at the community level in these areas.

The importance of the provision of medical services in remote communities is best illustrated by the increased number of admissions to Alice Springs Hospital of people from remote communities for routine investigations rather than for emergencies.

Allied health professionals employed by Remote Services and based in Alice Springs provide services to communities, and it is estimated that they spend 2/3rds of their time visiting remote communities. This translates into 1 visit per year to many communities.

Some allied health professionals are employed through the Community Health Centre in Alice Springs. This has also proved unsatisfactory. We were informed that information would be made available to Aboriginal communities, if requested. Of course, few Aboriginal people in bush communities would know that such information might be available, and would not necessarily know how to make such a request. It is possible that what people want is treatment, rather than just information. Thus both allied health and specialist visits to bush communities tend to be ad hoc.

From responses from health services, it appears that Dental and Renal Unit provided the most consistent visiting services to remote communities. Remote Services Physiotherapy and Occupational Therapy visits tended to be on an annual basis. Mental Health Services have increased their staff, but it appears that their visits to bush communities are varied. There have been attempts to better train primary health care staff (doctors, nurses and AHWs) in the management of mental health problems, but the outcomes of these initiatives are not known.

In-service education is provided to nursing staff, and relief staff are available. In-service education for AHWs has not been available for some time. There is no orientation for AHWs, although a program is currently being developed.

The T H S services have some advantages over other delivery methods and include:
- A certain degree of flexibility in deployment of staff so that if problems arise in one area of the service, assistance can be provided from another area.
- The ability to organise regional support for community-based service delivery that enables health care staff to concentrate on health care.

However, improvements could be made in some areas, including:
- Slow responses to community needs. This is partly a product of the central location of decision makers;
- Large amounts of time spent in travelling for all staff, but especially important for expensive staff like doctors. This would be improved by locating staff in communities where ever possible;
- AHWs and nurses providing the bulk of clinical care, when not trained or supported adequately for this role;
- Doctors providing inadequate clinical care due to central location and travel. Greater clarity about what is meant by public health medicine would also assist.
- The coverage of the Regional support role of T H S.

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29 Personal Communication, Helen Byrnes, Discharge Planner, Alice Springs Hospital.
30 This estimate is based on information from PHC services.
Some of these problems can be improved by allowing greater autonomy of practitioners in communities, whilst strengthening regional support to those practitioners.

2. **THS Funded Health Services through Service Agreements with Community Councils.**

In Central Australia these are located at:

- Santa Teresa; and
- Aputula.

These services are funded through a Service Agreement between THS and the Community Council. The Agreement is for the delivery of clinic based primary health care services in the community. This model was developed as a way of THS fostering community control of health services.

Staff employed in these services are nursing staff and AHWs. However, at Aputula the AHW is paid through the Community Development Employment Program (CDEP). Medical officer visits are through THS employed DMOs. Funds are also provided for pharmaceuticals, and other supplies. There are no resources provided for management and administration, for relief staff to enable permanent staff access to in-service training, or for preventive programs.

Services provided are limited to clinic based services including the treatment of sick people, and clinic based public health programs such as immunisations, child growth monitoring, and various screening programs. Neither service provides out-station visits.

Nurses at Santa Teresa have a tele-conference weekly with Remote Service nursing staff. Santa Teresa also receives generous support from visiting staff. This is partly due to the initiative of the Santa Teresa staff in seeking support, and is almost certainly helped by their proximity to Alice Springs. Aputula, on the other hand, is more poorly resourced and supported.

'Service Agreement' (previously known as Grant In Aid) health services has been the subject of strong debate as to whether they offer any real possibility of community control, or whether responsibility has been handed to Community Councils without adequate resources. In other words, they are a way of providing PHC services on the cheap. Difficulties relate to the lack of opportunities for in-service training, and when THS provides a community with a locum nurse which enables the nurse to access in-service training, an enormous administration fee of up to 54% has been charged. Likewise, pharmaceuticals are provided but with a 25% handling fee. No resources have been provided in these agreements for health service management that is where the means of control can occur. So they have suffered isolation from regional support and inadequate resources.

Potentially, this service agreement model could be reformed to ensure adequate resources, and the advantages that come with being 'independent'.

3. **OATSIHS Funded Community Controlled Health Services.**

These are:

- Central Australian Aboriginal Congress, Alice Springs;
- Ninyinyi Congress, Tennant Creek;
- Pintupi Homelands Health Service, Kintore;
- Mutitjulu Health Services, Mutitjulu (Uluru);
- Imanpa Health Service, Imanpa;
- Urapuntja Health Service, Utopia;
- Ampilatwatja Health Centre, Ampilatwatja.

The Congress Alukura provides specialised women’s health services with an emphasis on birthing. Mutitjulu and Imanpa service smaller communities and are staffed with nurses and AHWs. Mutitjulu has a nurse-administrator position, 1 nurse, 3 AHWs, and receive medical officer visits through Congress. Imanpa has no resources for administration, has 1 nurse employed, 3 AHWs, and receives medical visits through THS.
All other OATSIHS funded services have medical officers employed and resident in the community where the service is offered. All have nursing staff employed, although nurses employed at Congress and Anyinginyi mostly have roles other than clinical. Such roles include public health, health education, AHW education, and clinical support. They also have administrators, or managers employed, as well as some resources for cleaners, drivers, and other maintenance staff.

In the smaller remote services of Imanpa and Mutitjulu, services provided tend to be confined to clinical services – treating sick people and medical public health programs. In the larger remote services such as Urapuntja and Pintupi Homelands Services, there have been programs developed with the health committees from time to time, as well as community development programs around issues such as environmental health, and nutrition. An example of this was the health survey that was conducted by Urapuntja Health Service in the late 1980s, and the attempts by the Pintupi Homelands Health Service to establish a Western Desert Health Committee in the early 1990s. Ampilatwatja is a relatively new health service, and the only health service without AHWs, although 4 local people are enrolled for the next Batchelor College intake.

The main services provided are general type services, with some focus on public health issues in the community. Mostly these relate to communicable disease control, and child health. Congress and Anyinginyi run dental clinics, and community development/education programs.

These services do provide some services to out-stations. Urapuntja Health Service, which has no central community, whilst maintaining clinic-based services, visits out-stations on a weekly basis. Communications with the health service are also available on a 24-hour basis. Pintupi Homelands Health Service maintains communication with out-stations associated with Kintore, and provides visits as needed. Ampilatwatja provides twice weekly visits to the two out-stations related to that service. Anyinginyi Congress provides a service to both the Tennant Creek Town Camps and to out-stations within a hundred Km radius of Tennant. Congress provides a visiting service to out-stations at Yambah on a weekly basis. Congress is also attempting to meet the needs of people living on out-stations north of Tjitjikala and at Iwupataka (Jay Creek). They also run a community health program that has attempted to provide a service to Alice town camps, Amoonguna, and Yipirinya School. This has not always been a satisfactory service.

The OATSIHS funded health services have had a ‘mentor’ system where an Aboriginal administrator trainee was employed with an administrator with the intent that eventually the Aboriginal trainee would take over as Manager. Whilst this was successful at Congress, it has not been effective elsewhere. Indeed, the only community controlled health service in Central Australia with an Aboriginal manager or director is the Central Australian Aboriginal Congress.

Congress and Anyinginyi also deliver AHW education programs. Congress has provided this service only to its employed trainee AHWs. Anyinginyi has accepted people not employed by them into their course. These programs have had some success in that a number of AHWs over the years have been successfully registered with the NT AHW Registration Board. These two services have also had significant resources directed to non-health service programs such as childcare, banking agency, and welfare programs. Their administration is not simply involved in health service matters.

The remote health services receive some visits from some of the THS allied health professionals, specialists and from THS dental services. Congress Alukura provides regular women’s health visits to these communities. This has been the subject of dispute with THS women’s health programs from time to time.

Doctors in OATSIHS funded health services have been employed primarily as clinicians, although there has always been an expectation that medically driven public health programs would also be delivered. So, generally, these services have been better resourced than services delivered by THS or through Service Agreement arrangements. However, community controlled health services have also had problems. There are certain activities that are extremely difficult to organise in small stand alone health services in remote communities. Historically, DAA discouraged these services from having anything to do with the larger services in Alice Springs (ie Central Australian Aboriginal Congress). The reasons for this are complex, but relate to the larger organisations being seen by DAA bureaucrats as being too ‘political’. Over time this reduced the capacity Congress had to provide a regional support role, and THS had no interest in picking it up. Unfortunately, DAA had little experience in the health industry to know how to recruit medical officers or how primary health care services function.
Another issue has been the change in structure of Congress in the early 1980s. Before this time Congress had a Council which was made up of representatives of all communities in Central Australia. This arrangement ceased functioning for two main reasons. Firstly, the people most committed to health services to Aboriginal people often found that they were successful and became more involved in running their own health service, or other community organisation related to housing, community councils, the out-station movement or other developments. Secondly, the cost of maintaining the Council became prohibitive. These developments coupled with continued hostility from THS and claims that Congress only represented the town have increasingly marginalised Congress’ role. This has left the remote services relatively isolated and unsupported. In more recent years, the hostility has lessened. A collaborative approach would help overcome the problems that remote health services have experienced.

The OATSIHS funded services are the ones that have claimed to be the Aboriginal community controlled health services. Scrimgeour has pointed out the difficulty of people in these communities really taking control. Issues of health service management, financial management, health program development, implementation of public health programs, managing professional staff, etc etc are difficult and sophisticated matters that are performed within the mainstream by highly qualified professionals. In many bush communities literacy levels are poor, and people’s experience of a health service extremely limited. It is thus not surprising that attempts to get a local Aboriginal manager trained have not worked. All bush community controlled health services continue to be managed by non-Aboriginal administrators. There is also little doubt that largely either the doctor or nurse determines the dimensions of health service delivery. Scrimgeour argues that community control should not be a pre-requisite for clinical service delivery, and cites the problems of active and daily community control in bush services. However, in these services there has always been a degree of control by the community especially when difficult decisions have to be made, for example dismissing an inappropriately appointed medical officer. There have been times of instability in OATSIHS funded health services, but probably no more than in communities serviced by THS. Further, the definitions of community control have often been too rigid. A more flexible approach would facilitate people in communities taking control of the aspects of their service they wish to control, rather than an assumption that they must take control of the whole service or nothing. It is also clear that, even when full control is taken, health services remain reliant on support from other sections of the health sector.

There has been a viewpoint held that the remote community controlled health services have difficulty in being sustainable, and that they lurch from crisis to crisis. The Draft THS Review claimed that:

‘In remote communities which do have community controlled services, some services successfully answer their clients’ needs. Others teeter on the edge of viability: cope with inadequate budgets with no economies of scale, vacant, difficult to fill positions with little support from larger health services and lack of solid administrative skills.’

This is quite contrary to the findings of our work, which particularly concentrated on getting information from non-THS services that were not covered by the Draft THS Review. There is one service, Imanpa, funded by OATSIHS where we were told that the service was in disarray and currently without a nurse. This service received its medical support from THS, a decision made by that community some years ago. The description above may fit that community. However, it is the only OATSIHS funded community controlled health service to which this claim might apply. While criticism can be made of other services, they are hardly teetering on the brink of viability. Mutitjulu has had significant stability in staffing for a number of years. Urapuntja, Ampilatwatja, and Pintupi Homelands Health Service have all been adequately staffed over the past few years and with doctors resident in the community. All have reasonable budgets, and are better resourced than other services.

The advantages of community controlled health services are:

- Access to decision making by community members, at least when they perceive it necessary;
- Responsiveness of health service staff to local issues;
- Not constrained by bureaucratic requirements in decision making.

The structure of these health services allows professional staff the freedom to develop PHC programs appropriate to the community realities without needing to justify their actions to centrally located bureaucracies. There is also scope for spontaneity such as the initiative taken by the Pintupi Homelands Health Service in organising a Western Desert Health Council involving a number of other communities in the region. Centrally controlled services, on the other hand, are often constrained by the clerical demands of the bureaucracy and cumbersome and often inflexible hierarchical decision making processes.


The THS funded services at Aputula and Santa Teresa might be the services, which the Draft THS Review is referring to in the quotation above. Our findings suggest that this is unlikely to be the case for Santa Teresa, but may be more applicable to Aputula where there was concern about inadequate vehicles, and high work loads. We would not have described either of these services, however, as ‘teetering on the brink of viability’.

Central Australian Health Planning Study
Perth, July 1997
Disadvantages of community controlled health services have been related to isolation and lack of support. At times the conditions of employment have lagged behind government run services both in the NT and elsewhere (most notably, Western Australia), resulting in some recruitment difficulties. The smallness of these services can make it more difficult to deliver support to staff, and to maintain standards. These are issues that need to be addressed through a collaborative planning process.

4. Emergency Evacuations

Emergency evacuations from bush communities are organised through Remote Services. District Medical Officers provide 24 hour telephone advisory service and must authorise evacuations, which are then carried out either by St John’s Ambulance (often on a meet half-way basis) or by Royal Flying Doctor Service (RFDS). If the situation requires a medical escort, then this is provided by the DMO.

In understanding the strengths and weaknesses of this system, it is important to consider the skills of DMOs, and compare them with the skills required for medical escort. DMOs provide primary health care services to communities that could be likened largely to general practice services. That is, they diagnose and treat often fairly minor illnesses, and manage chronic disease alongside various communicable disease control measures such as immunisations. As mentioned previously, some emphasis in recent years has been placed on public health skills as well. The reason that a medical escort may be required in an evacuation is because of the life-threatening nature of the patient’s condition. This might mean that they risk having a respiratory arrest, which may require intubation of the airways or the performing of a tracheostomy. Or it may mean that the patient risks having a cardiac arrhythmia which might require urgent intervention such as cardio-version. Or it may involve a difficult labour where mother and/ or baby is at risk. These skills are not the skills of primary care, but that of emergency medicine. Regular practise and upgrading is necessary to maintain these skills.

It would seem that medical escorts required for evacuation should be the responsibility of the Alice Springs Hospital, rather than Remote Services. Apparently attempts at achieving this by establishing an Emergency Retrieval Team at the hospital were not successful. This was because of the relatively low work load, and difficulty in recruitment of medical officers trained in emergency medicine. Further, the arrangement was that Remote Services would lose 1 DMO position to the hospital, which put extra strain on Remote Services. The current intention is for DMOs to rotate through the hospital, and to be involved with evacuations. We are not sure this will solve the problem, as DMOs will still be relatively out of practise in emergency medicine skills. An alternative might be to use current hospital staff with appropriate skills to carry out evacuations without establishing an Emergency Retrieval Team as such. This issue needs to be kept under review.

5. Other Services

In addition to the above services primarily for Aboriginal people, in Alice Springs and Tennant Creek there are private general practitioners who are seen by some Aboriginal people. In these towns people also access the hospital Accident and Emergency Department. However, Alice Springs Hospital were unable to say what proportion of A&E clients were Aboriginal and seeking PHC services rather than A&E services.

B. Hospital Services

We have included this information for some completeness. It does not present any unexpected information. We wonder if an analysis of Diagnostic Related Groups (DRGs) and community of origin might show the different admission patterns from communities with inadequate PHC, compared with those from communities with more adequate services. We would hypothesise that such an analysis may show increased rates of admissions for conditions such as gastroenteritis and fewer admissions for investigations where there is poor access to PHC services. Where there is better access to PHC services we would hypothesise that there may be increased admissions for routine investigations and fewer admissions for gastroenteritis.

Hospitalisation rates in Central Australia are significantly different between Aboriginal and non-Aboriginal populations. Table shows hospital rates per 1000 population for 1994/95 and 1995/96 for Aboriginal and non-Aboriginal people. In Alice Springs urban hospitalisation rates for Aboriginal people are 7 to 8 times the rate for non-Aboriginal people. However, these rates are probably distorted by the high admission rate for renal dialysis. In Alice Springs rural and the Barkly District, Aboriginal hospitalisation rates are roughly double the non-Aboriginal rates.
Figure 9: Hospitalisation Rates per 1000 Population

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Alice Springs Urban</td>
<td>1025</td>
<td>1414</td>
<td>170</td>
<td>175</td>
</tr>
<tr>
<td>Alice Springs Rural</td>
<td>354</td>
<td>486</td>
<td>144</td>
<td>125</td>
</tr>
<tr>
<td>Barkly District</td>
<td>415</td>
<td>490</td>
<td>260</td>
<td>237</td>
</tr>
</tbody>
</table>

Source: Territory Health Services

There are two hospitals providing services to Central Australia: Alice Springs Hospital and Tenant Creek Hospital.

Alice Springs Hospital has 171 beds and provides general medical, surgical, obstetrics, paediatrics and psychiatric services to the town and surrounding population. In 1995/96 there were 14,741 admissions to Alice Springs of which 70 percent were Aboriginal patients. A large number of these admissions (5,493) were for renal dialysis. When all renal dialysis patients are excluded the Aboriginal: non Aboriginal ratio is 53:47.
Figure 10: Alice Springs Hospital: Separations and Bed-days by Specialty and Aboriginality, 1995/96

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Aboriginal Separations</th>
<th>Aboriginal Bed-days</th>
<th>Aboriginal Av length of stay</th>
<th>Non Aboriginal Separations</th>
<th>Non Aboriginal Bed-days</th>
<th>Non Aboriginal Av length of stay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental</td>
<td>20</td>
<td>22</td>
<td>1.1</td>
<td>83</td>
<td>83</td>
<td>1.0</td>
</tr>
<tr>
<td>ENT</td>
<td>79</td>
<td>246</td>
<td>3.1</td>
<td>95</td>
<td>176</td>
<td>1.9</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>85</td>
<td>329</td>
<td>3.9</td>
<td>89</td>
<td>136</td>
<td>1.5</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>231</td>
<td>529</td>
<td>2.3</td>
<td>595</td>
<td>881</td>
<td>1.5</td>
</tr>
<tr>
<td>General Medicine</td>
<td>897</td>
<td>6549</td>
<td>7.3</td>
<td>950</td>
<td>3327</td>
<td>3.5</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>602</td>
<td>3431</td>
<td>5.7</td>
<td>517</td>
<td>2052</td>
<td>4.0</td>
</tr>
<tr>
<td>Ophthalmics</td>
<td>161</td>
<td>858</td>
<td>5.3</td>
<td>306</td>
<td>1000</td>
<td>3.3</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>1386</td>
<td>12910</td>
<td>9.3</td>
<td>391</td>
<td>1724</td>
<td>4.4</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>88</td>
<td>594</td>
<td>6.8</td>
<td>130</td>
<td>1131</td>
<td>8.7</td>
</tr>
<tr>
<td>Renal Dialysis</td>
<td>5493</td>
<td>7149</td>
<td>1.3</td>
<td>163</td>
<td>185</td>
<td>1.1</td>
</tr>
<tr>
<td>General Surgery</td>
<td>987</td>
<td>6169</td>
<td>6.3</td>
<td>999</td>
<td>3509</td>
<td>3.5</td>
</tr>
<tr>
<td>Urology</td>
<td>6</td>
<td>25</td>
<td>4.2</td>
<td>25</td>
<td>69</td>
<td>2.8</td>
</tr>
<tr>
<td>Other</td>
<td>291</td>
<td>1952</td>
<td>6.7</td>
<td>72</td>
<td>200</td>
<td>2.8</td>
</tr>
</tbody>
</table>

Total: 10326 40763 3.9 4415 14473 3.3

Source: In-patient Statistics

Figure 10 shows the number of separations and bed days for Aboriginal and Non-Aboriginal people by specialty in 1995/96. Paediatric admissions represent the largest number of Aboriginal admissions after renal dialysis. Of the 1386 Aboriginal children admitted, 303 cases were for simple pneumonia and 437 were for gastro-enteritis. Among non-Aboriginal people most admissions are for general surgery, general medicine, obstetrics and gynaecology. Average length of stay is 3.9 days for Aboriginal people and 3.3 days for non-Aboriginal people. When renal dialysis is excluded, average length of stay for Aboriginal people is 7.0 days compared to 3.4 days for non-Aboriginal people. Paediatric admissions have an average length of stay of 9.3 days for Aboriginal children compared to 4.4 days for non-Aboriginal children.

Figure 11: Alice Springs Hospital: Area of Residence of Patients by Health Service Zones, 1995/96

<table>
<thead>
<tr>
<th>Separations</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Northern Barkly</td>
<td>160</td>
<td>1.5</td>
</tr>
<tr>
<td>2. Tennant Creek</td>
<td>292</td>
<td>2.8</td>
</tr>
<tr>
<td>3. Southern Barkly</td>
<td>74</td>
<td>0.7</td>
</tr>
<tr>
<td>4. Kaytetye/ W arlpiri</td>
<td>87</td>
<td>0.8</td>
</tr>
<tr>
<td>5. Alyawarre/ Anmatyerre</td>
<td>303</td>
<td>2.9</td>
</tr>
<tr>
<td>6. Eastern Arrernte/</td>
<td>46</td>
<td>0.4</td>
</tr>
<tr>
<td>7. Anmatyerre</td>
<td>259</td>
<td>2.5</td>
</tr>
<tr>
<td>8. W arlpiri</td>
<td>260</td>
<td>2.5</td>
</tr>
<tr>
<td>9. Luritja/Pintupi</td>
<td>340</td>
<td>3.3</td>
</tr>
<tr>
<td>10. W estern Arrernte</td>
<td>319</td>
<td>3.1</td>
</tr>
<tr>
<td>11. Alice Springs</td>
<td>5451</td>
<td>52.8</td>
</tr>
<tr>
<td>12. Pitjantjatjara/ Luritja</td>
<td>307</td>
<td>3.0</td>
</tr>
<tr>
<td>SA</td>
<td>1433</td>
<td>13.9</td>
</tr>
<tr>
<td>Other NT</td>
<td>603</td>
<td>5.8</td>
</tr>
<tr>
<td>NSW</td>
<td>1</td>
<td>0.0</td>
</tr>
<tr>
<td>Victoria</td>
<td>2</td>
<td>0.0</td>
</tr>
<tr>
<td>Queensland</td>
<td>1</td>
<td>0.0</td>
</tr>
<tr>
<td>WA</td>
<td>383</td>
<td>3.7</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>0.0</td>
</tr>
</tbody>
</table>

Total: 10326 100.0

Source: In-patient Statistics
Figure 11 shows the area of residence of patients admitted to Alice Springs Hospital. Over half live in Alice Springs. There is a significant proportion (14%) from just over the NT/SA border in SA - from communities such as Amata, Ernabella, Fregon, Indulkana, Mimili. The remainder comes from communities within the other 11 health zones. An additional 6% come from other parts of the Northern Territory and 4% come from just over the WA border.

Tennant Creek Hospital is 500 kms north of Alice Springs and has 20 beds and provides basic general medical, surgical, paediatric and obstetric services. In 1995/96 there were 1573 admissions to the hospital of which 69% were Aboriginal and 31% were non-Aboriginal. Medical admissions represented 52% of Aboriginal admissions and 60% of non-Aboriginal admissions. Children aged less than 10 were 29% of Aboriginal admissions - primarily for pneumonia, bronchitis and gastro-enteritis - but only 14% of non Aboriginal admissions. Average length of stay was slightly higher for Aboriginal patients - 3.2 days compared to 2.6 days for non Aboriginal patients. Aboriginal children had the longest average length of stay with 4.0 days compared to 2.1 days for non Aboriginal children.

Figure 12: Tennant Creek Hospital: Separations and Bed-days by Specialty and Aboriginality, 1995/96

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Aboriginal Separations</th>
<th>Aboriginal Bed-days</th>
<th>Aboriginal Av length of stay</th>
<th>Non Aboriginal Separations</th>
<th>Non Aboriginal Bed-days</th>
<th>Non Aboriginal Av length of stay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ophthalmology</td>
<td>1</td>
<td>1</td>
<td>1.0</td>
<td>1</td>
<td>3</td>
<td>3.0</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>17</td>
<td>42</td>
<td>2.5</td>
<td>15</td>
<td>23</td>
<td>1.5</td>
</tr>
<tr>
<td>General Medicine</td>
<td>561</td>
<td>1747</td>
<td>3.1</td>
<td>291</td>
<td>907</td>
<td>3.1</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>109</td>
<td>270</td>
<td>2.5</td>
<td>33</td>
<td>78</td>
<td>2.4</td>
</tr>
<tr>
<td>Orthopaedics</td>
<td>17</td>
<td>49</td>
<td>2.9</td>
<td>19</td>
<td>39</td>
<td>2.1</td>
</tr>
<tr>
<td>Paediatrics</td>
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<td>1248</td>
<td>4.0</td>
<td>67</td>
<td>138</td>
<td>2.1</td>
</tr>
<tr>
<td>Psychiatry</td>
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<td>10</td>
<td>3.3</td>
<td>4</td>
<td>4</td>
<td>1.3</td>
</tr>
<tr>
<td>General Surgery</td>
<td>69</td>
<td>139</td>
<td>2.0</td>
<td>56</td>
<td>70</td>
<td>1.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1087</td>
<td>3506</td>
<td>3.2</td>
<td>486</td>
<td>1262</td>
<td>2.6</td>
</tr>
</tbody>
</table>

Source: In-patient Statistics
Three quarters of Tennant Creek Hospital patients live in the Tennant Creek health zone with 10% from the Southern Barkly and 9% from the Northern Barkly. See Table.

Figure 13: Tennant Creek Hospital: Area of Residence of Patients, 1995/96

<table>
<thead>
<tr>
<th>Separations</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Northern Barkly</td>
<td>96</td>
<td>8.8</td>
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<tr>
<td>2. Tennant Creek</td>
<td>820</td>
<td>75.4</td>
</tr>
<tr>
<td>3. Southern Barkly</td>
<td>107</td>
<td>9.8</td>
</tr>
<tr>
<td>4. Kaytetye/ W arlpiri</td>
<td>8</td>
<td>0.7</td>
</tr>
<tr>
<td>5. Alyawarre/ Anmatyerre</td>
<td>15</td>
<td>1.4</td>
</tr>
<tr>
<td>6. Eastern Arrernte/ Alyawarre</td>
<td>4</td>
<td>0.4</td>
</tr>
<tr>
<td>7. Anmatyerre</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Warlpiri</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Luritja/ Pintupi</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Western Arrernte</td>
<td>1</td>
<td>0.1</td>
</tr>
<tr>
<td>11. Alice Springs</td>
<td>13</td>
<td>1.2</td>
</tr>
<tr>
<td>12. Pitjantjarra/ Luritja</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SA</td>
<td>1</td>
<td>0.1</td>
</tr>
<tr>
<td>Other NT</td>
<td>21</td>
<td>1.9</td>
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<tr>
<td>NSW</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Victoria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Queensland</td>
<td>1</td>
<td>0.1</td>
</tr>
<tr>
<td>WA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>1087</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Source: In-patient Statistics
PROPOSED MODELS OF PHC SERVICE DELIVERY

Overview of Proposed Model

The elements of this model are:

1. Health Service Zones within which services will be organised with PHC staff to live in the Zone wherever possible;

2. Core Functions of PHC:
   i. Clinical services which all can access through:
      - Resident health care services in the community;
      - Visiting professional services;
      - Provision of medicine kits to designated holders;
      - Access to medical advice via phone or radio.
   ii. Regional support for PHC - staff education, management and the provision of specialist and allied health professional services.
   iii. Access to Special Program funding for preventive programs addressing the underlying non-medical causes of poor health.

3. Establishment of a Regional Indigenous Health Planning Forum to oversee the development of collaborative planning of health services involving THS, OATSIH, AMSANT and ATSI C.

4. Pursue opportunities to increase community control (ie to increase the local communities say) of PHC services, and the further development of consumer inputs.

1. Health Service Zones

These Zones are based on:
- language groups and cultural relationships;
- knowledge of relationships;
- geographic proximity and other logistical considerations;

Figure 14: Population and Distribution of various sized communities by Health Service Zone

<table>
<thead>
<tr>
<th>HEALTH SERVICE ZONES</th>
<th>No of Places</th>
<th>Pop</th>
<th>&gt;800</th>
<th>400-799</th>
<th>250-399</th>
<th>75-249</th>
<th>&lt;75</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Northern Barkly</td>
<td>29</td>
<td>865</td>
<td>-</td>
<td>1 = 500</td>
<td>-</td>
<td>-</td>
<td>16</td>
</tr>
<tr>
<td>2. Central Barkly</td>
<td>46</td>
<td>1,190</td>
<td>1 = 930</td>
<td>-</td>
<td>1 = 300</td>
<td>2 = 265</td>
<td>5</td>
</tr>
<tr>
<td>3. Southern Barkly</td>
<td>14</td>
<td>660</td>
<td>-</td>
<td>-</td>
<td>1 = 300</td>
<td>1 = 100</td>
<td>4</td>
</tr>
<tr>
<td>4. W arrirri-Kayteye</td>
<td>7</td>
<td>450</td>
<td>-</td>
<td>-</td>
<td>1 = 300</td>
<td>1 = 100</td>
<td>4</td>
</tr>
<tr>
<td>5. Alyawarra - Anmatjere</td>
<td>27</td>
<td>1,240</td>
<td>-</td>
<td>-</td>
<td>1 = 250</td>
<td>3 = 230</td>
<td>19</td>
</tr>
<tr>
<td>6. Eastern Arrernte- Alyawarra</td>
<td>19</td>
<td>805</td>
<td>-</td>
<td>1 = 400</td>
<td>-</td>
<td>1 = 120</td>
<td>15</td>
</tr>
<tr>
<td>7. Anmatjere</td>
<td>17</td>
<td>1,125</td>
<td>-</td>
<td>-</td>
<td>1 = 300</td>
<td>4 = 590</td>
<td>9</td>
</tr>
<tr>
<td>8. W arrirri</td>
<td>28</td>
<td>1,290</td>
<td>-</td>
<td>1 = 700</td>
<td>1 = 270</td>
<td>1 = 180</td>
<td>7</td>
</tr>
<tr>
<td>9. Luritja - Pintupi</td>
<td>35</td>
<td>1,215</td>
<td>-</td>
<td>1 = 400</td>
<td>1 = 300</td>
<td>1 = 200</td>
<td>20</td>
</tr>
<tr>
<td>10. Western Arrernte</td>
<td>47</td>
<td>1,255</td>
<td>-</td>
<td>1 = 450</td>
<td>-</td>
<td>2 = 350</td>
<td>26</td>
</tr>
<tr>
<td>11. Alice Springs</td>
<td>69</td>
<td>5,280</td>
<td>1 = 3,710</td>
<td>1 = 540</td>
<td>-</td>
<td>1 = 230</td>
<td>40</td>
</tr>
<tr>
<td>12. Pitjantjatjara – Luritja</td>
<td>77</td>
<td>1,510</td>
<td>-</td>
<td>-</td>
<td>2 = 570</td>
<td>3 = 560</td>
<td>34</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>415</strong></td>
<td><strong>16,885</strong></td>
<td><strong>2 = 4,640</strong></td>
<td><strong>6 = 2,990</strong></td>
<td><strong>3 = 2,290</strong></td>
<td><strong>9 = 2,825</strong></td>
<td><strong>209 = 4,140</strong></td>
</tr>
</tbody>
</table>
The table in Figure 14 shows the proposed Health Service Zones with their approximate population. The last 5 columns show the number of communities of various population sizes in each Zone. This illustrates something of the population density and distribution within these Zones. The number of places column shows the total number of outstations and communities that we have information about. It can be assumed that figure, less the number of outstations/communities with populations in that row, are the numbers of out-stations probably not occupied at this time. However, many are likely to be occupied in the future. We have not included the non-Aboriginal population in the estimates for Tennant Creek and Alice Springs because there are other services in these towns that are largely used by the non-Aboriginal population. However, in other communities (such as Elliott) we have included the total population regardless of racial origin, because all will be utilising the same health service. The boundaries of the proposed Zones are shown in the Map in Figure 15.

**Figure 15: Map of Central Australia showing Boundaries of Health Service Zones.**
The Health Service Areas that have been proposed by the Draft THS Review are a positive step forward in developing a system that can more effectively ensure appropriate development of health services in Central Australia. However, they are limited in that they do not include the whole geographic or demographic area of Central Australia. They only apply to those communities who receive their primary health care service from THS. Thus it does not include those communities that have other providers of primary health care, whether they be funded through OATSIHs or THS Service Agreements. It also fails to include those out-stations that do not have any service at all.

It is quite appropriate that THS should develop an approach that assists their more effective administration of PHC services that they are responsible for. However, the other purpose of such areas is to assist both the THS, OATSIHS and other agencies to better ensure the provision of regional services which might be described as support to primary health care, and to develop health strategies for the population regardless of primary health care service provider. Such services include specialist and allied health visits (eg physiotherapist, dentist, occupational therapist, dementia workers, nutritionist), communicable disease control as well as other supportive PHC activities such as monitoring and evaluation. These services should be available from the Government services to all citizens in the region, not just to those who have PHC services delivered by THS. Further, ongoing health service planning processes require all populations and health service resources in the region to be considered. Inevitably, any possibility of attracting anywhere near adequate resources to the Region will require funds from both Territory Health Services and OATSIHS.

Thus we have developed Health Service Zones which include the whole population of Central Australia. These are largely based on language and cultural relationships as well as the logistics of health service delivery such as geographic proximity, and consideration of economies of scale.

We have largely adopted the Draft THS Review Areas, although there are some issues that require further consideration. None of these areas necessarily have strong community backing. Indeed, we are aware of significant divisions between communities in many of these areas. People's identity is bound up with a complexity of issues and administrative areas have not become part of the way people think about issues generally speaking. The question of governance has been a point of dispute between sections of communities, Land Councils, community councils, as well as Territory and Commonwealth Governments. The significance of this for health service development within these Zones is that it will continue to be necessary to identify resources that belong to particular communities. Thus, for example, in the Pitjantjatjara - Luritja region, there is a history of difficulty in the provision of services. Maktujuju and Imanpa have community controlled health services funded through OATSIHS, whilst Aputula is funded through THS. Titjikala and Kaltukatjara are directly serviced through THS. The Draft THS Review has criticised those who have suggested that a doctor might be shared to service communities in this zone. However, it is not surprising that community people may feel threatened by possible changes. Kaltukatjara have had one of the more stable THS-delivered PHC services in the region. They have had continuity of the one nursing sister for many years, until she retired recently. The visiting doctor has worked in Central Australia for many years, speaks the local language, and works as a part time DMO only servicing that community resulting in him being able to be more refreshed in his clinical practice. However, other communities do not share this advantage, and some changes in arrangements are essential if issues of equity are to be addressed. It ought be possible to provide communities with clarity about which services they can expect, and how often they can expect them, as part of a revamped health care system that provides better access for all. One of the barriers to achieving this will inevitably be health professionals who have particular interest in maintaining the status quo. THS, OATSIHS, AM SANT and ATSIC will need to consider how these barriers can be minimised. Potential mis-representations to the community could easily result in community resistance to change, when such change would actually increase their share of health service resources.

There are a number of anomalies in the proposed Health Service Zones that we will deal with under the relevant Zone headings. We have adopted the names of these zones from the Draft THS Review. However, we think it would help orient staff who chose to work in these areas if they were named consistently after the dominant language group(s) living in the Zones. Their names are most appropriate will require further Aboriginal input. We have avoided the use of the notion of central community because it has become clear that in many cases the smaller communities do not see the larger community as being central for them.

We have included, as an appendix, Community Profiles for each community/ out-station organised by Health Service Zones. The information in these profiles is incomplete, and is subject to change. We have no information about some out-stations. However, these profiles do give some idea about these communities, and the services available to them.

2. Primary Health Care Services

Primary Health Care Services that people should have access to are based on the Core Functions of Primary Health Care. These include:

Central Australian Health Planning Study
July, 1997
A. **Clinical Services.**  
These services include sick care services and medical public health or preventive services. The staff required to deliver these services are AHWs, nursing staff and doctors. These staff will be resident in the Health Service Zones in the larger communities wherever possible. In some Health Service Zones, there is more than one large community. Each of these communities should have designated residential staff, with a visiting doctor on a schedule to be negotiated. However, this will require staff accommodation that is not available in all communities. It is also possible that some communities will not want a non-Aboriginal person living in their community. In these cases, at least the time and frequency of nurse visits to such out-stations communities should be specified. The same applies to doctor visits.

Primary health care services will be delivered to the larger communities in these Zones in a way which identifies specifically what level of clinical health service resource is ‘owned’ by each group. That is that each community group will know what level of service they can expect to have access to, and that level will be promoted as belonging to them.

The health service staff that have responsibility of delivering clinical services are AHWs, nurses and doctors. The ratios of staff to populations that we have adopted are:
- AHWs – 1 for every 50 people.
- Nurses – 1 for every 200 people
- Doctors – 1 for every 400 people.

These ratios have been modified so as to be more realistic for larger communities. For example, if the 1:50 ratio for AHWs were applied to Alice Springs, there would need to be 74 AHWs. This is clearly not the case. In larger populations economies of scale, and access to a range of other human services (health and otherwise) means that fewer numbers of AHWs can be effective. These ratios are to a large extent arbitrary. But they do offer smaller communities the chance to get some health service resource in their communities. Further, smaller communities/out-stations will depend on visiting services. Thus smaller staff: population ratios help accommodate some of the time spent travelling. Thus, we have adopted the following scaled ratios:

<table>
<thead>
<tr>
<th>Population Range</th>
<th>AHW Ratio</th>
<th>Nurse Ratio</th>
<th>Doctor Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt; 800</td>
<td>1: 200</td>
<td>1: 400</td>
<td>1: 800</td>
</tr>
<tr>
<td>400 - 799</td>
<td>1: 100</td>
<td>1: 200</td>
<td>1: 600</td>
</tr>
<tr>
<td>250 - 399</td>
<td>1: 75</td>
<td>1: 200</td>
<td>1: 400</td>
</tr>
<tr>
<td>75 - 249</td>
<td>1: 50</td>
<td>1: 150</td>
<td>1: 400</td>
</tr>
<tr>
<td>&lt;75</td>
<td>1: 50</td>
<td>1: 150</td>
<td>1: 400</td>
</tr>
</tbody>
</table>

For smaller out-stations most will not have a family member who is an AHW, and it is unlikely that someone not affiliated with a group could join as their AHW. This will mean for the vast majority of out-stations, that a family member will require support to train as an AHW, or to be supported as a medicine kit holder. Given the significance of out-station living to people’s health status it is important that the health care system supports services to out-stations wherever possible. Thus we propose that a dynamic program be developed aimed at identifying and supporting people in small communities/out-stations to become AHWs or medicine kit holders.
Access to clinical service for people in larger communities will be through their health service resident in the community. For smaller communities and out-stations without resident health care services in their communities, access will be through:

A. **Visiting Services** - AHW, nurse, and/or doctor visits organised from neighbouring communities or from Tennant Creek or Alice Springs. This will require a re-orientation of PHC services to servicing out-stations in their area rather than just the community in which they reside. The frequency and length of visits will need to be negotiated with the out-station or community.

B. **Provision of Medicine Kits**, supported by a regionally organised supply and training program. Medicine Kits should be provided at a level determined by the qualifications and experience of the holder. Some basic medicines such as paracetamol, Acabsiol, antiseptics, methyl-salicylate (rubbin’ medicine) and oral rehydration salts ought be fairly readily available. Others such as antibiotics, narcotic analgesia and other more uncommon drugs should only be available where a qualified AHW is resident. Specific drugs for people with particular medical conditions could be provided through this scheme via dosette boxes. The list of drugs provided would need to be modified according to the availability of refrigeration. The Health Care Agents Subsidy Scheme is a currently operating program in the NT where unqualified persons on pastoralist properties are designated as health care agents. They are provided with a subsidy of up to $20,468 per annum depending on the number of people in the area. We suggest that this scheme be scrapped, and replaced with a program designed to support individuals in small communities' out-stations without access to resident health facilities, to play a primary health care function. Small subsidies could be tied to people’s participation in regionally organised training support programs. This scheme would require regional support that would:

- Organise provision of medicine kits with Regional Pharmacy, or other regional pharmaceutical distribution service;
- Maintain supplies to medicine kits through the pharmaceutical distribution service;
- Liaise with designated PHC services to ensure coordination with nurse and medical officer visits.
- Organise regular training support.

**Figure 17: Health Care Agents Subsidy Scheme.**

<table>
<thead>
<tr>
<th>Size of Community</th>
<th>Percentage of Subsidy (%)</th>
<th>Amount of Subsidy ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>200</td>
<td>100%</td>
<td>20,468.00</td>
</tr>
<tr>
<td>160-199</td>
<td>80%</td>
<td>16,374.40</td>
</tr>
<tr>
<td>120-159</td>
<td>60%</td>
<td>12,280.80</td>
</tr>
<tr>
<td>80-119</td>
<td>40%</td>
<td>8,187.20</td>
</tr>
<tr>
<td>40-79</td>
<td>20%</td>
<td>4,093.60</td>
</tr>
</tbody>
</table>

Source: Territory Health Services

This table shows the current subsidies available to unqualified persons who are designated Health Care Agents by size of community.

C. **Telephone Health Care Advice Service** requiring access to telephone or radio.

Development of a telephone health care advice service that people can access 24 hours a day will assist people without other resident health care services to access advice when needed. The regional health system will need to work with other agencies such as Telstra to ensure that people have access to either telephone or radio so that they can access this service. There are two levels to how this could work. In some areas the service may be through the community PHC service. Indeed this already occurs to some extent in some services. Urapuntja Health Service, for example, is contactable 24 hours a day. However for many of the more isolated out-stations, it may be more appropriate to access advice through a more central location such as Alice Springs. The staffing of this service could be by an experienced bush nurse and AHW, with back up from a medical officer.

It should be understood that this is not to replace the DMO emergency on call responsibilities. AHWs and nurses in bush communities contact the on call DMO for advice. The proposed service is primarily for people on out-stations who do not have resident health professionals. It is a primary health care advisory service for consumers who cannot access such advice any other way. For example, the early treatment of scabies can prevent the development of infected sores. This might help prevent kidney disease in later life. It might be inappropriate for the DMO to take on this potentially large load.

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Telstra is currently providing us with a complete list of communities and out-stations with telephones.

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Central Australian Health Planning Study
Perth, 3rd July, 1997
Support Services.
In order to ensure high quality clinical services in remote communities, adequate support for PHC must be provided. Some of this support needs to be provided at the community level. This includes administrative support and support to maintain equipment, buildings, and vehicles. Other support needs to be provided at the Regional level – that is either in Tennant Creek or Alice Springs.

Local Administrative Support
We propose that each Health Service Zone have at least one Administrator. Zones containing more than one reasonably sized community will need more than one. This person should not be designated a manager or the ‘boss’ in an hierarchy of power, but rather they should have their administrative responsibilities detailed, and encouraged to work harmoniously with other PHC staff. If PHC is best delivered through a “team” approach, then an hierarchy of power is inappropriate. In most of these remote services the numbers of staff are going to be small. A devolved management structure still firmly set in hierarchy is likely to be disruptive to health service delivery. If the intent is to devolve power of decision making to the community as far as PHC services is concerned, then the first step is for those with the power to loosen their grip – to allow more space for the community to have a say. The appointment of managers who are responsible to the centrally located bureaucracy, will not necessarily reduce the tension between health service staff and managers, or the health service and the community. A focus on the administrative tasks required as part of a team geared to delivering health care appropriate to their client community, is likely to be more harmonious and productive. The difficulty in recruiting competent, and experienced health service managers in the context of Aboriginal health should not be underestimated. The difficulty of the task they may be expected to perform should also not be underestimated.
Administrators should be resident in the community they serve, wherever possible.

Regional Support
One of the lessons to be learned from PHC service development in Central Australia, with the development of autonomous primary health care services in a number of communities, is the difficulty that these services have with a number of functions ranging from management, to program development and in service education for staff.

Regional support programs require particular emphasis in the next period in order to develop arrangements that free up community based resources to concentrate on PHC service delivery. Given the history of health service development in Central Australia, these supports should be developed within a collaborative framework which helps ensure the support of all agencies with major responsibilities for Aboriginal health service development (THS, OATSIHS and AMSANT), and ensures that roles and responsibilities of different agencies are clear. The role of the Central Australian Rural Health Training Unit is particularly important in regard to the provision of regional support. Clear and unambiguous direction from THS, OATSIHS and AMSANT would assist them to provide optimal support to PHC services. The mechanism for this is through the proposed establishment of a Central Australian Indigenous Health Planning Unit.

Management
We have divided management into two types. The first is administrative management, and the second is health program development. The reason for separating these is that they are fundamentally different in their objectives and underpinning philosophies.
Administrative

Regional management support is important so that those in the community can concentrate on community issues. The following areas lend themselves to regional approaches:

- **Recruitment of Staff.** It is likely that financial savings are to be made from a regional approach. While a small health service may need to recruit a nurse every 2 years, say, on a regional level nurses will be recruited at much more frequent intervals. Recruitment processes get lost in the PHC service, but can be more efficiently maintained at a regional level. A previous attempt to develop a regional recruitment service some years ago did not receive the wide support that it needed to be effective. It should be stressed that this function is not to decide who will be employed, but rather assists the client service to develop job description, selection criteria and process with the PHC staff or community members. The service should advertise the job, check any police record, check previous employers, short listing applicants, organise interviews with selection panel, and inform applicants of the result. This task should also include organising relocation of successful applicant, and being clear about terms of employment. The regional recruitment service would also assist with the packaging of salaries. For this to work, funding bodies should consider insisting that services avail themselves of such a facility.

- **Financial management.** Regional support in financial management, including how to access funds, accountability requirements, and how to utilise resources to achieve outcomes is issues that have proved difficult in the past. If health councils or other community groups are to play a role in determining the direction of health programs, then they need to be able to access guidelines about financial management. Such guidelines could be developed at a regional level.

- **Industrial relations – protocols for hiring and firing staff, award wages, leave entitlements, overtime, time in lieu, and other entitlements need to be developed.** Such policies can be modified at the community level to suit local needs, but will need to comply with legislative requirements.

- **Maintenance of assets – vehicles, office and medical equipment – asset register, maintenance protocols, depreciation protocols. Guidelines and computerised systems could be developed at a regional level.**

- **Insurance – fire/ burglary, workers compensation, public liability, and professional indemnity insurance.**

- **Workers health and safety matters – such as workers compensation procedures, workplace health and safety policies and medical waste disposal arrangements.**

- **Other administrative policies and procedures – drivers/ vehicles policy, assets register and maintenance, confidentiality, complaints procedures, consumer rights, smoking, alcohol, and staff grievance procedures.**

Many of these matters can be dealt with from a Regional management support unit. It should be stressed that this unit would not set the policies, but would ensure that policies sit within legal responsibilities, and would facilitate the community PHC service to say what they wanted in the policy.

Many of these areas of management have proved difficult for small stand alone health services. Larger services have developed some of these policies, as have THS. Further, CHASP “provides a framework for considering policy issues in terms of the objectives of the service. They have also produced a manual for small rural and remote PHC services and, with Nganampa Health Council and Menzies School of Health Research developed a manual modified for use in Aboriginal health services. A regional approach could build on work already done, and draft policies made available to smaller health services. There is an education and training component to these issues that could be part of in servicing for health service administrators and managers. The CARHTU could have carriage of this function.

People elected to Boards of Management of community controlled health services frequently do not realise their rights and responsibilities that go with the position. The development of straightforward guidelines would assist a better understanding of the roles and responsibilities of these Boards.

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34 CHASP (Community Health Accreditation & Standards Program) ‘Manual of Standards for Community and Other Primary Health Care Services.’ Australian Community Health Association, Sydney, 1993.


**Health Program Support**

Public health programs such as immunisations, STD control, and other communicable disease control, as well as well women’s programs, chronic disease and child health programs require systems to be put in place so that health service staff can efficiently follow people up to achieve appropriate health outcomes. The mobility of people makes it difficult for health service staff to get current information about what action is required. It ought be possible to have a regional approach which allows staff to efficiently access the information they require about people who may not normally be part of their client population. Assistance with the establishment of local PHC information systems would facilitate greater efficiency in these matters. The CARPA Standard Treatment Manual and the Women’s Business Manual are examples of regionally developed resources that are widely used throughout PHC services in Central Australia.

Other aspects of PHC support that could be facilitated from regional support includes:

- **Program development** – facilitating local staff with the setting of objectives, the means of reaching them, and how they can be evaluated.
- **Referral agencies** – regional support mechanisms should ensure that there is regularly updated information to community-based PHC service staff about what allied health, and specialist services are available, and their referral guidelines.
- **Resource management** – how to mobilise available resources to achieve the objectives of the program.
- **Delivery, monitoring and evaluation** – aspects of this need to involve regional resources. Evaluation requires some external input to assist local staff to better set their objectives, and their program activities, as well as the criteria they will use in judging their progress.
- **Community participation issues/consumer input** – this relates to specific program issues such as involvement of carers of children in growth promotion programs, rather than health service control issues.

**Staff Development Education & Training**

Continuing education of staff is critical to the maintenance of high standards of health service delivery. This must include orientation of new staff to ensure that already developed systems for various health programs are built on, rather than duplicated. In service sessions (staff development) and orientation programs should be delivered by (or involve) the new Central Australian Rural Health Training Unit, and (for doctors) the Central Australian Division of General Practice and the Rural Incentives Program (RIP). The issue of AHW education requires different processes through accredited education institutions such as IAD, Batchelor College and the resurrection of the ‘basic skills’ approach. The CARPA Conference has been held twice a year for over 10 years. This established forum should be utilised as part of continuing education for PHC staff.

- **Orientation of Staff.** New staff, whether Aboriginal or non-Aboriginal requires orientation to their new work. For local Aboriginal staff, orientation will need to be more focused on how the health care system works, and what their expected role in it is. For others, there will need to be orientation about the region generally, including general cultural issues, the nature of Aboriginal organisations and communities, and the specifics of the health care system. Much of this can be organised at the regional level. The Aboriginal Cultural Awareness Program (ACAP) needs to be supported so that employees of all services can access their program. Local orientation will also be required, and ACAP or the CARHTU could assist the development of a local orientation program for each Health Service Zone, and communities within them.

- **Staff development (In service)** All health service staff needs to access these programs. Small services have little capacity to develop such programs for their staff. Again, the CARHTU combined with THS and the larger community controlled health service in-service programs could be the vehicle for these programs. Doctors are able to access specifically focused education programs through the Rural Incentives Panel, and the activities of the Central Australian Division of GPs. Collaborative educational programs with the CAHTU is appropriate for some areas.
• **Aboriginal Health Worker Education.** Basic AHW education is beyond the scope of the CARHTU or individual service providers. However, appropriate, community based programs could be developed by CARHTU to address particular skills when and where they are needed. For example, a person who is paraplegic after a motor vehicle accident has spent some months in a rehabilitation unit in Adelaide, and is ready to return to their home in a bush community in Central Australia. The health services staff in that community has never cared for someone with these sorts of problems before. The CARHTU could use its brokerage funds to buy a training package that could accompany the client back to their community where the local health service staff would be trained in the care of that person. Given the relatively small populations, and the generalist nature of PHC, the purchase of education programs specifically focused to particular needs could improve the quality of care available in bush communities dramatically.

• **Management.** Some of these issues have been discussed under the heading of management. However, there is also an education component. At present there is virtually no support for PHC service managers. A number of professional organisations exist for health service managers in the mainstream health system, but these seem to have had little impact in Aboriginal PHC. Again, the CARHTU could play a significant role by organising in-service sessions for managers and administrators which would enable improvements in their work, as well as the sharing of experiences and development of networks.

• **Health Service Boards of Management.** Community members elected to Boards of Management often have poorly developed ideas about legal roles and responsibilities of their position. Well-timed workshops (possibly organised by CARHTU) would assist Board members to understand their roles and responsibilities and strengthen their role in representing their community's interest in health service development. This process should involve more experienced health service Board members both in the particular community and those from other services. Otherwise, there will be a risk that health service providers will train Board Members to conform to provider agendas.

**Evaluation & Support.**

All of these programs will require evaluation and support. Regional evaluation mechanisms need to be identified and applied to ensure that people generally have access to the core functions identified at a high level of quality. David Scrimgeour and Komla Tsey of the Menzies School of Health Research have provided this type of support to a range of health services and community development programs. Some public health monitoring processes (eg such as have been developed by Congress in their clinical QA program, or Nganampa in their STD program) could be applied to other smaller health services who lack the capacity to develop such systems themselves.

**Special Health Prevention Programs**

In developing health care programs, a distinction has been made between those services that are clinical, and those that are non-clinical. The purpose of this distinction is:

i. to relieve clinical staff of often self imposed expectations that they have to deliver non-clinical preventive programs. This is quite unrealistic, and can actually result in a decline in quality of clinical services. Clinical staff has enough to do without being expected to take up these other responsibilities.

ii. to recognise that, whilst clinical services can be delivered to passive recipients, that this is not the case for the non-clinical special health prevention programs. The point here is that issues like healthy store policy, environmental health programs, dog programs, and substance abuse programs require community action for there to be any chance of sustainable beneficial outcomes. Thus, assessing community action about the issue, rather than program parameters being determined by people outside the community identifying the problem and targeting that community, should be what drives the release of funds to these programs.

iii. to develop funding guidelines for these programs that are appropriate to their nature.

iv. to ensure a maintenance of balance between clinical and non-clinical aspects of a strategic approach to improving Aboriginal health.

This area needs further work in order to be operational.
Central Australian Indigenous Health Planning Forum.

Regional planning is important in order to ensure the efficient, effective and equitable mobilisation and distribution of available resources with the objective of improving Aboriginal health.

This should include those organisations responsible for health service delivery to Aboriginal people in Central Australia. Lessons from the Tripartite Forum suggest that such a body should be small so that it is workable, and that it be focused specifically on health service issues. Participants should be limited to THS, OATSIHS, ATSIC and AMSANT, with this group being able to co-opt other organisations and individuals for specific purposes, possibly through limited term working parties to investigate and inform the Forum on specific health service issues. Issues requiring inter sectoral action, can be addressed as necessary, and should include ATSIC.

A regional planning process is necessary to ensure that there is a movement towards all people in the region having appropriate access to health care services.

The current way in which both NT and Commonwealth agencies (eg ATSIC) are organised tends to create competition between town and bush. This builds on the historic racist attitudes about 'half castes' and 'full bloods' or 'traditional' and 'non-traditional', rather than an understanding that Alice Springs is the resource centre for the whole region. By administratively separating town and bush, it makes it much harder to organise resources in a way which both maximises services available to people in the bush as well as ensuring appropriate regional support, and the provision of secondary and tertiary services when they are needed.

A regional planning process is designed to help overcome this.

The Draft THS Review makes the point that some community members had concern about being 'left in the lurch' by THS should they take the community control path. The Review paints a despairing picture of community controlled health services in the bush which is hardly justified. Indeed, one of the reasons that collaborative regional approaches to health service development is so critical, is to ensure that regional support for PHC is geared to meet the needs of all citizens regardless of how their PHC services are delivered. The historic practise of THS withdrawing regional supports, such as in-service training, recruitment support, and the like from health services that have chosen a different delivery model, has created the concern that people expressed to the THS Review team. The inadequate support to communities who have their services funded through a Service Agreement emphasises the point that when communities have accepted some degree of responsibility for running their health services, they have not been provided with the support necessary for unqualified success.

Health planning is necessary in Central Australia to:
1. Allow consideration of needs across the whole Region to ensure a degree of equity of access to health care services between and within all Health Service Zones.
2. Allow changes to occur in health service delivery in terms of changing demographic patterns – ie the movement of people to out-stations, etc.
3. Identify changing needs in terms of illness patterns, and available specialist and other services;
4. Provide coordinated effort in disease control programs that are unsustainable by small PHC services alone;
5. Identify gaps in services, and to prioritise the expenditure of new resources as they become available;
6. To optimise equity and access of all in the Region to health care services.

These should occur in ways that is cognisant of the needs for developing increased consumer input into health service development processes, both at community and regional levels. This should ensure that there is a process at these levels to increase the capacity of communities to be involved with their health care services.

An Integrated Approach:
As professionals, and health bureaucracies have become more aware of the need to involve Aboriginal people in their work, there have been an increasing number of invitations either to AMSANT or to individual health services like Congress to join project steering committees, reference groups or to endorse particular projects (often developed as submissions for funding). Whilst this confirms the recognition of the leadership responsibilities of these players, it has also been impossible for AMSANT or the individual health services to adequately assess and contribute to these processes.

This model provides integration between information flows, research projects, and service delivery. The current inadequacies of basic PHC service in communities makes this a primary concern. The analysis of routinely collected data (eg hospital separations) and research programs need to inform the development of more adequate PHC service delivery.
The Working Groups/Task Force idea is flexible. How many groups and what they should focus on are matters for the Forum to decide. We recommend, however, that:

- the number of working groups be kept fairly small;
- they be driven by specific short term objectives (rather than establishing permanent committees) and that clear time frames are set and monitored by the Forum;
- they be made up of those people who have the responsibility for working in this area. Aboriginal people should only be on these for the same reason, or because they have made significant specific contributions to this area. Care should be made NOT to take people away from their communities where they are doing important work just so they can sit on a committee.

In this model existing resources are more integrated to serve a collaborative planning process.

The issue of the development of consumer input into health service delivery is an issue that the Planning Forum itself should address. Here resources may be required to conduct bush meetings, or other agreed processes. It needs to be stressed that the interim make-up of the Forum does not include consumer representatives.

Possible Agendas for Working Groups:

The sorts of agendas that might be appropriate for the Working groups/Task Forces are:

1. PHC programs at community level:
   - Clinical services – particularly defining which services people should have access to;
   - Community care of people with disabilities and the aged;
   - Child growth promotion strategies.
   - AHW education and support.

2. Regional support for:
   - Program development.
   - Follow up systems.
   - Quality Assurance.
   - Data flows.
   - Staff development, orientation, and in-service training.
   - Specialist and Allied Health Services.
   - Transport.
   - AHWs.
   - Consumer input.
GAPS IN PHC SERVICE DELIVERY

Priorities in primary health service development have been determined by examining a number of factors independently of each other. We have ranked each Health Service Zone according to:

1. Ratio of AHW: population.
2. Ratio of Nurse: population
3. Ratio of Doctor: population

With these measures, the higher the number the greater the need. This measure gives an absolute measure of relative health service need, but does not relate it to any other standard. In other words, it simply compares one health service zone with another. Both may, in fact, be quite seriously under resourced.

The other measure we have applied is to set a standard and then to compare the actual health service resource available with that standard. This gives a better idea about the degree of health resource disadvantage being experienced by a population. We have thus worked out what percentage of health service resource a population/community has compared to our standard of what that population should be able to expect. Thus, if a group has a result of 100%, it means that they have exactly the level of health service resource that they should according to the standard. If they have less than 100%, they have less than they should.

The other factors that need to be taken into account are:

1. Distance from other significant health services.
2. Number of people in population.
3. The availability of other health services (eg private GPs)

In the ranking of Health Service Zones, there are some anomalies that have had to be taken into account. For example, Central Australian Aboriginal Congress in Alice Springs, and Anyinginyi Congress in Tennant Creek employ doctors as clinicians rather than nurses. Thus they appear to be terribly under resourced if looking at nursing needs. This is an artefact, and thus we have removed these from the ranking of nurses.

We have not weighted the ranking according to relative value as a health service resource. This is partly because we believe the skills of the three types of PHC resources are different and complementary, and because any such emphasis should be open to communities to make for themselves. We have assumed that, at least in remote areas, comprehensive primary health care requires all three.

One of the main issues for service delivery in Central Australia is the dispersion of small groups of people across the vast area of the region. In our work, we have identified groups that have not been recognised by health service providers. These groups have had no service delivery at all. The task is to address the health service needs of these groups. This is one of the main findings of our work, and presents a challenge to primary health care providers in terms of how they practice. Being clinic-based and bound will not provide the degree of flexibility demanded by such a mobile population.

Funding bodies, too, will need to recognise the extensive travelling that is required for mobile service delivery, and the need for people to work in pairs, or even larger teams. The use of aircraft should be considered to minimise the time of staff spent travelling, and maximise their time providing services to communities.
Health Resources and their Distribution

The following show how the various Health Service Zones rank in terms of health service staff: population ratios for AHWs, nurses, and doctors. The number in the Pop/ AHW, RN or Dr are the number of people in the serviced community for each of those type of staff. For example, in the Anmatjere Health Service Zone each AHW there are 536 people. There is the equivalent of 1 doctor for every 4,500 people in the Kaytetye-Warlpiri Zone. For doctors, the number of people/ doctor vary according to the type of place. For Capital cities there is one non-specialist doctor for every 1,043 population, whilst in remote Australia there is only one doctor for every 1,409 people. As can be seen in the table below, most areas of Central Australia are worse off than that.

Figure 18: Ranking of AHWs, Nurses & Doctors to Population Ratios by Health service Zone.

<table>
<thead>
<tr>
<th>Rank</th>
<th>AHWs</th>
<th>Pop/ AHW</th>
<th>Rank</th>
<th>Nurses</th>
<th>Pop/ RN</th>
<th>Rank</th>
<th>Doctors</th>
<th>Pop/ Dr</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Anmatjere</td>
<td>536</td>
<td>1</td>
<td>Alyawarra/Apmatjere</td>
<td>413</td>
<td>1</td>
<td>Kaytetye-Warlpiri</td>
<td>4,500</td>
</tr>
<tr>
<td>2</td>
<td>Alyawarra/Aomatjere</td>
<td>310</td>
<td>2</td>
<td>Eastern Arrernte/Alyawarre</td>
<td>393</td>
<td>2</td>
<td>Northern Barkly</td>
<td>4,325</td>
</tr>
<tr>
<td>3</td>
<td>Alice Springs</td>
<td>251</td>
<td>3</td>
<td>Kaytetye-Warlpiri</td>
<td>375</td>
<td>3</td>
<td>Southern Barkly</td>
<td>3,976</td>
</tr>
<tr>
<td>4</td>
<td>Southern Barkly</td>
<td>220</td>
<td>4</td>
<td>Northern Barkly</td>
<td>360</td>
<td>4</td>
<td>W estern Arrernte</td>
<td>3,447</td>
</tr>
<tr>
<td>5</td>
<td>Northern Barkly</td>
<td>216</td>
<td>5</td>
<td>W estern Arrernte</td>
<td>314</td>
<td>5</td>
<td>Eastern Arrernte/Alyawarre</td>
<td>3,220</td>
</tr>
<tr>
<td>6</td>
<td>W estern Arrernte</td>
<td>157</td>
<td>6</td>
<td>Anmatjere</td>
<td>296</td>
<td>6</td>
<td>Pijiantjataja/Luritja</td>
<td>2,796</td>
</tr>
<tr>
<td>7</td>
<td>W arlpiri</td>
<td>143</td>
<td>7</td>
<td>Southern Barkly</td>
<td>287</td>
<td>7</td>
<td>Anmatjere</td>
<td>2,250</td>
</tr>
<tr>
<td>8</td>
<td>Eastern Arrernte/Alyawarre</td>
<td>134</td>
<td>8</td>
<td>Pijiantjataja/Luritja</td>
<td>240</td>
<td>8</td>
<td>W arlpiri</td>
<td>1,985</td>
</tr>
<tr>
<td>9</td>
<td>Pijiantjataja/Luritja</td>
<td>119</td>
<td>9</td>
<td>Luritja/Pintupi</td>
<td>225</td>
<td>9</td>
<td>Alice Springs</td>
<td>1,082</td>
</tr>
<tr>
<td>10</td>
<td>Kaytetye-W arlpiri</td>
<td>113</td>
<td>10</td>
<td>W arlpiri</td>
<td>215</td>
<td>10</td>
<td>Luritja/Pintupi</td>
<td>838</td>
</tr>
<tr>
<td>11</td>
<td>Luritja/Pintupi</td>
<td>93</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Central Barkly</td>
<td>92</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

From Figure 18 it can be seen that the Anmatjere, Alyawarra-Anmatjere, Alice Springs, Southern Barkly, and Northern Barkly are the worst of areas for AHWs; Alyawarra-Anmatjere, Eastern Arrernte-Alyawarre, Kaytetye-W arlpiri, Northern Barkly and W estern Arrernte are worst off for nurses; and Kaytetye-W arlpiri, Northern Barkly, Southern Barkly, W estern Arrernte and Eastern Arrernte-Alyawarre are worst off for doctors.

We might therefore decide that the Northern Barkly is the high priority area, because it is represented in the top 5 of each three ranking. Kaytetye-W arlpiri, Eastern Arrernte-Alyawarre, Southern Barkly, W estern Arrernte and Alyawarra-Anmatjere all appear in the top 5 in two of the three lists. Anmatjere and Alice Springs appear in the top 5 of one of the lists. However, this ranking does not take into account variability of resource distribution within Zones. It also fails to take account of degrees of remoteness, or access to alternative services. Further the actual qualifications and the different skills of the different types of staff are not considered. We have not attempted to put loadings on to different types of staff – that is for another process to determine.

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Figure 19: Ranking of the Actual: Ideal Health Service Resource for each PHC professional resource (AHWs, Nurses & Doctors).

<table>
<thead>
<tr>
<th>Rank</th>
<th>AHWs</th>
<th>%</th>
<th>Rank</th>
<th>Nurses</th>
<th>%</th>
<th>Rank</th>
<th>Doctors</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Anmatjere</td>
<td>10%</td>
<td>1</td>
<td>Alyawarre/ Anmatjere</td>
<td>38%</td>
<td>1</td>
<td>Kaytetye/ W arlpiri</td>
<td>9%</td>
</tr>
<tr>
<td>2</td>
<td>Alyawarre/ Anmatjere</td>
<td>17%</td>
<td>2</td>
<td>Eastern Arrernte- Alyawarre</td>
<td>44%</td>
<td>2</td>
<td>Southern Barkly</td>
<td>10%</td>
</tr>
<tr>
<td>3</td>
<td>Southern Barkly</td>
<td>27%</td>
<td>3</td>
<td>Kaytetye/ W arlpiri</td>
<td>48%</td>
<td>3</td>
<td>Northern Barkly</td>
<td>11%</td>
</tr>
<tr>
<td>4</td>
<td>Northern Barkly</td>
<td>33%</td>
<td>4</td>
<td>Northern Barkly</td>
<td>49%</td>
<td>4</td>
<td>W estern Arrernte</td>
<td>14%</td>
</tr>
<tr>
<td>5</td>
<td>Western Arrernte</td>
<td>39%</td>
<td>5</td>
<td>Western Arrernte</td>
<td>53%</td>
<td>4</td>
<td>Pitjantjatjara/ Luritja</td>
<td>14%</td>
</tr>
<tr>
<td>6</td>
<td>Alice Springs</td>
<td>47%</td>
<td>6</td>
<td>Anmatjere</td>
<td>54%</td>
<td>6</td>
<td>Eastern Arrernte- Alyawarre</td>
<td>15%</td>
</tr>
<tr>
<td>7</td>
<td>Pitjantjatjara/ Luritja</td>
<td>48%</td>
<td>7</td>
<td>Southern Barkly</td>
<td>59%</td>
<td>7</td>
<td>Anmatjere</td>
<td>18%</td>
</tr>
<tr>
<td>8</td>
<td>Eastern Arrernte- Alyawarre</td>
<td>50%</td>
<td>8</td>
<td>Pitjantjatjara/ Luritja</td>
<td>69%</td>
<td>7</td>
<td>W arlpiri</td>
<td>25%</td>
</tr>
<tr>
<td>9</td>
<td>W arlpiri</td>
<td>53%</td>
<td>9</td>
<td>Luritja/ Pintupi</td>
<td>78%</td>
<td>9</td>
<td>Luritja/ Pintupi</td>
<td>54%</td>
</tr>
<tr>
<td>10</td>
<td>Kaytetye/ W arlpiri</td>
<td>57%</td>
<td>10</td>
<td>W arlpiri</td>
<td>86%</td>
<td>10</td>
<td>Alice Springs</td>
<td>60%</td>
</tr>
<tr>
<td>11</td>
<td>Luritja/ Pintupi</td>
<td>71%</td>
<td>11</td>
<td></td>
<td></td>
<td>11</td>
<td>A lyawarre/ Anmatjere</td>
<td>65%</td>
</tr>
<tr>
<td>12</td>
<td>Central Barkly</td>
<td>132%</td>
<td>12</td>
<td></td>
<td></td>
<td>12</td>
<td>Central Barkly</td>
<td>166%</td>
</tr>
</tbody>
</table>

In Figure 19 the percentages represent the proportion of health service staff that Health Service Zones have compared with what they should have according to our standard. Thus, in the Anmatjere HSZ there is only 10% of the AHWs they should have.

It is difficult to put these ranks together. However, given that AHWs, nurses and doctors play diagnostic and therapeutic roles, with access to some central support it may be useful to consider overall staffing levels compared with our ideal standard. The results of this are shown in the following table.

Figure 20: Overall Rank of Percentage of Actual Staff to Ideal Staff (AHWs, Nurses, Doctors) for each Health Service Zone.

<table>
<thead>
<tr>
<th>Rank</th>
<th>Health Service Zone</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Anmatjere</td>
<td>21%</td>
</tr>
<tr>
<td>2</td>
<td>Alyawarre/ Anmatjere</td>
<td>26%</td>
</tr>
<tr>
<td>3</td>
<td>Southern Barkly</td>
<td>33%</td>
</tr>
<tr>
<td>4</td>
<td>Northern Barkly</td>
<td>35%</td>
</tr>
<tr>
<td>5</td>
<td>Western Arrernte</td>
<td>40%</td>
</tr>
<tr>
<td>5</td>
<td>Alice Springs</td>
<td>40%</td>
</tr>
<tr>
<td>7</td>
<td>Eastern Arrernte-Alyawarre</td>
<td>45%</td>
</tr>
<tr>
<td>8</td>
<td>Kaytetye/ W arlpiri</td>
<td>50%</td>
</tr>
<tr>
<td>8</td>
<td>Pitjantjatjara/ Luritja</td>
<td>50%</td>
</tr>
<tr>
<td>10</td>
<td>W arlpiri</td>
<td>59%</td>
</tr>
<tr>
<td>11</td>
<td>Luritja/ Pintupi</td>
<td>71%</td>
</tr>
<tr>
<td>12</td>
<td>Central Barkly</td>
<td>108%</td>
</tr>
</tbody>
</table>

Conclusions are difficult to reach with this data. Certainly it can be seen that some areas are in greater need than others. However, to rank them confidently is another matter. Reasons for this is include:

1. The great diversity of need within regions. That is, health service staff are often concentrated in one population group in the region.
2. The variation in the types of health service staff employed. For example, in some regions doctors are well represented, whilst AHWs are not.

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Central Australian Aboriginal Congress and Anyinginyi Congress have had a consistent policy for many years of employing doctors rather than nurses for clinical work. Thus, they both come in as the services of greatest need in regard to nurses. This is not really the case, and both have been excluded for this category. Further, the lack of nurses in these services, makes the role of doctors more prominent. Thus these services may appear relatively over-supplied with doctors. This should be modified by the absence of nurses.
Figure 21: Distribution of Health Service Staff by Health Service Zone

This graph shows the actual staffing levels for AHWs, nurses, doctors and all staff expressed as a percentage of the ideal for each Health Service Zone. If a Zone had all the AHWs that they should according to our standard, then they would have 100%. If they have less than they should, they will have less than 100%, and if they have more, they will have more than 100%.

Degrees of remoteness also need consideration. However, this is also complex, and not simply a matter of distance. The Southern Barkly Region is clearly poorly resourced, but is relatively close to the Stuart Highway and Tennant Creek. However, Epenarra and Canteen Creek are 3 hours on poor quality roads. Thus there is significant variation in degree of remoteness within Zones. The Warlpiri/Kaytetye Zone is also poorly staffed, but is close to the highway and to Ti Tree where there is a clinic. Of course being close to the highway does not help in the wet when, short, but poor, connecting roads are washed away.

On the other hand, people in the Eastern Arrernte-Alyawarre Health Service Zone east of Artyerre (Harts Range) in the Bonya area are quite remote with bad roads and long distances to Alice Springs.

Finally, we reiterate the lack of homogeneity within Health Service Zones. Thus it is the case in many of these Zones that one community is resource rich, whilst other communities have little. The resource rich areas have dominated the above ranking process, so that some Zones containing communities of high need do not appear as being in need.

Thus we will examine each Zone and the population groupings within them to identify areas of need within.
Needs Within Health Service Zones

1. Northern Barkly Health Service Zone

Figure 22: Northern Barkly HZ – Population Groups, Out-stations and Health Service Staff.

<table>
<thead>
<tr>
<th>Community</th>
<th>Number of Out-stations</th>
<th>Pop</th>
<th>AHWs</th>
<th>Nurses</th>
<th>Doctors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barkly Tablelands</td>
<td>6</td>
<td>180</td>
<td>0</td>
<td>0.4</td>
<td>0.1</td>
</tr>
<tr>
<td>Nicholson River</td>
<td>6</td>
<td>130</td>
<td>2.6</td>
<td>0.9</td>
<td>0.3</td>
</tr>
<tr>
<td>Elliott - including 2 Town Camps.</td>
<td>3</td>
<td>500</td>
<td>4</td>
<td>2.5</td>
<td>0.8</td>
</tr>
<tr>
<td><strong>Total for Zone</strong></td>
<td><strong>15</strong></td>
<td><strong>865</strong></td>
<td>4</td>
<td><strong>12.3</strong></td>
<td><strong>5</strong></td>
</tr>
</tbody>
</table>

*Includes 1 vacant due to 'sorry business' and 8 proposed new out-stations.

This Zone is made up broadly of 3 population groups:

- **Barkly Tablelands**: has 6 currently occupied small communities' out-stations with a population of around 180 people. They receive infrequent visits from the Barkly Mobile.
- **Nicholson River**: is very remote, being in the far north east corner of the Zone. People here are very mobile and in the wet spend significant amounts of time either at Tennant Creek, or in Queensland (Doomadgee or Mt Isa). They sometimes access clinic service at Borroloola in an emergency. However, they have virtually no health service resources.
- **Elliott**: this is where the current health service resources are concentrated.

We propose that strategies to improve health service resources in this zone concentrate on:

1. Negotiations with the Nicholson River people about developing a health capacity within their community that can remain with them wherever they are. This most likely means support to train an AHW, or for someone to accept responsibility for holding a medicine kit. Assistance might also be required to ensure access to communications (a radio might be the most appropriate).
2. For the Barkly Tablelands communities, a mixture of solutions will be needed which may include resident AHWs where possible, medicine kits, telephones and a visiting bush mobile service.

We note the Draft THS Review recommendations that 1 AHW and 1 nurse (located at Alexandria Station) be employed on the Tablelands. The AHW position is described as 1EFT (equivalent full time). It is difficult, however, in splitting up 1 such position among 5 out-stations. Further, we are concerned that 1 nurse located well away from any other health care resource will have great difficulty providing a service that will achieve equity of coverage, and be able to build a PHC capacity within small out-station communities.

Our informants have told us that Alexandria Station has a difficult history with Aboriginal people, and that a health service located at the Station may compromise access for Aboriginal people. These histories must be considered in the development of new service initiatives that are aimed at improving access for Aboriginal people.

We reiterate that the most effective model is based on a visiting service model. We should not underestimate the difficulty of that task. Mobile teams require close knit relationship with mutual respect and understanding, and an intimacy that allows the team to take into account each person’s strengths and weaknesses. They, therefore, must be located together where they can build a program of service to remote out-station communities. The role of the mobile bush team is to provide:

- Daily contact by phone or radio;
- Support the out-station based AHW or designated medicine kit holder;
- Organise weekly/fortnightly visits;
- Organise medical officer and other allied health or specialist visits.

Consideration should be given to the use of aircraft for bus visits that will enable health service staff to spend more time with clients in the community and refreshed enough to provide a service. A medical officer should be based in Elliott, but that their work should be split 50:50 between town and bush work. A full time mobile nurse and AHW team should also be based in Elliott, or some location that facilitates their capacity to provide that service.
2. **Central Barkly Health Service Zone**

Figure 24: Central Barkly HSZ – Population Groups, Out-stations and Health Service Staff.

<table>
<thead>
<tr>
<th>Community</th>
<th>Number of Outstations</th>
<th>Population</th>
<th>AHWs</th>
<th>Nurses</th>
<th>Doctors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Including 10 Town Camps</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tennant Creek</td>
<td>16</td>
<td>930</td>
<td>13</td>
<td>4.7</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>18*</td>
<td></td>
<td></td>
<td></td>
<td>1.2</td>
</tr>
<tr>
<td>Outstations</td>
<td>16</td>
<td>260</td>
<td>5.2</td>
<td>1.7</td>
<td>3</td>
</tr>
<tr>
<td>Total for Zone</td>
<td>16</td>
<td>1,190</td>
<td>9.9</td>
<td>4</td>
<td>3</td>
</tr>
</tbody>
</table>

*Includes 2 vacated due to 'sorry business' and 6 proposed new out-stations.

This region is serviced by Anyinginyi Congress, which is based in Tennant Creek. Overall this region is reasonably well resourced, but its resources tend to be concentrated in Tennant Creek. Anyinginyi is providing a mobile service to some out-stations/communities, but our information suggests that this service is not to all out-stations in this area, and that the service that is operating varies in its regularity from time to time. The resource allocation for this appears not to be a problem, and it may well be that strengthening of this program requires program development work, rather than an increase in clinical staff.

It should also be noted that Anyinginyi Congress, whilst having 3 funded doctor positions, had one position unfilled at the time of this report. It should also be noted that Anyinginyi has tended to employ doctors and AHWs, rather than nurses for the delivery of clinical services. This makes their apparent over supply of AHWs and doctors more exaggerated than it ought be.
Figure 25: Map of Central Barkly Health Service Zone showing Communities & Out-stations.

Out-stations not included on this map are Ngapagunpa (Ngapakuwinpa, Bindy’s Place), Crow Downs (Miyilpurnuru, Old Pistol Club), and W arlungaminypa.

3. **Southern Barkly Health Service Zone**

Figure 26: Southern Barkly HSZ – Population Groups, Out-stations and Health Service Staff.

<table>
<thead>
<tr>
<th>Community</th>
<th>Number of Out-station</th>
<th>Pop</th>
<th>AHWs</th>
<th>Nurses</th>
<th>Doctors</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Now</td>
<td>Ideal</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Now</td>
<td>Ideal</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Now</td>
<td>Ideal</td>
</tr>
<tr>
<td>Alekarenge</td>
<td>4</td>
<td>300</td>
<td>1.5</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>W utunagurra</td>
<td>120</td>
<td>1</td>
<td>2.4</td>
<td>0.15</td>
<td>0.8</td>
</tr>
<tr>
<td>Canteen Creek</td>
<td>145</td>
<td>0.5</td>
<td>0.15</td>
<td>1</td>
<td>0.03</td>
</tr>
<tr>
<td>Total for Zone</td>
<td>5</td>
<td>660</td>
<td>3</td>
<td>11.2</td>
<td>2.3</td>
</tr>
</tbody>
</table>

*Includes 2 proposed new out-stations. **Includes 1 vacated due to ‘sorry business’; 1 proposed without infrastructure (ATSIC moratorium).

It can be seen that the resources in this zone are concentrated at Alekarenge (Ali Curung). However, Alekarenge itself is not over resourced. On our standard, Alekarenge is under-resourced for doctors and AHWs. However, there are 95 people in 5 out-stations around Alekarenge who receive no service, as far as we can tell, and the services to Epenarra and Canteen Creek are unsatisfactory.

Resources need to be injected into this Zone. A doctor is justified, as well as a nurse who could possibly be shared between W utunagurra (Epenarra) and Canteen Creek. There are three out-stations in the vicinity of Canteen Creek and these are likely to become more permanently occupied in the near future.

There are no strong links between people at W utunagurra and Canteen Creek, and the location of a health service resource at one place, would probably not be accessible to people from the other. Thus a mobile approach appears most appropriate with the level of health service resource ‘owned’ by each group clearly indicated.

Canteen Creek CDEP has recently collapsed, and some people involved with that have returned, we understand, to Tennant Creek. An inquiry into this is under-way, and if the CDEP is resurrected, then the people who left are likely to return.

W utunagurra and Canteen Creek are clearly areas of need.
4. Kaytetye – Warlpiri Health Service Zone

This area is made up of two main populations. The Willowra population is largely Warlpiri, and the Tara community is largely Kaytetye. They have been put together in the one Zone because of geographic proximity, and the fact they are not part of the Anmatjere Community Council which also is proximal geographically.

Tara has 3 associated out-stations with a combined population of 45 with no services. Tara is under-serviced. Willowra is also under-serviced, and could well employ a second nurse.

A doctor is justified in this Zone, along with a nurse at Tara. If there are difficulties in housing staff in either of these communities, it would be more appropriate to house them in Ti Tree rather than Alice Springs. This would reduce wasted travelling time.
5. **Alyawarra – Anmatjere Health Service Zone**

Both Urapuntja and Ampilatwatja are poorly serviced in regard to AHWs. This problem is unlikely to be addressed at this Zone level alone, as it is a product of a more general crisis for AHWs in Central Australia. This Zone is well covered for medical officers, having 2 (1 in each health service). Urapuntja Health Service is particularly understaffed in regard to nurses.

Both these services are worthy of examination because they are based on a mobile service philosophy and have managed to maintain that for a long time. The lack of a central community on Utopia and the location of staff in the one place help it, of course. Although there is a clinic, the main thrust of the service is a mobile one, providing regular visits to all out-stations.

---

**Figure 29:** Map of Kaytetye-Warlpiri Health Service Zone Showing Communities & Out-stations.

Amerre (Pwerpatenthe, Awuly-awuly), an out-station of Tara does not appear on this map.

**Figure 30:** Alyawarra-Anmatjere HSZ – Population Groups, Out-stations and Health Service Staff.

<table>
<thead>
<tr>
<th>Community</th>
<th>Number of Outstations</th>
<th>Pop</th>
<th>AHWs</th>
<th>Nurses</th>
<th>Doctors</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Now</td>
<td>Ideal</td>
<td>Now</td>
</tr>
<tr>
<td>Utopia</td>
<td></td>
<td></td>
<td>Now</td>
<td>Ideal</td>
<td>Now</td>
</tr>
<tr>
<td>Out-stations</td>
<td>17</td>
<td>850</td>
<td>4.0*</td>
<td>17</td>
<td>2</td>
</tr>
<tr>
<td>Ampilatwatja</td>
<td>2</td>
<td>250</td>
<td>0</td>
<td>3.3</td>
<td>1</td>
</tr>
<tr>
<td>Out-stations</td>
<td>2</td>
<td>140</td>
<td>2.8</td>
<td>0.9</td>
<td>0.4</td>
</tr>
<tr>
<td>Total for Zone</td>
<td>19</td>
<td>1,240</td>
<td>4</td>
<td>23.1</td>
<td>3</td>
</tr>
</tbody>
</table>

* This represents 8 part time AHWs employed.
A perikel, Irrekirrek, Nanteth and Arnkawenyerr (New Camp), out-stations of Utopia and Areyn, an out-station of Ampilatwatja do not appear on this map.

6. **Eastern Arrernte-Alyawarre Health Service Zone**

This Zone does not appear in the ranking consistently as an area of great need, but rather comes in the middle order. But this is because both Artetyerre (Harts Range) and Alpurrurulam (Lake Nash) are well serviced with a nurse: population ratio averaging 1:130.

A third of the population of this area (255 people) lives in the south-eastern area of this Zone in 10 out-stations. Only 3 of these out-station have links with Artetyerre. Of the rest (amounting to 190 people), only 2 (Bonya and Urlampe) receive any service at all. This area is developing one, and it is likely that the population will actually increase. Clearly this area must be a high priority for service development. People on the 7 eastern out-station do not have an association with Alpurrurulam, or Artetyerre. A mobile service is most appropriate. There is some unoccupied infrastructure at Atula (Admin Centre, a number of houses). In considering options for location of a mobile health resource in the eastern area of this Zone, Atula may offer some options. There is a need for further negotiations about this. Alpurrurulam has only 1 nurse for 400 people, and receives a fortnightly visit from a medical officer. However, it is adequately covered for AHWs, with 4 working in the community.
Figure 33: Map of Eastern Arrernte-Alyawarre Health Service Zone Showing Communities & Outstations.

Marmany (Urandangie), an outstation associated with Alpurrurlam, does not appear on this map.
7. **Anmatjere Health Service Zone**

Figure 34: Anmatjere HSZ – Population Groups, Out-stations and Health Service Staff.

<table>
<thead>
<tr>
<th>Community</th>
<th>Number of Out-stations Occ Uocc</th>
<th>Pop</th>
<th>AHWs Now</th>
<th>AHWs Ideal</th>
<th>Nurses Now</th>
<th>Nurses Ideal</th>
<th>Doctors Now</th>
<th>Doctors Ideal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ti Tree</td>
<td>160 1 3.2 2.8 0.8 0.4 0.4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nturia</td>
<td>180 3.6 0.9 0.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>W ilora</td>
<td>65 1.3 0.1 0.4 0.2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pmara Junta</td>
<td>120 2.4 0.1 0.8 0.3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Out-stations</td>
<td>7 4</td>
<td>170</td>
<td>3.4 0.4 0.4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laramba</td>
<td>300 1 4 1 1.1 0.1 0.7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Engawala</td>
<td>130 2.6 0.1** 0.9 0.3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total for Zone</strong></td>
<td>7 4</td>
<td>1,125</td>
<td>2 20.5 4.1 4.9 0.5 2.8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Some receive visiting services from Ti T ree.

**Visiting service from Artetyerre.

This Zone is based on the boundaries of the Anmatjere Community Council. The current health service is one of the few that provide a visiting service to communities in the area. However, it tends to be under resourced for doctors and AHW s. Engawala (Alcoota) currently receives services from Artetyerre.

We understand that attempts have been made to establish a community controlled health service through the Anmatjere Community Council. However, we also understand that the Council is facing some difficulties. We are unsure what opportunities apart from the Council there might be for pursuing a community controlled service. If this were to proceed, it would present an opportunity for reorganising the health service to ensure adequate coverage of all in the Zone.

This Zone is amongst those of high priority. It is particularly lacking in AHW s.

Figure 35: Map of Anmatjere Health Service Zone Showing Communities & Out-stations.

Arnmanewenty, Woods Camp, and Illaparretye, out-stations in this Zone, do not appear on this map.
8. Warlpiri Health Service Zone

Figure 36: Warlpiri HSZ – Population Groups, Out-stations and Health Service Staff.

<table>
<thead>
<tr>
<th>Community</th>
<th>Number of Outstations</th>
<th>Pop</th>
<th>AHWs</th>
<th>Nurses</th>
<th>Doctors</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Occ</td>
<td>Unocc</td>
<td>Now</td>
<td>Ideal</td>
<td>Now</td>
</tr>
<tr>
<td>Yuendumu</td>
<td>4</td>
<td>9*</td>
<td>700</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Outstations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nyirripi</td>
<td>270</td>
<td>2</td>
<td>3.6</td>
<td>1</td>
<td>1.4</td>
</tr>
<tr>
<td>Outstations</td>
<td>5**</td>
<td>2***</td>
<td>60</td>
<td>1.2</td>
<td>0.4</td>
</tr>
<tr>
<td>Yuelamu</td>
<td>180</td>
<td>1</td>
<td>3.6</td>
<td>1</td>
<td>1.2</td>
</tr>
<tr>
<td>Outstations</td>
<td>2</td>
<td>1***</td>
<td>25</td>
<td>0.5</td>
<td></td>
</tr>
<tr>
<td>Total for Zone</td>
<td>11</td>
<td>12</td>
<td>1,250</td>
<td>9</td>
<td>16.2</td>
</tr>
</tbody>
</table>

*Includes 2 out-stations vacated due to sorry business.  
**Includes 3 out-stations out of Lajamanu.  
***Includes 1 out-station vacated due to ‘sorry business’.

There are 3 main population groups in this Zone.

Yuendumu is adequately resourced in terms of nurses, but under resourced for AHWs and doctors.

Nyirripi is poorly resourced in terms of AHWs and doctors. It is slightly under resourced for nurses, but with more AHWs this would not be a problem.

Yuelamu (Mt Allen) has recently been provided with a nurse, but remains seriously under resourced for AHWs and doctors.

We are concerned with the inclusion of Yuelamu in this Zone. One of the most articulate issues we were confronted with was how Yuelamu residents, who are predominantly Anmatjere people, did not feel comfortable about accessing health care from Yuendumu where people are predominantly Warlpiri. While Yuelamu are not part of the Anmatjere Community Council area, it appears that there ought be some possibility of them having their own full time resident nurse, 2-3 AHWs and to purchase doctor time from the proposed Anmatjere community controlled health service.

The importance of this issue relates to continuity of care issues. If people at Yuelamu are more likely to access health care resources at Ti Tree, rather than Yuendumu, then it would make more sense that the Ti Tree based doctor deal with them on a regular basis. This would provide a better possibility for ensuring good medical care for people at Yuelamu. This has been such an issue in Yuelamu that the Yuelamu Council has previously employed its own nurse to deal with the problem. This was a serious drain on Council resources and was not sustainable.

We propose that further negotiations are pursued about these arrangements, and that they be taken into account in the processes involved in establishing the Anmatjere health service.
Juturang, an out-station of Yuendumu, and Garden Bore (Arrunge), an out-station of Yuelamu, do not appear on this map.

9. **Luritja - Pintupi Health Service Zone**

There are a number of population groups in this area. Papunya, Mt Liebig and Haasts Bluff are in a similar geographic area, but it is unlikely that they would comfortably share a health service resource. This is partly because of previous experiences where the community of residence of health service staff tends to get the lions share of service.
Papunya has signed a Memorandum of Understanding with THS after a series of disputes about health service issues. They also have been receiving a program through World Vision employing a nurse and 2 AHWs. This program is focused on community development type programs, rather than clinical services and we have not included those resources in our analysis. According to our standard Papunya is under resourced in regard to AHWs, but given the MOU and the World Vision program, this may suit Papunya at this time. However, increased access to a medical officer ought be available to them.

Mt Liebig is fairly well resourced, but, again, ought have greater access to a doctor. Ikuntji (Haasts Bluff) has only visiting nursing services. Given the large out-station population associated with Ikuntji, a full time nurse position is justified as part of a mobile service to those out-stations and Ikuntji.

The issue of service delivery to the out-stations associated with Mt Liebig and Papunya requires attention.

Kintore has a resident medical officer along with 2 nurses and 5 AHWs in the Pintupi Homelands Health Service and is, consequently, adequately resourced. There are a number of out-stations around Kintore, and it is not clear how effective the service to those out-stations is from the PHHS.

Figure 39: Map of Luritja/ Pintupi Health Service Zone Showing Communities & Out-stations.

Kilili, an out-station of Kintore; Ngurnpa, an out-station of Mt Liebig; and Archie Creek (Atji Creek), an out-station of Ikuntji are not on this map.
**10. Western Arrernte Health Service Zone**

Figure 40: Western Arrernte HSZ – Population Groups, Out-stations and Health Service Staff.

<table>
<thead>
<tr>
<th>Community</th>
<th>Number of Out-stations</th>
<th>Pop</th>
<th>AHWs</th>
<th>Nurses</th>
<th>Doctors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ntaria</td>
<td></td>
<td>450</td>
<td>4</td>
<td>4.5</td>
<td>2.3</td>
</tr>
<tr>
<td>Out-stations</td>
<td>20</td>
<td>440</td>
<td>8.8</td>
<td>2.9</td>
<td>1.1</td>
</tr>
<tr>
<td>Wallace Rockhole</td>
<td></td>
<td>150</td>
<td>2</td>
<td>3</td>
<td>0.1</td>
</tr>
<tr>
<td>Areyonga</td>
<td></td>
<td>120</td>
<td>2</td>
<td>2.4</td>
<td>0.2</td>
</tr>
<tr>
<td>Out-stations</td>
<td>1</td>
<td>3**</td>
<td>15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total for Zone</td>
<td>21</td>
<td>23</td>
<td>1,175</td>
<td>8</td>
<td>18.7</td>
</tr>
</tbody>
</table>

*10 vacated due to ‘sorry business’. **1 vacated due to ‘sorry business’.

People in this Zone are Western Arrernte people and the communities in this Zone have a long relationship through the Lutheran Mission that established Hermannsburg (Ntaria) in the 1860s as a mission, and as a distribution point for rations.

The most remarkable thing to note about this region is the large numbers of people living on out-stations. It appears that few of these receive any service at all. Thus there is an urgent need to re-orient the service providers to servicing all people in the Zone. However, the resources are inadequate to achieve that at present. A doctor is required in this Zone, and a mobile service needs to be developed to serve the 25 out-stations associated with Ntaria, and possibly to assist with service delivery at Areyonga and Wallace Rockhole.

Nursing and medical services are inadequate to both Wallace Rockhole and Areyonga.

Special consideration needs to be given to out-stations that play a role in substance abuse programs. In this region Intjartnama has provided a residential rehabilitation program, mainly for alcohol problems, whilst W inparku has provided a residential rehabilitation program for petrol sniffers. The primary health care service needs to provide appropriate support to these programs with regular visits and communication.

Figure 41: Map of Western Arrernte Health Service Zone Showing Communities & Out-stations.

Inyipanti, an out-station of Areyonga, does not appear on this map.
11. Alice Springs Health Service Zone

The Zone involves two service providers of PHC - Central Australian Aboriginal Congress (Congress) and the service at Santa Teresa. The Santa Teresa service is funded through a Service Agreement with the Santa Teresa Community Council. The Catholic Church has been associated with this community from the Little Flower Mission in Alice Springs through to its relocation to Arltunga at the time of the military occupation of Central Australia in the second world War, to its final move to Santa Teresa because of inadequate water at Arltunga. The Church has had a relationship with the health service up until the present time, and indeed currently one of the nurses working in the clinic is a religious nun who lives in a community dwelling with other nuns from her order. Santa Teresa is around 80 kms East of Alice, and its proximity to Alice probably means that their level of servicing is not too bad, except that more doctor time is justified.

The rest of the Zone depends on Congress. If Congress were just servicing the town and town camps of Alice Springs, then its resources would be adequate. However, for some years it has been attempting to provide a visiting service to the Town Camps around Alice, as well as Yambah since a number of family groups were able to get title to excisions in the early 1990s. As a result of an Expenditure Review Committee decision in 1992, the THS withdrew their health services from Amoonguna and Jay Creek. Congress has been attempting to deliver services to these communities as well.

In 1996, people from out-stations north of Titjikala asked Congress to provide them with a service. At the time Congress was unable to respond positively. Since then a beginning has been made to provide a regular service to these out-stations.

Amoonguna presents particular difficulties as an area of need. It is 13 kms east of Alice, and has a population of 230 people. Many people do not have transport and a taxi fare to Alice costs $35. There are a number of elderly residents who need more continued attention than is currently provided. The size of the community justifies a functioning clinic. THS recently provided a one off grant to Amoonguna for a clinic building, but there are no resources for health service staff, supplies, etc. Attempts at negotiating options with the Council have not led anywhere. Given the poor resourcing of health services in more remote locations, it is unlikely that a full health service to Amoonguna can be justified.

However, there needs to be a strengthening of the capacity of Congress to deliver services more effectively to Amoonguna and the out-stations around Alice. Amoonguna requires a functioning clinic with resident AHWs (ideally 10), a nurse and a visiting doctor.

There are a large number (36) out-stations in the Zone, and often people living on them do not have transport. Providing these out-stations with a reasonable service is logistically difficult. However, the importance to health should be recognised. If these people were living in Alice Springs, their health would most likely be much worse. The lack of services often brings people back into town. Providing services to people can be an important contribution to their health apart from any impact of the service itself.

<table>
<thead>
<tr>
<th>Community</th>
<th>Number of Out-stations</th>
<th>Pop</th>
<th>Nurses</th>
<th>AHWs</th>
<th>Now</th>
<th>Ideal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alice Springs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Town Camps</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amoonguna</td>
<td>17</td>
<td>230</td>
<td>4.5</td>
<td>1</td>
<td>4.83</td>
<td>4.6</td>
</tr>
<tr>
<td>Out-stations</td>
<td>1</td>
<td>1</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yambah</td>
<td>2</td>
<td>155</td>
<td>3</td>
<td>1</td>
<td>0.4</td>
<td></td>
</tr>
<tr>
<td>Hamilton Downs</td>
<td>2</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jay Creek</td>
<td>22</td>
<td>505</td>
<td>10</td>
<td>3.4</td>
<td>1.3</td>
<td></td>
</tr>
<tr>
<td>North Titjikala</td>
<td>4</td>
<td>80</td>
<td>1.5</td>
<td>0.5</td>
<td>0.2</td>
<td></td>
</tr>
<tr>
<td>Santa Teresa</td>
<td>1</td>
<td>540</td>
<td>2</td>
<td>2.5</td>
<td>0.05</td>
<td>1.4</td>
</tr>
<tr>
<td>Total for Zone</td>
<td></td>
<td>39</td>
<td>5,280</td>
<td>21</td>
<td>43</td>
<td>17.7</td>
</tr>
</tbody>
</table>

*Includes 3 proposed new out-stations.
Figure 43: Map of Alice Springs Health Service Zone Showing Communities & Out-stations.

Figure 44: Map of Alice Springs (Inset) Showing Communities & Out-stations.

Alice Springs Town Camps not shown on the map include Ihyperenyne (Old Timers), Karnte, Ilpeye-Ilpeye (Goldie’s), Anhelke (Namatjira’s), Mpwetyerre (Abbott’s, BP), Anthepe (Drive-in), Ilparpa, Anthelk-Elpaya (Charles Creek), Iperlee Tyathe (Warlpiri Camp), Iwiyethwenge (Basso’s Farm).

Out-stations of Iwupataka (Jay Creek) not on this map include Angantyepe, Tywempe Nos 2,3,4,5,6,7 & 8 T nerte, T wetye No2, Arrillhejere, Iperleyenge No 1 & 2, Iteyepintye Nos 1,2 & 3, Iyulmul, Iwiyethwenge, and Ntwele.
12. **Pitjantjatjara – Luritja Health Service Zone**

Figure 45: Pitjantjatjara–Luritja HSZ – Population Groups, Out-stations and Health Service Staff.

<table>
<thead>
<tr>
<th>Community</th>
<th>Number of Outstations</th>
<th>Pop</th>
<th>AHWs</th>
<th>Nurses</th>
<th>Doctors</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Occ</td>
<td>U noc</td>
<td>Now</td>
<td>Ideal</td>
<td>Now</td>
</tr>
<tr>
<td>Kaltukatjara</td>
<td>10</td>
<td>20*</td>
<td>240</td>
<td>4</td>
<td>4.8</td>
</tr>
<tr>
<td>Mutitjulu</td>
<td>-</td>
<td>10</td>
<td>250</td>
<td>2.7</td>
<td>5</td>
</tr>
<tr>
<td>Imanpa</td>
<td>-</td>
<td>1**</td>
<td>140</td>
<td>3</td>
<td>2.8</td>
</tr>
<tr>
<td>Kings Canyon</td>
<td>7</td>
<td>1***</td>
<td>120</td>
<td>2.4</td>
<td>1</td>
</tr>
<tr>
<td>Titjikala</td>
<td>1</td>
<td>-</td>
<td>180</td>
<td>3.6</td>
<td>0.3</td>
</tr>
<tr>
<td>Aputula</td>
<td>8</td>
<td>1****</td>
<td>320</td>
<td>1</td>
<td>4.3</td>
</tr>
<tr>
<td>Total for Zone</td>
<td>26</td>
<td>46</td>
<td>1,510</td>
<td>13.7</td>
<td>27.9</td>
</tr>
</tbody>
</table>

*Includes 3 vacated due to ‘sorry business’.  
***This OS is unoccupied due to ‘sorry business’.  
****Includes 8 proposed new out-stations.

This Zone consists of 6 population groups.

Two doctors are justified in this Zone. One option would be for Kaltukatjara (Docker River), Mutitjulu, Imanpa and Kings Canyon to allocate one doctor position between them, and the second position could service Titjikala (Maryvale) and Aputula (Finke). Whilst the Draft THS Review has been critical of suggestions in this regard, we propose that this option needs to be further pursued in a collaborative and transparent way that minimises the tendency to misinformation and misunderstanding. Currently Kaltukatjara receives 2 days a fortnight (less travelling time). Under the proposed arrangement the medical support to all of these four communities would increase. Clearly this needs further negotiation.

Aputula is the most under resourced of the communities in this Zone. It is funded through a THS Service Agreement with the community council. However, there are only 1 AHW and 1 nurse with a doctor visiting 1 day a fortnight for a community of 320 people. Further there is a developing movement involving out-stations in the south eastern corner of this Zone. Some of this movement is from Oodnadatta, but many of these people have affiliation with Aputula. Thus this area is likely to become an increasing area of un-met need. Titjikala is also under resourced with only 2 AHWs and a visiting nurse. The out-stations to the north of Titjikala have no cultural or other affiliations with Titjikala but are Southern Arrernte people and relate directly to Alice Springs.
Figure 46: Map of Pitjantjatjara/ Luritja Health Service Zone Showing Communities & Outstations.

Figure 47: Inset shows Outstations around Kaltukatjara (Docker River).

Lawatjara, an out-station of Kaltukatjara; Kurily, Pirrpakagarin, Puka, Waltijtjata, W anatjuku Tjuku, outstations of Mutitjulu; Lindervale, an out-station of Imanpa; and Flinders, an out-station of Aputula are not on this map.
PRIORITIES FOR HEALTH SERVICE DEVELOPMENT:

Highest priority areas as a result of our analysis are:

A. **Northern Barkly**
   The two areas in urgent need are:
   - Nicholson River – this is a difficult area that requires a strategic approach aimed at getting some basic PHC resources attached to this mobile community that will travel with them.
   - Barkly Tablelands – Need to develop community-based PHC resources plus a better resourced mobile bush service to the out-stations/small communities on the Barkly Tablelands.

B. **Southern Barkly**
   This Southern Barkly area is an area of need, especially W utunagurra (Epenarra) and Canteen Creek.

C. **Eastern Arrernte-Alyawarre**
   The eastern area including Bonya and Urampe.

D. **Kaytetye – Warlpiri**
   This Zone is under-resourced in all areas other than that for AHWs. Tara is especially disadvantaged.

E. **Warlpiri**
   Yuelamu is especially disadvantaged. Its problematic relationship with Yuendumu needs to be appreciated, and it requires its own health service resources separate from that of Yuendumu.

F. **Western Arrernte**
   This Zone ranked within the top 5 most needy. This is largely because of the large number of out-stations associated with Ntaria with a combined population equivalent to that of Ntaria. A mobile bush service, or other option to meet this need, should be developed as a priority.

G. **Anmatjere**
   This Zone is poorly resourced in regard to AHWs in particular. However, the main problem in this area is the relatively large number of population centres without resident facilities, and which current staff based at Ti Tree are attempting to service. A reorganisation of PHC services in this Zone is required.

H. **Luritja – Pintupi**
   This Zone did not rank as a needy Zone, but that is largely because of healthy AHW numbers at Mt Liebig and Kintore, and healthy nurse numbers at Mt Liebig, Papunya, and Kintore. Further, Kintore has a resident doctor. Ikuntji, however, is a community that has been poorly serviced for some time. It has a number of associated out-stations and these receive virtually no service at all. Options should be investigated, but should include a mobile bush service based at Ikuntji that might also provide an assisted service for other out-stations in the area.

I. **Pitjantjatjara/Luritja**
   - Aputula is very poorly resourced. There are only 2 AHWs and 1 nurse for 300 people. Further, there are developments in the south-eastern area of this Zone which is likely to result in something like 100 people on out-stations. Some of these relate to Aputula as well as Oodnadatta and Pika Winya in Port Augusta. Two relate to Ernabella or Amata.
   - Titjikala is also poorly resourced. There is only a visiting nursing service.
Other Need identified.

A. Alice Springs

Amoonguna

Amoonguna is a community close to Alice Springs with a population of 230 people. The community has had difficulties in regard to instabilities in community governance from time to time. Since THS withdrew the clinic service from Amoonguna and Jay Creek, the community has been left without a service. Congress has attempted to reorganise its community health program resources to meet this need along with un-met needs for Yambah, Undoolya, Jay Creek, and continuing a service to the Alice Springs Town Camps. The GP Branch of Commonwealth Health and Family Services provided some extra resources (a public health nurse and AHW). However, this was inadequate to provide anywhere near a reasonable service. From time to time there has been an AHW resident at Amoonguna who Congress has employed to spend part of their time at Amoonguna, and part at Congress. However, these arrangements have been unsustainable.

Clearly this is an area of need. But Amoonguna will continue to have this need un-met because of the more critical needs of other communities in more remote locations. In other words, there appears little likelihood of Amoonguna attracting it's own resources for a new health service. It will continue to fall on Congress (who have always seen Amoonguna people in their clinic) to provide some level of support to the health service needs of that community. We are aware that people from Amoonguna have made approaches to both THS and Congress. We believe that the main issue is that the community wants a service. We deliver that service is not the prime concern of the community. It is up to those responsible for health services to work together to find a way to optimise the resources available so that the community can benefit.

We propose that the Planning Forum develop a collaborative negotiation with Amoonguna aimed at improving health service access.

Out-stations

There are 785 people living on 36 out-stations around Alice Springs. This number has increased significantly since the early 1990s when many families gained title to excisions on stock routes (red areas). Congress has provided a weekly service to Yambah, and some other out-stations, but has not provided a service to others at all. The logistics of delivering health care to these people is complex. A weekly service alone is inadequate. Congress requires support to better organise an effective mobile bush service.

B. Alyawarra/Anmatjere

This area is very well serviced with doctors, but not so well serviced with other staff according to our standard. Overall we are not suggesting that this Zone require further resources, although Urapuntja is clearly under staffed in regard to nurses. We are wanting, however, to highlight that Ampilatwatja employ no AHWs, and Urapuntja employ 8 part time (1 AHW to 210 people), which is inadequate to cover the large number of out-stations. This reflects some of the problems for AHW education in Central Australia since the AHW education responsibility and facility within THS was handed over to Batchelor College. We do not wish to deny people accessing the formally accredited qualifications that Batchelor offers, but it is inappropriate for many AHWs who have poor literacy, and who have no desire to leave their community. We were unable to identify any bush-based AHW educators in our work.

The situation is serious. If AHWs are part of a model of PHC delivery to Aboriginal people, then the health care system (the employers of AHWs) must develop the environment in which AHWs can receive training and support. This is an urgent matter.

We support the call by the AHW Association for the re-introduction of the Basic Skills path to full registration with the NT AHW Registration Board. There are no legal barriers to this in the NT. The Act governing registration requirement has not changed.
ISSUES IN SERVICE DEVELOPMENT

Community Control of PHC Services

REFLECTIONS ON THE HISTORY OF COMMUNITY HEALTH

Community control of health services has been advocated since the early 1970s. At that time a number of groups of women in various centres, but most notably in Sydney (Leichhardt and Liverpool) organised to run their own women’s health centres. A number of abortion clinics were also developed along the same lines. A workers health centre that combined primary health care and occupational health programs was also developed in the industrial western Sydney suburbs. Similar groups were developed in Wollongong, Newcastle, Brisbane, Fremantle, Melbourne and Adelaide. However, preceding all of these developments was the development of Aboriginal community controlled health services.

In all of these situations there have been debates about the nature of community, how the ‘community’ is represented. From these ‘extreme’ developments, the public health community more generally has embraced the ‘new public health’ which has as a central tenet the notion of community control/participation/involvement in health service delivery. In Alma Ata in 1978, the World Health Organisation (WHO) incorporated this into their declaration of Primary Health Care. This reflected developments around the world, and especially in some third world countries where community based primary health care programs were developed with little resources except the people of the community in which it developed.

In Australia, Aboriginal control of health services was somewhat inspirational to other groups about the prospects for taking control of health services in areas where the system was perceived to have failed them. Women were concerned about the lack of women doctors and the insensitivity that many male doctors had towards them. It was evident that many women at that time avoided having PAP smears because of this dis-ease. Some workers were concerned about hazardous conditions they worked in and the lack of information available to them.

There has always been some degree of confusion in the debates around these developments about who are consumers and who are practitioners. After a period of time a consumer (ie a person without health professional qualifications) who takes on senior management responsibilities in a community based health service, does develop health skills and tends to cease to be simply a ‘consumer’. In other words the process of consumers taking control of health services inevitably creates a new type of health professional – one that lacks formal qualifications in the health industry, but who becomes highly qualified in the dynamics of community based primary health care.

In all of these situations the process of establishing a ‘community’ controlled service has involved threats to the existing service providers. Health Departments have been defensive, private practitioners have felt that their livelihood might be threatened. All have felt the criticism of their practice implicit in the establishment of alternatives.

This conflict can be beneficial

In other words differences and some degree of conflict can have a creative influence. Certainly, in communities where health status is poor, complacency can be lethal. However, there is also a risk that conflict can become institutionalised – part of the stories institutions tell to those who enter their culture. This can perpetuate unproductive conflict at the expense of better-coordinated health care.

There is also some confusion about the notion of consumers of health services. People with chronic illnesses or women with large numbers of children may fairly readily identify themselves as such. However, most people do not. Early attempts at establishing consumer health organisations in Sydney attempted to include in their constitution that employees of health service providers could not be members of the organisation’s executive. This resulted in the ludicrous situation that academic health professionals could be, but cleaners employed by the local hospital couldn’t be.

Petersen and Lupton, citing Ife, warn:

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Petersen, AP et al ‘Coordinating Healthy Public Policy: An Analytic Literature Review and Bibliography.’ Department of Behavioural Science, University of Toronto, 1988, p 38.


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Participation often amounts to little more than tokenism, where affected people may be consulted to a limited extent but have no real power to affect decisions, and may even be coopted into the power structure that they set out to oppose. This is evident, for example, in those government-sponsored programs going by the name of "community development."

**Community Control of Health in Central Australia**

In considering an implementation strategy, it is useful to revisit issues of community control/participation/involvement. We have used these terms interchangeably because they do not have fixed or agreed meanings, and indeed involve a changing dynamic influenced by the degree of satisfaction people have with the status quo, personalities, other issues demanding community leaders attention, and issues of cohesiveness in communities. To try to give them particular meanings tends to create a rigidity, when the processes involved in a community seizing control is not an ordered or predictable phenomena. To a significant extent the process is determined by what is on offer – that is, what people in the community perceive as possible. To a significant extent this is determined by what Governments permit - how the funding lines are drawn, what is funded, and what the guidelines are that must be followed. Power deficits in relationships also influence responses. Unfortunately, the conflict over PHC service delivery in Central Australia has tended to result in an obsession by some with questions of who represents whom, and who speaks for whom. These questions occur within communities as well, and are what community politics is about. Thus it is possible for different people to get completely contradictory answers from apparently the same 'community'. It begs the question about the nature of community, and the realities that rarely do communities speak with one voice.

Part of the way to increase involvement of people in health issues is to develop a framework for health service delivery that enables people to better interact with possibilities. Continual changing of bureaucratic structures is a major factor in people’s difficulty in getting what they need from the system.

It is extraordinary that the model proposed by the Draft THS Review has totally excluded Congress (or AMSANT) from the tripartite approach. The one body that has successfully managed to nurture and develop community controlled health services in the bush is the Central Australian Aboriginal Congress. Congress was directly involved in the establishment of the following health services:

- Urapunta Health Service
- Pintupi Health Service
- Mutitjulu Health Service
- Imanpa Health Service
- Nganampa Health Council
- L yappa Congress, Papunya (which later collapsed)

In contrast, THS could be said to be responsible for Service Agreement Communities (Santa Teresa and Aputula) being a type of community control. Over the years, many communities with health services currently delivered by THS have approached Congress about getting their own health service. These include Nyirripi, Yendumu, I kunji and Ntaria. The barriers to these communities being successful in developing their own health service was partly due to the inability of funding bodies and Health Departments to strategically work together on these matters. To exclude Congress from the tripartite process makes little sense. The experience that Congress has to offer is invaluable, and should not be disregarded or ignored. Continued disputation about Congress and AMSANT and the legitimacy of their involvement is a significant barrier to better health care delivery in Central Australia.

The Draft THS Review has stressed the information deficit that hampers community involvement and decision-making. This is a further argument why the most experienced and developed of the community controlled health services should be participants in these planning processes.

The issue of representativeness demands some attention. This appears to be a major barrier in developing a collaborative process aimed at developing better access to health care for Aboriginal people. On the one hand, it is claimed that AMSANT does not represent all communities. The most bewildering aspect of this claim is the apparent absence of any claim to the contrary. Certainly AMSANT does not claim to represent all Aboriginal communities. Its membership comes from and thereby represents Aboriginal Community Controlled Health Services in the N T. Their interpretation of this has not included those communities who receive their services via a Service Agreement arrangement with THS. However, we understand that the only approaches to AMSANT about this issue have come from people working in THS either in Darwin or Alice Springs. We understand that AMSANT has established an Associate Membership for communities who are in a transitional phase in the development of their health service. We further understand that Tiwi Islands, who are in the process of developing their own service through the Coordinated Care Trials, have been accepted on this basis.
The issue of representativeness is indeed problematic. The Draft THS Review quotes people in the bush as saying ‘no-one talks for us but us’. Taken to its not unreasonable limits, short of reducing the Aboriginal population to individuals – that is, including representatives from all family groups and out-stations – this would result in such a large and vast forum that the resultant ‘representative’ forum would hardly enhance a community voice.

However, AMSANT is the legitimate voice of Aboriginal health services. It is up to them to determine their membership criteria. These Aboriginal leaders are responsible for the delivery of primary health care services to the Aboriginal communities in their areas. As such they are health service managers, sometimes with significant experience. They have responsibilities in regard to equitable regional planning processes, and should be included in those processes. The issue of consumer input to health planning is another matter altogether which should be an agenda item placed on the table at the health planning forum for those paid to plan health service delivery to consider.

In recent years, there has been a commitment by THS in Central Australia to develop stronger community involvement in their health service delivery. However, the criticism that is most relevant and significant is that they have attempted to develop community control of services in isolation from other players. The contradiction involved in government officials attempting to promote community control is fairly obvious. However, where there once was serious resistance from State and Territory Governments and their bureaucracies, it would appear that there is now support for developing community control of health services. However, if this is the case, then it is paramount that there is a collaborative approach that expands options. Sometimes these options come from outside the bureaucratic imagination. This indeed is why community control is so critical to the project of improving Aboriginal health.

There have always been tensions between THS and community controlled health services funded by the Commonwealth. These have been due to many factors including:
1. Claims by the THS that the Commonwealth funded services are a duplication of their mainstream services.
2. Concern by the THS that funds are going directly to these community services, rather than through the NT Government.
3. The community controlled health services have historically been vocal critics of the performance of THS.
4. Community controlled health services have claimed that THS makes decisions affecting Aboriginal primary health care without consultations. These claims were made repeatedly during the life of the TPF.
5. Confusion on the part of the Alice Springs Hospital and other sections of THS as to the legitimate roles of community controlled health services in regard to transport, and other liaison issues.
6. Arguments about the representative legitimacy of Aboriginal community controlled organisations.
7. Claims by the community controlled health services that the NT funded ‘Service Agreement’ communities are not adequately community controlled.

The list could probably go on. However, these conflicts have become a significant factor in health service delivery in Central Australia, and cannot be ignored in considering planning issues.

Indeed, a more constructive, collaborative approach to health service planning and development would help:
- reduce any duplications of service delivery
- allow for the development of agreed funding arrangements;
- allow for a forum for the airing of criticisms and the development of better understandings of the difficulties faced by providers;
- clarify roles and responsibilities of different parts of the health care system.
- address the issues around consumer inputs into health service development;
- allow for mechanisms to ensure that all primary health care services have the support they need.

We consider that there is a point at which being pre-occupied with issues of ‘who is the community?’, ‘who is representative?’ and ‘how to get consumer input?’ itself becomes a barrier to health service development. These issues are unresolvable. Indeed there are useful perceptions from both ends of the argument. At every consultative opportunity whether it be the Royal Commission into Aboriginal Deaths in Custody, the National Aboriginal Health Strategy or the THS Review, Aboriginal people have consistently stated that they want better health care services. It ought be time that we got on with the job. To continue arguing about some of the detail and philosophy of these matters is simply causing delay in getting services on the ground. There are some questions that require a good deal of educative background and health service experience. People who have no experience of an adequate health service are hardly in a position to provide direction to highly difficult logistic problems in health service delivery. We are not arguing that therefore community people be locked out of the process. Indeed we are highly committed to community control/ participation of programs. But we must strike the right balance.
There remain few opportunities in Central Australia for collaborative work to allow these issues to be sorted out. However, there are some exceptions. This planning study is directed by a steering committee which is collaborative and includes all providers of health care services to Aboriginal communities (including AMSANT and THS), OATSIHS and ATSIC. The recently formed Renal Forum also appears to include all appropriate stakeholders. The Central Australian Rural Health Training Unit has a collaborative management structure.

We propose that a collaborative planning process be adopted at a regional level to ensure effective delivery of health services, with optimal utilisation of available resources.

**Health Care Service Delivery**

**Out-stations**

It is clear from our work, and supported by the Draft THS Review that, generally speaking, out-stations do not receive any health care service. There are some exceptions to this. Congress in Alice and Anyinginyi in Tennant have specific programs that provide visiting services to out-stations, and Urapuntja Health Service is organised largely as a mobile service delivering services to out-stations. Ampilatwatja Health Service, Ti Tree and Artetyerre all provide some level of visiting service to the more populous communities in their area. Of course, the Barkly Mobile, and the service to Kings Canyon and Ti Tjakala also provide a mobile visiting service.

The logistics of providing such a service are complex and difficult. However, this difficulty needs to be balanced against a number of health advantages that are gained by out-station living. Firstly, out-stations are illustrative of people taking a degree of control over their lives. They need to take a degree of responsibility about their lives and health that is not so obviously required in settlements. People are more likely to have access to more bush tucker than they have in more populous communities. They are more likely to find roots, fruits and other plant foods, as well as game such as kangaroo, parentie and echidna. The highly nutritious quality of these foods is well documented, and even if such foods only account for 25% of the diet, it is likely to make a significant impact on people's health. One of the barriers to people managing to maintain their living on an out-station is the lack of services. It is important that primary health care service delivery provides support to the out-stations by ensuring regular visits by health staff.

Thus a major finding of our work has been the large number of people with extremely poor (or no) access to primary health care services. To provide these people with a resident service is clearly financially and logistically impossible. However, their access to PHC services could be organised through provision of medicine kits (of varying degrees of complexity depending on the experience and qualifications of the holder) and ensuring access to communications (through phone or radio). This will require the re-orientation of PHC service providers to a more mobile method of delivery. One aspect highlighting the importance of community control, whether this be through formal mechanisms, or through the more central involvement of AHWs and other community leaders in the day to day organisation of health care services, is the community knowledge that outsiders never really have. Where people are, who's in town, and who's just turned up is knowledge belonging to the community, and not so readily available to nurses and doctors. Effective communicable disease control often depends on knowledge about who went shopping where and with whom, and where the footie was last weekend.

**Pharmaceuticals**

The supply of pharmaceuticals to THS serviced communities is through the Regional Pharmacy. When other services, whether OATSIHS funded, or THS funded through Service Agreements, access the Regional Pharmacy for supply of pharmaceuticals they are charged 25% on top of the cost of drugs. For some items this is still competitive, but for many it is much cheaper for services to access other pharmaceutical supply houses.

Regional Pharmacy, however, does not currently have the staff and facilities to take on the supply of all pharmaceuticals for health services in Central Australia.

Congress, the largest of the community controlled health services, purchases its pharmaceuticals from 3-4 different suppliers. This is because it has the capacity to investigate the cheapest options, and to manage a diversity of suppliers. This is not the case with smaller services.
The supply of pharmaceuticals needs to be a straightforward and efficient system. If this can be achieved by expanding the capacity of Regional Pharmacy, then this should be pursued. However, it may be more appropriate to either develop a pharmaceutical supply house in Central Australia to provide pharmaceuticals to services, or to contract this with a local private pharmacist. Of course, the supply of dressings, other sundry items and basic medical equipment should be included.

The supply of out-station medicine kits and the management of dosette boxes for the management of chronic medications could also be built into these arrangements.

**Staffing Issues**

We note the recommendation of the Draft THS Review that an Allied Health Professional be allocated to cover two THS Health Service Areas. We propose an alternate strategy aimed at providing all people throughout Central Australia some access to these services through a regional workforce unit. We emphasise the following points:

1. All people in Central Australia should have access to these services, not just those living in communities whose PHC services are delivered by THS. Stand alone health services do not have the capacity to organise these services for themselves.

2. The term ‘allied health professional’ is extremely non-specific, and it is not clear how people will be able to access the variety of skills that different allied health professionals have.

We also propose that administrators be employed in bush services, but that they not be designated as being in charge.

Effective Primary Health Care is organised in multi-disciplinary professional teams, and they should have maximum freedom to work with their client communities to develop programs that are relevant and appropriate.

**Transport**

Transport is a major problem in Central Australia. We note, and support, the recommendation of the Draft THS Review that drivers be employed in each health service area. However, we believe this will be inadequate. In many of these health service areas, there is a lack of cohesion between communities in the area, and it will be difficult for one driver to meet the needs of all significant communities in that area. We would recommend that a driver or part-time driver be provided for all communities with a population exceeding 200 people. In some communities this position might also incorporate a ‘handy man’ function. Their focus would be primarily to increase access of local people to the health service. This might be driving health service staff to out-stations or picking up people who need assistance to bring them to the health service.

There is also an important issue relating to transporting people discharged from Alice Springs Hospital back to their community of residence. Outside Uluru, and communities located on or close to the Stuart Highway, there are no public transport facilities to remote communities. The PATS (Patient Assisted Travel Scheme) assists people to return to their community after hospital-based investigations and treatment. However, transport arrangements do not always correspond to time of discharge, and people often miss their arranged travel appointments. This means that frequently people discharged from hospital are stranded in Alice Springs for some days or weeks until they can find someone going back to their community. A proportion of these people will end up back in hospital as a result of violence or other mishap, often alcohol related.

We recommend that a system be developed so people return to their community by utilising transport opportunities of other organisations and sectors.

**Accommodation**

Many people come to Alice Springs for hospital-based investigations or treatment. This does not always necessitate hospitalisation, and hostel type accommodation is used. This is becoming an increasingly scarce commodity in Alice Springs. We have not looked at what is needed compared to what is available in this project. However, this is an issue which requires attention. If the Child Health Unit is to be disbanded, then the accommodation problems will become even more critical as this Unit is used to accommodate women awaiting birthing, as well as post-hospitalisation support for children and their carers.

The lack of accommodation available to the Alukura is a barrier to their accepting some women for birthing, thus necessitating such women accessing the services of the hospital, a significantly more costly option.
For some people, most notably people from remote communities requiring renal dialysis, long term accommodation in Alice Springs is a problem. This is an especially complex problem and should be an issue taken up by the Renal Forum.

**CHILD HEALTH**

Malnourished children are of continuing concern. The consequences of this are increased susceptibility to infections, and inadequate development of the child’s nervous system (including their intellectual development). While better primary health care services have reduced the number of children dying of infectious disease (eg pneumonia) these illnesses remain common. There are three main issues responsible for this calamity. Firstly there is the problem of poor physical environments in many communities with poor quality water, and inadequate sewerage and other waste disposal. This sets up an environment enabling the spread of infectious disease, particularly diarrhoea. Secondly, the availability of nutritious food and especially fresh fruit and vegetables is inadequate in many communities. The other factor is related to alcohol consumption. Where the carers of children are heavy drinkers the needs of the children tend to be neglected.

Programs designed to improve child health need to address the following issues:

1. The development of child health programs in primary health care services. These should ensure adequate growth promotion programs including the regular weighing of children in order to identify those at risk, and the maintenance of immunisation programs. These programs ought be conducted in a way that allows productive relationships to develop between carers and PHC staff.
2. Identifying barriers to access to nutritious food, and especially to help carers understand that different principles of nutrition apply to adults and children.
3. Supporting community initiatives to deal with issues of substance abuse, and specifically to deal with children whose families are unable to care for them.

**MEN’S HEALTH**

In many Aboriginal communities clinics are seen as ‘women’s places’ – most of the staff are women, and many women and children occupy the clinic space. Many men do not feel comfortable in this environment, and few men have taken on the role of AHW. The issues for men are underlined by the high death rate amongst young Aboriginal men from heart disease. Their lack of access to health care services means that high BP, diabetes and early signs of heart disease are not recognised. Of course, men also have need for diagnosis and treatment of STIs, along with the other reasons people seek health care. There is an urgent need to:

1. Create an environment in PHC service that are comfortable and accessible to men. For example, a separate men’s entrance, clinic or building.
2. To recruit male AHWs and to allow a different role for them to be developed. It may be that some male AHWs are able to play specific roles in environmental health, as well as the more clinical roles involved in men’s health.

Flexibility in educational requirements might enable clinical skills relevant to men’s health to be incorporated into environmental health courses (such as those conducted by the Centre for Appropriate Technology), and environmental skills to be incorporated into AHW courses.

**WOMEN’S HEALTH**

Women’s health has tended to focus on:

- Issues of birthing - antenatal care and the birthing process;
- Contraception;
- Childrearing issues;
- Issues related to STIs, and infertility;
- Cancers of the breast and cervix.
In Central Australia a study, funded by RADGAC\(^1\) was conducted in the early 1980s. This was conducted by Congress, and involved extensive consultation with women, and especially senior women throughout Central Australia. The main concern of these women was their desire to reclaim their 'birthing rights.' They were not happy with women having to go to Alice Springs to have their babies, or to have to deal with male doctors in the hospital. These things were in contravention of their tradition and culture.

Of course, Aboriginal women have always had responsibility for maintaining and passing on Aboriginal Law in relation to birthing. But over the years more and more women had ended up having their babies in Alice Springs Hospital.

Dr Berna Madill, an Alice Springs Hospital (ASH) Obstetric and Gynaecology Registrar began an outreach service to women living in remote communities during the late 1970s. A Rural Health (now Remote Services) nurse accompanied her and this service continued until the mid to late 80s until her retirement. THS have also provided other services from time to time, including a PAP Smear program, and in recent years have maintained a specific women's health program in Remote Services.

Until recent years, the THS policy was that all women must come into Alice Springs for birthing. This resulted in some women avoiding ante-natal care altogether. The exception to this was the practice of community birthing in some community controlled health services (eg Fregon) where there were midwives.

The consequence of the RADGAC study was the development of the Congress Alukura by the Grandmothers Law. A regional health care plan which incorporated women’s health and birthing based on the reassertion and integration of Aboriginal women’s Law and culture with modern obstetric care. The Congress Alukura Council was formed, and consisted of representatives of senior women from all language groups in the region.

The aim of the Council was to:
- enable women to be involved in negotiations about birthing issues and the development of the Alukura;
- involve the community in women’s health issues;
- maintain the influence and practise of women’s Law in birthing matters;
- ensure the development of culturally appropriate service programs

Attempts to operationalise the Alukura model has been thwarted by opposition from the health care system and lack of funding. The Alukura began a clinical service in a backroom of the old Hartley Street premise of Congress in 1985. In 1988 Aboriginal Hostels made a house available in Mueller St, which provided a women’s only environment, and an upgraded service. In 1992, as a consequence of funds from ATSIC through the NAHS funds, the Alukura moved into their current premises which include birthing suites. The Alukura has maintained bush visits to some communities and have included women’s screening, AHW education, and community education about women’s health issues. It’s work has incorporated well women’s checks, women’s screening, contraception as well as birthing services.

At the same time both the hospital and remote services have developed their programs separately form the Alukura. Much of the opposition to Alukura faded when it was clear that they were diagnosing many more women with gestational diabetes than had been diagnosed through THS services. But there was a failure to integrate services so that the work of the Alukura could be strengthened.

**Current Situation**

The current delivery of women’s PHC is fragmentary and conflicting. The Alukura continues to provide women’s PHC services both in town and in remote communities. The THS employed women’s health nurse/educator also visits remote communities.

There have also been efforts to introduce a program called ‘Strong Women, Strong Babies, Strong Culture Program’ which was developed in the Top End. This program is aimed at improving maternal and child nutrition and is to be implemented in Yuendumu, Docker River and Laramba. THS has not recognised the importance of collaboration with the Alukura Council in developing this project.

There is an urgent need to integrate women’s health programs in Central Australia. There has been a tendency for the Alukura to lose its way. This is a consequence of constant fights about funding and the Alukura’s legitimacy. It has tended to become a captive of its clientele to some extent. It’s outreach to bush communities has been limited. THS service to bush communities have also been limited.

Currently there are attempts by THS and the Alukura to work more collaboratively, and we urge this direction be persisted with.

\(^{1}\) Research and Development Grants Advisory Committee of the Commonwealth Department of Health.
The vertical women’s health programs funded by the Commonwealth have aggravated some of these problems. These aggravations include the Breast Screening Program, the Cervical Cancer Screening Program, and HIV programs.

Whilst STD/HIV programs have has a special funding line for indigenous programs, the other have been determined by mainstream agendas, and have failed to consider the poor state of Primary Health Care services available to many Aboriginal communities.

We urge the current collaborative effort be continued, but that it involve the reconvening of the Alukura Council, and mechanisms that can give more regular direction to the implementation of more integrated services in line with the priorities of Aboriginal women.

We propose the Central Australian Regional Indigenous Health Planning Forum facilitate a women’s health working group which has clear objectives for the strengthening of women’s PHC services.

**Mental Health**

In Aboriginal mental health, a clear distinction needs to be made between psychiatric problems such as schizophrenia and manic depressive psychoses, and the emotional stresses and malfunctioning consequent on the stresses of poverty, being dislocated from one’s family (stolen generations), and the problems people have coping with such things as petrol sniffing and alcohol consumption.

Whilst more classic psychiatric care is required for the former, a more culturally appropriate and community-based support system is required for the latter. In developing better programs for mental health it is important to be cognisant of the strong individuals that are in every community who are the supports and resource for people in times of crisis. Programs should build on these people, rather than taking their support role and replacing them with ‘professionals’.

The communities strengths are important building blocks for finding durable solutions to the poverty, alienation and despair felt by some community members. The role of the professionals is to recognise, support and strengthen the community leaders, networks and individuals who are providing the support to others.

These issues need to be balanced with the more classical, psychiatric programs required for those who are actually mentally ill.

In recent years the mental health service has improved its outreach to remote communities. However, their main services remain town based. They have also embraced a strategy aimed at improving the PHC sectors management of mental health problems. Given the resource limitations, this strategy needs to be maintained.

A series of circumstances have made grief a central emotion for many Aboriginal people. Loss has been a hallmark of Aboriginality – land, death, stolen generations. The reality of a life expectancy rate 20 years less than other Australians, is a community grieving. Whatever services are delivered, and whatever programs are developed, grief will be involved.

**Aged and Disability Services**

A detailed analyses of service for the frail aged and disabled is beyond the scope of this study. However, there are a number of issues that deserve consideration. Firstly it just be pointed out that, whilst aged services tend to operate separately to disabled services, there is really little that an aged person requires services for unless they are sick or disabled. Of course, young disabled people have needs quite different to aged disabled people.

In Alice Springs there are two nursing homes – Hetti Perkins operated by Aboriginal Hostels, and Old Timers operated by the Uniting Church. There is little doubt that many of the Aboriginal residents of these homes are not happy. They would prefer to be in their home communities – in their country – especially to die. This is of particular relevance to Primary Health Care services.

They provide a number of allied health services potentially relevant to aged and disabled care. These include a dementia worker, an incontinence worker, and the Adult Assessment Coordination Team.

As well, some communities run HACC (Home and Community Care) programs. These are aimed at providing various support to the aged and disabled, including meals, firewood and hygiene support.

There are also separate Advocacy Services, one focused on nursing home issues and the other on the rights of the disabled. Disability Services Central Australia provides support to clients with disturbed/challenging behaviour.

There has been a history of conflict between some of these services and Primary Health Care services in communities. Often PHC staff feel unable to cope with the demands that frail aged or disabled people present them with.
We suggest that a clear guide to agencies that offer services, and how to refer, would assist PHC staff to play a role. Case management plans that define the expected role of different agencies would also be of use.

We also suggest that the training program on Optional Standards of Care for Frail Aged Aboriginal People developed through the Central Australian Advocacy service, Menzies, and Congress be utilised in in-service training and orientation of staff about the issues of Aboriginal frail aged people.

**Aboriginal Health Workers**

Aboriginal Health Workers have been an integral part of primary health care service delivery to Aboriginal communities in Central Australia since the 1970s.

Education programs for AHWs leading to Registration through the NT AWHC Registration Board was initially through a process that was known as Basic Skills. Service providers, including T H S delivered this, Congress and other community controlled services. AHWs could take as long as required to gain the necessary skills. T raining was on the job, and assessments were oral and practical, rather than written and theoretical.

In the early 1990s, under the D awkins' plan to ensure tertiary educational institutions became large and cost effective, Batchelor College took an interest in taking on a number of education programs for Aboriginal people including Police Aide training and AHW training. In the early 1990s the T H S capacity for AHW education was handed to Batchelor College. Since then T H S have not had any involvement in AHW education. The transfer included the Bloomfield St Annex that was home to AHWs in a number of ways. It was where AHWs from remote communities could stay with their children when in Alice Springs. It was a safe haven, in what could otherwise be a dangerous place. It was also where they received their tuition. Many AHWs have complained and grieved the loss of this facility. Batchelor developed a Certificate level course for AHWs, which also led to Registration. Anyinginyi Congress took up delivering this course in Tennant Creek. Congress in Alice maintained its Basic Skills approach until recent years when the pressure about national competencies have led Congress to deliver an accredited course.

Up until the last few years Batchelor maintained a few bush based educators, but these have been withdrawn. AHW education is in deep crisis. The CA AHW Association has, we understand, again called for the re-introduction of the Basic Skills approach. T his approach does offer greater flexibility to AHWs, and implies the need for AHW employers to take more responsibility in providing educative support. The large number of qualified AHWs not working has been recognised for some years. The issues involve in this are complex, but their is little doubt that the lack of support is a major issue. Tregenza and Abbott have shown some of the clashes in perception of roles of AHWs between non-Aboriginal health professionals and AHWs and their communities. Better regional support for PHC services generally would assist in developing a more appropriate PHC function that recognised the diversity of roles for AHWs, rather than the assumption that they will be clinic based. T he particular crisis in the lack of male AHWs needs urgent attention. Tregenza & Abbott suggest that a role that is more focused on environmental health as well as some particular clinical tasks for men, and involvement in cultural matters might be more appropriate than male AHWs being expected to mirror the role of clinic nurses and female AHWs working in the clinic which is often seen as a women's place.

We note that the Draft T H S Review has recommended that educators be appointed to cover two Health Service Areas. We think this is an important step in the right direction. However, this regional support should be available to all AHWs, not just those employed through T H S. We are also concerned that 2 such areas are too large for effective AHW support. We suggest that at least 1 educator be employed for each Health Service Zone, but that the details of how these positions will work, and what access AHWs get to these educators be negotiated through the CA Indigenous Health Planning Forum.

We recognise the development of the CA Rural Health Training Unit, and its important role to provide targeted educational opportunities to AHWs in their communities. This should complement the work of the educators.

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Special (Preventive Health) Programs

We have avoided using the term ‘Health Promotion’ to describe programs in this report because promoting health should be included in the approach of all sections of the health system. This is consistent with the principles espoused in the Ottawa Charter.

Instead, we have drawn a distinction between clinical programs that should include various public health programs such as immunisation, growth promotion of children, nutritional advice in the context of clinic consultations, communicable disease control, and various screening programs, and programs that require action by the community.

It is widely appreciated that clinic based programs will not address many of the major causes of ill health. We have called these non-clinical programs special health prevention programs because they require community action (agency) for any chance of success. They include programs designed to deal with the following types of problems:

- Substance abuse (such as tobacco, alcohol and petrol)
- Nutrition. A distinction needs to be made between the nutritional advice given to patients who have been diagnosed as obese, diabetic, etc. and a nutrition program which is directed at working with the store to get healthy food stocked. The first is included under allied health professionals. The second is included here.
- Domestic and other violence.
- Child abuse or neglect.
- HIV/STD prevention – programs outside the clinical setting.
- Environmental health programs.
- Dog programs.
- Housing for health.
- Motor vehicle accidents – such as advanced driver education programs.
- Rubbish disposal.

Some of these programs may be delivered through primary health care services, but at times are also delivered through other community groups such as women’s centres, substance abuse agencies, or infrastructure agencies. Funding agencies need to recognise these needs, and allocate funds to them. However, such funds should only be released when certain criteria designed to detect community action are satisfied.

Substance Abuse Programs

It has been well documented over many years that substance abuse (particularly alcohol and petrol sniffing) are major problems in Central Australia. There has been a campaign conducted by the NT Government (Living with Alcohol) aimed at getting people to drink moderately. Whilst this has been an effective strategy for a significant proportion of the non-Aboriginal population who have been concerned to drink in a way that minimises harm, it is less effective amongst Aboriginal drinkers, who drink to get drunk.

There has been ongoing debate about different strategies for dealing with alcohol problems. Approaches that have some usefulness include:

1. Restrictions on availability: This has been shown to be effective in reducing overall community consumption of alcohol. However, it does not impact on all drinkers evenly. The way restrictions have been implemented include reducing the hours that outlets are open, and increasing the cost. Restrictions on availability should not be confused with prohibition.

2. Abstinence. Aboriginal programs have tended to focus on abstinence. Many Aboriginal communities have declared themselves dry, and the Central Australian Aboriginal Alcohol Programs Unit (CAAAPU) has concentrate on abstinence programs. Whilst this approach can be debated in regard to understanding of the nature of the problem, and the underlying causes of alcoholism (is it a disease, or not?), for people with the problem, abstinence is frequently the only way that they can lead a more normalised and useful life.
3. **Controlled drinking strategies.**

Many communities have wet canteens, frequently with some restrictions on both opening hours, and how much alcohol can be bought. In Alice Springs the Teweretye Club has been operating for some years. Outcomes are not easy to assess. But there is little doubt that some of the drinkers at the club would otherwise be drinking in drinking camps in the river bed, or other location. Some restrictions on quantity consumed can be achieved in the context of a club environment. Fights can be better controlled, and any episode of ill-health (eg convulsions) are more likely to receive more timely assistance, than would be the case in drinking camps.

We suggest that a mixture of approaches is appropriate. No one strategy will suit all sections of the community.

Current programs addressing alcohol abuse include:

1. Central Australian Aboriginal Alcohol Programs Unit (CAAAPU). CAAAPU has been slowly developing it's programs after suffering funding cuts. It currently provides day programs and liaises with the hospital. It currently has little funding, and the program is under self-review.
2. Anyinginyi Congress run a rehabilitation program at Likkaparta.
3. There is a residential rehabilitation facility at Injartnamu, an out-station of Ntaria (Hermannsburg). They have little funding, and the program is under self-review.
4. A bush rehabilitation program is also operating out of Mt Theo, an out-station of Yuendumu.
5. There is a small residential rehabilitation facility at Mt Theo (near Yuendumu).
6. THS have a program called "Living with Alcohol" which is based on the strategy of moderate drinking behaviours.
7. Teweretye Club are attempting to encourage social, controlled drinking amongst its clients.
8. DASA runs a sobering up shelter in Alice Springs, and a similar facility operates in Tennant Creek.
9. Hoalyoake runs co-dependency programs in Alice Springs.

Petrol sniffing is a major issue in some communities in Central Australia. While this is a problem in only some communities, it is devastating to the communities in which it has a hold. Petrol sniffing permanently damages the sniffer's brain if they sniff long enough. It causes hallucinations which appear to be responsible for much of the violent outbursts of sniffers. It also impacts on the family and community in which they live. Many people are fearful of sniffers, and feel powerless to do something. Unfortunately, competing ideologies have prevented some fairly straightforward action being taken.

There are few programs designed to deal with petrol sniffers. Petrol Link-up which operated for some years and encouraged the use of aviation fuel as an alternative to petrol appears to be non-functioning. There are residential or respite facilities outside a program for petrol sniffers and young offenders at Ilamurta, an out-station of Waliace Rockhole, although CAAAPU and some other mainly alcohol programs are prepared to take on this role. There is a view by some that the same principles apply to both poisons.

While it is beyond the scope of this project to develop detailed program guidelines, we believe that a centre capable of providing sniffers with support whilst they withdraw, and families/communities with respite from the problem is fundamental to improving the situation. Programs should also provide support to family/ carers so that they increase the likelihood of stopping this problem.

There appears to be an urgent need for residential rehabilitation and respite facilities for both alcohol and petrol users.

**Environmental Health**

It has been common for politicians and others to claim that Aboriginal health will not improve until the environmental living conditions - housing, water, sewerage and waste disposal - improve. There is no doubt that these issues are a cause of ill health. However, we can say that these factors relate largely to infectious disease (gastroenteritis, skin infections, respiratory infections) and particularly impact on children, the ill and elderly.

Improvement of environmental health factors depends on an intersectoral approach. It is beyond the capacity and expertise of the health care sector to deal with these problems. Housing associations, and resource agencies play an important role in this area.

Nganampa Health have contributed significantly in this area through their housing for health* programs (UPK*). They have shown that when the infrastructure works people use it. Thus there is an issue of what technology is incorporated into housing and other infrastructure - it must be durable and able to be maintained within the capacity of the community.

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Environmental health issues demand intersectoral action. The role of PHC is fairly minimal in this. A good system would allow the PHC sector to communicate promptly with appropriate resource agencies to ensure that particular problems such as blocked toilets, contaminated water supplies, and malfunctioning infrastructure are fixed promptly. The development of skills about settled living and the use of ‘health hardware’ are also required.

Male AHWs in some communities may be able to play an environmental health role alongside a men’s health role. These options should be pursued.

Consideration needs to be given to the development (or modification) of a database of infrastructure needs of communities which can be modified by inputs from the ground – such as through the work of environmental health workers, or male AHWs playing an environmental health role. At the present time, it is difficult for AHWs to know what to do when they find that sewerage is leaking, or the water supply is contaminated. An intersectoral focus on infrastructure issues may enable infrastructure/resource agencies to access information from AHWs who come across these types of problems.

**Nutrition**

Poor nutrition has a number of consequences to people’s health. Firstly, poor nutrition of children results in poor growth and development. This limits the physical and intellectual capacity of the child, and clearly child nutrition needs to be a major part of a child health program, and should include the encouragement and support of breast feeding.

The child’s start in life is influenced by the health of the mother during pregnancy, and this is largely determined by nutrition. Thus antenatal care should incorporate support for better nutrition.

In adulthood, poor nutrition is largely responsible for diabetes, high blood pressure and heart disease. Diabetes and heart disease both damage the kidney, and contribute to the high rate of end stage renal disease in Central Australia.

Issues that need to be addressed strategically are:

1. Better knowledge of nutritional information so that people can make more informed choices;
2. Changing eating habits (This does not necessarily simply flow from better knowledge.)
3. Ensuring the availability and accessibility of nutritious food.

Approaches that need to be developed in regard to better nutrition include:

1. Nutritional advice to women about the needs in pregnancy, and child health, as well as advice to people with diabetes, heart disease and other nutritionally related disease. This is the task of clinical nutritionists, or dieticians. In our proposed model, such professionals would be visiting communities on a regular basis.
2. Opportunities to develop groups of people with nutritionally related disease meeting together may lead to a strengthening of better attitudes about health and food in the community. That is this may help support a change in peoples behaviour. A visiting nutritionist/dietician may be able to play a role in initiating interest, but would require either a client themselves, or an AHW to take a facilitating role to enable meeting to occur on a regular basis.
3. The availability of nutritious food is, however the most critical of the three strategies. Even if the first two areas are effectively implemented, people will not be able to eat healthy food if none is available. Previous attempts at addressing this policy have included a joint health service staff-store managers workshop. However, this collaboration has not been sustainable. Methods of auditing store sales as a measure of community nutritional have been developed. This was done as part of a response to community concerns about heart disease, and included a program of labelling food in the store according to its nutritional value in regard to heart disease and diabetes. The community concern and involvement were key aspects to what was possible in that community. Some of this work has challenged some assumptions about people’s eating habits, as well as what makes a store profitable. Many stores have shown that profit can be made whilst also stocking fresh fruit and vegetables, for example.

Almost certainly, opportunities will present themselves for linking the clinical functions of individual nutritional counselling (and the distress the individual with diabetes or heart disease feels about their poor health) with the problem of the lack of availability of nutritious food in the store. Turning individual counselling into group activity focused on nutritious food, might help provide such opportunity. Developing positive working relationships between store managers, health service staff, and community members might help improve the situation.

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Central Australian Health Planning Study

Perth Health Rydals

July, 1997
The cost of food is a further problem affecting people's access to nutritious food, and sometimes any food at all. The lack of economic activity in many remote communities, and the consequent high unemployment rate, and poverty is a major determinant of people's health status. The high cost of food is a major barrier to overcoming the high rates of diabetes and heart disease in remote communities.

Where people live in smaller out-stations, there is more likely to be increased access to bush tucker, compared with living in larger population groups. A survey at Utopia (Urapuntja)\(^47\) estimated that at one out-station serviced by Urapuntja Health Service, around 40% of the people's diet came from bush tucker. It is difficult not to conclude that some of the lower rates of diabetes in that community were partly due to this significant intake of such high quality food.

The implications of this for health service development relate to the need to provide a flexible, but strategic, bureaucratic framework within which Primary Health Care services can be flexible and responsive to the needs of a dispersed and mobile client population.

**Renal Disease in Central Australia.**

Figure 48: Projected Number of New Cases of End Stage Renal Disease from 1994 to 2010.

Source: Territory Health Services.

This graph shows the projected increase in new cases of end stage renal failure expected in the Northern Territory until the year 2010. It shows a significant increase.

The graph on the next page shows the expected increase in the total number of people with end-stage renal disease over the same period.

The increase has significant implications for health service development. Existing renal dialysis facilities will be totally inadequate.

The cause of this epidemic of renal disease in Central Australia is not due to one factor alone. It is related to a mixture of factors including relative dehydration in a hot climate from childhood, kidney stones, urinary tract infections, poor water with high solutes such as nitrates, skin and throat infections, and adult chronic disease such as diabetes and hypertension, both of which damage the kidneys.

This problem highlights the need to support special health prevention programs aimed at improving water supplies, nutrition and general living conditions. Improved primary health care coverage is also important to ensure the timely treatment of infections (urinary, skin and throat) and to offer treatment for diabetes, hypertension and impaired renal function. It also means that more support needs to be given to people with renal disease to be able to remain in their communities, rather than having to move (usually with their families) to Alice Springs.

The recently formed Renal Forum needs to be supported to develop appropriate strategies to both try and prevent the expected increase in cases, and to better manage those with the disease, so that they might lead a more normalised life. The experience of the Renal Unit at the Royal Perth Hospital is worthy of further investigation. We understand that they have developed some success at getting people back to their communities where they can manage their dialysis. It depends on intensive training in the use of the equipment, the intimate involvement of a family member, and a hot line from the persons home direct to the Renal Unit in Perth for support.

Figure 49: Projected Increase Of Total Number (Cumulative) Of Clients With End Stage Renal Disease From 1994 to 2010.

Source: Territory Health Services.

The other major concern of the expected rise in people with renal disease is the high cost involved in dialysis and transplantation programs, and the overall impact this will have on the financing of the health care system. The resources available to primary health care in Aboriginal communities is already clearly inadequate. The cost of dealing with renal disease may make the resources available to other important health care issues even more limited.

A recent report\(^4\) has documented the social and cultural issues involved in renal disease in Central Australia. This is an invaluable resource for gaining insights which should help inform decision makers about action required.

One of the main recurring issues for people on renal dialysis, is their accommodation needs. They mostly come with their family, and have no experience dealing with the Department of Lands and Housing - the rules of tenancy, the need to pay rents regularly, the Departmental disapproval of large numbers of people living in the house, etc. Arrernte Council run a housing advisory service which is dealing with some of these issues. The Renal Forum should work with other departments and agencies in sorting out these problems.
BIBLIOGRAPHY

Aboriginal Health Policy Territory Health Services, Darwin, 1996.


ATSIIC Information Package, Attachment B ‘Proposed NAHS funding to 1994-95. ’Prepared for National Conference

ATSIIC Regional Plans - Alice Springs, Yaprakurlangu and Papunya.

Aboriginal Communities, Jan’97.


Bartlett B & Legge D Beyond the Maze: Proposals for more effective administration of Aboriginal health programs.


Carter E et al Borning:1987 Pmere Lâtyeke A wmerne A mpe M pwatetyeke Congress A lukura by the Grandmother’s

Census of Population Aboriginal and Torres Strait Islander Count, Cat. No 2722.0, ABS, Canberra 1991.

Centre for Appropriate Technology, Annual Report’94

Central Australian Aboriginal Health Training Unit, Australia: Development Committee Paper, 1996.


Central Land Council, Aboriginal Communities List.

CHASP (Community Health Accreditation & Standards Program) ‘Manual of Standards for Community and Other
Primary Health Care Services.’ Australian Community Health Association, Sydney, 1993.

CHASP Manual of Standards for Remote/ Rural Community and Other Primary Health Care Services.’ Australian
Community Health Association, Sydney, 1994.


Devitt, J & McMasters, A ‘Living on Medicine: Social & Cultural Dimensions of End Stage Renal Disease Among
Aboriginal People of Central Australia.’ Central Australian Aboriginal Congress, 1996.

DMO Report 1996 Barkly T H S.


Hunter, E ‘A Aboriginal Health and History: Power & Prejudice in Remote Australia.’ Cambridge University Press,

Institute of Aboriginal Development: ‘W erter!’ A survival guide to Central Australian Aboriginal Languages IAD Press
Alice Springs 1997.

Josif & Eldertson, C ‘W orking Together! A Review of a Aboriginal Health W orkers: Recruitment & Retention in the
Northern Territory’s Top End. ’ NT Department of Health & Community Services, Darwin, 1992.


Lea, D & Wolfe, J Community Development Planning and Aboriginal Community Control.’ NARU, ANU, Darwin, 1993.

Local Government Association of the NT: Straight Talking. A guide to negotiating and consulting with remote area
local government Councils.

Mammott, P, W right, A et al ‘Alice Springs ATSI Regional Council Regional Plan’ Vol 1 Planning Manual,
Aboriginal Environments Research Centre, Brisbane, April, 1993.

Memmott S, W orking Together: A Review of a Aboriginal Health W orkers: Recruitment & Retention in the
Northern Territory’s Top End. ’ NT Department of Health & Community Services, Darwin, 1992.


Lea, D & Wolfe, J Community Development Planning and Aboriginal Community Control.’ NARU, ANU, Darwin, 1993.

Local Government Association of the NT: Straight Talking. A guide to negotiating and consulting with remote area
local government Councils.

Mammott, P, W right, A et al ‘Alice Springs ATSI Regional Council Regional Plan’ Vol 1 Planning Manual,
Aboriginal Environments Research Centre, Brisbane, April, 1993.

Memmott S, Working Together: A Review of a Aboriginal Health Workers: Recruitment & Retention in the
Northern Territory’s Top End. ’ NT Department of Health & Community Services, Darwin, 1992.


Hunter, E ‘A Aboriginal Health and History: Power & Prejudice in Remote Australia.’ Cambridge University Press,

Institute of Aboriginal Development: ‘W erter!’ A survival guide to Central Australian Aboriginal Languages IAD Press
Alice Springs 1997.

Josif & Eldertson, C ‘W orking Together: A Review of a Aboriginal Health W orkers: Recruitment & Retention in the
Northern Territory’s Top End. ’ NT Department of Health & Community Services, Darwin, 1992.


Lea, D & Wolfe, J Community Development Planning and Aboriginal Community Control.’ NARU, ANU, Darwin, 1993.

Local Government Association of the NT: Straight Talking. A guide to negotiating and consulting with remote area
local government Councils.

Mammott, P, W right, A et al ‘Alice Springs ATSI Regional Council Regional Plan’ Vol 1 Planning Manual,
Aboriginal Environments Research Centre, Brisbane, April, 1993.

Memmott S, W orking Together: A Review of a Aboriginal Health Workers: Recruitment & Retention in the
Northern Territory’s Top End. ’ NT Department of Health & Community Services, Darwin, 1992.


Lea, D & Wolfe, J Community Development Planning and Aboriginal Community Control.’ NARU, ANU, Darwin, 1993.

Local Government Association of the NT: Straight Talking. A guide to negotiating and consulting with remote area
local government Councils.

Mammott, P, W right, A et al ‘Alice Springs ATSI Regional Council Regional Plan’ Vol 1 Planning Manual,
Aboriginal Environments Research Centre, Brisbane, April, 1993.
NT Cattle Stations Health Policy, Darwin (Undated).
NT Department of Lands, Planning and Environment. "NT Aboriginal Communities." Darwin, November, 1996.
OATSIHS Aboriginal Health Profile, NT Southern 1996.
Pederson, AP et al. 'Coordinating Healthy Public Policy: An Analytic Literature Review and Bibliography.' Department of Behavioural Science, University of Toronto, 1988.
Tangentyere Council Annual Report '95/96.
APPENDIX 1

Template for Data Collection

1. Population data
   • Populations of communities and out-stations organised by language group and including age-sex structure.
   • Population mobility patterns.
   • Population projections, if available.
   • Data regarding the hierarchy of communities/ out-stations. That is, to which larger communities do smaller communities/ out-stations relate. Is there data that can indicate the key determinants of this?
   • Distances between communities/ out-stations and the community offering the next level of support, and from Alice Springs, or (in the Barkly) Tennant Creek.

2. Health service resources in communities
   • Numbers of staff on-site by role, profession, and sex.
   • Buildings - clinic and staff accommodation. Is data available that indicates the condition of this infrastructure?
   • Data on separate gender space in clinics.
   • Medical equipment provided by community/ out-station.
   • First aid/ white boxes by community/ out-station.
   • Number of vehicles by type (eg sedan, troop carrier).
   • Computer hardware.
   • Communications hardware – radios, telephones, Tanami network, and television.
   • Visiting services provided to each community/ out-station by type of service (eg nurse, dentist, physiotherapist) and frequency.
   • Orientation and education/ training for staff – frequency, duration of sessions by target profession, and location.

3. Client Utilisation data:
   • Where do clients of each service come from? Number of clients using facility over time by facility and by community of main residence. How health services are accessed – visits by health service staff, travel to the health service, phone?
   • Referral patterns by degree of urgency – evacuation Vs routine (investigations/ treatment/ follow-up). Numbers of clients accessing secondary/ tertiary services by where they live and by referring agency?
   • Transport availability for access to health services.
   • Hospital utilisation by community, referring agency, diagnosis and age & sex.
These terms of reference were drafted in consultation with the major stakeholders and key community groups.

1. The region is to cover the ATSIC regions of Tennant Creek, Alice Springs and Papunya. It may also examine the needs of any communities which are beyond these regions but which have an established relationship with communities or health services within the regions.

2. The purpose of the plan is to identify health priorities and provide practical solutions to improving access to health care with emphasis on access to primary health care.

3. As part of the regional planning process the Plan will co-ordinate and inform future funding decisions for both the Commonwealth Department of Health and Family Services and Territory Health Services and ATSIC.

4. The plan will identify practical interventions that will have the greatest possible impact on improving health outcomes.

5. The process will also include an implementation plan which may involve more detailed local planning in communities that have been identified as having priority in the regional plan.

6. Planning will involve community participation and both quantitative and qualitative data. However, rather than repeat consultations carried out for other reviews, it will draw and build on work already undertaken in the communities of the region for this purpose. A list of known studies which have immediate relevance is at Attachment 1.

7. Where particular issues which are amenable to an immediate response are identified during the planning process, they will be referred to the appropriate agencies for attention.

8. An implementation strategy for the identified actions will also be part of the planning process. This plan will provide the framework for monitoring and evaluation of the plan for the region.

9. The plan will cover (but not be restricted to) the following issues:
   - renal issues;
   - access of men to appropriate health care; women's health issues;
   - diabetes;
   - patient transport issues, in particular transport home after hospitalisation; health promotion/prevention;
   - provision of specialist services;
   - referrals;
   - community health priorities;
   - traditional health structures and methods; ways of increasing community control of health; access to pharmaceuticals;
   - the potential to pool resources between community controlled health services ie. the establishment of a medical supply house; operational costs of health services;
   - staff recruitment and retention, including the need for staff housing; quality control issues regarding staffing; the needs of emerging out-stations; training and provision of Aboriginal Health Workers; and
   - double standards in treatment between Aboriginal and non-Aboriginal clients.

10. The current level of alcohol and substance misuse services to the communities is to be measured.described. However, recognising that responses to issues of substance misuse require particular expertise, these will be dealt with through a separate process.
APPENDIX THREE

STEERING COMMITTEE

William Tilmouth, Chair, Alice Springs ATSIC Regional Council.
Clarrie Robinya, Chair, Papunya ATSIC Regional Council.
Noel Hayes, Chair, Yapa Kulangu ATSIC Regional Council.
John Liddle, Aboriginal Medical Services Alliance, NT (AMSANT). (Stephanie Bell filled this position in the early part of the project.)
Alison Anderson, Papunya Community.
Shirley Dempsey, Urimpe Community.
Jimmy Haines, Anmatyerre Community Council.
David Scholz, Mutitjulu Health Service.
Ross Brandon, Director, Central Australian Region, Territory Health Services.
Phillipa Lowrey, OATSIHS, Project Officer.
Michelle Adams, OATSIHS, Alice Springs Regional Office.
CONSULTATIONS CONDUCTED

John Delaney, Commissioner responsible for health, ATSIC.
Geoffrey Shannon, Anyinginyi Congress, Tennant Creek.
Mollie Kennedy, Santa Teresa.
John Liddle, Central Australian Aboriginal Congress.
Stephanie Bell, Deputy Director, Central Australian Aboriginal Congress.
Lynore Geia, Central Australian Aboriginal Congress Aukura.
John Gill, Amphilatwaj Health Service.
Chris George, Central Australian Aboriginal Congress.
Lisa Young, Anyinginyi Congress, Tennant Creek.
Noel Hayes, Chair, Yapakurlangu ATSIC Region, Tennant Creek.
John Boffa, Central Australian Aboriginal Congress.
Bill Williams, Pintupi Homelands Health Service.
Graham Kelly, Urapunja Health Service.
Brian Nolan, Urapunja Health Service.
David Scholz, Muitjulu Health Service.
Don Blackman, Aputula.
Alice Springs ATSIC Region Council.
Elliott McAdam, Julalikari Council Aboriginal Corporation.
Helen Liddle, Central Australian Aboriginal Alcohol Planning Unit.
Mike Bowden, Tagencyere Council.
Dennis Williams, Ingkerke.
Toly Sowenko, Central Land Council.
Jack Crosby, Central Land Council.
James Ensor, Central Land Council.
Bruce Walker, Centre for Appropriate Technology.
John Lawrence, CA Rural Health Training Unit.
John Grundy, Menzies School of Health Research.
David Scrimgeour, Menzies School of Health Research.
Komla Tsey, Menzies School of Health Research.
John Tregenza, Aboriginal health consultant.
Barbara Schmidt, Remote Services, THS.
Ross Brandon, THS.
Sue Korner, THS.
Joyce Bowden, Alice Springs Hospital.
Jenny Mills, Community Health, THS.
Cynthia Ahamat, THS & AHW Association.
Rose Elliott, AHW Association.
Kathy Stowe, Barkly THS.
Barb Shaw, Barkly THS.
Sally Moley, Renal Unit, THS.
Helen Burns, Alice Springs Hospital.
Chris Burrows, Alice Springs Hospital.
Ilona Papajcsik, Population Health Unit.
Gill Hall, Population Health Unit.
Bruce Simmons, Community Health Centre.
Nick Williams, Remote Services, THS.
Fred Mclege, Palliative Care, THS.
Heather Boulden, THS.
Steve Byrnes, Royal Flying Doctor Service.
Steve Peers, St John's Ambulance.
Sandy Ambar, Central Australian Division of General Practitioners.
Elspeth Young, Australian National University Canberra.
John Taylor, Australian National University Canberra.
Bob Durnan, Jo Wynter and John Hill – community development consultants.
Barry Byerley, Amoonguna.
Alan Passmore, Docker River.
APPENDIX 5 - COMMUNITY HEALTH SERVICE PROFILES

The following community profiles incorporate information that was available to us at the time of preparing this report. The information is clearly incomplete, with detailed information available for some communities' out-stations and none for others. Some of this information will have changed since preparing this report.

NORTHERN BARKLY (JINGILI)

Nicholson River
These are a number of small communities' out-stations including Muran Murula, Wangalinji, Gumuluji, Burrumburru, Bajaminyi, and Nudgebarra. These communities are in the Yapakurlangu ATSIC and in the Northern Land Council (NLC) regions.

Location: They are very isolated located 300km NE of Tennant Creek near the Queensland border. It is an 8-hour drive on poor roads, which are unpassable in the wet. There are connections with Doomadgee and Mt Isa as well as Tennant Creek.

Muran Murula / Murul Murula
Population: The population is around 35, but is unoccupied for significant periods. More likely to be occupied during the dry season. Category 2.

Languages: Wombaya.

Land Tenure: Out-station on Waanyi/Garawa Aboriginal Land Trust (ALT). There is very little infrastructure.

Communications: Public telephone is available. School also has telephone and fax.

Current Health Services:
Clinic: There is no clinic. Some medical sundries are left in the community with a senior woman. In emergencies people sometimes access services at Borroloola.

Visiting Services: Barkly mobile and the medical officer visit intermittently, infrequently and irregularly – said to be 2-3 times per year, by road or air.

Airstrip is at Wangkalinyji, population 20 and 16 km away from the community.

Other out-stations, which are on the Waanyi/Garawa Aboriginal Land Trust and are also near the Queensland /NT border include:

Burrumburru
Population 15

Bajaminyi
Population 15

Najabarra
Population 40

Gumuluji
Population 0

Jilundari
Population 5

Elliott - Kulumindini

Location: Elliott is located 25km north of Tennant Creek on the Stuart Highway which ensures good road access all year round. Communities in this zone are within the NLC region.

Population: There are around 180 Aboriginal people living in Elliott plus another 70 people living in town camp. There is also a non-Aboriginal population of around 160 people, making a total of around 410 people. As well there are around 50 people living on out-stations fairly close to Elliott, making a total of 500 people.

Languages: W aramanja, Jingali, W ombaya and M utpurra.

History: Elliott was begun as an army depot half way between Darwin and Alice and was named after the army officer in charge. South Camp began 25 years ago. North Camp began in 1968 with people from Newcastle Waters Station.

Land Tenure: Elliott is a gazetted town. The Town Camps are managed under the Gurungu Council.

Communications: Telephones readily available in the town.

Current Health Services:

Category: A categorisation of out-stations (numbers 1-7) has been developed as part of a picture of population dispersion. See page 31.


Staff: 2 female nurses, 4 female AHW s and 2 trainee AHW s. 1 female & 1 male. A medical officer visits 2 days per fortnight. The trainee AHW s work in the clinic when not in school in Alice Springs. In recent times some effort has been made to visit the town camps, and especially elderly people.

Clinic: Clinic in good condition.

Vehicles: Service has 2 x 4wd vehicles.

Staff accommodation includes 1 x 3-bedroom house and 3 self-contained units for visiting staff.

Airstrip: is well maintained and available for night use.

Visiting Services: Dentist 3 times/year; Mental Health Services monthly.

**Elliott Town Camps:**
- Kurungu
  - Location: North (Camp) side of Elliott. Population 155. Telephone. Category 1
- Wilyuku
- Out-stations, which do not have any visiting services, include:
  - Jandaloo/ Beetaloo
  - Wulamanta/Murunji
  - Marlinja/Newcastle Waters
  - Jangirulu/Powell Creek

**The Barkly Tablelands:**

There are no clinic structures, staff accommodation or vehicles in any of the communities on the Tablelands. There are no AHW positions filled. Barkly Mobile visits every 4-6 weeks between Archer and Cootar. Medical officer visits every 8-12 weeks in the dry season. Mental Health Services visit every 3-4 months. These communities are also in the Yapakurlangu and NLC regions.

**Corella Creek:**
- Location: 370km SE of Elliott, 380km NE of Tennant Creek. Out-station on Brunette Downs Pastoral Lease (PL). Previously at Ngunarra near Brunette Downs homestead. Category 1. Population 45. Ten to twelve houses well occupied. There has been some recent ATSIC discussion of a resource centre for the Barkly at this location. Road not accessible in all weather.

**Brunette Downs:**
- Located 350km NE of Tennant Creek, 340km SE Elliott. It is a good road except for the last 16km. The community has now moved to 16sq km excision at Corella Creek. Pastoralist receives Health Care Agent Subsidy Scheme. There is an all-weather airstrip at the Brunette Downs Station.

**Connel’s Lagoon:**
- Location: 300km E of Elliott, 500km NE of Tennant Creek. Population 20. Category 1. No telephone but radio. Road is not accessible in all weather.

**Illiywurru:**
- Location: 300km E of Elliott, 500km NE of Tennant Creek. Population 15. Category 1. Telephone. Road is not accessible in all weather.

**Alexandria Station:**
- It appears that this is not a permanent camp but rather for station employees and can sometimes have a population of 30. Pastoralist receives the Health Care Agent Subsidy Scheme.

**Gulungurru/Alroy Downs:**
- Location: 230km ENE of Tennant Creek. Population 15. Category 1. Radio but no telephone, airstrip at station. Road is inaccessible in wet season.

**Wunara/Barry Caves:**
- Location: 310km E of Tennant Creek, 180km south west of Camooweal. Population 15. Category 1. Strong Mt Isa and Dajarra connections. Store and telephone. Road is inaccessible in wet season.

**Armchair:**
- Location: 14km E of Brunette at Tablelands Highway turn off. Population 5. Category 1. Bush camp that has persisted at this location without any services for 2 years. Brunette Downs has offered alternative area but not accepted by occupants. NLC involved in excision negotiations.

**Wakayala/Wogayala/Rockhampton Downs:**
- Location: 170km ENE of Tennant Creek. T wo and ½ hr drive. Population 35. Category 1. Telephone. Airstrip at station. Vulnerable in prolonged wet weather. Links to Tingkari town camp. Some of this area is in the NLC region.
Ngurrara/ Frewena/ Maranawili/ Archie’s place

Kumunu/ K G’s place
Location: S of Muckaty boundary on ALT N of Tennant Creek, W of Banka Banka. Bore and limited infrastructure. Proposals for out-stations in the Alexandria locality - Category 7, include:

Waramanta/ Corkwood Bore
Location 120km N of Tennant Creek and NE of Banka Banka. Excision application in preparation. This is within the NLC region.

Ranken Store, Muluparta Lorne Creek, Wumarana No 2, W arlungaminypa (on Karlantiipa N ALT) and Soudan.
Category 7.
Other Category 7 out-stations currently under going negotiation include:
Anthony’s Lagoon (Anthony’s Lagoon locality), Creswell Downs - 2 proposals here are under negotiation, as well as one proposal on Eva Downs.

CENTRAL BARKLY (WARAMANGA - WARLPIRI)

Tennant Creek
Location: Tennant Creek is located 500km N of Alice Springs on the Stuart Highway. The road access to Alice Springs is good all year round. This is within the Yapakurlangu ATSIC region and Central Land Council (CLC) region 6.
Population: According to the 1991 ABS Census, the Aboriginal population of Tennant Creek was 928 of a total town population of 3,480.
Communications: All telecommunications.
Current Health Services: Primary Health Care services are delivered primarily through Anyinginyi Congress. There is also a private general practitioner in Tennant Creek, along with a small community hospital, which has 20 beds. There are no specialists at the hospital and serious medical cases are transferred to Alice Springs. Specialists visit from Alice Springs for monthly Outpatient clinics.

Remote Area Services - Barkly
The Remote Area Service which is based in Tennant Creek, provides PHC services to remote communities in the Barkly through the Barkly Mobile, a medical officer and community-based services in some communities (eg Elliott and A lekarenge). Remote Area Services includes a population health unit with a nutritionist, environmental health worker and an Aboriginal health promotion officer.

THS services provided to Tennant Creek include:
- Aged and disability services.
- Family Youth and Children’s Services (FYCS).
- Children’s Services, which includes an occupational therapist and speech pathologist.
- Mental Health Services who also provide services to remote communities.
- Community based services include an alcohol program, infant and maternal health, a schools reading program, domiciliary care and women’s health.

Anyinginyi Congress:
Anyinginyi Congress is the main PHC provider in Tennant. Anyinginyi Congress runs services other than health care services. We have not included these activities, but only those that relate specifically to health service delivery.
Staff: 3 medical officer positions (2 currently filled, 1-male, 1 female), 10 AHW’s (7 female, 3 male), 1 clinic nurse.
Clinic: The clinic is in good condition, but too small for current needs.
Airstrip: Tennant has an all-weather air strip in good condition.
Visiting Services: There are regular visits by some specialists from Alice Springs including renal physician, paediatrician.

Anyinginyi Congress provides a medical service from their main clinic in Tennant Creek. They also service the Town Camps.

Tennant Creek Town Camps
Karguru telephone
Village Camp telephone
Kaytetye Camp telephone
Mulga Camp telephone
Blueberry Hill telephone
Wuppa/Little Mulga telephone.
Drive-In Camp no telephone.
Tingkarii, telephone.
Karguru North/Top Camp no telephone.
Karguru North/Bottom Camp no telephone.

Central Australian Health Planning Study
Par Health Pty Ltd
July, 1997
Anyinginyi provide support to the Continuous Ambulatory Peritoneal Dialysis (CAPD) program and employ a full time dentist and run a well-established dental clinic. Apart from clinical services Anyinginyi also conducts a community health program providing preventive programs in the community. A Family Support Program includes an under 5s program and a women’s health program are also provided. Anyinginyi is also involved in alcohol rehabilitation programs.

Anyinginyi also provides a mobile service to 15 out-stations within a 100km radius of Tennant. Some of these include:

**Kalumpurlpa**
- Location: Around 90km N of Tennant Creek. Population 15. Category 1. Telephone. Road not accessible in all weather requiring air food and medicine drop(evacuation) in recent past.

**Blue Bush**
- Location: NW of Tennant Creek. Population family group 10, Category 1. Telephone.

**Likkaparta**
- Location: 70km NE Tennant Creek. Population 30. Category 1. Telephone. Two houses leased by Anyinginyi for alcohol rehabilitation and currently visited by AHWs 2-3 times a week.

**Mangalawurru**

**Kurraya /Gosse River**
- Location: 45km E of Tennant Creek. Population 5. No telephone. Two houses.

**Jungkagi /Greenwood/Utyulunyu**

**Murtalki /Seismic**

**Warrego**
- Location: 50km west of Tennant Creek. Population UA. A mining town which has employment fluctuations. Mental Health Services visit. Anyinginyi Congress also visits.

Other out-stations within 100km radius of Tennant which receive no visiting services include:

**Nguyarrmini**
- Location: 70km SE of Tennant Creek. Population 20. Category 1. No telephone or airstrip. History of walking to TC in wet weather when cut off. Road inaccessible in all weather.

**Karliwampa/ Kantaraji/ Bush Camp**
- Location 15km SW of Tennant Creek. Population 10 min drive. Category 6/1. Presently unoccupied but plans to connect mains water supply in progress expect to bring re-occupation in near future. No telephone.

**Pingala/ Jurntujangu**

**Wiitin / Telegraph Station/ 7 Mile**
- Location: 15km N of Tennant Creek near Telegraph Station. Category 4. Recently established. Population N/A.

**Ngappamilarnu**
- Location: W of Tennant Creek. Out-station on Karlantijpa SALT occupied for short periods since infrastructure put in place in the late 1970s.

**Ngurrutiji/ Noorandidgee**
- Location: 75km SE of Tennant Creek. Category 2. Currently being considered as a site of reoccupation.

**Panjirriji**
- Location: 106km SSE of Tennant Creek. Category 6. Residents currently live at Mungkarta.

**Kunayungku**
- Location: W of Tennant Creek. Category 2. Unoccupied since coincidental events of a death of a senior woman and an earthquake. There is current interest to reoccupy.

**Myicampi/ Parntaparijji**
- Category 6. Bore only. Proposed Out-stations, Category 7, include:
Jananginyi/ 20 mile
Location: 28km SE of Tennant Creek. Category 7.

Pawuwa
Location: 50km NNW of Tennant Creek. Title issued. Out-station of Karguru Camp

Ngapagupanu
Location: N/A on K arlantijpa N ALT

Pukalki
Location: 54km NE of Tennant Creek via Barkly Hwy.

Other out-station proposals, Category 7, on land already under Aboriginal ownership include:
Purrurtu, Pinjinja, Crow Downs, Kuparla, Ngalyipiparnta, Wukalyi, Marrwaji.

Out-station proposals subject to ongoing land negotiation include:
Partakula/ Banka Banka and Jarrkirrki/ Brunchilly

SOUTHERN BARKLY (WARAMANGA - ALYAWARRE)

Alekarenge
Location: Located 170km S of Tennant Creek, and 20km east of the Stuart Highway. Roads are all weather roads.
These communities are in the Yapakurlangu ATSIC region and in CLC region 6.
Population: Estimated at 300.
Languages: Warlpiri, Kaytetye, Waramanga, and Alyawarr.
History: People were moved to here from Phillip Creek in the 1950s because of water problems at Phillip Creek.
Land Tenure: Land is owned by the Kaytetye and Alyawarr traditional owners.
Communications: Telephones are available at the council, school, clinic, store, police station and some houses.
Current Health Services:
Staff: There are 2 female AHWs, 1 full time and 1 part time. There are two nurses, one male and one female.
Clinic: A large clinic with multi-function facilities in adequate condition.
Vehicles: 2 x 4WD D vehicles, one fitted out as ambulance.
Staff accommodation: 4 flats are available for staff accommodation. There have been staff accommodation shortages for visiting staff.
Airstrip: Only useable in fair weather.
Visiting Services: Medical officer visits one day every two weeks. The dentist visits. Mental Health Services visit every month.

The following out-stations do not receive any visiting services.

Jarra Jarra

Imangker/ Imangara/ Murray Downs

Wakuipu/ Wauchope
Location: 60km NNW of AK and 45min drive. 116km S of Tennant Creek and 1hr and 10min drive. Population 15.
Category 1. Telephone and airstrip at Wauchope Hotel. Recently established. Historical residential and family ties with Alekarenge and Greenwood but resource base is Tennant Creek including health.

Imperrenth
Alepwyneh/ Hatches Creek

Canteen Creek
Location: Located to the north east of the Davenport Ranges 273km SE of Tennant Creek. The road is poor in wet weather. It is a 31/2hr drive to Tennant Creek and a 4 hour drive to Alekarenge on a very poor road. Access during the wet is sometimes impossible.
Population: 145 people.
Languages: Alyawarr and Waramanga
History: Long established minor community with full services.
Land Tenure: L and is under claim, no title as yet.
Communications: Telephone
Current Health Services:
Staff: 1 part time female AHW.
Clinic: There is a clinic, with separate men’s and women’s rooms.
Vehicles: The health service had a vehicle, but it was stolen and has not been replaced.
Staff accommodation: There is staff accommodation available, a 3 BR aluminium house.
Airstrip: The airstrip is poor. RFDS refuse to land on it. Needs an all weather strip.
Visiting Services: Barkly mobile visits every 6 weeks. The medical officer visits every 12 weeks. The dentist visits annually. Mental Health Services visit every 3-4 months.
Out-stations, which have no visiting services, include:
Kalpitapita/ Kalpitapita
Location 280km SE of Tennant Creek via Epenarra. Category 4. Recently established. Population N/A.
Tamatru/ Dimatru
Location SE of Tennant Creek via Epenarra & Canteen Creek. Category 7. Proposed at this stage.
Arrawajin/ Whistleduck/ Arajin
Location 187km SE of Tennant Creek via Epenarra Rd. Category 2.

W utunagurra/ Epenarra
Location on the western side of the Frew River, 211km SE of Tennant Creek. The road deteriorates in the wet. The community is located 2km south of Epenarra Station homestead. It is 4-hour drive to Alekareenge on a poor road.
Population: 120
Languages: Alyawarre
Land tenure: This is an excision of Epenarra Pastoral Lease.
Communications: There is a telephone at the school, which is 2km from the community. There is also a public telephone in the community.
Current Health Services:
Staff: There are two part time AHWs, 1 female and 1 male. Epenarra Station receives funding from THS through the Health Care Agent Subsidy Scheme.
Clinic: There is a one-room clinic, with an office in good condition, but there is no waiting rooms, and limited privacy.
Vehicles: No vehicle, but apparently there are plans by THS to provide one.
Staff accommodation: Nil
Airstrip: The airstrip is inadequate for twin-engine aircraft, and is not an all weather strip. Air North will land in good weather, but RFDS considers it unsafe.
Visiting Services: Barkly mobile visits once every 4-6 weeks, and the medical officer visits once every 8-12 weeks. Dentist visits annually. Mental Health Services visit every 3-4 months.

The following out-stations are currently unoccupied.
Purrukwarra
Location 250km E of Tennant Creek on Wakaya ALT. Category 6. This out-station has not been occupied for any length of time since it was established in the late 1980s.

Out-station proposals on land already under Aboriginal ownership include:
Iliyarne, Indangala, Tamatru, Pwelijante (Blusundi), Maralwengke

Out-station proposals subject to on-going land negotiation include:
Atheympelengwe, Ngamanakirlangu (Numagalong), Elkedra.

KAYTETYE - WARLPIRI

Tara/ Neutral Junction
Location: Located 96km north of Ti Tree. Related to the Thanhenharenge (Barrow Creek) Resource Centre. Located in Yapakurlangu ATSIC Region and CLC region 6.
Road is not accessible in wet weather.
Population: 100.
Languages: Kaytetye
Communications: Public telephone.
Current Health Services:
Staff: 1 female AHW.
Clinic: New clinic.
Vehicles: nil
Staff accommodation: Nil
Airstrip:
Visiting Services: nurse from Ti tree visits weekly.
The following out-stations do not receive any services.

Dingo Springs No information available
Irlewarre/Illurawarra 60km ESE of Tara. Population 10.
Angkweleyelengkwe this is an out-station of Thankeharenge (Barrow Creek) Resource Centre. Road is not accessible in wet weather. Population 15.

W illowra
Location: 250km NW of Alice Springs, 153km from Ti T ree, road not accessible in all weather. It is within Papunya AT SIC region and CLC region 4.
Population: 300
Languages: Warlpiri
History: this area was developed as a European run cattle station
Land tenure: Aboriginal Freehold Title (1981)
Communications: telephone, fax, radio
Current Health Services:
Staff: 2 female and 1 male AHW, 1 female nurse
Clinic: needs upgrade
Vehicles: 1 Troop Carrier
Staff accommodation: 1 3-bdr house
Airstrip: yes
Visiting Services: Dental, medical officer visits 1 day per fortnight.

Pawu/ Mt Barkly

EASTERN ARRERNTE/ ALYAWARRE

Artetyerre/ H arts Range/ Atitjere
Location: 215km NE of Alice Springs - the last 47km are gravel. Communities in this Health Service Zone are in the Papunya AT SIC region and CLC region 8.
Population: 120
Languages: Eastern Arrernte
History: European settlement has developed pastoral properties and mining for gemstones.
Communications: telephone, radio, TV
Current Health Services:
Staff: 2 female AHW s, 1 female nurse
Clinic: adequate
Vehicles: 1 troop carrier
Staff accommodation: 1x 3 bedroom house, 1 AT CO VOQ
Airstrip: Day use only
Visiting Services: medical officer visit 1 day per month, dentist

Out-stations of Artetyerre include:
Irrelerre (Mt Swan) Location 35km NE. Population 25. Category 1. Excision on McDonalD Downs Pastoral Lease. Telephone at the school.
Spotted Tiger Bore Location 5.5km SW. Population 5. ALT Mt Riddock locality.
Out-stations in the Eastern Area:

There is no central community

**Alatyeye/ Mud Tank**

**Bonya/ Orrtipa Thurma**
A clinic consists of a 2-room tin shed with running water and power. There are no vehicles, on-site staff or staff accommodation. RFDS flies in/out 1 day per fortnight, T H S medical officer fly in/out 1 day per 6 weeks. Mrs Johannsen who lives at Baikal homestead receives the Health Care Agent Subsidy Scheme from T H S.

**Urlampe/ Riwampw/ Tobermorey**
Location: 230km ENE of Bonya, population 20. Category 1. Telephone. Receives a visiting medical officer visit once a month.

**Maperte/ Lucy Creek**
Location: 42km NE. Population 15. Category 4. Excision of Lucy Creek Pastoral Lease established out of Bonya. Some Alice Springs interests. Receives no services.

**Ilparle**

**Penyem(e)/ Jinka**

**Warlpeyangke/ Tarlton Downs Stock Reserve**

**Atula/ Apiwentye**
Location: 75km S. Population 5. Category 2/6. Out-station on ALT. Infrastructure (houses and admin centre) in place - not all are occupied. Residents very mobile. Telephone and airstrip (not maintained). Receives no services.

**Atnoilya**
Location: WNW in Dulcie Ranges. Category 7. There is an agreement-in-principle with the NT Parks and Wildlife Commission for an excision of National Park. Receives no services.

**Anterreng/ Maperte**
Location: W in Dulcie Ranges. Category 7. There is an agreement-in-principle with the NT Parks and Wildlife Commission for an excision of National Park. Receives no services.

**Alpurrurulam (Lake Nash)**
Location: 450km SE of Tennant Creek. 645km NE of Alice Springs. 148k SW of Camooweal. Road is not accessible in wet weather. 8k south of homestead. Located in Yiapakurlangu ATSIC Region and CLC region 7.
Population: 400
Languages: Alyawarre.
Land Tenure: Community has freehold title of an excision from the Lake Nash Pastoral lease.
Communications: Radio, telephone, TV.
Current Health Services:
Staff: 2 male and 2 female AHW s. 1 female nurse.
Clinic: Good condition.
Vehicles: 1 x 4wd.
Staff accommodation: 1 x 3Bdr house, and 1 demountable.
Airstrip: Not all weather.
Visiting Services: medical officer visits 1 day per fortnight.

Out-stations, which do not receive any visiting services, include:

**Ilmarnez Out-station located 2½ hours by road from Alpurrurulam. Population: 30.**

**Urandangie (Marmany Out-station of Alpurrurulam. Population: N/A.**
ALYAWARRE/ANMATYERRE

Angarapa/ Utopia
The Urapuntja Health Service (UHS) is an Aboriginal community controlled health service, which was established in 1979 following the granting of freehold title to Utopia station. When the Health Service was initially established it serviced 6 communities (including Ampilatwatja). It was involved in and followed the development of further out-stations and in 1986 moved the clinic base to more appropriately service the area. UHS, which has no central community other than for a clinic and staff accommodation, provides a service to approximately 850 Anmatyerre and Alyawarre people in the area and has always been a mobile out-station service. A majority of these out-stations have communications such as radio or telephone. Ampilatwatja became an independent service in 1991. Two communities currently serviced by UHS are within the Yapaurlangu ATSIC region. All the other communities are within the Papunya region and in CLC region 7.

The Urapuntja Health Service visits out-stations weekly. The overall population of this area is around 850. About 5 out-stations have clinics, which are tin sheds, and in one community the clinic is not used. Other clientele include Eastern Arrernte, Anmatyerre and Alyawarre people from Ti Tree, Harts Range, Irrultja, Attungurpa, Ampilatwatja, and Alpurrurulam.

Out-stations in the Yapaurlangu region which receive a visiting service from Urapuntja include:

Antarrengeny
Location: 37km from Amengenternenh (UHS clinic base). Road is not accessible in all weather

Ngkwarlerlanem
Location: 17km from Amengenternen clinic. Road is not accessible in all weather. Population: 18 Category 1.

Amengernternen
This is the site of the UHS clinic. It is 270km NE Alice Springs. Road is not accessible in all weather.
Population: 6 staff residences
Languages: Anmatyerre, Alyawarre
History: relocation of clinic in 1986
Land Tenure: Freehold Title
Communications: telephone, fax
Current Health Services:
Staff: Administrator, medical officer, 2 nurses, 2 AHW, handyman.
Clinic: refurbished last year - good condition
Vehicles: 3 clinic vehicles
Staff accommodation: 6 houses in good condition
Airstrip: no night-time use
Visiting Services: Alukura, dentist, optometrist, and physician

Out-stations, which receive a weekly visit, include:

Ankerrapw
Location 55km from clinic, road is not accessible in all weather. Population 32. Category 1.

Arawerr
Location 14km from clinic - road is not accessible in all weather. Population 75. Category 1.

Alperr (New Store)
Location 23km from clinic, road not accessible in all weather. Population: N/A Category 1. The store opened in 1985 with the aim of being a service only site. However, some people are now living there on a more permanent basis. Public pay telephone.

Artekkerr
Location 62km from clinic, road is not accessible in all weather. Population U/A

Atheley
Location 8km from clinic, road is not accessible in all weather. Population 20. Category 1.

Atite
Location 20km from clinic, road is not accessible in all weather. Population U/A Category 1.

Amarara
Location 15km from clinic, road is not accessible in all weather. Population 45 Category 1.

Asmathey
Location 44km from clinic, road is not accessible in all weather. Population 70. Category 1.

Camel Camp
Location 60km from clinic, road is not accessible in all weather. Population 30. Category 1.

Angkula (Mulga Bore)
Location 107km from clinic, road is not accessible in all weather. Population 80. Category 1.
Ngkwelay (Kurrajong Bore)
Location 20km from clinic, road is not accessible in all weather. Population 60. Category 1.

Ankawenyerr (New Camp)

Prrawaw, Welere (Derry Downs), and Pungalindum are also Category 1 out-stations in the area.

Ampilatwatja
Ampilatwatja is serviced by their community controlled health service initially established in 1991 having been previously serviced by the Urapuntja Health Service. It was set up under the umbrella of the Anherrenge Association Inc but became separately incorporated in 1995. It provides services to about 500 people - 400 residents living in 3 communities and about 100 who present occasionally to the clinic on social, ceremonial or sporting visits from Tennant Creek, Alekarenge, Epenarra, Imanara, Utopia and Alpurrurulam.
Location: 320km NE of Alice Springs - road not accessible in all weather. In CLC region 7.
Population: 250
Languages: mainly Alyawarre
History: A/A
Land Tenure: Pastoral Excision
Communications: telephone, fax
Current Health Services:
Staff: Male administrator, male medical officer, female nurse, and occasional clinic drivers. There are currently no AHWs but 4 are enrolled to do Batchelor College's July intake for the certificate course. Batchelor College withdrew regional lectureship late 1996.
Clinic: 5-year-old purpose built in good condition
Vehicles: 1 troop carrier purchased new through ABTA in 1996; 1 troop carrier leased from DAS fleet 1997
Airstrip:
Visiting Services: Dentist 6/12; Alukura, physio/ ot, Diabetes Australia, Sexual Health Unit all visit annually and the Renal Unit visit as required.
Out-stations, whose clinics are tin sheds with running water but no power, receive visits twice-weekly visits from AHC. The out-stations both have telephones.

Irwelty

Atnwengerrp

ANMATJERE

Ti Tree town
Anmatjerre Community Council consists of a number of communities (Population approx 1200) who have joined together to form an administrative body. Health service staffs are resident at Ti Tree and provide some visiting services to the communities within the region. The Anmatjerre Council has been negotiating with the Commonwealth Department of Health and Family Services to establish a community controlled health service in this area.
Location: 190km N of Alice Springs on the Stuart Highway. These communities are in the Papunya and CLC region 9.
Population: 160
Languages: Anmatjere, English
Land Tenure:
Communications: telephone
Current Health Services:
Staff: 1 female AHW, 1 female and 2 male nurses
Clinic: adequate clinic
Vehicles: 2x4W D, 1 station wagon
Staff accommodation: 3x 1 bdr flats, 1x 3bdr house
Airstrip: all day use
Visiting Services: medical officer visits 2 days a week

The following communities in this area, which receive some visiting services, include:

Nturiya
Location: 20km W of Ti Tree. Population 180. Category 1. Telephone. There are no on site staff but a new clinic is being constructed.
Pmara Jutunta
Location: 10 km S of Ti Tree. Population 120. Category 1. Telephone. A new clinic is currently being constructed. A nurse from Ti Tree visits weekly.

Wilora (Stirling)
Location: 250 km north Alice Springs. Related to the Thakenharenge (Barrow Creek) Resource Centre. Actively located in Yapakurlangu ATSIC Region. Good bitumen road, but creek can stop traffic in wet weather. Population: 60.
Languages: Anmatjere, Kaytetye, and Alyawarr.
History: Excision from Stirling Station in 1980.
Communications: Telephone and radio.
Current Health Services:
Staff: nil
Clinic: Silver bullet caravan.
Vehicles: nil
Staff accommodation: Nil
Visiting Services: Periodic visit by nurse from Ti Tree.

Laramba (Napperby)
Location: 85 km SW of Ti Tree
Population: 300
Languages: Anmatjerre
Communications: telephone, radio
Current Health Services:
Staff: 1 female AHW, 1 female nurse
Clinic: being upgraded
Vehicles: Nil
Staff accommodation: 1 3bdr house, 1 ATCO VOQ
Airstrip:
Visiting Services: medical officer 1 day fortnight.

Engawala (Alcoota)
Engawala is now part of the Anmatjerre Council but is currently serviced by Artetyerre.
Location: 143 km NE of Alice and 72 km W of Artetyerre. Road not accessible in all weather. It is in CLC region 8.
Population: 130
Languages: Anmatjerre, Eastern Arrernte
Communications: Telephone
Current Health Services: visited by Nurse from Artetyerre one afternoon per week.
Clinic: Silver bullet being upgraded
Vehicles: Nil
Staff accommodation:
Airstrip:
Visiting Services: medical officer visits one morning per month

Other communities in the region with no health resources who may receive periodic visits from staff at Ti Tree include:
Werle
Yanginj
Anyungumba/Pine Hill
Location: 70 km SW of Ti Tree. Population 5. Category 1.
Alyuen
Mt Wedge
Petyale
Woods Camp
Pulardi

Armenewenty
Category 6

Ilpararreye
Category 6

Mamp/Coniston
Category 6

WARLPILI

Yuendumu
Location: 290km NW of Alice Springs, road not accessible in all weather. These communities are in the Papunya ATSC region and in CLC region 4.
Population: 700
Languages: Warlpiri
History: The Baptists established a mission and school here in 1957 to which the Warlpiri people became more settled
Land Tenure: Freehold title
Communications: radio, telephone, TV

Current Health Services:
Staff: 2 male & 4 female AHWs, 3 female nurses
Clinic: needs upgrade
Vehicles: 1 TC, 1 SW
Staff accommodation: 1x 2br ATCO, 7x1&2 bdr flats
Airstrip: all day/night use
Visiting Services: medical officer visits 1 day per fortnight
Outstations associated with Yuendumu, which consist of family groups who have no health resources nor receive any visits from staff at Yuendumu include:

Chilla Well
Location: 130km NW. Category 6

Mt Theo/Putulu
Location: 170km NE. Population 15. Category 1.

Puyurru
Location: 80km NW.

Yumurrpa
Location: 105km NW.

Mala Bore
Location: 130km NW.

Tjulpungu
Location: 80km between Chilla and Yuendumu.

Yuwarli
Location: 45km N. Category 2.

Wakalba
Location: 30km N. Category 4.

Juturangi
Location: N. Category 6.

Wayillilinypa
Location: 60km SW. Category 4.

Yarrapilangu
Location: 70km SW. Category 4.

Yatjalu
Location: 65km SW.

Yinjirimardi
Location: 70km SW. Category 6.

Mt Denison
Location: 50km N of Yuelamu.

Ngurliykirra
Location: 40km N. Category 2.
Nyirripi
Location: 450km WNW from Alice Springs, 150 WSW of Yuendumu, road not accessible in all weather. It is in CLC region 4.
Population: 270
Languages: Warlpiri, Pintupi
History: began as an out-station of Yuendumu and developed as an independent community
Land Tenure: Freehold Title
Communications: radio, telephone, TV
Current Health Services:
Staff: 1 male, 1 female AHW, 1 female nurse
Clinic: adequate
Vehicles: 1 4x4 SW
Staff accommodation: 1x3bdr house
Airstrip: authorised for night landings
Visiting Services: medical officer visits 1 day per fortnight
Out-stations associated with Nyirripi which do not have any health resources include:

Ngarupalya/Ethel Creek
Location: 80km NW. Category 6

Nginyirrpalangu
Location: NW Nyirripi. Population 10. Category 4

Emu Bore
Location: 80km from Nyirripi. Category 2

Mungkururru
Population 50, often associated with Lajamanu

Ngarrilykiri
Location: N. Population 12.

Parrulyu
Population 15

Ngarnka
Piccaninny Bore
Population 25

Yuelamu
Location: 270km NW of Alice Springs, 60km E of Yuendumu. It is in CLC region 9.
Population: 180
Languages: Anmatyerre
Land Tenure: the Aboriginal Land Fund Commission in 1975 purchased the Mt Allen pastoral property for the Yuelamu community
Communications: Radio, telephone
Current Health Services:
Staff: Nil
Clinic: Caravan
Vehicles: Nil
Staff accommodation: Nil
Airstrip: can be used at night
Visiting Services: medical officer one day per month.

Out-stations of Yuelamu, which consist of family groups and have neither resources nor visiting services include:

Yulyupunyu,
Location: 35km W of Yuelamu. Category 2.

10 Mile
Location: 20km SE of Yuelamu Population 15. Category 1.

Garden Bore
**LURITJA /PINTUPI**

**Papunya**
Location: 276km WNW of Alice Springs, road not accessible in all weather. It is in CLC region 5.
Population: 300
Languages: Luritja, W estern Arrernte, Warlpiri, Pintupi
History: Established as a government settlement in the 50s with a mixture of Luritja, Western Arrernte, Pintupi and Warlpiri people.
Land Tenure:
Communications: Radio, telephone, TV
Current Health Services:
Staff: 2 female nurses
Clinic: needs upgrade
Vehicles: 1 TC
Staff accommodation: 2x3 bdr houses, 3x1 bdr flats
Airstrip: day and night
Visiting Services: medical officer visits 1 day per week
Outstations, which have no health resources, include:
- **Alkipi**
  Location: 2km SW. Population 5. Category 1.
- **Kapikiti**
  Location: 3km S. Population 20. Category 3.
- **Mbunghara**
  Location: 55km E. Population 10. Category 1
- **Ulambara**
  Location: 9km S. Population 9.
- **Warumpi**
  Location: 3km E. Population 15. Category 1.
- **Illili**
  Category 6
  **5 Mile**
  Category 6

**Mt Liebig**
Location: 325km WNW of Alice Springs
Population: 200
Languages: Luritja, Pintupi
History: Began as an out-station in 1978
Land Tenure: part of the Haasts Bluff Aboriginal Reserve
Communications: Radio, telephone, TV
Current Health Services:
Staff: 3 female & 1 male AHW, 1 female nurse
Clinic: adequate
Vehicles: 1 troop carrier.
Staff accommodation: 1x3br house, 1 ATCO VQ
Airstrip: day only
Visiting Services: Medical officer visits 1 day per fortnight
Outstations, which have neither health resources nor visiting services, include:
- **Lizard Bore**
  Location: 20km W.
- **Warren Creek**
  Location: 15km W. Population 20. Category 1
- **New Bore**
  Location: 12km NE. Population 15. Category 1
- **Inyilingi**
  Location: 20km E. Population 15. Category 1
- **Amundurungu Springs**
  Location: 25km E. Population 10. Category 1
- **Illypili**
  Location: 150km W.
- **Ngumpa Tjintirjintirpa**
  Location: 3-4km S.
- **Tarrawarra**
Ikuntji/ Haasts Bluff
Location: 230km West of Alice Springs, road not accessible in all weather
Population: 70
Languages: Luritja
History: began as a ration depot of the Finke River Mission in 1941
Land Tenure: Aboriginal Land Trust
Communications: Radio, telephone
Current Health Services: RFDS have a Nurse who does a fly in/out 1 day per fortnight, THS provide a nurse for 3 days the alternate week.
Staff: 2 female & 1 male AHW
Clinic: adequate
Vehicles: Nil
Staff accommodation: Caravan VO Q
Airstrip:
Visiting Services: Medical officer 1 day per fortnight
Out-stations which have no health resources or visiting service, include:
Ngankiritja S. Location: S. Population 10. Category 1
Archie Creek Location: N.E. Population 5. Category 1.

Kintore (Walungurru)
Location: 550km WNW of Alice Springs, road not accessible in all weather. It is in CLC region 5.
Population: 400
Languages: Pintupi, Luritja. Others include W arlpiri, Pijantjajara, Ngaatjatjarra,
History: Pintupi returned to this country in 1980
Land Tenure:
Communications: Radios, telephones, fax
Current Health Services:
Staff: 5 AHWs, 1 p/t cleaner, 1 yardman, 1 Yanangu administrator, 1 medical officer, 2 nurses, 1 administrator, 1 P/T medical director
Clinic: not adequate
Vehicles: 2 troop carriers, 1 utility
Staff accommodation:
Airstrip:
Visiting Services: Dental (x2 a year), paediatrician (1-2x year), physician, ophthalmologist (x2 in 5 years), physio, o/t (both x 1 year), social welfare (x2 year).
Out-stations, which consist of family groups, are visited on a need basis and have telephones, include:
Redbank Location: 20km N W., Population 5. Category 3.
Mantardi Location: 70km W.
Muyin Location: 50km W. Category 2.
Nguman Location: 50km SE. Category 3.
Yuwalki Location: 30km S. Population 10.
Tingki Location: 25km E.
Ngutjul Location: 14km E. Category 3.
**Pinpirringa**
Location: 20km N. Population 10.
**Kilili** Category 6.

**Western Arrernte**

**Ntaria/ Hermannsburg**
Location: 130km W of Alice Springs. Communities are in the Papunya ATSIC region and in CLC region 1.
Population: 450
Languages: Western Arrernte
History: Established as a Lutheran Mission in 1877. It was the site of distribution of government rations until 1963. There has been a massive development of about 40 out-stations in the area since the 1970s.
Communications: Radio, telephone, TV
Current Health Services:
Staff: 3 female AHW s, 2 female & 1 male nurse
Clinic: needs upgrade
Vehicles: 1 TC, 1 SW
Staff accommodation: 1x1br house, 2x3 bdr houses, 3x1 bdr flats
Airstrip: day only
Visiting Services: medical officer visits 1-2 days per week
Out-stations, which range in population from 6-35 and total 551(HINS) and have no health resources or regular visiting services, include:
- Alkngarintja 51km W. Category 1.
- Armstrongs 20km N.W. Category 1.
- Gantjatkerra 55km SW. Category 4.
- Five Mile 12km N.E. Category 3.
- Ilkarilalama 60km W. Category 2.
- Intjartnama 30km E. Category 1.
- Ipsila 15km W. Category 2.
- Kaporiya 12km W. Category 1.
- Kulpirarra 90km W. Category 1.
- Labrapuntja 25km N.E. Category 1.
- Litra 20km E. Category 1.
- Lyllalana 5km W. Category 2.
- M erra 15km N.E. Category 3.
- M pakaputa 18 E. Category 1.
- Ntakarrara 20km W. Category 4.
- Red Sandhill III 15km E. Category 1.
- Rutjinka 8km N.E. Category 1.
- T nawurta 12kmE.
- Ulpunda 1km W. Category 1.
- Undurana 80km W. Category 1.
- Yateman's Bore 160km W. Category 6.

**Areynongha/ Utju**
Location: 240km W of Alice 98km WSW of Ntaria, road not accessible in all weather. It is in CLC region 2.
Population: 200
Languages: Pitjantjatjara, Luritja
History: It was the site of a Lutheran mission 1940-1990
Communications: Radio, telephone
Current Health Services:
Staff: 1 male and 1 female AHW
Clinic: has had recent minor upgrade
Vehicles: Nil
Staff accommodation: 1x3 bdr house
Airstrip: day use
Visiting Services: medical officer visits 1 day per month
Outstations which, consist of family groups and have no health resources or visiting services, include:

**Inyipanti** SW. Category 4  
**Kurkutjini** E. Category 2  
**Manyiri** SE. Category 3  
**Tent Hill** SW. Category 6

**W allace Rockhole**

**Location:** 100km W of Alice Springs. It is in CLC region 1.

**Population:** 147

**Languages:** Western Arrernte

**History:** Developed as an out-station by the Abbott family

**Land Tenure:** Freehold Title

**Communications:** Telephone, radio, TV

**Current Health Services:**

- **Staff:** 1 female AHW
- **Clinic:** adequate
- **Vehicles:** Nil
- **Staff accommodation:** Nil
- **Airstrip:** Nil
- **Visiting Services:** Medical officer visits ½ day per month

**ALICE SPRINGS**

**Population:** 3,710 Aboriginal people live in town houses and town camps, plus 785 people live in out-stations around Alice. It is the resource centre of Central Australia, and its services are utilised by all people throughout the region. It is in the Alice Springs AT SIC region and in CLC region 1.

**Languages:** all Central Australian languages

**History:** established in 1973

**Communications:** telephone, fax

**Current Health Services:** Alice Springs is serviced by the Central Australian Aboriginal Congress (Congress), T H S and private practitioners.

**Territory Health Services**

**Community Health Centre**

**Location:** Flynn Drive, Alice Springs

**Population:** Alice Springs, Tennant Creek and some Aboriginal communities (on request)

**Current Health Services:**

- Adolescent and Adult Services Team has a manager and an administration support.
- Regional Services provided to Alice Springs and Tennant Creek (and in some cases to Aboriginal communities) include: Dementia Care-1 male worker, Continence Care - 1 female adviser, Adult Assessment and Coordination Team - 1 male welfare worker, 1 female Aboriginal liaison officer, 1 female administration support, TIMES/SEAT Program - 1 female administration support, 1 female occupational therapist, Disability Liaison- one female officer, one female administration support, Adult Guardianship - one male and one female officer, Hearing Services: 1 nurse/audiometrist and 1 audiologist.
- Alice Springs Services: 6 female nurses, occupational therapist (vacant), both the physiotherapist and social worker are female. The Lifestyle Team – nutritionist, medical officer, cardiac educator, diabetes educator are all female. Four female nurses work on the Infant and Child Health Team. Allied Health includes 1 occupational therapist, 1 female Aboriginal liaison officer, 1 female administration support, 1 male speech therapist, 1 female physiotherapist and 1 female social worker.
- Family, Youth and Children’s Services includes 1 female manager/social worker, 3 female administration support, 1 female senior social worker, 5 female (1 Aboriginal) community workers.
- Preventive Family Care has 1 vacant family support worker.
- Child Protection has 1 male senior social worker, 3 female community welfare workers, 1 female Aboriginal community worker and 1 vacant Aboriginal child protection worker.
- Foster Parent Support has 1 female placement coordinator
- Children’s Services has 1 female coordinator
- Women’s Information Centre has 1 female coordinator, 1 female Non Government support worker and 1 female admin support
- Palliative Care employs 1 male coordinator and p/t female medical officer
- Sexual Assault Referral Centre has 1 female sexual assault counsellor.
- Breast Screening Clinic has 1 female nurse and 1 radiologist.
- The Renal Unit has a male and female AHW, a female Aboriginal liaison officer, a vacant educator position, 1 liaison nurse, 1 outreach nurse and 18 nurses who are all female.
- Dental has 2 teams, which provide a rural and urban service. This service was the most visible in the bush usually visiting each community x2 a year.
Public Health and Regional Programs

Population Health Unit

The Population Health Unit was set up to support primary health care providers to plan, implement and evaluate population health projects. The components and staff that include a director and administration officer of the Population Health Unit are:

- Environmental Health: 4 positions
- Health Promotion: coordinator, 1 position, and 3 administration officers
- Health Information: 1 position and administration officer
- Public Health Nutrition: 1 position
- Sexual Health: 3 RNS, 5 administration officers, 1 medical officer
- Tri-State Project: manager, administration officer
- Communicable Disease Control: manager, 3 nurses and administration officer
- Inter-Cultural Brokerage Demonstration Project: 1 position

Mental Health Services are based in Alice Springs and Tennant Creek and provide the following staff and services:

- Forensic: 1 nurse, a sessional psychologist, a sessional psychiatrist
- Remote Community Health Service: 2 nurses in Alice Springs, 1 nurse and psychologist in Tennant Creek, 1 registrar
- Acute In-patient Facility: psychiatrist, 12 nurses and 1 medical officer
- Community Mental Health has a 10 person multi-disciplinary team
  - Alcohol and Other Drug Services: 1 manager, 1 administration assistant, a community educator, key worker (nurse-ASH base), clinical nurse adviser
  - Alcohol and Other Drugs: health promotion officer, clinical nurse adviser

Non-Government Liaison: A list of programs funded through this service has been presented both for Alice Springs and Barkly districts.

The other service that is Alice Springs based is the Royal Flying Doctor Service (RFDS). RFDS provide a minimal PHC service to Bonya on a fly in/out basis and Haasts Bluff where a nurse visits on a fly in/out basis for a day on alternate weeks.

Congress

Staff: Congress employs 80 staff who are involved in health care provision, health service management, design and development, education, dental, child care, welfare, family support, administration and transport. Congress also provides a medical officer to Mutitjulu on a visiting basis.

Clinic: adequate

Vehicles: Health Services currently have a utility, a twin cab and econovan in good condition, a Toyota coaster, which needs replacement, and a Toyota Camry, which is in fair condition.

Visiting Services: Congress provides services to the Town Camps, and out-stations around Alice Springs including Yambah, Iwupataka, Northern Tjilijika and Undoolya. Congress also has attempted to provide a service to Amoonguna.

Town Camps of Alice Springs:

- Ilparpa
  - Warlpiri
  - Palmer's Camp
- Bassa's Farm
  - W arlipirri
- Anhelk-Ilpa - Charles Creek
- Anhelk-Endi - Morris Soak
- Y arrunya-Ant - Larapinta
- Inarlenge - Little Sisters
- Ilparpa
  - W hitegate
- Lhenpe Artnwe
- Anmatyerre
- Namatjira's

Yambah outstations:

These outstations are affiliated to the Mpweringe-Arnapipe Out-station Council and are served by the Ingkerreke Out-station Resource Centre.

Alkupitja


121. Central Australian Health Planning Study

Farr Health Pty Ltd
July, 1997
Alkupita 2  

Alkngirrwelye/ Snake Well/ Saltbush Bore  

Artankerre / McGrath  
Location: Excision on Yambah Pastoral lease. Category 1.

Black Tank Bore/ Awperre  

Sandy Bore/ Armapipe  

Untyeyampa/ Harry Creek  
Location: N of Alice Springs via Stuart Highway. On central Yambah Pastoral lease. Category 1. Residents are out of Santa Teresa.

Burt Creek/ Mpweringe  
Location: N of Alice Springs via Stuart Highway. On central Yambah Pastoral lease. Category 1. There is substantial movement between here and Amoonguna for school and health reasons.

Athenge Lhere/16 Mile  
Location: On ALT in Bond Springs. On central Yambah Pastoral lease. Category 1. There is substantial movement between here and Amoonguna, White-gate and various town locations.

Injulkama  

Iwupataka/ Jay Creek  
This is a former welfare settlement 43km WSW of Alice. It is currently unoccupied but a full range of infrastructure remains in place. It is potentially a site for a resource centre for all Iwupataka communities.
The following out-stations use Alice Springs as a resource base and have water carted by Ingkerreke Out-station Resource Centre. ATSIC funds have been secured for town water supply pipeline to these out-stations but will not extend beyond 30km from Alice Springs in the foreseeable future.

Tywenpe (1)  

Angantyepe  

Tywenpe (2)  

Tnerte  

Twyete (1)  

Twyete (2)  

Tywenpe (3) & (4)  

Tywenpe (5) & Irriltyere (1) & (2)  

Tywenpe (6)  
Location 27.5km W SW of Alice Springs. Population included in Tywenpe 7-8. Category 1. Tywenpe (7) & (8)  

Arrilhejere  
Location 30.5km W SW of Alice Springs. Population 2. Category 1.

Itperlyenge (1) & (2)  

Inteyepintye (1), (2) & (3)  

Elitjia  

Central Australian Health Planning Study  
Par Health Pty Ltd  
July, 1997
Alkamilya
Location 38.5km WSW of Alice Springs. Population UA. Category 1.
Payeperrentye (1)
Angkerle-renge (1)
Angkerle-renge (2)
Payeperrentye (2)
Perte Therre

There are two out-stations NW of Alice Springs which have strong historical and traditional ties to the Iwupataka ALT and strong contemporary links with Nyewente (T trucking Yards) town camp. They are:
Thakeperte/ Were Therre
Ntwele/ Twellar/ Mt Twellar
Location 45km NW of Alice Springs via Stuart and Tanami Highways. Population 50. Category 1. Telephone. There is a high town movement and intermittent residence for school and employment.

Amoonguna
Location: 15km E of Alice Springs via Ross River Highway. It is in CLC region 1.
Population: 230
Languages: most Central Australian Aboriginal languages.
History: Established as a Government Reserve in 1950s
Land Tenure: Freehold Title
Communications: One public telephone in the community
Current Health Services:
Staff: Nil
Clinic: In 1995 THS gave Amoonguna a grant of $31,000 to set up a clinic. The Council has purchased an ATCO and set it up as a clinic. It has, however, no money for medical supplies or staffing.
Vehicles: Nil
Staff accommodation: Nil
Airstrip: Nil
Visiting Services: Congress provides an irregular transport system for people who have an appointment. In the event of an emergency people get a taxi or call an ambulance at considerable expense.

Out-stations
Undoolya Bore/ Melkngne ALT
Location 35km E of Alice Springs. 24km E of Amoonguna. Category 3. No telephone or radio. Strong family ties to Whitegate (A/Sp town camp).
Williams Bore/ Pwanye ALT
Location: 35km E of Alice Springs. 24km E of Amoonguna. Population 20. Category 3. No telephone or radio. As much an out-station of Santa Teresa due to long term residency and continued family and resource associations.

Northern Titjikala Out-stations
There are out-stations north of Titjikala east of the Stuart Highway which have been established out of Alice Springs and which have no central community. Alice Springs remains a major service centre for this group and the residential location of related families. There is no Titjikala service link but there is some stores, fuel and cheque cashing from Maryvale station. There is no formal affiliation with the Tapatjatjaka Council. These are all within CLC region 2. Congress has begun offering a service to these out-stations.
Mpwelarre/ Walkabout Bore
Mt Peachy/ No 1 Bore
Oak Valley
Location: 100km S of Alice Springs. 30km N of Titjikala. Population 10. Category 1. Telephone.
John Holland Bore/ Twententye/ Orange Creek
Santa Teresa
Location: 85km SE of Alice Springs. Communities here are located in the Papunya ATSIC region and CLC region 1.
Population: 540
Languages: Arrernte
History: Established as a mission following relocation from Arltunga
Land Tenure: Freehold Title
Communications: Radio, telephone, fax
Current Health Services:
Staff: 3 female AHWs, 2 female nurses
Clinic: adequate
Vehicles: Ford econovan, 2 troop carriers - one is converted as ambulance and used only for evacuations which are mostly done by road.
Staff accommodation: 1x3bdr house in good condition. 1 nurse belongs to the religious order that has its own dwelling in good condition. The community also has 6 self-contained bed-sitters for visitors
Airstrip: day use only
Visiting Services: medical officer visits 1 day per month, Alukura, Dental, occupational therapist.

Out-stations in this zone and in CLC region 1 include
Aluraikwe/ Little Well
Panthrarrpilenhe/ Panels Well
Uluperte
Location: E of Numery boundary on Illogwa Creek. Category 6/4. Two houses. No telephone, radio or reliable transport.
Proposed out-stations, Category 7, in this area include:
Pmwarekenhe/ Salt Bore/ Loves Creek
Laughton Excision/ Paddy’s Plain/ Loves Creek
Uretjingke/ No 7 Bore/ Mount Kathleen

PITJANTJATJARA/LURITJA

Titjikala/ Maryvale/ Tapatjatjaka
Location: 120km SE of Alice Springs, road not accessible in all weather. Communities here are in the Papunya ATSIC region and in CLC region 2.
Population: 180
Languages: Arrernte, Luritja, Pitjantjatjara
History: Long established minor community on excision of Maryvale Pastoral Lease with mixed language affiliations. The Lutheran Church has had an association for many years. The Tapatjatjaka Council operates under the Northern Territory Government Local Government Act.
Land Tenure: Freehold Title
Communications: Radio, telephone
Current Health Services:
Staff: 2 part-time female AHWs
Clinic: Silver Bullet
Vehicles: Nil
Staff accommodation: 1 ATCO VOQ
Airstrip: day only
Visiting Services: medical officer visits 1 day per month, nurses do a mobile 2-4-6 weekly.

Out-stations, which have no health resources or visiting services, include:
Alwe Welle (inarme)
Aputula
Location: 409km SE of Alice Springs via Erldunda. It is in Papunya AT SIC region and CLC region 2.
Population: 260
Languages: Luritja, Southern Arrernte
History: A railway town was developed here in the late 1920s. The Australian Inland Mission provided a clinic and staff in 1976 and was taken over by a mobile unit, which covered Titjikala and Aputula. The Railways moved their operations to Kulgera in 1980. THS negotiated a Grant-in-Aid in 1993
Land Tenure: this gazetted township is surrounded by ALT.
Communications: Telephone, fax
Current Health Services:
Staff: 1 female AHW (paid through CDEP), 1 male nurse, 1 cleaner
Clinic: a grant has been approved and a new clinic is presently being designed
Vehicles: 2 4WD, 1 desperately needs replacing – a grant application has gone to THS
Staff accommodation: 1 house, which needs some maintenance
Airstrip: day and night
Visiting Services: medical officer visits each fortnight, Mental Health Services every 3/12, dentist 6/12, physician, Alukura, women’s health nurse visit annually.
Out-stations, which are supported by Aputula, have no telephones, health resources or visiting services, include:
Beer St Bore
Antere
Location: 17km SW. Population. Category 4.
Halfway Camp
Bloodwood Bore
Location: 34km SW. Category 6.
Charlotte Waters
Location: 50km E. Population 25. Category 1
Flinders

Other out-stations which have Aputula ties and are near Kulgera include:
Ulbulla
Location: excision of Umbeara Pastoral lease. Previously occupied but vacated due to ill health and returned to Aputula. Category 6.
Wirrmalyanya/ Welmala
Location near Kulgera. Excision of Umbeara Pastoral lease. Infrastructure established. Category 3.

Out-stations in the South East Relating to Aputula and/or SA.
The Irrwanyere Aboriginal Corporation holds a 99 year lease from the SA Government for the area of W Itjira National Park (incorporating Dalhousie Springs) that provides rights for occupation, management and tourism enterprises development. Its administrative base is Alice Springs and the majority of its members are Aputula based although others come from Oodnadatta and Port Augusta (SA). Its residential interests span the SA/NT border in the Simpson Desert and combine out-stations occupied and listed below. A large amount of emphasis is placed on training initiatives to allow people to take up residence and be involved in the management and commercial development of the W Itjira National Park. Amongst its greatest difficulties in servicing the essential needs of its members is dealing with cross border issues such as two state authorities and Commonwealth authorities. Efforts towards addressing emergency health issues have been made to RFDS and Pika W Iya (Aboriginal Health Service in Port Augusta). The RFDS will provide a W hile Box to be held at Dalhousie Springs if Irrwanyere Aboriginal Corporation pay for it (it would be restocked from SA Health in Oodnadatta). The limit of Pika W Iya’s outreach support appears to extend to Oodnadatta. Lack of reliable health supports limits confidence to take up opportunities available. Irrwanye see a visiting health service out of Aputula as the best option until a clinic can be established within the W Itjira National Park at 3 o’clock Creek.
Anacoora Bore/Alpawerke
Location: 160km SE (7km N SA border). Category 7.
Dakota Bore/ Pmer-Ulperre
Location: 170km SE (4km N of SA border). Category 7.

The following out-stations, represented by the Irrwanyere Aboriginal Corporation, are associated with Aputula but are in South Australia.
Oasis Bore
Anniversary Bore

Dalhousie Springs

Three O’clock Creek
Location: 160km SE of Aputula, 10km W of Dalhousie Springs. Proposed resource centre site for the above out-stations. Bore recently drilled and equipped. No telephone.

Opossum Bore
Location: 150km SE of Aputula, 20km W of Dalhousie Springs. Category 7. This will be occupied from Oodnadatta. Other out-stations in this zone, which have Aputula ties include:

Wapirrka/Victory Downs
Location: excision of Victory Downs Pastoral Lease. Infrastructure in place although water quality is an issue. Two families are involved. Population 15. Category 3. Proposed excisions, which have an agreement-in-principle and are expecting title in two years include:

Erdunda
Umbeara (Aputula & Ernabella ties)
Andado

Watarrka-Kings Canyon Area
There is no central community. Watarrka, which is the tourist resort, is where the clinic and staff accommodation has recently been built. All communities receive a visit for ½ a day a week by a nurse, a medical officer visits the out-stations 2/12 and is at the clinic 1/12.

Other out-stations in this zone, which have Aputula ties include:

Ukaka

Upanyali

Wanmara

Lilla

Other out-stations which have been established out of Alice Springs in the Henbury locality, which is west of the Stuart Highway are serviced by Ngurratjuta Corporation’s out-station resource centre. They include:

Pertarratenge/Boomerang Bore

Ilpurla/Cave Hole Yard/Pantyinteme/Armstrong’s place

Akanta/No 5 Bore

Illamurta/Illamurta Springs
Location: SW of Alice Springs via Kings Canyon and Tempe Downs roads. Established out of W allace Rockhole but may have relocated to Ilpurla. Rehabilitation centre for petrol sniffers and young offenders.

Imanpa
Location: 260km SW of Alice Springs. Located in the Papunya ATSIC region and CLC region 2.
Population: 160
Languages: Luritja, Pitjantjatjara, Yankunytjatjara

Land tenure: the community is located on an excision of Mt Ebenezer cattle station, has the Pastoral Lease for Angus Downs Station and owns the Mt Ebenezer roadhouse.

Communications: Telephone, fax
Current Health Services:
Staff: 1 male and 2 female AHW (1 trainee), 1 nurse.
Clinic: adequate
Vehicles: 1 troop carrier and 1 purpose built ambulance
Staff accommodation: 2 bdr house
Airstrip: day use only, road not accessible in the wet
Visiting Services: medical officer visits 1 day per fortnight

Lindervale - Out-station of Imanpa.

Other out-stations in this vicinity include:
Waju (Mt Cavenagh) - resource base is Ernabella, SA. Category 3.
Wanakula (Rocket Bore) - resource base is Amata/Ernabella, SA. Category 1.

Mutitjulu
Location: 460km SW Alice Springs. It is in the Papunya ATSIC region and CLC region 2.
Population: 200
Languages: Pitjantjatjara, Luritja, Yankunytjatjara
Land Tenure: Freehold Title
Communications: Telephone, radio, fax
Current Health Services:
Staff: 3 female & 1 male AHWs, 1 male nurse/administrator, 1 female nurse, 1 male cleaner, 1 female administration & clinic support
Clinic: good
Vehicles: 1x4WD SW. Service would like to have a separate AHW vehicle
Staff accommodation: 1x2 bdr house in fair condition, 1x3 bdr house in good condition
Airstrip: day & night
Visiting Services: medical officer visits 21/2 days every 3 weeks, optometrist 3/12, physiotherapist 3-4/12.

Mutitjulu has a high number of visiting clients – 35%.
Out-stations which have had limited developments have intermittent use. We understand they are currently unoccupied. They include:
Alyapa Kulpitjata Kurily
Mantarau SW Pirrpakagarin W Puka SW
Umbeara Umutju SE W altitjata
W anatjuku Tjuku S Yulara Pulka 17km

KALTUKATJARA/ DOCKER RIVER
Location: 720km SW from Alice Springs, 10km from WA border, road not accessible in all weather. These communities are in the Papunya ATSIC region and in CLC region 2.
Population: 240
Languages: Pitjantjatjara, Ngaatjatjarra, Ngaanyatjarra
History: a permanent settlement was established here in 1967-8
Land Tenure: Freehold Title
Communications: Radio, telephone, TV
Current Health Services:
Staff: 1 male, 3 female AHW s, 1 female nurse
Clinic: needs upgrade
Vehicles: 1 4x4wd station wagon
Staff accommodation: 1x3bdr house, 3x1 bdr flats
Airstrip: day use only
Visiting Services: medical officer visits 2 days per fortnight
Out-stations that have no health resources or a regular visiting service include:
Eagle Valley
Location: Population 5-10. Category 3.
Wankari
Location: S. Population 2-5. Category 3.
Kunapula
Location: S. Population 6.
Umputjuta
S. Category 6.
Tjunti
Location: E. Population 12.
Tjununta
Population 20.
Puta Puta
Little Puta Puta
Location: Population 10.
Ngankurr
Location: SE. Population 10. Category 4
Karu Kali
Location: SE. Category 6.
Kulung
Location: W. Category 2.
Mulga Green
Pikakatal
Location: SE. Population 7.
Punritjanta
Location: NE. Category 6.
Wataru
Tjuawata
Undooloo
Walu
Location NE. Population 5.
Tjitjnardi
Category 6.
Pitalu
Category 6.
Walka
S. Category 6.